I-200 Central Line Dressing Change

Purpose

Inspect the catheter and insertion site.

Assure catheter integrity.

Prevent infection.

Applies To

Registered Nurses

Licensed Practical/Vocational Nurses

Other (*Identify*): _____

Equipment/Supplies

- Central line dressing change kit.
- Alcohol swabs.
- Povidone swab stick.
- Sterile injection cap.
- Appropriate flush (heparin 100u/ml or saline).
- Disposable sterile gloves.
- Sterile gloves.

Special Considerations

Sterile dressings are required on central line sites until the exit site is well-healed. Either gauze or transparent dressings are acceptable. Gauze dressings are changed every 48 hours. Transparent dressings are changed at least weekly, or whenever they become loose or wet.

Dressings are routinely changed twice a week. Frequency may be decreased to once a week with physician's order and the client's compliance with reporting signs of inflammation, dislodged or loose dressing.

Antimicrobial ointments are not routinely used unless specified in the physician's order.

Transparent, semi-permeable dressing is routinely used.

The Registered Nurse will determine if it is appropriate to teach the client to do his/her own dressing change. If the client is to do the dressing change, written and verbal instruction will be given to the client. The client's competency and comfort with the procedure will be evaluated.

With each dressing change, a new injection cap will be placed and the catheter flushed per protocol.

The greatest risk of catheter dislodgement occurs during the first few weeks after catheter insertion. Clients require instruction to avoid pulling on the catheter, and to be alert for signs of dislodgement, such as a greater length of catheter being visible or the Dacron cuff being extruded.

Procedure

1. Explain the procedure to the client. Position the client for comfort.
2. Wash hands. Refer to the Hand Washing procedure.
3. Assemble equipment and prepare flush.
4. Open dressing change kit and put on mask.
5. Apply non sterile gloves and gently remove old dressing, being careful not to dislodge catheter.
6. Examine the catheter insertion site for signs of redness, swelling, inflammation, and tenderness.
7. Inspect the catheter and hub for any evidence of kinked or weakened areas, loss of integrity, or changes in the length of exposed tubing.
8. Discard old dressing and remove non-sterile gloves and dispose.
9. Apply sterile gloves.
10. Clean catheter site with alcohol swab sticks three times, starting from exit site and moving outward in circular motion to cover an area 10 cm in diameter.
11. Follow three times with Povidone swab stick.
12. Let Povodine air dry. Do not wipe off.
13. Clean length of the catheter from exit site to tip two times with alcohol swab.
14. Redress the site with sterile transparent dressing, sealing catheter in straight position. *Do not coil the catheter.*
15. Anchor catheter to the client's skin using tape. Avoid placing tape on transparent membrane.
16. Using alcohol swab, clean old injection cap and catheter end.
17. Make certain the catheter is clamped (unless GROSHONG) and remove old cap. Wipe the end of the catheter with alcohol swab for 30 seconds.
18. Replace new cap. **Refer to Cap Replacement Procedure.**
19. Flush vigorously with appropriate flush. Refer to Flush Procedure.
20. Wash hands. Refer to the Hand Washing procedure.

Documentation Guidelines

Document in the clinical record:

1. The appearance of the site.

2. The client's tolerance of the procedure.
3. The patency of the line and the flush used.
4. The date and time of dressing change.

Related Procedures

PICC Line Dressing Change

Policy History

Approval Date Approved By	11/1/2009 Anne Tyson, Herman Pippin, Sandra Hill
Revision Date Approved by	12/31/2009 Anne Tyson, Herman Pippin, Sandra Hill
Revision Date Approved by	
Revision Date Approved by	