SPSP Networking Day – VTE
Tuesday 30 May 2017
COSLA, Edinburgh
Welcome

John Harden
National Clinical Lead for Quality and Safety
Scottish Government
Housekeeping

• Please put mobile phones on silent.

• If you hear a fire alarm, please proceed to the nearest fire exit.

• Complimentary WiFi:
  – Username - **COSLA**  Password – 5804269531

• Yellow lanyards – here to help.
Aims of the day

Over the last 12 months SPSP has supported a project in NHS Borders on reliable delivery of thromboprophylaxis for patients in acute hospitals. The aim of the day is to share the learning from this work.
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Lead</th>
</tr>
</thead>
</table>
| 11:15 | Chair’s welcome        | John Harden  
National Clinical Lead for Quality and Safety, Scottish Government |
| 11:20 | The story so far       | Alison Hunter  
Improvement Advisor, Healthcare Improvement Scotland                  |
| 11:30 | Diagnosing the problem | Nada Walker  
Improvement Advisor, NHS Borders  
Simon Watkin  
Consultant Physician, NHS Borders |
| 12:15 | Lunch                  |                                                                      |
| 13:00 | Testing changes        | Nada Walker  
Improvement Advisor, NHS Borders  
Simon Watkin  
Consultant Physician, NHS Borders  
Andrew McClarey  
Specialty Registrar, NHS Lothian |
| 14:00 | World café             | Alison Hunter  
Improvement Advisor, Healthcare Improvement Scotland                  |
| 15:15 | Next steps             | Alison Hunter  
Improvement Advisor, Healthcare Improvement Scotland                  |
| 15:20 | Chair’s closing        | John Harden  
National Clinical Lead for Quality and Safety, Scottish Government   |
| 15:30 | Close                  |                                                                      |
The story so far...

Alison Hunter
Improvement Advisor
Healthcare Improvement Scotland
The Scottish Patient Safety Programme

National Health & Wellbeing Outcome 7:

People using health and social care services are free from harm
VTE Programme: 2012 - 2014

**AIM**

Improve delivery of evidence based care in prevention of Venous Thromboembolism (VTE)

**OUTCOME:**

- Reliable risk assessment and appropriate thromboprophylaxis administration
- 95% of adult admissions in pilot ward by December 2012
- 95% of all adult hospital admissions by December 2014

**JOINT COLLABORATIVE – VENOUS THROMBOEMBOLISM DRIVER DIAGRAM**

**PRIMARY DRIVERS**

- Reliable Risk Assessment
- Reliable Care Delivery
- Education & Awareness
- Culture of Safety & Quality Improvement
- Patient & Family Centred care

**SECONDARY DRIVERS**

- Prevent VTE by ensuring a documented VTE risk assessment is completed within 24 hours of admission. Include all elements of SIGN 122 – prevention and management of venous thromboembolism.
- Ensure reliable and documented appropriate thromboprophylaxis.
- Ensure timely prescribing and administration of anticoagulant therapy/mechanical intervention.
- Provide education and raise awareness of VTE and improvement methodology.
- Ensure competent practitioner completes risk assessment/prescribes and administers pharmacological/mechanical thromboprophylaxis.
- Provide a culture of safety and quality improvement.
- Ensure executive sponsorship.
- Provide clinical leadership.
- Reliable collaboration of multi-disciplinary team.
- Develop measurement framework to guide improvement.
- Ensure Patient and family centred care.
- Provide patient information on admission.
- Involve Patient/Family in risk assessment and treatment process.
- Promote open communication among team and family.
- Optimise transitions to home or other facility.
Evaluation

Evaluation of the Scottish Patient Safety Programme sepsis VTE collaborative: Short Report

Carolyn Tarrent, Barbara O’Donnell, Graham Martin, Julian Bion

BOX 2: Reasons that the collaborative approach was less impactful for VTE (than for sepsis)

