

BCUHB response for one day enquiry in to VTE 2012

Implementation of NICE guidance

Implementation has varied across the specialities. This paper will report on each Clinical Programme Group (CPG) and then move to more general issues. DVT risk assessment form completion, the prescription and use of appropriate thromboprophylaxis is assessed in BCU monthly as a rolling audit of a random sample of 50 random case notes.

General Surgery: A risk assessment has been in use within this specialty for several years. The All Wales Risk Assessment has been modified to include an assessment for bleeding risk, with excellent compliance. Patients are offered both pharmacological and mechanical thromboprophylaxis. Within BCUHB Clexane (a type of Heparin) is the pharmacological thromboprophylaxis used. Anti-embolic stockings are currently prescribed for all patients unless contraindicated. Patient information is provided to all patients both verbally and in written form. Stockings are changed every three days to increase their effectiveness. We do not currently reassess after 48 hours, but this is currently being reviewed. Intermittent pneumatic compression pumps are available on the surgical floor for those high risk patients for whom pharmacological thromboprophylaxis is contraindicated. A report, with supporting data is currently being drafted assessing the benefits to extended thromboprophylaxis in major abdominal and pelvic surgery for cancer, and will hopefully be implemented within the near future.

Orthopaedics: Within Nice guidelines all patients are offered both pharmacological and mechanical thromboprophylaxis on admission. As for general surgery patient information concerning anti embolic stockings is available in written form. Intermittent pneumatic compression pumps and foot pumps are regularly used for patients undergoing lower limb surgery. Consistent with NICE guidance, following Hip surgery patients are discharged on extended thromboprophylaxis for 28 days and after knee surgery, two weeks. Work is currently underway, but in the very early stages, to implement the All Wales risk assessment tool. More recently we have progressed to administering thromboprophylaxis to high risk patients, under specific consultants, being managed with a lower limb plaster of Paris.

Gynaecology: Unless contraindicated patients are offered both pharmacological and mechanical forms of thromboprophylaxis. Written information is available concerning the anti-embolic stockings. Cancer patients who had had surgery are sent home on extended thromboprophylaxis for 28 days.

General Medicine: Work within this area has been slow yet steady; this being the area where our team have encountered the greatest difficulty in securing improvement. DVT risk assessment is integrated into the clerking proforma. Unless contraindicated patients are prescribed pharmacological methods of thromboprophylaxis. Mechanical thromboprophylaxis is not currently used. In 2008 – 2009 our Acute Medical Unit (AMU) had a thromboprophylaxis prescription rate of 20 – 30%. With the investment of education and working closely with staff this has increased to 95%. Completion of DVT risk assessment remains low at 45%.

Maternity: at present we are implementing the All Wales Risk Assessments tool in our 3 maternity units. In addition we are looking to develop a compliance tool which will capture data on DVT risk assessment. Building on other work within BCU, the team is developing a hospital acquired thrombosis rate for maternity across the three sites. Unless contraindicated all patients undergoing caesarean section delivery are prescribed clexane for 5 days post procedure. Other high risk patients receive the same for up to six weeks post-partum.

A staff education programme is in place at one of the sites, and will be extended to cover all. A patient information leaflet has been successfully piloted which is distributed to all patients, on one of the other sites. Once printed this will be made available in the other two units.

Implementation of the 1000 Lives Plus risk assessment

The implementation and usage of this risk assessment tool across BCUHB has been limited in some specialities like Orthopaedics, where as in others compliance has been excellent with evidence of sustained usage.

As part of the development work to roll out the All Wales Risk assessment across BCUHB a steering group has been set up and has been running now for over 18 months with a multidisciplinary membership from across the board. In two of the three District General Hospitals there are established locality groups with the responsibility to roll out the work to their local teams. These are best placed to deal with local issues and will escalate, where appropriate issues of significance to the main steering group. Each group regularly reviews compliance data for risk assessment and the outcome rates for Hospital acquired thrombosis.

Within Glan Clwyd and Bangor where locality teams have been established, these have demonstrated excellent multidisciplinary working. In Glan Clwyd this is chaired by an Orthopaedic surgeon; in Bangor by a Haematology Consultant. Both are supported by clinicians from other specialities. Having regular outcome data has enabled the team to target Specialities with the highest Rates of Hospital acquired thrombosis and the lowest compliance with risk assessment rates.

