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## Towards appropriate prevention and treatment of venous thromboembolism

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## ABSTRACT

### Introduction

The prevention and management of venous thromboembolism (VTE) is often at variance with guidelines, despite its prevalence, cost, morbidity and mortality. The CareTrack Australia (CTA) study reported that appropriate care (in line with evidence- or consensus-based guidelines) is being provided for VTE at just over half of eligible encounters. Here, we report indicator-level CTA findings for VTE.

### Methods

Indicators were extracted from Australian VTE clinical practice guidelines and ratified by experts. A sample designed to be representative of the Australian population was recruited. Participants' medical records from 2009 and 2010 were retrospectively reviewed and analysed for compliance with 38 VTE indicators. The main outcome measure was the percentage of eligible healthcare encounters with documented compliance with indicators of appropriate care for VTE.

### Results

Of the 35,145 CTA encounters, 1,078 (3%) were eligible for scoring against VTE indicators. There were 2 - 84 eligible encounters per indicator at 27 hospitals. Overall compliance with indicators for VTE was 51%, and ranged from 34 - 64% for aggregated sets of indicators. Of the 70 VTE patients discharged on anti-coagulant therapy, 46% had a documented discharge plan and a date for cessation of treatment.

### Discussion

The prevention and management of VTE was appropriate for only half of the at-risk patients in our sample. There is a need for national agreement on clinical standards, indicators and

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tools to guide, document and monitor care for VTE, and for measures to increase their uptake, particularly in areas where deficiencies have been identified.

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## INTRODUCTION

Each year in Australia about 1 in every 1,000 people develop a first episode of venous thrombo-embolism (VTE), manifesting as deep venous thrombosis (DVT) and/or pulmonary embolism (PE).(1, 2). This amounts to about 20,000 cases, of which 80% occur during or soon after an admission to hospital.(1, 2) Including loss of productivity, total costs amount to well over AUS\$1 billion per year.(3)

There is evidence that the appropriate use of pharmacological and mechanical prophylaxis in orthopaedic, general surgical and medical patients can reduce the incidence of VTE,(4-6) although a recent paper has questioned use of pharmacological prophylaxis in lower risk medical patients.(7) Clinical practice guidelines (CPGs) have been developed, in Australia(8, 9) and elsewhere,(10, 11) to prevent VTE and to standardise the management of DVT and PE. Several initiatives have been undertaken to promote and facilitate their uptake, including implementation guides,(12) templates,(13) learning modules,(14) hospital medication self-assessments,(15) and patient information pamphlets.(16) However, despite these initiatives and the considerable harm from VTE, much of the care provided for VTE is not in line with CPGs.(17)

As healthcare is facing an affordability crisis, there is an urgent need to move towards being able to monitor the appropriateness of care (“care in line with evidence- or consensus-based guidelines”).(18) The CareTrack Australia (CTA) study was designed to establish baseline estimates of the appropriateness of care delivered, at a population level, by a range of practitioners in real-world settings, and to determine what would be needed to monitor the ongoing appropriateness of care.(19) CTA showed that adult Australians received appropriate care for 22 common conditions at 57% of eligible healthcare encounters during 2009 and 2010; VTE compliance was reported at 58%.(20) Here we present and discuss the detailed CTA results for VTE.

## METHODS

The CTA methods have been described in detail elsewhere.(19, 20) Some aspects of relevance to VTE are summarised here.

### Development and ratification of indicators

An initial list of 15 indicators (with 54 sub-criteria) was sourced from the National Health and Medical Research Council guidelines(8, 9) and sent to three practising specialist haematologists who were Heads of Departments, asking them to comment on and rate each on a scale of 1 to 9 for appropriateness(21) in the Australian context during 2009 and 2010. This resulted in 39 indicators being accepted as appropriate: 31 relating to pharmacological and mechanical prophylaxis and eight to risk assessment, discharge care and management of DVT or PE (see Table 1).

### Recruitment of participants and healthcare providers

A sample designed to be representative of the Australian adult population was used. Households were randomly selected from a phone directory (the Telstra White Pages) from defined regions within New South Wales and South Australia.(19, 20) One adult was randomly selected from each household and recruited over the phone. Those who agreed were sent a mail package containing information about the study and a consent form to allow access to their medical records. Participants who provided consent were called back and asked if they had been admitted overnight to a hospital or had one or more of the CTA conditions, and which healthcare providers they had seen for these in 2009 and 2010. Hospitals identified by the participants were contacted and asked to provide their consent for medical record access. Human Research Ethics Committee (HREC) approval was obtained from Hunter New England Local Health District as the lead HREC and other relevant bodies and local sites.(20)

## Review of medical records

Medical record reviews were undertaken for the 1,154 consenting participants whose healthcare providers had also provided consent. Healthcare encounters were deemed eligible for scoring of VTE indicators if a participant had been admitted overnight during 2009 and/or 2010.

Experienced registered nurses were recruited and trained as surveyors to conduct the medical record reviews using a web-based tool for on-site encrypted data collection. They were provided with formal training and received a manual with detailed criteria for inclusion, exclusion and scoring of indicators.

Estimates of compliance were measured as the percentage of eligible encounters for the VTE indicators that were answered 'yes'.(19, 20) The inclusion criteria for the indicators for VTE prophylaxis were specific to particular types of surgery (e.g. hip fracture surgery or abdominal surgery) or medical conditions (e.g. decompensated cardiac failure or acute on chronic lung disease).(8, 9) As the CTA study was designed to measure the overall appropriateness of the healthcare delivered for 22 conditions and was not powered for significant results at indicator level, the number of eligible encounters for many indicators was low. To address this, indicators were aggregated into broader, clinically meaningful categories. For example, orthopaedic conditions with pharmacological prophylaxis (indicators 45-48) were grouped and included hip arthroplasty, hip fracture surgery, knee arthroplasty, and lower limb fractures (see Table 1).

Data relating to documentation of VTE risk assessment (indicator 42) was not included in the analysis reported here, as a review of surveyor practices revealed that some had assumed that a risk assessment had been carried out whenever appropriate prophylaxis had been prescribed, whether or not explicit documentation of an assessment was found. This was in breach of the criteria for this indicator, and these data were thus excluded.

## Statistical analysis

Mean compliance and associated 95% confidence intervals (using a modified version of the Clopper–Pearson (exact) method) were obtained using the SURVEYFREQ procedure in SAS version 9.3 for Windows (SAS Institute, Cary, NC, USA). To address biases arising from the study design (including adjustment for non-response), two different weighting options and five version of weights (three based on approaches used in the similar US study(21)) were used to generate weighted estimates of compliances. These were not significantly different to unweighted compliances overall or for any condition (including VTE). Hence, unweighted compliances were used for this analysis.(20) Appendix 2 of the CTA study outlines the detailed methodology and overall results.(20)

## RESULTS

Of the 1,154 CTA participants, 481(42%) were admitted overnight to hospital at least once, with a total of 751 admissions eligible for assessment against the VTE indicators. There were 279 females (58%), and the mean age was 64 years (6% were aged 18 – 39, 17% 40 – 54, 56% 55 – 74 and 21% were over 70 years of age).

Of the 35,145 CTA encounters (with duplicates and the risk indicator removed), 1,078 (3%) were eligible for scoring against VTE indicators; the number of eligible encounters per indicator ranged from 2 - 84. Records were reviewed at 33 hospitals, with 27 having eligible encounters. Eight of the hospitals had 50 or more eligible encounters.

Overall compliance with the VTE indicators was 51% (CI 95%: 47-54%), with results for aggregated sets of indicators ranging from 34 - 64% (Table 1). Omission of the risk assessment indicator from the overall score reduced compliance from the 58% reported originally(20) to the 51% reported here. For the eight hospitals with 50 or more eligible encounters, compliance ranged from 45 - 70%.

