Central Line Dressing Change

Student Name:_____ Student Signature: _____

Evaluator Signature: 1st attempt_____Date:_____☐ Satisfactory* ☐ Unsatisfactory^

Evaluator Signature: 2nd attempt_____Date:_____☐ Satisfactory* ☐ Unsatisfactory^

Evaluator Signature: 3rd attempt_____Date:_____☐ Satisfactory* ☐ Unsatisfactory^

**** Critical Behaviors that need to be stated or done in order to pass the skill.**

PERFORMANCE BEHAVIORS	S*	U^	COMMENTS
Assessment			
1. Verify facility policy and procedure for central line dressing changes.			
2. **Check chart for allergies, noting tape allergies.			
3. Assess condition of patient's central line and dressing. Check if dressing is wet loose or soiled.			
Planning			
4. Identify expected outcomes.			
5. Gather necessary equipment a. Clean gloves b. Central line dressing kit c. Measurement guide *(caps and saline flush: caps would also be changed, but not for this demonstration)			
Implementation			
6. Upon entering: a. **Perform hand hygiene b. Be aware of your spatial safety, have call light within reach. c. Identify self d. **Identify patient using 2 forms of identification e. Assure privacy f. Explain what is about to occur g. Allow for patient questions h. **Ask patient if he/she has allergies and check for identifying arm band. i. Raise bed to comfortable working height			
7. Place bedside table and waste receptacle in close proximity to your work area.			
8. **Perform hand hygiene again.			
9. Don clean gloves			
10. Assess the condition of the insertion site, noting drainage, redness, or swelling. Also note if it is sutured in place. Measure amount of exposed catheter.			
11. Open sterile dressing kit and carefully lift out and apply facemask.			
12. Instruct patient to turn head away from central line (don mask for patient, if facility policy).			
13. Carefully remove dressing by pulling up corners, use adhesive tape remover. a. Stabilizing the catheter at the insertion site. b. Apply counter pressure on the dressing and stretch the transparent dressing. c. Allowing the dressing to be lifted off rather than traumatizing the top skin layers. d. If using Biopatch stabilize the catheter dressing and remove the dressing pulling toward the insertion site.			

***S=Satisfactory, ^U= Unsatisfactory**

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14. Gathering old dressing in dominant hand, remove clean gloves and dispose in waste receptacle.			
15. If a sterile drape is provided, carefully open it touching only the one inch margin, and place it on the bedside table. This becomes your sterile field. Take out your sterile gloves. Drop all other contents onto the sterile field being careful to maintain sterility. **Note:** If biopatch or tube attachment device is used, they can be dropped onto the sterile field at this time.			
16. Don sterile gloves. Maintain sterile field.			
17. Activate chlorhexidine. Beginning at insertion site, scrub back and forth using over insertion area for 30seconds. Allow to dry for 30 seconds.			
18. Open skin prep swab to wherever dressing will lie EXCEPT around catheter exit site. approximately the size of the tegaderm (transparent) dressing**.** Allow to dry completely.			
19. Avoid kinking, twisting or tension on the catheter. Peel backing off the tegaderm (transparent dressing) and apply, centering the catheter's insertion site.			
20. Label the dressing with the time, date, and your initials, being careful not to cover visibility of the insertion site.			
PERFORMANCE BEHAVIORS	**S***	**U^**	**COMMENTS**
21. Before leaving room a. Dispose of equipment b. Position patient comfortably c. Lower bed d. Raise appropriate side rails e. Leave call light and belongings in reach f. **Perform hand hygiene			
22. Document time, date, site condition, length of exposed catheter and that the dressing change was performed using sterile technique.			
Evaluation			
23. Reassess the dressing, ensuring that it is intact. Reassess the site per facility policy.			
24. Write a sample nursing note:			

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