



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

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| Department: | Neonatal Intensive Care Unit (NICU) | | |
| Document: | Multidisciplinary Policy and Procedure | | |
| Title: | Insertion of Peripherally Inserted Central Catheter (PICC) | | |
| Applies To: | All NICU Staff and X-ray Technicians | | |
| Preparation Date: | January 05, 2025 | Index No: | NICU-MPP-004 |
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1. PURPOSE:

- 1.1 Provide long-term vascular access for the delivery of life sustaining medications and nutrition.
- 1.2 The peripherally inserted central catheter (PICC) provides central vascular access that can be inserted at the patient's bedside and can remain in place for several weeks or months.
- 1.3 The small diameter of its lumen is ideal for the extremely small neonate.

2. DEFINITIONS:

- 2.1 It is a central venous catheter that is inserted percutaneous through a peripheral vein e.g. basilic, cephalic, brachial, saphenous.
 - 2.1.1 The tip of the catheter terminates close to the heart in the superior vena cava or the inferior vena cava at their juncture with the right atrium.
 - 2.1.2 Used for short-, intermediate-, or long-term therapy.
 - 2.1.3 May be single, dual, or triple lumen.
- 2.2 Midline catheter: Does not enter central veins e.g. inserted via the antecubital fossa into the proximal basilic or cephalic veins with the tip terminating not beyond the axillary vein. These are considered peripheral catheters.

3. POLICY:

- 3.1 Early identification of patients who require long term vascular access and early central catheter placement decreases the number of skin punctures and increases the success rate of neonatal PICC placement.
- 3.2 Indications :
 - 3.2.1 Very low birth weight infants who require continuous parenteral nutrition at high caloric densities.
 - 3.2.2 Infants who require long term intravenous medications with hyperosmolar or irritating high acidity or alkalinity that cannot be administered through peripheral IV cannulas.
 - 3.2.3 Deliver a critical infusion of life-sustaining medication e.g. prostaglandin, dopamine, dobutamine.
 - 3.2.4 Infants in whom peripheral access cannot be achieved or maintained.
- 3.3 Contraindications:
 - 3.3.1 Presence of an active bloodstream infection (i.e. a positive blood culture within the preceding 48 hours).
 - 3.3.2 Presence of a thrombus in the targeted vein.
 - 3.3.3 The patient can be treated adequately with peripheral IV access.
- 3.4 Catheter size:
 - 3.4.1 Determined by the infant's size and intravenous needs.
 - 3.4.2 Choose the catheter with the smallest diameter possible, to decrease the risk of thrombus formation, and with the fewest number of lumens possible for patient care.
 - 3.4.3 Most commonly used sizes in neonates include: 1.1 or 1.2 Fr (gauge 28) 1.9 Fr (gauge 26) and 2 Fr (gauge 24). For infants less than 1000 gm use gauges 28.