- VTE imposed as a ‘top down’ initiative with a lack of a drive from the clinical community;
- lower national and international profile of VTE (e.g. a lack of campaigns such as World Sepsis Day);
- a lack of evidence of the scale of harm from VTE, less availability of powerful patient stories;
- a lack of belief that the problem was rooted in failing to assess and take preventative action in non-surgical patients in hospital;
- lack of a good evidence base (or belief in the evidence base) for interventions;
- interventions primarily process based, involving documentation and prevention, and seen as less high profile and important work;
- VTE outcomes decoupled from clinical actions on the ground;
- lack of an outcome measure for VTE;
- some VTE interventions, particularly around reassessment, were less amenable to small-scale testing (e.g. via PDSA cycles);
- some of the changes required for improvement were outside the scope of control of the local project team
Diagnosing the problem

Nada Walker
Improvement Advisor, NHS Borders

Dr. Simon Watkin
Consultant Physician, NHS Borders
VTE prophylaxis

• We know it’s important
• Prophylaxis is effective
• Patient safety is number one
• Omission is not intentional
VTE prophylaxis

• Results don’t match expectations
• Considerable local and national efforts
• New thinking needed
• Cultural change
VTE prophylaxis

• 1 year project
• An improvement expert
• The story so far
VTE prophylaxis

• Spread and sustainability
• Patient empowerment
• Proof of effect
Diagnostic in Borders
Content

- What was the overall aim?
- What results were obtained?
- How did we do it?
- What did we do?
- Baseline measurement “New measurement plan”
- Identifying key barriers and failure modes
- Design for improvement
- Aim – What results were obtained?
- Spread/ sustainability
- Next Steps
What was the overall aim?

By June 2017 ≥ 95% of patients in pilot ward(s) receive:

- **Documented** VTE risk assessment
- Correct thromboprophylaxis.
What results were obtained?
Correct Prophylaxis Prescribed (regardless of risk assessment completion)

General Surgery – 05/09/16 to May 17

Mean = 96%  13%

Kick start – process change implemented
Prompt

Target = ≥95%
How did we do it?
By the delivery of:

- Six Sigma DMAIC Improvement methodology (Define, Measure, Analysis, Improve, and Control)
- Problem-solving and root cause analysis techniques
- Reliable data
- Reliable risk assessment
- Involvement, education and awareness for health care staff
- Patient / Public engagement and involvement
What did we do?

Diagnosing the problem
### Structured approach

1. Setting up a steering group
2. Approving quality improvement model
3. Lessons learned from past efforts
4. Conduct a survey
5. Reliable data collection and tracking
6. Infrastructure review of education and guidelines
7. Engage and observing clinical and pharmacy staff
8. Process mapping the system
Setting up a steering group

Agreeing:

• Project Charter
  • Problem
  • Aims
  • Scope
• Driver diagram
• Measurement plan
• Gantt chart
Approving QI model – 6 Sigma

- Disciplined model uses a structured approach
- Reliable data driven
- Problem-solving root cause analysis tools and techniques
- Understand variation
- Model is ideal for long standing complex problems
- Multiple processes and their interactions with each other
Define

- Steering group set up
- Charter: Problem statement; Aim; Scope
- Project Plan: (key milestones)
- Driver diagram
- Measurement plan
- Thought process mapping
- Process mapping
- Root cause identification
- Literature review
- Clinical and Pharmacy staff engagement

Improve

- Data reliability
- Set up measurement system
- Establish baseline measurement
- Survey

Measure

- Brainstorming / detailed root cause analysis (RCA)
- Process mapping
- FMEA
- Projects identified and prioritised
- Design for improvement

Control

- Establish and implement control and monitoring plan
- Training: On-going programme
- Communication
- Visual controls etc.

