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 d**o?

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"?]