Table 1: CTA indicators (and aggregated sets of indicators) by compliance

Indicator Number	Indicator and sets of indicators	Eligible encounters (N)	Compliant encounters (N)	Compliance* (%)	95% confidence limits† (%)
<b>45-48</b>	<b>Patients undergoing certain orthopaedic procedures or care received appropriate pharmacological anticoagulant therapy</b>	<b>55</b>	<b>34</b>	<b>62</b>	<b>48 - 75</b>
45	Patients who had a hip arthroplasty have received anticoagulant therapy for up to 35 days‡	22	12	Insufficient data to report	
46	Patients who had hip fracture surgery have received anticoagulant therapies for up to 35 days§	2	2	Insufficient data to report	

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47	Patients who had a knee arthroplasty received anticoagulant therapies for up to 28 days	24	16	Insufficient data to report	
48	Patients who had a lower limb fracture received anticoagulant therapies for at least 5 days or until fully mobile§	7	4	Insufficient data to report	
<b>62, 68-70, 73-75</b>	<b>Patients undergoing certain orthopaedic procedures or care received appropriate mechanical anticoagulant therapy</b>	<b>104</b>	<b>49</b>	<b>47</b>	<b>37 - 57</b>
62	Patients having a total hip replacement have been prescribed graduation compression stockings	20	19	Insufficient data to report	
68	Patients having a total hip replacement have been prescribed an intermittent pneumatic compression device	18	11	Insufficient data to report	
69	Patients having hip fracture surgery have been prescribed an intermittent pneumatic compression device	3	1	Insufficient data to report	
70	Patients having a total knee replacement have been prescribed	21	15	Insufficient data to report	

	an intermittent pneumatic compression device				
73	Patients having a total hip replacement have been prescribed a foot pump	18	1	Insufficient data to report	
74	Patients having a total knee replacement have been prescribed a foot pump	22	2	Insufficient data to report	
75	Patients having hip fracture surgery have been prescribed a foot pump	2	0	Insufficient data to report	
<b>49-54</b>	<b>Patients undergoing non-orthopaedic surgical procedures (general, gynaecological, abdominal, cardiac, thoracic or vascular, trauma or spinal surgery) or who had cancer and underwent surgery received appropriate pharmacological anticoagulant therapy</b>	<b>226</b>	<b>76</b>	<b>34</b>	<b>27 - 41</b>
49	Patients who had a general surgical procedure received anticoagulant therapies (unless contraindicated) until hospital	55	19	35	22 - 49

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	discharge or fully mobile¶				
50	Patients who had gynaecological surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	26	5	Insufficient data to report	
51	Patients who had abdominal surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	61	29	48	18 - 78
52	Patients who had cardiac, thoracic or vascular surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	31	12	39	16 - 66
53	Patients who had trauma or spinal surgery received anticoagulant therapies commenced after primary haemostasis was established (unless contraindicated) until hospital discharge	18	0	Insufficient data to report	

	or fully mobile¶				
54	Patients who have cancer that underwent surgery received one of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	35	11	31	5 - 74
<b>63-67, 71-72</b>	<b>Patients undergoing non-orthopaedic surgical procedures received appropriate mechanical anticoagulant therapy</b>	<b>294</b>	<b>176</b>	<b>60</b>	<b>52 - 67</b>
63	Patients having general surgery have been prescribed graduated compression stockings	72	63	88	78 - 94
64	Patients having gynaecological surgery have been prescribed graduation compression stockings	28	21	Insufficient data to report	
65	Patients having abdominal surgery have been prescribed graduation compression stockings	66	48	73	46 - 91
66	Patients having cardiac, thoracic or vascular surgery have been	52	17	33	2 - 85

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	prescribed graduation compression stockings				
67	Patients having neurosurgery have been prescribed graduation compression stockings	13	11	Insufficient data to report	
71	Patients having cardiac, thoracic or vascular surgery have been prescribed an intermittent pneumatic compression device	50	7	14	2 - 41
72	Patients having neurosurgery have been prescribed an intermittent pneumatic compression devices	13	9	Insufficient data to report	
<b>55-61</b>	<b>Medical patients admitted to hospital with certain conditions received appropriate pharmacological anticoagulant therapy</b>	<b>167</b>	<b>77</b>	<b>46</b>	<b>36 - 57</b>
55	Medical patients admitted to hospital with ischemic stroke received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	5	1	Insufficient data to report	

56	Medical patients admitted to hospital with myocardial infarct (where full anticoagulant is not in use) received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	15	6	Insufficient data to report	
57	General Medical patients admitted to hospital assessed as being at risk of VTE received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	84	43	51	40 - 62
58	Medical patients admitted to hospital with active cancer received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	23	8	Insufficient data to report	
59	Medical patients admitted to hospital with decompensated cardiac failure received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	7	3	Insufficient data to report	

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60	Medical patients admitted to hospital with acute on chronic lung disease received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	31	15	48	30 - 67
61	Medical patients admitted to hospital with acute on chronic inflammatory disease received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	2	1	Insufficient data to report	
<b>76-80</b>	<b>Patients with suspected PE/DVT were managed with appropriate investigations, or had anticoagulant therapy commenced as soon as clinically suspected; or if PE/DVT confirmed, were managed appropriately</b>	<b>89</b>	<b>57</b>	<b>64</b>	<b>51 - 76</b>
76	Patients with a suspected DVT had a venous duplex ultrasound performed	12	10	Insufficient data to report	
77	Patients with a suspected PE had investigations performed <sup>‡‡</sup>	21	17	Insufficient data to report	

78	Patients with a suspected DVT or PE where ultrasound was delayed, had anticoagulant therapy commenced (unless contraindicated) as soon as clinically suspected	10	8	Insufficient data to report	
79	Patients with a confirmed DVT / PE received anticoagulant therapies <sup>A</sup>	6	3	Insufficient data to report	
80	Patients who were administered heparin therapy had it continued until the <i>International Normalized Ratio</i> (INR) had been therapeutic for 48 hours (INR range 2.0 - 3.0)	40	19	48	26 - 70
<b>Patients discharged on anticoagulant therapy have an appropriate documented care plan including details on the intended duration of treatment AND a review date<sup>B</sup></b>		70	32	46	31 - 61
43	Patients who are discharged on anticoagulant therapy have a documented care plan that includes details on the intended duration of treatment	73	43	59	46 - 71

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44	Patients who are discharged on anticoagulant therapy have a documented care plan that includes a review date	70	35	50	29 - 71
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Footnote:

- † compliance and % compliance were not calculated for <30 encounters
- ‡ enoxaparin 40mg/day; dalteparin 5000u/day; low dose unfractionated heparin (LDUH) 5000u TDS; fondiparinux 2.5mg/day [commenced 6 – 8 hours post op]; rivaroxaban[PO]; dabigatran [PO]
- § enoxaparin 40mg/day; dalteparin 5000u/day; LDUH 5000u TDS; fondiparinux 2.5mg/day [commenced 6 – 8 hours post op]
- || enoxaparin 40mg/day; dalteparin 5000u/day; LDUH 5000u TDS; fondiparinux 2.5mg/day [commenced 6 – 8 hours post op]; rivaroxaban[PO]; dabigatran [PO]
- ¶ enoxaparin 20mg/day; dalteparin 2500U/day
- †† enoxaparin 40mg/day; dalteparin 5000U/day; LDUH 5000U BD or TDS; assumed implicit and explicit risk assessments included.
- ‡‡ One of: ventilation perfusion scan; CT angiography; pulmonary angiography
- A heparin administered together with warfarin for at least 5 days; unfractionated heparin IV (Activated Partial Thromboplastin Time (APTT)) or subcutaneous (dose/kg); Low Molecular Weight Heparin (LMWH) subcutaneously at least once daily.

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6 B Compliance for this aggregated indicator was both indicators 43 and 44 were compliant for a participant in an episode of hospitalisation. In  
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8 other aggregated indicators, compliance was measured by adding each individual encounter as each episode of hospitalisation was an  
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10 independent event.  
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## DISCUSSION

Despite the prevalence, cost, morbidity and mortality associated with VTE, prophylaxis and treatment is often not in line with CPGs. This analysis of CTA data has shown that our sample of 481 Australian adults in 27 hospitals received appropriate care for VTE during 2009 and 2010 at 51% of eligible healthcare encounters.

