

Quality Improvement Activity: DVT post-ORIF

On August 27, 2021, a patient was moved back into their hospital room after having an ORIF to fix their broken femur. The patient had extensive surgery and would have to be on bed rest for an extended period till they healed. The nurse that received the patient did a head-to-toe on the patient but did not assess either of the patient's legs because they assumed the patient would be fine. After completing their transfer charting the nurse decided to give the patient their scheduled medication. When in the patient's room the nurse scanned the patient's prescribed enoxaparin but figured the patient had low platelets, so she decided to omit the enoxaparin without checking. The next day the same nurse had this patient. The nurse noticed the patient had sequential compression devices on, but she did not think the patient would need them, so she took them off and went on with her day. The nurse also saw in the chart that the patient was prescribed to be turned and that they should be moved to the chair, but the nurse thought this was too much work, so she decided not to. Halfway through the shift, the nurses got a call on their Vocera saying that the patient was asking for the nurse. Upon entering the room, the patient told the nurse that their right leg was painfully cramping. The nurse decided to check the patient's leg which ended up being swollen, red, and warm to the touch. Knowing it was probably a DVT because of the care the nurse decided not to provide, the nurse immediately alerted the charge nurse.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario presented above the patient ended up getting a DVT because of care that was not provided for the patient. The nurse decided things were not needed so they decided not to do them which led to the patient getting a DVT. The patient was post-ORIF which puts them at risk

for DVTs already and not providing proper care to prevent them resulted in DVT. The nurse did not provide the care needed to prevent DVTs from occurring. Throughout the scenario, it can be shown that patient care was lacking. The nurse did not provide the correct care on multiple occasions because of not wanting to and disregarding what needed to be done. Some examples are taking off the SCDs, not administering the enoxaparin, and not moving the patient. The environment was also lacking the proper healing and therapeutic touch that the patient needed. This whole scenario is an exaggeration of what happens, but it does commonly occur. Many nurses do not properly assess their patients or make assumptions about a patient's needed care. They also may just become complacent with patient care.

What circumstances led to the occurrence?

One of the circumstances that lead to this occurrence was the fact that the patient was on bed rest which helped cause the formation of the DVT. It also was affected by the nurse being complacent and not providing the patient proper care. The nurse is a big factor because they took off the SCDs, did not administer the enoxaparin, did not fully assess the patient, and the nurse disregarded the patient needing to move.

In what way could you measure the frequency of the occurrence? (Interviewing nurses, examining charts, patient surveys, observation, etc.)

The frequency of occurrence of this can be measured by the number of DVTs experienced by patients after an ORIF. These DVTs would be documented so someone could go back and see how frequently they occur. It can also be measured by examining patient charts that ended up getting DVTs and what could have caused them. Lastly, nurses could be surveyed to see what care they provide to patients in similar scenarios to see the root of the problem.

What Evidence-based ideas do you have for implementing interventions to address the problem?

There are a couple of ideas that could help prevent DVTs from occurring in these patients. One is by either creating a checklist to assure all preventative measures are followed or by making nurses do assessments in pairs to confirm accuracy. Another idea would be to have nurses have to cosign with another nurse when omitting meds so that nothing the patient needs is omitted. Lastly, another idea would be to give patients care plan checklists so that they can see what should be done and be more involved with their care. This would allow patients to also know what is not being done so that they can ask the nurse and assure that they receive quality care.

How will you measure the efficacy of the interventions?

Measuring efficiency can be done by seeing how many patients still end up with DVTs compared to when these measures were not in place. Hospitals could also have people come in to assess if the nurses are providing adequate care to prevent DVTs. If fewer DVTs occur after implementing these changes to prevent them then the changes were successful.