SPECIAL PROCEDURES
S10 / PRE-EXISTING VASCULAR ACCESS DEVICES (PVAD)

These PVADs should only be accessed if the patient is in **cardiac arrest** or **status epilepticus** or **hypoglycemia with a Glascow Coma Scale of 3** when peripheral venous access is unobtainable.	**FINAL EFFECTIVE 8/25/08**

Base Physician Contact must be made to access the PVAD for those patients who are in severe distress and do not meet the conditions listed in above.

Type A, B, C Catheters	**Type D Catheters** (subcutaneously implanted)	**Type E Catheters** (Arteriovenous Shunts and Fistulas)
1. Prepare two (2) 10 ml syringes, one with 10 ml of normal saline flush; 2. Attach 10 ml syringe to port you will be accessing, then unclamp or release the stops on the port; 3. Using aseptic technique, withdraw 5 to 10 ml of fluid from the catheter using a syringe or, in some cases a needleless access device. Aspirate 5-10 ml of blood from the port and discard. This preparation procedure is done to clear any additional **Heparin** that the catheter would have contained; 4. Close the clamp on the port you are accessing whenever a syringe or cap is not attached to the port; 5. Maintaining asepsis, vigorously flush the PVAD port with 5 to 10 ml of normal saline using a syringe or needleless access device. Note any signs of resistance or infiltration; 6. Attach flushed IV tubing, continuing aseptic technique, to access port. Tape the tubing hub or needleless access device to the PVAD to prevent accidental disconnection. 7. Once PVAD has been accessed the IV should run at a TKO rate	1. Using aseptic technique, fill the Huber needle and tubing with normal saline and clamp the tubing; 2. Cleanse and swab in a circular motion from the center of the Port-a-Cath skin area with the appropriate county recommended antiseptic cleanser; 3. With gloved hands, using non-dominate hand stabilize the port-a-cath, with dominate hand insert the Huber needle or other non-coring needle perpendicular to the port until the needle touches the port's posterior wall; 4. Unclamp and aspirate 10 ml of blood and discard; 5. Clamp and attach the IV tubing to the Huber needle and tubing, unclamp and open gravity clamp on IV tubing. 6. Once the PVAD has been accessed the IV should run at a TKO rate.	1. Assemble supplies and have IV bag and tubing flushed and placed inside a slightly inflated pressure bag, or place blood pressure cuff around IV bag; 2. Locate venous side of the fistula by applying pressure to center of the graft loop, occluding much of the blood flow. Next, feel both sides of the graft. The strongly pulsating side of the loop will be the arterial or supply side and the other will be the venous or return side; 3. Once venous side is determined, obtain access using aseptic technique and no smaller IV than an 18 gauge catheter. Be prepared for blood to spurt out from access point since the fistula is normally under pressure; 4. Control bleeding with sterile gauze over hub of IV cannula; 5. Quickly connect IV tubing. Do not completely tamponade fistulas or grafts as they may become clotted or rupture. 6. Once the PVAD has been accessed the IV should run at a TKO rate.

Disrupted Communications - In the event of a "disrupted communications" situation, the EMT-P in Solano County may utilize all portions of this treatment protocol without Base Hospital Contact as is needed to stabilize an immediate patient.