VTE/DVT Prophylaxis

Reminder: Any **examples** you can provide that help me understand your responses to my questions would be helpful.

**ADMISSION**

1. **What influences whether or not** you order VTE prophylaxis on admission? **Why** do you order VTE prophylaxis? Please be specific.

2. **Where/from whom do you get the information** you need to determine whether or not to order VTE prophylaxis?
   - What **information contained in the EHR** helps you determine whether to order VTE prophylaxis?
   - Who are the **key people** involved in VTE prophylaxis ordering. What are their **roles**? – **What do they do**?

3. **When** do you review this information?

4. In what way, if any, does the **patient play a role in or influence whether or not you order prophylaxis on admission**?
   - Does the **patient ever influence** what **type** of prophylaxis you order?

4. Do you have **anything to add** that further explains **what you think about or what information you need** when you determine whether or not to order VTE prophylaxis on admission?
VTE PROPHYLAXIS – THROUGHOUT THE STAY
During the patient stay; patient receiving prophylaxis:

1. What **information do you need on a daily basis** for patients already on VTE prophylaxis?

2. **Where/from whom** do you get the information?

3. Who are the **key people** involved in daily monitoring of VTE prophylaxis? What are their **roles? What do they do?**

4. **When** is this information reviewed or shared?

**Stopping an order:**

1. What **triggers cause you to review and (possibly) stop** an order for VTE prophylaxis?
   - Are there particular
     - patient physical or clinical cues or triggers (e.g., patient bleed or thrombocytopenia), or
     - certain types of procedures, or
     - input by others on the team that cause you to stop a VTE prophylaxis order?

2. **Where** do you get the information?

3. Who are the **key people** involved in noting the need to stop VTE prophylaxis? What are their **roles? What do they do?**

4. **When** is this information reviewed or shared?
Reinitiating the order:

1. In instances when you previously stopped an order for VTE prophylaxis, what mechanism do you use/rely on to remind you that the patient is not on prophylaxis?
   What triggers you to be aware that a patient’s VTE prophylaxis order was stopped?

2. Where do you get the information?

3. Who are the key people involved in noting the need to reinitiate VTE prophylaxis? What are their roles? What do they do?

4. What mechanism do you use/rely on to ensure an order is reinitiated? When does this occur?

No order for VTE prophylaxis placed on admission:

1. What information do you review/receive for patients who were not placed on VTE prophylaxis on admission?
   What triggers awareness that the patient is not on prophylaxis?

2. Where do you get the information?

3. Who are the key people involved in noting the need to initiate VTE prophylaxis? What are their roles? What do they do?

4. When is this information reviewed or shared? How often is this reviewed?
Patient transfer

1. Please explain the process you go through ensure an order for VTE prophylaxis is appropriately continued, stopped or initiated for patients transferred to your service.
   
   What triggers you to address VTE prophylaxis? What information do you need to determine whether to order VTE prophylaxis?

2. Where do you get the information?

3. Who are the key people involved in noting the need to review the need for VTE prophylaxis on transfer? What are their roles? What do they do?

4. Does the patient or their (family) caregiver have a role in monitoring VTE prophylaxis orders during the patient’s hospitalization? What is the role?

Do you have anything to add that further explains what you think about or what information you need to monitor VTE prophylaxis orders throughout a patient’s stay?
IDEAL HEALTH IT DESIGN

This project intends to develop EHR design requirements that facilitate how you think about and the processes associated with VTE prophylaxis.

- What would your ideal EHR system look like? What functionality would it have? (e.g., auto-populated fields, auto-populated order sets)

- What can the EHR do to improve information display or information provision?

- What VTE prophylaxis-related information must be shared? With whom? How? When? [PROBE: How is a shared understanding of the patient and their need for (or not) VTE prophylaxis achieved? What is needed to achieve “shared situation awareness”?]