# Venous Needle Dislodgement –
# Is it necessary to report?

Presented by
Sebastien Bollue & Tai Mooi Ho Wong

Joint Project between EDTNA/ERCA & Redsense Medical

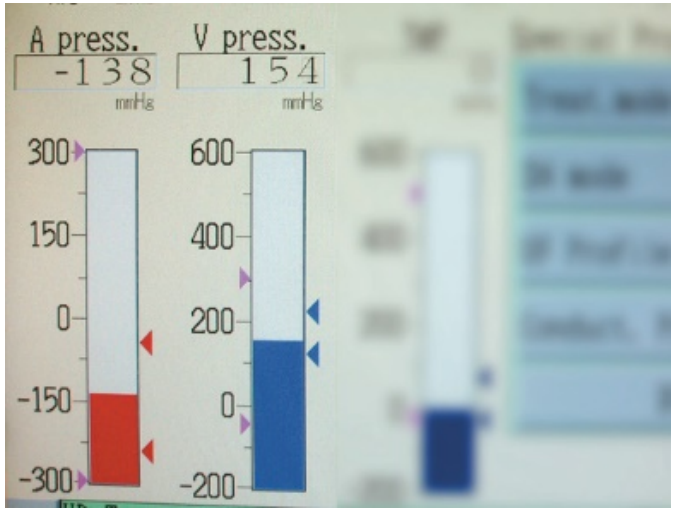
48th EDTNA/ERCA International Conference September 14th – 17th, 2019, Prague,

# SEBASTIEN BOLLUE

- Sebastien has a Master Degree of International Business focusing on Sales & Marketing
- During Sebastien's Master Studies, Sebastien took on a project together with Redsense Medical which later formed the platform of his thesis
- In 2016 Sebastien started to work at Redsense Medical as the Commercial Operations Manager
- Current position at Redsense Medical, Director Commercial Operations and Member of the Management Team

# BACKGROUND

- **ALL patients on HD** are exposed to the **risk of VND** - a potentially life-threatening complication during treatment
- A dislodged needle can cause **SEVERE BLOOD LOSS** within a few minutes




*Reference*

*Hurst J. Venous Needle Dislodgement-A Universal Concern. European Nephrology, 2011;5(2):148–51.*
*Axley B, Speranza-Reid J, Williams H. Venous Needle Dislodgement in Patients on Hemodialysis. Nephrology Nursing Journal, 2012; 39(6):435-445.*

It all started in 2008 when EDTNA/ERCA identified the gap of knowledge about VND - Venous Needle Dislodgement and the question was…

*If nobody acts, how and what can we do to increase the awareness about VND and the consequences?*

# THE AIM OF THIS COLLABORATION IS TO

- Optimize patient safety during HD/HDF treatment
- Ensure that staff, patients and carers are aware of “Venous Needle Dislodgement risks” and the consequences
- Facilitate accessible tools to determine patients at risk of VND and minimize the risks