Define

- Analyse

6 Sigma

- Improve
- Measure
- Analyse
- Define
- Control
Lessons learned from past efforts

- Successes
- Challenges
- Feedback
Evaluating current process

There were two main components:

1. VTE survey of clinical and pharmacy staff

   - 17 questions
   - Total 100 VTE survey forms distributed
   - 56% surveys completed and returned
   - 59% of respondents were doctors
VTE survey

• Survey was an opportunity for staff to give their honest views regarding the current VTE risk assessment

• Results of the survey were used to inform the best approach to improve VTE prophylaxis
Survey questions:

Deliberately designed with key areas of interest:

- Background
- Thoughts
- Prophylaxis
- Re-assessment
Survey results:

Junior Physicians - Background (n=12)

Do you know where to find the VTE risk assessment? 92

Do you fully complete the VTE risk assessment? 75

Do you consider the VTE risk assessment important? 100

Questions  1, 3 & 4
Survey results:

Junior Physicians - Background (n=11)

Q8: Why do you think the VTE risk assessment is poorly completed? Is it because:

- Time constraints/ pressure: 37%
- Too busy: 27%
- If obvious it is time wasting: 18%
- Low in priority list: 18%
- Thought to apply to selective patients: 0%

Other: 10%
Survey results:

Junior Physicians - Thoughts (n=12)

Do you consider the VTE risk assessment as another tick box exercise? 58% YES, 42% NO

Do the nurses help with the VTE risk assessment? 33% YES, 67% NO

Do you think that there is anything that can be done to improve compliance with completing the VTE risk assessment? 75% YES, 25% NO

Questions 15, 16, 17

Nurse involvement, Education, Simplify, Administer only if risk assessment completed
Survey results:

Junior Physicians - Prophylaxis (n=12)

- Are you anxious when prescribing prophylaxis? 9% YES, 33% Sometimes, 58% NO
- Are you confident the VTE Prophylaxis prescription is correct without the VTE risk assessment being completed? 33% YES, 0% Sometimes, 67% NO

Questions 5 & 6
Survey results:

Junior Physicians - 48 Hours (n=12)

Do you think VTE risk re-assessment after 48 hours of admission important?

- YES: 50%
- Sometimes: 33%
- NO: 16%

Do you VTE risk re-assess after 48 hours?

- YES: 0%
- Sometimes: 42%
- NO: 58%

Questions 10 & 11
Survey results:

Mid - Grade Physicians - Background (n=18)

Q 8. Why do you think the VTE risk assessment is poorly completed? Is it because:

- Time constraint: 67%
- Clinical judgement: 22%
- Uncertain diagnosis: 5.5%
- Busy: 5.5%
- Lower in priority list: 0%
Survey results:

Mid - Grade Physicians - Prophylaxis (n=18)

Are you anxious when prescribing prophylaxis?

<table>
<thead>
<tr>
<th></th>
<th>% YES</th>
<th>% Sometimes</th>
<th>% NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(J=9%)</td>
<td>0</td>
<td>22</td>
<td>78</td>
</tr>
<tr>
<td>J=33%</td>
<td>56</td>
<td>44</td>
<td></td>
</tr>
</tbody>
</table>

Are you confident the VTE Prophylaxis prescription is correct without the VTE risk assessment being completed?

Questions 5 & 6
Survey results:

Nurse (n=17)

- **6. Are you confident the VTE Prophylaxis prescription is correct without the VTE risk assessment being completed?**
  - Yes: 21%
  - Sometimes: 79%
- **7. Do you consider pharmacological prophylaxis necessary?**
  - Yes: 60%
  - Sometimes: 30%
- **10. Do you think VTE risk re-assessment after 48 hours of admission important?**
  - Yes: 80%
  - Sometimes: 13%
  - No: 7%
- **Do you consider mechanical thromboprophylaxis (TEDs) to be important?**
  - Yes: 94%
  - Sometimes: 6%
  - No: 0%

Questions 6, 7, 10, 12
Survey results:

Nurse- Background (n=17)

Q 8: Why do you think the VTE risk assessment is poorly completed? Is it because:

- Time constraint: 56%
- Lack of commitment: 31%
- Pressure during admission: 13%
- Too much paperwork: 0%
- Education: 0%
- Other: 0%
Survey - Analysis of the results
Survey summary

100% VTE Risk Assessment important

Leadership

Responsibility

Education (all staff) to increase confidence / understanding

Documenting risk assessment: Time constraint / too long / unclear / simplify / shorter

Pharmacy: more involvement / training staff

Review guidelines (SIGN122 & NICE) / update local guidelines

TEDS: Review excision protocol / evidence

48hrs: Review possible methods to flag / prompt
Evaluating current process

2. Analysis of previous data reliability

VTE and bleeding risk factors were combined as a single unit of assessment, although individual patient’s risk of both VTE and bleeding are considered separately.
Evaluating current process

Pharmacological and mechanical prophylaxis prescribed was recorded as correct solely on the basis of a physician signature.

