NICE National Institute for Health and Care Excellence

Medical Technologies Evaluation Programme

MT291 - The SecurAcath device for securing percutaneous catheters

Expert Adviser Questionnaire Responses

Name of Expert Advisers	Job Title	Professional Organisation/ Specialist Society	Nominated by	Ratified
Mr Maurice Madeo	Deputy Director for Infection Prevention and Control	Infection Prevention Society	NICE	Yes
Ms Jackie Nicholson	Consultant Nurse in Vascular Access	National Infusion and Vascular Access Society	Sponsor	Yes
Ms Meinir Hughes	Intravenous Access Nurse Specialist	Royal College of Nursing	Sponsor	Expected
Mr Matthew Hobley	IV Nurse Practitioner	Royal College of Nursing	Sponsor	Expected
Dr Lisa Dougherty	Nurse Consultant	National Infusion and Vascular Access Society	Sponsor	Yes
Ms Carol McCormick	Clinical Interventions Team Manager	Royal College of Midwives	Sponsor	Yes
Ms Dympna McParlan	Infusion Services Coordinator	Nursing and Midwifery Council	Sponsor	Yes
Dr Andrew Johnston	Consultant in Intensive Care Medicine and Anaesthetics	Royal College of Anaesthetists	NICE	Yes
Ms Rachel Binks	Nurse Consultant, Digital and Acute Care	Royal College of Nursing	Specialist Society	-
Ms Liz Simcock	Clinical Nurse Specialist	Royal College of Nursing	Sponsor	Expected

YOUR PERSONAL EXPERIENCE (IF ANY) WITH THIS TECHNOLOGY

Question 2: Please indicate your experience with this technology?

Expert Advisers	I have had direct involvement with this	I have referred patients for its use	I manage patients on whom it is used in another part of their care pathway	I would like to use this technology but it is not currently available to me
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	Blank	Blank	Blank	**Yes**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Yes**	**Yes**	No	Blank
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Yes**	**Yes**	Blank	Blank
Mr Matthew Hobley **IV Nurse Practitioner**	**Yes**	**Yes**	**Yes**	No
Dr Lisa Dougherty **Nurse Consultant**	**Yes**	Blank	Blank	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	**Yes**	**Yes**	**Yes**	Blank
Ms Dympna McParlan **Infusion Services Coordinator**	**Yes**	Blank	Blank	Blank
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	No	No	No	**Yes**

Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	Blank	Blank	Blank	**Yes**
Ms Liz Simcock **Clinical Nurse Specialist**	**Yes**	No	No	No
Any Comments?				
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	Blank			
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	Blank			
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**We have placed over one thousand securacath devices in our organisation in the past 3 years specifically and only with the use of single and dual lumen PICC lines (Peripherally Inserted Central Catheters). I am the lead nurse for this service.**			
Mr Matthew Hobley **IV Nurse Practitioner**	**I have used this product for the last year, placed in all chemotherapy patients who need central/long term access, and also in patients in the hospital that are confused or likely to pull out a line**			
Dr Lisa Dougherty **Nurse Consultant**	**I have used this product for 4 years and we were the first Trust to evaluate it in the UK**			
Ms Carol McCormick **Clinical Interventions Team Manager**	**I have successfully used the SecurAcath on all my adult patients who have a PICC line for over 3 years (700-800 lines per annum). I first introduced it to my practice due to a high number of lines migrating out of the optimum position at which time I realised that we were able to cleanse the exit site more effectively without the fear of pulling the line out. I would like to see it used more widely by other organisations**			
Ms Dympna McParlan **Infusion Services Coordinator**	Blank			
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**I would consider using this technology after evaluation in my own institution**			

Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	Blank
Ms Liz Simcock **Clinical Nurse Specialist**	**I run a nurse-lead central venous catheter team. We now offer SecurAcath to all our patients having Peripherally Inserted Central Catheters (PICCs) inserted.**

Question 3: Have you been involved in any kind of research on this technology? If Yes, please describe?

Expert Advisers	Yes/No	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	No	Blank
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	No	Blank
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	No	**I have not undertaken a research study but I have evaluated the device and published these findings. British Journal of Nursing 2014 (IV Therapy Supplement) Vol 23, No 2.**
Mr Matthew Hobley **IV Nurse Practitioner**	No	Blank
Dr Lisa Dougherty **Nurse Consultant**	No	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	No	Blank
Ms Dympna McParlan **Infusion Services Coordinator**	No	Blank

Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**No**	**Blank**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**No**	**Blank**
Ms Liz Simcock **Clinical Nurse Specialist**	**Yes**	**No proper trials or research as such but my team have carried out two audits of patients' attitudes by means of a telephone / face-to-face questionnaire. We have also carried out a survey of nurses' attitudes to the device (ie the nurses who care for patients with PICCs on our wards and in our outpatient units)..**

THIS PRODUCT (TECHNOLOGY) AND ITS USE

Question 4: How would you best describe this technology?