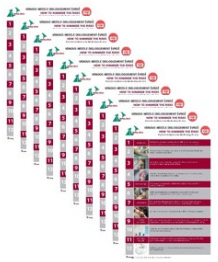
# THE COLLABORATION

2008 — Start up of the Collaboration between EDTNA/ERCA and Redsense Medical

2009 — Survey

2010

2011 — Posters developed into 11 languages



2012

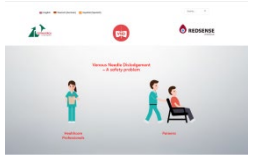
2013 — Survey

2014

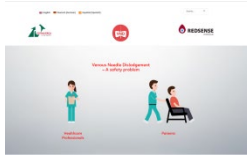
2015 — Survey

2016 — Design & Development of the Application

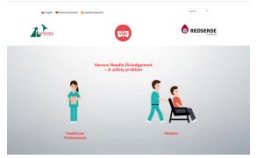
2017 — English



German



2018 — Spanish

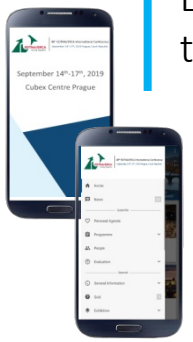


2019

# THE COLLABORATION

Start up of Phase 4

Design & development of the Survey

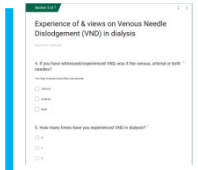


Launch of the Survey

Translation of the Survey into 18 languages

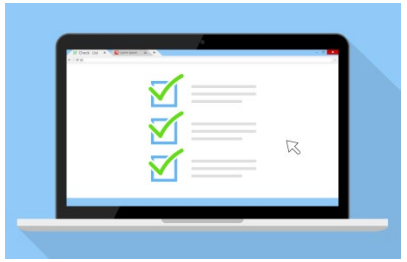
| | |
|---|---|
| Arabic | Italian |
| Croatian | Lithuanian |
| Czech | Polish |
| Danish | Portuguese |
| Dutch | Romanian |
| French | Serbian |
| German | Slovenian |
| Greek | Spanish |
| Hebrew | Turkish |

