

## IDENTIFYING ONESELF

“We Silence Our Profession When We Fail to Identify Ourselves as Nurses” (*Viewpoint*, August 2012) struck a cord. I’m often frustrated when I hear my colleagues introduce themselves using only their first names and don’t articulate what kind of nurse they are.

By using our whole names, we are making ourselves accountable to the patient and the community in which we practice. Moreover, we establish that we are professionals. My taxes aren’t completed by “Kendra, Accountant,” and bridges aren’t planned by “Sally, Engineer.” Why should nurses be privy to patients’ most sacred information and be able to inject them with potentially lethal substances if we don’t feel they should know our full names and credentials?

When we clearly articulate which profession we belong to, we also tie ourselves to a scope of practice, a code of ethics, and, most importantly, a regulatory body. Because RNs, LPNs, and RPNs in Canada have differing scopes, standards, and regulators, I believe it’s imperative that we clearly identify ourselves. The noun “nurse” deserves an adjective, such as “registered” or “practical.”

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## INFUSION THERAPY

Many aspects of “We Can Improve the Safety of PICC Lines” (*Viewpoint*, November 2012) don’t reflect national standards of practice.

The safety of peripherally inserted central catheter (PICC) insertion at the bedside has been well established, yet the author questions this practice without the benefit of fluoroscopy. Fluoroscopy is not necessary for PICC insertion. While there are challenges with proper tip location based on external measurement, a postinsertion chest X-ray is mandatory.<sup>1</sup> Technology advancement now allows

for the identification of PICC tip location during the insertion procedure by using electrocardiogram changes, a much more accurate method.<sup>2</sup> The primary or original tip location can change during the catheter dwell time, producing a secondary malposition.<sup>1</sup>

Saying that PICCs have an “inherent characteristic of instability” is not accurate. The author is confusing two different types of secondary catheter malposition. First, there is tip migration, which can occur with any type of central vascular access device (CVAD) and is caused by changes in intrathoracic pressure, such as coughing, sneezing, congestive heart failure, and mechanical ventilation. There is no change to the external catheter length. It’s the nurse’s responsibility to know the clinical signs and symptoms of tip migration and to take appropriate action if it’s suspected. There are no nursing interventions that could easily prevent this type of tip movement.<sup>1</sup>

Another type of secondary malposition is known as catheter dislodgment or displacement. In this case, the catheter is either pulled out of or pushed into the insertion site. This involves a change in the external catheter length, which subsequently produces a change in the catheter’s tip location.<sup>1</sup> The most common cause of this problem is lack of catheter stabilization.

The Infusion Nurses Society and the Centers for Disease Control and Prevention (CDC) recommend CVAD stabilization with an engineered, sutureless catheter stabilization device.<sup>1,3</sup> A transparent membrane dressing alone or “sticky occlusive clear dressing,” as stated by the author, is not a stabilization device. While a dressing has an important role in catheter care, relying on a dressing alone for stabilization puts patients at risk for catheter dislodgment. This is not the fault of the catheter design but rather the

absence of proper catheter stabilization techniques, a lack of appropriately engineered products for this purpose, and a lack of knowledge and skill by the nursing staff to adequately use these stabilization devices.

During each CVAD dressing change, measurement of the external catheter length with comparison to the original length is required.<sup>1</sup> A label on the catheter or dressing would assist nurses in locating this critical information. A simple piece of tape with this information can be added to the edge of the dressing.

Infusion nursing practice is measured against the documents produced by the Infusion Nurses Society and the CDC, and nurses must be familiar with these.

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## REFERENCES

1. Infusion Nurses Society. Infusion nursing standards of practice. *J Infus Nurs* 2011;34(1 Suppl):S1-S109.
2. Smith B, et al. Intravenous electrocardiographic guidance for placement of peripherally inserted central catheters. *J Electrocardiol* 2010;43(3):274-8.
3. O’Grady NP, et al. *Guidelines for the prevention of intravascular catheter-related infections*, 2011. Atlanta: Centers for Disease Control and Prevention; 2011. ▼

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