Death of a patient from haemorrhage associated with a dialysis catheter.

There has been an incident reported of the unintended decannulation of a haemodialysis catheter whilst a patient was unsupervised in a side room in a critical care area. The catheter was not in use at the time. This incident may have significantly contributed to the death of the patient as a result of external haemorrhage. Following the incident it was noted that the “wings” that were used to suture the catheter in place remained in situ and the dressing which had been in place for 5 days was partially detached.

The issue has been reported to appropriate risk management teams and authorities, including the MHRA who are investigating with the manufacturer.

The following is general advice until investigations are complete and any final judgments are made.

**Action:**

Renal Units and all critical care areas where renal replacement therapy is undertaken should take note of the following:

- As this appears to be an isolated incident it is imperative that full details of any other incidents related to haemodialysis catheters are reported to the MHRA. This will allow MHRA to assess the scale of any problem that exists.

- Units should have heightened awareness of the possibility of haemodialysis catheters unintentionally decannulating.

- Units should ensure manufacturer’s instructions for use are regularly reviewed and followed.

- Units should ensure that they follow the manufacturer’s recommendations about the use of cleaning fluids and other externally applied substances such as lotions and creams.

All healthcare workers should ensure any device failures or critical incidents related to devices are reported promptly through your own internal governance systems and also to the MHRA.

Please submit comments, solutions, and personal experience to:

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