Consolidation of the result from the Survey



Design & development of the online Checklist & Incident Report in English

Launch & Implementation of the online Checklist & Incident Report

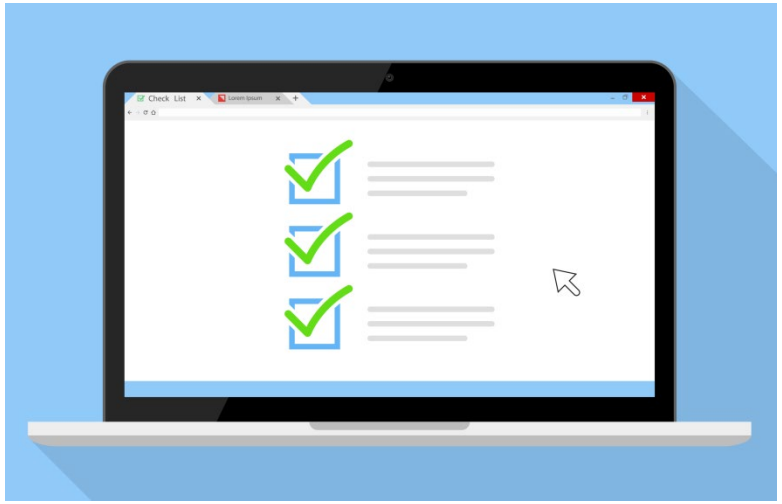


2021

2019 Q1 Q2 Q3 Q4 2020 Q1 Q2 Q3 Q4 2021

# NEXT STEP

Design & development of an online Checklist & Incident Reporting tool



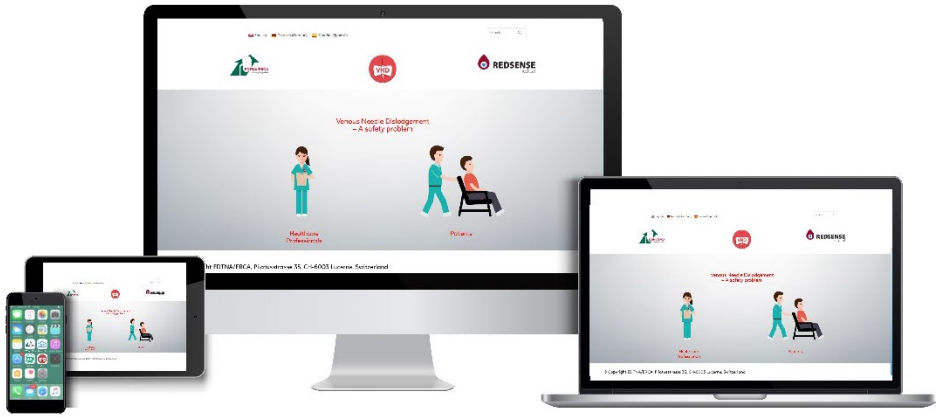
# TAI MOOI HO WONG

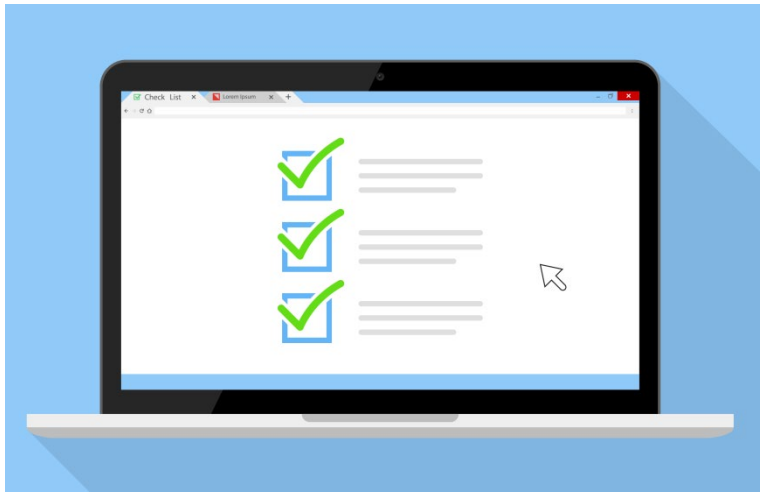
- Tai Mooi Ho is a Registered Nurse from Barcelona
- She has worked in nephrology nursing since 1980, covering several aspects of this specialist area and gained experience in adult haemodialysis.
- She has been a member of the EDTNA/ERCA since 1990, and currently is EDTNA/ERCA Executive Committee Member.

# CALL TO ACTION

Development of an online Checklist and Incident Reporting tool to be implemented as **a Standard procedure in Dialysis**

**…so we need your valuable input!**






*Reference*

- *World Health Organisation (2005). WHO draft guidelines for adverse event reporting and learning systems: From information to action. WHO Press: Geneva.*