Expert Advisers	It is a minor variation on existing technologies with little potential for different outcomes and impact	It is a significant modification of an existing technology with real potential for different outcomes and impact	It is thoroughly novel - different in concept and/ or design to any existing
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	Blank	**Yes**	Blank
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Yes**	**Yes**	**Yes**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank	Blank	**Yes**
Mr Matthew Hobley **IV Nurse Practitioner**	No	**Yes**	Blank
Dr Lisa Dougherty **Nurse Consultant**	Blank	Blank	**Yes**
Ms Carol McCormick **Clinical Interventions Team Manager**	Blank	Blank	**Yes**
Ms Dympna McParlan **Infusion Services Coordinator**	Blank	Blank	**Yes**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	Blank	**Yes**	Blank
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Yes**	Blank	Blank

Ms Liz Simcock **Clinical Nurse Specialist**	Blank	Blank	**Yes**
Any Comments?			
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Given thee is no adhesive required it has a major advantage over competitors and allows cleansing of the skin to be undertaken between dressing changes.**		
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**It is a minor variation in that there are other ways of securing central venous catheters.** **It is a significant modification in that the action of the securement is very different** **It is thoroughly novel in that there is no other device that uses this action of securment**		
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank		
Mr Matthew Hobley **IV Nurse Practitioner**	**Am not sure which bit to tick for this bit as it is a novel idea and nothing like it on the market, but it is still linked to existing technology as a line securement device ie statlock/griplock/stitching**		
Dr Lisa Dougherty **Nurse Consultant**	**Its unique design means it provides securement of a CVC and does not require changing has resulted in a huge reduction malpositioned PICCs**		
Ms Carol McCormick **Clinical Interventions Team Manager**	**The Securacath device is an innovative method of securing a line reducing line migration, pistoning and the costs of extra dressings**		
Ms Dympna McParlan **Infusion Services Coordinator**	Blank		
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**All other technologies are dependent on an adhesive securing device which needs changing every 7 days - this regular device change increases the chance of catheter dislodgement**		
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**It is a minor variation but may have potential for significant impact**		
Ms Liz Simcock **Clinical Nurse Specialist**	Blank		

Question 5: What is the most appropriate use (e.g. clinical indication) for the technology?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**To secure PICC and central lines**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**It is used to primarily secure peripherally inserted central catheters although it is marketed as also being used to secure acute central venous catheters**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**We place numerous peripherally inserted central catheters (PICC) in our organisation and all of these catheters, unless allergies proclude their use are secured using the Securacath device.**
Mr Matthew Hobley **IV Nurse Practitioner**	**Used for securing any indwelling intravenous device. Used to make sure that the indwelling line does not move. Used to help keep the device in place on patients that are confused and pull at indwelling lines. Used to secure central lines as an alternate to stitching**
Dr Lisa Dougherty **Nurse Consultant**	**It can be used on most long term CVADs but we have used it extensively on PICC securement. The only time we have not used it is if a patient is allergic to nickel and if a patient has had problem with previous removal and requests to have an adhesive device.**
Ms Carol McCormick **Clinical Interventions Team Manager**	**The Securacath device should be used on any patient without a Nickel allergy to secure their peripherally inserted central catheter (PICC) at the time of insertion. This is to ensure that the line remains at the optimum position during the period that the line remains insitu; for some cancer patients this can be for many months. This reduces the ongoing weekly costs of specific dressing securement plasters and enables the exit site to be cleaned entirely around and beneath the line.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Insertion at the time of all PICC insertions to prevent catheter migration unless the patient has a nickel allergy**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**To secure PICCs in patients who are likely to need them for longer than 1-2 weeks**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**I haven't used or seen the product but it may have a use for patients with burns or skin conditions where fixation devices cant be used at present without stitching them in**

Ms Liz Simcock **Clinical Nurse Specialist**	**This product is most appropriate for patients with PICCs where the PICC is going to be required for longer than 1 week. I don't have any experience of it being used for other types of vascular access device or for drains.**

COMPARATORS (including both products in current routine use and also "competing products")

Question 6: Given what you stated is the appropriate indication (clinical scenario) for its use, what are the most appropriate "comparators" for this technology which are in routine current use in the NHS?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Statlock**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Statlock and Griplok**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**I would say that there is no comparative device available for use. Previous securement methods have involved the use of adhesive plasters which are placed on the skin. In our experience these were unreliable and lead to many instances of catheter migration.**
Mr Matthew Hobley **IV Nurse Practitioner**	**statlock, griplock, stitches**
Dr Lisa Dougherty **Nurse Consultant**	**The only other products are the adhesive securing devices**
Ms Carol McCormick **Clinical Interventions Team Manager**	**I do not know of a substitue under the skin securement device similar to the Securacath. I am only aware of on the skin line securement plasters, either the Grip-lok or the Stat-lok that are designed to keep the line in place. However, often when the dressings are removed the line is pulled out or migrates naturally out of the optimum position which then increases the risks of line occlusions, exit site infections and thrombus rates as the lines cannot be secured adequately. The cost implication of migrations include the loss of the line needing line replacements, costly dressings every week, and the increased risks of infections as staff are worried about causing the line to be pulled out or pushed in further than needed.**
Ms Dympna McParlan **Infusion Services Coordinator**	**BARD Statlock Securement Device**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**The most commonly used comparator is the Statlock adhesive securing device which is commonly used for PICCs.**

Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Sutures**
Ms Liz Simcock **Clinical Nurse Specialist**	**There are various other devices for securing PICCs but unlike SecurAcath they are adhesive devices which have to be changed once a week. Changing the dressing and the device carries a high risk of dislodgement. Statlock is the most widely used but there are other manufacturers making comparative devices. I think Vygon make one but I don't know the name and I have no experience of it. I have also seen another one called Modulare CVC/PICC but again I have no experience of it.**

