Procedure: Central Venous Access Devices - Dressing Change

Approved:

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**CVAD DRESSING CHANGE**

**Essential Information**
1. Intravenous Therapy, Blood Draws via a VAD, and Venipuncture Competency required.
2. Change initial dressing 24 hours after CVAD insertion.
3. When using a transparent dressing and cleaning with chlorhexidine/alcohol applicator, change every 7 days.  
4. When using a transparent dressing and cleaning with povidone, change every 3 days.  
5. Dressings that are non-transparent or have gauze inside must be changed and site inspected every 48 hours.  
6. Change dressings on an as needed basis if dressing is loosened, soiled or compromised.  
7. Chlorhexidine may cause a chemical burn if it is not allowed to completely dry prior to application of skin prep or dressing.  
8. For lines placed in the operating room or in an outside facility, external length is documented in the VAD Observations Flowsheet with first dressing change 
9. See CVAD Dressing Selection Guide.

**Equipment List**
1. Mask  
2. One pair non-sterile gloves  
3. One pair sterile gloves  
4. Sterile barrier  
5. One chlorhexidine/alcohol applicator (ChloraPrep)  
6. Two alcohol pads (for tunneled catheters)  
7. One protective skin barrier swabstick or pad (recommended)  
8. Sterile occlusive or transparent dressing  
9. One 4x4 Gauze  
10. Adhesive remover (optional)  
11. Sterile anchoring device (i.e. Stat-lock and/or steri-strips), as needed  
12. Sterile cotton tip applicator or sterile tongue depressor (optional)  
13. Tape measure  
14. Securing material (tubular bandage, tape, compression bandage)

<table>
<thead>
<tr>
<th>STEPS</th>
<th>KEY POINTS</th>
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<tbody>
<tr>
<td>1. Check documentation for previous external catheter length measurement.</td>
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<td>2. Put on mask</td>
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<td>3. Perform hand hygiene</td>
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<td>4. Set up sterile field with supplies.</td>
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<td>5. Put on non-sterile gloves.</td>
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<td>6. Instruct patient to put on mask or turn face away from exposed site.</td>
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<td>7. While stabilizing catheter, remove old dressing and anchoring device from edges to exit site.</td>
<td>7. A sterile cotton tip applicator or tongue depressor placed on the PICC line may help stabilize the catheter while the dressing is being removed.</td>
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<td>8. For PICC lines, remove dressing in the direction of the catheter towards the shoulder to help prevent accidental dislodgement of catheter.</td>
<td>8. PICCs are usually not sutured in place and require careful removal of dressing to prevent catheter migration.</td>
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<td>9. Inspect the catheter exit site, tunnel integrity, surrounding skin, and/or track of the vein for skin and suture (if applicable) integrity, signs and symptoms of infection, redness, swelling, and bleeding.</td>
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10. Notify LIP of abnormal findings.

11. Remove non-sterile gloves and put on sterile gloves.

12. With sterile gauze, grasp catheter with non dominant hand, lifting catheter to allow for better cleansing.

13. Clean the exit site and surrounding skin with chlorhexidine/alcohol applicator using a bidirectional scrub.

14. For tunneled catheters, clean the catheter with an alcohol pad by anchoring catheter at exit site and gently wiping from proximal to distal end of catheter.

15. Swab the area that will be underneath the adhesive dressing with protective skin barrier and allow to dry (recommended).

16. Secure the catheter with anchoring device (i.e. stat-lock) to provide stability and prevent catheter migration.

17. For non tunneled percutaneous catheters, an anchoring device (i.e. Stat Lock) is required.

18. Additionally, PICCs, Hickman and midline catheters should be looped if length allows, insuring additional security. Loop the catheter towards the shoulder, avoiding the antecubital fossa.

19. Apply transparent dressing over catheter site. Form an occlusive seal by pinching the adhesive portion of the dressing around the catheter.

20. For percutaneous catheters, measure length of the catheter from insertion site up to the area of the catheter that starts to widen (also called the ‘body of the catheter’).
21. If the catheter has migrated in or out 2 cm, notify LIP for possible X-ray confirmation of the catheter tip location.

22. Provide additional stability by securing the catheter extension tubing with tape, tubular bandage, or compression bandage.

23. Remove gloves and mask, and perform hand hygiene.

24. Label the dressing with the date, time and initials.


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References:

8. ONS Guidelines 2012.

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Contributing Standards or Practice, Procedure, or Guides

1. CVAD Dressing Selection Guide, NPCS 2/16/2012