Department of Nursing
POLICY AND PROCEDURE

POLICY NUMBER: 231
VERSION: 1

SUBJECT: STAPLE/SUTURE REMOVAL

PURPOSE: To outline the procedure for providing safe removal of staples or sutures from a patient wound.

POLICY: Staples and sutures may be removed only with an order from the healthcare provider.

EQUIPMENT FOR STAPLE REMOVAL:

- Disposable staple removal kit
- Steri strips, if requested
- Clean gloves
- Sterile normal saline solution
- 4x4 gauze
- Liquid adhesive

PROCEDURE FOR STAPLE REMOVAL:

1. Confirm presence of written provider order and review details.

2. Identify the patient using two identifiers.

3. Confirm allergy status.

4. Explain procedure to patient.

5. Perform hand hygiene.

6. Position patient to expose staples.

7. Apply clean gloves.

8. Examine wound for signs of infection;
   a. Inflammation/warmth to the touch
   b. Redness
   c. Swelling
   d. Pain
   e. Purulent drainage

9. Notify provider of any signs of infection before removing staples. If no signs of infection, proceed with removal of staples.

10. Using saline soaked gauze, cleanse suture line to remove any old dried blood or debris.

11. Slide staple remover under staple and squeeze the handle to remove the staple.

12. Continue the procedure removing every other staple. Assess wound for dehiscence. Notify provider immediately if wound shows indication of dehiscence.

13. If wound is well approximated, remove remaining staples.

14. If necessary, apply liquid adhesive on each side of the incision.

15. Apply steri strips across incision, securing ends with liquid adhesive.

16. Remove gloves and perform hand hygiene.

EQUIPMENT FOR SUTURE REMOVAL:

- Disposable suture removal kit
- Clean gloves
- Sterile normal saline solution or pre-packaged antiseptic swabs
- Steri strips, if requested
- Liquid adhesive

PROCEDURE FOR REMOVAL OF PLAIN INTERRUPTED SUTURES:

1. Confirm presence of written provider order and review details.

2. Validate patient identity using two identifiers.

3. Confirm allergy status.

4. Explain procedure to patient.

5. Perform hand hygiene.

6. Position patient to expose suture line.

7. Apply clean gloves.

8. Assess wound for signs of infection
   a. Inflammation/warmth to the touch
   b. Redness
   c. Swelling
   d. Pain
   e. Purulent drainage
   f. Embedded sutures

9. Notify provider of any signs of infection before removing sutures. If no signs of infection, proceed with removal of sutures.

10. Using saline soaked gauze, cleanse suture line to remove any old dried blood or debris.

11. Using the forceps from the kit, grasp the suture near the knot. Pull to gently lift suture up and away from patient's skin.

12. Cut suture close to the skin and pull the knot out in one piece. (No segment of the suture on the exterior should be drawn below the skin surface. To permit this would introduce skin-surface contaminants subcutaneously with risk of infection.)

13. Discard sutures onto the gauze as they are removed.

14. Repeat steps until all sutures removed.

15. Discontinue procedure and notify provider immediately if wound dehiscence noted.

16. If necessary, apply liquid adhesive on each side of the incision.

17. Apply steri strips across incision, securing ends to the liquid adhesive.

18. Remove gloves and perform hand hygiene.

DOCUMENTATION:

1. Date and time procedure performed.

2. Patient's tolerance of procedure.

3. Condition of incision.

4. Any patient education performed:
   a. Signs of infection
   b. Notify provider of purulent drainage, fever, or separation of wound
   c. May shower if ordered by provider

REFERENCES:

University of North Carolina Hospitals, Nursing Procedure Manual, 2007

Kowalak, J., (Ed.) (2009). Lippincott's nursing procedures (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Approved By: Susan Knapp (CHIEF NURSING OFFICER I)	
Date: 10/15/2013	Original Date: 04/01/2008
Reviewed: 12/30/2014	Next Review Date: 12/15/2015
Supersedes:	