Question 7: "Competing products": Are you aware of any other products which have been introduced with the same purpose as this one?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	No
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**As above**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Not any which are comparable to this product type that I am aware of however leading on from the comment above the adhesive dressings which I'm aware of are 'Statlock' and 'Griplock'.**
Mr Matthew Hobley **IV Nurse Practitioner**	No
Dr Lisa Dougherty **Nurse Consultant**	No
Ms Carol McCormick **Clinical Interventions Team Manager**	No
Ms Dympna McParlan **Infusion Services Coordinator**	**Vygon Grip-Lok Securement Device**

Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Statlock**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	No
Ms Liz Simcock **Clinical Nurse Specialist**	No

POSSIBLE BENEFITS FOR PATIENTS

Question 8: What are the likely additional benefits for patients of using this technology, compared with current practice/ comparators?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**No adhesive involved so less issues re allergy and skin damage when removing device. Using this device will negate need to suture vascular device insitu.**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Ability to clean around the catheter exit site without risk of catheter dislodgement, securement for the dwell time of the catheter and no requirement to change the securement weekly.**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**This device prevents migration of PICCs in most cases. Of the one thousand catheters that we have placed using the securacath device, the migration incidence is between 1 and 2% which is a substantial decrease from the rate of migration prior to using the securacath. The benefits to patients are:** **Reduces the incidence of inadvertent catheter movement. Migration of the tip into sub optimal position can lead to:** **Having to experience a repeat procedure (PICC placement).** **Thrombosis (Abdullah et al, 2005)** **The administration of medication into a sub-optimal position, i.e a small vein** **Increased cost owing to X-ray and PICC replacement** **Reduction in the episodes of allergic reactions to dressings** **Reduction in the ongoing cost of weekly dressings** **Simplification of the dressing technique owing to minimal dressings** **Improved cleansing technique due to the 360-degree access to the exit site.** **Reduction in staff time being spent on managing migration**
Mr Matthew Hobley **IV Nurse Practitioner**	**securement of iv device so less likely to be moved, less likely than stiching to cause trauma to skin or infection. Due to keeping iv device in the perfect spot less likely to cause dvt**

Dr Lisa Dougherty **Nurse Consultant**	**Reliable securement - no more malpostioned catheters** **Doesn't require changing every week** **Very unlikey to move during dressing changes** **Securment allows nurses to lift catheter and clean around it easily - so improved skin cleaning** **Better staff confidence when changing the dressing**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Patients who have the Securacath device gain a higher level of confidence when moving their arm which is vital for those patients who are discharged home with a PICC to reduce the liklihood of a thrombus development and during their activities of daily activities. Patients also gain confidence when other practitioners care for the line due to the reduced risks of line removals and then possible line replacements.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Reduced/No migration** **Reduced skin reactions** **Improved cleansing of catheter exit site** **Reduced catheter replacements** **Reduced thrombosis rates** **Decreased dressing times** **Increased confidence of community staff** **Increased patient confidence** **Reduced costs associated with the above** **Would be very beneficial to paediatrics (although I have no experience in this area) as this would reduce the risk of catheter removal substantially**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**1. Reduces the need to regularly change the adhesive securing device - each change increases the likelihood of catheter dislodgement.** **2. Easier to clean around the catheter insertion site without dislodgement.** **3. Potentially reduces the incidence of skin excoriation from the adhesive securing device.** **4. Fixes catheter in one posiiton close to exit site - this could theoretically reduce infection rates, thrombosis rates etc but there is limited evidence for this**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Less likelihood of the device coming out**
Ms Liz Simcock **Clinical Nurse Specialist**	**Less risk of the PICC becoming dislodged during dressing changes and therefore fewer patients having to have X-rays to re-check the position, and fewer patients having their line removed and replaced because of dislodgement. We insert about 900 PICCs per year for haematology and oncology patients**

	having inpatient and outpatient chemotherapy. Before we started using SecurAcath 7% of our PICCs had to be removed because they had become dislodged which meant that internal tip of the PICC was no longer optimal. The actual dislodgement rate was much higher than 7% which is just the number of lines which were actually removed. If a line had been dislodged by a few cm and an xray showed the tip was still in an acceptable position then the PICC would stay in. (If the tip of the PICC has moved out of the superior vena cava or right atrium then the risk of thrombosis has been shown to be higher. Our patients are already at high risk of thrombosis because they have cancer and because of the chemotherapy, so we are very strict about internal tip position. We require the nurses looking after the patients to measure the external portion of the PICC each time they give treatment to check the line has not moved. Other hospitals / units may not be so strict about this so may not have such a big percentage of lines removed because of dislodgement.) **Dislodgement of PICCs can occur in two different ways. A) when the dressing is changed: when peeling off the transparent dressing and securement device (eg Statlock) it is quite hard not to pull the PICC out a little bit each time. In my experience this is the most frequent reason for PICC dislodgement. B) if the PICC is tugged hard accidentally it can pull out the PICC in a sudden event. This is most likely to happen to patients who have IV fluids running through drips or backpacks attached to their PICC. Sudden dislodgement can happen if the patient accidentally steps on the giving set or it catches on a door handle etc.** **SecurAcath is extremely effective in reducing the risk of A and in our practice has made a big difference to the number of lines removed because of dislodgement during dressing changes. I haven't formally measured it but it is now rare for a PICC to migrate out during dressing changes whereas it used to be very common.** **SecurAcath is not as effective as Statlock at reducing the risk of B. A sharp tug on the PICC can stretch it which makes it slip out of the SecurAcath. For this reason we take a "belt and braces" approach with patients who have IV fluids running through drips or backpacks and we use SecurAcath AND Statlock. However for patients who are having short intermittent treatments or simple home infusers we don't tend to use Statlock as well.** **Interestingly you don't ask the question "are there possible disadvantages to patients?" in your questionnaire. The possible downside for patients are as follows:** **- Discomfort for a week or so may still occur in some patients though we think this has reduced since we started using tissue adhesive. We intend to carry out another patient survey when time allows.** **- Arguably slightly more discomfort during dressing changes than without SecurAcath but on the other hand the dressing change is simpler and less risky for dislodgement of the line.**