Box 6: Risk Assessment Date/ Sign/ Name
Evaluating current process

The prescription decision sections **medical / surgical** were not considered in the routine data collection.
Infrastructure review of education and guidelines

• **Gap analysis:** Review and update current internal guidelines

• Improve guidelines by simplifying accessibility in local internet

• Implement on-going structured education programme
Engage and observing clinical staff and pharmacy

- Ward Round
- Hand over
- Grand round etc.
- Teaching session
Process mapping the system – high level

Patient admitted to hospital

Acute Assessment Unit (AAU)

Nursing:
- Initial assessment
- Baseline investigations: e.g. Bloods, ECG

Physician:
- Initial assessment
- Medicine Reconciliation
- History & examination
- Differential diagnosis
- Electronic - Blood s and Chemistry results available

Test results transferred from electronic to AUPR - including renal function

VTE Risk Factor documented (Drug KARDEX)
- Failure
  - Ward A = 65%
  - Ward B = 70%

Bleeding risk factor documented (Drug KARDEX)
- Failure
  - Ward A = 50%
  - Ward B = 48.5%

Prescription
- Dose decision making
  - Failure
    - Ward A = 56%
    - Ward B = 44%

Correct pharmacological prophylaxis
- Failure
  - Ward A = 86%
  - Ward B = 85%

Mechanical prophylaxis
- Prescribed / administered
  - Failure
    - Ward B = 25%

Drug KARDEX completed

Patient admit to Ward A/ B

Nurse:
- BMI recorded in MUST

Post Take Ward Round
- 0% = review of VTE risk assessment

Reassessment after 48hrs
- 0%
Let's Do Lunch!
Testing changes

Nada Walker
Improvement Advisor, NHS Borders

Dr. Andrew McClarey
Specialty Registrar, NHS Lothian
Baseline measurement - “NEW measurement plan”

- VTE risk factors
- Bleeding risk factors
- Prescription dose decision making section
- Actual / correct prophylaxis prescribed
- Prescribing / administering TEDS
- Name / date / signature
## Incorrect prophylaxis – Analysis

<table>
<thead>
<tr>
<th>MAU</th>
<th>% Incorrect</th>
<th>Surgical</th>
<th>Over dose</th>
<th>11</th>
</tr>
</thead>
</table>

![Pareto Chart - Incorrect Prophylaxis/ MAU (n=30/ 207)](pareto_chart.png)
Incorrect prophylaxis prescribed

- This failure mode was selected because it represented a more thought provoking and surprising outcome
- It challenged the view of medical staff that prescribing was consistently correct
- It was shared in many ways including during Grand Round meeting by BGH Medical Director
Identifying key barriers and failure modes (high risks)

A concise list of common failure modes were identified by using the following problem solving techniques:

- Survey
- Process mapping
- Root cause analysis
- Brainstorming
- Engaging and observing clinical and pharmacy staff
FMEA - Failure Mode and Effect Analysis  
Used to establish and prioritise root causes.

Requires the identification of the following basic information:

- Process step
- Failure mode
- Potential failure effect (Y’s)
- Severity
- Potential causes of failure (X’s)
- Occurrence
- Current process controls
- Detection
- Risk priority number (RPN)
- Recommended actions
FMEA – Projects identified in order of priority

Projects

Ward round prompt
VTE risk assessment tool / re-design
Leadership communicate importance / enforce
In-correct Prophylaxis
Guidelines / Education, awareness
Ward round / Pharmacy
TED’s
Patient Leaflet / Information
Responsibility

RPN (Risk Priority Number)

Cumulative %
Design for improvement

QI methodology **PDSA** was used for rapid testing in the following areas:

- Ward round prompt
- VTE risk assessment tool / re-design
Develop a simple ward round prompt check list to improve reliability of VTE thromboprophylaxis prescribing.
Ward round “Prompt” Check List- General Surgery

I Imaging & Investigations

C Charts: Observation / Investigation

A Antibiotics / Kardex:
Indication / Duration / Consider change to oral antibiotics

N Nutrition: Fluid Chart / Nutritional Status

T VTE: Documented Risk Assessment
BMI & eGFR available / up to date?
Mechanical Prophylaxis prescribed & administered
Reassess / any changes?

