

## Nursing – PICCs

### **POLICY**

The purpose of this policy is to describe the expected practice relating to access, ongoing management and removal of peripherally inserted central catheters (PICCs).

### **GUIDELINES**

This guide applies to the management and access of a central venous access device (CVAD) and is relevant to Westmont's Community Registered Nurses.

For the purpose of this guideline, the term 'CVAD' refers to peripherally inserted central catheters (PICCs).

PICCs are commonly inserted into the brachial, basilic or cephalic veins in the arm with the tip sitting in a central vein.

May be single, double or triple lumen.

May remain insitu for up to 12 months, typically used for intravenous therapy expected to last more than one to two weeks.



### **Indication for ongoing placement**

A CVAD is typically used for the administration of hypertonic, vasoactive, vesicant or irritating solutions, or if reliable intravenous access is needed when limited options are available. A CVAD may also be used for reliable, long-term access (ie. chronic conditions requiring ongoing therapy).

Ongoing need for a CVAD requires a thorough risk assessment. Alternatives such as oral medication or administration of medication via a peripheral intravenous cannula should be considered. There must always be a clinical justification for a CVAD due to the risks associated with this device.

Ongoing necessity of a CVAD must be assessed and recorded on the CVAS Management Chart.

### **Post insertion considerations**

Prior to first use, ensure the position of the PICC tip has been confirmed by the Radiologist or Medical Practitioner and the device is suitable to use. This must be recorded either in the medical record or CVAD Management Chart, and must include the name and contact number of the verifying Medical Practitioner.

Following the insertion of a CVAD, monitor the client's vital signs and insertion site as appropriate. Monitor client for any shortness of breath, swelling, pain, fever, erythema, bleeding, line breakage or difficulty flushing. Escalate concern to the client's GP, as appropriate.

## **Client education**

A client with a CVAD should be educated and provided with information (if appropriate) about the following:

- Report immediately any shortness of breath, pain, swelling, inflammation, fever or leakage.
- Keep the CVAD dry – if showering, ensure the CVAD insertion site is covered with a waterproof dressing and avoid exposure to water.
- Brief explanation of dressing and flushing regime.
- Avoid heavy lifting if a PICC is insitu.

## **INSERTION SITE MANAGEMENT**

### **Assessment**

The CVAD insertion site must be inspected every service. The insertion site dressing does not need to be removed to perform an assessment. The site may be palpated over the dressing to assess for tenderness, localised swelling, heat, bleeding, leakage, exudate, loose/broken sutures or noticeable erythema. Also check that the device has not migrated or dislodged.

Any abnormalities should be further investigated by removing the dressing. Variations and actions must be documented on the medical record or CVAD Management Chart, with complications detailed in the medical notes along with a clear plan for resolution. Escalate concerns to the client's GP, as appropriate.

### **Catheter securement**

Specific securement device. Generally, not to be sutured in. Exemptions may apply but must be documented on insertion.

Securement device should be changed as part of the dressing procedure.

Upon insertion of a PICC, two measurements must be documented: total PICC length (internal length) and measurement at the skin. This information should be documented in the insertion notes (either in the medical record or CVAD Management Chart).

PICC measurement at the skin must be documented on the medical record or CVAD Management Chart with every dressing change and should be visually inspected through the dressing every service. This measurement should match the measurement at the skin documented on insertion. Discuss any variance with the client's GP before proceeding.

Upon removal of the PICC, the total PICC length (internal length) documented in the insertion notes must be the same as the length of the device that has been removed.

Internal catheter breakage is a medical emergency.

### **Chlorhexidine impregnated sponge**

Adult clients with a PICC should have a chlorhexidine impregnated sponge placed around the catheter at the insertion site, unless:

- The client has a known allergy to chlorhexidine
- The CVAD is positioned near a chlorhexidine incompatible device

Monitor the site for adverse skin reactions in the client.

The chlorhexidine impregnated sponge can hold up to eight times its own weight in fluid and can continue to release chlorhexidine in the presence of blood, serum and protein. It is recommended that the sponge (and dressing) is changed if it is greater than 50% saturated.

The chlorhexidine impregnated sponge must have 360 degrees contact with the skin around the catheter insertion site, with the blue side facing upwards. Change the chlorhexidine impregnated sponge with the dressing. Refer to the Procedures for pictorial guide.

