

Why Consider VTE Prophylaxis:

- ◇ Patients undergoing major surgery have an increased (20x greater) risk for VTE.
- ◇ VTE can be life-threatening.
- ◇ VTE is an expensive post-operative morbidity. Its recurrence and the development of life altering long-term complications like venous insufficiency and pulmonary hypertension can occur.
- ◇ In the near future, hospitals may not receive reimbursement for hospital-acquired VTE.

Preventing VTE:

◇ ASSESS

When to assess risk:

Pre Admission Testing (PAT): during the patient interview

Preop: during preop assessment, review with the patient his/her risk for VTE from the PAT assessment and communicate risk to the appropriate provider(s)

Inpatient Unit: periodically reassess for VTE risk through discharge—document and communicate changes to the Provider

What to assess:

1. **Use the MSQC Risk Assessment Scale** (see *MSQC Recommended VTE Risk Scoring System pocket card*).
2. **Document Risk Factors and any contraindications to prophylaxis.**
3. **Assign level of risk** (see *MSQC Recommended VTE Risk Scoring System pocket card*).
4. **Initiate Intervention:** Document risk and communicate risk to providers: anesthesiology team, surgeon, mid-level provider (MLP), nurses and patient.

◇ INTERVENE

Patient Education:

1. Provide education and rationale for VTE Prophylaxis in the context of the patient's personal VTE risk score (improves compliance).
2. Communicate risk-reducing interventions to the patient so he/she may anticipate them.
3. Empower patients/family/support persons to remind providers if/when regimen is not being followed.
4. Set expectations for early ambulation targets upon admission to the inpatient unit.

Nursing Intervention:

1. Ensure prophylaxis orders are written for each surgical patient.
2. Ensure timely initiation and consistent administration and documentation of prophylaxis regimen including early ambulation.
3. Notify ordering provider if prophylaxis is withheld.
4. Monitor for common reasons for non-compliance with prophylaxis and provide appropriate intervention:
 - SCD machines/compression sleeve availability
 - proper application/reapplication and start of the device
 - patient refusal of SCDs/anticoagulants (may require patient re-education, provider notification)
5. Monitor and reassess patient's VTE status/risks periodically during hospitalization
6. Document any changes in VTE status or treatment
7. Ensure prophylaxis through discharge: planning and patient education

VTE PREVENTION

MECHANICAL PROPHYLAXIS	PHARMACOLOGICAL PROPHYLAXIS
SCDs: Sequential Compression Devices IPCs: Intermittent Pneumatic Compression Devices	Anticoagulation Therapy: SQ Heparin, Enoxaparin/ Lovenox or other low-molecular-weight heparin (LMWH) of choice Patients with "minimal risk" or greater may receive pharmacological prophylaxis (see MSQC Prophylaxis Guidelines pocket card)
Apply immediate preop/ intraoperatively or when patient is in immediate postoperative recovery	-Reoffer missed doses—unless close to the next administration time; -Notify Provider of missed doses/refusals
Devices are to be worn continuously until the patient is fully ambulatory (be sure to educate the patient on this point)	Based on the patient's assessed risk, orders for appropriate prophylaxis should be obtained