THE GAP

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NP

What are the influencing factors on the GAP in rate of conversion from VTE risk assessment completion in hospitalised adult inpatients for which a prescription was required, to implementation of the prescribing decision on the drug chart?

THE PROBLEM

- Venous Thromboembolism is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE) [1].
- When this occurs in hospital or within 90 days it's called a hospital acquired thromboembolism (HAT) [2].
- HATs are largely preventable with timely thromboprophylaxis [3]
- Assessments have increased nationally [4] BUT this isn't equal to increased treatments leading to....

12,000 DEATHs YEARLY [5]

55-60% VTEs being HATS [6]

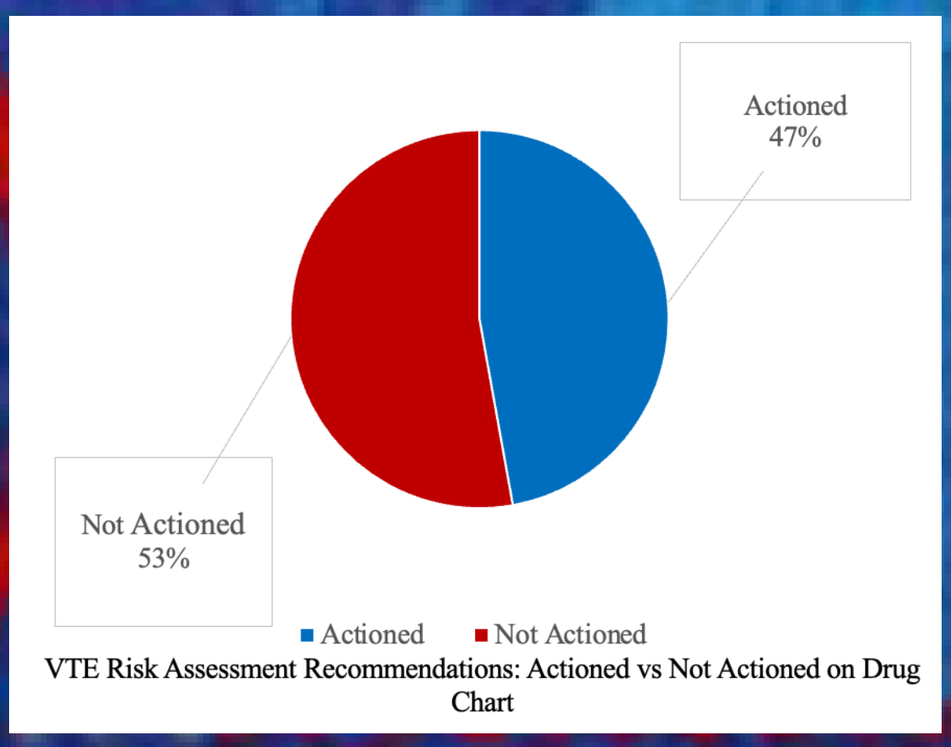
COSTING THE NHS 280 MILLION A YEAR

METHODOLOGY

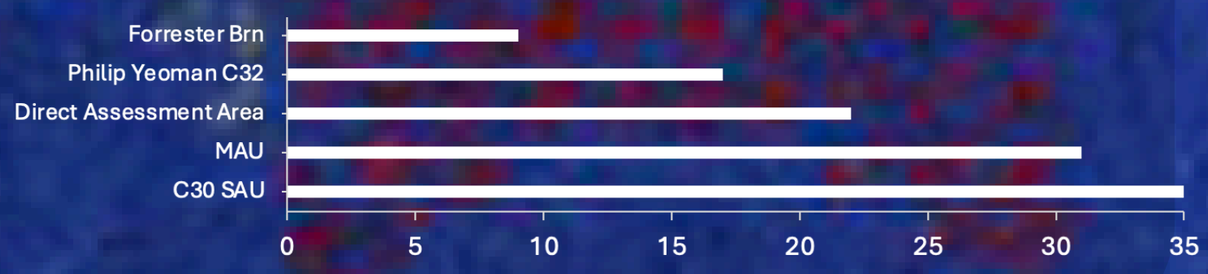
- Data collection from retrospective data from electronic patient record via business intelligence report.
- Sample size: 301 patients
- Compliance with Data Protection Act 2018 & UK GDPR 2021.
- Data cleaned for inconsistencies.
- Descriptive statistics and inferential statistics calculated
- Significance set at $p < 0.05$. [7]

RESULTS

- 53% of assessments not actioned
- Significant Factors : NEWS score, ward area, time of assessment, medication type, correct weight/eGFR dosing, and prescribing/administering VTE prophylaxis within 14 hours of admission.
- ONLY 36% received assessment and prophylaxis within 14 hours



VTE Risk Assessment Recommendations: Actioned vs Not Actioned on Drug Chart



Top 5 Wards with Highest Unactioned VTE Assessments

RECCOMENDATIONS

- Conduct similar research across hospitals with diverse demographics
- Increase VTE education for staff and patients
- Require prescribers to be specific on assessment
- Ensure weights and renal function are updated regularly
- Introduce mandatory hard-stop workflows [8]
- Random audits, especially in high-risk wards
- Use a "second checker" system (in-person or virtual)
- Regular refresher training for prescribers [9]

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#10000 BLACK INTERNS

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Check out the references