## **Chlorhexidine and/or alcohol: considerations and contraindications**

≥0.5% chlorhexidine in 70% alcohol is recommended for skin disinfection before CVAD insertion and during dressing changes unless advised otherwise by a Medical Practitioner.

In the case of chlorhexidine allergy, povidone-iodine 10% solution can be used as an alternative, giving due consideration to any additional devices that may be present.

## **DRESSINGS**

### **Assessment and planning**

Care must be taken when removing CVAD dressings to minimise the risk of inadvertent cutting/dislodgement of intravascular devices:

- Plan the dressing procedure
- Ask for assistance if the dressing is complicated
- Remove transparent semi-permeable dressing carefully
- Avoid using a stitch-cutter or scissors to remove the dressing
- If sutures must be removed with a stitch-cutter, ensure that the correct device and suture have been identified

Assess the insertion site dressing with the first 24 hours after insertion. Only change during this period if required. Otherwise change as per the dressing frequency described below.

### **Cleaning solution, dressing type and frequency**

- The catheter insertion site should be cleaned with ≥0.5% chlorhexidine in 70% alcohol solution. Refer to above for chlorhexidine special considerations and contraindications.
- 'Sandwich dressings' are not recommended because they are difficult to remove and require excessive manipulation of the insertion site. This excessive manipulation increases the risk of infection.
- Dressings must be kept dry.
- Dressings that promote moist wound healing (e.g. Comfeel or Duoderm) must not be used for CVAD insertion sites.

### **Dressing type**

The preferred dressing type is a chlorhexidine impregnated sponge with a sterile, polyurethane film dressing.

As an alternative, if insertion site is wet (ie. site oozing or patient diaphoretic), use chlorhexidine impregnated sponge with sterile gauze and tape. When oozing/diaphoresis resolved, continue with preferred dressing above.

### **Dressing frequency**

Change the preferred dressing (entire dressing) every 7 days or sooner if the dressing is wet, soiled or non-occlusive.

Change the alternative dressing (entire dressing) at least every 48 hours or sooner if the dressing is wet, soiled or non-occlusive.

### **Clients with burn injuries**

The above dressing regime may not be appropriate for a client with burn injuries and a CVAD. This should be at the discretion of the client's GP.

As an alternative, nanocrystalline silver dressings (ie. acticoad) have been used in burn clients.

## **ACCESSING A PICC LUMEN**

Prior to first use, ensure that position of the tip has been confirmed and the device is suitable to use.

Always wear protective eyewear when accessing a CVAD in case of accidental disconnection and splash injury.

## **Commencing an infusion**

A CVAD must be aspirated (with aspirate discarded) before use if:

- There is heparinised saline in the lumen and it not appropriate to be flushed into the client
- There is any doubt as to whether a lumen has been adequately flushed clear of previous medication
- The CVAD has not been accessed for one week or longer

### **‘Scrub the hub’**

Scrub the hub of any CVAD access port prior to access following aseptic techniques.

## **LUMEN MANAGEMENT**

### **Maintenance of patency**

Fibrin clots can cause occlusion of CVAD lumens. This can increase the risk of central line-associated bloodstream infection as these clots are an ideal medium for microbial growth. An occluded lumen may necessitate CVAD removal and insertion of a new line, with associated risks for the client. Occluded lumens must be reported to the client’s GP and Adverse Event Form should be completed.

### **Needless access devices**

Westmont supports the use of needless access devices that create a ‘closed lumen system’ so a lumen does not need to be completely exposed for access.

The PICC’s internal mechanisms displaces fluid upon disconnection of a syringe resulting in a small bolus of fluid from the distal end of the lumen tip. This reduces the risk of catheter occlusion when not in use.

Avoid clamping PICCs unless the needless access device has been removed/during valve change. Clamp after disconnection of syringe so that positive displacement can be generated by the valve.

The PICC should be primed before use.

The PICC lines should be changed:

- If unable to flush clear (e.g. visible blood or precipitate)
- If damaged

### **Flushing**

A CVAD should not be flushed using a syringe smaller than 10mls. Smaller syringes generate greater pressures which will rupture the device.

CVADs should be flushed utilising a ‘pulsatile’ flushing technique. This involves pushing 1mL of fluid, pausing, pushing another 1mL etc. This creates a turbulent flow clearing the lumen more effectively than a straight flush.

Never use excessive force when attempting to flush a CVAD regardless of syringe size.

