INTRODUCTION

DVT and PEs are the most preventable cause of death in hospitalized patients. There is evidence that routine prophylaxis reduces morbidity, mortality and cost in hospitalized patients at risk for DVT and PE as highlighted in national and international guidelines. The initial DVT or PE event increases median hospital costs by $7,512 for DVT alone and $18,901 for PE. The median cost incurred for subsequent post thrombotic syndrome is approximately $29,554.

BACKGROUND

A recent audit found 73% of patients with active IPC orders were not wearing the devices, most lying in bed. Additionally:
- 38% of the patients with an active IPC order did equipment in rooms
- 49% of patients not wearing IPC devices had no documented reason for not wearing the devices.

OBJECTIVES

- To improve compliance with physician ordered IPC therapy
- To promote sustained compliance improvement

METHODS & RESULTS

Phase 1: Root cause analysis to determine if IPC supply and demand were related to non-compliance for patients with no equipment in the rooms, including patient tracking to determine if transferring impacted unit IPC compliance.

Results:
- Device supply was almost twice device demand
- Patients admitted to the surgical units were more likely to have IPCs in place if transferred from units routinely stocking IPCs on unit.

Phase 2: Nurses surveyed to assess knowledge and perceptions about IPC therapy and DVT prevention.

Results:
- A lack of knowledge related to risk factors for DVT
- Self reported inconsistencies in practice related to IPC
- Respondents reported checking IPCs during hourly rounding yet audits showed low compliance.

Phase 3: Pilot project conducted on the surgical floor - two units changed practice, two units served as controls. Change in practice included housing IPCs in all beds at all times and staff nurse education by the Clinical Nurse Specialists utilizing a standardized, evidence based curriculum. Weekly point prevalence counts for the entire floor were conducted.

Results:
- A marked reduction in non-compliance occurred on pilot units.

CONCLUSION

IPC use can improve with changes in in device accessibility, nurse education, patient education, and routine monitoring. Nursing procedure was changed at the institution to reflect the following:
- House IPC devices in all surgical patient rooms
- Implement new mandatory nursing staff education
- Implement new patient education
- Implement new monthly compliance monitoring

REFERENCES

