POLICY

PICC dressings are changed on a PRN basis by a PICC Certified Doctor of Medicine (PCMD) or PICC Certified Registered Nurse (PCRN) and RN’s who have been specifically certified for PICC dressing changes.

- PICC dressing change is a two person procedure.
- The bedside nurse is responsible for identifying the need for a PICC dressing change and for providing assistance during the dressing change.
- The PICC dressing is changed when:
  - The transparent dressing is non-occlusive within 1cm of insertion site
  - Insertion site is inflamed
  - There is an accumulation of fluid beneath the dressing
  - The entire catheter or a portion of the catheter is exposed

Applicability: PICC dressing change occurs within the Neonatal Intensive Care Unit

PROCEDURE

Gather Equipment

1. Dressing change tray
2. Mask
3. Sterile gloves
4. Dexidin 2 solution (2% chlorhexidine with 4% alcohol)
5. Sterile cotton tipped applicators
6. Sterile wound closure strips
7. Transparent dressing
8. Sterile 0.9% NaCl or sterile water non-injection vials (for rinsing of skin)
9. Sterile forceps and scissors set
10. Sterile drapes
11. Sterile gauze (2”x 2”)
12. PICC securing device
13. Sterile single clear glove (for the assistant)

- PCMD, PCRN or Registered Nurse specifically certified for PICC dressing changes
- Assistant: Registered Nurse

Preparation

1. Check registry for PICC position
2. Obtain an assistant for the procedure
   - Assistant must also put on mask and wash hands
   - Assistant will provide facilitative tucking and developmental support care to help reduce stress
3. Clean working surface with Cavi wipes
4. Put mask on. Wash hands for one minute
   Open dressing tray and add necessary supplies. Prepare a single disposable sterile glove within reach of assistant

Dressing Change Procedure

5. Place sterile drape under PICC site
6. Assistant - put on single sterile glove
- Assistant needs to secure PICC at insertion site when old dressing is removed with sterile glove

7. Remove and discard old dressing
- Loosen opposite corners of the dressing
- Stretch and pull the dressing horizontally and parallel to the skin while placing pressure on the insertion site to prevent catheter from slipping
- Use counter-traction to stretch and pull away from the insertion site

8. Assistant - secure catheter at insertion site with single sterile gloved hand
- PICCs are not sutured, the assistant is essential to help keep the line in place

9. Confirm catheter position
- Verifying the catheter position helps to determine if a repeat x-ray is required to reconfirm tip location
- If x-ray is repeated, document changes in position on the “NICU Arterial and CVC Insertion Registry”

10. Assess PICC site for redness, swelling, tenderness or drainage.
- Culture site if ordered
- Call physician to assess if significant drainage is noted.

11. Wash hands again and put on sterile gloves

12. Place sterile field under insertion site

13. Initial clean around insertion site covering minimum of 1 centimeter (cm) radius and areas of skin where catheter will be in contact. Remove any crusting and discharge.

14. Clean for skin antisepsis with Dexidin 2 solution for 30 seconds and let dry for up to 60 seconds.
- For infants ≤ 1000gm:
  - Cleanse site for 30 seconds
  - Allow solution to dry on skin for 60 seconds
  - Remove residual solution using sterile NS or sterile water prior to redressing PICC. NICU Skin Antisepsis protocol
15. Secure and dress PICC with these steps:
- Place an “X” with trimmed wound closure strips over the insertion site. Do not use chevron technique.
- Slightly loop external portion of catheter.
- Secure remaining external catheter with a single wound closure strip to stabilize PICC if necessary.
- Transparent dressings are placed over the insertion site and over remaining external catheter. Do not encircle transparent dressing around limb. Do not use gauze under transparent dressing, use sterile foam or hydrocolloid.

16. **Securing Device**:
If a securing device is in situ:
- Clean catheter on device with chlorhexidine. Let dry.
- Replace transparent dressing over device.

If the securing device requires changing:
- Remove PICC hub from device.
- Unsnap catheter from old device.
- Remove device from skin using gauze dampened NS or sterile water.
- Discard device.
- Cleanse skin site for device with Sterile 0.9% NaCl or sterile water and let dry completely.
- Snap the PICC hub onto the posts of the securing device with arrows pointing in the direction of venous flow towards the heart (figure 6).
- Remove device backing and secure to skin. Place transparent dressing over the device site (figure 6).
- Do not use a limb board to secure a PICC because it can result in decreased range of motion or contractures in the extremity.

**Documentation**

- Update the PICC registry under the “Dressing Change” section.
- Arterial and CVC Daily Maintenance and Tracking Log.

A PICC securing device is used to hold the “butterfly wing” hub of the PICC and prevent movement of the line.

Place device with “arrows” pointing towards the heart.

Always snap PICC hub onto the device posts before adhering the device pad onto the skin.

Never use a limb board to enhance PICC securement because it limits mobility of limb.
REFERENCES

Arterial and CVC Daily Maintenance Tracking Log. BC Women’s.


NANN Peripherally Inserted Central Catheters: Guideline for Practice, 3rd edition

Neonatal Policy Manual Peripherally Inserted Central Catheter Policy (PICC)

Neonatal Policy Manual NICU Arterial and Central Venous Catheter Registry

Neonatal Policy Manual Skin: Antiseptic Protocol


Neonatal Program Peripheral inserted central catheters supplemental education package. Vancouver, Women’s Hospital of British Columbia.