Following blood sampling, aspiration of blood or administration of blood, 20mL of 0.9% sodium chloride for injection may be necessary to flush the lumen clear. The viscosity of blood means it is more difficult to clear from the lumen and valve with only 10mL.

## **ADMINISTRATION LINES**

### **Anchor for administration lines**

It is important to prevent any movement or trauma to the CVAD insertion site. This immobility will encourage healing which will provide a barrier to infection.

For PICCs consider the use of adhesive tape or a dedicated securement device to secure attached administration lines.

## Administration line changes

All infusion bags and administration lines must be labelled.

To reduce the risk of catheter blockage and for client safety, intravenous fluids should generally be delivered using an intravenous infusion pump.

Reconnection of previously used administration lines may increase the risk of contamination and subsequent infection, as well as possible exposure to blood-borne viruses through connecting a used administration line with the incorrect client. Discard disconnected administration lines.

If a new CVAD is inserted, new administration lines should be attached.

Where possible, parental nutrition should run on a separate dedicated lumen and must not be disconnected unless lines and flasks are changed. If running on a lumen with other infusions (check with a pharmacist for compatibility data) all infusions should be changed simultaneously to reduce the risk of contamination.

When an administration line set is discharged, if the plastic spike at the top of the set is exposed (ie. removed from the fluid bag), it must be disposed of as a sharp.

## BLOOD SAMPLING FROM A PICC

Blood sampling via a CVAD can increase the risk of catheter occlusion and subsequent infection, particularly if a lumen is not flushed properly afterwards.

If required, blood sampling via a CVAD should be limited to the following clinical scenarios:

- Poor venous access
- Frequent blood sampling
- Severe needle phobia
- PICC suspected as source of sepsis

If a blood sample is taken from the CVAD, attention must be paid to:

- Aseptic technique principles
- Completing the procedure promptly. The lumen must be flushed without delay after the blood is drawn

## REMOVAL OF A CVAD

CVAD necessity should be assessed daily with the device removed as soon as it is no longer required.

Consider removal of the CVAD if there is evidence of local infection (redness, tenderness or pus around catheter insertion site or unexplained systemic sepsis (e.g. rigors, shivering/chills or haemodynamic changes with or without fever).

Blocked lumens may increase the risk of infection. If efforts to unblock the lumen fail, consideration should be given to removal and replacement of the CVAD.

## CVAD RISK MANAGEMENT

Although not a comprehensive list of all complications associated with CVADs, the following table is designed to assist nurses with trouble shooting and preventing some complications that may be encountered.

For all of the following complications, nurses must escalate concerns to the client's GP, as appropriate.

Complications	Signs and Symptoms	Prevention	Comments
Pneumothorax	Shortness of breath, cyanosis, chest pain, tachycardia, hypoxia/oxygen desaturation, wheeze, restlessness or anxiety.		Generally, insertion related.

Haematoma formation	Bruising, local swelling, patient complains of pain and/or pressure.	Assess site regularly. Consider coagulation status and monitor as clinically indicated.	
Migration of catheter tip (inwards)	Pain in ear, neck, chest, shoulder or back. Neck, hand, arm or chest swelling. Client complaint of hearing a 'swish' or 'gurgling' sound during flushing. Inability to aspirate blood. Arrhythmia.	Ensure CVAD is well secured. Check/document PICC measurement. Assess device regularly.	
Catheter dislodgement (outwards)	External catheter length appears longer, differences in catheter length measurement.	Ensure CVAD is well secured. Check/document PICC measurements. Assess device regularly.	Do not attempt to push catheter back into place.
Thrombus	Pain, swelling, numbness, tingling, discolouration of neck, chest or arm (on side of CVAD) cool peripheries.	If possible, mobilisation of the catheterised extremity, performance of normal activities of daily living, gentle limb exercise, adequate hydration.	
Systemic infection (Central line-associated bloodstream infection)	Unexplained fever, rigors. Fever, rigors or chills post flushing. Note: these signs may be altered if the client is neutropenic.	Meticulous hand hygiene, scrub the hub of the CVAD lumen before access, occlusive dressing maintained and aseptic technique adhered to during dressing changes, valve changes and lumen access. Use of chlorhexidine impregnated sponge where applicable.	
Local/site infection	Local pain, inflammation, swelling, bleeding, leakage or exudate, loose or broken sutures, cellulitis or tracking near the insertion site. Note: these signs may be altered if the client is neutropenic.	Meticulous hand hygiene, scrub the hub of the CVAD lumen before access, occlusive dressing maintained and aseptic technique adhered to during dressing changes, valve changes and lumen access. Use of chlorhexidine impregnated sponge where applicable.	
Occlusion	Difficulty flushing or infusing fluid, difficulty aspirating blood. Partial occlusion – may allow infusion of fluid but not aspiration.	Use of appropriate needleless access devices. Flushing technique. Appropriate flushing frequency.	<b>External occlusion:</b> Perform a visual inspection of the CVAD and administration lines for kinks, and resecure line/redress if indicated. Inspect needless access device for visible blood. <b>Internal occlusion:</b> Ask client to cough, take a deep breath, hunch shoulder or reposition. Attempt gentle irrigation with 0.9% sodium chloride using pulsatile method alternating between flushing and aspirating. Do

