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Improving patient safety

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Vascular access specialists are at the forefront of modern healthcare, providing expert vascular access device selection, insertion and maintenance. Without intravenous (IV) therapy, hospitals would be unable to provide desperately needed care for our communities. This has always been true, but today, globally, we are witnessing this even more acutely during the COVID-19 pandemic. We have seen collaboration and mutual support within teams, as well as life-saving innovations geared towards protecting both patients and staff.

As I write this, my region and my country have not yet seen the peak of cases and the surge seems to grow ever higher. I am hopeful that, by the time this issue is published, the whole world will be well on its way to recovery. Through the fear, the confusion, the doubt and the mistrust there have also been tremendous displays of bravery and selflessness, as well as a spreading determination to come together by stepping out of our silos. And many of us have witnessed our communities embrace us with generous donations of precious personal protective equipment (PPE), sometimes handsewn, meals and other acts of kindness as we arrive or depart our hospitals.

As an infection preventionist, I am an ardent advocate for optimal vascular access outcomes. To this end, one of my main mantras is 'data, data, data'. It is important to not only measure our outcomes, but to also evaluate the processes that lead us there to mitigate future, undesirable end points. I believe that, in the current critical climate, it is necessary to ask that we all reflect on this. Although innovation is crucial for advancing our science, the challenges we face today might tempt us to make hastened innovations due to both supply chain and human resource challenges, forcing us to practise differently from our status quo. Some of these changes may be temporary, but many may become an unexpected advancement that we will maintain long after our personal and professional lives normalise.

It is now our responsibility as infusion therapy experts to work together, to monitor and learn. Initially, it may seem an impossible and arduous task, but I urge you to take the time, garner that resilience and establish simple processes to track your outcomes. For example, today, in the USA, our federal government has suspended the mandates for public reporting of central line-associated bloodstream infections (CLABSI) for at least 6 months, and made optional submission of the prior quarter (4th quarter 2019) data. Let us not use this as an excuse to allow patient harm to occur without notice or analysis.

Surviving respiratory failure secondary to COVID-19 is not an acceptable trade-off for succumbing to a CLABSI or a peripheral intravenous (PIV)-related meticillin-resistant *Staphylococcus aureus* bacteremia. Losing a limb due to vesicant extravasation should not be explained away because our monitoring protocols needed to be modified. The occurrence of a significant patient harm should not be our first awareness that this alternate system is not working. Internal monitoring should be decentralised to create an early warning system to alert us when proposed solutions are not achieving their intended objective. We must protect patients by correcting our practice if we find that outcomes are not what we intended.

As a strategy to conserve PPE and eliminate unnecessary staff exposure, many of us have been asked to decrease our bedside rounding. Although chart reviews are limited in their accuracy, we can facilitate feedback when we find lapses in basic prevention strategies (including appropriate device types for prescribed infusates), alerting clinical staff when documentation suggests that items such as dressing changes or administration set changes may have been omitted. When suboptimal device choices have been made, we can keep a watchful eye and provide gentle guidance, once the patient is stabilised, to consider replacement when clinically appropriate.

In my own practice, I am fortunate to have access to a database/application on my phone and tablet that allows me to enter and aggregate this data for instant trends, which can be viewed on individual units. This is a luxury, but spreadsheets with simple formulas to calculate rates are at all of our fingertips. In the absence of that, a paper tally can still help you understand where patients need you to intervene. Please do not let limitations stop you from trying.

For those of you who are practising in settings that have been spared the influx of critically ill patients, my plea is the same—collect the data, and share the data. Whenever we collect data, we should always question, 'How can we do better?'

Will you join me in seizing this opportunity to advocate for our patients and be the stewards of safe practice? My heartfelt thanks to each of you at the bedside and in supporting roles during this global crisis. We are ALL in this together. **BJN**