CONVERTING A CONTINUOUS PERIPHERAL INTRAVENOUS INFUSION TO SALINE OR HEPARIN LOCK

PURPOSE

To outline the policy and procedure for flushing a peripheral intravenous device or converting a continuous peripheral intravenous infusion to a saline or heparin lock.

POLICY STATEMENTS

A registered nurse may initiate a saline lock for peripheral infusions without a physician order when the infusion is not required for fluid requirements, parenteral nutrition, medication or blood product administration.

The use of heparin lock solution for flushing a peripheral intravenous device requires a prescriber’s order. If the prescriber orders “heparin lock peripheral IV”, Heparin 10 units/mL solution is used unless otherwise ordered.

A peripheral intravenous used for intermittent infusions is flushed and locked immediately following use.

If a peripheral intravenous device is in situ but is not being used for any infusion, routine flush is done every 12 hours.

For patients in the Emergency department, Ambulatory care or out on pass returning every 24 hours for IV medications the catheter is flushed only following medication infusion (i.e. every 24 hours). A positive pressure cap is used to create positive displacement in these situations.

The practice of running an intravenous at a minimum rate will be done only if a specific rate is ordered. To Keep Vein Open (TKVO) orders will be interpreted as saline lock unless:

- The physician identifies an immediate need for access
- IV access is required again within the next 2 hours.

SITE APPLICABILITY

Applicable to all patient care areas.

PRACTICE LEVEL/COMPETENCIES

Flushing a peripheral intravenous device or converting a continuous peripheral intravenous infusion to a saline or heparin lock is a foundational nursing competency.

EQUIPMENT

- needleless connector or positive pressure cap
- pre-filled syringe of Sodium Chloride 0.9%, without preservative and/or heparin flush 10 units/mL
- 2% Chlorhexidine in 70% alcohol wipes
- tape
- Swabcap™

PROCEDURE

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<th>Rationale</th>
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<td>1. CHECK chart for prescriber order if heparin locking.</td>
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<td>2. ASSEMBLE equipment.</td>
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<td>4. VERIFY patient identity and EXPLAIN procedure.</td>
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**DOCUMENTATION**

**DOCUMENT** on Medication Administration Record (MAR) or other unit approved record in areas where MARs are not used:
- procedure and time
- patency of IV
- amount of saline or heparin flush
- patient response to procedure.

**REFERENCES**


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