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CVAD = central venous access device
Note: Gauze dressing is any non-transparent dressing without CHG impregnated disc or gauze and tape.

CVAD POST INSERTION DRESSING CARE\(^1\)

**MANAGEMENT**

Is a sterile transparent dressing used?\(^1\)

- **Yes**
  - Sterile transparent dressing with CHG impregnated disc\(^2\) or for sterile transparent dressing without CHG, if clinically indicated, dressing change should occur 7 days post-insertion or if clinically indicated\(^3\)

- **No**
  - To ensure gauze dressing (see note on this page) is removed\(^2,4\), initiate dressing change within 2 days post-insertion or as clinically indicated\(^5\)

Is port accessed with needle in place?\(^5\)

- **Yes**
  - Apply sterile transparent dressing with CHG impregnated disc, unless contraindicated

- **No**
  - Is site open to air?\(^5\)
    - **Yes**
      - Dressing and needle must be changed after 7 days or if clinically indicated\(^3,5\)
    - **No**
      - Steri-Strips\(^6\) or surgical glue should not physically be removed during the first two weeks post-surgery

Post-CICC/PICC insertion

For post-procedure patient education, refer to patient education materials\(^6\)

Post-implanted venous port insertion

1 Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)
2 Best practice indicates that gauze should only be used when clinically appropriate; sterile transparent dressing with CHG impregnated disc is recommended post-insertion
3 Immediate dressing change is required when dressing becomes damp, loosened, or soiled. Refer to VAD Maintenance Care: Dressing Care on Page 3.
4 If unable to determine if gauze was placed under a non-transparent dressing, initiate VAD Maintenance Care: Dressing Care within 2 days post-insertion or as clinically indicated (see Page 3)
5 Needle change is only required if port has been accessed > 7 days
6 See Central Line (CVC/PICC) Patient Education
Vascular Access Device (VAD) Management

Note: Gauze dressing is any non-transparent dressing without CHG impregnated disc or gauze and tape.

VAD MAINTENANCE CARE: DRESSING CARE

**DRESSING TYPE AT PRESENTATION**

- CHG impregnated dressing or transparent dressing with CHG impregnated disc
- Non-transparent dressing with CHG impregnated disc
- Transparent dressing without CHG impregnated disc
- Gauze dressing (see note on this page)

**MANAGEMENT**

- Change dressing using institutional standard dressing change process at least every 7 days or as clinically indicated
- If skin or site related complications are noted, refer to Pages 9-10 for management

Note:
- For patients with CHG allergy, refer to Appendix A for Skin Prep Allergy Recommendations
  - First line: alternative bordered transparent dressing with equivalent skin prep; change every 7 days or as clinically indicated
  - Second line: non-transparent dressing with equivalent skin prep; change every 2 days or as clinically indicated

- Change dressing using institutional standard dressing change process at least every 2 days or as clinically indicated
- If skin or site related complications are noted, refer to Pages 9-10 for management

CHG = chlorhexidine gluconate

1 Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)
2 Institutional standard; considered best practice and recommended as dressing of choice for standard of care
3 Avoid non-transparent dressing in patients with implanted ports, receiving vesicants, or inability to verbalize pain or discomfort. For patients receiving a vesicant, see Extravasation Management (Vesicant and Contrast Agents) algorithm and Vascular Vesicant/Irritant Administration and Extravasation Policy (#CLN0986)
4 Immediate dressing change is required when dressing becomes damp, loosened, or soiled (i.e., dressing corners are lifted to the extent that allows access to the insertion site, or exposure of catheter wings)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care.
Vascular Access Device (VAD) Management

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VAD MAINTENANCE CARE: FLUSH MANAGEMENT - ADULT

**CATHETER TYPE**

- **PIV**
- **Adult CICC 10 French or less (excluding implanted venous ports)**
- **Implanted venous ports or CICC > 10 French (i.e., apheresis catheters)**

**History of heparin adverse events**

- **Yes**
- **No**

**MANAGEMENT**

**Flush with preservative-free (PF) 0.9% NS 10 mL before and immediately after each use, and every 12 hours when not in use**

- **Inpatient:** Flush each lumen with PF 0.9% NS 10 mL before and immediately after each use
- **Outpatient:** Flush each lumen with PF 0.9% NS 10 mL before and immediately after each use
- **Home care:** Flush each lumen with PF 0.9% NS 10 mL daily for CICC and monthly for implanted venous port

