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The Quest for Patient-Centered Vascular Access: Insights from a New Care Model

Announcer:
Welcome to *Vascular Viewpoints* on ReachMD, brought to you by Becton Dickinson. Here's your host, Dr. Paul Doghramji.

Dr. Doghramji:
Providing vascular access care for patients is a critical component of treatment. With that in mind, how can a patient-centered experience model help improve patient care?

This is *Vascular Viewpoints* on ReachMD. I'm Dr. Paul Doghramji, and joining me to discuss the quest for patient-centered vascular access is Miss Nadine Nakazawa, vascular access nurse specialist at Stanford Health Care in Stanford, California. Ms. Nakazawa, welcome to the program.

Ms. Nakazawa:
Thank you for this opportunity.

Dr. Doghramji:
So let's start with some background, Ms. Nakazawa. You've been in the field of vascular care for a long time. How have you seen vascular access care performed?

Ms. Nakazawa:
Well, over the 40 plus years that I've been a nurse, we've gone from, this is the way we've always done it to a vastly scientific approach incorporating all of the vast changes we've seen over the decades that have provided advances in medical surgical care of increasingly complex patients. Invariably, I.V. therapy and more complex I.V. therapies go along with that.

So besides seeing tremendous changes in advances with that, we've seen advances in devices in insertion technologies, in guidance technologies, and technologies that help us land these devices appropriately.

And along with all of that, in terms of securement and dressings and the skeptics have been tremendous advances. So I would say, changes in patient populations, what we can do for them, those advances, changes in technology that allow us to deliver more complex I.V. therapies.

And then thirdly is the overarching change in medicine and nursing altogether, which is a scientific approach that leads us to eventually have experts come together and develop appropriate recommendations and guidelines to help us as clinicians do the right thing. So the focus is patient safety and increasing success and redefining what that success is for our patients.

Dr. Doghramji:
And, Ms. Nakazawa, getting to the topic at hand, what were some of the objectives of the patient-centric experience model for vascular access care that originated in Canada?

Ms. Nakazawa:
There's a program in British Columbia over the past 15 plus years that has asked patients in many, many hospitals, in many settings about their care. They developed a mind-set that patient experiences and satisfaction with care are patient outcomes. Taking careful evaluation of patient feedback. They developed a patient/family-centric approach, focusing on initiatives, including improving nursing competencies related to I.V. therapy, patient education aligning with patient safety principles, and engaging senior leadership and policymakers to endorse action plans for improvement.

Dr. Doghramji:
And can you describe how the patient-centric experience model for vascular access care that differs from what we're used to doing?

Ms. Nakazawa:
Many clinicians who do vascular access may or may not actually view vascular access as a specialty with specific recommendations and guidelines. So those of us who recognize or identify as a vascular access specialist, we generally as a group tend to be aware of what these recommendations are. But there are many people who do vascular access who are not aware of what these recommendations are.

Even among people who specialize in vascular access, their teams or their hospitals may be driven to align their practice around a current recommendation. And the one that comes to mind is certainly the penalties for CLABSIs in hospitals. So I've heard nurses tell me that the pressure on them is to place fewer PICC lines. Fewer PICC lines means there's fewer opportunities to count any infection that patient encounters as being related to that central line. In other words, when I look at that or I hear that, I think, are you really evaluating patients for need? Are you evaluating whether or not they need a central line? Are you evaluating what's appropriate for that patient? Or are you really trying to find a reason not to place a particular line, particularly PICC lines?

Another example is the recommendation to avoid PICC lines in lots of different categories of patients based on timing or whether or not infusions are “peripherally compatible.” And I hear nurses saying that they place far fewer PICC lines. And again, I have to ask them, are you actually evaluating patients for appropriateness? Do they need this central line? Is the alternative that you're suggesting, midline or ultrasound-guided peripheral I.V. or peripheral I.V.s, is that really the appropriate device, or is it that you're simply trying to prevent PICC-related thrombosis?

So a patient-centered approach would really keep those recommendations in mind, but it would not be the driver in terms of device selection. The driver should be really what does the patient need?

Dr. Doghramji:
For those just tuning in, you're listening to *Vascular Viewpoints* on ReachMD. I'm Dr. Paul Doghramji, and I'm speaking with Ms. Nadine Nakazawa about the development and goals of patient-centered vascular access.

So then, Ms. Nakazawa, shifting over to what patient-centered care model looks like in the real-world setting, can you give us an example of what that type of care looks like in practice?

