Nurses and PICC insertion: a worldwide perspective

PICCs in France

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Drum Cartridge® (Abbott) in the 70’s
Today Jonnathan catheters are used in pediatric units

Early 2000’s: PICCs return (better device and context)

National guidelines in 2013

90 000 PICCs sold in France in 2015 (not a new market anymore)

It’s possible to insert PICCs in a large number of hospitals, nationwide

French physicians and nurses know about PICCs

BUT THE PROBLEM IS:

The need for venous catheterization is transverse and growing (oncology, hematology, infectious diseases, ageing population ...)

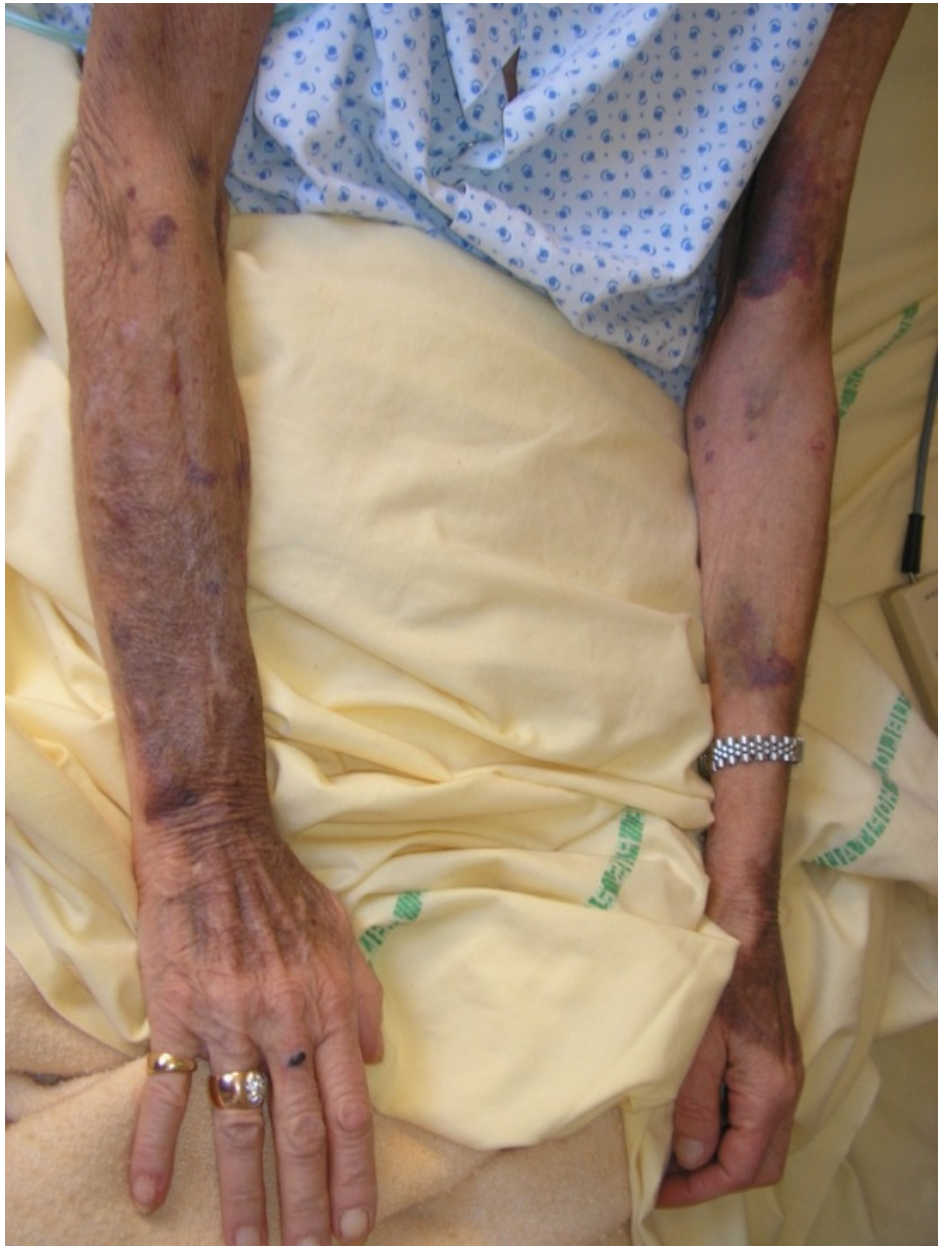
The organisation of the activity around PICCs (and catheters in general) is widely heterogeneous from one hospital to another *(and sometimes in the same hospital)*