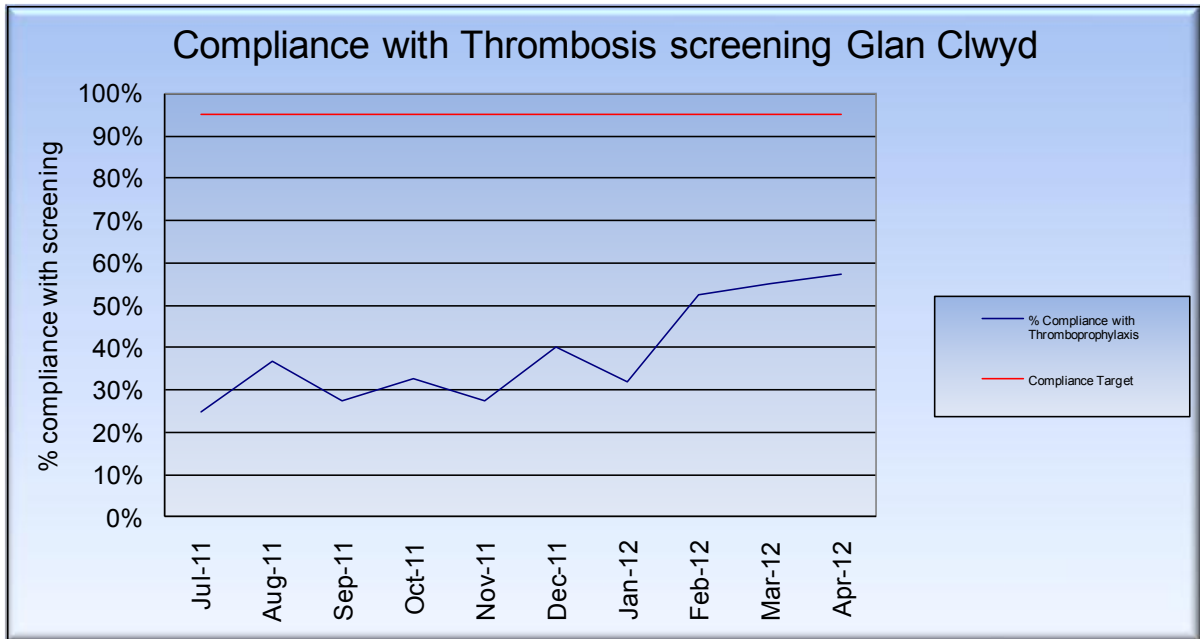
In General Surgery the CPG have now incorporated the risk assessment tool in to their new clerking proforma. This clerking proforma is now in the process of being rolled out across the health board. Before it was introduced in General Surgery at Glan Clwyd, compliance was in the region 50%. Between January and March 2012, with excellent clinical engagement and a 'must do' approach, this has risen to, and become consistent at 100%. The BCUHB All Wales risk assessment tools has now been approved and awaiting role out in the following new areas:

- Non ambulatory Medical Patients
- Elective Orthopaedic
- Emergency Orthopaedic
- Maternity

Like General Surgery, Urology has started to incorporate the All Wales risk assessment tool within their clerking proforma. Once finalised and printed they will be used across the whole of BCUHB.

