04-0408 – Pre-Existing Vascular Access Devices - PVAD

Authority

Health and Safety Code Division 2.5, California Code of Regulations, Title 22, Division 9

Purpose

1. To provide intravenous access via a pre-existing access catheter/port.
2. When a life threatening patient condition exists establish peripheral IV or IO for immediate access as to not delay care/resuscitation.
3. Only MICPs and MICNs with previous PVAD skill training may attempt PVAD access.

Definition

1. Pre-existing Vascular Access Device (PVAD): A PVAD is an indwelling catheter/device placed into the lower aspect of the superior vena cava to provide vascular access for those patients requiring long-term intravenous therapy or hemodialysis.
2. Central Chest Lines: Catheters that are tunneled subcutaneously into the subclavian vein from a point on the anterior chest wall that terminates into the lower Superior Vena Cava.
3. PICC Line or Mid-Line: Peripherally Inserted Central Catheter usually inserted into the lower Superior Vena Cava via the antecubital vein, basilic vein or cephalic vein.

Precautions

1. Personal protective equipment.
2. Consider the patient or reliable family member as a source of information about their lines and IV access catheters.
3. Contact base hospital physician prior to discontinuing pre-existing IV medications.
4. Use extreme caution when discontinuing an IV infusion containing chemotherapy to minimize exposure.
5. Aspirate the contents of the line and discard before flushing. Some medications (Dobutamine, narcotics, etc.) may cause a serious adverse reaction if flushed into the patient line, resulting in an unwanted bolus.
6. If any doubt with catheter/ PVAD establish peripheral IV access or IO.

Procedure - Central Chest and PICC/Mid-lines

General Instructions

1. Wash hands thoroughly and/or cleanse with alcohol/hand sanitizer.
2. Don clean gloves.
3. NEVER USE A SYRINGE WITH LESS THAN A 10 ml BARREL for flushing or administering medications through PVADs.
4. Prepare medication and normal saline flush, or IV solution and tubing using 18-gauge one (1) inch needle and purge all air from lines and syringe.
5. Cleanse cap with three (3) Betadine swabs; allow 90 seconds drying if time allows. Follow with three (3) alcohol swabs and allow drying if time allows. Never blow on or wave a hand to facilitate drying.
6. Administering Medications:
    a. Flush with 10 ml normal saline, if medication is being administered to patient. If resistance is met when trying to inject, reclamp catheter and do not use.
    b. Administer IV medication. All Central Catheter Lines shall be connected via a luer lock configuration to prevent inadvertent disconnection.
    c. Avoid using excessive pressure when injecting medication into the line to avoid rupturing the line.
    d. Flush well with 10 cc NS following each medication administered. Remember, speed of flush will determine speed of medication bolus; flush slowly if you want the medication to infuse slowly, flush rapidly if you want the medication to infuse rapidly or it is not contraindicated.

Procedure - Sterile Dressing Change

The Central IV Line requires a sterile dressing. Some physicians may allow a clean dressing (or no dressing) once tissue has grown into the cuff, which usually occurs several weeks after insertion. If dressing becomes contaminated or is inadvertently detached, perform the following:

1. Wash hands or cleanse with alcohol swabs.
2. Don clean gloves, remove existing dressing and discard appropriately.
3. Inspect site for redness, swelling or drainage.
4. Don sterile gloves.
5. Using iodine swabs, cleanse exit site rotating in a circular method from inside outward approximately four (4) to six (6) inches. Do this three (3) times.
6. Repeat the above step with alcohol swabs. Allow to dry.
7. Cover site with transparent membrane or sterile gauze.

Documentation

1. In PCR, note date, time and location of pre-existing line or port.
2. Notify receiving caregiver of pre-existing line or catheter.