THE STUDY VAULT

Clinical Chaos

PICC Lines

SKILL SNAPSHOT

Purpose
- Maintains safe long-term central venous access through a peripherally inserted catheter while preventing infection, occlusion, and

When to use
- Ordered central access for prolonged IV therapy, vesicants, irritants, TPN, antibiotics, or frequent blood sampling.

Supplies needed
- Antiseptic; sterile caps/dressings as needed; preservative-free flush; syringes; securement; labels; PPE; measuring tape.

PREP + PATIENT SETUP
- Verify line type, lumen count, tip confirmation, indication, orders, and restrictions.
- Assess site, dressing, securement, external length, arm circumference if required, and catheter function.

VAULT TIP
- Every PICC check has four parts: site, length, securement, and function.

STEP-BY-STEP
1. Hand hygiene; identify patient; explain care and position arm comfortably.
2. Inspect insertion site and entire arm for redness, drainage, tenderness, swelling, warmth, streaking, bleeding, or leakage.
3. Compare external catheter length with baseline. Do not advance a migrated catheter back into the vein.
4. Assess dressing integrity and securement. Change loose, wet, soiled, or nonocclusive dressings promptly using sterile technique.
5. Before every access, disinfect the needleless connector with vigorous friction for the policy-specified time and allow it to dry completely.
6. Use a new sterile device for each access. Maintain a closed system and minimize connections.
7. Check patency using facility-approved flush technique and correct syringe size. Never force against resistance.
8. Clamp and sequence flushing according to catheter/connector type; use prescribed volume and positive-pressure technique when required.
9. Trace all infusions, verify compatibility, and use the appropriate lumen. Keep TPN or other ordered therapy dedicated.
10. Secure tubing to prevent traction; avoid BP cuffs, venipuncture, and constriction on the PICC arm when policy directs.
11. Monitor for infection, thrombosis, occlusion, rupture, migration, phlebitis, and air embolism.
12. Reassess ongoing need daily and remove promptly when no longer necessary by trained personnel/order.

SAFETY REMINDERS
- Never force flush or reinsert an externalized catheter.
- New arm/neck swelling, pain, dyspnea, chest pain, or line dysfunction requires urgent evaluation.
- Use strict aseptic technique for every access.
- Do not use scissors near catheter.

COMMON MISTAKES
- Skipping external-length check.
- Accessing before antiseptic dries.
- Using excessive force.
- Leaving a loose/wet dressing.

DOCUMENTATION
- Site/arm assessment and external length.
- Dressing/securement condition.
- Patency, flush, blood return per policy.
- Connector/tubing changes and infusions.
- Complications, teaching, notifications.