- 3.4.4 These sizes should not be used for routine blood draws or the routine administration of blood products.
- 3.5 Precautions to prevent catheter related blood stream infection are strictly followed.
 - 3.5.1 Before procedure: perform antiseptic hand wash.
 - 3.5.2 During insertion:
 - 3.5.2.1 Use maximal sterile barrier precautions, including the use of a cap, mask, sterile gown, sterile gloves, and a sterile full body drape and never break the sterility of the field.
 - 3.5.2.2 Proper skin disinfection is mandatory.
 - 3.5.2.3 Infection control practitioner/charge nurse observes and documents the Central Line Bundle. She has the authority to stop the procedure if sterility of the field is broken.
 - 3.5.3 After insertion:
 - 3.5.3.1 Dressing is frequently observed and changed as needed under complete aseptic technique.
 - 3.5.3.2 Catheter hubs, needleless connectors and injection ports must be properly disinfected before accessing the catheter.
 - 3.5.4 Daily perform careful risk / benefit analysis for the need of the PICC and promptly remove it when no longer essential.
- 3.7 PICC position: All PICC insertions should have tip placement confirmation done prior to use:
 - 3.7.1 Catheter tip should be in the superior or inferior vena cava, at the junction of the vena cava and the right atrium outside the pericardial reflection a distance estimated to be about 1 cm outside the cardiac silhouette for preterm and 2 cm outside the cardiac silhouette in term neonate.
 - 3.7.2 When the PICC is inserted into an upper extremity or scalp, the catheter tip should end in the superior vena cava at or beyond T2 vertebra and above T4 outside the heart; just below the carina (Right atrium junction with SVC is usually located around T4 to T5).
 - 3.7.3 When the PICC is inserted into a lower extremity, the catheter tip should end in the inferior vena cava at a level above the fourth or fifth lumbar vertebral body or the inter-iliac crest line but outside the right atrium i.e. at or below T 9, just above the diaphragm and not deeper on lateral view (right atrium junction with IVC is around T7).
 - 3.7.4 It must be ensured that PICC is not entering the heart (right atrium) due to the risk of perforation, pericardial effusion and cardiac tamponade. If the tip of the catheter is in the heart repeat x-ray to document that catheter tip has been successfully pulled out of the heart. Ultrasound or injection of contrast may also be used to determine catheter tip position.
 - 3.7.5 If unable to advance the catheter tip to central venous circulation, the catheter can be used as a midline. Position the midline catheter tip so that it terminates in the proximal portion of the leg, parallel to the femur, or in the arm, parallel to the humerus.
- 3.8 Staff members manipulating central catheters are required to attend a hands-on training class in the proper techniques for caring for and accessing catheters followed by a competency evaluation of central venous catheter insertion site and hub care.

4. PROCEDURE:

- 4.1 Written physician order is required.
- 4.2 PICC lines are usually inserted during morning shifts, except if it is urgently needed.
- 4.3 Explain procedure to parents if they are available.
- 4.4 Identify the patient by two identifiers (four names for Saudi/ complete name for Non-Saudi and medical record number).
- 4.5 Provide non-pharmacologic and pharmacologic pain management e.g. swaddling and the oral administration of sucrose 24%, fentanyl bolus (even if baby is on opioid infusion as he/she can still have pain associated with the procedure).
- 4.6 Support the infant with artificial ventilation as required.
- 4.7 Functioning resuscitation equipment should be available at bedside.
- 4.8 Assess infant coagulation status clinically and by laboratory.
- 4.9 Order chest and/or abdominal X-Ray to be done after insertion; indicate the time X-Ray is required.

- 4.10 For selecting site of insertion and measuring anticipated length of catheter, properly wash hands. Before catheter insertion the physician must perform aseptic hand wash.
- 4.11 **Select insertion site:**
- 4.11.1 **The basilic vein** is larger and less tortuous than the cephalic vein. The right basilic veins preferred over the left basilic because the right vein has a more direct route to central circulation. Basilic vein penetrates into deep fascia and should not be cannulated near fascia unless using ultrasound guidance due to potential for damaging other structures.
- 4.11.2 **The cephalic vein** may be more difficult to thread to the central position because of narrowing of the vessel as it enters the deltopectoral groove and the acute angle at which it joins the axillary vein.
- 4.11.3 **The axillary vein** is large and provides a direct route to the subclavian vein, however, the axillary and external jugular veins are the last choices because they are close to arteries and nerves, be careful to avoid cannulation of the axillary artery which runs lateral to the vein.
- 4.11.4 **Leg veins** offer multiple sites for neonatal PICC placement, but advancing the catheter at the level of the femoral fold can be difficult.
- 4.11.4.1 Greater Saphenous: Connects to join the femoral vein, runs on medial aspect of leg.
- 4.11.4.2 Small Saphenous: Lateral aspect of leg, it usually drain into the popliteal vein, smaller in diameter.
- 4.11.4.3 Femoral veins and jugular veins are best cannulated with ultrasound guidance.
- 4.12 Position of infant:
- 4.12.1 When using an insertion site in the upper extremity veins:
- 4.12.1.1 Supine position.
- 4.12.1.2 Abduct arm 90 degrees from trunk.
- 4.12.1.3 Turn the patient's head facing toward the insertion arm with chin down (to help reduce the likelihood that the catheter will be malposition in the internal jugular vein).
- 4.12.2 When using axillary vein:
- 4.12.2.1 Supine position, externally rotate and abduct arm 120 degrees, flex forearm and place baby's hand behind head; vein is found above artery between medial side of humeral head and small tuberosity of the humerus.
- 4.12.3 When using saphenous or popliteal vein:
- 4.12.3.1 Legs extended.
- 4.12.3.2 Supine position for greater saphenous vein.
- 4.12.3.3 Prone for small saphenous or popliteal.
- 4.13 Measure the anticipated length of the catheter in centimeters. Use this measurement as a guide for the depth at which to insert the catheter:
- 4.13.1 For insertions in the arm:
Measure from the insertion site along the course of the vein to the sternal head of right clavicle, to the third right intercostal space just to right of sternum.
- 4.13.2 For insertions into the leg:
- 4.13.2.1 Measure with the leg fully extended.
- 4.13.2.2 From the insertion site along track of Saphenous vein to inguinal area to 1cm below xiphoid process (level of the diaphragm).
- 4.13.3 Insertion depth scalp PICC:
- 4.13.3.1 From insertion site to head of right clavicle.
- 4.13.3.2 To 3rd intercostal space just to the right of the sternum.
- 4.14 **MAXIMUM STERILE BARRIER PRECAUTIONS:** Must be taken by the physician and his/her direct assistant (if assistant needed):
- 4.14.1 Perform antiseptic scrub for hands, wrists and forearms before the procedure, put on hat and mask:
- 4.14.1.1 Remove any jewelries.
- 4.14.1.2 Wash hands and forearms for 15 seconds with antimicrobial soap using the proper technique under running water.
- 4.14.1.3 Clean under nails with nail stick.