**CICC:** Heparin lock flush solution 200 units/2 mL (100 units/mL)

- **Inpatient:** Flush each lumen with PF 0.9% NS 10 mL before and immediately after each use. Flush with PF 0.9% NS 10 mL followed by a heparin lock flush solution daily for lumens not in use and upon hospital discharge.
- **Outpatient:** Flush each lumen with PF 0.9% NS 10 mL and heparin lock flush solution upon completion of treatment
- **Home care:** Flush each lumen with heparin lock flush solution daily

**Implanted venous port:** Heparin lock flush solution 200 units/2 mL (100 units/mL)

- **Inpatient:** Flush with PF 0.9% NS 10 mL before and immediately after each use, or every 12 hours when not in use. Upon discharge and deaccess, flush with PF 0.9% NS 10 mL and heparin lock flush solution.
- **Outpatient:** Flush with PF 0.9% NS 10 mL before and after each use, and heparin lock flush solution upon completion of treatment
- **Home care:** Flush with PF 0.9% NS 10 mL and heparin lock flush solution monthly

---

**Notes:**

1. Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)
2. For flushing/locking arterial catheters, dialysis catheters, or implanted peritoneal ports, follow specific institutional orders as directed by physician
3. Refer to Nursing Heparin Catheter Lock Protocol: Central Venous Access Device Patency Management (ATT3306) and Nursing Flush Protocol: Venous Access Device Flush Management (ATT3308)
4. If heparin is not available/shortage, follow the steps for heparin allergy

---

CICC = centrally inserted central catheter
PIV = peripheral intravenous line

Approved by The Executive Committee of the Medical Staff on 04/18/2023
Vascular Access Device (VAD) Management

CATHETER TYPE

PIV

Pediatric routine catheter flush

Pediatric central lines (e.g., implanted venous ports or CICC)

History of heparin adverse events

Yes

No

CICC:

For patients > 10 kg: Heparin lock flush solution 200 units/2 mL (100 units/mL)
For patients ≤ 10 kg: Heparin lock flush solution 20 units/2 mL (10 units/mL)

● Inpatient: Flush each lumen with PF 0.9% NS 10 mL before and immediately after each use. Flush with PF 0.9% NS 10 mL followed by heparin lock flush solution daily for lumens not in use and upon hospital discharge.
● Outpatient: Flush each lumen with PF 0.9% NS 10 mL daily and heparin lock flush solution upon completion of treatment
● Home care: Flush each lumen with heparin lock flush solution daily

Implanted venous port:

For patients > 10 kg: Heparin lock flush solution 200 units/2 mL (100 units/mL)
For patients ≤ 10 kg: Heparin lock flush solution 20 units/2 mL (10 units/mL)

● Inpatient: Flush with PF 0.9% NS 10 mL before and immediately after each use, or every 12 hours when not in use. Upon discharge and deaccess, flush with PF 0.9% NS 10 mL and heparin lock flush solution
● Outpatient: Flush with PF 0.9% NS 10 mL before and after each use, and heparin lock flush solution upon completion of treatment
● Home care: Flush with PF 0.9% NS 10 mL and heparin lock flush solution monthly

Flush with preservative-free (PF) 0.9% NS 10 mL before and immediately after each use, and every 12 hours when not in use

VAD MAINTENANCE CARE: FLUSH MANAGEMENT - PEDIATRIC

Flushing/locking arterial catheters, dialysis catheters, or implanted peritoneal ports, follow specific institutional orders as directed by physician

1 Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)
2 For flushing/locking arterial catheters, dialysis catheters, or implanted peritoneal ports, follow specific institutional orders as directed by physician
3 Refer to Nursing Heparin Catheter Lock Protocol: Central Venous Access Device Patency Management (ATT3306)
4 If heparin is not available/shortage, follow the steps for heparin allergy

CICC = centrally inserted central catheter
PIV = peripheral intravenous line

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VAD MAINTENANCE CARE: NEEDLELESS CONNECTOR MANAGEMENT¹

EVALUATION

Is needleless connector present?²

No

Yes

Is connector accessed?

