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Extended Dwell Peripheral Intravenous Catheter		**II.D.4.22**	1
Content Expert / Coordinating Department(s)	Prior Issue Date	Issue Date	
IV Team/Nursing	**NEW**	**06/01/2015**	

POLICY:
This policy is to define proper insertion, care and maintenance of extended dwell catheters. The scope of this policy is for nurses responsible for insertion care and maintenance of the extended dwell catheters in the inpatient and emergency department settings.

QUALIFIED PERSONNEL: Intravenous Team, Midlevel Providers

PROCEDURE/GUIDELINES:

A. **Definition**: The extended dwell catheter is inserted into a patient's vascular system for short-term use (<29 days) to sample blood or administer fluids intravenously. These catheters may be used for any patient population with consideration given to adequacy of vascular anatomy and appropriateness of the procedure. The extended dwell catheter is suitable for use with power injectors.

B. Insertion Procedure

1. Preparation
   a. Identify patient
   b. Explain procedure to the patient
   c. Gather supplies
   d. Perform hand hygiene
   e. Place patient in recumbent position, as tolerated
   f. With ultrasound; scan for vein and mark vein intended for insertion
   g. Measure the distance from insertion site to desired termination of the tip.
      NOTE: Tip does not extend beyond the level of the axilla
      NOTE: No more than 2 attempts at catheter placement will be made by any one nurse

2. During the procedure:
   a. Cleanse insertion site with antiseptic solution. Allow to air dry
   b. Apply tourniquet above the intended insertion site
   c. Remove needle sheath from plastic housing on extended dwell catheter
   d. Place a sterile cap or probe cover over ultrasound probe
   e. With ultrasound, scan within the clean marked area and locate the vessel intended for insertion
   f. Insert the needle into the vein, when venous access is achieved a blood return can be seen
   g. Hold the needle in place, use the front grips of extended dwell catheter to advance the guide wire. Using the guide wire, push off until the guide wire is fully extended and locks into place
   h. Grip the plastic housing by holding the back grips and fully advance the catheter using the catheter handle. This will insert the catheter into the vein.
   i. Hold catheter in place using catheter handle and remove housing. The needle safely mechanism should activate upon removal from handle.
   j. Hold catheter hub and twist to remove catheter handle
   k. Attach needleless connector
   l. Remove tourniquet
   m. Flush the vascular access devise with 10 ml of 0.9 Normal saline
   n. Stabilize catheter with securement device

3. After the procedure:
   a. Stabilize the catheter and apply sterile dressing
   b. Label dressing
      i. "Extended Dwell Catheter"
      ii. Date and time of insertion
      iii. Gauge and length of catheter
      iv. Initials of inserter
      v. Date of catheter expiration

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4. Care and Maintenance
   a. Review daily to assess continued need for line. Inspect for signs and symptoms of infection or infiltration.
   b. RN will document patency and inspect the site and document in the electronic record for each shift. Complications noted require call to IV Team for further evaluation.
   c. Verification of blood return should be completed prior to use for power injection.
   d. Flush the catheter with 10 mL of saline every 12 hours or after each use.
      NOTE: Use a 10 mL or larger syringe.
   e. Any access to catheter hub requires to ("scrub the hub"), a minimum of 10-15 second disinfection.
   f. Dressing and connectors are changed every 7 days by IV Team nurse.

5. Removal
   a. Obtain order to remove IV. NOTE: Removal by RN only.
   b. Perform hand hygiene.
   c. Verify correct patient using two identifiers.
   d. Don exam gloves. Remove stabilization device and transparent dressing using alcohol swabs.
   e. Grasp the catheter at the hub. Pull the catheter out slowly – do not pull against resistance. If resistance felt, stop removal. Apply warm compress and wait 20-30 minutes to retry.
   f. Resume removal. NOTE: If resistance is still present, consult with IV Team Nurse or physician.
   g. Once removed, cover site with sterile dressing.
   h. Ensure that the entire catheter was removed. Assess if tip of catheter is intact.
   i. Dispose of catheter in appropriate receptacle. Remove gloves and perform hand hygiene
   j. Observe site for evidence of bleeding, redness, pain, drainage, or swelling.
   k. Instruct patient to notify nurse if bleeding or drainage is noted at insertion site or if pain or tenderness is experienced.

DOCUMENT PROCEDURE IN THE ELECTRONIC MEDICAL RECORD.