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ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Taking a Multidisciplinary Approach to Vascular Access Care

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DR. CAUDLE: Vascular Access Teams are comprised of a variety of healthcare professionals that all approach managing their patients differently. But who are these team members, and how do they work together and independently to improve patient care?

Welcome to Vascular Viewpoints on Reach MD. I'm your host, Dr. Jennifer Caudle, and joining me on today's panel to discuss the multidisciplinary approach to vascular access care are Dr. Kevin Baskin, an Interventional Radiologist from Pittsburgh, Dr. Andre Holder, a Critical Care Physician at Emory University, and Hildy Schell-Chaple, a Clinical Nurse Specialist in Critical Care from the University of California. It's great to have all of you on the program today. Welcome.

DR. BASKIN: Thank you, Dr. Caudle.

MS. SCHELL-CHAPLE: It's great to be here today.

DR. HOLDER: Thank you, Dr. Caudle. I appreciate the opportunity.

DR. CAUDLE: To kick things off, I want to get a sense of your respective vantage points on what constitutes a Vascular Access Team, and how each of you contribute within that team. So, Dr. Holder, why don't we start with you, especially since you're on the critical care side.

DR. HOLDER: Sure. So, I think of a Vascular Access Team sort of in layers. So, first off, there are those frontline folks, basically the bedside nurses, the physicians, who would be putting in peripheral IVs and central venous catheters. I'm an Intensivist, as you mentioned, an ICU physician, so we deal with that a lot. I've put those in fairly commonly in my practice. And then we have the extension of the Vascular Access Team, those who are responsible for putting in central venous catheters and also PICC lines. So, there are usually, at least at my site, a team associated with that of nursing specialists, who put in those PICC lines, and then if they're facing difficulty – they try and do that ultrasound-guided, usually – if they're facing difficulty with that and are having issues, then they would go on to our interventional radiologist colleagues to try to put that in.

DR. CAUDLE: Excellent. And I think that's actually a really great segue because you're mentioning interventional radiologist, and Dr. Baskin, that is your specialty. So, turning to you, Dr. Baskin, can you talk about your experience as an interventional radiologist on the Vascular Access Teams?

DR. BASKIN: Well, thank you, Dr. Caudle. So, Dr. Holder rightly recognized a number of the potential participants. We might also think about the specialist nurses, infusion and intestinal care nurses, apheresis nurses, interventional radiologists, from my perspective, but also hepatologists, surgeons, nephrologists, gastroenterologists, infectious disease physicians, hematologists, pharmacists and even home health planning experts are vital components who deliver important aspects of venous access related care. And so, from my perspective, the challenge is to get all of these providers of components of care together on the same page, and to coordinate and integrate the patient's and other affected person's – their families and caregivers – to make decisions together, not only in the moment, but prospectively over the expected patient's lifespan or the span of the disease process for which they're receiving access.

DR. CAUDLE: And, you know, finally, Ms. Schell-Chaple, you also have a unique perspective as a critical care nursing specialist with leadership positions in patient safety and regulatory affairs. So how do you look at these Vascular Access Teams?

MS. SCHELL-CHAPLE: Thank you, Dr. Caudle. Well, being around since the introduction of peripherally inserted central catheters, the management of these catheters is a team approach from including the patients and their families all the way through all the different services. And we tend to see the Vascular Access Team here, where we have a cohort of expert nurses trained and skilled at vascular access and not only insert these lines, but actually work with the teams on assessing the

appropriate indications and site selection, looking at the patient's need and their desires, and whether they're going home with the line, et cetera.

DR. CAUDLE: Now I'd really try to focus on the essential components that drive how these multidisciplinary teams are formed. So, let's return back to the acute care setting. Dr. Holder, can you comment on this for us regarding acute care?

DR. HOLDER: Sure. So, I think the formation of these teams, a lot of times, is driven by what the indication would be? What are the needs that we have for those Vascular Access Teams and for these types of access in general? So, where I am in the acute care setting, many times we're asking is this patient going to be on reasonably long-term medications? Can we get a central venous catheter placed first, especially if we're thinking that this is going to be a very short-term situation? And if it's short term, then we refer back again to our frontline folks, specifically our bedside nurses and the primary physicians who are taking care of the patient. If that's something longer term, then we would then turn to the Vascular Access Team our colleagues, specifically our nurse specialists and/or interventional radiologists, to put in more of a long-term access in these patients.

DR. CAUDLE: And I think that's a really great segue into the chronic care setting, which we understand has different priorities. So, Dr. Baskin, maybe can you comment a little bit about that as we move into the long-term care setting?

DR. BASKIN: Well, sure. So, there's kind of a difference in the way we look at patients who are going to be receiving intravenous therapy over a long term. And by long term, I mean an undefined but long part of their life, sometimes for life. If we look at intestinal failure patients, at hemodialysis patients, or even patients receiving chemotherapy, they may have a need for venous access that ranges from months to years, and for them, loss of venous access can be a mortal event. In other words, they may die not as a result of their underlying disease, but as a result of lack of access. We only have so many central venous pathways that are available to use conventionally, and when we lose those pathways, access becomes an extraordinarily difficult project. To preserve those pathways, we have to look prospectively at what we can do to prevent avoidable events. So, finding ways to keep up with a patient's history and indications is really a critical need in our area.

DR. CAUDLE: Ms. Schell-Chaple, given your role in patient safety and really thinking through protocols to prevent line infections and other issues, how does a patient's own experience and concerns influence those best practices for you and your team?