	- A very small number of patients experience acute pain because of the device. If this happens we can administer local anaesthetic and remove it. **- There are some problems we see very occasionally only: in a couple of patients the device appeared to have erode through the patient's skin and had to be removed. Occasionally the patient's skin becomes sore under the device. This could be a pressure problem caused by a too tight dressing or just the skin not being able to "breath". This requires an additional padding under the device.** **- Removal of the device can cause pain in about half of patients. Local anaesthetic can be used if they experience discomfort when the device is wiggled but local anaesthetic itself causes brief pain when administered.**

Question 8.1: Is each additional benefit likely to be realised in practice? What are the likely obstacles?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Education and pricing of device**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Yes, likely obstacles are cost and ease of insertion and removal**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Yes. Minimal obstacles. Some patients may have an allergy to nickel - not many in our experience.**
Mr Matthew Hobley **IV Nurse Practitioner**	**yes each benefit would be realised in practice. Likely obstacles would be difficulty in inserting, difficulty on removal**
Dr Lisa Dougherty **Nurse Consultant**	**Yes - no obstacles in use** **The only disadvantage is they can be problematic on removal due to the device becoming embedded in the tisues which can make removal painfula nd require local anaesthetic and use of a scalpal**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Yes. The main obstacle is as the Securacath is still not in every area some practitioners do not understand how to remove the device when the line is no longer needed, or how to redress the line to ensure comfort**
Ms Dympna McParlan **Infusion Services Coordinator**	**Yes. Likely obstacles are the lack of data to substantiate the benefits**

Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**The technology has been introduced without good clinical evidence. The benefits are mainly theoretical.**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Infection and pain at the site may be an issue**
Ms Liz Simcock **Clinical Nurse Specialist**	**The success of this device relies on proper training of those inserting and removing it and those providing line care. It also depends on how motivated the insertion team are, and this will depend on how much of a problem line migration is for their patients. As we were amongst the first users of this device in the UK we had some teething problems which might have been an obstacle for a team less convinced of the rewards of persisting. a) It took us time to learn that if the device is not implanted deep enough in the tissues it can cause acute pain making it intolerable to the patient. This happened to a small handful of patients in the early days but now is extremely rare because we make a point of inserting the device as deep as possible. b) Bleeding from the exit site in the first few hours following insertion could cause blood to "cake" around the nooks and crannies of the device which was difficult to clean off and raised infection concerns. We have addressed this by using tissue adhesive on the exit site immediately following insertion of the PICC and SecurAcath and this is no longer a problem. The company who make SucurAcath have also, I believe, improved the design of the device to make it less likely for blood to get into the device. c) Some patients experienced mild to moderate pain for the first week or so after PICC insertion which then settled down. This is less likely now because as we are now using tissue adhesive on the exit site, we can now apply a dressing which is unlikely to need to be disturbed for a week. In the past we used to use a temporary dressing and this was changed within a few days and if had become bloody more likely to cause discomfort to the patient. d) Another potential obstacle is that removing the device can be daunting to those with no experience. The nurses on our wards and day-unit are now used to removing SecurAcath so this is no longer an issue. Removing SecurAcath can also cause pain. Our patient survey suggested that half of patients said removal did not hurt but half said it did. We have produced a video to show nurses how to administer local anaesthetic for those patients who find it painful. We give all our patients a leaflet about how to remove the device so that if they need to have their line removed at another hospital, they can give the leaflet to the team caring for them who are unlikely to have seen the device before.**

Question 8.2: How might these benefits be measured? What specific outcome measures would enable assessment of whether additional benefits for patients are being realised?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Monitor rates of device infection and adverse skin reactions**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**catheter dislodgement rates, time taken to perform weekly catheter dressing**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Patient questionnaires. Staff questionnaires. Observational studies.**
Mr Matthew Hobley **IV Nurse Practitioner**	**how many lines are needing to be changed due to movement of that line. DVT rates, and how many confused patients that pull lines out now keep them in**
Dr Lisa Dougherty **Nurse Consultant**	**Number of malpositioned CVADs - we compared our rate before and after introduction**
Ms Carol McCormick **Clinical Interventions Team Manager**	**The number of line migrations and line replacements could be monitored to ensure benefits. Patient satisfaction surveys would be able to capture patient perceptions and confidence.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Audit trail of all insertions and collation and reporting of associated complications** **Patient and staff satisfaction surveys.** **Cost analysis of a PICC insertion against reduced number of replacements**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Introduction needs proper clinical research or at least audit/evaluation. Key outcome indicators would be catheter dislodgment, infection rates, VIP scores, patient satisfaction**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**infection via microbiolgy and pain from the patient experience**
Ms Liz Simcock **Clinical Nurse Specialist**	**The number of lines having to be removed because of dislodgement. The number of patients having to undergo x-rays to check the tip position following dislodgement.**

