University Hospitals of Leicester NHS
NHS Trust

Vascular Access in Adults and Children

Policy and Procedures

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Review November 2017 - Changes: All reference to CVC changed to CVAD, LocSSIP documentation added, ongoing care bundles for PVAD and CVAD revised with addition of midlines to the PVAD care bundle. Definitions of LocSSIPS and NatSSIPS included and definitions of midlines and PICC updated. Need for mandatory removal at 72hours removed. Guidance in education for staff trained elsewhere updated

January 2017 – Review of V2 (Approved April 2010) undertaken

Changes: All reference to CVC changed to CVAD, insertion care bundle changed to UHL LocSSIP, ongoing care bundles for PVAD and CVAD revised, change from do not replace cannula routinely to change every 72 hours

KEY WORDS

Vascular access, cannula, PICC, Hickman, CVC, midline, arterial line, CVAD, PVAD, LocSSIP

1 INTRODUCTION AND OVERVIEW

1.1 This Document outlines the standard required within University Hospitals of Leicester (UHL) NHS Trust policy for the safe insertion and care of peripheral and central vascular access catheters (CVAD)

2 POLICY SCOPE

2.1 This policy applies to all Healthcare Professionals working within UHL who insert or care for peripherally and centrally inserted vascular access devices, including those on honorary, bank or agency contracts

2.2 This policy applies to all types of peripheral and central vascular access devices irrespective of indications and use

2.3 This Policy applies to all patients within UHL over 2 months of age. Please refer to local guidance and associated procedures for infants less than 2 months of age; a separate policy is available on the NNU BADGER system

3 DEFINITIONS AND ABBREVIATIONS

3.1 **Arterial Line** An arterial line (aka art-line or a-line) is a thin catheter inserted into an artery. It is most commonly used to monitor blood pressure directly and in real-time and to obtain samples for arterial blood gas analysis. Arterial lines **must not** be used for the administration of any infusate. Patients with an arterial line in position must be nursed in a level 2 unit

3.2 **Central Vascular Access Device** (CVAD) is defined as a device inserted into the superior or inferior vena cava or the right atrium via the internal jugular, subclavian or femoral veins. Patients with a short term non-tunnelled CVAD in place must be nursed in a level 2 unit

3.3 **LocSSIP** Local Safety Standards for Invasive Procedures Local adaptation of NatSSIP (National Safety Standard for Invasive Procedures)

3.4 **Midline catheters** are peripheral vascular access devices used for medium to long term access. They are usually 20cm in length and placed in an upper arm peripheral vein such as the brachial or cephalic with the tip ending below the level of the axillary line

3.5 **Peripherally inserted central catheter** (PICC) is defined as a device that is inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in a central vein in the chest near the heart

3.6 **Peripheral Vascular Access Device** (PVAD) is defined as a small, flexible tube placed into a peripheral vein in order to administer medication or fluids

4 ROLES AND RESPONSIBILITIES

4.1 The Medical Director and Chief Nurse are the executive leads for the policy and are responsible for:

a) Ensuring that appropriate mechanisms are in place across the Trust to make sure that vascular devices are inserted and cared for safely

b) Policy and guideline development is via the Vascular Access Committee, endorsed by the Executive Quality Board via the Trust Infection Prevention Assurance Committee

4.2 Clinical Management Groups Responsibilities

a) Clinical Directors and Heads of Nursing are responsible for ensuring all staff within their CMG who insert and/or care for vascular access devices have the appropriate education and level of supervised practice and are deemed competent

b) The CMG Clinical Directors and Heads of Nursing are responsible for ensuring there is a horizontal and vertical sharing of information to ensure staff at all levels receive key information updates

c) Matrons are responsible for ensuring regular audit of compliance with this policy is carried out with timely feedback to staff

d) Clinical Directors and Heads of Nursing are responsible for ensuring that any remedial action resulting from compliance audit is acted upon

4.3 Ward Sister/Charge Nurse/Line Managers/Heads of Service are responsible for:

a) Ensuring that relevant staff receive the appropriate training, supervised practice and assessment of competence in the insertion and care of vascular access devices

b) Maintaining accurate and up to date training records and competency assessments

c) Perform quarterly observational audits of staff practice within their area of responsibility (see the Monitoring table in Appendix One for further information)