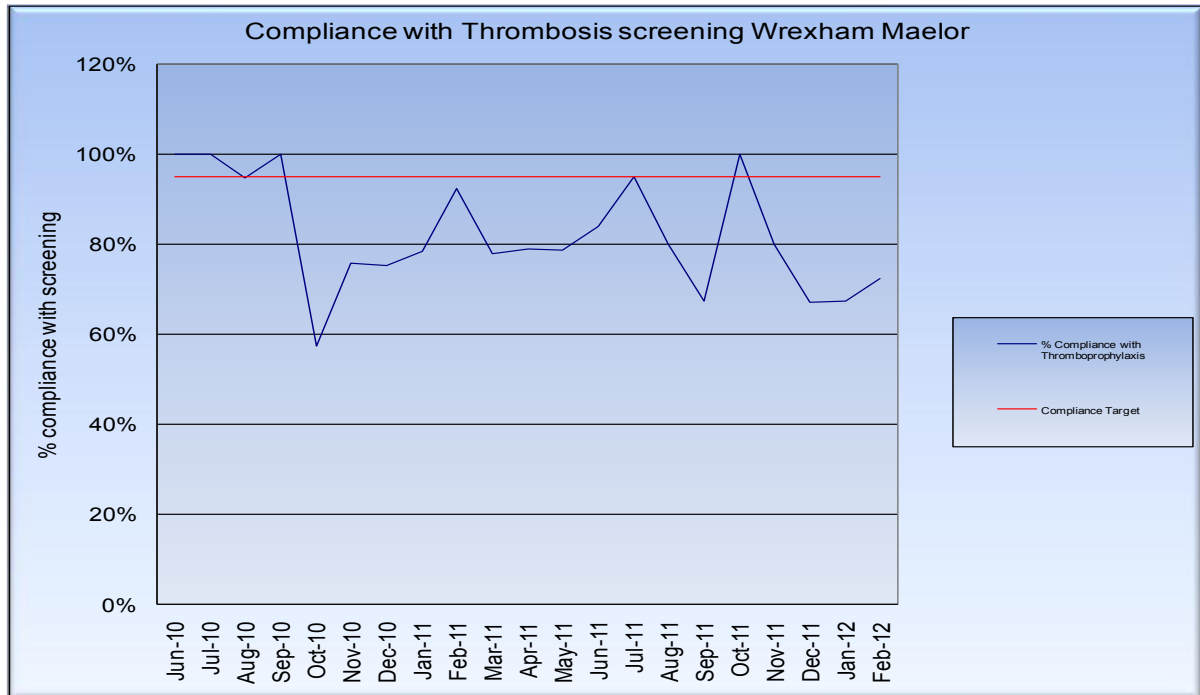
BCUHB Friday, 04 May 2012

Gynaecology is in the very early stages of implementation. The risk assessments have been amended slightly and the all wales maternity risk assessment has been incorporated. Assuming approval it is anticipated it will be implemented at Glan Clwyd on the 1st June, and thereafter to other two sites.



In Wrexham all elective Surgical and Orthopaedic patients are now risk assessed in Pre-operative assessment clinic by a pharmacist achieving a compliance of more than 95%. However, for the rest of the hospital population, a compliance of 73% shows room for improvement. In medicine data collection relies on ward staff and is supplied sporadically. Once again this is an area for further

attention and work.



In summary Current compliance rates for BCUHB are as follows for February 2012:

- Bangor: 33%
- Glan Clwyd: 53%
- Wrexham Maelor: 73%
- **BCUHB compliance with risk assessment= 53%**

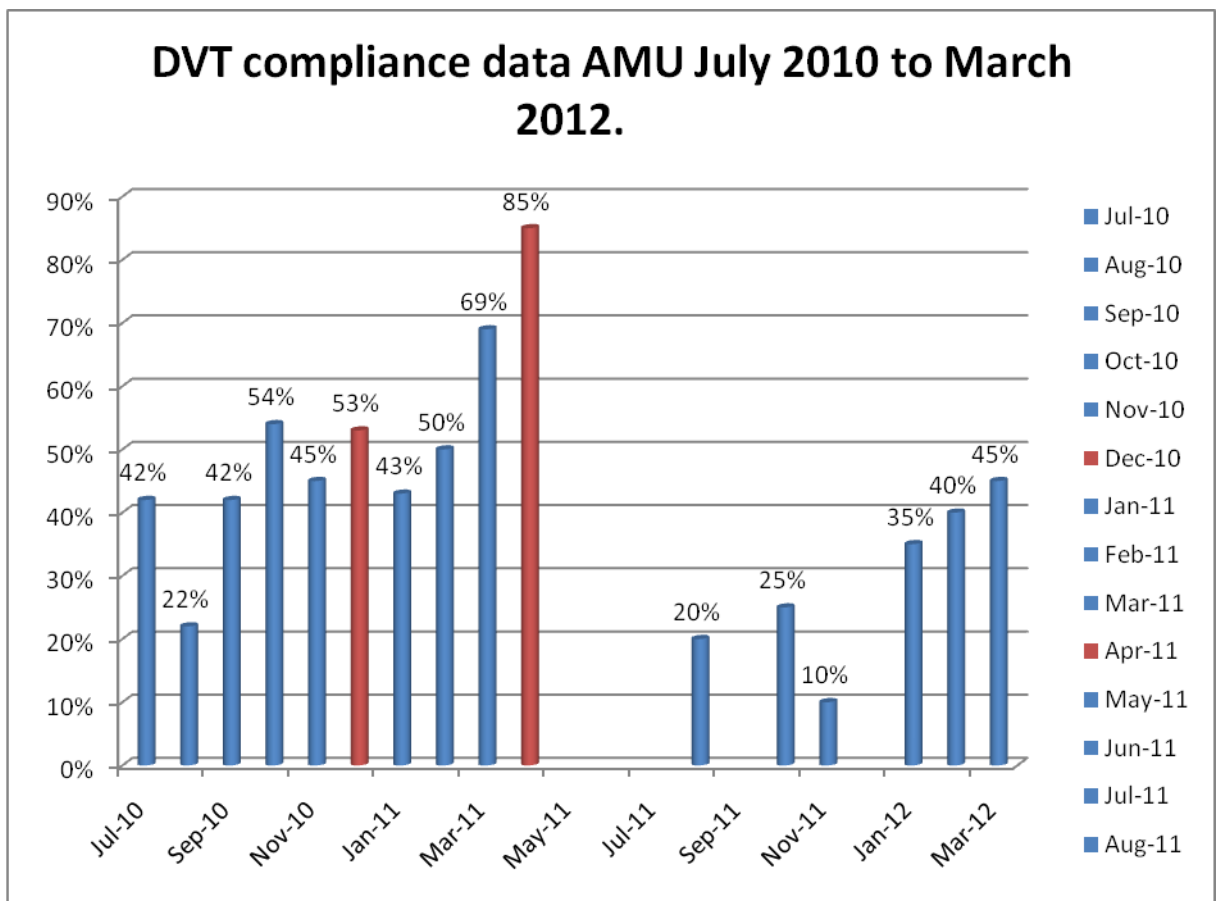
Effectiveness and utilisation of pharmacological and mechanical prophylaxis for VTE

