Midline Dressing Changes

Level III

Purpose

The purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings.

General Guidelines

1. Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way.
2. Use sterile technique when changing a midline catheter dressing.
3. Use a sterile, transparent, semipermeable membrane (TSM) or gauze dressing.
4. If gauze dressing is used, cover the gauze with a TSM dressing and change the dressing every 48 hours.

Equipment and Supplies

1. To place new dressing:
   a. Sterile dressing kit for catheters (sterile gloves, mask, TSM dressing, antiseptic cleaning solution, tape, label, gauze).
2. To remove old dressing:
   a. Non-sterile gloves; and
   b. Alcohol wipes.

Steps in the Procedure

Procedure to remove old dressing:

1. Clean the over the bed table with soap and water, or alcohol.
2. Place equipment on table.
3. Perform hand antisepsis. Wear non-sterile gloves.
4. Resident should be positioned with head facing away from dressing site. If resident is coughing or has a tracheostomy, apply mask to resident if he or she can tolerate it.
5. Ask resident to keep arms at side of body or have someone help him or her to do this.
6. The dressing can be rubbed with alcohol wipes to help dissolve the adhesive and loosen the dressing. Never use scissors near the catheter.
7. Remove any tape on the dressing.
8. While stabilizing the catheter, remove the dressing in the direction of the catheter insertion (from the hub of the catheter toward the head) to avoid dislodging the catheter. This is especially important with Midlines and PICC lines.

Procedure to apply sterile dressing:

1. Open sterile dressing kit.

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2. Apply mask.
3. Apply sterile gloves. Once the gloves are on, only the contents of the kit can be touched. Do not pick up the catheter with the sterile gloves. The outside of the catheter is not sterile. Use sterile gauze to pick up catheter when cleaning underneath the catheter to preserve the sterile gloves.
    a. Clean catheter insertion site with approved antiseptic solution.
    b. Allow to air dry completely before placing dressing (at least 30 seconds for chlorhexidine/alcohol wipe).
4. Apply sterile transparent dressing or gauze with transparent dressing to area, making sure to center the dressing over the insertion site. Starting at the catheter, smooth dressing outward toward the edges to remove air. While removing the paper around edges of dressing, press down on the edges of the dressing. Label with initials, date and time.
5. The sterile tape from the kit may be used to secure edges if needed. Placing a piece of tape across the bottom of the dressing can help secure the catheter in place and keep the catheter from pulling on the dressing. The tape should not cover the insertion site.
6. If the resident has hair on the dressing site:
    a. Do not shave with a razor or cut the hair with scissors, as this may cut the skin and/or damage the catheter.
    b. Instead, apply a skin protecting agent (e.g., Skin Prep™) after the area has been cleaned with antimicrobial agents.
    c. Apply skin protectant only around the perimeter of the insertion site where the dressing will be placed. Do not apply directly to the insertion site.
    d. Allow skin protecting agent (e.g., Skin Prep™) to dry completely before applying transparent dressing.
7. If catheter is inserted in area of flexion, place the sterile TSM dressing over the insertion site. Then, cut sterile TSM dressing in two pieces and reinforce the edges of the original dressing with cut pieces of the second.
8. Dispose of gloves, equipment and old dressing in appropriate containers.
9. Reposition resident for comfort.

Documentation

1. The following information should be recorded in the resident's medical record:
    a. Date and time dressing was changed.
    b. Location and objective description of insertion site.
    c. Any complications, interventions that were done.
    d. Condition of sutures (if present).
    e. Any questions, education given to resident, resident's statement regarding IV therapy and response to procedure.
    f. Signature and title of the person recording the data.

Reporting

1. Report any signs and symptoms of complications to physician, supervisor and oncoming shift.
2. Intervene as necessary.

References	
Related Documents	Guidelines for Preventing Intravenous Catheter-Related Infections
Revision Dates	Date:_____ Date:_____ Date:_____ Date:_____