Title	Competency Document for Nurses Accessing, De-needling and Blood Sampling an Implantable Port
Version	2.0

- It is the responsibility of each registered nurse to:
- Have their own set of competencies signed and dated by an assessor.
- Observe accessing, administering intravenous medication and de-needling an implantable port THREE times.
- Be supervised accessing, administering intravenous medication and de-needling an implantable port for a minimum of THREE times.
- Discuss with an assessor when they are confident to be signed off as competent. Must be already competent in ANTT.

	ACTION	OBSERVED Date & Signature	SUPERVISED Date & Signature	**COMPETENT Date & Signature**
1	Introduce yourself and obtain consent. Check patient's identification and the date their portacath was last accessed and flushed. Discuss and document potential risks if the last access and flush exceeds recommended guidelines of 4 weeks. Explain procedure to the patient/carer.			
2	Wash hands, put on apron. Open up equipment onto a clean surface using ANTT. All key parts must be protected throughout to maintain the principles of ANTT. (Refer to the SOP for accessing implantable ports for a list of consumables)			
3	Ensure the patient is comfortable. Wash hands; remove any topical local anaesthetic cream from the port site. Locate the port and identify the septum. Assess the depth of the port and thickness of the patient's skin.			

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4	Wash hands, apply gloves and continue with the procedure using ANTT. Draw up prescribed 0.9% sodium chloride and heparin flushes.			
5	Flush the Portacath needle and extension set with sodium chloride 0.9%. Clamp the line, remove Luer lock syringe and replace the protective cap from the gripper extension set.			
6	Clean the patient's skin over the port site with 3ml of 2% chlorhexidine with 70% alcohol. Gently apply to the skin using repeated up and down, back and forth strokes for 60 seconds. Allow to dry for 30 seconds.			
7	Stabilise the port between your thumb and index finger. Using a perpendicular angle, push the portacath needle through the skin and port septum until the needle just hits the back plate of the port.			

	ACTION	OBSERVED Date & Signature	SUPERVISED Date & Signature	**COMPETENT** **Date & Signature**
8	Remove protective cap from the gripper extension set and attach an empty 10ml luer lock syringe. Maintain positive pressure on the syringe plunger prior to unclamping/clamping. Undo the line clamp; draw back on the syringe to obtain a" flashback". (There is not always a flashback – proceed if confident the needle is in the correct place).			
9	If blood samples are required, take a 3ml discard of blood, clamp the line, disconnect the syringe, then attach a new 10ml luer lock syringe and obtain the sample then clamp the line. **Observe the port site for signs of swelling throughout, increased resistance or the patient reports signs of discomfort.**			
10	Attach a new 10ml luer lock syringe filled with sodium chloride 0.9%. Maintain positive pressure on the syringe plunger prior to unclamping/clamping. Undo the line clamp and flush with 10ml 0.9% sodium chloride using pulsatile pressure.			
11	If blood samples have been taken flush with 20-30ml of 0.9% saline. Clamp the line. If removing portacath needle, flush with 4mls of 100units/ml of Heparin. **If not flushing refer to SOP for The Management of implantable ports.** **All medication including Heparin should be prescribed.**			

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12	To remove the portacath needle – press down on either side of the port with two fingers to stabilise the device. Withdraw the needle using steady traction, discard needle in sharps container.			
13	No dressing is usually required but a small plaster may be applied. Document date of access, size of gripper needle and number of attempts in the patient's notes. If the needle is to be left in situ. Secure Portacath needle by placing gauze around entry site (if required), remove plastic grip tab and apply a semi permeable dressing. Discard waste and equipment safely and appropriately (IP Manual, IP01b).			