			not exert excessive pressure or suction. Note: if one lumen of a multi lumen CVAD becomes blocked, consideration should be given to removal and replacement of the device due to the increased infection risk that a clot presents.
Air embolus	Sudden onset of dyspnoea, continued coughing, breathlessness, chest pain, hypotension, jugular venous distension, tachyarrhythmias, wheezing, tachypnoea, altered mental status, altered speech, changes in facial appearance, numbness and paralysis. If suspected, immediately call an ambulance.	Remove CVAD in accordance with recommended practice. Ensure client is positioned appropriately and does not inhale while CVAD is being removed. Protect open lumens from air entry by using clamps or temporarily kinking lumen while valve is being changed. Regularly assess connections to ensure tightened securely. Ensure air is purged from syringes, administration sets, needless connectors.	Air embolism is a rare but serious complication associated with the removal of a CVAD. If suspected breakage, see below.
Catheter breakage	Visible catheter damage. Upon removal of CVAD from client, tip noted to be missing. Following removal of a PICC line, actual length of catheter must match total documented length in insertion notes (these should be checked prior to removing PICC).		If CVAD remains in place, for an external breakage, clamp the CVAD with guarded artery forceps close to the insertion point to prevent blood loss, air embolism, infection and catheter migration. Wrap the catheter with sterile gauze (or sterile towel). Catheter will need to be removed. Internal catheter breakage is a medical emergency as the catheter fragment is a potential embolus.
Accidental disconnection	Blood loss. Prolonged signs of air embolus.	Ensure connections are secure.	Immediately occlude lumen.

## DOCUMENTATION

Please use the CVAD Management form to document the following:

- Provision of initial client education
- Date the device was inserted
- Daily review of device necessity (including reason for ongoing use)
- Dressing changes
- PICC measurement
- Assessment of insertion site
- Lumen and administration care, including add-on devices
- Date of device removal

For serious complications that require more details than the CVAD Management form allows for (e.g. leakage, dislodgement, migration, trauma, infection) document in the medical record and escalate concerns to client's GP as appropriate. Complete an Adverse Event form if necessary. Include preceding events (e.g. disconnection/blood sampling/medication administration etc) and details of action taken.

## PROCEDURES

### Dressing Change Procedure

#### EQUIPMENT REQUIREMENTS

- Clean and disinfected working area
- Dressing pack
- Sterile gloves
- Non-sterile gloves
- $\geq 0.5\%$  chlorhexidine in 70% alcohol solution
- Sterile, polyurethane film dressing
- Chlorhexidine impregnated sponge if appropriate
- Securement Device
- Waste bag
- Adhesive tape (optional)

#### PROCEDURE

- Explain the procedure to the client and gain consent.
- Hand wash and sanitise.
- Open the dressing pack, add chlorhexidine in alcohol solution, and place required sterile items into aseptic field.
- Position client appropriately and gain access to insertion site. Consideration should be given to the best position for application of the new dressing to avoid skin stretching and dressing being pulled off.
- Hand wash and sanitise.
- Don non-sterile gloves and remove old dressing. Take care to avoid dislodging the CVAD.
- Remove securement device. Do not leave the client unattended. Assistance may be required by another nurse to ensure that PICC position is maintained.
- Check PICC measurement at skin by visualising marking at insertion site.
- Remove non-sterile gloves.
- Hand wash and sanitise.
- Don sterile gloves and clean the catheter insertion site and catheter line with chlorhexidine in alcohol solution. Note: the entire area of skin and catheter line covered by the dressing must be cleaned.
- While visualising insertion site, perform site assessment.
- Allow cleaning solution to dry by evaporation.
- Place PICC into the securement device and affix to the client.
- Apply chlorhexidine impregnated sponge to insertion site (if appropriate), with blue-side facing upwards (remember: blue-sky-up).
- Apply sterile, polyurethane film dressing, with insertion site at centre of dressing. Ensure catheter is not kinked, is well secured and dressing is occlusive with no open track along lumen to insertion site. If possible, avoid placement of PICC dressing over the arm joint to prevent intermittent catheter occlusion.
- Additionally, to further secure the dressing, consider placing a border Hypafix around the edges.
- Dispose of waste.
- Hand wash and sanitise.
- Document procedure on CVAD Management Chart. Document measurement at skin.



