A. CVC Catheter Care Procedure:

1a. Hub Entry - Use for the following procedure: Continuous Infusion Administration Set Change

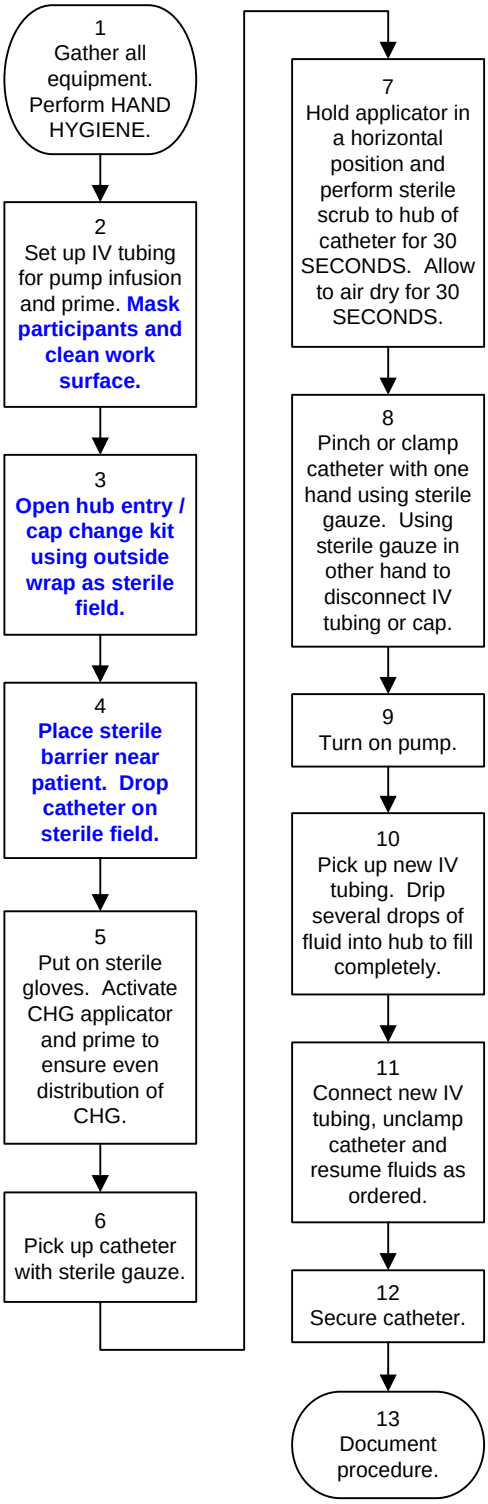
Equipment:
* Sani-Cloth™ to clean work surface
* Hub entry / Cap change kit (CHG Frepp Applicator, 4X4's, sterile gloves, mask, cap, sterile barriers)
* Primed 72 hour administration set with sterile device to protect end of tubing

POLICY:

1. △ **All Primary and Secondary CONTINUOUS Administration Set tubing and add on devices (ports, t-pieces and stopcocks) MUST BE changed:**
   - **a) Every 72 hours**
   - **b) Immediately upon suspected contamination**
   - **d) When the integrity of the product or system has been compromised**
2. **Continuous Infusion Systems are connected directly to the catheter hub without a cap.**
   - △ **Exceptions: Lipid Emulsions**
   - **a) Secondary IV tubing used for administration of lipid emulsions MUST BE changed within 24 hours of initiating the infusion.**
   - **b) Attach lipid tubing to the closest junction on the administration set to the catheter hub.**
3. Prime all IV fluids using caution to protect sterility of fluid pathway, add sterile end cap.
4. ☞ **The number of entries into a CVC MUST BE kept to the necessary minimum to prevent catheter related complications.**
5. A 30 second CHG scrub followed by a 30 second air dry MUST BE performed at the junction being opened prior to any entry into the IV system between the CVC hub and the pump or manifold.
6. All open ports, stopcocks MUST BE covered with an approved injection cap when not accessed with continuous fluids or medications.
7. IV tubing and bottles/bag that have been infusing through a peripheral catheter MUST NOT BE connected to a CVC system.
8. ☞ **Sterile pre-filled syringes may be added to the sterile field of the hub entry / cap change procedure.**
9. △ **10mL size syringes should be used for flushing a CVC per manufacturer recommendations.**
10. ALL connections on a CVC, tubing and add on devices, MUST BE luerlocked.

NURSING GUIDELINES:

1. ☞ **Check each IV fluid container with MAR or MD order for CORRECT: patient, medication, concentration, IV fluid and rate of flow.**
2. All CVC entries should be documented.
3. Any discontinued medication or fluid should be removed from the IV system, unless nursing judgment or physician order deems otherwise. Precede removal with:
   - A 15 second alcohol scrub for any junction at or above the manifold.
   - A 30 second CHG scrub followed by 30 seconds air dry for ANY junction below the manifold, to and including, the catheter hub.
4. Dextrose concentrations 12.5% and greater MUST BE infused through a CVC; Dextrose concentrations that are less than 12.5%, may be infused through a peripheral IV or CVC that is peripherally placed.
5. 2 Fr catheters or smaller infusing at a low rate may require heparin to be added to the fluid. PHYSICIAN ORDER IS REQUIRED. (See Appendix VII.)



SAFETY GUIDELINES:

1. Hemostats MUST NOT BE used on a PICC or the hub, to prevent catheter injury.
2. Secure catheter using securement device as indicated for patient activity and developmental level.
3. Eliminate any air within IV system during priming of fluids.
4. PRIOR to line change, give consideration to medications that are remaining in the tubing; consider appropriate adjustments before performing line change.
5. CVC administration system and site should be checked hourly and assessment of the invasive line completed and documented at the beginning of each shift.
6. It is preferable to limit IV stopcock use with administration systems. If stopcocks are needed, the prefabricated manifold system is preferred.
7. Whenever a continuous infusion MUST BE interrupted, the end of the system MUST BE protected with a sterile device and maintained in a clean, safe area.

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