4.4 Staff authorised to <u>insert</u> vascular access devices are responsible for:

a) Successful completion of appropriate education, assessment and supervised practice prior to independent practice

b) Utilising and completing the appropriate LocSSIP/insertion documentation

c) Ensuring their practice is compliant with this policy

d) Documenting the clinical indication for the device, date of insertion, type and size of device. The identification of the inserting practitioner must be clearly legible. The insertion should be recorded on the insertion care pathway provided in the insertion pack to evidence compliance with the care bundle elements

e) Contacting the Vascular Access Team at the earliest opportunity if venous access is difficult or the patient will require venous access for > 5 days

4.5 Staff responsible for the <u>ongoing care</u> of vascular access devices are responsible for:

a) Ensuring they are competent to care for the device, or seek advice to ensure delivery of safe care

b) Ensuring their practice is compliant with this policy

c) Ensuring that the care bundle documentation is completed at least once during each shift

d) Reviewing the need for all vascular access devices daily and remove as soon as possible

e) Ensuring all cannulae are inspected twice daily and removed if any signs of phlebitis or other complications. Only in exceptional circumstances should a cannula remain in situ for more than 5 days at which stage a referral to the vascular access team is required and these circumstances must be clearly documented in medical and nursing notes.

f) Ensuring that removal of a CVAD is not on the basis of fever alone. Use clinical judgment regarding the appropriateness of removing the device if infection is evidenced elsewhere or if a non-infectious cause of fever is suspected

f) Ensuring that antimicrobial therapy is prescribed based on clinical signs and not on microscopy from contaminated devices (refer to the Antibiotic Guide for IV Line-associated Infections in adults @ http://insite.xuhl-tr.nhs.uk/antibiotic

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

All procedures relating to the insertion and care of VADs must be performed in line with the following principles:

5.1 Selecting the most appropriate device

a) Vascular access devices must only be inserted where there are sound clinical reasons and the type of device selected should take into account the patients clinical needs

b) If unsure about the type of access required or length of time it will be in situ consult with senior colleagues or the specialist vascular access team. Use a tunnelled or implanted central vascular access device with a subcutaneous port for patients in whom long-term vascular access is required

c) Use a CVAD with the minimum number of ports or lumens essential for the management of the patient

d) If the CVAD is suspected as a source of infection catheter exchange via placing a guide wire through the existing catheter is not acceptable

e) Non-ported cannulae must be used. The only agreed exemption areas are theatres, emergency department or in a cardiac arrest situation

5.2 Device insertion site

a) Avoid using the femoral vein for central vascular access in adult patients unless there is overriding clinical justification

5.3 Ultrasound Imaging for CVAD insertion

Two-dimensional (2-D) imaging ultrasound guidance is the preferred method for insertion of CVADs into the internal jugular vein (IJV) in adults and children in elective situations, and should be strongly considered in emergency situations

5.4 Maintaining Asepsis

a) All vascular access devices must be inserted using the principles of Aseptic Non-Touch Technique (ANTT)

b) A cannulation pack must be used in all areas other than agreed exceptions such as theatres and emergency department

c) A disposable standard CVAD insertion pack must be used. (Exceptions may be made in an emergency situation where a pack is not immediately available)

d) Use maximal sterile barrier precautions, including the use of a cap, mask, sterile gown, sterile gloves, and a sterile full body drape, for the insertion of all CVADs

e) The skin must be decontaminated with 2% chlorhexidine gluconate (CHG) in 70% isopropyl alcohol (IPA) in a single use sterile applicator (unless sensitive to chlorhexidine in which case alcoholic povidone iodine may be used)

f) Use a sutureless securement device or a monofilament non-silk suture to secure CVADs

g) All access and ongoing care of CVADs must be provided using the principles of Aseptic non-Touch Technique (ANTT) to avoid the introduction of infectious agents. Access ports must be cleaned using a 70% ipa and 2% CHG impregnated cloth using friction, and allowed to dry before use ('scrub the hub')

h) If ANTT has been breached during the insertion of a vascular device then the procedure must be abandoned and re-started except when patient's life is at risk if no access is obtained. In this situation it should be clearly documented in the medical notes the reason for continuing with the procedure and the device must be removed when the patient is stable