No

Yes

MANAGEMENT

- Scrub needleless connector injection sites before and in between each access using a CHG antiseptic swab³ and per manufacturer’s recommendations, unless contraindicated by patient allergy
  - If contraindicated, scrub needleless connector with alcohol per manufacturer’s recommendations. Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441) for additional considerations (i.e., blood culture collection).
- Access the needleless connector using only sterile devices and with clean technique
- For inpatient CVAD maintenance care, change needleless connectors during primary tubing change
- Needleless connectors are not to be changed earlier than 4 days, unless blood is visible or needleless connector is removed
- Change un-accessed needleless connector at least every 7 days
  - Needleless connectors are not to be changed earlier than 4 days, unless blood is visible or needleless connector is removed for therapy
  - For inpatient, any un-accessed needleless connectors or unused y-sites or ports, use a single-use passive disinfecting port protector cap (i.e., Curos™ cap) according to manufacturer’s recommendations

- For lumens without needleless connector: clamp lumen, clean hub, and attach new needleless connector
- Label lumen(s) with “DO NOT USE” and consult VA&P Team to evaluate

CHG = chlorhexidine gluconate
CVAD = central venous access device
VA&P = Vascular Access & Procedures

¹ Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)
² A neutral needleless connector should be used with all vascular access devices
³ CHG antiseptic swab is comprised of > 0.5% chlorhexidine gluconate and 70% isopropyl alcohol

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Approved by The Executive Committee of the Medical Staff on 04/18/2023
VAD MAINTENANCE CARE: TUBING MANAGEMENT

**EVALUATION**

Is this a new VAD insertion?

- Yes
- No

Tip verification confirmed?

- Yes
- No

**MANAGEMENT**

A

- Confirm EHR Tip Verification note is documented
- Aseptically connect new primary tubing to VAD lumen needleless connector
- Use extension tubing minimally and only when indicated [i.e., outpatient self-care or for procedure(s)]
- If applicable, use new secondary tubing

Change primary and secondary tubing at least every 4 days unless otherwise indicated

If applicable, use new secondary tubing

- Consult Primary Team or VA&P Team for tip verification
  - Once Primary Team or VA&P Team confirms tip verification, see Box A above for management

Change primary tubing and secondary tubing at least every 4 days unless otherwise indicated

---

VA&P = Vascular Access & Procedures

1. Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)
2. Tip of the CVAD is in satisfactory position when the tip resides in the superior vena cava or upper right atrium. See Central Vascular Access Device (CVAD) Assessment and Tip Position Verification Policy (#CLN1036).
3. Change extension tubing in the inpatient setting every 4 days during manifold change when in use. In the outpatient setting, or when not in use, change within 7 days. Change if blood is noted in the tubing or in the needleless connector.
4. Change tubing:
   - Every 24 hours if used for intermittent infusions when directly connected to VAD lumen
   - Every 24 hours if used for blood products, total parenteral nutrition (TPN), or lipid emulsions
   - Every 6-12 hours if used for propofol (dependent on indication and per manufacturer’s recommendation)
   - Every 3 days if used for interleukin-2

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Vascular Access Device (VAD) Management

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IMPLANTED VENOUS PORT: ACCESS AND MANAGEMENT

PRESENTATION

Patient presents with an implanted port and requires access

Is access site intact and free of signs of infection?

Confirm EHR Tip Verification note is documented

Contact Primary Team and VA&P Team

MANAGEMENT

Is port patent and blood return present?

Is pain and swelling during infusion?

Pain and swelling during infusion?

Yes

No

Proceed with port access

For flushing, needleless connector and tubing maintenance, see Pages 4-7

Proceed with port access

For dressing management, see Page 3

Port cannot be used until patency and blood return have been established

Consult VA&P Team

No

Yes

Port can remain accessed for sequential daily treatment but requires a needle change and flush/lock change every 7 days

Pain and swelling during infusion?

Yes

No

Stop the infusion

Assess patient, including capillary refill, motor function and sensation

Notify provider STAT

Follow additional nursing interventions

Yes

No

Refer to the Extravasation Management (Vesicant and Contrast Agents) algorithm for suspected extravasation and Vascular Vesicant/Irritant Administration and Extravasation Policy (#CLN0986)

Port cannot be used until patency and blood return have been established

Consult VA&P Team

VA&P = Vascular Access & Procedures

1 Manage, access, and de-access implanted ports as clinically indicated. Refer to Peripherally Inserted Central Catheter, Implanted Venous Port, Midline (Peripheral) Catheters, and Peripheral Intravenous Vascular Access Devices: Nursing Policy (#CLN3484)

2 Refer to Central Vascular Access Device (CVAD) Assessment and Tip Position Verification Policy (#CLN1036). If no note documented, consult Primary Team or VA&P Team for confirm and document Tip Verification.