Question 8.3: How good is this evidence for each of these additional benefits?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Baseline data available e.g. Matching Mitchigan**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**I'm not sure what the evidence is but it would be easy to measure**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Not much evidence - not many published papers on securacath as it is a new device. Our published artice does give some evidence to substantiate theses benefits.**
Mr Matthew Hobley **IV Nurse Practitioner**	**From my own evidence from what I have seen whilst using the product the evidence has been very good. With chemotherapy piccs the reinsertion rate has gone from about 40% to 0 due to migration of the line. Confused patients removing lines has also gone down considerably. DVT rates in the chemotherapy patients has also reduced**
Dr Lisa Dougherty **Nurse Consultant**	**t is very rare now that we ave any malpositioned PICCs**
Ms Carol McCormick **Clinical Interventions Team Manager**	**The evidence of line replacements and migrations can be captured accurately, the evidence for confidence is much harder to report and quantify.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Will depend on the quality of the data collected**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Very limited low quality evidence**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Not sure**

Ms Liz Simcock **Clinical Nurse Specialist**	**The evidence I can offer is experiential. There is no doubt in my mind that this product has produced significant benefits to our patients in terms of the outcome measures. Our audit figures are still being analysed but I'm sure they will show a reduced number of lines removed for dislodgement. We have not carried out a controlled randomised trial so I won't be able to prove scientifically that it is the use of SecurAcath that has made the difference but it is obvious to me that it has achieved the benefits. My team used to have at least three phone calls per week from nurses asking advice because a PICC had migrated out whereas now it happens about once every two months and usually because the patient had a line put in without SecurAcath by another team. I should point out that I can't prove that the reason nurses no longer ring us so often is because PICCs have stopped migrating out. It might be that they have become less vigilant at measuring the external length of the PICC because they no longer think they need to because they believe SecurAcath to be so effective!** **I do have some quantitative data including a small pilot study of 22 patients and two subsequent audits which were carried out 6 months apart, where we surveyed 100 consecutive patients by means of telephone or face-to-face questionnaire. We managed to contact 83 patients in the first audit and 70 in the second. I attach the powerpoint presentation which shows the results which I presented at the World Congress of Vascular Access in 2014.**

Question 8.4: Please add any further comment on the claimed benefits of the technology to patients, as you see applicable

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**main advantage is no adhesive involved therefore allowing skin to be cleaned between dressing changes**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Patients might feel that this device is more secure and that their catheter is less likely to dislodge. If there is a proven lower risk of dislodgement this would be more convenient for patients**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank
Mr Matthew Hobley **IV Nurse Practitioner**	**patients feel at ease now on dressing changes, knowing that the device is not going to move, also feel a lot more comfortable going home with lines in situ knowing that they are a lot more secure.**
Dr Lisa Dougherty **Nurse Consultant**	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	Blank
Ms Dympna McParlan **Infusion Services Coordinator**	Blank
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	Blank
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	Blank
Ms Liz Simcock **Clinical Nurse Specialist**	**I think this device brings excellent benefits to patients as long as it is in the hands of a specialist team who are motivated to learn to use it properly, and as long as proper training is in place for those who care for and remove the device. It is of limited use for PICCs that are likely to stay in for less than 1 week.**

POSSIBLE BENEFITS FOR THE HEALTHCARE SYSTEM

Question 9: What are the likely additional benefits for the healthcare system of using this technology, compared with current practice/ comparators?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**May be a reduction in line related infections**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**reduced time taken to perform a peripherally inserted central catheter dressing, possible reduction in the number of dislodged catheters**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Cheaper in dressing costs, staff costs, PICC replacement costs and X-ray costs. Minimising staff time dealing with migration complications. Fewer episodes of delayed therapy - this is beneficial in respect to capacity issues.**
Mr Matthew Hobley **IV Nurse Practitioner**	**Lines stay in the perfect spot, lines do not migrate, lines are less likely to be pulled out when a patient is confused, if pulled you are less likely to cause any trauma to the skin and infection rates should be reduced**
Dr Lisa Dougherty **Nurse Consultant**	**No changing of securing device so cost savings at dressing change as well as the reducing the need to replace catheters and the cost and impact on patient therapy and experience**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Cost savings as line replacements are reduced** **Grip-loks and Stat-lok dressings are not needed every week. The cost of the Securacath device is covered in 4 weeks of care, while PICC's can remain in situ for up to a year requiring dressings every week**
Ms Dympna McParlan **Infusion Services Coordinator**	**Reduced costs** **Staff who are more confident** **Patients who are more satisfied**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**There are costs involved with regularly changing PICC adhesive securement devices - these would be reduced by using this technology. There may be additional benefits if the theoretical advantages are proven .**

Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Less re-insertion of devices**
Ms Liz Simcock **Clinical Nurse Specialist**	**Potential cost savings though I have not myself checked that there have been actual cost savings. The direct cost of using SecurAcath include the device itself and the tissue adhesive. Cost savings would include fewer x-rays, fewer dressing changes, fewer Statlock dressings and fewer lines needing replacing because of migration.** **Other benefits are that it saves nursing time and reduces stress for the patient and the nurse during dressing times.**

Question 9.1: Is each additional benefit likely to be realised in practice? What are the likely obstacles?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Cost is the main obstacle and appropriate education in use and availability**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**reduced time yes, dislodgement would need to be measured, obstacles would be performing audit of dislodgement rates**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Yes**
Mr Matthew Hobley **IV Nurse Practitioner**	**benfits would be realised on using this product as I have witnessed in my area. Likely obstacles would be the training on use of this product, on insertion and removal**
Dr Lisa Dougherty **Nurse Consultant**	**yes - upfront cost is more but long term there are cost savings**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Yes**
Ms Dympna McParlan **Infusion Services Coordinator**	**Yes. Likely obstacles are the lack of data to substantiate the benefits.**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Remains to be seen**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**As above**
Ms Liz Simcock **Clinical Nurse Specialist**	**Same answer as previous section**