We have observed a difference in compliance in use of the assessment tools and the numbers receiving some form of prophylaxis. Across BCU 80 – 95% of patients receive some form of either mechanical or pharmacological thromboprophylaxis. We are currently performing a retrospective case note audit of all the patients with hospital acquired thrombosis for 2011 to look at the prophylaxis they received.

Particular problems in the implementation and delivery of VTE prevention actions

➤ Day to Day Leadership

Using commercial sponsorship, BCU have employed a part-time thromboprophylaxis Nurse to assist with this work. With a package of focussed training and support the risk assessment completion rate in one of our AMU increased from 22 to 85% at the beginning of 2011. Unfortunately funding difficulties meant the post ceased to exist in April 2011. This was subsequently reinstated, with further temporary funding. Much of the ground gained was lost and we are still in the process of recovery. Funding runs out this month, with no prospect of further commercial sponsorship. Nevertheless, BCU, recognising its evident value are exploring alternatives, and it would appear likely, though not as yet certain, this will be extended for a further year.



➤ **Clinical Engagement** –

In general, medical staff do not see this as a priority issue. Nevertheless, developing and providing outcome data has proven of great help.

➤ **Consultant Leadership**–.

This would appear key. Our success within General Surgery on one of our DGH sites has in no small part been attributable to the leadership and support of an enthusiastic Consultant ‘champion’. This individual is also the clinical lead for the Hospital Acquired Thrombosis Collaborative.