## Needless Access Device Changes Procedure

### EQUIPMENT REQUIREMENTS

- Cleaned and disinfected working area
- Dressing pack
- Sterile gloves
- Protective eyewear
- Required needleless access device/s
- ≥0.5% chlorhexidine in 70% alcohol solution
- 10mL syringes x 1 for lumen
- 0.9% sodium chloride for injection x 10mL for each lumen

### PROCEDURE

- Explain the procedure to the client and gain consent.
- Wash and sanitise hands.
- Ensure lumen is accessible for valve change (ie. turn off infusions if safe to do so, plan procedure thoroughly if drug infusions cannot be interrupted).
- Ensure CVAD lumen is clamped (to prevent air entry and blood loss during change procedure).
- Wash and sanitise hands.
- Open dressing pack, add chlorhexidine in alcohol solution, and place required sterile items onto aseptic field.
- Wash and sanitise hands.
- Don sterile gloves.
- Draw up 0.9% sodium chloride (10mL for each needleless access device being replaced). Assistance may be required to maintain sterility of gloves.
- Prime valve with 0.9% sodium chloride – leave 10mL 0.9% sodium chloride filled syringe attached to valve, sitting on aseptic field.
- Using a non-tough technique, place sterile sheet from the dressing pack under the lumen.
- Ensuring lumen is clamped shut, use a piece of chlorhexidine-soaked gauze and remove old valve.
- Clean exposed lumen with chlorhexidine in alcohol solution. 'Scrub the hub' and remove all visible debris (allow to dry by evaporation).
- Attach new, primed valve.
- Release clamp.
- To ensure line patency, flush lumen (with 10mL of 0.9% sodium chloride).
- Remove gloves and dispose of waste.
- Wash and sanitise hands.
- Document valve change on CVAD Management Chart

## Blood Sampling Procedure

### EQUIPMENT

- Clean and disinfected working area
- Non-sterile gloves
- Protective eyewear
- Blood Specimen request slip
- 1 x 10mL syringe (for aspiration) OR spare blood specimen tube marked 'discard'
- 1 x 20mL syringe (for flush)
- 0.9% sodium chloride for injection 10mL x 2
- Vacutainer collection barrel assembly
- 70% alcohol swabs x 2
- Blood specimen tubes
- Sharps container

### PROCEDURE

- Explain the procedure to the client and gain consent.
- Verify client identity.
- Check client identity matches blood request slip. If there are any discrepancies, do not proceed.
- Turn off all infusions before sampling (if safe to do so).
- Clean and sanitise hands.

- Prepare equipment. Consider required order of specimen tube collection.
- Wash and sanitise hands.
- Don non-sterile gloves and protective eyewear.
- If blood sampling via a three-way tap, close tap off to infusion line and open to catheter lumen and valve end designated for blood sampling.
- 'Scrub the hub' of the designated needleless access device/connection with 70% alcohol swab.

Vacutainer System	Syringe Method
<ul style="list-style-type: none"> <li>• Attach vacutainer system to needleless access device.</li> <li>• Aspirate approximately 10mL of blood using spare specimen tube (marked 'discard'), and discard in sharps container.</li> <li>• Fill required specimen tubes using vacutainer system.</li> <li>• Flush CVAD with 20mL of 0.9% sodium chloride for injection, using pulsatile method. Ensure line is visibly clear.</li> </ul>	<ul style="list-style-type: none"> <li>• Attach syringe to needleless access device.</li> <li>• Aspirate 10mL of blood using the 10mL syringe and dispose in sharps container.</li> <li>• Aspirate required blood volume, and place blood-filled syringe (temporarily) in tray.</li> <li>• Flush CVAD with 20mL of 0.9% sodium chloride for injection, using pulsatile method. Ensure line is visibly clear.</li> <li>• After CVAD has been flushed clear, distribute blood from syringe to specimen tubes.</li> <li>• Warning: needling of blood into specimen tubes poses an extreme risk of needle-stick injury and splash injury. A blood transfer device must be used to distribute blood and protective eyewear must be worn.</li> </ul>

