

“Best Practice (HOW & WHY?) Messages from the Units that Consistently Achieve AVF Utilization Rates \geq 66% and Helpful Hints from the Network”

The following items are being shared for your review, discussion and use within your dialysis unit’s QAPI activities and/or physician practice.

1. **“INTERDISCIPLINARY DIALYSIS HEALTH CARE TEAM, including PATIENTS COMMITTED TO IMPROVING VASCULAR ACCESS FOR HEMODIALYSIS”.**
 - Ask the social worker for assistance if resources (financial, transportation) are problematic for permanent vascular access placement and/or follow-up.
 - Review your facility’s aggregate and practitioner-specific vascular access management outcomes monthly. Outcomes should include both % AVF’s placed and % AVF’s in use
 - Provide and/or Discuss practitioner-specific outcomes with applicable personnel

2. **“WORK WITH SURGEONS WHO USE VESSEL MAPPING IN ACCESS CREATION”.**
 - Discuss vessel mapping and its potential to improve vascular access placement with your surgeons / interventionalists
 - Surgeons performing their own ultrasound studies prior to access creation
 - Contact the Network for educational resources (http://www.network13.org/ff_tools.asp)

3. **“A MINORITY OF SUCCESSFUL AVF’S ARE LOCATED AT THE WRIST; ABOUT 60 – 75% OF SUCCESSFUL AVF’S” ARE LOCATED IN THE UPPER ARM¹”.**
 - Does your surgeon know about upper arm access?
 - Has your surgeon(s) placed successful upper arm accesses?

4. **“IF YOUR PATIENT’S AVF IS NOT MATURE (AND BEING USED) BY 6-8 WEEKS, INTERVENTION (i.e., angioplasty) OR SURGICAL REVISION IS RECOMMENDED.”²**
 - Expect 30-50% of patients to need intervention³ **BEFORE FIRST USE.**⁴
 - Do you have a written access maturation policy?
 - Are you utilizing the Network 13 AVF Functionality Tool?
 - (http://network13.org/QI/Facility_Info_Packet/4C6B_AVF_Functionality_Tool.xls)

5. “RE-EVALUATE THE AVF IF NOT IN USE 4 WEEKS AFTER INTERVENTION OR REVISION...IF NOT SUCCESSFUL, RETURN TO STEP 4!”

- Need to keep “MOVING FORWARD”
- Waiting alone or using arm exercises will rarely lead to a useable access

6. “EVALUATION AND CANNULATION OF AVF’S ARE IMPORTANT CLINICAL PROCESSES”

- The evaluation and cannulation of new AVF’s requires experience
- Have you reviewed the recently released “Fistula First – Cannulation of the Arteriovenous Fistula (AVF) DVD?
- Have you attended a Network 13 Cannulation training session?
- Do you utilize a vascular access competency checklist?
- Do you have it outlined in policy or procedure when to “Back Off” on sticking a fistula?
- Is the Buttonhole technique being used in your facility?
- Is there interest in establishing patient ‘self-cannulation’ training for appropriate/applicable patients?

FOOTNOTES:

1. Because of the nature of the current patient population, most patients’ vessels will not support a radio-cephalic (Cimino) fistula, leading to the placement of upper arm AVF’s.
2. In the units with the highest AVF utilization rates, the patients are seen in follow-up by their surgeons within four (4) to six (6) weeks.
3. A variety of newer interventions are available to salvage immature fistulas. Those interventions could be AV Fistulogram (road map), angioplasty, surgical revision, or accessory vein ligation.
4. A high rate of fistula utilization will necessitate placing fistulas that might not mature without intervention (i.e., even in the most successful units). Interventions are expected to convert “fistulas placed” to “fistulas used”.