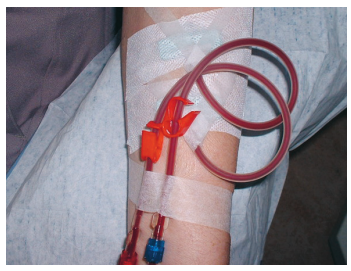
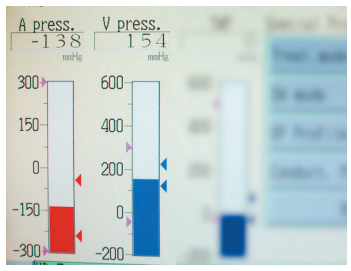
EDTNA/ERCA
Recommendations for Renal Nurses
Educational & Research Board EDTNA/ERCA

VENOUS NEEDLE DISLODGEMENT (VND)

HOW TO MINIMIZE THE RISKS

1	AWARENESS	Staff, patients and carers should be aware of VND and the consequences.
2		An area around the vascular access large enough for taping should be cleaned and dried before cannulation.
3		Haemodialysis units should have a consistent procedure for taping needles and blood lines.
4		Blood lines should be looped loosely to allow movement of the patient and to prevent blood lines pulling on the needles.
5	REPOSITIONING	If it is necessary to reposition a needle, all taping should be replaced.
6		Staff to patient ratio should be adequate to allow routine monitoring of vascular access during treatment.
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 blood lines 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.

For a detailed explanation of these recommendations please go to www.edtnaerca.org

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