- If blood sampling via a three-way tap, close tap off to valve end designated for blood sampling. Have tap open to administration line and CVAD lumen.
- Restart any infusions.
- Label tubes by the clients side and place in sealed biohazard bag with specimen request slip.
- The identification on the specimen must match the request slip.
- Complete the collection certification on the request slip with the collector's printed name and signature once satisfied that the client, the specimens and the request slip all carry the same identification, and that slip/s and labels meet the minimum identification criteria.
- Initial pre-printed labels, if used, to indicate that his check has been done.
- Note: any mismatch or inaccuracy of information will lead to rejection of specimens by Pathology
- Remove gloves and protective eyewear and dispose of waste.
- Wash and sanitise hands.
- Send specimens to Pathology, as appropriate.

## PICC Removal Procedure

### EQUIPMENT REQUIREMENTS

- Clean and disinfected working area
- Dressing pack
- Non-sterile gloves
- Protective eyewear
- ≥0.5% chlorhexidine in 70% alcohol solution
- Extra gauge
- Occlusive dressing
- Waste bag
- Yellow tip specimen jar and sterile scissors if time to be sent for micro and culture

Consider use of sterile gloves and dressing pack to avoid contamination of the tip.

### PROCEDURE

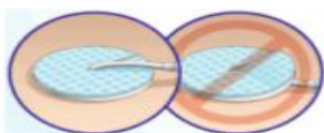
- Confirm medical officer request for line removal.
- Confirm total PICC length from insertion documentation to ensure an accurate assessment can be made as to whether the device is intact upon removal.
- Consider alternate IV access prior to removal (eg peripheral cannula) if required.
- Explain the procedure to the client and gain consent.
- Confirm client identity.

- Put on protective eyewear.
- Wash and sanitise hands.
- Open the dressing pack, add chlorhexidine in alcohol solution, and place required sterile items onto aseptic field.
- Wash and sanitise hands.
- Turn off and disconnect infusion/s.
- Position client in a comfortable position, with arm extended (45 to 90 degrees) as this give the catheter the straightest possible path for removal.
- Wash and sanitise hands.
- Don gloves.
- Remove the existing dressing and securement device.
- Clean the area with chlorhexidine in alcohol solution and all to air dry.
- Place gauze over insertion site in preparation for removal.
- Withdraw the catheter slowly, pulling from near the insertion point, exerting intermittent traction by with applying pressure to the insertion site.
- Do not stretch the catheter during the removal process
- Do not pull against resistance.
- Immediately upon line removal, apply firm pressure using gauze to the puncture site.
- Continue pressure until bleeding ceases.
- Whilst applying pressure, visually inspect the catheter to ensure it is fully intact. If it is not, this is a medical emergency and an ambulance must be called. Continue to monitor the client.
- Apply occlusive sterile dressing to puncture site (and leave in place for at least 24 hours).
- Remove gloves and protective eyewear and dispose of waste.
- Wash and sanitise hands.

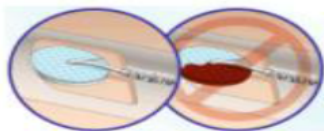
Follow up post PICC removal:

- Assess the site for bleeding or infection, as clinically indicated.
- Instruct the client to report any bleeding, undue pain, shortness of breath or redness/inflammation at the insertion site and respond appropriately.

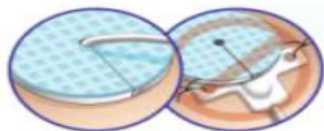
## Chlorhexidine Impregnated Sponge Procedure



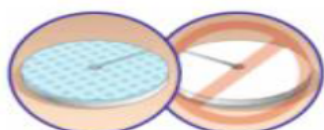
Place the catheter through the hole in the centre of the sponge.



Change the sponge if it is greater than 50% saturated with blood.



Ensure the sponge has 360 degree contact with the skin.



Apply the sponge *blue side up*, white foam side down.

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