



Service Priorities and Programmes Electronic Presentations

Convention ID: 534

Submitting author: Mr H C CHAN

Post title: Nurse Consultant, United Christian Hospital

Hospital-wide Compliance towards prevention of Venous Thromboembolism (VTE) in surgical patients in United Christian Hospital

CHAN HC (1), CHU KL (2)

(1) Nursing Services Division, UCH/KEC

(2) Department of Ana & PM, UCH

Keywords:

Hospital wide

Compliance

VTE

Surgical patients

Introduction

All surgical team members are acutely aware of Venous Thromboembolism (VTE) been still a life-threatening complication that can happen after a major surgery. In United Christian Hospital (UCH), there have been different practices & department guidelines on the VTE risk assessment, continuity care of peri-operative mechanical thromboprophylaxis and utilization of SCD. This not only creates confusion in the practice amongst surgical care professionals in various specialties, but also deviates from the benchmark for the prevention of VTE. With the support from the Hospital Management, a hospital based project is launched with the ultimate aim of establishing a standardized practice and achieving compliance in the prevention of VTE in surgical patients.

Objectives

- To make an alignment with revised practices of VTE assessment & prophylaxis at the hospital
- To reinforce a standardized practice & clinical pathways for continuity care of perioperative VTE mechanical prophylaxis

Methodology

By project management

Initiating

- Identified the practice gaps in prevention of VTE used by various departments
- Identified inadequate stock of sequential compression devices in hospital

Planning

- Established a working group including medical and nursing representatives of different specialties from Ana & PM, Surgery, O&T, O&G, ENT, Eye, DMF, OR, ICU

and hematological expert as an advisor.

- Verified the local and hospital incidence of VTE and application of VTE risk assessment scale compared with international & regional data and found significantly varied results.
- Planned an estimated budget on mechanical prophylaxis for approval by the Hospital Management.

Executing

- Conducted literature review on different guidelines including ACCP 2012 guideline² & NICE 2010 guideline³ in the prevention of VTE.
- Held consecutive meetings for the standardized practice
- Established the standardized guidelines with evidence-based support
- Increased additional quantity of Sequential Compression Devices

Monitoring/controlling-

- Conducted A 2-week hospital wide audit of staff compliance on prophylactic care of VTE
- Monitor the available source of SCD console for patients in need to identify the time delay continuous SCD post-operatively in 4 week-records.

Result

- I. A hospital based standard guideline for the prevention of VTE in surgical patients was adopted.
- II. The staff compliance on standard guidelines is very high to 99.78% with patient samples (n=168)
- III. Only 4 cases were identified to delay continuous SCD post-operatively in median time 75 minutes due to unavailability of SCD.