



Defining the Scope of the Problem: the Hospice Thromboprophylaxis Project

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Background

- Accepted that VTE is a cause of preventable death
- DoH priority/ CQUINS
- PTP not necessarily accepted practice in hospices
 - Current practice variable (my involvement)
 - Routine risk assessment is unusual
 - PTP likely to be given depending on place of admission rather than 'clinical risk and indication'
- But, are the national guidelines applicable?
 - NICE guidelines
 - PBCN guidelines



Background cont..

- Is it feasible?
- Will it lead to hundreds of hospice inpatients being on primary thromboprophylaxis (PTP)?



A collaborative study

PBCN guidelines

Step 1:
General
assessment



Step 2:
Risk assessment
for VTE



Step 3:
Assessment of
benefit of
prophylaxis



Step 4:
Palliative Team
decision



The study

Part 1:

- 3 hospices: Leeds, Scarborough, Cardiff
- Retrospective casenote review 300pts
- Data extraction proforma
 - demographics
 - level of risk for VTE (THRIFT criteria)
 - contraindications to PTP
 - prescription of PTP
 - documentation of decisions re PTP



Part 2

Implementation of VTE prevention policy

- Included PBCN modification of the THRIFT VTE risk assessment tool
- introduced in each hospice according to local operational structures and procedures.