5.5 Dressings

a) The transparent semi permeable dressing provided for use in the cannulation pack must be used for peripheral cannulae

b) A transparent semi permeable dressing must be used for CVADs unless the site is bleeding or oozing after insertion in which case a dressing may be used until wound is dry

c) Gauze dressings must be replaced with a transparent dressing within 24 hours to allow observation of the insertion site

d) Loose or visibly soiled dressings must be replaced immediately

e) Dry intact dressings should **not** be replaced routinely. Replace every 7 days in situ or upon removal of the device whichever is sooner

5.6 Care Bundles

All devices must be inserted and cared for using the relevant care bundles:

Appendix 1 – Local Safety Standards for Invasive Procedures (LocSSIP) Checklist: CVC/ PICC/ Midline Insertion

Appendix 2 – Peripheral Vascular access Device Care Bundle

Appendix 3 – Central Vascular Access Device Care Bundle

5.7 Removal of Devices

a) All devices must be removed as soon as no longer clinically indicated using the RAID assessment .If longer term access, eg greater than seven days is required, a referral should be made to the specialist vascular access team for insertion of the most appropriate device

b) All cannulae must be inspected twice daily and removed if any signs of phlebitis or other complications. Only in exceptional circumstances should a cannula remain in situ for more than 5 days at which stage a referral to the vascular access team is required and these circumstances must be clearly documented in medical and nursing notes.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Provision of Education

The Clinical Education Team provides face to face cannulation training. The Vascular Access Committee have produced short training videos linked by QR codes on the devices or the care bundles. All staff delivering training or producing training aids are responsible for ensuring the education material is updated and in line with current guidance

6.2 All staff who insert VADs must:

a) Be taught by a registered health care professional who is experienced in the insertion of the device and has been assessed as competent themselves

b) Have completed a period of supervised practice, the time span of which will be agreed by the assessor but to be completed within 6 months

c) Successfully complete a final competency based assessment by an appropriately trained assessor

d) Maintain records of the competency assessment as to provide evidence if required

e) Successfully completed mandatory Aseptic Non-touch Technique training on HELM

f) Maintain knowledge and skills and provide evidence of this as agreed with line manager as part of the annual appraisal process

6.3 Staff new to the Trust who have been trained elsewhere must:

a) Provide evidence of the training and assessment programme they have successfully completed

b) Comply with the relevant Trust policies and undertake additional training relating to equipment and documentation as required

c) Undertake a one off practical assessment by an appropriate assessor within own CMG/Ward/Unit if deemed necessary or insufficient evidence of previously competence provided

6.4 To be able to assess the knowledge and competencies of others, the assessor must:

a) Be confident and competent in performing the skill

b) Practice the skill regularly

c) Have a sound knowledge of current policies and procedures

d) Be identified by their line manager as an assessor

e) Ideally be able to show evidence of Continuing Professional Development relating to the skill

7 PROCESS FOR MONITORING COMPLIANCE

7.1 Compliance with this policy will be monitored through quarterly observation of the use of the Peripheral Vascular Access Device Care Bundle, Central Vascular Access Device Care Bundle (appendices 2 and 3) and annual compliance audit of Insertion of CVC checklist (appendix 1)

7.2 Processes of measuring compliance with aseptic non touch technique and compliance with high impact intervention care bundles are currently under review

7.3 Policy monitoring table

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Use of a CVAD insertion care pathway	Matron	Ward Audit Tool	Quarterly	Quarterly ward audit report
Use of PVAD care pathway	Matron	Ward Audit Tool	Quarterly	Quarterly ward audit report

Audit of central venous access devices across the trust	Vascular Access Committee	CVAD audit tool	Annually	Trust Infection Prevention Assurance Group, CMG IP groups and circulation via CMG leads

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

HPS (2012) what are the key infection prevention and control recommendations to inform a central vascular catheter (CVC) maintenance care quality improvement tool? Literature review and recommendations; http://www.documents.hps.scot.nhs.uk/hai/infection-control/evidence-for-care-bundles/literature-reviews/cvc-maintenance-review.pdf

Loveday et al, (2014) **epic3:** National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England; Journal of Hospital Infection 86S1 (2014) S1–S70

Mukerji S, Daniels R, Maung K, Mattin A, (2009) Central venous catheter-related infection: a cohort study evaluating dedicated central venous catheter packs; Crit Care. 2009; 13(Suppl 4): P22