Question 9.2: How might these benefits be measured? What specific outcome measures would enable assessment of whether additional benefits for the healthcare system are being realised?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Reduction in number of lines to be inserted if reduction in lines becoming dislodged and infected - reduced costs.**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**audit of dressing time and dislodgement rates**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Observational studies**
Mr Matthew Hobley **IV Nurse Practitioner**	**amount of lines having to be replaced, infection rates, dvt rates**
Dr Lisa Dougherty **Nurse Consultant**	**Cost out the initial insertion and then against cost over time for all dressing changes**
Ms Carol McCormick **Clinical Interventions Team Manager**	**A reduction in the dressing requirements for line care when the Securacath device is insitu**
Ms Dympna McParlan **Infusion Services Coordinator**	**Cost analysis** **Staff and patient satisfaction survey**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Introduction needs proper clinical research or at least audit/evaluation. Key outcome indicators would be catheter dislodgment, infection rates, VIP scores, patient satisfaction**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**As above**
Ms Liz Simcock **Clinical Nurse Specialist**	**You would have to compare the costs of xrays and replaced lines before and after the switch to SecurAcath.**

Question 9.3: How good is this evidence for each of these additional benefits?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Varies depending on local surveillance measures in place**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**There are several accounts of the use of this device in practice in peer reviewed journals. I'm not sure whether there are any high quality research studies**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**As previous**
Mr Matthew Hobley **IV Nurse Practitioner**	**personally in my area evidence has been good, but needs a national study to confirm**
Dr Lisa Dougherty **Nurse Consultant**	**Easy to show evidence for cost savings - Trust can show how many additional procedures for malpositioned catheters against savings made.**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Cost are easy to calculate**
Ms Dympna McParlan **Infusion Services Coordinator**	**Will depend on the quality of the data collected**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Very limited low quality evidence**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**?**
Ms Liz Simcock **Clinical Nurse Specialist**	**I don’t have evidence**

Question 9.4: Please add any further comment on the claimed benefits of the technology to the healthcare system, as you see applicable

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	Blank
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Time is a precious commodity so anything that reduces time (i.e. shorter dressing time and reduced number of dislodgements) would be welcomed**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank
Mr Matthew Hobley **IV Nurse Practitioner**	Blank
Dr Lisa Dougherty **Nurse Consultant**	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	**These cost savings amount to significant savings over time when calculated.**
Ms Dympna McParlan **Infusion Services Coordinator**	Blank
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	Blank
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	Blank
Ms Liz Simcock **Clinical Nurse Specialist**	Blank

FACILITIES, TRAINING AND FUNCTIONING

Question 10: Are there any particular facilities or infrastructure which needs to be in place for the safe and effective use of this technology?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Good education during initial use as key so appropriate level of support from manufacturer**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**minimal training on insertion, considerable training for removal as patients move to many different areas with this device in situ and all areas would need to know either how to access removal information or how to remove**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Minimal**
Mr Matthew Hobley **IV Nurse Practitioner**	**just adequate taining for individuals who use the product**
Dr Lisa Dougherty **Nurse Consultant**	**No**
Ms Carol McCormick **Clinical Interventions Team Manager**	**The staff placing the line places the Securacath, which requires minimal training. More training is required for all those who care for the line to be made aware of the best way to care for the line with this device so that it is comfortable for the patient. Also staff need to be trained how to remove the Securacath when the line is eventually removed.**
Ms Dympna McParlan **Infusion Services Coordinator**	**No**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**No**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Training of staff**

Ms Liz Simcock **Clinical Nurse Specialist**	**Proper training for those who insert and remove the lines and those who care for the patients with the device.**

Question 11: Is special training required to use this technology safely and effectively?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Yes**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Yes**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Placement technique is easlily mastered in little time. Staff training is necessary in respect to care and management and removal of the device.**
Mr Matthew Hobley **IV Nurse Practitioner**	**special training would help with ease of use**
Dr Lisa Dougherty **Nurse Consultant**	**Yes for both insertion and removal**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Yes. Some training is needed.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Yes, but this is simple and easily delivered**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Yes. Insertion and removal are different from current adhesive technologies and training would have to be given. There would need to be protocols for how to manage infections/inflammation at the Securacath site.**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Probably**
Ms Liz Simcock **Clinical Nurse Specialist**	**Yes**

Question 12: Please comment on any issues relating to the functioning, reliability and maintenance of this technology which may be important to consider if it is introduced

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**As this is a new device appropriate monitoring in terms of longevity and reliability will need to be in place.**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**Can be tricky to remove - needs a degree of skill and understanding**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Removal of this device is the most challenging aspect of its management. Occasioanally, the device anchors adhere to the tissues making removal difficult. However this is not insurmountable with education and training for staff. Staff can be trained to follow advice flow charts and administer local anaesthetic where required. Additionally there have been cases of local reaction to the anchors and indentation beneath the device. Some devices have been removed due to the pain and discomfort this has caused. In our experience, this improves as staff develop skills to prevent.**
Mr Matthew Hobley **IV Nurse Practitioner**	**just needs to be adequately inserted, if not inserted properly can cause discomfort**
Dr Lisa Dougherty **Nurse Consultant**	**We have had no problems with the reliability of this product.**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Patients who have a Nickel allery should not be fitted with the device, but they can be used in a MRI scanner.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Clear instructions on the insertion technique.** **Supported training on removal of the device.**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**I have not used this technology but I have heard that patients find removal very uncomfortable and frequently require infiltration of local anaesthetic.**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Blank**