# THE AIM

To help promote and support a blame-free work environment

**to improve patient safety**

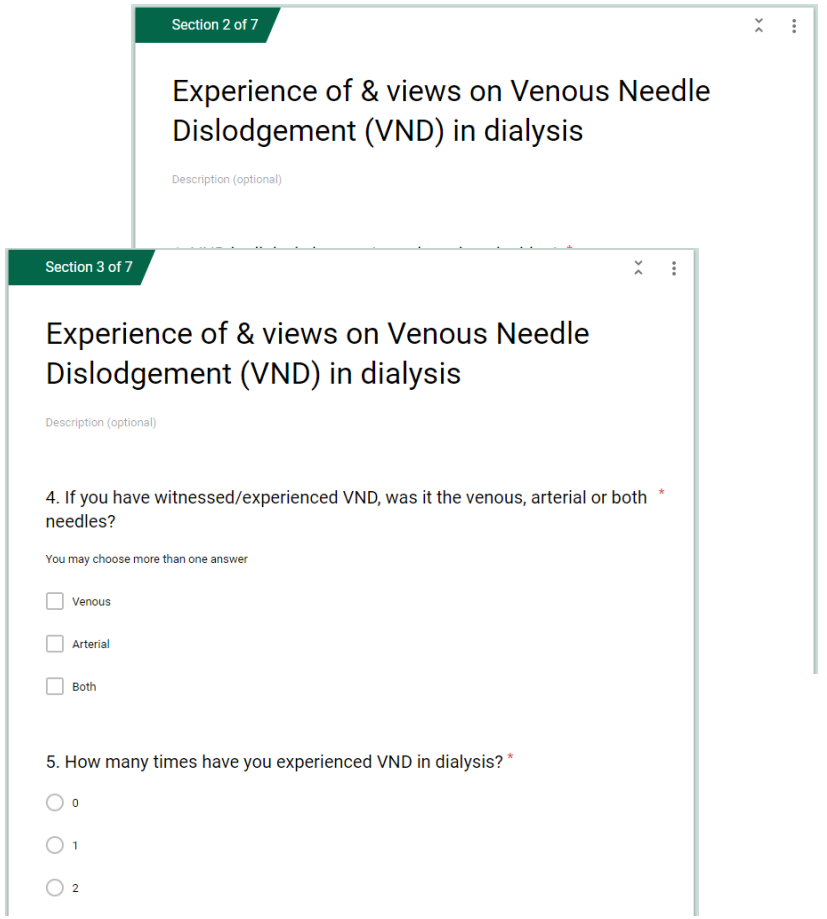

*References*

- *Aveling EL, Parker M, Dixon-Woods M. What is the role of individual accountability in patient safety? A multi-site ethnographic study. Sociol Health Illn. 2016;38(2):216–232. doi:10.1111/1467-9566.12370*
- *Cooper J, Edwards A, Williams H, et al. Nature of Blame in Patient Safety Incident Reports: Mixed Methods Analysis of a National Database. Ann Fam Med. 2017;15(5):455–461. doi:10.1370/afm.2123*

# STARTING OFF WITH A SURVEY

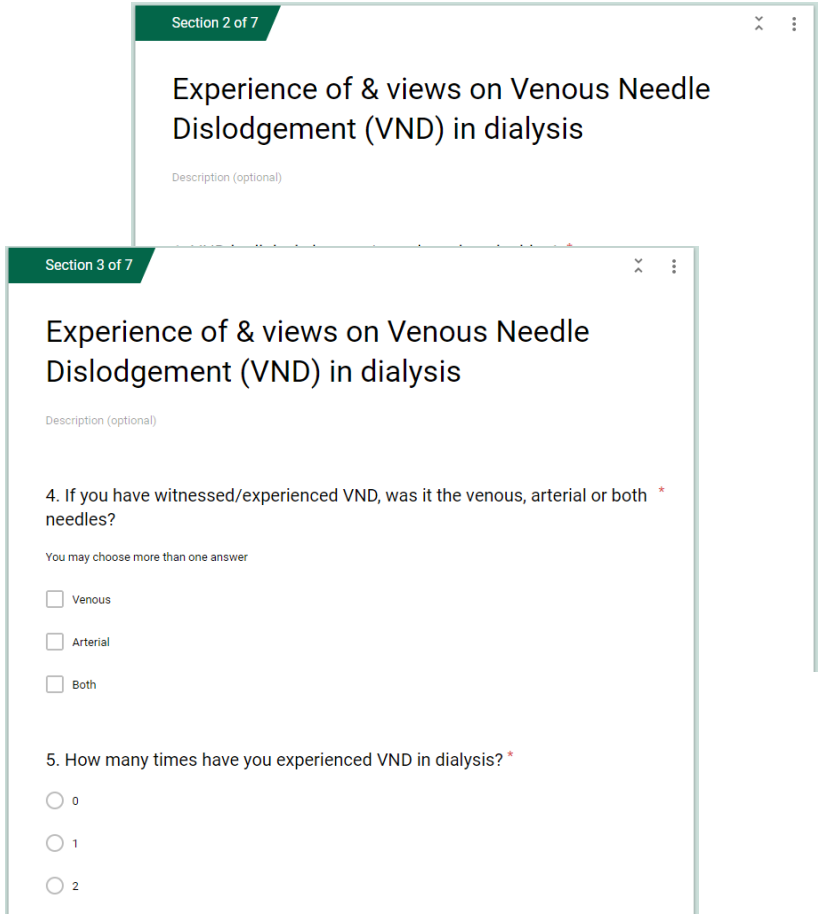
To explore HD nurses' experience of & views on VND in dialysis

Your valuable opinion will be the platform of the design of the Checklist and a VND Incident Reporting tool



# METHOD

- Multicenter online survey across the Globe
- September – November, 2019
- A convenience sample → EDTNA/ERCA Membership database
- Participation is voluntary
- Anonymous data
- Multiple choice questions
- Translation into 18 different languages by EDTNA/ERCA Brand Ambassadors

