Raising Awareness: Venous Thromboembolism Prevention and Reduction in the Orthopedic Patient Population

VIDANT HEALTH"

Unified Quality Improvement Symposium March 31, 2017





- Venous thromboembolism (VTE) is a serious, and potentially life-threatening complication following orthopedic surgery (Falck-Ytter et al., 2012).
- The Joint Commission (TJC) and The Centers for Medicare & Medicaid Services (CMS) identify VTE as a core measure set, specifically tracking the incidence of potentially preventable VTE (The Joint Commission, 2016).
- Clinical nursing staff is in a unique position in the prevention of VTE and play a vital role in ensuring mechanical VTE prophylaxis is implemented.

### Profile of an Orthopedic Patient





- Typically 50 years or older
- Has been living with chronic pain in joints related to arthritis
- Mobility challenged
- Often overweight
- May present with multiple comorbitities (hypertension, diabetes, dementia, etc.)
- High risk for falls
- High risk for deep vein thrombosis (DVT) and venous thromboembolism (VTE)

# **Collaborative Team Members**

- Stephanie Ellis, BSN, RN-BC
- C. Renee Mayo, MSN, RN-BC, NE-BC
- Ortho 6 Staff
  - Nursing
  - Nursing assistants
  - Physical therapists
  - Occupational therapists



VIDANT HEALTH

Team Leader key contacts: <u>Cynthia.mayo@vidanthealth.com</u> <u>Stephanie.L.Ellis@vidanthealth.com</u>

## **AIM Statement**



The aim/goal for this improvement project was to increase staff awareness of the need for mechanical VTE prophylaxis on bilateral lower extremities and reduce the occurrence of VTE's by 15% on the Orthopedic Unit.







Process Measure(s):

1. Compliance with nursing assistant documentation of SCD/Foot pumps every four hours

2. Staff compliance with one form of mechanical prophylaxis on orthopedic patient's

Outcome Measure(s):

- 1. 100% Ortho clinical staff educated on importance of mechanical prophylaxis (sequential compression devices)
- Reduction in occurrence of venous thrombus embolisms (VTE's) by 15%

# **Pilot Baseline Data**



#### Audits

Type of audit	%
Patient wearing at least one form of mechanical prophylaxis.	68%
Nursing assistant documentation every four hours.	68%

### VTE's

Year	Number of VTE's
2014	18
2015	19



## **Improvement Strategies**



- 1. Brainstorming sessions on how nursing staff could impact prevalence of VTE's
- 2. Developed a standard of utilizing foot pumps or sequential compression devices on bilateral lower extremities
- Developed unit standard for nursing assistants to document SCD/Foot Pump use every four hours
- Educated clinical staff, including physical therapy and occupational therapy, on new unit standards for mechanical VTE prophylaxis
- 5. Developed audit tool to track compliance with documentation and patient use of mechanical prophylaxis
- 6. Reviewed case by case VTE occurrence drill downs for improvement opportunities
- Created bulletin board for staff awareness of occurrences of VTE's

# **Summary of Outcomes**



### For 2015-2016

- 100% staff educated, including physical and occupational therapy
- 41% increase in compliance with applying mechanical prophylaxis to bilateral lower extremities
- 30% increase in compliance with documentation every four hours by nursing assistants.
- 21% decrease in occurrences of VTE's on the unit

### Outcomes: Percentage of DVT/PE's for Ortho 6 Patients





	Inpatient	Outpatient		
	discharges	discharges	Total	DVT's
FY14	2318	133	2451	18
FY15	2248	149	2397	19
FY16	2324	158	2482	15

- Discharged patients include:
  - Total knee replacements
  - Total hip replacements
  - Total shoulder replacements
  - Joint revisions
  - Hip fractures
  - Tibia/Fibula fractures
  - Compression fractures
  - Spinal fusions
  - Infections
  - Orthopedic trauma
  - Medicine patients

## **Outcomes:** Audits



#### **Compliance Audits**



### **Challenges Encountered in QI Process**

 Need for revised audit tool to include more information and improve reliability

VIDANT

• Education and compliance of new and temporary staff (ie.

travel and central staffing nurses and nursing assistants)

Machine malfunctions and troubleshooting

### Lessons Learned



- It's not easy to change a culture.
- Compliance requires constant surveillance and education.
- PDSA cycles help to maintain focus.
- Engagement from nursing staff improved our quality of care!

### Next Steps for Sustainability



- Visual reminders for all staff.
- Welcome kit for all new hires to include our Quality standards.
- Explore use of foot pumps in the OR.
- Continue auditing for compliance.

## References



Falck-Ytter, Y., Francis, C. W., Johanson, N. A., Curley, C., Dahl, O. E., Schulman, S., ...

Colwell, C. W. (2012). Prevention of VTE in Orthopedic Surgery Patients:

Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American

College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest,

141(2 Suppl), e278S-e325S. http://doi.org/10.1378/chest.11-2404

The Joint Commission. (2016). Venous Thromboembolism. Retrieved January 5, 2017,

from <a href="https://www.jointcommission.org/venous\_thromboembolism/">https://www.jointcommission.org/venous\_thromboembolism/</a>