| SECTION 8C: VASCULAR ACCESS DEVICES | POLICY: 8C.4 |
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| POLICY: REMOVAL OF NON-TUNNELED CATHETERS | PAGE: 1 OF: 3 |

## PURPOSE:

- To promote consistency of practice and ensure the safe removal of non-tunneled catheters thereby minimizing injury and infection risk.

## POLICY:

- As directed by a physician's written or verbal order, infusion patients under the care of this Agency with non-tunneled catheters will have catheter removal performed by a trained Agency nurse in accordance with this policy.
    - Nurses **cannot** remove tunneled catheters in the home.

- Non-tunneled catheters can be removed with a physician's order to do so. If an order for catheter removal is written in the original order for the end of therapy, the nurse should confirm the plan to remove the catheter with the Agency prior to removal to ensure there has been no change to the plan of care.

## PROCEDURE:

1. Check patient ID and verify patient information.
2. Perform hand hygiene. (Refer to Hand Hygiene policy.)
3. Verify MD order and necessary supplies/equipment.
4. Explain procedure to patient as appropriate.
5. Inspect the general condition of the catheter.
6. Discontinue all infusions into the device.
7. Wear gloves (non-sterile to remove the dressing). Discard old dressing.
8. Don sterile gloves. Clean catheter insertion site per Dressing Change policy.
9. If present, cut sutures. **Extreme caution should be used if a PICC line has been sutured because the soft catheter may inadvertently be cut and result in catheter embolism.**

10. Instruct the patient to take a deep breath and to breathe out while the catheter is being removed. Grasp hub of non-tunneled catheter and gently and steadily retract catheter until completely removed. Withdraw a PICC line in 1-to-2-inch increments; reposition your hand to grasp the catheter at the skin and repeat as necessary until the entire length of the catheter is removed.
11. **For PICCs:** if resistance is met while withdrawing, tape the catheter with slight tension on it. Apply warm packs to the upper arm and wait 5-15 minutes before attempting to remove.
12. Place removed catheter on sterile field if catheter culture is ordered.
13. Apply constant firm pressure to site with 4x4 gauze. Maintain pressure for all catheter types for 2-3 minutes or until hemostasis is achieved and bleeding stops.
14. Once hemostasis is achieved and bleeding stops, apply an occlusive sterile dressing over the site.
15. Visually inspect catheter for damage or missing parts.
    - **For PICCs:** measure the catheter to ensure the entire length has been removed. If length is shorter than expected or edges appear broken, assess patient for respiratory distress and notify the physician immediately.
16. If culture of the catheter tip is ordered, cut the distal one inch of the catheter with sterile scissors, and place in sterile specimen container using aseptic technique.
17. Discard supplies (as applicable), remove gloves, and wash hands.
18. Document date, time, procedure, integrity of the catheter, condition of the exist site, any bleeding and patient tolerance of the procedure.
    - **For PICC:** note length of catheter on insertion in progress notes (if the information is available).

## POST-PROCEDURE CLIENT EDUCATION:

1. Instruct patient to leave pressure bandage in place for at least 24 hours and avoid getting it wet to ensure bleeding has stopped
2. If the site resumes bleeding at any time after line removal and does not stop after holding firm pressure for 3 – 5 minutes, patient should notify healthcare provider immediately

3. Patient should avoid lifting anything heavy with the extremity from which the PICC line was removed for at least 24 – 48 hours
4. Patient should avoid getting the PICC site wet for 24 – 48 hours
5. Patient should contact their healthcare provider if any concerning symptoms present in the extremity from which the PICC line was removed including redness, swelling, draining pus, foul odor, severe pain, or numbness



*Reference: PDN Policy 13025*