



The Challenge of VTE

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About Us

- Tertiary care medical center in the urban core
- 496 Licensed Beds
- Average daily census 240
- Level one Trauma Center
- 32 bed Medical/Surgical ICU
 - Open model ICU
 - Medical director with complete responsibility and authority
- Cardiac/Pulmonary Telemetry Units
- Medical Surgical Unit



Where we were

ICU Patients Receiving VTE prophylaxis within 24 Hours of Arrival

| Quarter | % Compliance |
|---------|--------------|
| 2Q2011 | 42% |

Patients Receiving VTE Prophylaxis within 24 hours of arrival (non-ICU)

| Quarter | % Compliance |
|----------|--------------|
| 2 Q 2011 | 40% |



Barriers

- Not everyone was convinced of the importance of the project
- Buy-in was often temporary
- Misinformation was common, e.g. Who is at risk?
- Confusion regarding correct documentation
- Had to utilize a manual order set
- How to identify patient's who had VTE prophylaxis?



What We Did

- The VTE Team was formed in August of 2009
- Gathered data regarding prophylaxis
- Developed an evidence-based order set
- Implemented process to get the order sets on the chart.
- Identified the patients who didn't have VTE prophylaxis and notified all stakeholders
- ICU Medical Director took ownership of VTE prophylaxis in the ICU and was the physician champion for the entire facility
 - DVT prophylaxis of all ICU patients was reviewed everyday
 - Fallouts were identified and attempts were made to rectify
- A standing order mandating SCDs for all ICU patients was established (contraindications defined by protocol)



What Resulted

ICU Patients Receiving VTE prophylaxis within 24 Hours of Arrival

| Quarter | % Compliance |
|---------|--------------|
| 3Q2011 | 97% |
| 4Q2011 | 97% |
| 2Q2012 | 96% |

* Identification of patients without VTE prophylaxis documented and physician champion started 3 Q 2011.

Patients Receiving VTE Prophylaxis within 24 hours of arrival (non-ICU)

| Quarter | % Compliance |
|----------|---|
| 3 Q 2011 | 89% |
| 4 Q 2011 | 91% |
| 1 Q 2012 | 86% (72% of failures occurred on the weekend) |

* Identification of patients without VTE prophylaxis documented began in 3 Q 2011



Lessons Learned & Next Steps

- Summary
 - Find a way to identify patients who need VTE prophylaxis
 - Find a champion
 - Diligently work on this everyday
 - Audit, verify, and reinforce the process on a continuous basis
 - Educate but more importantly, make a process change
- Next Tests of Change (TOC)
 - VTE Core Measures



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