Part 3 – re-audit

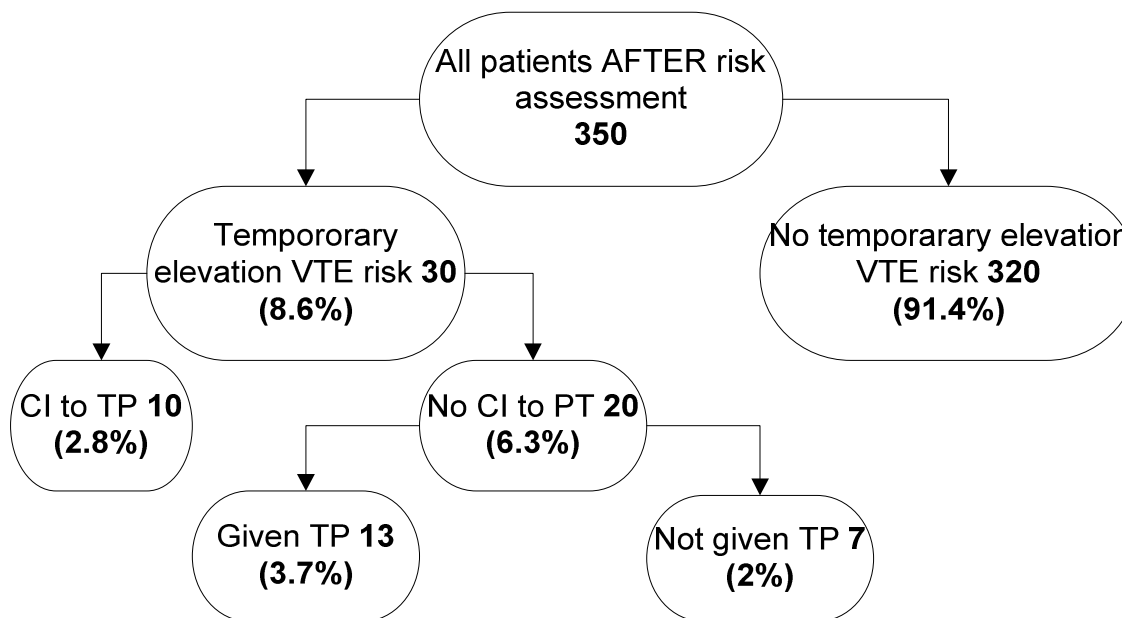
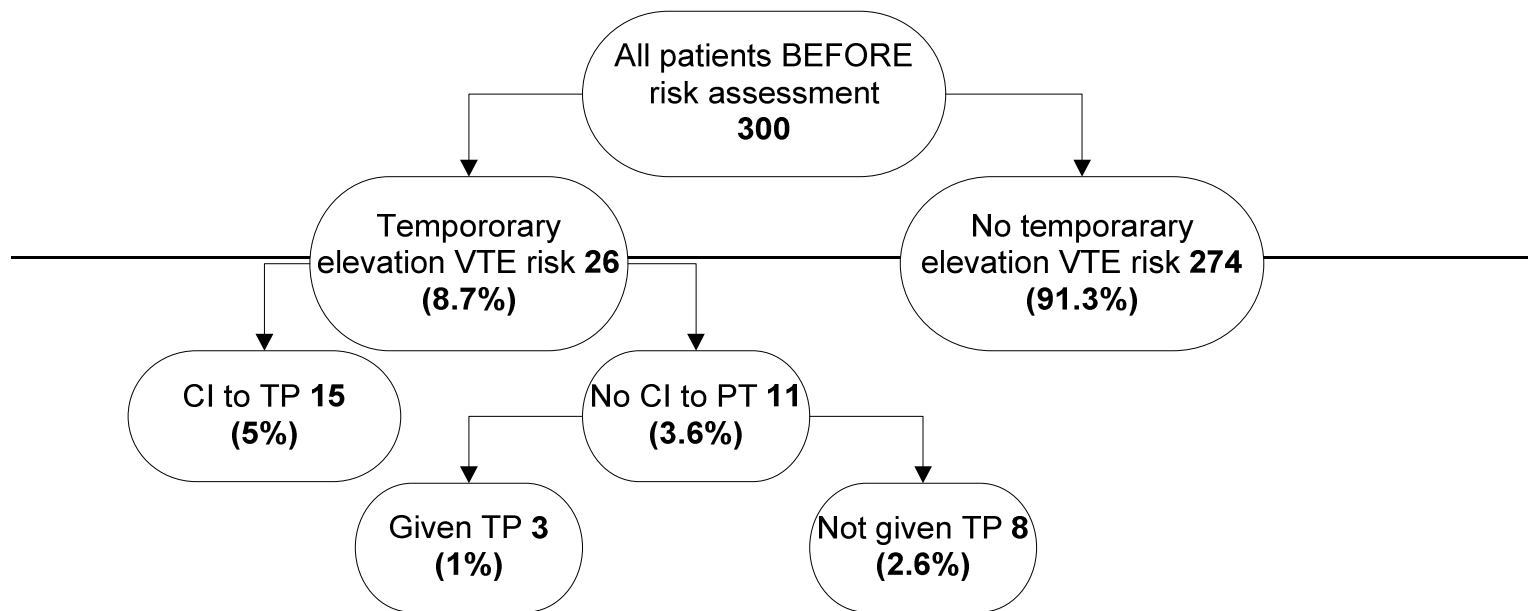
- Initial audit revisited in all 3 hospices after new policy introduced
- Consecutive admissions (ie diff. numbers)
 - (350 pts in total)
- Recording of clinical symptoms in 2 hospices possibly related to VTE (at routine assessment):
 - new onset chest pain, new onset leg swelling or new onset breathlessness.



Results

Population (before & after groups):

- Mean age 70
- Approx 50% male
- 86% cancer; 14% non-cancer
- VTE risk:
 - low: <4%
 - moderate: 75-80%
 - high: 16-24%
- CI to PTP = 40%
- Temporary elevation of risk = 8.6%





Results 2

- PTP administration
 - 3/11 patients with temp. elevation risk (& no CI) → 13/20 after
- Documentation
 - 5% notes before → 81% notes after



Symptoms

250 patients

- average length of admission was 10 days
- New CP – 1
- New leg swelling – 3
- New SOB – 7
- SOB & leg swelling – 3
- none would have received TP using the PBCN guidelines as nine did not fulfil the criteria for initiating TP and the other five had contra-indications to anticoagulation.



Discussion points

- It is feasible to introduce a VTE prevention policy in hospices
- Many patients have CIs to PTP
- <10% of patients would receive PTP under the PBCN criteria
- PBCN guidelines consensus-based only
- Those who developed possible VTE events would not have received PTP, therefore it is unclear if following these criteria would result in a useful reduction in events in this population



Discussion cont..

- Should the criteria for commencing PTP in our patients be broadened?
 - 1) Give to all patients without CI?
 - 2) Give for longer period following admission?
- Can only be usefully answered by more evidence!



Any Questions?