

# Safer Vesicant Administration: Improving Communication Across Provider Lines

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The administration of vesicant drugs involves nurses and physicians as stakeholders in providing safe patient care. Improving communication often is the first step to increasing the awareness and problem-solving for the patient care team.

Outpatient infusion nurses have many variables to juggle every day—patient acuity, increasingly complex treatments, and the performance of support services such as laboratory and pharmacy, just to name a few. Further challenges exist when nurses have limited opportunity to directly interact with their physician colleagues on a face-to-face basis, as may occur in infusion treatment units. Building working relationships with colleagues is difficult when they seldom see each other. Because improving the nurse-physician relationship can contribute to better patient care and more satisfying work roles, encouraging collaborative resolutions to practice issues can be viewed as a win-win situation for all (Lindeke & Sieckert, 2005). For safer vesicant administration, improved collaborative communication is an essential piece of the nurse-physician dynamic. As noted by Erickson and Clifford (2008), “truly caring and competent practice relies upon strong collaboration among physicians and nurses” as well as the willingness of both groups to “confront each other with important issues of care” (p. 6).

Crucial facets of chemotherapy administration are knowledge of the vesicant potential of a drug and management of extravasation. Extravasation is defined as the inadvertent leakage of a medication into the surrounding tissue during administration (Sauderland, Engelking,

Wickham, & Corbi, 2006). It is a relatively uncommon event, estimated to occur in only 0.1%–6% of adults treated with chemotherapy (Schulmeister, 2008). Extravasation of a vesicant drug can cause significant tissue damage and is one of the most dreaded treatment complications facing oncology nurses and patients. Long-term side effects may include necrosis, tendon damage, pain, permanent disability, and disfigurement. Despite precautions, extravasations happen. Central venous access devices (CVADs) are recommended in many settings, but they come with risks of their own, including potential for infection, line-related thrombosis, and complications related to catheter placement. Notably, use of a CVAD does not eliminate the risk of extravasation but reduces that risk (Schrijvers, 2008).

## Practice Issue

As a new clinical nurse educator for outpatient oncology in a Magnet® hospital, the author asked nurses about their ideas for practice improvement. The infusion nurses reported frustration over the perceived lack of physician understanding of the risks of multiple venipunctures in patients receiving pe-

ripheral vesicant chemotherapy (PVC). Several nurses reported experiencing physician resistance when a nurse called to request CVAD placement for a patient with limited venous access. This situation was foreign to the author. In her previous job as an infusion nurse, all vesicant drugs had been administered through CVADs. Many of the staff admitted that they rarely had the chance to talk in person with the physicians because two hospital buildings separate the infusion units from the rest of the cancer center. No forum was established for communicating practice concerns. This issue presented an opportunity for physicians and nurses to work together to improve patient outcomes.

The staff wanted to address their perceptions of unrealistic physician expectations related to PVC. To start, the nurses collected data over a three-month period on patients ( $n = 54$ ) who had undergone more than two venipuncture attempts. Thirty percent of the patients in the sample had orders to receive vesicant drugs and had an average of 3.6 venipunctures for peripheral IV access. No institutional guideline existed to address the maximum number of venipuncture attempts for peripheral IV access.

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