3 Pain, swelling, tenderness, and redness

4 Needle selection based on:
   - Appropriate gauge for therapy or testing (i.e., 20 gauge is considered standard of care; some diagnostic imaging studies require a 19 gauge needle)
   - Appropriate length based on reservoir palpation (i.e., 3/4 inch, 1 inch, 1 ¼ inch, 1 ½ inch)
   - Appropriate needle type: access power injectable ports with power rated needles

VAD COMPLICATIONS: SKIN IMPAIRMENT

PRESENTATION

Patient presents with skin impairment

Skin injury\(^1\) (i.e., MARSI)

- Is the skin intact?
  - Yes
  - No

Skin irritation\(^2\) (i.e., contact dermatitis)

- Is extravasation suspected?
  - Yes
  - No

MANAGEMENT

- Consider using an alternative dressing that is non-irritating and non-sensitizing, see Appendix B
- Ensure skin prep solution is completely dry before applying dressing
- Ensure skin barrier is applied to area of skin where dressing is placed (do not apply at insertion site)
- If skin injury not resolved within 1 week, contact Primary Team and VA&P Team for further evaluation

- Consult VA&P Team
  - Assess and approximate size of skin injury
  - Use a non-alcohol containing antiseptic agent and an alternative dressing that is non-irritating, see Appendix A and Appendix B
  - If skin injury not resolved within 2 days, contact Primary Team and VA&P Team for further evaluation

- Refer to the Extravasation Management (Vesicant and Contrast Agents) algorithm for suspected extravasation and Vascular Vesicant/Irritant Administration and Extravasation Policy (#CLN0986)
  - Stop the infusion
  - Assess patient, including capillary refill, motor function and sensation
  - Notify provider STAT
  - Follow additional nursing interventions\(^3\)

- Consult VA&P Team
  - Change type of skin prep solution, see Appendix A for Skin Prep Allergy Recommendations and reassess in 2 days or sooner as clinically indicated. In the inpatient setting, VA&P Team will assess patient. In the outpatient setting, instruct patient to return to VA&P Clinic for re-assessment.
  - If skin injury not resolved, consider changing dressing type and reassess in 2 days or sooner if symptoms worsen, see Appendix B or Alternative Adhesive Dressing Recommendations
  - If no improvement, VA&P APP will make recommendations for management. Dermatology consult or referral may be warranted for persistent skin irritation.

---

MARSI = medical adhesive-related skin injury
VA&P = Vascular Access & Procedures

\(^1\) Presence of skin tears, blistering, irregular shiny skin, appearance or lesions lasting > 30 minutes

\(^2\) Redness, burning, presence of lesions, and/or pruritis

VAD COMPLICATIONS: SITE COMPLICATION/INFECTION

EVALUATION

Are there signs of site infection\(^1\)?

Yes

Is the patient febrile?

Yes

Yes

Outpatient:
- Notify Primary Team and/or send patient to Acute Cancer Care Center (ACCC) or Pediatric Acute Cancer Care Center (PACCC) as clinically indicated
- Consult VA&P Team for further evaluation

Inpatient:
- Notify Primary Team and VA&P Team immediately
- Monitor for signs and symptoms of infection progression\(^2\)

No

No

Assess site, apply dressing\(^2\) and notify Primary Team and VA&P Team

If site impairment worsens or requires more than 2 dressing changes within 2 days, notify Primary Team and VA&P Team for further evaluation and intervention

No

Yes

VA&P = Vascular Access & Procedures

\(^1\) Redness, warmth, induration, and/or purulent drainage

\(^2\) Refer to Infection Control Associated with Vascular Access Devices (VADs) Policy (#CLN0441)

\(^3\) Follow VAD Maintenance Care: Dressing Care on Page 3
VAD COMPLICATIONS: PHLEBITIS

<table>
<thead>
<tr>
<th>PRESENTATION</th>
<th>POTENTIAL CAUSE(S)</th>
<th>EVALUATION/MANAGEMENT</th>
</tr>
</thead>
</table>
| Patient presents with suspected phlebitis¹ | Infectious | ● For PICC:  
○ Notify Primary Team and VA&P Team to consider alternative vascular access and order removal of PICC  
○ Post-catheter removal assess exit for 2 days² |
| | Mechanical | ● Assess site and notify Primary Team and VA&P Team  
● Stabilize catheter, apply heat, elevate limb, and monitor for 24 hours²  
○ If signs or symptoms worsen, notify Primary Team and VA&P Team |
| Post infusion (≤ 48 hours post catheter removal) | Chemical (during infusion) | Assess site, apply heat, elevate limb, and notify Primary Team and VA&P Team.  
Other pharmacologic interventions may be warranted. |
| | | Stop infusion, assess site, and notify Primary Team and VA&P Team |