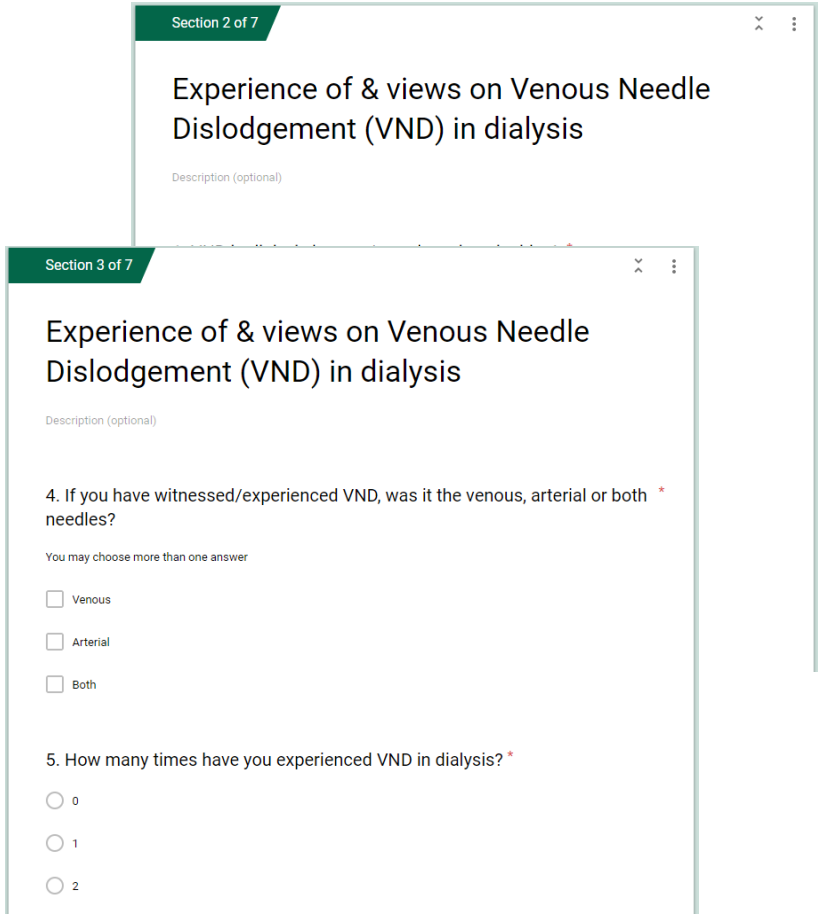


# SOME OF THE QUESTIONS

4) If you have witnessed/experienced VND, was it the venous, arterial or both needles?
   - Venous / Arterial / Both

7) How did you report the VND incident?
   - Reported to the medical staff and documented it in the patient's clinical record
   - In the VND Incident Reporting System
   - In the general Adverse Incident Reporting System
   - Other:

8) At your place of work, do you have a reporting system ONLY for VND incidents?
   - Yes
   - No



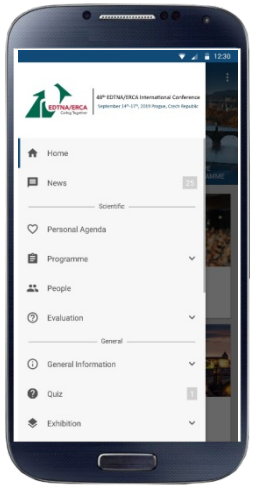
# TIMELINE

2019 - 2020

| | | |
|---|---|---|
| 1. | Sept 14th – November 30th, 2019 | Online Survey underway |
| 2. | December 1st, 2019 – March 2nd, 2020 | Consolidation of Survey result |
| 3. | March 3rd – July 1st | Design & development of the online Checklist & Incident Reporting tool – English version |
| 4. | September 12th, 2020 | Launch of the Online checklist & Incident Reporting tool |

We would appreciate very much if you would take 10 minutes of your time to fill in the survey.

You will find the link to the Survey in our Conference Application.


**Please contribute with your Valuable Input!**

# Thank You for listening!

Sebastien Bollue & Tai Mooi Ho Wong

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