Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Picc Removal		Clinical Procedures	11-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY:

Every attempt must be made for the client to have the peripherally inserted central catheter (PICC) removed in a designated referral site. If special circumstances arise and the client must have the PICC line removed in the community health centre, the Registered Nurse may remove the PICC when ordered by a physician. The nurse must receive additional training with the Nurse Educator or Delegate prior to performing this skill.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Infection Control Manual
Guidelines 10-002-01 Universal Precaution Guidelines
Procedure 11-002-01 PICC Removal

REFERENCES:

Macklin, D. (2000). Removing PICC. American Journal of Nursing (100) 1, 52-54
Potter, P.A. & Perry, A.G. (2010). Clinical Nursing Skills & Techniques, 7th edition, Mosby: Toronto.
Wall, J., Kierstead, V. (1995). Peripherally Inserted Central Catheters: Resistance to Removal: A Rare Complication. Journal of Intravenous Nursing (18)5, 251-254

NURSING CONSIDERATIONS:

1. Factors which may induce resistance to removal include: venous spasm, phlebitis, thrombosis, fibrin formation, kinking of catheter,
2. If resistance is encountered when attempting to remove the catheter, stop, reposition the arm and attempt removal again. If resistance continues, apply warm compress for 5-10 minutes, then re-attempt. If still unsuccessful, notify the physician.
3. If catheter breaks during removal, but is still long enough to be pulled (2-3 cm), clamp exposed end (if open-ended catheter) and continue removal.
4. If catheter breaks at insertion site or tip of catheter is missing, apply tourniquet around upper arm at axilla (tight enough to occlude venous flow) and position the client left lateral trendelenburg. Notify physician immediately. Retain external catheter.

CLEANSING SOLUTION:

1. Chlorhexidine (CHG) gluconate 2% in alcohol 70%

2. Total contact time for cleansing solution will be 30 seconds.

3. Cleansing solutions must be allowed to air dry prior to covering the catheter site with a dressing. This will ensure the proper contact time. In addition, if the skin is covered while still moist, a reaction between the cleansing solution and the dressing adhesive can occur and may result in cutaneous reaction.

4. In the event that the client is allergic to chlorhexidine (CHG):
    a. Isopropyl alcohol 70% (contact time 30 seconds)
    OR
    b. 10% providone iodine (PI contact time 2 minutes) may be substituted.

EQUIPMENT
✓ 1 pair non-sterile gloves ✓ Cleansing solution: chlorhexidine (CHG) gluconate 2% in alcohol 70% **If allergic to CHG:** ✓ 10% Providone Iodine (PI) solution or swabsticks OR isopropyl alcohol 70% ✓ 2 x 2 gauze ✓ Bandaid (optional) ✓ Sterile scissors and specimen container if infection suspected

PROCEDURE:

1. Apply warm compresses to upper arm of affected limb for 5 – 10 minutes prior to removal. (This will promote venous dilation).

2. Glove. Remove old dressing, steri-strips, and suture wing if present.

3. Clean the insertion site with antiseptic solution.

4. Position arm below the level of the heart with arm extended away from body at 45-90 degrees, while the catheter is being removed.

5. Grasp the catheter at the insertion site and gently pull it out at 2 – 3 cm intervals. Pause briefly in between (pausing will help prevent venous spasm). Continue removing the catheter in this manner. Always return to the insertion site to avoid stretching and breaking the catheter.

    a. Markings (black dots or a number) will be noted at different locations along the catheter, as it is removed. For example, 4 dots (number 40) indicate that there are 40 cm of catheter remaining in the client.
    b. When 1 dot (10 cm) is seen, grasp the gauze and hold it gently above the insertion site. Apply pressure to the site once the catheter comes out and until hemostasis is achieved.

6. Inspect the tip. If it is a Groshong® PICC, the end should be closed, with a rounded black tip on the end. All other PICC's are open-ended.

7. Place a Band-Aid over the site (optional).

8. Send catheter tip for C&S, if infection suspected.

DOCUMENTATION:

Document the following in the client's health record:

1. Site assessment
2. Difficulties encountered and interventions
3. Condition of catheter and catheter tip
4. Specimens obtained as applicable
5. Client response

CLIENT TEACHING:

Ensure client/family have been advised of the following:

1. Notify the nurse on call if increased redness, swelling, drainage or discomfort
2. May remove bandage after 24 hours
3. Apply warm compresses x 20 minutes, 4 times per day, if catheter removed due to mechanical phlebitis

REFERENCES

Macklin, D. (2000). Removing PICC. American Journal of Nursing (100) 1, 52-54

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Approved by:	Effective Date:
Chief Nursing Officer — Date: 11 FEB 2011	April 1, 2011
Deputy Minister of Health and Social Services — Date: February 11, 2011	