VA&P = Vascular Access & Procedures  
PICC = peripherally inserted central catheter  
PIV = peripheral intravenous line

¹ Refer to The Visual Infusion Phlebitis Scale (see Appendix C)  
² For inpatient: assess and document every shift  
For outpatient: assess and document once daily
Vascular Access Device (VAD) Management

FINDINGS

B
Severed, ruptured, or leaking catheter
(CICC, PICC, implanted port)

Assess for symptoms of embolism¹ and clamp catheter above the severed or ruptured portion (if applicable and visible)

Is patient hemodynamically stable?

Yes

Notify Primary Team and VA&P Team for further interventions

No

• Immediately position patients showing symptoms of air embolism onto left side in Trendelenburg and place patient on oxygen
• Notify Merit Team/Code Blue (Rapid Response) Team
• Notify Primary Team and VA&P Team

Balloon catheter
(CICC, PICC)
(Do not use CVAD until evaluated for safe use)

• Stop any infusion and clamp catheter.
• Assess catheter integrity if severed or ruptured. Refer to Box B above if catheter is severed, ruptured, or leaking.
• Notify Primary Team for further interventions
• Exchange or removal must occur immediately, consult VA&P Team for recommendations

Catheter resuture²
(CICC, PICC)

Consult VA&P Team² to evaluate for resuture if loose, tight or missing sutures are noted

CVAD tip malposition³,⁴
(Do not use CVAD until evaluated for safe use)

Consult VA&P Team to evaluate/recommend appropriate intervention

CVAD COMPLICATIONS: CVAD DEVICE-RELATED

CICC = centrally inserted central catheter
CVAD = central venous access device
PICC = peripherally inserted central catheter
VA&P = Vascular Access & Procedures

¹ Catheter embolism symptoms: changes in blood pressure, arrhythmias, cough, shortness of breath, chest pain, or weak pulse
² Catheter re-suture may be performed by specially trained provider
³ Tip of the CVAD is in satisfactory position when the tip resides in the superior vena cava or upper right atrium. Refer to Central Vascular Access Device (CVAD) Assessment and Tip Position Verification Policy (#CLN1036).
⁴ Obtain new chest x-ray if malposition is > 30 days from insertion confirmation x-ray
APPENDIX A: Skin Prep Allergy Recommendations

- **Allergy to CHG:**
  - Intact skin: Use 70% isopropyl alcohol\(^1\) followed by povidone-iodine\(^2\) or a combination of alcohol and iodine solution\(^3\)
  - Non-intact skin: Use povidone-iodine\(^2\) only
- **Allergy to alcohol:**
  - Use a non-alcohol containing CHG prep solution if available or povidone-iodine\(^2\)
  - If CHG allergy, use povidone-iodine\(^2\) only
- **Allergy to povidone-iodine and CHG:**
  - Use iodine povacrylex and isopropyl alcohol or
  - Use 70% isopropyl alcohol\(^1\)
  - Do not use CHG impregnated dressing or disc
- **Allergy to all skin prep dilutions (CHG, povidone-iodine, and alcohol):**
  - Use sterile saline\(^4\)
  - Do not use CHG impregnated dressing or disc

CHG = chlorhexidine gluconate

\(^1\) Scrub site using friction with isopropyl alcohol for a total of 60 seconds, and allow to dry

\(^2\) Scrub site with povidone-iodine (Dura-Prep\(™\)) for a total of 60 seconds or per manufacturer’s recommendations, and allow to dry for 2 minutes

\(^3\) Refer to manufacturer’s recommendations

\(^4\) High risk for infection related to sterile saline use
## APPENDIX B: Alternative Adhesive Dressing Recommendations