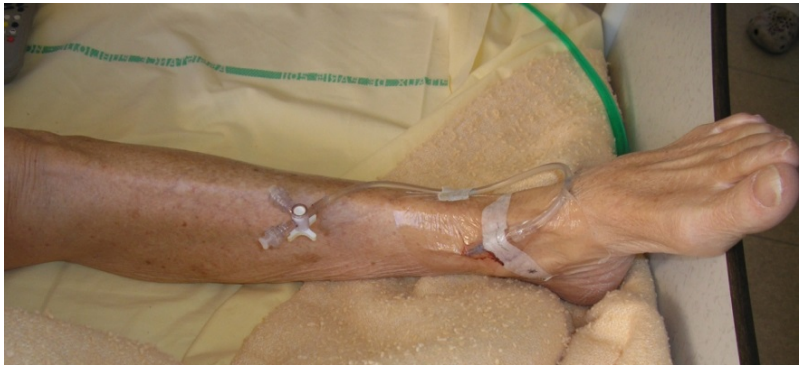
Prority is given to decreasing the delay of PICC insertion

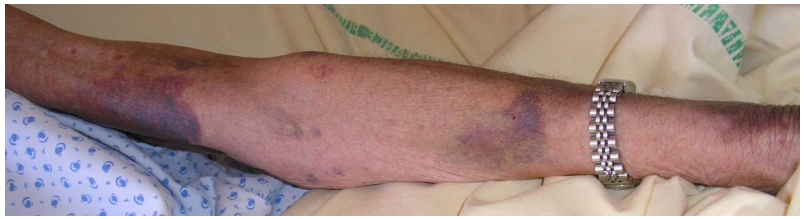
Sometimes I.V. activity (training of the physicians, pharmacists and paramedicals , evaluation of all process, research) is not even organized.

I.V. TEAM		
No I.V. TEAM	Only I.V. physicians	I.V. nurses and physicians
61%	23.4%	15.6%

WHAT IS THE IMPACT OF THIS PROBLEM ON PATIENT CARE?







Prority is given to reducing the delay of PICC insertion

Today, in France we focus on:

Patient

Care needs (what does he/she know? What can he/she tolerate?)

+

Physician

Medical needs (what does he/she know or can finally do?)

INSERTION

CVC operator

1st Choice

(discussion between patient and physician?)

2nd Choice

(what does he / she know? What solution can he/she offer? What can finally be done?)

Today, in France we focus on:

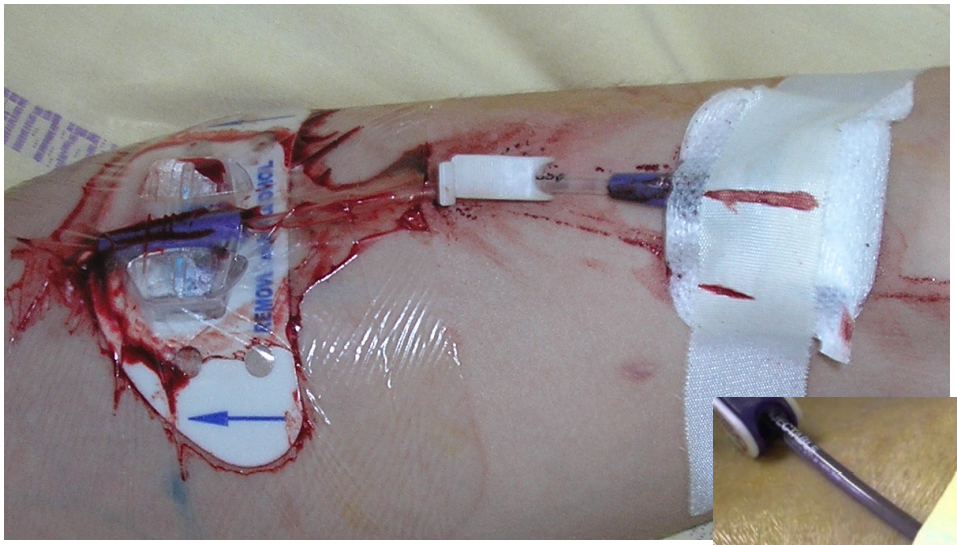
- The possibility of PICC insertion
- **The up and coming solution :** CVC insertions by paramedical staff (decreased medical demands, lower costs, reduction of time between prescription/insertion)