Ms. Nakazawa:
So I think each of us as clinicians can think of many examples in our own practice. Most recently I had a young man who I got the order, he was an outpatient, and he had already had a PICC line a number of months prior to the appointment when he came to see me. And so I was wondering, he had the PICC line placed. It looked like it was an easy insertion. The indication was every two weeks of a very intense chemotherapy regimen. And for some reason he was coming back for another PICC line. So when I met with him, I asked him to tell me what was the reason and why did he need a second PICC line? And he said that he really, really needs to exercise aerobically, heavy aerobic exercise. And when he found out after the PICC line was placed and he had his first round of chemotherapy, the nurses in the cancer center told him that he should avoid doing vigorous upper arm exercise to avoid thrombosis, and he decided that he could do this peripherally. The nurses told me they can give me my chemo peripherally, so he had them take it out. And subsequent to that, every two weeks, this very intense chemotherapy regimen he had given to him peripherally.

Unfortunately, he also developed very severe peripheral thrombophlebitis. It was painful. It took a long time for each of those thrombotic phlebitic veins to heal. And he pointed out to me where they felt hard. He had several on both arms. And he got to the point where that was so distressing, he decided he wanted another PICC line. Now, at this point, certainly, I did consider an implanted port and kind of threw that idea out because he really only had another five sessions, less than two months’ worth of chemotherapy. So an implanted port didn't really make sense for him. And I talked to him about the pros and cons of making this decision. And what we came up with in listening to him and his need to exercise is he came up with a plan and I supported him in the plan where we would place the PICC line the day that I saw him, he would get his chemotherapy. He would come in every week for labs and dressing change, in two weeks get another chemotherapy regimen, in another two weeks get another chemotherapy regimen, have the nurses remove the line and give him a two-week line, basically what we call a line holiday. And then a new PICC line place for the remaining two sessions. That he could agree with.

In other words, being patient centric means I take his input for what will work and what he can agree to, and that what can accommodate his need in sort of his psychosocial sense of comfort about being able to avoid further severe thrombophlebitis, peripheral thrombophlebitis, get his treatments appropriately, and yet also incorporate his need for a lot of exercise. And he was happy with that approach.

The other thing was he was really sensitive to pain and was upset about it. I mean, he was extremely athletic and not that he wasn't a really big guy, but his veins were just a tad deep. They were good veins, but a tad deep. And so he experienced a lot of pain associated with all of those peripheral I.V.s. And I made sure that during the procedure I used anesthetic cream and used a 30-gauge needle and injecting lidocaine; it was virtually, from his perspective, a pain-free procedure.

So I really try and tailor my approach, listening to the patient, getting the patient input. And – together, we come up with a plan that made him much happier with the device he ended up with and the care that that device will require over the ensuing weeks.

Dr. Doghramji:
Now, looking ahead, how do you see this patient-centered model impacting vascular access care for patients?

Ms. Nakazawa:
Many of us have been using a patient-centric approach for a long time. It behooves us, however, to explain to our colleagues how and why this is important. How to elicit patient input and how to frame device selection within the context of what they need and what they want or expect. Clinicians need to remember that any given patient has limited access points for any particular device. Even with the explosion in the use of ultrasound-guided peripheral I.V.s, we're experiencing a loss of deep peripheral vein access sites in both inpatient and outpatients who repeatedly get these devices. We are oftentimes the advocates for devices that the medical teams push back on. How we frame the vascular access deficits and patient needs are crucial to preserving their remaining viable veins for access. We call this vessel preservation, and the approach is obviously patient centric.

Dr. Doghramji:
Before we wrap up, Ms. Nakazawa, do you have any takeaways on patient-centered vascular access that you'd like to share with our audience?

Ms. Nakazawa:
As I've alluded to or talked about is really looking at the total patient. You can do this pretty quickly once you get into the habit of doing this. There's certain things that I look for. But even after I do a look through the EMR, I briefly look at their previous procedures, vascular access devices that have been placed, any problems that were associated with that, any medical history that could preclude using one arm or the other, looking at the plan of care for that particular I.V. therapy now and in the future. And what is clinician preference? Am I going to support that or am I going to advocate for a different device based on what I think might work better for the patient? All of that is a part of a pattern of behavior and practice that expands your general assessment each and every time you look at patients. And once you begin to do that, being patient centric, it becomes a very easy part of your practice and should be for all of us who do this - any kind of specialty practice or even generalist practice, we should be looking at the total patient. And then when we meet the patient is explaining that listening to them and getting their input. Sometimes I've changed my mind based on what they tell me. So their input is extremely important as well.

Dr. Doghramji:
Those are interesting thoughts to leave us with as we come to the end of our discussion. I want to thank my guest, Ms. Nadine Nakazawa, for joining me to discuss the progress and incorporation of patient-centered vascular access. Ms. Nakazawa, it was great having you on the program.

Ms. Nakazawa:
Thank you.

Announcer:
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