# Relocation or Rotation of Peripheral IV Catheters

## Purpose

The purpose of this procedure is to provide guidelines for the safe and aseptic relocation/rotation of vascular access devices in order to reduce the risk of infections and complications associated with contaminated indwelling catheters.

* May only be performed by Licensed Nurse with previous IV certification per state Nurse Practice Act.

## Preparation

1. Determine if a physician’s order is necessary for this procedure.
2. Review the resident’s care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

## General Guidelines

1. Rotate peripheral IV catheters (<3 inches) not more frequently than every 72-96 hours. If ongoing phlebitis rate is > 5 percent, catheter should be rotated at 48 hour intervals. Catheters placed under emergency conditions should be replaced within 48 hours.
2. The maximum number of venipuncture attempts on one resident is two per IV nurse. If the IV nurse is unsuccessful after two attempts, another nurse should attempt once. After a total of three unsuccessful venipuncture attempts, consult with the nursing supervisor.
3. The veins of the lower extremities shall not be accessed for IV therapy without a specific order from the physician.
4. Do not insert a catheter on an extremity with an A-V shunt. Do not insert a catheter on a mastectomy side, or on the affected side of a CVA, without a physician’s order specifying the use of that side.
5. Use a new catheter for each venipuncture attempt. Never reinsert a stylet after it has been removed from the catheter hub; never push a dislodged catheter back into place.
6. A syringe barrel size of 10 ml or greater shall be used when flushing any VAD/CVAD to avoid excessive pressure and potential rupture of the catheter, and/or dislodgment of clots.

## Equipment and Supplies

1. Replacement catheter;
2. Tourniquet;
3. Gloves;
4. Antiseptic solution (e.g., 2% tincture of chlorhexidine, or alcohol) for site preparation;
5. Alcohol pledgets;
6. Sterile dressing;
7. Tape; and
8. Labels.

## Assessment

1. Inspect intravenous catheter site for signs of infection and/or complications at scheduled intervals and upon routine site care and administration set changes.
2. Assess old catheter site for signs catheter-related infection or complications. For example:
   a. phlebitis;
   b. occlusion;
   c. infiltration/ extravasation; or
   d. redness, tenderness, purulent drainage.

*continues on next page*
Steps in the Procedure

1. Perform hand antisepsis.
2. Prime tubing of new administration set, if indicated.
3. Apply tourniquet proximal to intended venipuncture site.
4. Select access site proximal to previous cannulation sites.
5. Place catheter according to manufacturer’s instructions for placement of IV catheter, or:
   a. prepare insertion site with antiseptic skin cleanser. Recommended solutions include 2% tincture of chlorhexidine or 70% alcohol pledgets. Disinfect by working from the site outward in concentric circles;
   b. allow to air dry;
   c. perform hand antisepsis, and don clean gloves;
   d. re-apply tourniquet;
   e. stabilize vein below intended venipuncture site with non-dominant hand;
   f. insert catheter (bevel up) at a 30 degree angle;
   g. when blood return is observed in flashback chamber, lower the angle of the catheter to 15 degrees and minimally advance into the center of vein (approximately 1/16”);
   h. remove tourniquet;
   i. slowly and continuously, advance the catheter off the stylet until the catheter hub rests against the skin;
   j. occlude the tip of the catheter (with fingers of non-dominant hand) over approximate vein pathway to prevent retrograde bleeding; and
   k. remove stylet.
6. Connect administration set tubing to catheter and open clamp.
7. Restart infusion of prescribed solutions or medications.
8. Observe for patency of catheter.
9. Remove old catheter after new access site has been established.
10. Discard contaminated needles in sharps container.
11. Discard other materials in appropriate waste container.
12. Remove gloves, wash hands and/or apply antiseptic skin-rub.

Documentation

The following information should be recorded in the resident’s medical record:

1. The date and time of the procedure.
2. Reason for restart/relocation.
3. The number of venipuncture attempts.
4. Type, length, and gauge of catheter.
5. Site of insertion.
6. The interventions and treatment initiated or resumed.
7. Notification of the physician, if any.
8. Resident’s response.
9. The signature and title of the person recording the data.
Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

References

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<thead>
<tr>
<th>MDS (RAPs)</th>
<th>K5a, K6, P1c, P8 (RAP # 12; RAP # 14)</th>
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<tbody>
<tr>
<td>Survey Tag Numbers</td>
<td>F328</td>
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<tr>
<td>Related Documents</td>
<td>Intravenous Therapy: Preventing Catheter-Related Infections (Infection Control)</td>
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<td>Risk of Exposure</td>
<td>Blood–Body Fluids–Infectious Diseases</td>
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Revision date: 6/25/2012