CTA patients who had surgery received appropriate pharmacological or mechanical anticoagulant therapy on only 39% and 57% of occasions respectively (aggregations from Table 1). The ENDORSE study, a multi-national cross-sectional survey, also examined the proportion of at-risk patients who received effective prophylaxis.<sup>(17)</sup> It found, for 804 patients from eight Australian hospitals studied in 2006-07, that 82% of at-risk surgical patients received appropriate prophylaxis. This study did not separate pharmacological and mechanical prophylaxis.<sup>(17)</sup> Baseline (pre-intervention) compliances for surgical patients were also higher than CTA compliances in two single hospital studies (65 and 74% for pharmacological prophylaxis and 89 and 64% for mechanical prophylaxis).<sup>(22, 23)</sup> Possible reasons for the lower CTA compliances are that CTA was a population-based study at 27 hospitals which were effectively randomly selected, whilst ENDORSE mainly collected data from prominent teaching hospitals, and the two single hospital studies were about to start an intervention for VTE prophylaxis, possibly raising awareness of the problem.

In contrast, the CTA compliance for at-risk medical patients at 46% (aggregations from Table 1) was similar to those in the eight Australian ENDORSE hospitals and a regional hospital (51%, and 64%, respectively).<sup>(17, 23)</sup> No equivalent Australian studies could be found for indicators associated with management of suspected or confirmed DVT or PE (CTA compliance 64%), or patients with a documented discharge plan and a date for cessation of treatment (CTA compliance 46%), but it would seem reasonable to conclude that both of these areas of practice also require attention.

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2 The risk assessment indicator was studied in two Australian single-hospital studies  
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4 which both found 0% compliance at the pre-intervention stage, with modest post-intervention  
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6 increases to 28 and 36%.(22, 24)  
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9 The poor compliances with VTE indicators in Australia are consistent with the lack of  
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11 a system-wide approach. Compliance measures or outcomes are not publicly reported at  
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13 hospital level,(25) VTE is not included in national standards,(26) nor is it a national health  
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15 care goal,(27) Australian clinicians have identified that setting agreement on clinical  
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17 guidelines and standards (agreement on risk categories, risk assessment tools, mandatory  
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19 actions and protocols, provision of summaries), decision-support tools, and reporting results  
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21 are enablers to delivering appropriate VTE care.(28, 29) The fact that compliance ranged  
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23 from 45% to 70% between hospitals suggests that some facilities are faring better than  
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25 others at managing VTE appropriately.  
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## 28 **Strengths and weaknesses**

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31 The key strength of the CTA study is that it is designed to be representative of the  
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33 Australian population rather than a convenience- or purposive-based sample. However, an  
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35 unavoidable consequence of this strategy, coupled with finite research funds, is that the  
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37 number of participants and/or eligible encounters are low for some indicators. The review of  
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39 medical records, while costly and difficult, allowed compliance to be measured in a real  
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41 world setting and avoided the limitations inherent in asking health care providers to respond  
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43 to clinical vignettes(30, 31) or questionnaires.(32) Accordingly CTA provides some baselines  
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45 against which progress on the provision of appropriate care for VTE could be compared and  
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47 tracked.  
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50 The approach used was associated with a high rate of attrition of potential  
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52 participants and several sources of possible bias. However, weighting using two methods  
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54 and five different options made no significant difference to the overall compliance  
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percentage, or that for VTE;(20) this is consistent with providers not altering their clinical practices for patients of different ages, gender, or socio-economic or health literacy status.

Commentators have raised issues with respect to the levels of evidence, choice of indicators, effects of comorbidities, inter-rater reliability, and the possibility of care having been provided but not recorded.(33, 34) These have all been addressed:(20, 35) compliance was shown to be no different for consensus-based and evidence-based recommendations; the CTA indicators were designed to be clinically relevant but not affected by comorbidities; inter-rater reliability was moderate, but was in line with other studies using implicit medical record review;(35) and the effect on overall compliance of care received but not documented is thought to be no more than 10%.(21, 36, 37)

## CONCLUSION

Our analysis of the VTE indicators from the CTA study show that compliance is modest at 51%, despite resources and guidelines being available, and the high associated cost and burden of disease. This is consistent with the lack of a system-wide focus on VTE. In line with recommendations arising from the overall CTA study and feedback from clinicians, the challenge is to now move towards agreement on national clinical standards and on the development of indicators and tools to guide, document and monitor the appropriateness of care for VTE. An inclusive, national wiki-based process for achieving this has been proposed.(18) VTE data could then be monitored at hospital level and the data aggregated at national level to track progress and inform policy.

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## COMPETING INTERESTS

The authors have no competing interests.

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## REFERENCES

1. Heit JA. The epidemiology of venous thromboembolism in the community: implications for prevention and management. *J Thromb Thrombolysis*. 2006;21(1):23-9.
2. University of Western Australia. The incidence and risk factors for venous thromboembolism in hospitals in Western Australia 1999–2001. National Institute of Clinical Studies; 2005.
3. Access Economics. The burden of venous thromboembolism in Australia. Report for the Australia and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism; 2008.
4. Palmer AJ, Kopenhagen K, Kirchhof B, et al. Efficacy and safety of low molecular weight heparin, unfractionated heparin and warfarin for thrombo-embolism prophylaxis in orthopaedic surgery: a meta-analysis of randomised clinical trials. *Haemostasis*. 1997;27(2):75-84.
5. Palmer AJ, Schramm W, Kirchhof B, et al. Low molecular weight heparin and unfractionated heparin for prevention of thrombo-embolism in general surgery: a meta-analysis of randomised clinical trials. *Haemostasis*. 1997;27(2):65-74.
6. Kanaan AO, Silva MA, Donovan JL, et al. Meta-analysis of venous thromboembolism prophylaxis in medically ill patients. *Clin Ther*. 2007;29(11):2395-405.
7. Flanders SA, Greene M, Grant P, et al. Hospital performance for pharmacologic venous thromboembolism prophylaxis and rate of venous thromboembolism : A cohort study. *JAMA Internal Medicine*. 2014.
8. The Australian and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism. Best Practice Guidelines for Australia and New Zealand Health Education and Management Innovations. 4th Edition. 2007.
9. National Health and Medical Research Council. Clinical practice guideline for the prevention of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to Australian hospitals. Melbourne: National Health and Medical Research Council, 2009.
10. National Institute for Clinical Excellence. CG92 Venous thromboembolism - reducing the risk: full guideline. NICE; 2010.
11. Hirsh J, Guyatt G, Albers GW, et al. Antithrombotic and thrombolytic therapy\*: American college of chest physicians evidence-based clinical practice guidelines (8th edition). *CHEST Journal*. 2008;133(6\_suppl):110S-2S.
12. National Health and Medical Research Council. Stop the Clot: Integrating VTE prevention guideline recommendations into routine hospital care. Melbourne: National Health and Medical Research Council, 2011.
13. Australian Commission on Safety and Quality in Health Care. Template for hospital venous thromboembolism prophylaxis policy. Sydney: ACSQHC, 2011.
14. National Prescribing Service. QUM for health professional students learning objectives 2013 [cited 2013 6th May]. Available from: <http://www.nps.org.au/health-professionals/professional-development/online-learning/qum-for-health-professional-students-learning-objectives>.
15. Clinical Excellence Commission. Medication Safety SELF ASSESSMENT for Antithrombotic Therapy in Australian Hospitals. Sydney: New South Wales Therapeutic Advisory Group, 2007.
16. National Health and Medical Research Council. Blood Clots: reducing your risk. In: NHMRC, editor. 2010.

