	The Johns Hopkins Hospital Nursing Practice and Organization Manual Vol II: Clinical Protocols and Procedures	<i>Policy Number</i>	GEN341
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	<i>Subject</i> IV Therapy: Central Venous Access Device (VAD), Dressing Change Procedure	<i>Page</i>	1 of 3
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Keywords: hemodialysis, hemepheresis, dressing, dressing change, VAD, vascular access device, PICC

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I. EQUIPMENT


Equipment	Source
Chlorhexidine Gluconate 2% w/ Isopropyl Alcohol 70% (CHG)	Unit
Sterile gloves, appropriate size	Unit
Clean gloves, appropriate size	Unit
Transparent dressing of appropriate size or gauze dressing	Unit
Skin Prep	Unit
Tape for gauze dressing, if applicable	Unit
Cone mask for patient (note: cone mask is not fluid resistant)	Unit
Mask for nurse	Unit

II. RESPONSIBILITY

- A. Only nursing personnel who have demonstrated competency may perform a central VAD dressing change.
- B. If changing PICC dressing with StatLock®, see PICC with StatLock® dressing change procedure.
- C. Refer to VAD policy, Dressing Changes, for frequency of dressing changes and options for types of dressing, frequency and cleansing agent based on clinical conditions. www.insidehopkinsmedicine.org/icpm/IFC035-VAD.html.

III. PROCEDURE

- A. Wash hands
- B. Apply mask to patient. (for dialysis, pheresis and Oncology patients)
- C. Don mask. (for dialysis, pheresis and Oncology patients)
- D. Don clean gloves
- E. Remove old dressing.

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1. Visually inspect insertion site of catheter for signs of infection, being careful not to touch site with gloved hand.
 2. Take culture, if appropriate.
- F. Remove gloves.
- G. Open sterile gloves and create a sterile field using sterile glove package.
- H. Open Chlorhexidine Gluconate 2% w/ Isopropyl Alcohol 70% swab and drop onto sterile field.
- I. Open transparent or gauze dressing and drop onto sterile field.
- J. Open skin prep and place on outer edge of sterile field.
- K. Don sterile gloves.
- L. Clean skin with Chlorhexidine Gluconate 2% w/ Isopropyl Alcohol 70% swab. Begin directly at the insertion site and move swab in a circular fashion without retracing the area already done. Use friction when cleaning area.
- M. Allow Chlorhexidine to dry for 1-2 minutes.
- N. Using unsterile hand, pick up skin prep packet. Remove skin prep pad with sterile hand.
1. Apply skin prep on outer perimeter of skin where dressing edge will touch patient. Do not put skin prep over the catheter insertion site or the immediate surrounding area. Allow to completely dry.
- O. Apply transparent or gauze dressing per manufacturer recommendations.
- P. Remove gloves, unless indicated by isolation policy.
- Q. Label dressing with date/time/initials and if PICC dressing, length of internal/external catheter segments.

IV. DOCUMENTATION

Document dressing change and site assessment in medical record and/or flowsheet.

V. SUPPORTIVE INFORMATION

See Also:

JHH Interdisciplinary Clinical Practice Manual

- Vascular Access Device, IFC035
JHH Nursing Practice & Organizational Manual, Clinical Volume


- PICC with StatLock® Dressing Change, #343

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National Kidney Foundation. Clinical Practice Guidelines for Vascular Access: Update 2000. www.kidney.org/professionals/doqi/guidelines/doqiupva_intro.html.

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