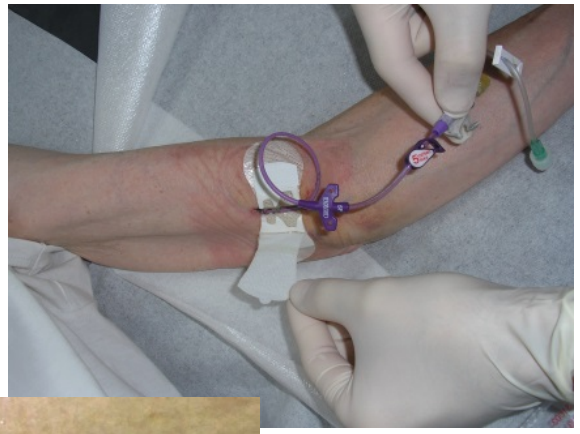
Physicians

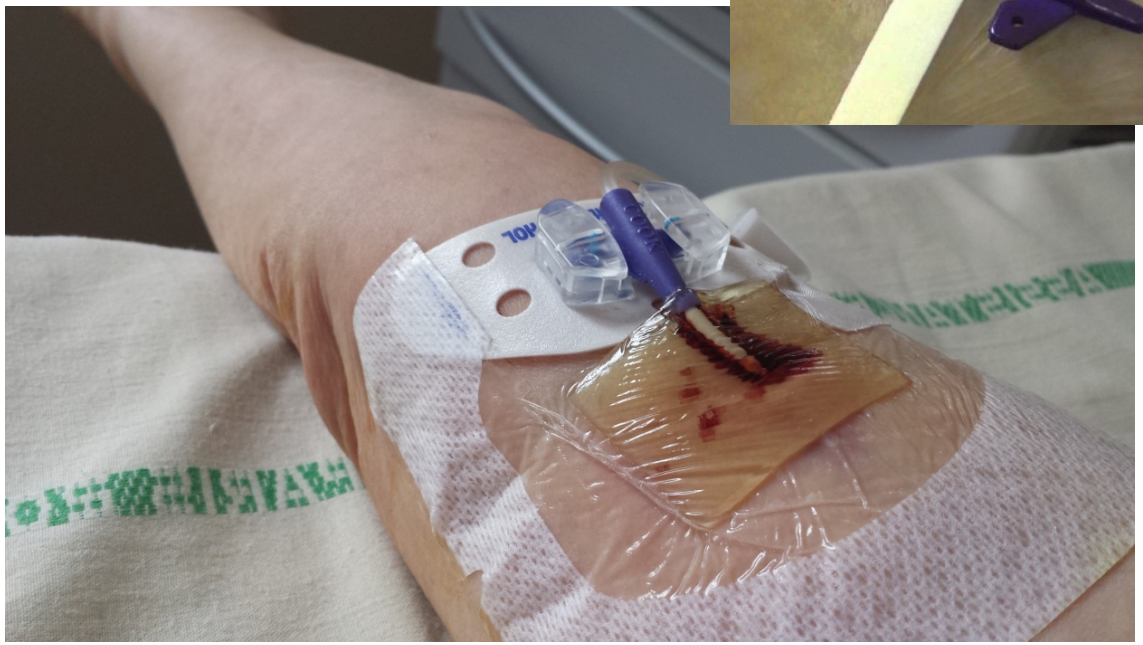
+

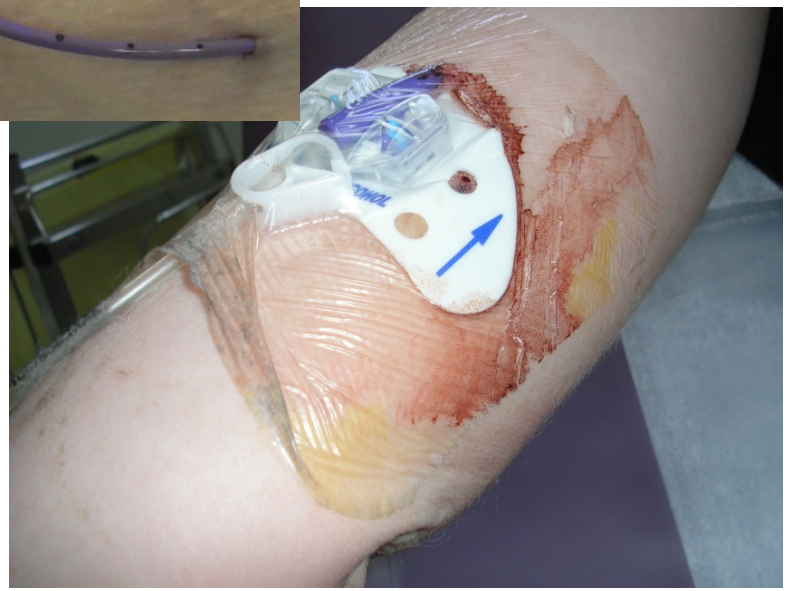
PICC nurses

Is it enough ?