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17. Cohen AT, Tapson VF, Bergmann JF, et al. Venous thromboembolism risk and prophylaxis in the acute hospital care setting (ENDORSE study): a multinational cross-sectional study. *Lancet*. 2008;371(9610):387-94.
  18. Runciman WB, Coiera EW, Day RO, et al. Towards the delivery of appropriate health care in Australia. *Med J Aust*. 2012;197(2):78-81.
  19. Hunt TD, Ramanathan SA, Hannaford NA, et al. CareTrack Australia: assessing the appropriateness of adult healthcare: protocol for a retrospective medical record review. *BMJ Open*. 2012;18(2):2011-000665.
  20. Runciman WB, Hunt TD, Hannaford NA, et al. CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust*. 2012 Jul 16;197(2):100-5. PubMed PMID: 22794056. Epub 2012/07/17. eng.
  21. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003 Jun 26;348(26):2635-45. PubMed PMID: 12826639. Epub 2003/06/27. eng.
  22. Duff J, Walker K, Omari A. Translating venous thromboembolism (VTE) prevention evidence into practice: a multidisciplinary evidence implementation project. *Worldviews Evid Based Nurs*. 2011;8(1):30-9.
  23. Liu DS, Lee MM, Spelman T, et al. Medication chart intervention improves inpatient thromboembolism prophylaxis. *Chest*. 2012;141(3):632-41.
  24. Li F, Walker K, McInnes E, et al. Testing the effect of a targeted intervention on nurses' compliance with "best practice" mechanical venous thromboembolism prevention. *J Vasc Nurs*. 2010;28(3):92-6.
  25. National Health Performance Authority. My Hospitals 2013 [cited 2013 15th August]. Available from: <http://www.myhospitals.gov.au/>.
  26. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: ACSQHC, 2011.
  27. Australian Commission on Safety and Quality in Health Care. Overview of the Australian Safety and Quality Goals for Health Care. Sydney: ACSQHC, 2011.
  28. National Health and Medical Research Council. Venous Thromboembolism Prevention Policy Summit May 2010: Summary Report. Melbourne: National Health and Medical Research Council, 2011.
  29. National Health and Medical Research Council. Preventing Venous Thromboembolism in hospitalised patients. Summary of NHMRC Activity 2003-2010. NHMRC, 2011.
  30. Johnson MJD, Sheard LD, Maraveyas AD, et al. Diagnosis and management of people with venous thromboembolism and advanced cancer: how do doctors decide? a qualitative study. *BMC Med Inform Decis Mak*. 2012;12(1):75.
  31. Bikdeli B, Sharif-Kashani B, Raeissi S, et al. Chest physicians' knowledge of appropriate thromboprophylaxis: insights from the PROMOTE study. *Blood Coagul Fibrinolysis*. 2011;22(8):667-72.
  32. de Franciscis S, Agus GB, Bisacci R, et al. Guidelines for venous thromboembolism and clinical practice in Italy: a nationwide survey. *Ann Vasc Surg*. 2008;22(3):319-27.
  33. Ackermann E. Barriers to "appropriate care" in general practice. *Med J Aust*. 2012;197(2):76.
  34. Scott IA, Del Mar CB. A dog walking on its hind legs? Implications of the CareTrack study. *Med J Aust*. 2012 Jul 16;197(2):67-8. PubMed PMID: 22794036. Epub 2012/07/17. eng.
  35. Runciman WB, Hunt TD, Hannaford NA, et al. CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust*. 2012;197(10):549-50.
  36. Dresselhaus TR, Luck J, Peabody JW. The ethical problem of false positives: a prospective evaluation of physician reporting in the medical record. *Journal of medical ethics*. 2002 Oct;28(5):291-4. PubMed PMID: 12356955. Pubmed Central PMCID: 1733636. Epub 2002/10/03. eng.

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37. Luck J, Peabody JW. Using standardised patients to measure physicians' practice: validation study using audio recordings. *Bmj*. 2002 Sep 28;325(7366):679. PubMed PMID: 12351358. Pubmed Central PMCID: 126653. Epub 2002/09/28. eng.

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## STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation	
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	We have described a retrospective medical review in the Methods of the Abstract.
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	The abstract outlines the key definition of the dependent variable used, the indicator review process, sampling aim, medical record review, data collection timeframe; and the abstract results outlining the quantum of data collected, overall result and range.
<b>Introduction</b>			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	See Introduction with particular attention to the third paragraph.
Objectives	3	State specific objectives, including any prespecified hypotheses	See last paragraph of the Introduction.
<b>Methods</b>			
Study design	4	Present key elements of study design early in the paper	See Methods section including sub-sections Development and ratification of indicators, Recruitment of participants and healthcare providers, Review of medical records, and Statistical analysis. More detail is provided in the referenced protocol paper and main CareTrack Australia results paper (references 19 and 20).
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	Settings, locations, and relevant dates – see sub-section Recruitment of participants and healthcare providers in the Methods. Data collection – see Review of medical records in the Methods. More detail is provided in the referenced protocol paper and main CareTrack Australia results paper (references 19 and 20).
Participants	6	(a) <i>Cohort study</i> —Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up (b) <i>Case-control study</i> —Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of	Cross-sectional study – the eligibility criteria, sources and methods of selecting participants is outlined in the sub-section “Recruitment of participants and healthcare

		cases and controls <i>Cross-sectional study</i> —Give the eligibility criteria, and the sources and methods of selection of participants	providers” in the Methods. More detail is provided in the referenced protocol paper and main CareTrack results paper (references 19 and 20).
		(b) <i>Cohort study</i> —For matched studies, give matching criteria and number of exposed and unexposed <i>Case-control study</i> —For matched studies, give matching criteria and the number of controls per case	Not applicable
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	See Table 1 for descriptions of the indicators used.
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	The sub-section Development and ratification of indicators in the Methods outlines the process for developing the indicators. The sub-section Review of medical records in the Methods outlines the assessment method.
Bias	9	Describe any efforts to address potential sources of bias	Potential sources of bias are outlined in the Strengths and Weaknesses section of the Discussion. Weighting is discussed in the sub-section Statistical Analysis in the Methods.
Study size	10	Explain how the study size was arrived at	See first paragraph of the sub-section Review of medical records in the Methods. More detail is provided in the referenced protocol paper.
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	See third paragraph of the sub-section Review of medical records in the Methods for explanation of how the variables were aggregated. These variables are reported in Table 1.
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	See Statistical Analysis in the Methods.
		(b) Describe any methods used to examine subgroups and interactions	Not applicable.
		(c) Explain how missing data were addressed	See second paragraph of the Results.

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		<p>(d) <i>Cohort study</i>—If applicable, explain how loss to follow-up was addressed</p> <p><i>Case-control study</i>—If applicable, explain how matching of cases and controls was addressed</p> <p><i>Cross-sectional study</i>—If applicable, describe analytical methods taking account of sampling strategy</p>	<p>See Statistical Analysis subsection in the Methods for weighting process. See Appendix 2 of the CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.</p>
		<p>(e) Describe any sensitivity analyses</p>	<p>See Statistical Analysis subsection in the Methods for weighting process. See Appendix 2 of the main CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.</p>

Continued on next page

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Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	See first two paragraphs of the Results section. More details are available in the Results section of the CareTrack Australia study (reference 20).
		(b) Give reasons for non-participation at each stage	See first paragraph of the Results section. More details are available in the Results section of the CareTrack Australia study (reference 20).
		(c) Consider use of a flow diagram	Flow diagrams are provided in the protocol paper (reference 19) regarding stage design and the CareTrack Australia study (reference 20) for non-participation.
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	See first paragraph of the Results section.
		(b) Indicate number of participants with missing data for each variable of interest	Not applicable
		(c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)	Not applicable
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time	Not applicable
		<i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure	
		<i>Cross-sectional study</i> —Report numbers of outcome events or summary measures	See Results.
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	See Results.
		(b) Report category boundaries when continuous variables were categorized	Not applicable
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	Not applicable
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	See Statistical Analysis sub-section in the Methods for weighting process. See Appendix 2 of the CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.
Discussion			
Key results	18	Summarise key results with reference to study	See first paragraph of the Discussion.

		objectives	
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	See Strengths and Weaknesses sub-section of the Discussion.
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	See first paragraph of the Results and the Conclusion for interpretation of results; in the second, third, and fourth paragraphs of the Discussion, our results are compared with other Australian studies and potential reasons for differences.
Generalisability	21	Discuss the generalisability (external validity) of the study results	Firstly, we have compared at indicator or aggregated indicator level, our results with other Australian results in the second, third, and fourth paragraphs of the Discussion; we have discussed broader policy developments and their limitations related to our results in the fifth paragraph of the Results. Despite our sample being collected from a large number of hospitals (27), we have been cautious in generalising to the wider population.
<b>Other information</b>			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	See Funding section.

\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at [www.strobe-statement.org](http://www.strobe-statement.org).

