STUDENT'S NAME

DATE

FOR FACULTY USE ONLY DATE

EDUCATOR'S NAME PASS / FAIL

Skills Modules 3.0 Checklist: Central Venous Access Devices
Implanted Port – Accessing and Deaccessing the Site

INSTRUCTIONS: Use the following checklist to evaluate competency in completing this skill. Select Satisfactory (S) or Unsatisfactory (U) for each step and provide comments as needed.

*Document the relevant information (assessment findings, pharmacological and nonpharmacological interventions) in the client's medical record.

Beginning Steps

STEP	S	U	EVALUATOR'S COMMENTS
Verify prescription for accessing port.			
Gather necessary equipment.			
*Introduce yourself to the client.			
*Provide privacy as needed.			
*Verify client identification.			
*Determine whether the client has allergies.			
*Provide client education.			

STEP	S	U	EVALUATOR'S COMMENTS
*Perform hand hygiene and put on appropriate PPE if indicated.	☐	☐	
Assemble equipment near bedside.	☐	☐	
Adjust the height of the bed to a comfortable working level.	☐	☐	
Assist the client to a comfortable position.	☐	☐	

Accessing Implanted Port

STEP	S	U	EVALUATOR'S COMMENTS
If prescribed: Apply local anesthetic to port site and allow time to take effect.	☐	☐	
Place necessary equipment on sterile field.	☐	☐	
Apply mask. Have client wear mask or turn head away from insertion site.	☐	☐	
Apply clean gloves and locate the port by palpation.	☐	☐	
Apply sterile gloves.	☐	☐	
Prime extension tubing on noncoring needle with a sterile 0.9% normal saline flush.	☐	☐	

STEP	S	U	EVALUATOR'S COMMENTS
Clean port insertion site and 2 to 3 inches around with chlorhexidine for at least 30 seconds. Allow to dry.	☐	☐	
Once dry, use your nondominant had to stabilize the port and pull the skin taut.	☐	☐	
Insert needle at 90-degree angle in the center of port.	☐	☐	
Gently flush with 3 to 5 mL of 0.9% normal saline.	☐	☐	
Aspirate for blood to verify placement.	☐	☐	
Flush or lock per prescription or agency policy and clamp tubing.	☐	☐	
Apply end cap per agency policy.	☐	☐	
Apply antimicrobial dressing, skin protectant, and transparent dressing according to agency policy.	☐	☐	

Deaccessing Implanted Port

STEP	S	U	EVALUATOR'S COMMENTS
Apply clean gloves.	☐	☐	
Clean end cap of extension tubing with antiseptic and allow to dry.	☐	☐	
Connect syringe containing 0.9% normal saline.	☐	☐	
Aspirate for blood return.	☐	☐	
Flush line with 0.9% normal saline per agency policy.	☐	☐	
Instill locking solution in line per prescription or agency policy.	☐	☐	
Remove transparent dressing and any other stabilization device.	☐	☐	
Assess site for any discharge or drainage.	☐	☐	
Stabilize port with nondominant hand.	☐	☐	
With dominant hand, grasp wings of needle and firmly pull needle straight up, out of port.	☐	☐	

STEP	S	U	EVALUATOR'S COMMENTS
Immediately deploy needle safety device and discard in sharps container.	☐	☐	
Hold gentle pressure with gauze over site.	☐	☐	
Apply small bandage if necessary.	☐	☐	
Remove gloves and perform hand hygiene.	☐	☐	
*Ensure that the client is in a safe position prior to leaving the room and has the call light within reach.	☐	☐	

References

Lynn, P. (2019). Taylor's clinical nursing skills (5th ed.) Philadelphia: Wolters Kluwer.