NHS Improvement (2015) National Safety Standards for Invasive devices https://improvement.nhs.uk/uploads/documents/natssips-safety-standards.pdf

NICE (2002) Guidance on the use of ultrasound locating devices for placing central venous catheters (TA49)

O'Grady et al, (2011) Guidelines for the Prevention of Intravascular Catheter-RelaPRATTPted Infections, 2011Center for Disease Control http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

Pratt RJ et al (2007). **epic2**: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England. Journal of Hospital Infection 2007; 65S: S1-64

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system

10.2 This Policy will be reviewed every three years or sooner in response to indentified clinical risks. The review will be commissioned by the QPMG

Appendix 1

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Local Safety Standards for Invasive Procedures (LocSSIP)

INVASIVE PROCEDURE SAFETY CHECKLIST: CVC / PICC / Midline Insertion

Patient Identity Sticker:

Patient specialty	
Indication for central venous access	Venous access / Nutrition / Renal support / CVP measurement Other
Operator grade:	FY / CT1-3 / ST3-5 / ST5+ / SAS / Consultant / Advanced Practitioner
Operator experience:	Previous insertions: <10 / 10-50 / 50+
Operator specialty:	Anaesthesia / ICM / Nephrology / Medicine / Radiology/ EM.Other
Site	LRI / GH / LGH
Clinical area	Theatre / ICU / ED resus / radiology / procedure room /Other
Procedure date:	
Time:	
Operator:	
Supervisor:	
Assistant:	
Level of supervision:	ST3+ / SAS / AP/ Consultant

Signature of assistant completing the form	
Signature of Operator inserting line	

BEFORE THE PROCEDURE		
Appropriate patient consent	Yes	No
Appropriate supervision (if needed)	Yes	n/a
Consider avoiding femoral route	Yes	No
Ultrasound to be used? (recommended with internal jugular insertion)	Yes	No
Is all equipment available?	Yes	No
Hand washed by operator and assistant?	Yes	No
Parenteral nutrition required – single lumen CVC selected? *If no document below….*	Yes	No

TIME OUT Verbal confirmation between team members before start of procedure		
Is position optimal for procedure and to avoid air embolism?	Yes	No
All team members identified and roles assigned?	Yes	No
Agree to call for senior help after 3 unsuccessful attempts to access vein	Yes	No
Correct line ready? (12.5cm RIJ / 16cm LIJ / 20cm Fem)	Yes	No
Ensure guidewire visible at all times	Yes	No
Any concerns about procedure?	Yes	No
If yes– please document below		

SIGN OUT		
Guidewire removed?	**Yes**	**No**
Number of lines opened		
Are all guidewires accounted for?	Yes	No
Blood aspirated from all lumens before flushing with saline	Yes	No
Needle-free connectors to all port sites except CVP measurement line	Yes	No
Secured with non-silk suture or adhesive device	Yes	No
Transparent sterile dressing applied	Yes	No
Chest X-Ray required/ordered	Yes	No
Any adverse events? (Documented in adverse events Log)	Yes	No
MRSA decolonisation prophylaxis prescribed?	Yes	No
Nasal mupirocin 2% TDS **and** antibacterial bodywash (Stellisept) OD	Yes	No

During the procedure (please circle as appropriate) **Any 'no' circled; notify operator immediately and halt procedure until deviation from best practice corrected**		
Sterile gloves and gown worn by operator	Yes	No
Hat, mask and eye protection worn by operator	Yes	No
Site sterilised with 2% chlorhexidine in 70% alcohol and allowed to dry	Yes	No
Large sterile drape used	Yes	No
Local anaesthetic or sedation used	Yes	No
Sterile field maintained throughout including sheath and gel for ultrasound probe	Yes	No
Cannula used to access vein	Yes	No
Venous position confirmed with venous pressure or fluoroscopy prior to dilation	Yes	No
Dilator is not inserted fully	Yes	No
Number of attempts (skin puncture with needle)		

Procedure	**Catheter type**	**Insertion site**		
Elective	Multi-lumen	Subclavian		
Emergency	Single-lumen	Jugular		
Technique used	Dialysis	Femoral		
Real time U/S	Introducer/Sheath	Right	Left	
U/S assisted landmark	PICC	Guidewire removed?	Yes	
Landmark	Midline			