# BMJ Open

## Towards appropriate prevention and treatment of venous thromboembolism

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Manuscripts

## Full title: Towards appropriate prevention and treatment of venous thromboembolism

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**Abstract word count:** 290

## ABSTRACT

### Objectives

The prevention and management of venous thromboembolism (VTE) is often at variance with guidelines. The CareTrack Australia (CTA) study reported that appropriate care (in line with evidence- or consensus-based guidelines) is being provided for VTE at just over half of eligible encounters. The aim of this paper is to present and discuss the detailed CTA findings for VTE as a baseline for compliance with guidelines at a population level.

### Setting

The setting was 27 hospitals in two states of Australia.

### Participants

A sample of participants designed to be representative of the Australian population was recruited. Participants who had been admitted overnight during 2009 and/or 2010 were eligible. Of the 1,154 CTA participants, 481(42%) were admitted overnight to hospital at least once, comprising 751 admissions. There were 279 females (58%), and the mean age was 64 years.

### Primary and secondary outcome measures

The primary measure was compliance with indicators of appropriate care for VTE. The indicators were extracted from Australian VTE clinical practice guidelines and ratified by experts. Participant's medical records from 2009 and 2010 were analysed for compliance with 38 VTE indicators.

### Results

Of the 35,145 CTA encounters, 1,078 (3%) were eligible for scoring against VTE indicators. There were 2 - 84 eligible encounters per indicator at 27 hospitals. Overall compliance with indicators for VTE was 51%, and ranged from 34 - 64% for aggregated sets of indicators.

## Conclusions

The prevention and management of VTE was appropriate for only half of the at-risk patients in our sample; this provides a baseline for tracking progress nationally. There is a need for national agreement on clinical standards, indicators and tools to guide, document and monitor care for VTE, and for measures to increase their uptake, particularly where deficiencies have been identified.

## ARTICLE SUMMARY

### Strengths and weaknesses of this study

- The study is designed to be representative of the Australian population rather than a convenience- or purposive-based sample.
- The review of medical records, while costly and difficult, allowed compliance to be measured in a real world setting.
- Numbers of participants and/or eligible encounters are low for some indicators.
- There was a high rate of attrition of potential participants and several sources of possible bias. However, weighting using two methods and five different options made no significant difference to the compliance percentage.

## INTRODUCTION

Each year in Australia about 1 in every 1,000 people develop a first episode of venous thrombo-embolism (VTE), manifesting as deep venous thrombosis (DVT) and/or pulmonary embolism (PE).(1, 2). This amounts to about 20,000 cases, of which 80% occur during or soon after an admission to hospital.(1, 2) Including loss of productivity, total costs amount to well over AUS\$1 billion per year.(3)

There is evidence that the appropriate use of pharmacological and mechanical prophylaxis in orthopaedic, general surgical and medical patients can reduce the incidence of VTE,(4-6) although a recent paper has questioned use of pharmacological prophylaxis in lower risk medical patients.(7) Clinical practice guidelines (CPGs) have been developed, in Australia(8, 9) and elsewhere,(10, 11) to prevent VTE and to standardise the management of DVT and PE. Several initiatives have been undertaken to promote and facilitate their uptake, including implementation guides,(12) templates,(13) learning modules,(14) hospital medication self-assessments,(15) and patient information pamphlets.(16) However, despite these initiatives and the considerable harm from VTE, much of the care provided for VTE is not in line with CPGs (17) in both the developed (18) and developing worlds (19).

As healthcare is facing an affordability crisis, there is an urgent need to move towards being able to monitor the appropriateness of care ("care in line with evidence- or consensus-based guidelines").(20) The CareTrack Australia (CTA) study was designed to establish baseline estimates of the appropriateness of care delivered, at a population level, by a range of practitioners in real-world settings, and to determine what would be needed to monitor the ongoing appropriateness of care.(21) CTA showed that adult Australians received appropriate care for 22 common conditions at 57% of eligible healthcare encounters during 2009 and 2010; VTE compliance was reported at 58%.(22) The aim of this paper is to present and discuss the detailed CTA findings for VTE as a baseline for

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3 compliance with guidelines at a population level, from which to track progress resulting from  
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5 future interventions.  
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## 7 8 **METHODS** 9

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11 The CTA methods have been described in detail elsewhere.(21, 22) Some aspects of  
12  
13 relevance to VTE are summarised here.  
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### 15 16 **Development and ratification of indicators** 17

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19 An initial list of 15 indicators (with 54 sub-criteria) was sourced from  
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21 recommendations within the National Health and Medical Research Council guidelines(8, 9)  
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23 and sent to three practising specialist haematologists who were Heads of Departments,  
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25 asking them to comment on and rate each on a scale of 1 to 9 for appropriateness(23) in the  
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27 Australian context during 2009 and 2010. A two-round review process was used and a  
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29 formal process was employed for managing discrepancies between specialists.(21) Opinions  
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31 of other specialists were not canvassed for logistical reasons. This resulted in 39 indicators  
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33 being accepted as appropriate: 31 relating to pharmacological and mechanical prophylaxis  
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35 and eight to risk assessment, discharge care and management of DVT or PE (see Table 1).  
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### 39 40 **Recruitment of participants and healthcare providers** 41

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43 A sample designed to be representative of the Australian adult population was used.  
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45 Households were randomly selected from a phone directory (the Telstra White Pages) from  
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47 defined regions within New South Wales and South Australia and contacted using a  
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49 Computer-Assisted Telephone Interview (CATI).(21, 22) One adult was randomly selected  
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51 from each household and was asked to participate. Those who agreed were sent a mail  
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53 package containing information about the study and a consent form to allow access to their  
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55 medical records. Participants who provided consent were called back and asked if they had  
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57 been admitted overnight to a hospital or had one or more of the CTA conditions, and which  
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3 healthcare providers they had seen for these in 2009 and 2010. Hospitals identified by the  
4 participants were contacted and asked to provide their consent for medical record access.  
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6 Human Research Ethics Committee (HREC) approval was obtained from Hunter New  
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8 England Local Health District as the lead HREC and other relevant bodies and local  
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10 sites.(22)  
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## 12 13 14 **Review of medical records**

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17 Medical record reviews were undertaken for the 1,154 consenting participants whose  
18 healthcare providers had also provided consent. Healthcare encounters were deemed  
19 eligible for scoring of VTE indicators if a participant had been admitted overnight during 2009  
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21 and/or 2010.  
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26 Experienced registered nurses were recruited and trained as surveyors to conduct  
27 the medical record reviews using a web-based tool for on-site encrypted data collection.  
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29 They were provided with formal training and received a manual with detailed criteria for  
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31 inclusion, exclusion and scoring of indicators.  
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36 Estimates of compliance were measured as the percentage of eligible encounters for  
37 the VTE indicators that were answered 'yes'.(21, 22) The inclusion criteria for the indicators  
38 for VTE prophylaxis were specific to particular types of surgery (e.g. hip fracture surgery or  
39 abdominal surgery) or medical conditions (e.g. decompensated cardiac failure or acute on  
40 chronic lung disease).(8, 9) As the CTA study was designed to measure the overall  
41  
42 appropriateness of the healthcare delivered for 22 conditions and was not powered for  
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44 significant results at indicator level, the number of eligible encounters for many indicators  
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46 was low. To address this, indicators were aggregated into broader, clinically meaningful  
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48 categories. For example, orthopaedic conditions with pharmacological prophylaxis  
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50 (indicators 45-48) were grouped and included hip arthroplasty, hip fracture surgery, knee  
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52 arthroplasty, and lower limb fractures (see Table 1).  
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3 Data relating to documentation of VTE risk assessment (indicator 42) was not  
4 included in the analysis reported here, as a review of surveyor practices revealed that some  
5 had assumed that a risk assessment had been carried out whenever appropriate prophylaxis  
6 had been prescribed, whether or not explicit documentation of an assessment was found.  
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8 This was in breach of the criteria for this indicator, and these data were thus excluded.  
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## 13 **Statistical analysis**

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15 Mean compliance and associated 95% confidence intervals (using a modified version  
16 of the Clopper–Pearson (exact) method) were obtained using the SURVEYFREQ procedure  
17 in SAS version 9.3 for Windows (SAS Institute, Cary, NC, USA). To address biases arising  
18 from the study design (including adjustment for non-response), two different weighting  
19 options and five versions of weights (three based on approaches used in the similar US  
20 study(23)) were used to generate weighted estimates of compliances. These were not  
21 significantly different to unweighted compliances overall or for any condition (including VTE).  
22 Hence, unweighted compliances were used for this analysis.(22) Appendix 2 of the CTA  
23 study outlines the detailed methodology and overall results.(22)  
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## 36 **RESULTS**