P Follow Up Plan: Outpatient / Inpatient
Ward Round “Prompt” Testing for solution

PDSA – Surgical

Cycle 3 (n =13):

• Ward round led by consultant – A
• “ICANTP” prompt check list introduced
• “ICANTP” written by ward round scriber in patient report

Results:

• Clear verbal review by consultant at end of each patient round
• 23% = prophylaxis doses required intervention
Ward Round “Prompt” Testing for solution

Cycle 4 (n =18):

- Ward round led by consultant – B
- “ICAN TP” prompt check list used
- “ICAN TP” written by ward round scriber in patient report

Results:

- Clear verbal review by consultant at end of each patient round
- 11% = Prophylaxis doses required intervention
- 22% = VTE risk assessment required intervention
Ward Round “Prompt” Check List-MAU

MR  Medicine Reconciliation (Med Rec): 2 Sources used

F  Fluids: On IV Fluids / Fluid status assessed / More Fluid prescribed

A  Antibiotics: Indication / Duration / Consider change to oral antibiotics

C  CPR Capacity: CPR documented / Capacity assessed

T  VTE: Documented Risk Assessment  Is BMI & eGFR available / up to date? Reassess / any changes?
Ward Round “Prompt” Testing for solution

PDSA – Medical

Cycle 4 (n=15):
• Ward huddle briefing
• “MRFACT” stickers added to patient reports

Result:
• 80% = “MRFACT” ticked
• 33% = VTE risk assessment required intervention
• 13% = prophylaxis doses required intervention due to eGFR & BMI not being considered
Ward Round “Prompt” Testing for solution

Cycle 5 (n=10):

- Ward huddle briefing
- Prompt checklist poster “MRFACT” : includes eGFR & BMI checking
- “MRFACT” stickers added to patient reports

Result:

- 90% = prophylaxis doses and documenting the VTE risk assessment required intervention
Analysis of results - Prompt

• The key outcome of the results is the dependence of the consultant leadership ability; commitment, understanding and enforcing the value of a structured ward round process

• Unfortunately, very few consultants had buy-in to this process with the usual comment of “we do this anyway”

• It was apparent that the majority of new junior physicians were dissatisfied by the overall ward round process due to its lack of structure and the variation depending on consultants leading
Prompt – Logo

• A prompt logo was designed by physicians in the medical unit to promote the use of “MRFACT” and thus compliance

• This created a buzz and demonstrated competitiveness

• It was a short term fix
Prompt – Establishing long term solution

- Long term solution for compliance to adhere and demonstrate the use of the check list needed to be found

- Consultant’s leadership to communicate, demonstrate importance and enforce

- A test was designed outside the scope of this project to analyse the compliance of the other prompts of the ward round check list
Prompt – Establishing long term solution

Ward round test analysis - MRFACT (n=26)
% compliance of applicable subjects

<table>
<thead>
<tr>
<th>Ward round/ Subject</th>
<th>Comply</th>
<th>Not comply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr-2 Sources Used</td>
<td>73</td>
<td>27</td>
</tr>
<tr>
<td>Fluids: On IV Fluids</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Fluids: Fluid status assessed</td>
<td>50 50</td>
<td></td>
</tr>
<tr>
<td>Fluids: More Fluid prescribed</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>Antibiotics: Indication</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>Antibiotics: Duration</td>
<td>63</td>
<td>38</td>
</tr>
<tr>
<td>Antibiotics: Consider change to oral...</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>CPR Capacity: CPR documented</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>CPR Capacity: Capacity assessed</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>VTE: Documented Risk Assessment</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>VTE: Is BMI &amp; eGFR available/ up to...</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>VTE: Reassess/ any changes?</td>
<td>55</td>
<td>45</td>
</tr>
</tbody>
</table>
Prompt – Establishing long term solution

