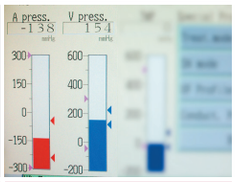
VENOUS NEEDLE DISLODGEMENT (VND)

HOW TO MINIMIZE THE RISKS

Recommendations for Nephrology Nurses

1	AWARENESS	Staff, patients and carers should be aware of VND and the consequences. Ref; Hurst, RN, CLNC, Venous Needle Dislodgement – A Universal Concern. European Nephrology, Volume 5, issue 2, Winter 2011
2		An area around the vascular access large enough for taping should be cleaned, properly disinfected, and air dried before cannulation.
3		Haemodialysis units should have appropriate training and a secure, clean, and consistent procedure for taping needles and bloodlines.
4		Bloodlines should be looped loosely to allow movement of the patient and to prevent bloodlines pulling on the needles.
5	REPOSITIONING	If it is necessary to reposition a needle, lower the blood flow to 150ml/min and replace all taping.
6		Staff to patient ratio should be adequate to allow routine monitoring of vascular access during treatment, if not report it as a near miss.
7	ASSESSMENT	All patients should be assessed for level of risk of VND and, if appropriate, an alarm device intended for monitoring venous needle dislodgement used.
8		Vascular access and needles should be visible at all times during haemodialysis.
9	ALARM ACTIVATION	When the venous pressure alarm is activated, the vascular access and fixation of needles and bloodlines should always be inspected prior to resetting the alarm limits.
10		The lower limit of the venous pressure alarm should be set as close as possible to the current venous pressure.
11	DETECTION FAILURE	Staff, patients and carers should be aware that the venous pressure monitoring system of the dialysis machine will often fail to detect VND.
12		Additional protection can be provided by devices intended to detect blood loss to the environment.

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