➤ **Time to train** –

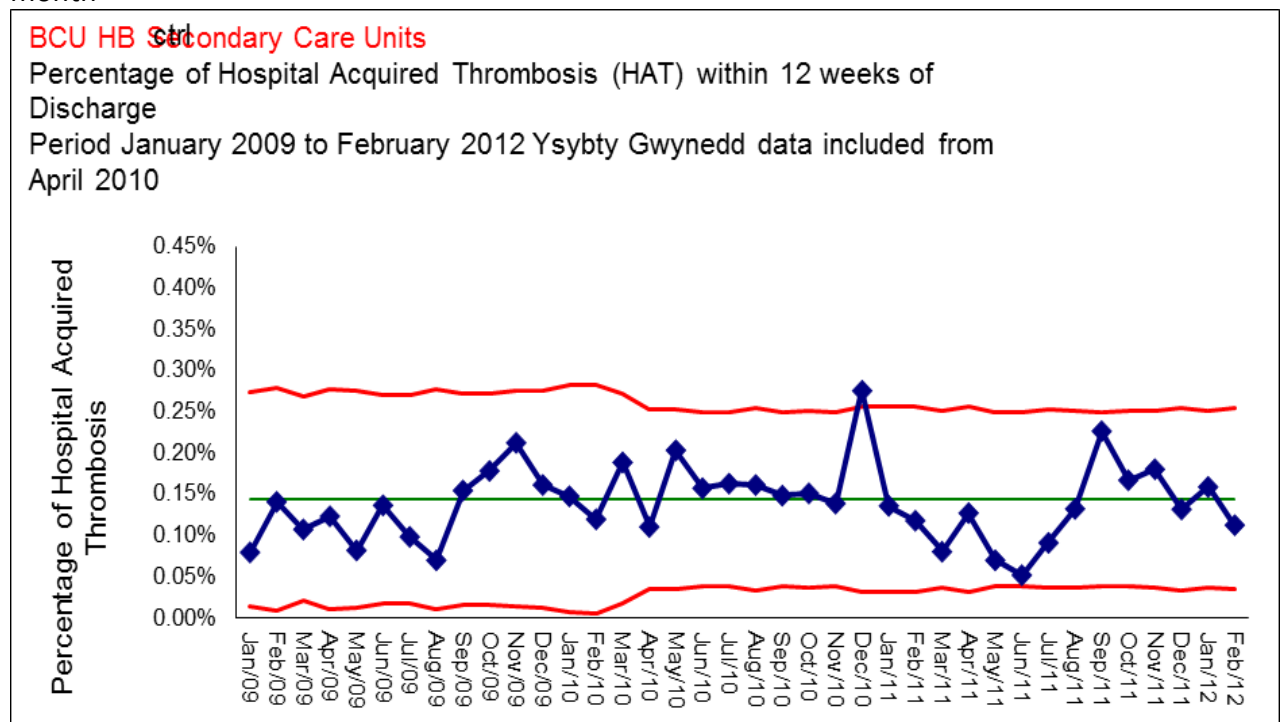
Already heavily subscribed it has been difficult to convince postgraduate departments to give time to training in this area. Were this provided at induction, its anticipated this would produce an improvement in use of the assessment tool and prescription of appropriate prophylaxis. With increasing availability of HAT rate and the effect we have noted in general surgery, this should improve.

Hospital acquired thrombosis rate :

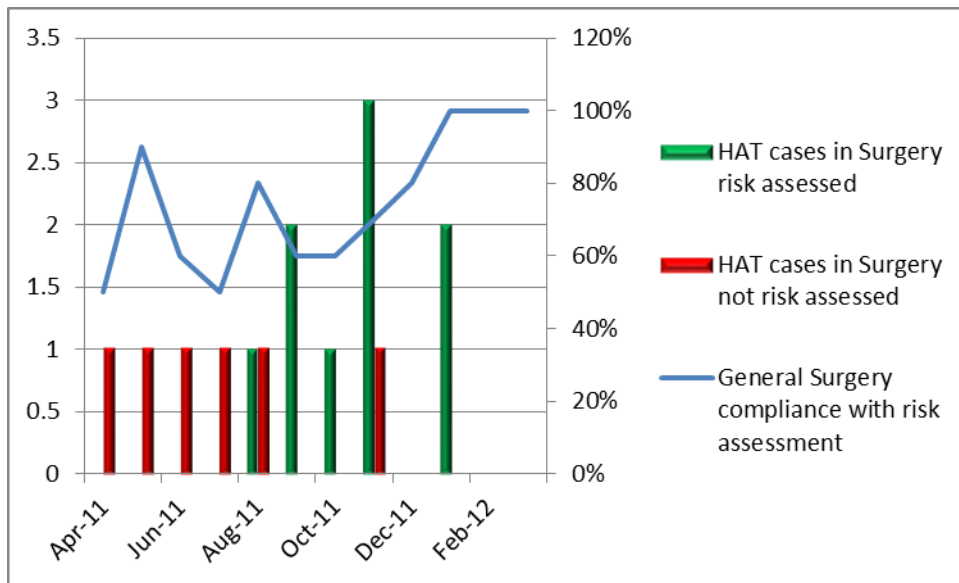
We have determined across BCU, for all Specialities and all methods of admission, there are between 5 and 23 cases per month . From this we have determined a rate using the formula:-

Number of Hospital acquired thrombosis x 100= HAT rate

Number of discharges for the month



Prior to the introduction of this outcome measure, as the majority of HAT is managed in primary care or out-patients, there was limited feedback on HAT. Clinicians were aware of guidance and the advice to provide prophylaxis, but had little to indicate, for their patients, this was a problem meriting their attention. Identifying actual numbers; determining a rate; and bringing this to departmental level has proven a spur to action. The best evidence for this has been in General surgery as below:-



This is early data, in one specialty, on one site, but provides for the first time a link between risk assessment and incidence of HAT.