- 4.14.1.4 Scrub hands and forearms to elbow vigorously with antiseptic soap for a further at least 2 minute ensuring friction to all areas of hands, fingers and forearms by using the proper hand-washing steps.
- 4.14.1.5 Rinse thoroughly under running water keeping hands held higher than elbows.
- 4.14.1.6 Dry hands with sterile towel prior to drying forearm.
- 4.14.1.7 Wear the sterile gown and gloves.
- 4.14.2 Fill two 10 ml syringes with heparinized saline and flush the catheter with the filled syringe and keep it attached. Flush the introducer to verify patency and prevent blood stasis within its lumen. Attach the luer-lock extension set to one of the 10 cc syringes of normal saline.
- 4.14.3 Trim the catheter:
 - 4.14.3.1 If guide wire used: pull back the guide wire at least 1 cm away from planned cut marking to ensure guide-wire not cut. Using a trimming device (guillotine) supplied by manufacturer or a sharp scalpel, cut the distal tip of the catheter squarely (not bevelled) to the desired length (scissors create a more irregular cross sectional surface). At the hub of the catheter, bend the guide wire at a 90 degree angle to prevent the guide wire from advancing beyond the tip of the catheter.
 - 4.14.3.2 Be sure to avoid cutting the guide-wire and minimize movement of the guide wire within catheter.
 - 4.14.3.3 Cut the line to a length corresponding to insertion length + 0-3 centimeters.
 - 4.14.3.4 Ensure that the catheter does not touch non-sterile surfaces during preparation; maintain sterility while cutting the catheter.
 - 4.14.3.5 The catheter is fragile and any handling should be minimized.
- 4.14.4 Disinfect site:
 - 4.14.4.1 Use skin antiseptics as follows:
 - 4.14.4.1.1 Neonates more than 2 weeks and weight more than 1500 grams; use 1% chlorhexidine Gluconate wipes in 70% alcohol or povidone-iodine.
 - 4.14.4.1.2 Neonates 2 weeks of age or less or 1500 grams or less: use 2% chlorhexidine in aqueous or povidone iodine.
 - 4.14.4.2 Allow antiseptic to dry for at least 30 seconds before procedure.
- 4.15 Catheter insertion
 - 4.15.1 Apply tourniquet (optional). Providing slight skin traction, perform venipuncture using introducer (break away) needle at a 15-30 degree angle, about 1 cm below the intended vein. Observe for blood return. Stop advancing the needle as soon as there is blood return to prevent puncture of the posterior wall of the vein.
 - 4.15.2 Using non-toothed iris forceps gently grasp the catheter about 1 cm from its distal end and insert it into the introducer needle using short, steady strokes a few millimeters (0.5 cm) at a time. The catheter should advance with ease. Advance the catheter through the needle to a distance about 5 or 6 cm.
 - 4.15.3 Do not withdraw the catheter back through a splitting needle to avoid causing catheter embolism. ALSO, never advance the needle or retract the catheter after inserting it into the needle; the catheter may be severed by doing this.
 - 4.15.4 Stabilize the catheter by applying gentle pressure over the vein proximal to the needle and withdraw the introducer needle slowly and carefully until it is 5 or 6 cm away from the entry site.
 - 4.15.5 Break the introducer needle by gently pinching the wings of the needle together to break the bottom and the top part of the needle hub. Peel the wings of the needle apart.
 - 4.15.6 Continue to advance the catheter into the vein to the premeasured length, by nudging it farther, a few millimetres (0.5 cm) at a time.
 - 4.15.7 Aspirate to visualize blood return in the catheter. Once the catheter is properly located in the inferior or superior vena cava, blood should return with ease.
 - 4.15.8 Flush with 0.5 to 1 ml of heparinized saline to clear the catheter.
 - 4.15.9 Verify length of catheter inserted and adjust as necessary with forceps.
 - 4.15.10 Apply gentle pressure on insertion site with sterile gauze pad to stop any bleeding.
 - 4.15.11 Maintain patency of catheter by attaching syringe with normal saline running at 1 ml/hour until the catheter position is confirmed by x-ray,.