Ms Liz Simcock **Clinical Nurse Specialist**	**See other comments in other sections**

COSTS

Question 13: Please provide any comments on the likely cost consequences of introducing this technology. In particular, please comment on the implications of this technology replacing the comparator/s you have described above

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**Needs to be competitively priced**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**This device is more expensive than the comparator for the first month of use but then becomes cheaper after this.**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Securacath use is more likely to be cheaper but this is dependant on local practice. As an example, when using 'statlock' dressing alongside steri-strips and transparent dressing, all changed weekly, the cost saving considering a dwell time of 3 months is £25 per PICC.**
Mr Matthew Hobley **IV Nurse Practitioner**	**cost savings on dressings and cost savings on having to replace lines**
Dr Lisa Dougherty **Nurse Consultant**	**As above savings can be made both in long term maintenance and redcuing replacement of malpostioned cathters**
Ms Carol McCormick **Clinical Interventions Team Manager**	**This has been covered above**
Ms Dympna McParlan **Infusion Services Coordinator**	**The cost of the device is substantially more than the comparator but this is offset by the fact that it is a one off placement compared to a weekly change. The additional cost savings in relation to the benefits wil reduce Trust costs substantially.**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Only suitable in patients who need PICC lines for longer than a couple of weeks. For shorter term use then an adhesive securement device will be adequate. The exact time at which this device becomes cost effective will need to be determined.**

Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Not sure of cost**
Ms Liz Simcock **Clinical Nurse Specialist**	**See above (9). In situations where it replaces Statlock, the cost of a SecurAcath and tissue adhesive will quickly be saved within a few weeks for a given patients because Statlock has to be replaced weekly. In situations where Statlock is used in addition to SecurAcath this cost saving would not apply. but there would still be potential savings in the cost of xrays and line replacement.**

GENERAL ADVICE BASED ON YOUR SPECIALIST KNOWLEDGE

Question 14: Is there controversy about any aspect of this technology or about the care pathway?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**No**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**There may be issues with not knowing how to remove the device**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**We have experienced a couple of episodes where the local reaction to the device has been fairly severe - this may be due to an unkown allergy to nickel or infection or unexplained. These episodes have been infrequent. In the event, devices can be removed without the catheter having to be removed which usually resolves the problem.**
Mr Matthew Hobley **IV Nurse Practitioner**	**Not that I know**
Dr Lisa Dougherty **Nurse Consultant**	**Only the issues with removal bu this just requires additional training of staff**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Yes, staff perceive this as a painful device, however when placed correctly, dressed and removed with understanding, there are more risks when lines migrate and are used when they are not in the optimum position.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Not that I am aware of**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Pain on removal and how long a PICC needs to be in situ before this device becomes cost effective.**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Pain, infection risk and scarring**

Ms Liz Simcock **Clinical Nurse Specialist**	**Not to my knowledge**

Question 15: If NICE were to develop guidance on this technology, how useful would this be to you and your colleagues?

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**It would be an alternative option to consider so useful**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**I don't think it would be particularly helpful - the product has advantages and disadvantages and healthcare professionals would weigh these up when considering which securement device to use.**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**Yes useful**
Mr Matthew Hobley **IV Nurse Practitioner**	**yes would be very useful to have nice guidance to back up its use**
Dr Lisa Dougherty **Nurse Consultant**	**We already use it so it would support ongoing use but for colleagues it would be useful to have a reliable device that may cost more upfront but save in long term**
Ms Carol McCormick **Clinical Interventions Team Manager**	**I believe many colleagues would benefit from using the device as they would have more capacity to place new lines rather than spending time replacing lines that have been pulled out either by other professionals or accidently by patients. I would like to see NICE produce guidance for this.**
Ms Dympna McParlan **Infusion Services Coordinator**	**Not sure that it would influence myself or my colleagues given the wealth of knowledge we have regarding the product and our expertise in its use. However, I think it would be extremely useful to those who are only starting or considering use of the product.**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**Useful**

Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**Not much**
Ms Liz Simcock **Clinical Nurse Specialist**	**Not very because we are already using the product but it may be useful to others**

Question 16: Do any subgroups of patients need special consideration in relation to the technology (for example, because they have higher levels of ill health, poorer outcomes, problems accessing or using treatments or procedures)? Please explain why

Expert Advisers	Comment
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	**No**
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	**We would always be concerned about using this device on patients who have clotting disorders e.g. haemophilia as there may be too much mechanical irritation of the subcutaneous tissue**
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	**I am not able to recognise this from any other perspecive but an anecdotal one. Patients who are morbidly obese tend to react to the securacath more than others. A large study is probably required in order to answer this question.**
Mr Matthew Hobley **IV Nurse Practitioner**	**No**
Dr Lisa Dougherty **Nurse Consultant**	**No**
Ms Carol McCormick **Clinical Interventions Team Manager**	**Cancer patients rely highly on PICC lines to receive chemotherapy, for IV access and phlebotomy which means they become fearful of unnecessary line removals and migrations. Patients in ITU and HDU units are also heavily dependent on IV access device being reliable and consistant**

