Collaborative working to reduce VTE

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- How to improve VTE prevention

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Abstract

The thrombosis team at King’s College Hospital used innovative methods to bring about a change in the trust’s VTE prevention practice. The team took a structured approach with a focus on positive aspects of practice. The aim was to involve clinical staff by forming partnerships rather than using a dictatorial approach. The creation of a nurse and midwife link network and valuing the individuality of clinical areas were fundamental to successful change.

In 2010, the prevention of venous thromboembolism (VTE) came into the spotlight when the National Institute for Health and Clinical Excellence (2010a; 2010b) published guidance and quality standards and the Commissioning for Quality and Innovation (CQUIN) payment framework linked healthcare providers’ income to the implementation of VTE risk assessment. Trusts were given a structure in which to achieve the highest standards of VTE prevention and a way of illustrating this to patients and commissioners.

The thrombosis team at King’s College Hospital felt the best way to change VTE practice throughout the trust would be to devise a strategy that involved staff and encouraged a collaboration. The team, set up in 1999, comprises three doctors, one consultant nurse, six specialist nurses, four research fellows, two pharmacists and an administrator.

Getting staff involved
A five-step involvement continuum was used to encourage staff to become involved with VTE prevention; this had been designed to develop public involvement in healthcare and we adapted it for use with clinical staff (Department of Health, 2003). Its five steps progress from minimum to maximum involvement (Box 1).

Alongside the involvement continuum, we used “appreciative enquiry” – a method of organisational development that focuses on affirmation and being positive. In healthcare, there is a culture of learning from clinical incidents and undertaking analysis when things go wrong. Appreciative enquiry enhances learning by looking at what went right, celebrating these achievements and disseminating the information to improve practice. It has been described by nurses as a fresh approach in a context that tends to focus on the negative (Kavanagh et al, 2010).

Giving information
The aim of the information-giving phase was to raise awareness and educate staff about VTE prevention and what the NICE guidance meant for them and their patients.

First, we identified who needed to be reached and which methods would suit different groups. The VTE thrombosis team delivered a large amount of in-house training and created an electronic VTE learning module, which we made available to all clinical staff.

Throughout this phase we worked to increase awareness in the trust through display stands at hospital events and a VTE awareness event that coincided with junior doctors starting at the trust. We used local media to reach staff by promoting our

5 key points

1. A systematic trustwide approach to preventing venous thromboembolism is crucial for patient safety and to reduce costs
2. When planning change involving other people, it is important to be flexible
3. Staff involvement and development should be tailored to the needs of the individuals, teams and areas involved
4. Staff often appreciate the opportunity to highlight, celebrate and learn from successes
5. Time and resources spent on gathering and disseminating information is invaluable for building partnerships

Keywords: Venous thromboembolism/ Risk assessment/Appreciative enquiry/ Engagement

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already-established thrombosis website, and posted information/guidelines and events on the intranet.

To reach patients, we developed a VTE information leaflet and encouraged clinical departments to make it available to all inpatients. The leaflet outlines the risk of thrombosis and what clinicians and patients can do to reduce the risk. It also informs patients of the signs and symptoms of VTE and what to do if they develop.

**Getting information**

This stage involved the thrombosis team collecting audit data and feedback from staff; the audit data gave us an idea of how well the trust was already performing.

We worked closely with the IT department and the business intelligence unit, and included data entry information in our education programme.

To make sense of the data and understand what was working well and what barriers were faced, we gathered more qualitative information from formal and informal discussions with key clinical staff.

Gradually, we built a picture of what was needed and where. It soon became obvious that each area had specific issues that needed to be tackled separately. At this point we began to enlist help from colleagues throughout the trust as the workload was more than one team could manage. We also felt that change was more likely to take effect if it was led from within the various departments.

We found that VTE “champions” across professional groups already existed throughout the trust. Identifying these people and using their energy and drive was vital in spreading good practice.

Soon after the VTE prevention project began, we set up a VTE link nurse and midwife group, which was critical in achieving the trust’s VTE prevention goals. We arranged monthly meetings and quarterly study days for these link staff and secured funding for places on an accredited national VTE prevention course. As the network became established, we appointed a lead link nurse, allowing us to hand over responsibility to clinical areas. For example, after attending meetings with the thrombosis committee, a lead obstetrician and a group of midwives significantly improved VTE maternity care. This included the creation of a specialist obstetric VTE risk assessment by combining the Department of Health (2010) tool and the Royal College of Obstetricians and Gynaecologists (2009) VTE guidelines.

**Partnership**

This stage represented engagement, a level at which patient care could be positively changed in a sustainable way.

This was gradual and dynamic and we achieved partnership with some areas sooner than others. In some cases, the strategy had to be revised when, for example, a ward manager left or wards were restructured.

This stage marked a transition period where the thrombosis team began to hand over responsibility to clinical areas. For example, after attending meetings with the thrombosis committee, a lead obstetrician and a group of midwives significantly improved VTE maternity care. This included the creation of a specialist obstetric VTE risk assessment by combining the Department of Health (2010) tool and the Royal College of Obstetricians and Gynaecologists (2009) VTE guidelines.

**Conclusion**

Changing practice across a large trust was daunting. It was particularly challenging as the changes were perceived differently and had different relevance to each clinical area and staff group.

Celebrating and learning from positive aspects of practice was an effective way to form lasting partnerships and doing so rapidly improved care.

The key to success appeared to be valuing the uniqueness of each clinical area and adapting strategies to suit them rather than imposing blanket methods of change.

A lot of hard work, perseverance, resilience, innovative thinking and leadership were needed from all involved and we learnt a lot that will greatly enhance future work. NT

**References**


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**BOX 1 INVOLVEMENT CONTINUUM FIVE STEPS**

- **Giving information** – education, raising awareness
- **Getting information** – audit, analysis, observation, feedback
- **Forums for debate** – dialogue, meetings, focus groups
- **Participation** – staff and patient involvement
- **Partnership** – sustainable development and progress as an organisation

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