Complications			
Pneumothorax	Arterial puncture	Malposition	Haemorrhage
Senior help required	Unable to cannulate	Other	None

Complication Actions/Comments:

Appendix 2

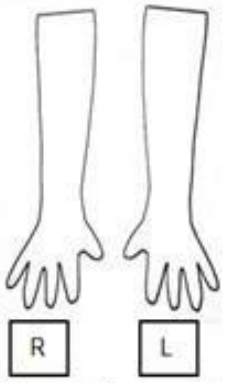
Peripheral Vascular Access Device Care Bundle – Cannula or Midline*

University Hospitals of Leicester NHS Trust

Please use one sheet per device

*A local safety standards for invasive procedures (LocSSIP) form must be completed when a midline is inserted

Name:
Hospital number:
Ward:



Please mark successful cannulation with an X and failed cannulations with an F

IV Cannula Insertion Record or manufacturers label
Date
Time
Size and Lot Number
Number of attempts
Reason for insertion
Signature
Inserted by (print)
IV Cannula Removal Record
Date removed
Number of days in situ
VIP score upon removal
Reason for removal
Signature
Removed by (print)

Care Bundle Elements during ongoing care

Cannula Replacement
All cannulae must be inspected twice daily and removed if any signs of phlebitis or other complications. All cannulae must be removed as soon as they are no longer required. If the cannula is likely to be needed for more than 72hrs consider early referral to vascular access team for longer term access. Only in exceptional circumstances should a cannula remain in situ for more than 5 days and these circumstances must be clearly documented in medical and nursing notes

Hand Hygiene Hands are cleaned before every contact with the device	**Continuing Clinical Indication (Required)** Need for IV access must be assessed and recorded twice daily and the device removed if no longer clinically indicated	**Appropriate Device** Is this the most suitable device for the patient e.g. if the patient has had multiple cannulae or requires IV access for more than 7 days refer to Vascular Access Team for midline
Signs of Infection The insertion site should be inspected and the VIP score documented at a minimum twice daily	**Dressing Intact** Ensure that the dressing is intact and does not obscure visual inspection of the insertion site	**Administration Sets** Administration sets must be labelled with the date they are due to be changed (72 hours fluid sets, 24 hours TPN, and 12 hourly for blood or according to manufacturer's guidance)
Disconnection Do not disconnect giving sets other than for disposal	**Device Access** Ensure key parts are protected when accessing the device. Scrub the hub with 2% chlorhexidine gluconate in 70% isopropyl alcohol for fifteen seconds and allow to dry	**Documentation** Document date and time of removal, identifying grade and name of operator legibly with signature

RAID assessment: Must be completed for all devices (cannula or midline) and a VIP score to evidence observation of insertion site twice daily														
	Date:		Date:		Date:		Date:		*Date:		Date:		Date:	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Required? Device used in last 12 hours (Y/N) if N remove														
Appropriate? Is this the best device for the patient? (How long is access required)														
Infected? Is there any evidence of swelling or redness along a midline?														
Dressing? Is the dressing transparent, semi-permeable and intact?														
VIP score? Record VIP score twice daily before accessing the device														
Identification of practitioner														
*If a peripheral cannula is required to remain in situ for more than 5 days refer to the Vascular Access Team (a midline can remain in situ for up to four weeks)														

Continuing Midline Care Pathway														
	Date:		Date:		Date:		Date:		Date:		Date:		Date:	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Required? Device used in last 12 hours (Y/N) if N remove														
Appropriate? Is this the best device for the patient? (How long is access required)														
Infected? Is there any evidence of swelling or redness along a midline?														
Dressing? Is the dressing transparent, semi-permeable and intact?														
VIP score? Record VIP score twice daily before accessing the device														
Identification of practitioner														

All saline flushes must be documented as administered on the prescription below

AS REQUIRED MEDICINES

MEDICINE	SODIUM CHLORIDE 0.9%			DATE					
DATE	DOSE 5-10ml	ROUTE IV		TIME					
INDICATION	Flush Cannula	MAX FREQUENCY		DOSE					
SIGN	BLEEP No.	PHARM.	SUPPLY	ROUTE					
				GIVEN					

MIDLINE MIDLINE Scan QR code for information

Appendix 3

NHS
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Central Venous Access Device (CVC) Care Bundle – Including PICC