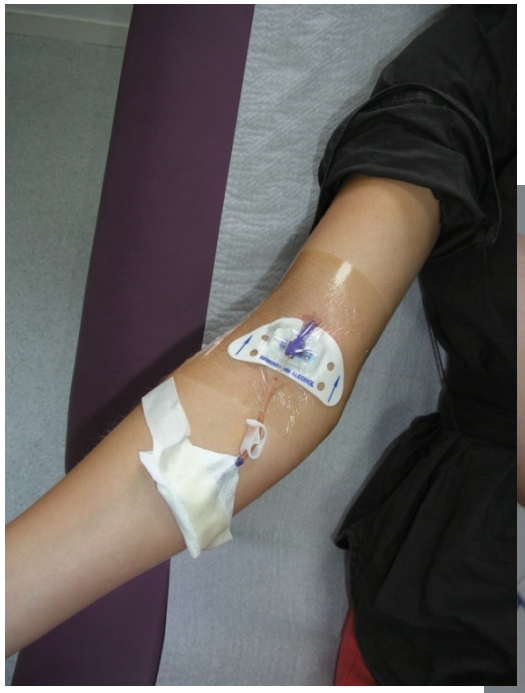


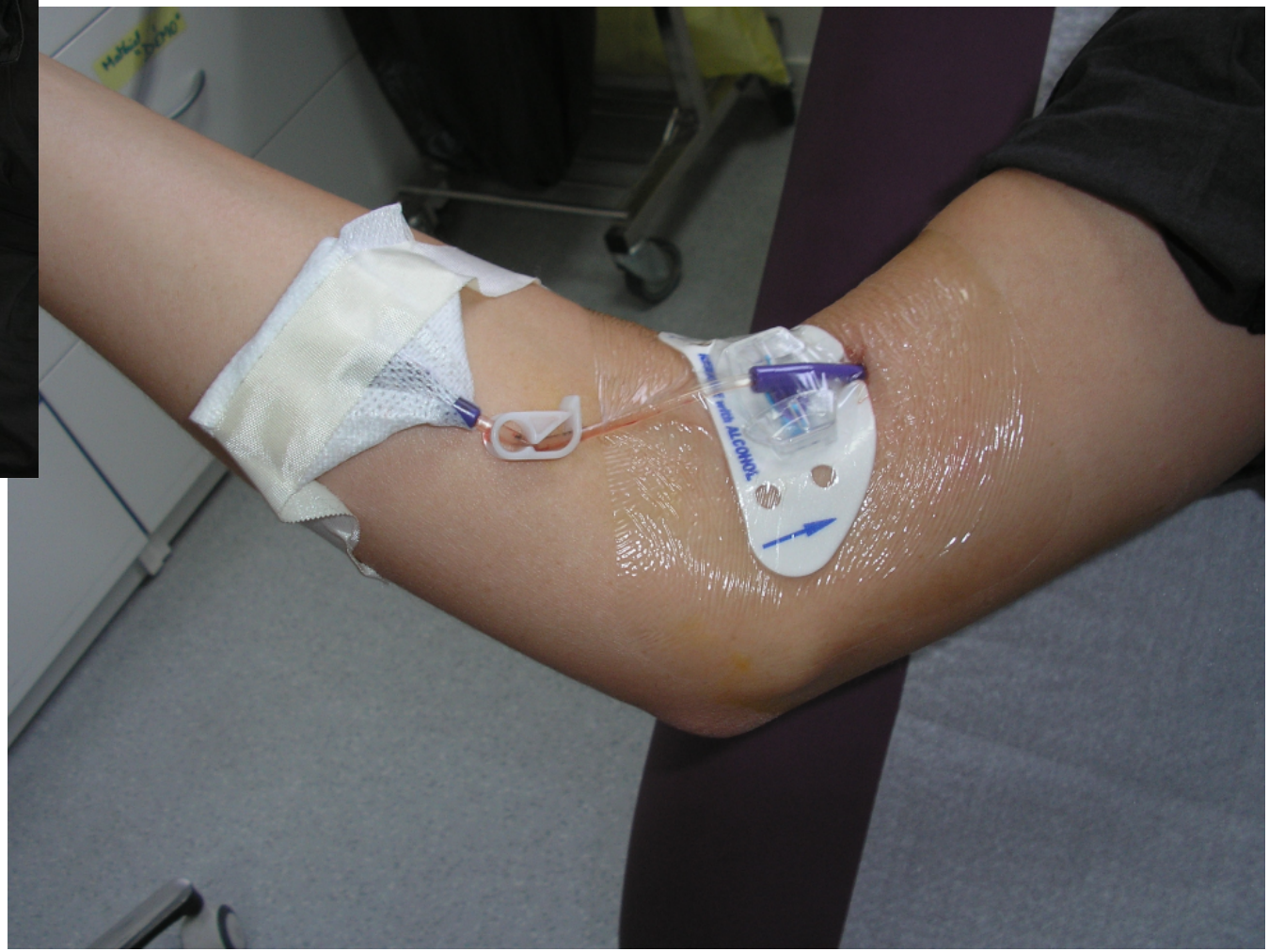


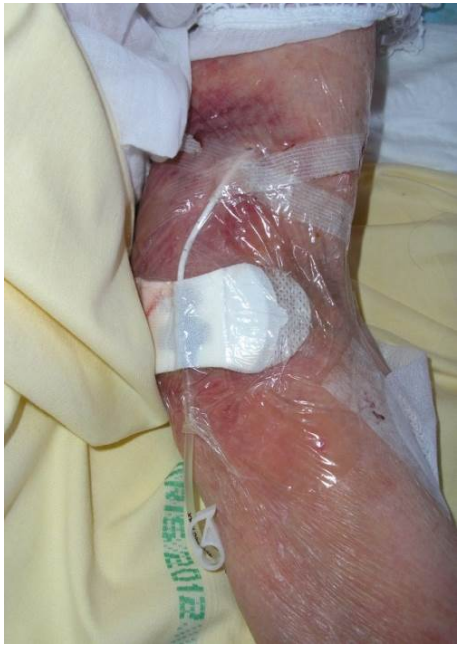




Inserted by physicians







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