Dressing Change
Arterial *and* Central Venous Lines

Ensure patient and health care provider safety standards are met during this procedure including:

- Risk assessment and appropriate PPE
- 4 Moments of Hand Hygiene
- Two patient identification
- Safe patient handling practices
- Biomedical waste disposal policies

1. Assess patient's ability to maintain positioning and obtain assistance as required
2. Administer analgesic or sedation as needed before starting procedure.
3. Assist others to meet dressing change standards; correct application reduces central line infection risk and usually results in less frequent dressing changes.
4. Apply CHG transparent dressing unless excessive oozing. Change Q7 days and PRN
5. Use gauze dressing for oozing site. Change DAILY.
6. Remove hair PRN using sterile clippers BEFORE skin cleansing and draping.
7. Obtain sterile Central Line and Arterial Line Dressing Tray, plus dressing, sterile gloves and Cavilon™

Dressing Change Steps:

1. Perform hand hygiene, then open dressing tray
2. Don clean bouffant, gown and mask with face shield, then perform hand hygiene
3. Prepare dressing tray aseptically. Add supplies using transfer forceps
4. Don clean gloves.
5. Remove old dressing and perform hand hygiene.
6. Don sterile gloves.
7. Drape area
8. Remove securement device if present (shovel off with a chlorhexidine swab)
9. Cleanse skin:
   i. With first swab, scrub skin in vertical direction while moving from one side to the other.
   ii. Flip swabstick over and scrub in a horizontal direction, moving swab from top to bottom.
   iii. Using second swabstick, scrub catheter tubing (entire area that will lie below the dressing).
   iv. Lift tubing, flip swabstick over and scrub undersurface of tubing.
10. Allow skin to dry a MINIMUM 2 minutes; *inadequate dry time causes of skin reactions*
11. Apply Cavilon™ (AVOID INSERTION SITE AND AREA UNDER CHG PAD). Minimum 1 minute dry time
12. Apply new securement device if indicated
13. Apply dressing by laying it over the desired area (do not stretch); pressing slowly from site toward outer edges
14. Tape catheter to prevent it from pulling on the dressing. For jugular IVs, individually taping of each lumen after looping in a downward direction helps to reduce traction on dressing.
15. Perform hand hygiene at end of procedure
16. Ensure that tracheostomy ties and cervical collars do not come in contact with dressing.
17. Document dressing assessment findings Q Shift and PRN in the Device band of the EHR.
18. Document each dressing change in the Device section of the EHR.
19. Update "date due" for dressing and IV changes in the Actions and Situational Awareness section in Nurse View of the EHR.
20. **Every member of the team is expected to remind others/stop procedures if any step is missed**

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