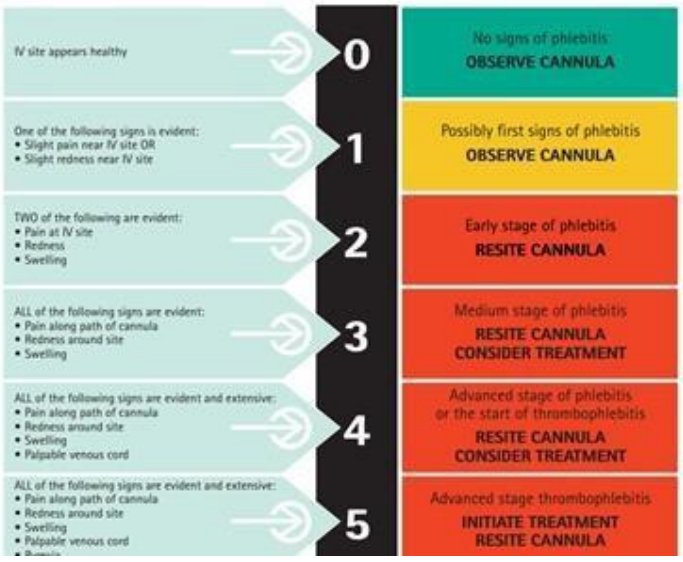
A LOCSIP form must be undertaken for all midlines, PICCS, central lines (including renal dialysis access) inserted in UHL

Name:
Hospital number:
Ward:

Care Bundle Elements during **ongoing care**		
If vascular access is required for longer than seven days, a multi lumen device is not appropriate. Outside of critical care please refer to the specialist vascular access team for insertion of the most appropriate device.		
Hand Hygiene Hands must be cleaned before contact with device	**Continuing Clinical Indication (Required)** Need for IV access must be assessed and recorded twice daily and the device removed if no longer clinically indicated	**Appropriate Device** Is this the most suitable device for the patient e.g. if the patient has a multi lumen non-tunnelled device is this required, refer to Vascular Access Team for PICC assessment
Signs of Infection The device is inspected for signs of infection eg tracking, swelling or redness at insertion site and documented at least twice daily	**Dressing Intact** Ensure that the dressing is intact and does not obscure visual inspection of the insertion site	**Administration Sets** Administration sets must be labelled with the date they are due to be changed (72 hours fluid sets, 24 hours TPN, and 12 hourly for blood or according to manufacturer's guidance)
Disconnection Do not disconnect giving sets other than for disposal	**Device Access** Ensure key parts are protected when accessing the device. Scrub the hub with 2% chlorhexidine gluconate in 70% isopropyl alcohol for fifteen seconds and allow to dry	**Occlusion prevention** Do not allow IV bags to stand empty. Following use (or weekly if lumen not in use), flush with sodium chloride 0.9% for intravenous use. Use a 10 ml syringe and clamp under positive pressure.
Measurement of PICC Measure the residual length of the PICC prior to access to ensure the device has not been dislodged	**Documentation** Document date and time of removal, identifying grade and name of operator legibly with signature	**Removal of CVAD** All CVADs must be removed as soon as no longer clinically indicated.

RAID assessment: Must be completed for all devices and a VIP score to evidence observation of insertion site twice daily														
	Date:		Date:		Date:		Date:		Date:		Date:		Date:	
Required? Device used in last 12 hours (Y/N) if N remove	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Appropriate? Is this the best device for the patient? (How long is access required)														
Infected? Is there any evidence of swelling or tracking (redness) along the vein?														
Dressing? Is the dressing transparent, semi-permeable and intact?														
VIP score? Record VIP score twice daily before accessing the device														
Identification of practitioner														

RAID assessment: Must be completed for all devices and a VIP score to evidence observation of insertion site twice daily														
	Date:		Date:		Date:		Date:		Date:		Date:		Date:	
Required? Device used in last 12 hours (Y/N) if N remove	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Appropriate? Is this the best device for the patient? (How long is access required)														
Infected? Is there any evidence of swelling or tracking (redness) along the vein?														
Dressing? Is the dressing transparent, semi-permeable and intact?														
VIP score? Record VIP score twice daily before accessing the device														
Identification of practitioner														



PICC TEACHING LABEL

PICC TEACHING LABEL

Scan QR code for information