PURPOSE

This document provides guidelines for the care of patients with a newly inserted PICC and for ongoing care and maintenance of the PICC.

YOUR PATIENT HAD PICC INSERTED TODAY…

1. **RECORD** external length of the PICC catheter on the Central Venous Line (CVL) Flowsheet. Obtain this information from the Central Venous Access Device Insertion Record.

2. **CHECK** the markings on the catheter to ensure the external length is consistent with the insertion record. PICCs can easily slip in and out especially when first inserted and serious complications can occur if the line is not in the correct place. Contact IV team if the external length has changed.

3. **ENSURE** new IV lines are hung as per Administration Set Priming and Loading procedure. Never use old IV tubing from a peripheral intravenous line or another central line on a PICC.

4. A **SAFETY CLAMP** (metal bulldog clamp with gauze package) should be with the patient at all times, and “clamp, cover and call” reviewed with the family prior to leaving the unit with the patient.

5. **EXPECT** there to be blood at the insertion site because the introducer for the insertion of a PICC is larger than the PICC itself. It takes time for the skin to heal around the site. It is most important that the blood have adequate time to clot and dry so the skin can heal. Radiology will sometimes place gauze over the insertion site to help stop the bleeding and occasionally it may be necessary to apply pressure or wrap pressure gauze around the site to help limit the bleeding. On occasion the bleeding will cause the dressing to lift off or blood will leak around it, if blood is noted outside of the dressing **CALL** IV team to change the dressing.

6. When a PICC is inserted in radiology, regardless of how old the patient is, it can be used immediately, as placement is confirmed at time of insertion. Infants under 1 year of age require a repeat X-ray to reconfirm placement in 4-6 hours as there is a risk that the PICC may migrate deeper into the circulation as the small veins relax. If migration has occurred the MD will order the catheter to be pulled back the required distance for proper placement. This will be done by the IV team - **ENSURE** CVL Flowsheet and kardex are updated with the new exit marking.

YOUR PATIENT HAS A PICC …

1. Be aware of the **external length** of the catheter. There are small black markings starting at “0” for every cm and actual #s for every 5 cm. If the external length is not recorded on the CVL Flowsheet, it can be found on the insertion record. Note this information on the CVL Flowsheet and kardex. If inward migration of the catheter has occurred it can be pulled back to the external length recorded on the insertion record. If outward migration has occurred the catheter may not be advanced forward. Assess the external length with hourly IV site checks. If the length has changed, contact the IV team. An x-ray may be required to check tip placement.

2. **ENSURE** that the PICC dressing is intact; the entire line should be covered. Re-enforce the dressing with another transparent dressing if edges are lifting. Do not apply any tape to the transparent dressing as it can cause lifting. A stockinette can also be used to help protect and cover the dressing.

3. **Blood sampling** from a PICC will be done using Syringe Method only from:
   - Single PICCs 3 French or larger
   - Double PICCs 4 French or larger using the larger lumen for sampling
     - e.g. 4 French double PICC has a 3 French (20 Gauge green label) lumen, and a 2 French (23 gauge blue label) lumen. **Use the 3 French lumen for drawing blood.**

4. **PICC dressings** are changed by the IV team every 7 to 10 days, the IV team keeps track of the date that it is due. It is the responsibility of the bedside RN to call IV team when the dressing is soiled or
falling off for PRN dressing changes. Cuffed PICC dressing changes can be performed by RNs with central line competencies in the same manner as changing a CVL dressing.

5. **ASSESS** patient’s skin integrity around and under the PICC dressing with hourly site-to-source checks. NOTE any swelling, redness, or breakdown. If the patient has had a skin reaction to the CHG Gel pad or any transparent dressing, a silicone or gauze dressing may be necessary. Do not remove silicone or gauze or “peek under” when doing hourly checks as this will impede the sterility of the dressing. **OBSERVE** the dressing for securement or any leaking as part of you site to source check. The IV team will check the exit site and document with dressing changes. Gauze will be changed every 1 – 2 days and silicone dressings weekly. Betamethasone cream may be required daily for severe reactions. See: Management of dressing related contact dermatitis.

6. **ASSESS** for presence of phlebitis using the Infusion Nursing Society Phlebitis Scale.

7. **DOCUMENT** assessment, care, complications and interventions on CVL flowsheet and other pertinent documents as required.

8. **Positive Pressure caps** are changed by the bedside RN every 96 hours, every 24 hours for TPN and 4 hours for blood products and prn as per policy and procedure - Initiating or Changing the Needleless Connector. A good time to do this is with tubbing changes.

9. If patient leaves the unit for any reason without an RN, the family/patient/caregiver (e.g. porter, physiotherapist, and teacher) must know Central Line Emergency Procedures and have emergency equipment available to them (gloves, clamp, gauze).

10. If patient may be discharged home with their PICC line or need home IV, **NOTIFY** the IV team as soon as possible so PICC teaching with the family can be done in a timely manner. This includes patients being transferred to other facilities as we provide information for the receiving institution.

11. **If the PICC breaks, it can be repaired.** When an IV team member is not available, a temporary repair must be done to maintain catheter patency. Follow instructions as outlined in the Temporary Repair of Central Lines Procedure. Contact an IV team to arrange for a permanent repair.

12. The extension tubing connects to the hub of the PICC line to prevent tension on the catheter from the weight of the IV tubing. The extension tubing is placed on the PICC during insertion and is consider part of the line and is not changed regularly. If the extension tubing leaks or breaks it will need to be changed.
   a. Clamp the catheter using the emergency clamp (this may be applied overtop of the dressing or the dressing may need to be partially lifted to properly clamp the catheter).
   b. Open the new extension set, apply a positive pressure cap and prime the cap and tubing using a 10 mL Normal Saline syringe.
   c. Scrub the connection between the PICC hub and the old extension tubing for 30 seconds with an alcohol/chlorhexidine swab.
   d. With a second swab clean up the tubing, with a third swab clean down the tubing, discard swabs.
   e. Remove the old extension tubing and apply the new tubing, remove the clamp and flush with 9 mL NS.
   f. Remove syringe and connect IV tubing to positive pressure cap, resume IV infusion.
   g. Document extension tubing change on CVL flowsheet.

**REFERENCES**
