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Elements of dialysis nursing practice associated with successful cannulation: result of an international survey

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ABSTRACT

Background/aim: Vascular access (VA) cannulation is an essential skill for dialysis nurses: failure to correctly repeat this operation daily may result in serious complications for the patients. This study investigates if different aspects of arteriovenous fistula and graft cannulation have an effect on the development of acute access complications, which may affect the VA survival.

Methods: In April 2009 a cross-sectional survey was conducted in 171 dialysis units located in Europe, the Middle East and Africa to collect details on VA cannulation practices. Information on cannulation retrieved from the survey comprised fistula type and location, cannulation technique, needle size, use of disinfectants and of local anaesthetics, application of arm compression at the time of cannulation, needle and bevel direction, needle rotation, and needle fixation. Five categories of complications were investigated: multiple-cannulation, infiltration, haematoma, haemorrhage and unknown.

Results: There were 10,807 cannulation procedures evaluated in the same number of patients. Of these, 367 showed some kind of complication, the most frequent (33.8%) being the need for multiple-cannulation. The following were associated with a significantly higher odds ratio for occurrence of an acute complication: prescription of back-eye needles, use of rope-ladder cannulation technique, insertion of venous needle as first needle, and rotation of the arterial needle. Use of 16-17-gauge needles was also significantly associated with complications, but this possibly reflects poor quality of the VA.

Conclusions: The risk of an acute VA complication could be reduced with appropriate training of nurses, physicians and patients. This could potentially prolong the VA life.

Keywords: Acute cannulation complications, Cannulation, Haemodialysis, Nursing practice, Vascular access

Introduction

Patients on extracorporeal dialysis treatment depend on well-functioning vascular access (VA) for their survival. The arteriovenous fistula (AVF) presents as the optimal VA, having a lower rate of complications, lower morbidity and fewer maintenance costs compared to central venous catheters (1). In 2006 the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (KDOQI) introduced a list of features that define a well-functioning VA among which was the statement "it can be easily cannulated", thus shifting focus from the surgical aspects of VA preparation to the way in which the VA is handled in normal clinical practice (1). Although

the usual insertion of two needles into the vessels is a basic nursing action, if we consider that it has to be repeated roughly 156 times a year we can understand its importance in the medium-/long-term maintenance of the VA. Cannulation is an essential skill for dialysis nurses: failure to correctly repeat this operation safely and effectively day after day may result in serious complications for the patients. The matter is not only related to expertise: in the current almost "assembly line" factory attitude for dialysis treatment (2), the pressure to execute all operations in the shortest possible time has led to focus more on the time required for an action than on the result thereof. In fact, time of conducting an action can be immediately measured, but the result of the action that is the medium- to long-term damage of the VA cannot be directly related to poor cannulation practices.

AVF or arteriovenous graft (AVG) cannulation, even if usually considered a simple action, is actually a procedure involving several steps. Each step can be executed in a variety of ways. The first is the selection of the needle, which can be with or without back-eye, of bigger or smaller size, and of shorter or longer cannula. Then, after the skin disinfection with different agents, a local anaesthetic can be used. A tourniquet or some form of vessel engorgement technique (e.g., compression of the arm by the patient or a member of the staff)