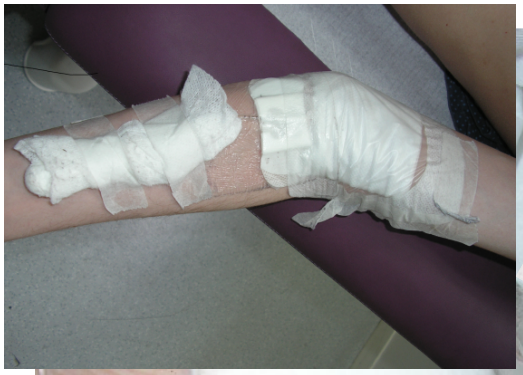
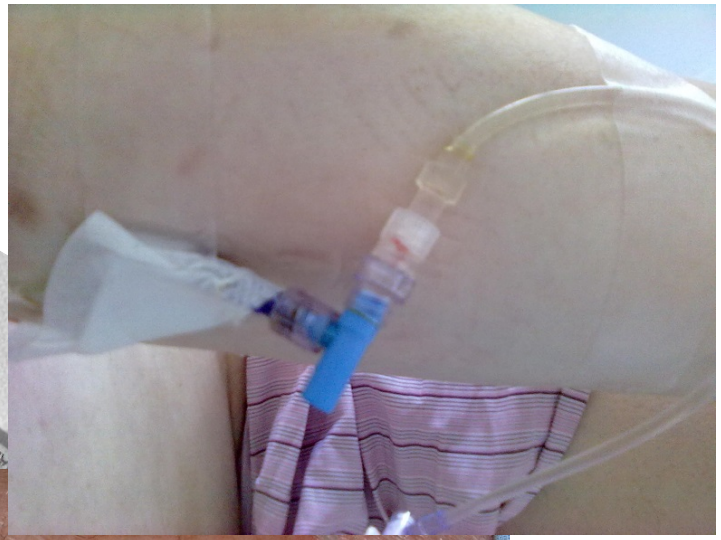
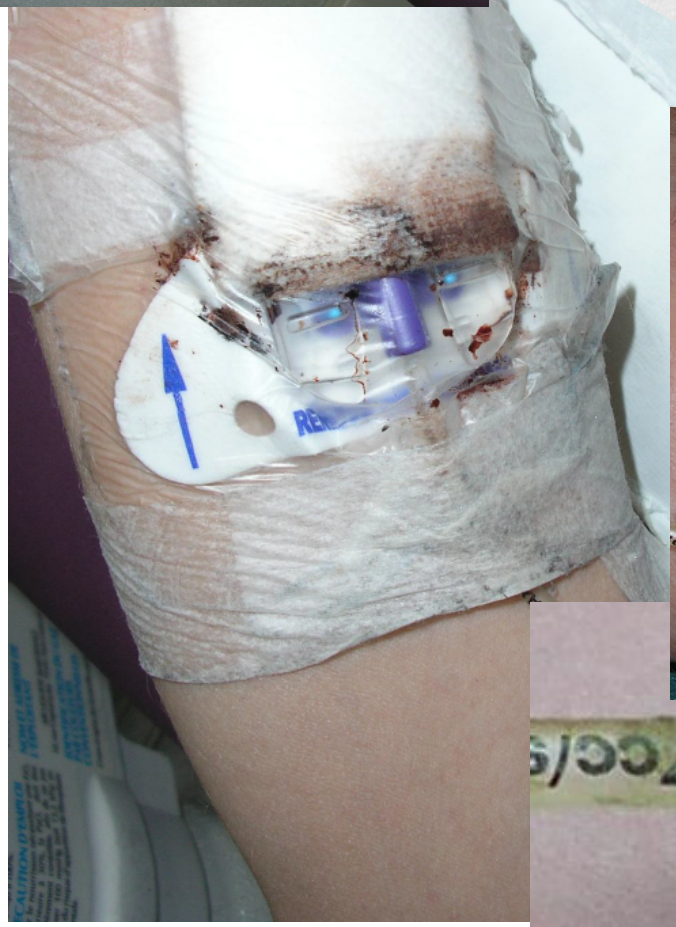
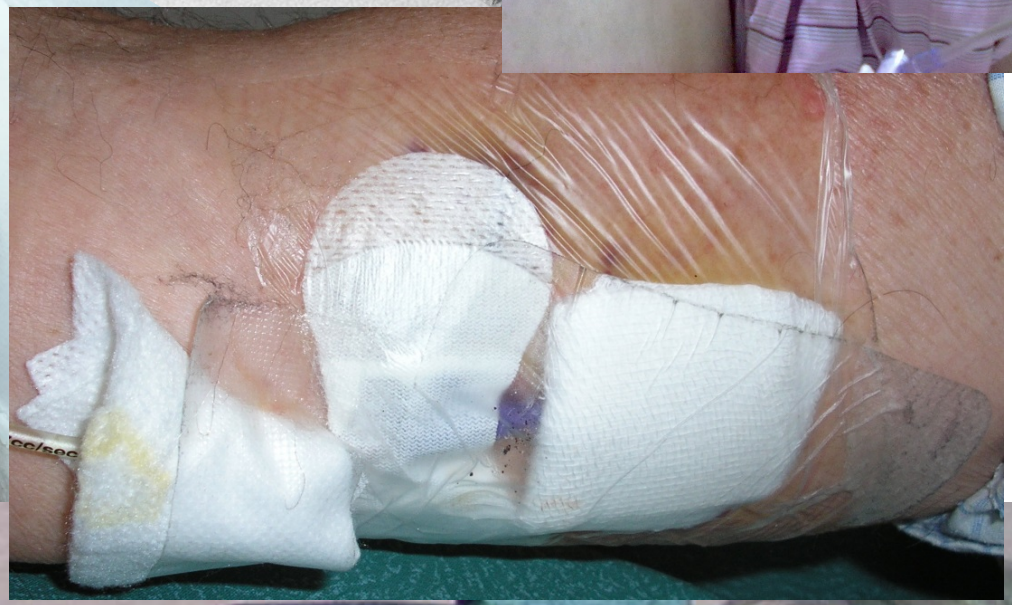