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38 Of the 1,154 CTA participants, 481(42%) were admitted overnight to hospital at least  
39 once, with a total of 751 admissions eligible for assessment against the VTE indicators.  
40 There were 279 females (58%), and the mean age was 64 years (6% were aged 18 – 39,  
41 17% 40 – 54, 56% 55 – 74 and 21% were over 70 years of age).  
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49 Of the 35,145 CTA encounters (with duplicates and the risk indicator removed),  
50 1,078 (3%) were eligible for scoring against VTE indicators; the number of eligible  
51 encounters per indicator ranged from 2 - 84. Records were reviewed at 33 hospitals, with 27  
52 having eligible encounters. Eight of the hospitals had 50 or more eligible encounters.  
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3 Overall compliance with the VTE indicators was 51% (CI 95%: 47-54%), with results  
4 for aggregated sets of indicators ranging from 34 - 64% (Table 1). Omission of the risk  
5 assessment indicator from the overall score reduced compliance from the 58% reported  
6 originally(22) to the 51% reported here. For the eight hospitals with 50 or more eligible  
7 encounters, compliance ranged from 45 - 70%.  
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Table 1: CTA indicators (and aggregated sets of indicators) by compliance

Indicator Number	Indicator and sets of indicators	Eligible encounters (N)	Compliant encounters (N)	Compliance* (%)	95% confidence limits† (%)
45-48	Patients undergoing certain orthopaedic procedures or care received appropriate pharmacological anticoagulant therapy	55	34	62	48 - 75
45	Patients who had a hip arthroplasty have received anticoagulant therapy for up to 35 days‡	22	12	Insufficient data to report	
46	Patients who had hip fracture surgery have received anticoagulant therapies for up to 35 days§	2	2	Insufficient data to report	

47	Patients who had a knee arthroplasty received anticoagulant therapies for up to 28 days	24	16	Insufficient data to report	
48	Patients who had a lower limb fracture received anticoagulant therapies for at least 5 days or until fully mobile§	7	4	Insufficient data to report	
<b>62, 68-70, 73-75</b>	<b>Patients undergoing certain orthopaedic procedures or care received appropriate mechanical anticoagulant therapy</b>	<b>104</b>	<b>49</b>	<b>47</b>	<b>37 - 57</b>
62	Patients having a total hip replacement have been prescribed graduation compression stockings	20	19	Insufficient data to report	
68	Patients having a total hip replacement have been prescribed an intermittent pneumatic compression device	18	11	Insufficient data to report	
69	Patients having hip fracture surgery have been prescribed an intermittent pneumatic compression device	3	1	Insufficient data to report	
70	Patients having a total knee replacement have been prescribed an intermittent pneumatic compression device	21	15	Insufficient data to report	

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73	Patients having a total hip replacement have been prescribed a foot pump	18	1	Insufficient data to report	
74	Patients having a total knee replacement have been prescribed a foot pump	22	2	Insufficient data to report	
75	Patients having hip fracture surgery have been prescribed a foot pump	2	0	Insufficient data to report	
<b>49-54</b>	<b>Patients undergoing non-orthopaedic surgical procedures (general, gynaecological, abdominal, cardiac, thoracic or vascular, trauma or spinal surgery) or who had cancer and underwent surgery received appropriate pharmacological anticoagulant therapy</b>	<b>226</b>	<b>76</b>	<b>34</b>	<b>27 - 41</b>
49	Patients who had a general surgical procedure received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile	55	19	35	22 - 49

50	Patients who had gynaecological surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	26	5	Insufficient data to report	
51	Patients who had abdominal surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	61	29	48	18 - 78
52	Patients who had cardiac, thoracic or vascular surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	31	12	39	16 - 66
53	Patients who had trauma or spinal surgery received anticoagulant therapies commenced after primary haemostasis was established (unless contraindicated) until hospital discharge or fully mobile¶	18	0	Insufficient data to report	
54	Patients who have cancer that underwent surgery received one	35	11	31	5 - 74

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	of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶				
<b>63-67, 71-72</b>	<b>Patients undergoing non-orthopaedic surgical procedures received appropriate mechanical anticoagulant therapy</b>	<b>294</b>	<b>176</b>	<b>60</b>	<b>52 - 67</b>
63	Patients having general surgery have been prescribed graduated compression stockings	72	63	88	78 - 94
64	Patients having gynaecological surgery have been prescribed graduation compression stockings	28	21	Insufficient data to report	
65	Patients having abdominal surgery have been prescribed graduation compression stockings	66	48	73	46 - 91
66	Patients having cardiac, thoracic or vascular surgery have been prescribed graduation compression stockings	52	17	33	2 - 85
67	Patients having neurosurgery have been prescribed graduation compression stockings	13	11	Insufficient data to report	

71	Patients having cardiac, thoracic or vascular surgery have been prescribed an intermittent pneumatic compression device	50	7	14	2 - 41
72	Patients having neurosurgery have been prescribed an intermittent pneumatic compression devices	13	9	Insufficient data to report	
<b>55-61</b>	<b>Medical patients admitted to hospital with certain conditions received appropriate pharmacological anticoagulant therapy</b>	<b>167</b>	<b>77</b>	<b>46</b>	<b>36 - 57</b>
55	Medical patients admitted to hospital with ischemic stroke received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	5	1	Insufficient data to report	
56	Medical patients admitted to hospital with myocardial infarct (where full anticoagulant is not in use) received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	15	6	Insufficient data to report	

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57	General Medical patients admitted to hospital assessed as being at risk of VTE received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	84	43	51	40 - 62
58	Medical patients admitted to hospital with active cancer received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	23	8	Insufficient data to report	
59	Medical patients admitted to hospital with decompensated cardiac failure received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	7	3	Insufficient data to report	
60	Medical patients admitted to hospital with acute on chronic lung disease received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	31	15	48	30 - 67
61	Medical patients admitted to hospital with acute on chronic inflammatory disease received anticoagulant therapies until	2	1	Insufficient data to report	

	resolution of the acute medical illness or until hospital discharge††				
<b>76-80</b>	<b>Patients with suspected PE/DVT were managed with appropriate investigations, or had anticoagulant therapy commenced as soon as clinically suspected; or if PE/DVT confirmed, were managed appropriately</b>	<b>89</b>	<b>57</b>	<b>64</b>	<b>51 - 76</b>
76	Patients with a suspected DVT had a venous duplex ultrasound performed	12	10	Insufficient data to report	
77	Patients with a suspected PE had investigations performed††	21	17	Insufficient data to report	
78	Patients with a suspected DVT or PE where ultrasound was delayed, had anticoagulant therapy commenced (unless contraindicated) as soon as clinically suspected	10	8	Insufficient data to report	
79	Patients with a confirmed DVT / PE received anticoagulant therapies <sup>A</sup>	6	3	Insufficient data to report	

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80	Patients who were administered heparin therapy had it continued until the <i>International Normalized Ratio</i> (INR) had been therapeutic for 48 hours (INR range 2.0 - 3.0)	40	19	48	26 - 70
<b>Patients discharged on anticoagulant therapy have an appropriate documented care plan including details on the intended duration of treatment AND a review date<sup>B</sup></b>		70	32	46	31 - 61
43	Patients who are discharged on anticoagulant therapy have a documented care plan that includes details on the intended duration of treatment	73	43	59	46 - 71
44	Patients who are discharged on anticoagulant therapy have a documented care plan that includes a review date	70	35	50	29 - 71

Footnote:

† compliance and % compliance were not calculated for <30 encounters

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5 ‡ enoxaparin 40mg/day; dalteparin 5000u/day; low dose unfractionated heparin (LDUH) 5000u TDS; fondiparinux 2.5mg/day [commenced 6 –  
6 8 hours post op]; rivaroxaban[PO]; dabigatran [PO]  
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9 § enoxaparin 40mg/day; dalteparin 5000u/day; LDUH 5000u TDS; fondiparinux 2.5mg/day [commenced 6 – 8 hours post op]  
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11 || enoxaparin 40mg/day; dalteparin 5000u/day; LDUH 5000u TDS; fondiparinux 2.5mg/day [commenced 6 – 8 hours post op]; rivaroxaban[PO];  
12 dabigatran [PO]  
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14 ¶ enoxaparin 20mg/day; dalteparin 2500U/day  
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17 †† enoxaparin 40mg/day; dalteparin 5000U/day; LDUH 5000U BD or TDS; assumed implicit and explicit risk assessments included.  
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19 ‡‡ One of: ventilation perfusion scan; CT angiography; pulmonary angiography  
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21 A heparin administered together with warfarin for at least 5 days; unfractionated heparin IV (Activated Partial Thromboplastin Time (APTT)) or  
22 subcutaneous (dose/kg); Low Molecular Weight Heparin (LMWH) subcutaneously at least once daily.  
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24 B Compliance for this aggregated indicator was both indicators 43 and 44 were compliant for a participant in an episode of hospitalisation. In  
25 other aggregated indicators, compliance was measured by adding each individual encounter as each episode of hospitalisation was an  
26 independent event.  
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## DISCUSSION

Despite the prevalence, cost, morbidity and mortality associated with VTE, prophylaxis and treatment is often not in line with CPGs. This analysis of CTA data has shown that our sample of 481 Australian adults in 27 hospitals received appropriate care for VTE during 2009 and 2010 at 51% of eligible healthcare encounters.

CTA patients who had surgery received appropriate pharmacological or mechanical anticoagulant therapy on only 39% and 57% of occasions respectively (aggregations from Table 1). The ENDORSE study, a multi-national cross-sectional survey, also examined the proportion of at-risk patients who received effective prophylaxis.<sup>(17)</sup> It found, for 804 patients from eight Australian hospitals studied in 2006-07, that 82% of at-risk surgical patients received appropriate prophylaxis. This study did not separate pharmacological and mechanical prophylaxis.<sup>(17)</sup> Baseline (pre-intervention) compliances for surgical patients were also higher than CTA compliances in two single hospital studies (65 and 74% for pharmacological prophylaxis and 89 and 64% for mechanical prophylaxis).<sup>(24, 25)</sup> Possible reasons for the lower CTA compliances are that CTA was a population-based study at 27 hospitals which were effectively randomly selected, whilst ENDORSE mainly collected data from prominent teaching hospitals, and the two single hospital studies were about to start an intervention for VTE prophylaxis, possibly raising awareness of the problem.

In contrast, the CTA compliance for at-risk medical patients at 46% (aggregations from Table 1) was similar to those in the eight Australian ENDORSE hospitals and a regional hospital (51%, and 64%, respectively).<sup>(17, 25)</sup> Lower compliances for medical than surgical patients in the ENDORSE study and the regional hospital are consistent with the more complex indications in medical patients, and have been noted elsewhere.<sup>(26)</sup> No equivalent Australian studies could be found for indicators associated with management of suspected or confirmed DVT or PE (CTA compliance 64%), or patients with a documented discharge

1 plan and a date for cessation of treatment (CTA compliance 46%), but it would seem  
2 reasonable to conclude that both of these areas of practice also require attention.  
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6 The risk assessment indicator was studied in two Australian single-hospital studies  
7 which both found 0% compliance at the pre-intervention stage, with modest post-intervention  
8 increases to 28 and 36%.(24, 27)  
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12 The poor compliances with VTE indicators in Australia are consistent with the lack of  
13 a system-wide approach. Compliance measures or outcomes are not publicly reported at  
14 hospital level,(28) VTE is not included in national standards,(29) nor is it a national health  
15 care goal.(30) Australian clinicians have identified that setting agreement on clinical  
16 guidelines and standards (agreement on risk categories, risk assessment tools, mandatory  
17 actions and protocols, provision of summaries), decision-support tools, and reporting results  
18 are enablers to delivering appropriate VTE care.(31, 32) The fact that compliance ranged  
19 from 45% to 70% between hospitals suggests that some facilities are faring better than  
20 others at managing VTE appropriately.  
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## 23 **Strengths and weaknesses**

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25 The key strength of the CTA study is that it is designed to be representative of the  
26 Australian population rather than a convenience- or purposive-based sample. However, an  
27 unavoidable consequence of this strategy, coupled with finite research funds, is that the  
28 numbers of participants and/or eligible encounters are low for some indicators; 25 of 38 had  
29 insufficient data to report. Findings for these must be disregarded or interpreted with caution.  
30 The review of medical records, while costly and difficult, allowed compliance to be measured  
31 in a real world setting and avoided the limitations inherent in asking health care providers to  
32 respond to clinical vignettes(33, 34) or questionnaires.(35) Accordingly CTA provides some  
33 baseline estimates for compliance against which progress on the provision of appropriate  
34 care for VTE could be compared and tracked.  
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1 The approach used was associated with a high rate of attrition of potential  
2 participants and several sources of possible bias. However, weighting using two methods  
3 and five different options made no significant difference to the overall compliance  
4 percentage, or that for VTE;(22) this is consistent with providers not altering their clinical  
5 practices for patients of different ages, gender, or socio-economic or health literacy status.  
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11 Commentators have raised issues with respect to the levels of evidence, choice of  
12 indicators, effects of comorbidities, inter-rater reliability, and the possibility of care having  
13 been provided but not recorded.(36, 37) These have all been addressed:(22, 38)  
14 compliance was shown to be no different for consensus-based and evidence-based  
15 recommendations; the CTA indicators were designed to be clinically relevant but not affected  
16 by comorbidities; inter-rater reliability was moderate, but was in line with other studies using  
17 implicit medical record review;(38) and the effect on overall compliance of care received but  
18 not documented is thought to be no more than 10%.(23, 39, 40)  
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## 30 CONCLUSION

31 Our analysis of the VTE indicators from the CTA study show that compliance is  
32 modest at 51%, despite resources and guidelines being available, and the high associated  
33 cost and burden of disease. This is consistent with the lack of a system-wide focus on VTE.  
34 In line with recommendations arising from the overall CTA study and feedback from  
35 clinicians, the challenge is to now move towards agreement on national clinical standards  
36 and on the development of indicators and tools to guide, document and monitor the  
37 appropriateness of care for VTE. An inclusive, national wiki-based process for achieving this  
38 has been proposed.(20) VTE data could then be monitored at hospital level and the data  
39 aggregated at national level to track progress and inform policy.  
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## CONTRIBUTORSHIP STATEMENT

I confirm that all listed authors have contributed substantially to the conception and design of the study, or acquisition of data or analysis and interpretation of the finding. All have also been actively involved in either the drafting of the manuscript or revising it critically for important intellectual content; and have given approval for this version to be published.

Peter D Hibbert was Program Manager for the NHMRC Program Grant who also assisted with the analysis and interpretation of findings and made a substantial contribution to review the literature, synthesising results and findings from other relevant studies, and the drafting of the manuscript.

Natalie A Hannaford was responsible for the selection, development and ratification of all the indicators used in the study and assisted Tamara Hunt with surveyor recruitment and training. She also contributed to the revision of the manuscript.

Tamara D Hooper was the Project Manager for CareTrack and coordinated the data collection for the entire study including the extraction of patient medical records. She also coordinated all the necessary approvals and managed the training and performance of surveyors and contributed to the revision of the manuscript.

Diane M Hindmarsh was the main Statistician for CareTrack and undertook analysis of the CareTrack. She also contributed to the interpretation of the statistical information included in the manuscript.

Jeffrey Braithwaite was involved in the design and conception of CareTrack Australia as the Chief Investigator-A of the NHMRC Program Grant, and extensive editing and revision of the manuscript.

Shanthi Ramanathan developed the initial sampling plan for CareTrack Australia; provided advice for the process of recruiting participants and organised and managed telephone recruiters.

