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## **Improving pharmacological venous thromboembolism prophylaxis assessment and prescription on an acute surgical ward (2022)**

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**Introduction:** Venous thromboembolism represents a major cause of morbidity and mortality of acute surgical admissions. Previous audits, and NHS campaigns, have greatly increased VTE prophylaxis (pharmacological/mechanical methods). In trusts, with electronic prescribing, the VTE risk assessment tool often prompts doctors to complete the assessment through multiple, window notification reminders. NICE/SIGN/Trust guidelines recommend VTE risk assessments and prophylaxis is completed within 14 hours post-admission, with reassessment 24 hours post-admission if high bleeding/thrombosis risk.

**Methods:** 269 patients were assessed in total, across 6 months, through 3 PDSA cycles. Data collection was undertaken retrospectively post-discharge; the specified timepoints were within 14 hours post-admission and 24 hrs post-admission. Initial data collection (first cycle) was used to determine baseline practices with additional 2 further data collection points 2 months/4 months post-intervention (departmental poster education and awareness). Average VTE prophylaxis rates were averaged at each point of data collection and an unpaired T-test was used to determine a p-value for significance.

**Results:** Current baseline practice assessment revealed 92% and 16% of patients, had VTE risk assessment tool and appropriate prophylaxis prescribed within 14 hours and 24 hours of admission respectively. Post-intervention 2 months later, VTE risk assessment and prophylaxis improved to 98% ( $p<0.05$ ) and 86% ( $p<0.001$ ) respectively for 14 hours and 24 hours post-admission. At 6 months VTE risk assessment and prophylaxis rates decreased to 96% and 62% of patients respectively for 14 hours and 24 hours post-admission. ( $p<0.05$ ,  $p<0.001$  compared to baseline practice respectively).

**Discussion:** VTE reassessment significantly improved post departmental poster-education and awareness at both 14 hours and 24 hours post-admission. This is an important consideration, given the high turnover of the acute surgical admission; often with blood results, investigations, and surgical/anaesthetic operation risk assessment guiding further patient management requiring VTE reassessment to minimise bleeding/thrombosis. The drop in VTE risk assessment and prophylaxis at the 6-month time point could be explained by the new cohort of junior doctors, in their first foundation year job, with a lack of exposure to previous departmental VTE education.

### **Biography**

He is currently a medical doctor working in the United Kingdom.

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