Used only by nurses

INSERTION

Patient

Care needs (what does he/she know? What can he / she tolerate?)

\+

Physician

Medical needs (what does he / she know or can finally do?)

→ 1st Choice

(Discussion between patient and physician?)

↓

CVC operator → 2nd Choice

(what does he / she know? What solution can he / she offer? What can finally be done?)

↓

Nurse outside Hospital → 3rd Choice

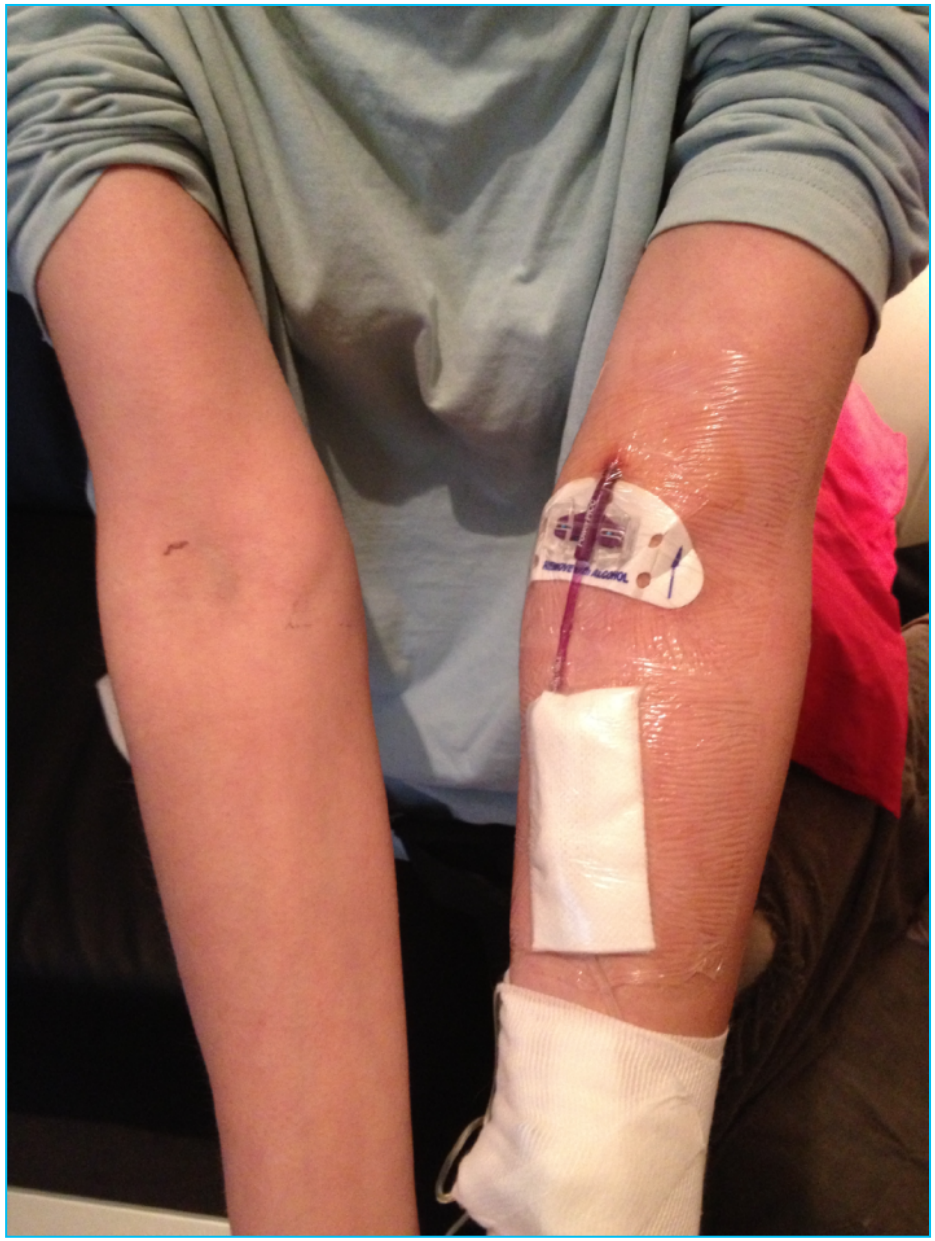
(What does he / she know? What solution can he / she offer? What can finally be done?)

