

## What is a PICC?

### Peripherally Inserted Central Catheter

This catheter is inserted at the bedside into an arm vein (brachial, basilic, or cephalic) using ultrasound to access the vessel. The catheter is advanced to a final tip location in the superior vena cava/right atrium. The tip is confirmed by portable chest x-ray.

The PICC is available in a single, dual, or triple lumen.

The Purple Power PICC can be used for injection of CT contrast and for CVP monitoring in the ICU.

PICCs have lower complication and infection rates vs. central lines.

### Why does a Patient Need a PICC?

- Medications that are irritating to the peripheral vein
- Poor peripheral vein access
- Multiple Intravenous Infusions
- Multiple CT Scans
- CVP Monitoring
- Home / Alternate infusion
- Chemotherapy
- Total Parenteral Nutrition

## How to Schedule a PICC

Nurses staffed in-house  
7am to 7pm Monday - Friday.  
(nurses are available on-call after 7pm.)

Nurses are also available on-call all day  
Saturdays, Sundays and holidays.

Call, **414-649-5758** and leave a message, if calling after 7pm or on the weekend/holiday, press "0" the answering service will page our on-call PICC Nurse.



2901 West Kinnickinnic River Pkwy  
Suite LL9 Milwaukee, WI 53215  
tel 414-649-5775 fax 414-649-7494 pager 414-222-2905

BEDSIDE PICC PLACEMENT

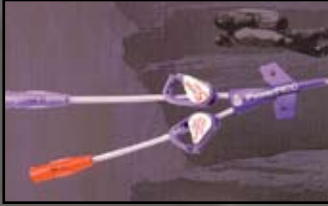


Nursing-based  
PICC Team  
Providing  
Bedside Vascular  
Access Services

## Early Assessment

### Order Early

The number one factor affecting *patient satisfaction* is the *number of needle sticks* they received during hospitalization.



### Be Proactive

Assess the drugs and diagnosis of your patient so the appropriate venous access device is provided.

### Irritating Drug Considerations

- Vancomycin
- Dobutamine
- Amiodarone
- Phenergan
- Levaquin
- Potassium
- Morphine
- Dopamine

### Diagnosis Considerations

- Septicemia
- Osteomyelitis
- Pneumonia
- Cellulitis
- Bowel disorders
- CHF/COPD

## Care and Maintenance

### Keep Your PICC Working

- 10 ml NS before and after each use or q 12 hrs when not in use
- 20 ml NS after blood draw/TPN
- Use a 10 ml or larger syringe

### Flushing Technique for Reduction of Occlusions

- “Push/Pause” flush
- Do not bottom out syringe
- Disconnect syringe during final 0.5 ml, then clamp

### Indicators of Catheter Occlusion

- Sluggish flow
- Inability to infuse fluids
- Lack of free-flowing blood return
- Increased flushing resistance

### For Early Occlusion Indicators

- Remove cap--flush through PICC
- Use thrombolytic agent per protocol and/or call PICC Team

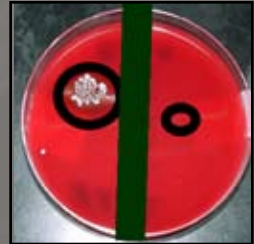
## Infection Control

### WASH YOUR HANDS

- Change Dressing, Biopatch, and Statlock every 7 days or prn if loose or soiled.
- During sterile dressing change, use Cloraprep 3ml, scrubbing site for 30 seconds. Replace Biopatch and Statlock.
- Change Injection Cap q 96 hrs, when visibly soiled, or for sluggish blood draw.

### SCRUB THE HUB

- Bacteria will live on the hub surface unless you kill them.



1. Prior to **EVERY USE**
2. Use an alcohol wipe
3. Scrub the top of the needleless connector or catheter hub
4. Rotate the alcohol wipe around the hub/connector four times



Avoid frequent peripheral IV attempts



Improve patient satisfaction