Excerpt:

“Flushing central venous access devices with heparin to maintain patency is considered standard practice in healthcare. However the use of heparin in pediatric and neonatal populations is associated with significant risks. Heparin increases clotting times and when doses are too high it can result in fatal hemorrhages (U.S. Food and Drug Administration, 2011). Newborns are at a higher risk due to their size and weight. Heparin is supplied in different strengths and in vials with similar labeling which heightens the risk for error. According to the U.S. Food and Drug Administration (2011), “Pediatric patients, including neonates, have died as a result of medication errors in which Heparin Sodium injection vials have been confused with “catheter lock flush” vials” (Precautions, para. 3). In November 2007, three infants at Cedars-Sinai Medical Center were overdosed with heparin due to a medication mix-up (Phend, 2007).

In an effort to decrease the amount of unnecessary heparin pediatric and neonate patients receive and to prevent future heparin errors in this vulnerable population, science based venous access device flushing guidelines are needed. This article outlines the evidence-based practice process used to develop and implement venous access device flushing guidelines.”
Evidence-Based Practice Process: Development of central venous access device flushing guidelines | 2