• The results clearly show the prompt demonstrating to work well for 2 out of 3 components of the VTE project; risk assessment documentation, correct prescribing according to BMI & eGFR

• However, the prompt does not work for the rest of the check list due to the subjects not being the focus point and standardisation was not the aim

• A check list prompt to standardise the ward round process ultimately would result in consistent delivery of high quality safe care to each patient
VTE risk assessment tool / re-design

VTE risk assessment has been identified as inadequate due to its unreliable approach to prescribing correct prophylaxis
VTE risk assessment tool/ re-design

Multi disciplinary team of Consultants including Pharmacy:

- Review / updating VTE and bleeding risk factors
- Combining medical and surgical dose decision
- Adding to prescription : “Mechanical prophylaxis”
- Simplifying but improving the effectiveness
- Following SIGN 122
Tool/ re-design - Testing for solution

PDSA Cycles

Cycle 1 - 3:
• Tool re-design

Cycle 4 – 12:
• 3 x patient scenarios tested

Result:
Re-designed tool test was found to be an improvement (user friendly and effective)
VTE risk assessment tool – re-design

<table>
<thead>
<tr>
<th>VTE Risk Factors:</th>
<th>Bleeding Risk Factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt; 60</td>
<td>Normal Renal Function</td>
</tr>
<tr>
<td>Active cancer or cancer treatment</td>
<td></td>
</tr>
<tr>
<td>Obesity, diabetes, active paralysis</td>
<td>Normal Renal Function</td>
</tr>
<tr>
<td>Medical condition: Heart failure, metastatic syndrome, COPD, Venous disease</td>
<td>None Present</td>
</tr>
<tr>
<td>VTE at any point in the past 6 months</td>
<td>None Present</td>
</tr>
<tr>
<td>Anticoagulation therapy</td>
<td>None Present</td>
</tr>
<tr>
<td>Any Present</td>
<td></td>
</tr>
<tr>
<td>None Present</td>
<td></td>
</tr>
</tbody>
</table>

**VTE Prevention**

- Use standard care and monitor for bleeding.
- Consider mechanical prophylaxis (e.g., TEDS) unless contraindicated.
- Reassess patient every 48 to 72 hours or sooner if condition changes.

**Bleeding Risk Factors:**

- Hemoglobin < 10 g/dL
- Platelet count < 50,000/mm³
- Elevated INR
- History of bleeding or clotting disorders
- Recent surgery or invasive procedure
- Other medical conditions (e.g., liver disease, renal failure)

**Table:**

<table>
<thead>
<tr>
<th>Date</th>
<th>COMMENTS/ CALCULATIONS</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Dosage:**

- Heparin 5000 units every 12 hours
- Enoxaparin 1 mg/kg every 12 hours
AIM - what results were obtained?

By June 2017 ≥ 95% of patients in pilot ward(s) receive:

- **Documented** VTE risk assessment
- Correct thromboprophylaxis
Correct Prophylaxis Prescribed (regardless of risk assessment completion)
General Surgery – 05/09/16 to May 17

Kick start - process change implemented
Prompt

Mean = 96% ± 13%
VTE risk factors completion rate (NHSB) General Surgery
05/09/16 to May 17

Mean = 90% 19%
Bleeding risk factors completion rate (NHSB) General Surgery
05/09/16 to May 17

Mean = 75%  25%

Mean = 75%
Correct Prophylaxis Prescribed (regardless of risk assessment completion)
Medical Admission Unit (MAU) – 05/09/16 to May 17

Mean= 93%  7%

Kick off start – process change implemented

Prompt
VTE risk factors completion rate (NHSB) Medical Admission Unit (MAU)
05/09/16 to May 17

Mean = 76% 11%
Bleeding risk factors completion rate (NHSB) Medical Admission Unit (MAU)
05/09/16 to May 17