Ms Dympna McParlan **Infusion Services Coordinator**	**Patients with nickle allergy cannot use the product.** **I would not consider using the product for patients who are likely to have a catheter dwell time of a week or less due to the cost.**
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	**No**
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	**No**
Ms Liz Simcock **Clinical Nurse Specialist**	**Can't be used for patients with allergy to nickel. Shouldn't be used for patients with no access to specialist follow-up care.**

CONFLICTS OF INTEREST

Question 18.1: Do you or a member of your family have a personal financial interest? The main examples are as follows:

Expert Advisers	Consultancies or directorships	Clinicians receiving payment for a procedure	Fee-paid work	Shareholdings	Financial interest in a company's product	Expenses and hospitality	Funds	Personal non-pecuniary interest
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	No	No	No	No	No	No	No	No
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	No	No	No	No	No	No	No	No
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	No	No	No	No	No	No	No	No
Mr Matthew Hobley **IV Nurse Practitioner**	No	No	No	No	No	No	No	No
Dr Lisa Dougherty **Nurse Consultant**	No	No	No	No	No	No	No	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	No	No	No	No	No	No	No	No
Ms Dympna McParlan **Infusion Services Coordinator**	No	No	No	No	No	No	No	No

Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	No	No	No	No	No	No	No	No
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	No	No	No	No	No	No	No	No
Ms Liz Simcock **Clinical Nurse Specialist**	No	No	No	No	No	No	No	**Yes**
If you have answered YES to any of the above statements please describe the nature of the conflict(s) below.								
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	Blank							
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	Blank							
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank							
Mr Matthew Hobley **IV Nurse Practitioner**	Blank							
Dr Lisa Dougherty **Nurse Consultant**	Blank							
Ms Carol McCormick **Clinical Interventions Team Manager**	Blank							
Ms Dympna McParlan **Infusion Services Coordinator**	Blank							

Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	Blank
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	Blank
Ms Liz Simcock **Clinical Nurse Specialist**	**It doesn't sound as if this counts but I have presented the audit findings in the attached powerpoint presentation at the World Congress of Vascular Access (WoCoVA) in 2014 and at Gli Accessi Venosi Centrali a Lungo Termine (GAVeCeLT) in 2014. I also ran a skills station at GAVeCeTL about SecurAcath (showing delegates how to use the device and answering any questions they had). The skills station was sponsored by SEDA who distribute SecurAcath in Italy. Interrad Medical who make SecurAcath contributed £320.90 to my expenses for the trip to Italy. I am a strong supporter of this product but only because it has proved so useful to our patients and practice.**

Question 18.2: Do you have a non-personal interest? The main examples are as follows:

Expert Advisers	Grant for the running of a unit	Grant or fellowship for a post or member of staff	Commissioning of research	Contracts with or grants from NICE
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	No	No	No	No
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	No	No	No	No
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank	Blank	Blank	Blank
Mr Matthew Hobley **IV Nurse Practitioner**	No	No	No	No

Dr Lisa Dougherty **Nurse Consultant**	No	No	No	No
Ms Carol McCormick **Clinical Interventions Team Manager**	No	No	No	No
Ms Dympna McParlan **Infusion Services Coordinator**	No	No	No	Blank
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	No	No	No	No
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	No	No	No	No
Ms Liz Simcock **Clinical Nurse Specialist**	No	No	**Yes**	No
If you have answered YES to any of the above statements please describe the nature of the conflict(s) below.				
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	Blank			
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	Blank			
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank			
Mr Matthew Hobley **IV Nurse Practitioner**	Blank			

Dr Lisa Dougherty **Nurse Consultant**	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	Blank
Ms Dympna McParlan **Infusion Services Coordinator**	Blank
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	Blank
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	Blank
Ms Liz Simcock **Clinical Nurse Specialist**	**Interrad Medical have expressed interest in creating a training video of the insertion, maintenance and removal of SecurCath. I have informally offered to facilitate this next year by taking the video myself with a hand-held camera which I would then pass to them to edit. I have not yet discussed this with my hospital's publicity department but would obviously seek the organisations approval before doing this. I have suggested that if this happens, I would ask Interrad Medical to make a contribution to our team's charitable fund which is administered by the Trust and which we use to pay for low-cost items for the benefit of patients and staff: eg stress balls for patients, expenses for team members to attend conferences, Christmas night out etc. No firm plan in place.**

Question 18.3: Do you or your organisation or department have any links with, or funding from the tobacco industry?

Expert Advisers	Yes or No?	*If you have answered YES to any of the above statements please describe the nature of the conflict(s) below.*
Mr Maurice Madeo **Deputy Director for Infection Prevention and Control**	No	Blank
Ms Jackie Nicholson **Consultant Nurse in Vascular Access**	No	Blank
Ms Meinir Hughes **Intravenous Access Nurse Specialist**	Blank	Blank
Mr Matthew Hobley **IV Nurse Practitioner**	No	Blank
Dr Lisa Dougherty **Nurse Consultant**	No	Blank
Ms Carol McCormick **Clinical Interventions Team Manager**	No	Blank
Ms Dympna McParlan **Infusion Services Coordinator**	No	Blank
Dr Andrew Johnston **Consultant in Intensive Care Medicine and Anaesthetics**	No	Blank
Ms Rachel Binks **Nurse Consultant , Digital and Acute Care**	No	Blank
Ms Liz Simcock **Clinical Nurse Specialist**	No	Blank