

Staple and Suture Removal

Purpose	The purpose of this procedure is to provide guidelines for the removal of staples or sutures from a healing wound or a tube/drain site.
Preparation	<ol style="list-style-type: none">1. Verify that there is a physician's order for this procedure.2. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs.3. Assemble the equipment and supplies as needed.
Equipment and Supplies	The following equipment and supplies will be necessary when performing this procedure. <ol style="list-style-type: none">1. Disposable suture removal set or staple remover;2. Sterile dressing strips, if requested by physician; and3. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).
Steps in the Procedure	<ol style="list-style-type: none">1. Place the clean equipment on the bedside stand. Arrange the supplies so they can be easily reached.2. Wash and dry your hands thoroughly.3. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely.4. When removing staples, take out alternate staples to ensure wound edges are approximate.5. To remove staples:<ol style="list-style-type: none">a. Insert one side of the staple remover under the staple;b. Depress handle of staple remover; andc. When the staple releases, gently pull the staple from the wound.6. To remove sutures<ol style="list-style-type: none">a. Lift the knot with the suture forceps;b. Using scissors, clip the suture next to the skin; andc. Pull suture from skin.7. Discard all suture material into the designated container.8. Clean wound area according to physician orders.9. Allow area to dry.10. Apply sterile dressing strips, if ordered by physician.11. Discard disposable items into the designated container.12. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly.13. Reposition the bed covers. Make the resident comfortable.14. Place the call light within easy reach of the resident.15. Clean the bedside stand.16. Wash and dry your hands thoroughly.17. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

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Documentation

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

1. The date and time the staples/sutures were removed.
2. The name and title of the individual(s) who removed the staples/sutures.
3. All assessment data (e.g., skin condition) obtained when removing the staples/sutures.
4. Document the number of sutures removed.
5. Any problems or complaints made by the resident related to the procedure.
6. If the resident was non-adherent with the procedure, the reason(s) why and the intervention taken.
7. The signature and title of the person recording the data.

Reporting

1. Report other information in accordance with facility policy and professional standards of practice.