<table>
<thead>
<tr>
<th>Dressing</th>
<th>Skin Injury</th>
<th>Skin Irritant</th>
<th>Other Considerations</th>
<th>Dressing Change Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>SorbaView® SHIELD Dressing</td>
<td>• Skin Intact: 1st choice dressing</td>
<td>1st choice dressing</td>
<td>1st choice dressing for patients that are diaphoretic and are unable to tolerate</td>
<td>• Every 7 days with or without presence of Biopatch®</td>
</tr>
<tr>
<td></td>
<td>• Non-Intact Skin: Contact VA&amp;P Team for usage</td>
<td></td>
<td>Tegaderm™ with CHG</td>
<td>• Every 2 days if gauze is present over insertion site with or without presence of Biopatch®</td>
</tr>
<tr>
<td>Covaderm Plus® Vascular Access Dressing¹</td>
<td>• Skin Intact: Contact VA&amp;P Team for usage</td>
<td>3rd choice dressing</td>
<td>1st choice dressing if patient requires pressure dressing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Non-Intact Skin: Contact VA&amp;P Team for usage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allevyn dressing¹</td>
<td>• Skin Intact: 2nd Choice dressing (preferred when patient diaphoretic)</td>
<td>2nd choice dressing</td>
<td></td>
<td>• Every 7 days with presence of Biopatch®</td>
</tr>
<tr>
<td></td>
<td>• Non-Intact Skin: 1st choice dressing (preferred when patient diaphoretic)</td>
<td></td>
<td></td>
<td>• Every 2 days if no Biopatch® is present</td>
</tr>
<tr>
<td>Mepilex® Border Dressing¹</td>
<td>• Skin Intact: 2nd choice dressing</td>
<td>2nd choice dressing</td>
<td></td>
<td>• Every 7 days with presence of Biopatch®</td>
</tr>
<tr>
<td></td>
<td>• Skin Non-Intact: 1st choice dressing</td>
<td></td>
<td></td>
<td>• Every 2 days if no Biopatch® is present</td>
</tr>
<tr>
<td>DuoDERM® Extra Thin Dressing</td>
<td>• Skin Intact: Not recommended, contact VA&amp;P Team</td>
<td>4th choice dressing</td>
<td></td>
<td>• Every 7 days with presence of Biopatch®</td>
</tr>
<tr>
<td></td>
<td>• Non-Intact Skin: Not recommended, contact VA&amp;P Team</td>
<td></td>
<td></td>
<td>• Every 2 days if no Biopatch® is present (gauze must be placed over insertion site)</td>
</tr>
<tr>
<td>Kerlix™ Gauze Dressing</td>
<td>• Skin Intact: Contact VA&amp;P Team for usage</td>
<td>Contact VA&amp;P Team</td>
<td></td>
<td>• Dressing must be changed daily by VA&amp;P Team</td>
</tr>
<tr>
<td></td>
<td>• Non-Intact Skin: Contact VA&amp;P Team for usage</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CHG = chlorhexidine gluconate  
VA&P = Vascular Access & Procedures  
¹ Perform and document assessment every 12 hours in inpatient setting
## APPENDIX C: Visual Infusion Phlebitis Scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>IV site appears healthy</td>
</tr>
<tr>
<td>1</td>
<td>One of the following is evident: Slight pain near IV site or slight redness near IV site</td>
</tr>
<tr>
<td>2</td>
<td>Two of the following are evident: ● Pain at IV site ● Erythema ● Swelling</td>
</tr>
<tr>
<td>3</td>
<td>All of the following signs are evident: ● Pain along path of cannula ● Induration</td>
</tr>
<tr>
<td>4</td>
<td>All of the following signs are evident and extensive: ● Pain along path of cannula ● Erythema ● Induration ● Palpable venous cord</td>
</tr>
<tr>
<td>5</td>
<td>All of the following signs are evident and extensive: ● Pain along path of cannula ● Erythema ● Induration ● Palpable venous cord ● Pyrexia</td>
</tr>
</tbody>
</table>

SUGGESTED READINGS


Continued on next page
SUGGESTED READINGS - continued


MD Anderson Institutional Policy Attachment #ATT3306 – Nursing Heparin Lock Protocol: Central Venous Access Device Patency Management


MD Anderson Institutional Policy #CLN0441 – Infection Control Associated with Vascular Access Devices (VADs) Policy

MD Anderson Institutional Policy #CLN0986 – Vascular Vesicant/Irritant Administration and Extravasation Policy

MD Anderson Institutional Policy #CLN1036 – Central Venous Access Device (CVAD) Assessment and Tip Position Verification Policy

MD Anderson Institutional Policy #CLN3484 – Peripherally Inserted Central Catheter, Implanted Venous Port, Midline (Peripheral) Catheters, and Peripheral Intravenous Vascular Access Devices: Nursing Policy


This practice consensus statement is based on majority opinion of the Vascular Access Devices Management experts at the University of Texas MD Anderson Cancer Center for the patient population. These experts included:

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