INTERVENTIONAL NEPHROLOGY UNIT SPECIFIC POLICY

IN2b Removal of Tunneled Central Venous Catheters
(Subclavian, Internal Jugular-IJ, External Jugular-EJ, Femoral)

PURPOSE OF THE TUNNELED VENOUS CATHETER:

The tunneled central venous catheter:

- Serves as a route for plasmapheresis and hemodialysis.
- Is also known as a permcath, permacath, tunneled dialysis or tunneled central catheter.
- Can be used as a route for IV medications, IV blood products and TPN in special circumstances as determined by Staff physician.

RATIONALE FOR TUNNELED VENOUS CATHETER REMOVAL:

- Tunneled Venous Catheter cannot be exchanged, for example, during catheter exchange procedure new catheter will not navigate existing tunnel.
- Tunneled Venous Catheter related bacteremia or exit site infection.
- Tunneled Venous Catheter no longer needed, for example patient has a functioning extremity internal access or peritoneal dialysis access.

POLICY:

Refer to Interventional Nephrology Unit specific policy IN2a Placement of Tunneled Central Venous Catheter.

Additionally:

1. **Physician’s responsibility**
   The physician shall be responsible for the following:
   b) Marking the surgical site. See Hospital Policy 5.32.0 Surgical site marking. [http://www.sh.lsuhsc.edu/policies/policy Manuals_ms_word/hospital_policy/h_5.32.0.pdf](http://www.sh.lsuhsc.edu/policies/policy Manuals_ms_word/hospital_policy/h_5.32.0.pdf).
REMOVAL OF A TUNNELED CENTRAL VENOUS CATHETER

Tunneled Central Venous Catheters already in place in the Internal Jugular Vein, External Jugular Vein, Femoral Vein and Subclavian Vein can be removed.

Tunneled Central Venous Catheters can be removed in 8J02, 8J04 or at the patient’s bedside, with curtains drawn and all present wearing a cap and mask.

EQUIPMENT FOR TUNNELED CENTRAL VENOUS CATHETER REMOVAL PROCEDURE DONE IN 8J02, 8J04 OR AT BEDSIDE

1. Sterile Towels.
2. Chloraprep 26ml.
3. Chlorhexidine scrub brushes.
4. Sterile Pediatric Cutdown tray.
5. Lidocaine 2% with epinephrine.
6. Sterile gloves for skin prep and for physician performing procedure.
7. Sterile labels.
8. 2 x 5cc Sterile Syringes.
9. 2 x 10cc Sterile Syringes.
10. Sterile gauze for dressing.
11. Elastoplast tape.
14. Sterile specimen tube for catheter tip if needed.
15. Sterile swab and medium if needed for exudate.

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<tr>
<th>Responsible Party</th>
<th>Action</th>
<th>Rationale</th>
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<tr>
<td>MD, RN, RN Applicant</td>
<td>Explains procedure to patient/guardian. Marks intended site with skin marker. Completes a Procedure note in Epic or Post Procedure note form SN 1124 and a procedure note on the Progress Note form SN 1137 during downtime. Completes Discharge Instructions and discusses these with the patient/care giver.</td>
<td>Patient/guardian understands steps in procedure. Patient/guardian knows how to take care of dressing and what to do if problems for example bleeding. Communication.</td>
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<tr>
<td>Role</td>
<td>Task Description</td>
<td>Notes</td>
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| RN, RN Applicant, CNA | Assembles equipment.  
Dons hat/mask, shoe covers.  
Records baseline vital signs.  
Assists patient to don hat and mask.  
Removes drapes, disposes of soiled equipment in appropriate containers. | Reduces chances of patient having a procedure related complications. |
| RN, RN Applicant, Administrative Coordinator | Verifies fax consent present for patient’s Chronic Dialysis unit etc.  
Refer to Hospital Policy 6.3.1 Fax Policy.  
Makes a follow up appointment if needed.  
Faxes discharge instructions to patient’s Chronic Dialysis unit (see Appendix A).  
Prints AVS and explains it to the patient/care giver.  
Records lot number of any implants removed. | Maintains patient’s privacy.  
Communication and follow up. |
| MD | Dons cap and mask.  
Performs 6 min surgical hand scrub with Chlorhexidine, dons sterile gown and gloves.  
Refer to Infection control policy IC 2.0 Hand Hygiene.  
Drapes patient with sterile drapes from pediatric cut down tray.  
Prepares and maintains a sterile field.  
Removes tunneled Central Venous Catheter.  
Holds pressure at venotomy site until bleeding stopped.  
Applies/ requests sterile dressing.  
Dressing is a sterile pressure dressing with maximum pressure placed at the venotomy site and along tunnel.  
Bacitracin ointment is applied to | Reduces chances of patient having a procedure related complications. |