- 4.15.12 If it is impossible to advance the catheter to a satisfactory position, withdraw the needle and catheter simultaneously.
- 4.15.13 Secure catheter at skin insertion site with sterile adhesive skin closing strips, and cover with sterile gauze until radiographic confirmation of position.
- 4.15.14 After x-ray, if PICC needs to be pulled back, use iris forceps and pull line back.
- 4.15.15 Once line position is confirmed, remove the povidone iodine solution from the skin with sterile water or saline except immediate insertion site and allow drying before placing dressing.
- 4.15.16 If the catheter has not been trimmed, loosely coil the excess length of catheter away from the insertion site, ensure that there is no kinking or stretching of the catheter under the dressing
- 4.15.17 Apply a sterile, clear occlusive semipermeable transparent dressing over the insertion site and coiled excess catheter length. Maintain visibility of the insertion site. Do not use steristrip directly on catheter as the adhesive may damage catheter integrity.
- 4.15.18 To prevent skin breakdown, place a skin barrier under the hub e.g. Duoderm or soft gauze and ensure that the hub is secured.
- 4.15.19 Using sterile technique connect the catheter to a bag of infusion fluid.
- 4.16 Confirmation of catheter Placement
 - 4.16.1 It is important to take two radiographic views; antero-posterior and lateral e.g.:
 - 4.16.1.1 Catheters placed in a lower extremity; the catheter may inadvertently be in an ascending lumbar vein and may appear to be in good position on an anteroposterior view.
 - 4.16.1.2 On anterior-posterior view alone, it is difficult to assess whether PICC is in the right atrium.
 - 4.16.2 If catheter tip is difficult to see on a standard radiograph use radio-opaque contrast to improve localization of the catheter tip. Inject 0.3-0.5-ml of 0.9% saline into the catheter to check patency, follow by 0.3-0.5 ml of contrast. Take a radiograph few seconds after injecting then flush the line again with 0.5 ml of 0.9% saline.
 - 4.16.3 Ultrasonography may also be useful in localizing the catheter tip.
 - 4.16.4 If the catheter tip is beyond the desired position it **MUST** be withdrawn. This **must** be done as an aseptic procedure, following which the position of the tip of the catheter must be confirmed radiographically, using contrast again if necessary. The tip of the catheter **must never** be left inside any part of the heart.
 - 4.16.5 Catheters that are not far enough in may only be advanced if the insertion site is still sterile.
 - 4.16.6 The decision to use a catheter that is not centrally located must be made after a careful assessment of the necessity of needing vascular access versus the higher risk of catheter complications.
- 4.17 Catheter Removal
 - 4.17.1 Central catheters should be removed as soon as they are no longer needed.
 - 4.17.2 Before removing a catheter, perform hand hygiene.
 - 4.17.3 Don clean gloves, and removes the neonatal PICC dressing.
 - 4.17.4 Put on sterile glove. Cleanse the removal site with povidone iodine and alcohol and gently pull out the catheter. Neonatal PICCs should be easy to remove.
 - 4.17.5 Document the length of the catheter that was removed, and ensure that the catheter has been removed in its entirety.
 - 4.17.6 When the removal of a neonatal PICC is difficult, it may be necessary to redress the catheter, to flush the catheter, and to then make another attempt at removal after a period of several hours or to obtain a surgical consultation.
 - 4.17.7 A catheter that is difficult to flush may be an indication of a thrombus at or around the tip of the catheter. Do not force catheter removal, because excess tension may fracture it.
 - 4.17.8 One technique that may facilitate removal is the application of a warm compress to the tract of the vein for 20 to 30 minutes, flushing of the catheter, and massaging of the area near the insertion site.

