STANDARDIZED PROCEDURE
CENTRAL VENOUS CATHETER REMOVAL (CVC)

These procedures are intended to describe procedures performed by Nurse Practitioners and/or Certified Nurse Midwives (depending on the clinical privileges granted to the individual practitioner) at UC San Diego Health.

I. Policy

a. Function: To remove a central venous catheter when indicated
b. Circumstances:
   i. Setting: See Cardiothoracic Surgery Nurse Practitioner General Policy Standardized Procedure
   ii. Supervision: See Cardiothoracic Surgery Nurse Practitioner General Policy Standardized Procedure
   iii. Patient Conditions/Indications for removal of CVC including but not limited to:
      - Patient no longer requires central venous access
      - Incorrect placement as evidenced radiographically
      - Possible source of infection
      - CVC is past standardized practice for length of indwelling placement (i.e.: longer than 7 days)

II. Protocol

a. Definition: Central Venous Catheter removal for the above indications
b. Objective: See section I-b-iii for indications for central venous catheter removal
c. Assessment: Patient which meets central venous catheter removal as described above in section I-b-iii
d. Plan:

Equipment Necessary

- 4x4 cotton gauze (2)
- Petroleum Gauze Dressing (1)
- Iris Scissors
- Forceps
- Nonsterile Gloves
- Iodine-Povodine swabs
- Sterile Culture Cup (if culturing catheter tip is indicated)

Pre-Procedure

1. Explain the procedure to the patient and family (if patient alert and if family is present)
2. Answer any questions family or patient may have
3. Instruct the patient that he/she must lay flat for approximately 20 minutes following the procedure

Catheter Removal Process

1. Disconnect all fluids infusing through the line
2. Assess that the patient has sufficient peripheral or alternative central access
3. Place the patient in Trendelenburg Position
4. Remove dressing and cut any securing sutures
5. On inspiration, pull the catheter out and immediately place gentle pressure over the insertion site with the petroleum gauze and 4x4 gauze.
6. Apply pressure for approximately 5-10 minutes
7. Apply sterile dressing to site with petroleum gauze and 4x4 with paper tape
8. Using sterile scissors cut distal portion of catheter and place in sterile cup, if bacterial culture is necessary
9. Remove patient from Trendelenburg Position and instruct to lie flat for 20 minutes

Patient Conditions Requiring Physician Consultation (Limitations):

- Hemorrhage
- Ischemia or necrosis to site
- Infection
- Local Hematoma

Follow Up:

a. Further evaluation and treatment as indicated
b. Instruct nursing staff to observe for signs of infection, hemorrhage, or ischemia

e. Record Keeping

See Cardiothoracic Surgery Nurse Practitioner General Policy Standardized Procedure

III. Requirements for the Nurse Practitioner

a. Education and Training: See Cardiothoracic Surgery Nurse Practitioner General Policy Standardized Procedure
b. Evaluation: See Cardiothoracic Surgery Nurse Practitioner General Policy Standardized Procedure

IV. RESPONSIBILITY

Please contact the Advanced Practice Council if you need help. The administrative assistant for the Chief Nursing Officer can direct you. Call; 619-543-3438.

V. HISTORY OF PROCEDURE

Revised by the Committee of Interdisciplinary Practices: 2/26/2014, 9/28/2016

Reviewed by the Medical Staff Credentials Committee: 3/5/2014, 10/6/2016

Approved by the Medical Staff Executive Committee: 3/20/2014, 10/7/2016