MS. SCHELL-CHAPLE: A lot of my experience is when patients are going home with these lines, they want to get back to their daily routine as much as possible. Some people go back to work. Can they

shower? Their ability to exercise. Those are concerns that come up and I think this is another area where we can secure devices so much, but how do we assure them and teach them how to best care for their devices when at home. So, I've seen the home care aspect evolve over time as well.

DR. CAUDLE: Let's dive a little deeper into the patient experience with some thoughts about communication barriers that crop up, both within Vascular Access Teams, and with patients directly. So, staying with you for a moment, Ms. Schell-Chaple, what sort of challenges do you face when communicating your priorities with patients and other team members?

MS. SCHELL-CHAPLE: Well, working in a teaching hospital, there's ongoing education, if you will, or heightening awareness with trainees that are ordering these devices, and when our nurses are screening, it's like, oh, well what's the indication? Because from their screen of the patient's history and other needs, they don't see any, and sometimes it's, oh, well just frequent blood draws, and things like that, and really trying to balance that with really any other ways we can meet the patient's needs.

DR. CAUDLE: So then, from your vantage points, Dr. Holder and Dr. Baskin, what communication barriers do you all commonly need to address while working within these teams? So, Dr. Holder, why don't we start with you?

DR. HOLDER: Sure. So, often times, particularly in patients in my practice, we have patients who stay in the ICU longer than we would have anticipated when we first put a specific type of vascular access into them, and under those circumstances, when that time has passed, and the need is no longer present, reassessing that need and potentially dialing down, if you will, the access that they have is important. Could they just suffice with a peripheral IV? Something that's less invasive. So, I think the reassessment as well, in those specific situations, is important. I think another point that I'd bring up that touches on something that was already addressed is the constant communication with families and the patients about what those changes are and actually what the indications were in the first place. Making sure that everyone is clear on why it was placed and, if indicated, why it still needs to be present for whatever therapy they need.

DR. CAUDLE: And, finally, Dr. Baskin, what contributions do you have to this conversation about how we look at this and what we're dealing with?

DR. BASKIN: Well, I think that there's such a variability in common, everyday practice related to venous access. Under ideal conditions, when you have Dr. Holder doing these assessments and communicating effectively with his team and Hildy and her team of expert nurses, we can really do wonderful things in maintaining viable access with low rates of complication. But what really frightens patients, and this is what patients and families have reflected to me across the country, is that they

don't feel confident that their providers respect the contributions that patients and families are capable of making after years gaining frontline expertise in care and maintenance of their devices. So, I think that we have a long way to go toward integrating patients and their expertise into the conversation.

DR. CAUDLE: Taking everything into consideration that we've discussed, I'm curious to know what each of you think are the priority areas in vascular access care that will need to improve going forward. So, Dr. Baskin, let's start with you here and let's get your thoughts about this.

DR. BASKIN: Well, I think that the personnel may vary from venue to venue who are involved in central venous access or venous access care, in general. But what doesn't really vary are the critical components of care that are vital to provide complication-free access for the duration of intended therapy. And so, I think if we can focus more on components of care and less on who wears the hat, identify at each location who covers those critical components of care, which components are uncovered and need to be addressed, then I think we might have more rationally-based venous care teams. I think that an effort to integrate all of those providers that Dr. Holder and Hildy and I have mentioned, into one coherent, policy-generating team that looks at care across the institution from the initial indication for access through its removal at the end of care, these things would really help move us forward. And then, finally, data – we just need data that extends beyond one ward or one ICU or one institution.

DR. CAUDLE: Excellent. Dr. Holder, what are your thoughts about this topic?

DR. HOLDER: Well, to add to the points that were already raised by Dr. Baskin, there's two very key things that I think would be beneficial going forward with respect to how Vascular Access Teams practice. I would say that the first is developing very comprehensive protocols by which – for the things that we know work and for the things that we know make sense and are considered as best practice across the spectrum. So, I think standardizing the care as much as possible with respect to access will be the first step, in my opinion. And secondly, I would say is just again that line of communication. And I think that those both feed into each other. If the process by which we attempt to gain vascular access for patients is protocolized, I think that the communication piece can actually be built into that because you would have the frontline folks identifying what the indication would be for access. And there can be some dialogue about well, do we think that this indication warrants a more specialized type of access? Then we escalate to the person who is more specialized in getting a more specialized access.

DR. CAUDLE: Excellent. Definitely some overlapping themes between your comments, Dr. Holder, and Dr. Baskin, your comments as well. And finally, Ms. Schell-Chaple, I'd love to get your intake on this as well. To bring us home, what are your thoughts about this?

MS. SCHELL-CHAPLE: Well, I agree with Dr. Baskin and Dr. Holder's comments. I think my perspective is that we've done a really good job and kind of nailed the insertion bundle in terms of preventing complications and preventing malpositioned catheter placement, et cetera, but we need ongoing new evidence and more data, if you will, on the maintenance because this is where, to me, we don't have strong evidence on all the things we do while the catheter's in place. From the type of assessment and monitoring that goes on to the intervention, beyond dressing changes. And I think comments about engaging patients and families – definitely more of that, and I think they are early detectors of complications, even while patients are in the hospital, so kind of engaging them in – hey we need you looking too, all hands on deck in terms of early detection with our staff, and then when they go home as well.

DR. CAUDLE: Well, you know, I really think it's safe to say that based on the insights shared from you all that we now have a much richer sense for how multidisciplinary teams are working to improve vascular access care. I'd like to thank my guests, Drs. Kevin Baskin and Andre Holder, and Ms. Hildy Schell-Chaple, for joining me today. It was really great having you all on the program. Thank you so much.

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