5. MATERIAL AND EQUIPMENT:

- 5.1 All equipment used, except the mash head cover, and measuring tape (which should be properly disinfected and used only before disinfecting the skin), must be sterile
- 5.2 Radio-opaque central venous catheter with break-away needle introducer
- 5.3 Sterile gown and gloves, masks and surgical caps for both the operator and assistant
- 5.4 Sterile drape with central aperture
- 5.5 (4-6) sterile 2x2 gauze
- 5.6 Antiseptic solution; Povidone iodine, 70% alcohol
- 5.7 Iris forceps
- 5.8 Transparent dressing
- 5.9 Sterile tape strips
- 5.10 Sterile heparinized saline solution (0.5-1 U of heparin/ml)
- 5.11 2 syringes 10ml
- 5.12 Tape to measure
- 5.13 Normal saline for flushing
- 5.14 Injectable radio-opaque contrast to inject if catheter tip is difficult to see on a standard radiograph

6. RESPONSIBILITIES:

- 6.1 Physician
- 6.2 Nurse
- 6.3 X-Ray Technician





7. APPENDICES:

- 7.1 Time out procedural form


8. REFERENCES:

- 8.1 McCay A. S. et al. PICC Placement in the neonate. *New England Journal of Medicine*. 2014; March 13; e 17(1-5).
- 8.2 A Jain, P Deshpande and P Shah. Peripherally inserted central catheter tip position and risk of associated complications in neonates. *Journal of Perinatology*. 2013; 33, 307-12
- 8.3 Joint Commission International. Preventing Central Line Blood Stream Infections: A global Challenge, A Global Perspective. 2012
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- 8.5 Rorke J M. et al. Central venous catheterization. *Atlas of Procedures in Neonatology 2007*. MacDonald MG.; Ramasethu, J. 199-220.

9. APPROVALS:

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Appendices 7.1

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| <p>KINGDOM OF SAUDI ARABIA</p>  <p>وزارة الصحة Ministry of Health</p> <p>Hospital: _____ مستشفى: _____ Region: _____ المنطقة/المحافظة: _____ Dept./Unit: _____ القسم/الوحدة: _____</p> | <p>MRN: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> رقم الملف الطبي</p> <p>NAME: _____ الاسم: _____</p> <p>NATIONALITY: _____ الجنسية: _____</p> <p>AGE: <input type="checkbox"/> YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS العمر (سنة/شهر/يوم): _____</p> <p>DATE OF BIRTH: ____/____/14__ H ____/____/20__ تاريخ الميلاد: _____</p> <p>GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female الجنس: _____</p> | | | | | | | | | | | | | | | | | | | | | |
| TIME-OUT FOR INVASIVE PROCEDURE FORM (Surgical safety checklist) | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis: _____ | | | | | | | | | | | | | | | | | | | | | | |
| Procedure: _____ | | | | | | | | | | | | | | | | | | | | | | |
| Date: _____ | Time: _____ | | | | | | | | | | | | | | | | | | | | | |
| Call "Time -out" record | | | | | | | | | | | | | | | | | | | | | | |
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| Correct site | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
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| Correct procedure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| Consent | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| All documents and equipment Required are correct, available And functioning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| Physician / surgeon signature: _____ Stamp: _____ Procedure nurse signature: _____ Date: _____ | | | | | | | | | | | | | | | | | | | | | | |
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