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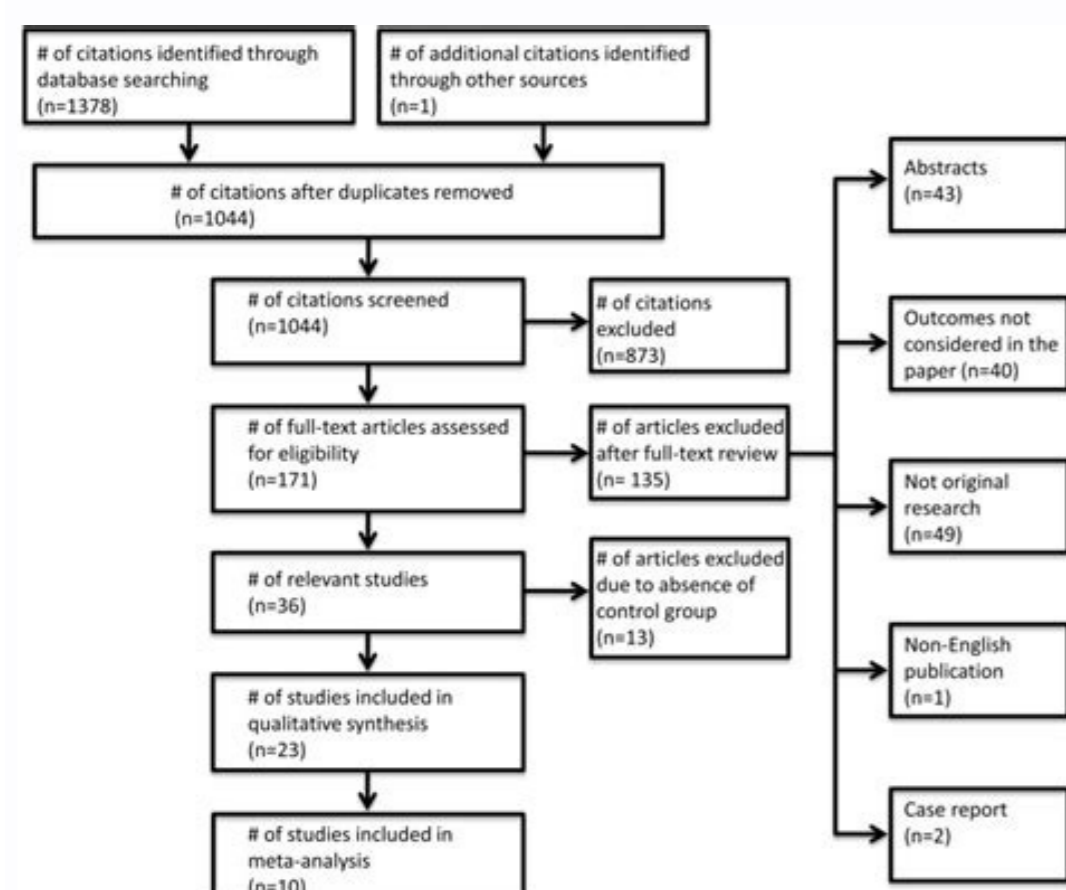


Table 3. Technique for Mature AVF Cannulation

Technique	Rationale
After skin preparation, apply a tourniquet to increase the venous pressure, and pull skin taut in opposite direction of needle insertion. Avoid excessive pressure to the cannulation site to prevent flattening of the vessel. Stabilize but do not occlude the vessel.	Compresses peripheral nerve endings between epidermis and dermis. Increases surface tension thereby facilitating incision of skin with less surface area contacting cutting edge of needle. Enables better stabilization of graft or vessel to be cannulated.
For easily palpated vessel, use approximately 25° angle with the bevel up. Arterial needle placement can be retrograde (up or in the direction of the blood flow) or retrograde (down or against the direction of blood flow). The venous needle should always be in the same direction as the blood flow.	Less steep angles increase risk of dragging cutting edge of needle along surface of vessel. Steeper angles increase risk of perforating underside (backwall) of vessel.
Needle direction of the venous needle in the same direction as the blood flow will prevent excessive pressure at the needle site. The arterial needle in either direction will not increase the risk of recannulation as long as the access blood flow is greater to the blood pump patient.	Needle direction of the venous needle in the same direction as the blood flow will prevent excessive pressure at the needle site. The arterial needle in either direction will not increase the risk of recannulation as long as the access blood flow is greater to the blood pump patient.
Once the vessel has been penetrated:	Any manipulation may traumatize the intima of the vessel. The use of a back-eye needle will eliminate the need to rotate the needle due to poor flow.
• Advance the needle slowly with cutting edge facing top of vessel and do not rotate axis.	Pressing the needle shaft flat against the skin moves the needle tip from the directed position within the vessel lumen.
• Tap the needle at the same angle or one similar to the angle of insertion.	Avoid trauma to any intima by dragging cutting edge along it. Avoid pressing cutting edge into vessel when applying pressure for HD.
• Remove needle at same or angle similar to angle of insertion, and NEVER APPLY PRESSURE BEFORE NEEDLE IS COMPLETELY OUT.	

Successful First Cannulation of a New AVF

- A "New AVF Cannulation Protocol" should be developed by the entire healthcare team, including access surgeon and interventional nephrologist/radiologist
- Protocol should provide:
 - Clear instructions for the initial cannulation
 - Subsequent cannulations
 - Interventions for complications



Cannulation of AV fistula



What is cannulation in dialysis.

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