↓

Nurse in Hospital → 4th Choice

(What does he / she know? What solution can he / she offer? What can finally be done?)

Is it enough ?



Identified only by patient, nurse and the radiologist who inserted the PICC but not by the ED physician

INSERTION

Patient

Care needs (What does he/she know? What can he/she tolerate?)

+

Physician

Medical needs (What does he/she know or can finally do?)

→ 1st Choice

(discussion between patient and physician?)

CVC operator

→ 2nd Choice

(What does he / she know? What solution can he/she offer? What can finally be done?)

Nurse outside Hospital

→ 3rd Choice

(What does he / she know? What solution can he/she offer? What can finally be done?)

Nurse in Hospital

→ 4th Choice

(What does he / she know? What solution can he/she offer? What can finally be done?)

REMOVAL

Patient

Care needs (what does he/she know? What can he/she tolerate?)

+

Physician

→ 5th Choice

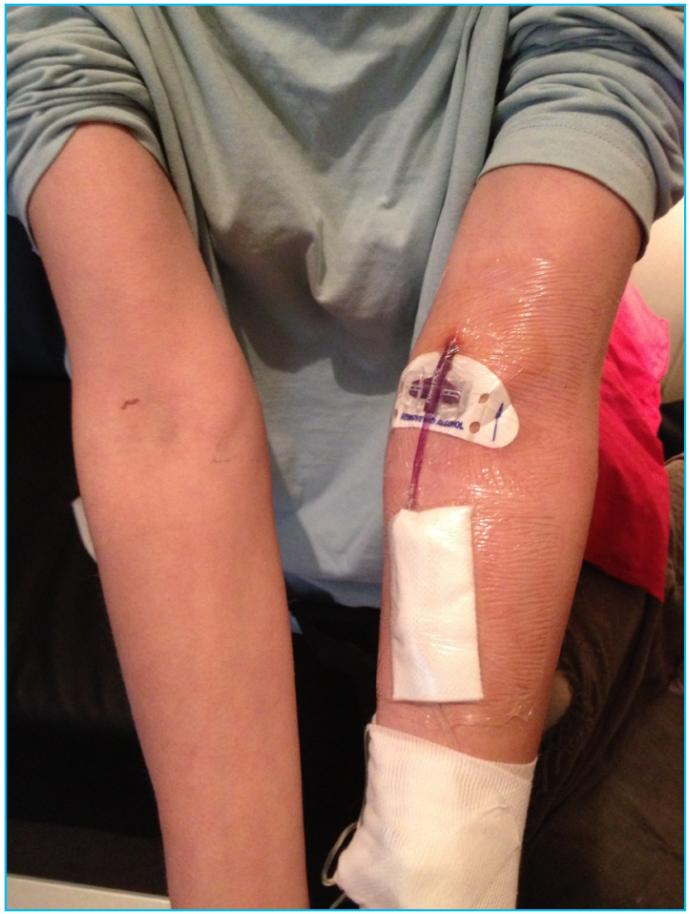
(Discussion within the health care team?)

Medical needs (What does he/she know or can finally do?)

CVC operator

→ 6th Choice

(What does he know or can propose to patient and finally do?)



- Operators and users must know how to identify and manage complications
- Fundamental question: Is it possible to maintain the PICC?
- Fundamental need: operators must follow the PICC they inserted

From the beginning to the end of the insertion of the CVC,
Were the best medical and paramedical solutions
applied to the case of this patient?

Today, in France we focus on:

- Theoretical or E-learning training sessions (easy to do, cheap, shows that you're involved in professionnal training ; but very limited impact)

- Training sessions conducted by experienced caregivers in hospital and by private providers of medical devices (but who regulates the training sessions?)

Is it enough ?

How can you learn a technique only by reading?

What about the evaluation?

