# Purpose

To highlight patient safety risks associated with insert local VTE problem and to recommend that the insert relevant local committee takes a lead role in governance of improvement activities to address these risks.

# Background

* VTE is a leading cause of morbidity and mortality in Australia with more than 14,000 Australians diagnosed with a VTE each year, and more than 5,000 cases resulting in death1. The incidence of VTE in hospitalised patients is more than 100 times greater in community patients2.
* Appropriate use of VTE prevention methods is ranked as the top intervention hospitals can make to improve patient safety3-4. Studies have found 30-65% of VTE cases to be preventable if appropriate provision of prophylaxis is provided5-6, which relies on timely and appropriate risk assessment.
* Insert local VTE data such as HIE VTE hospital-acquired complication (HAC) rates etc

# Issues

(Select/modify/insert issues below as relevant to your health service and where possible insert local data from incident reports or audits to support the case for change)

* As per [Prevention of Venous Thromboembolism PD2019\_057](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2019_057), NSW Health facilities are required to insert problem which requires improvement.
* Insert unit/facility/district name has not been able to appropriately implement insert local VTE process or policy and as a result, patients are not receiving the best possible care to prevent VTE formation.
* There is inconsistency in the way that insert problematic VTE prevention process is carried out. Ideally, insert details of ideal process including clinicians involved, when and how etc should occur, however insert actual process is occurring.
* A recent audit conducted on insert date/ward/patient group showed that only insert percentage of patients are receiving appropriate insert VTE prevention process.
* Since insert date, there have been insert data if available instances of patients developing a VTE during their hospital admission which has led to insert known complications, leading to an increase of average number of bed days.
* The average cost of a VTE related complication at insert ward/facility/district is insert cost and in the past year, there have been insert number of VTE related complications.
* As can be seen from the above, inconsistency in insert VTE prevention process at insert unit/facility/district name may be contributing to preventable harm from VTE.

# Recommendations

That insert relevant local committee notes the patient safety risks highlighted and supports improvement activities to improve insert local VTE problem by: (amend list below as appropriate)

* Supporting the formation of a multidisciplinary quality improvement project team to:
	+ Evaluate current VTE prevention processes and establish improvement project goals
	+ Identify and enlist clinical champions
	+ Develop, implement and evaluate improvement strategies
	+ Disseminate results and findings
* Establishing reporting and approval processes
* Assisting with overcoming barriers to implementation

**Contact:** (insert name of person co-ordinating the improvement activities)

# Phone: Date:

**References**

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