IN the last 10 years there has been a huge expansion in research, literature, expert opinion, new technology and government strategies aimed at reducing complications associated with invasive biomedical devices. The incidence of healthcare-associated infections (HCAIs) is a fundamental statistic measured by the Care Quality Commission by which NHS trusts are judged.

The benchmark of standard practice for intravenous (IV) access is drawn from the Department of Health’s (2007) Saving Lives and based on the findings of epic2 (Pratt et al, 2007). Despite introducing evidence-based strategies to eliminate HCAIs why do we continue to see bad practice on wards?

In my role as a practice facilitator in vascular access I have seen a huge variety of practice. I have witnessed a senior doctor inserting a cannula without either hand-washing or cleaning the patient’s skin, as well as exceptional levels of line care from senior oncology nurses. Although most nurses are well versed in principles of IV care, such as aseptic non-touch technique (ANTT), many decline to put it into everyday use. It seems IV line care is given a low priority and when the team is busy it is one of the first care practices to be dropped.

There may be several reasons for this. Infections are not instantaneous events and staff may feel detached from their role in the contamination process. Nurses may feel as the risk of contamination is low it does not warrant all the time, care and attention we now expect for IV devices. Although the risk of contamination from an IV device is small, the consequences are potentially fatal if the patient develops a bloodstream infection (septicaemia). When bloodstream infections occur we need to learn what went wrong and how we can prevent it happening again. Should this include reviewing the competency of individual practitioners directly involved in the patient’s care?

My view is IV devices are seen simply as tools to deliver care, with the prescribed care itself (for example the IV antibiotic) being of great importance and the device less so. Standardising IV line care is a necessary step in changing this practice. All nurses come with some experience of IV line care, yet almost all need to adapt some aspect of their practice to comply with the evidence-based standard set out by the DH.

The responsibility to improve patient safety must be supported by trusts. Most are developing training programmes and have a nurse or team of nurses responsible for addressing the problem of infection and IV devices. Communicating, publishing results and networking to share the success stories and continuing problems is another step towards sustainable good practice.

Every time we miss a step of IV practice we put the patient at risk. Every patient deserves quality care delivered safely.

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**References**