In the best case, we have beautiful solists but the patient needs an I.V. competent team

Elements that can impact the quality of the final choice

- **Knowledge**
- **Trust in knowledge**
- **Practical application of guidelines**
- **Collaboration between administratives and physicians and pharmacists**
- **Collaboration between administratives, physicians, pharmacists and paramedicals**
- **Recognition**
- **Legislation**
- **Homecare activity**

What do they need?

Regulation of training by a specialized scientific committee

Multidisciplinary I.V team to help prescription, insertion, training, follow up and research

Specialized caregivers available to help their colleagues in hospital units or in homecare teams

The lack of organisation impacts the quality of care
And discredits the discussion (ex. : PICC nurses)

But where to begin?

Creating the national scientific vascular association ?

Describing the local state of play to inform decision makers?

Proving the need for true organisation?

Initially requesting recognition as a specialized activity for being able to do the above?

Conclusion

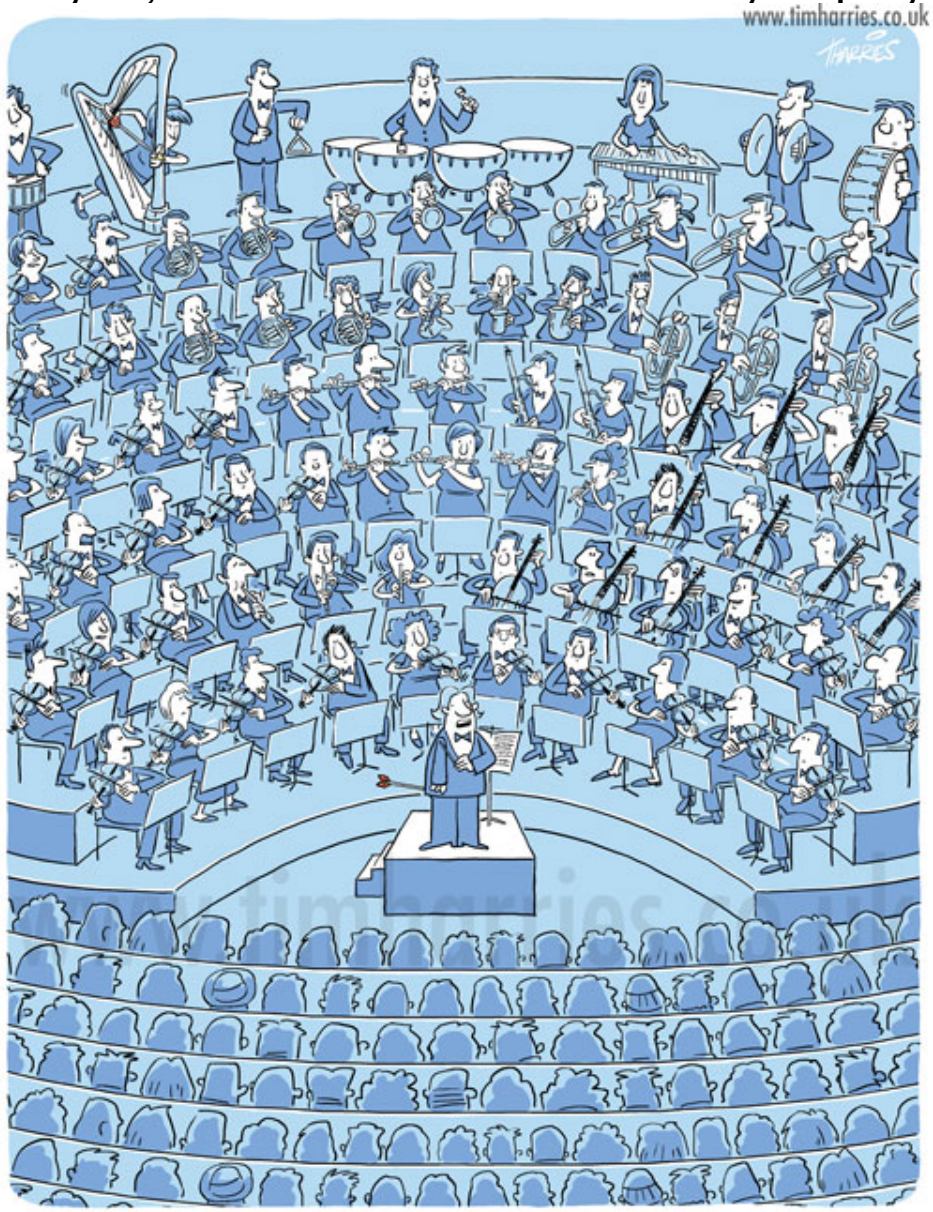
PICCs revealed a national need of pluridisciplinary I.V. teams in France

PICC nurses are confused with I.V. clinicians nurses

An I.V. specialization supported by a national I.V. scientific society can be a solution

The absence of I.V. teams is detrimental to patients, caregivers and the industry

And you, what kind of orchestra do you play in?



« On further reflection, I have decided this piece needs a real multidisciplinary execution »