Mean= 67%  17%
Spread / sustainability

- Policy
- Establish an effective control and monitoring plan of VTE key performance indicators (KPI)
- Introducing VTE into the “Executive Walk Round” that includes conversations with staff and patients in clinical areas would highlight the organisation’s VTE policy
- Training: On-going programme
- Implementing visual displays of VTE performance measurements
- Feedback from completed audits given to consultants to be shared with their team
- Prompt process needs to be established as a standard practice
Next Steps

• Final report shared with boards
• Revise driver diagram and change package to reflect learning
• Focus on correct delivery of thromboprophylaxis as a desirable outcome
Thanks
World cafe
Alison Hunter
Improvement Advisor
Healthcare Improvement Scotland
Aims of the World Cafe

• To discuss today’s learning and share your own

• To get some help with your challenges and generate new ideas

• To make new contacts who can help in the future
Introduction to World Cafe

- Four questions altogether
- Introduce yourself on 1\textsuperscript{st} round
- Your table facilitator will take notes
- A familiar warning will be made 30 seconds prior to moving table!
- Hosts stays at table – all others move together.
Session Introduction 14:00 – 14:05

Question Discussion 14:05 – 14:17

Question Discussion 14:17 – 14:29

Question Discussion 14:29 – 14:41

Question Discussion 14:41 – 14:53

Whole Group Feedback 14:53– 15:15

Key themes from each table
World café flow diagram
Question 1

Education and Awareness

What barriers to effective education and awareness exist in VTE improvement activities?
Question 2

Clinical engagement

How can we improve clinical engagement with VTE work?
Question 3

VTE risk assessment

What is the process of completing VTE risk assessment?
What is working and not?
Question 4

Data and measurement

How reliable is the delivery of VTE prophylaxis?
How are you measuring this?
Discussion

Education and awareness
What barriers to effective education and awareness exist in VTE improvement activities?

Clinical engagement
How can we improve clinical engagement with VTE work?

VTE risk assessment
What is the process of completing VTE risk assessment?
What is working and not?

Data and measurement
How reliable is the delivery of VTE prophylaxis?
How are you measuring this?
Discussion

Education and awareness
What barriers to effective education and awareness exist in VTE improvement activities?

Clinical engagement
How can we improve clinical engagement with VTE work?

VTE risk assessment
What is the process of completing VTE risk assessment?
What is working and not?

Data and measurement
How reliable is the delivery of VTE prophylaxis?
How are you measuring this?
Discussion

Education and awareness
What barriers to effective education and awareness exist in VTE improvement activities?

Clinical engagement
How can we improve clinical engagement with VTE work?

VTE risk assessment
What is the process of completing VTE risk assessment?
What is working and not?

Data and measurement
How reliable is the delivery of VTE prophylaxis?
How are you measuring this?
Discussion

Education and awareness
What barriers to effective education and awareness exist in VTE improvement activities?

Clinical engagement
How can we improve clinical engagement with VTE work?

VTE risk assessment
What is the process of completing VTE risk assessment?
What is working and not?

Data and measurement
How reliable is the delivery of VTE prophylaxis?
How are you measuring this?
Free Feedback Session
Discussion

Education and awareness
What barriers to effective education and awareness exist in VTE improvement activities?

Clinical engagement
How can we improve clinical engagement with VTE work?

VTE risk assessment
What is the process of completing VTE risk assessment?
What is working and not?

Data and measurement
How reliable is the delivery of VTE prophylaxis?
How are you measuring this?
Next steps
Alison Hunter
Improvement Advisor
Healthcare Improvement Scotland
Improvement Programmes

Care Delivery
- Living Well in Communities
- Primary Care
- Mental Health
- Acute
- Dementia
- Place, Home and Housing
- Maternity and Children’s

System Enablers
- Strategic Planning
- Outcomes-based commissioning
- Transformational Service Redesign
- Third and Independent Sector Engagement
- QI Infrastructures
- Evidence, Evaluation and Knowledge Exchange
- Person Centred Health and Care

Tailored and Responsive Improvement Support

Grants and Allocations
Next steps

- Final report shared with boards
- Revise driver diagram and change package to reflect learning
- Focus on correct delivery of thromboprophylaxis as a desirable outcome
Close

John Harden
National Clinical Lead for Quality and Safety
Scottish Government