Removal of a Peripheral IV Catheter

Purpose

The purpose of this procedure is to provide guidelines for the safe and aseptic removal of a peripheral IV catheter.

Preparation

* Can only be performed by licensed staff.

1. Determine if a physician's order is necessary for this procedure.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

General Guidelines

1. IV Catheters should be removed only with a specific order from the physician, or:
   a. during site rotation;
   b. when infection or complication is suspected.
2. Only nurses with documented education and training in infusion therapy, and as designated by the facility, may remove midline catheters, PICCs, or non-tunneled central venous catheters.
3. Follow manufacturer's guidelines for the removal of midlines, PICCs and non-tunneled central venous catheters.
4. Do not remove tunneled, cuffed, or implanted ports. (**Note**: The removal of these devices is a medical procedure.)

Equipment and Supplies

1. Gloves;
2. Suture removal kit (if necessary);
3. Measuring tape;
4. Antiseptic Ointment;
5. Dressing Material (e.g., gauze, transparent semipermeable membrane);
6. Tape; and
7. Labels.

Assessment

Inspect intravenous catheter site for signs of infection and/or complications at scheduled intervals and upon routine site care and administration set changes.

Steps in the Procedure

1. Discontinue administration of all infusates and clamp tubing.
2. Wash hands and don gloves.
3. Remove dressing over catheter insertion site.
4. Inspect skin around access site for signs of infection or complications.
5. Disinfect access site at catheter-skin junction.
6. Remove sutures or tape, if necessary.
7. Gently retract catheter from site. **Do not use force if resistance is felt**. Discontinue removal and notify physician.
8. Inspect removed catheter for any defects. If any defects are noted, report to manufacturer and appropriate regulatory agencies, and complete and Incident Report.

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Steps in the Procedure (continued)

9. Assess length of catheter against original size to ensure that entire catheter has been removed.
10. Dress exit site:
    a. apply gentle pressure with gauze to stop any bleeding;
    b. apply new gauze with antiseptic ointment to exit site;
    c. secure with sterile tape; and
    d. change every 24 hours until site is healed.
11. Discard used supplies.
12. Remove gloves and perform hand antisepsis.
13. Document procedure in resident's medical record.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time the catheter was removed.
2. The reason for the removal.
3. Condition of the catheter exit site.
4. Type, size and condition of the removed catheter.
5. Notification of the physician, if any.
6. Resident's response.
7. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (RAPs)	K5a, K6, P1c, P8 (RAP # 12, RAP # 14)
Survey Tag Numbers	F328
Related Documents	Intravenous Therapy: Preventing Catheter-Related Infections (*Infection Control*)
Risk of Exposure	Blood–Body Fluids–Infectious Diseases
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____