As demand from other trusts to release it has also increased, the challenge has been how to validate it quickly, without incurring significant costs. The MR VICTOR tool has been designed specifically for use in the NHS and could be implemented easily across the UK, given junior and inexperienced nurses' confidence in the assessment process of CVC care.

The MR VICTOR tool has highlighted to staff how simple research problems encountered in practice can be resolved with a team approach led by experienced project leaders. As staff have become familiar with the tool and followed the guidelines for obtaining swabs and blood cultures, the numbers sent for analysis have fallen.

The tool has given patients the opportunity to self-manage exit site care and promoted a sense of empowerment. Patients now have confidence that regular surveillance will be carried out and any signs of infection detected at an early stage, possibly preventing bacteraemia. The associated documentation ensures that CVCs do not remain in situ longer than necessary. Since adopting MR VICTOR scores of 3-4 – the most severe signs of infection – have been eradicated in patients undergoing haemodialysis.

While the original tool was renal specific, it soon became evident it has universal appeal, in areas from paediatrics to any adult specialty. Since it was presented at local and national educational meetings, the interest generated has highlighted the demand for such a tool in the NHS.

MR VICTOR is a simple surveillance tool that could be introduced at negligible cost, with minimal training. We believe it is unique in its design, and its multiracial perspective addresses a neglected dimension in catheter care.

**CONCLUSION**

HCAIs are linked to hospital admissions, prolonged length of stay, additional antibiotic therapy and potential loss of vascular access (Bishop et al, 2007; Harnage, 2007; National Audit Office, 2004). Furthermore, undetected infections can lead to increased morbidity and mortality (DH, 2003).

Using MR VICTOR could lead to fewer bacteraemias, contributing to reduced antibiotic costs, hospital admissions and loss of vascular access, as well as increasing patients’ quality of life.

CVC surveillance involves minimal nursing input, compared with the time, cost and quality of life implications for patients if they develop a bacteraemia.

This tool could reduce the risk of HCAIs in CVCs, speed up referral, and improve management of complications in all patients.

**REFERENCES**