Note: MD is required to remove own Sharps from sterile field.
venotomy and exit site prior to pressure dressing.
Removes and disposes of sharps.
Completes Dialysis Unit Discharge Information orders (see Appendix A).
REFERENCES:
Interventional Nephrology Unit Specific Policy – Procedure Room Infection Control Guidelines
Hospital Policy: 5.16.1 Informed Consent
Hospital Policy: 5.32.0 Surgical Site Marking
Hospital Policy: 5.33.0 Time Out
http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/hospital_policy/h_5.33.0.pdf.
Hospital Policy: 5.43.0 Patient Handoff
http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Hospital_policy/h_5.43.0.pdf.
Hospital Policy: 8.21.0 Medication Reconciliation
Hospital Policy: 6.3.1 Fax Policy for Transmitting Patient Information
http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Hospital_policy/h_6.3.1.pdf.
Hospital Policy: 6.5.0 Medical Records Content Documentation
http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Hospital_policy/h_6.5.0.pdf.
Infection Control Policy: IC 2.0 Hand Hygiene
Infection Control Policy: IC 15 Invasive Procedures normally done in OR
Infection Control Policy: IC 22 Skin Prep for Invasive Procedures
http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Infection/IC%20%2022.0.pdf.
Nursing Policy: N-25 Nurse’s 24 Hour Patient Progress Report/Plan of Care Philosophy
http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Nursing/N-25.pdf
ASDIN Curriculum For Training In Interventional Nephrology Volume 1, 2006, Gerald A. Beathard, MD, PhD, FASN.
Appendix A

INTERVENTIONAL NEPHROLOGY

318-675-6387

DISCHARGE INFORMATION

Dialysis Unit: ____________________________  Patient’s Name: __________________________

Date of Admission: ____________ Date of Discharge: ____________ Date of Last HD: ________

Admitting Physician/Fellow: _________________________________________________________

Significant History/Diagnosis: ____________________________________________________________________________

Follow Up: __________________________________________________________________________

**Chronic Dialysis Orders:**

Access: __________________________

Dialyzer: _________ Dialysate: K+ ______ Ca++ ______ Epogen _______ units

Dry Weight: ______ kg  Heparin: _______ units  Duration: ______ hrs

Zemplar _____ mcg  Calcitrol _____ mcg  Hectrol _____ mcg  Sensipar _____ mcg

Antibiotic: 1. _____________________ x _____ days  2. __________________ x _____ days

**INTERVENTIONAL NEPHROLOGY**

Procedure: __________________________________________________________________________

Follow Up: __________________________________________________________________________

Antibiotic: 1. _____________________ x _____ days  2. __________________ x _____ days

Physician: ____________________________  Date: __________________________

Signature: ____________________________  Beeper: ____________________________
INTERVENTIONAL NEPHROLOGY DISCHARGE INSTRUCTIONS

Patient care instructions after Tunneled Catheter Removal
You have just had a Tunneled Catheter Removed.

What to expect
Some pain, slight bruising, and swelling are normal on your catheter removal site. If the pain, bruising, or swelling gets worse instead of better over the next few days, please call for advice.

Diet
Resume your pre-hospitalization diet.

Your dressings
- You will have a pressure dressing initially, which should stay in place for 24 hours.
- Don’t do anything that causes stretching or strain in the area.

Medications
- Resume your pre-hospitalization medications.
- If you were taking blood-thinners such as aspirin or warfarin (Coumadin) before surgery, please talk with your doctor about when to resume this medicine. You should go back to taking any other medicines you were on before surgery.

Activity
- Rest in bed or sit in a chair and do minimal activity for 8 hours after the catheter is placed. This will decrease the chance of bleeding.
- Avoid lifting anything weighing more than 10 pounds for the next three days. Ten pounds is about the weight of two phone books or a gallon of milk. Lifting may put a strain on the old catheter site before it has had a time to heal.
- Other activities such as work, housework, or sex may be resumed when you are ready, using common sense, and following the other restrictions outlined above.

Please contact us at the numbers listed below if you notice any of the following:
1. Bleeding or ‘golf ball sized’ swelling at the catheter removal site. Apply pressure with your finger to stop the bleeding. If the bleeding does not stop, go to the Emergency Room or call 911 for assistance.
2. The pressure dressing becomes saturated with blood.
3. You have a fever of more than 100°F and/or chills.

Follow-up appointment
You will follow up in your dialysis unit. If you have question about the procedure please call us at 318-675-6387 (Answering Machine) or 318-675-5000 and ask for Nephrologist on Call.