**PURPOSE:**

To provide a protective barrier over catheter exit site allowing for assessment of site and prevention of bacterial contamination.

**CONSIDERATIONS:**

1. **Review Pain Medications via Epidural/Intraspiral Route Administration**, for information regarding the placement, use, types of epidural access devices, potential complications of epidural pain control, and initiation and maintenance of epidural pain management.

2. **ALCOHOL IS CONTRAINDICATED** for the cleansing of the exit site or injection port because of the potential for migration of alcohol into the epidural space and possible nerve damage.

3. All procedures involving an epidural catheter are to be done with strict aseptic technique.

4. If the patient is allergic to iodine, obtain specific orders from the physician for an alternate solution for site care, i.e., Hibiclens.

5. Dressings on external catheters should be sterile, occlusive and changed 3 times a week if gauze, weekly if transparent, according to physician’s orders, or PRN at anytime the dressing becomes wet or incompletely adherent.

6. Tape is not used around the transparent dressing as this negates the properties of the dressing.

7. If gauze is used beneath the transparent dressing, it is considered a gauze dressing and should be treated accordingly.

8. Tape catheter securely to patient's body to prevent accidental dislodgement.

9. Notify physician immediately of:
   a. Inflammation or signs and symptoms of infection.
   b. Unusual resistance or catheter occlusion.
   c. Pain at insertion site.
   d. Greater than 1.5 mL CSF or blood-tinged CSF aspirated from catheter.

**EQUIPMENT:**

- Gloves, non-sterile
- Gloves, sterile (2 pair)
- Transparent permeable adhesive dressing CVC dressing change kit
- Antimicrobial applicators (wipe/swab/disk/ampule)
- Hydrogen peroxide
- Q-tips, sterile
- Antimicrobial ointment (optional)
- 2x2 gauze sponge, sterile
- Tape
- Disposable, absorbent pad
- Extension tubing (optional)
- Injection port (optional)

**PROCEDURE:**

1. Adhere to Standard Precautions.
2. Identify patient and explain the procedure and purpose to the patient/caregiver.
3. Assemble the equipment on a clean surface close to the patient.
4. Place patient in comfortable position, making sure that site is accessible.
5. Ensure adequate lighting.
6. Remove old dressing being careful not to dislodge catheter.
7. The catheter tract and exit site should be assessed for signs and symptoms of infection.
8. Position disposable, absorbent pad under the patient to prevent soiling of the bed linens during cleaning.
9. Open all supplies onto sterile field.
10. Don sterile gloves and mask.
11. Clean exit site with hydrogen peroxide using sterile Q-tips moving from the exit site outward in a circular fashion to remove any debris or crusting. Repeat three times using antimicrobial applicator moving from exit site outward in a circular fashion 2 - 3 inches in diameter. Allow to air dry. DO NOT blot.
12. Apply ointment to site, if ordered.
13. Apply dressing securely using aseptic technique.
14. If appropriate, replace old injection port and 0.2 micron filter at this time using strict aseptic technique.
15. Discard soiled supplies in appropriate containers.

**AFTER CARE:**

1. Document in patient's record:
   a. Date, time, procedure and observations.
   b. Appearance of exit site and stability of sutures, if applicable.
   c. Patient's response to procedure.
   d. Instructions given to patient/caregiver.

**REFERENCE:**

Centers for Disease Control and Prevention (CDC), Guidelines for the Prevention of Intravascular Catheter-Related Infections