Purpose:
To maintain a patent IV site for intermittent IV therapy.

Considerations:
1. Review Administration of Intravenous Therapy in the Home.
2. The injection port can be connected to a cannula with extension tubing to convert to an intermittent infusion line.
3. Intermittent IV insertion sites must be changed every 72 hours or as physician orders.
4. Peripheral site care must be done as needed.
5. Check the patency and placement of the cannula prior to infusion.
6. The cannula must be flushed immediately after each infusion and every 24 hours when not in use with 3-5 mL of bacteriostatic normal saline followed by 1 mL of 10 units per mL heparin solution or as ordered per physician.

Equipment:
- Gloves
- Tourniquet
- Cannula
- 3-5 mL syringes (2)
- Sterile needles, 25-gauge 5/8 inch or needle less adapters (2)
- Normal saline
- Heparin solution (10 units/mL, or as prescribed)
- Alcohol wipe applicator (wipe/swab/disk/ampule)
- Antimicrobial applicator (wipe/swab/disk/ampule)
- 2x2 gauze sponge, sterile
- Transparent dressing
- Antimicrobial ointment (optional)
- Tape
- Microbore extension
- Injection port
- Puncture-proof container
- Impervious trash bag

Procedure:
1. Adhere to Standard Precautions.
2. 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. Follow considerations and procedures under (See Administration of Intravenous Therapy in the Home.) for selection of vein, inserting and securing the cannula.
7. Remove cover of new injection port and insert the port into the cannula extension. Flush with saline as ordered by the physician.
8. Saline/heparin flushes:
   a. Clean end of injection port with alcohol applicator using friction. Allow to air dry.
   b. Insert needle less adapter of normal saline syringe into injection port and flush gently to determine patency of lock.
   c. Follow with heparin flush, before removing syringe close clamp to reduce possibility of clot formation.
9. Discard soiled supplies in appropriate containers.

After Care:
1. Document in patient's record:
   a. Procedure and observations.
   b. Type and appearance of venous access site.
   c. Amount of saline and heparin flush, including strength of heparin.
   d. Patient's response to procedure, side effects and management.
   e. Instructions given to patient/caregiver.
   f. Communication with physician.