1 Nicholas Wickham was involved as a CareTrack Australia clinical expert, assisted in  
2 the ratification of the SSI indicators and provided clinical input into the editing and revision of  
3 the manuscript.  
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7 William B Runciman was the primary instigator of CareTrack and responsible for its  
8 conception and design. He was also involved in all aspects of the project from data collection  
9 to analysis and interpretation of findings. He has been heavily involved in the editing and  
10 revision of the manuscript providing invaluable advice and guidance to the corresponding  
11 author.  
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## 17 **COMPETING INTERESTS**

18 The authors have no competing interests.  
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## 26 **DATA SHARING STATEMENT**

27 There are no additional available data to be published  
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## 30 **REFERENCES**

- 31 1. Heit JA. The epidemiology of venous thromboembolism in the community: implications for  
32 prevention and management. *J Thromb Thrombolysis*. 2006;21(1):23-9.
- 33 2. University of Western Australia. The incidence and risk factors for venous thromboembolism  
34 in hospitals in Western Australia 1999–2001. National Institute of Clinical Studies; 2005.
- 35 3. Access Economics. The burden of venous thromboembolism in Australia. Report for the  
36 Australia and New Zealand Working Party on the Management and Prevention of Venous  
37 Thromboembolism; 2008.
- 38 4. Palmer AJ, Koppenhagen K, Kirchhof B, Weber U, Bergemann R. Efficacy and safety of low  
39 molecular weight heparin, unfractionated heparin and warfarin for thrombo-embolism prophylaxis  
40 in orthopaedic surgery: a meta-analysis of randomised clinical trials. *Haemostasis*. 1997;27(2):75-84.
- 41 5. Palmer AJ, Schramm W, Kirchhof B, Bergemann R. Low molecular weight heparin and  
42 unfractionated heparin for prevention of thrombo-embolism in general surgery: a meta-analysis of  
43 randomised clinical trials. *Haemostasis*. 1997;27(2):65-74.
- 44 6. Kanaan AO, Silva MA, Donovan JL, Roy T, Al-Homsi AS. Meta-analysis of venous  
45 thromboembolism prophylaxis in medically ill patients. *Clin Ther*. 2007;29(11):2395-405.  
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- 1 7. Flanders SA, Greene M, Grant P, et al. Hospital performance for pharmacologic venous  
2 thromboembolism prophylaxis and rate of venous thromboembolism : A cohort study. *JAMA Internal*  
3 *Medicine*. 2014.
- 4 8. The Australian and New Zealand Working Party on the Management and Prevention of  
5 Venous Thromboembolism. Best Practice Guidelines for Australia and New Zealand Health Education  
6 and Management Innovations. 4th Edition. 2007.
- 7 9. National Health and Medical Research Council. Clinical practice guideline for the prevention  
8 of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted  
9 to Australian hospitals. Melbourne: National Health and Medical Research Council, 2009.
- 10 10. National Institute for Clinical Excellence. CG92 Venous thromboembolism - reducing the risk:  
11 full guideline. NICE; 2010.
- 12 11. Hirsh J, Guyatt G, Albers GW, Harrington R, Schünemann HJ. Antithrombotic and  
13 thrombolytic therapy\*: American college of chest physicians evidence-based clinical practice  
14 guidelines (8th edition). *CHEST Journal*. 2008;133(6\_suppl):110S-2S.
- 15 12. National Health and Medical Research Council. Stop the Clot: Integrating VTE prevention  
16 guideline recommendations into routine hospital care. Melbourne: National Health and Medical  
17 Research Council, 2011.
- 18 13. Australian Commission on Safety and Quality in Health Care. Template for hospital venous  
19 thromboembolism prophylaxis policy. Sydney: ACSQHC, 2011.
- 20 14. National Prescribing Service. QUM for health professional students learning objectives 2013  
21 [cited 2013 6th May]. Available from: [http://www.nps.org.au/health-professionals/professional-](http://www.nps.org.au/health-professionals/professional-development/online-learning/qum-for-health-professional-students-learning-objectives)  
22 [development/online-learning/qum-for-health-professional-students-learning-objectives](http://www.nps.org.au/health-professionals/professional-development/online-learning/qum-for-health-professional-students-learning-objectives).
- 23 15. Clinical Excellence Commission. Medication Safety SELF ASSESSMENT for Antithrombotic  
24 Therapy in Australian Hospitals. Sydney: New South Wales Therapeutic Advisory Group, 2007.
- 25 16. National Health and Medical Research Council. Blood Clots: reducing your risk. In: NHMRC,  
26 editor. 2010.
- 27 17. Cohen AT, Tapson VF, Bergmann JF, Goldhaber SZ, Kakkar AK, Deslandes B, et al. Venous  
28 thromboembolism risk and prophylaxis in the acute hospital care setting (ENDORSE study): a  
29 multinational cross-sectional study. *Lancet*. 2008;371(9610):387-94.
- 30 18. Golian M, Moussa M, White C, Aletta G, Koley L, Seifer C. Venous Thromboembolism  
31 Prophylaxis on a Cardiology In-Patient Unit: A Surprising Result? *The Canadian journal of cardiology*.  
32 2015.
- 33 19. Atmakusuma TD, Tambunan KL, Sukrisman L, Effendi S, Rachman A, Setiawati A, et al.  
34 Underutilization of anticoagulant for venous thromboembolism prophylaxis in three hospitals in  
35 Jakarta. *Acta medica Indonesiana*. 2015;47(2):136-45.
- 36 20. Runciman WB, Coiera EW, Day RO, Hannaford NA, Hibbert PD, Hunt TD, et al. Towards the  
37 delivery of appropriate health care in Australia. *Med J Aust*. 2012;197(2):78-81.
- 38 21. Hunt TD, Ramanathan SA, Hannaford NA, Hibbert PD, Braithwaite J, Coiera E, et al. CareTrack  
39 Australia: assessing the appropriateness of adult healthcare: protocol for a retrospective medical  
40 record review. *BMJ Open*. 2012;18(2):2011-000665.
- 41 22. Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, et al.  
42 CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust*.  
43 2012;197(2):100-5.
- 44 23. McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, et al. The quality of health  
45 care delivered to adults in the United States. *N Engl J Med*. 2003;348(26):2635-45.

- 1 24. Duff J, Walker K, Omari A. Translating venous thromboembolism (VTE) prevention evidence  
2 into practice: a multidisciplinary evidence implementation project. *Worldviews Evid Based Nurs*.  
3 2011;8(1):30-9.
- 4 25. Liu DS, Lee MM, Spelman T, MacIsaac C, Cade J, Harley N, et al. Medication chart  
5 intervention improves inpatient thromboembolism prophylaxis. *Chest*. 2012;141(3):632-41.
- 6 26. Pow RE, Vale PR. Thromboprophylaxis in patients undergoing total hip and knee  
7 arthroplasty: a review of current practices in an Australian teaching hospital. *Intern Med J*.  
8 2015;45(3):293-9.
- 9 27. Li F, Walker K, McInnes E, Duff J. Testing the effect of a targeted intervention on nurses'  
10 compliance with "best practice" mechanical venous thromboembolism prevention. *J Vasc Nurs*.  
11 2010;28(3):92-6.
- 12 28. National Health Performance Authority. My Hospitals 2013 [cited 2013 15th August].  
13 Available from: <http://www.myhospitals.gov.au/>.
- 14 29. Australian Commission on Safety and Quality in Health Care. National Safety and Quality  
15 Health Service Standards. Sydney: ACSQHC, 2011.
- 16 30. Australian Commission on Safety and Quality in Health Care. Overview of the Australian  
17 Safety and Quality Goals for Health Care. Sydney: ACSQHC, 2011.
- 18 31. National Health and Medical Research Council. Venous Thromboembolism Prevention Policy  
19 Summit May 2010: Summary Report. Melbourne: National Health and Medical Research Council,  
20 2011.
- 21 32. National Health and Medical Research Council. Preventing Venous Thromboembolism in  
22 hospitalised patients. Summary of NHMRC Activity 2003-2010. NHMRC, 2011.
- 23 33. Johnson MJD, Sheard LD, Maraveyas AD, Noble SD, Prout HM, Watt IP, et al. Diagnosis and  
24 management of people with venous thromboembolism and advanced cancer: how do doctors  
25 decide? a qualitative study. *BMC Med Inform Decis Mak*. 2012;12(1):75.
- 26 34. Bikdeli B, Sharif-Kashani B, Raeissi S, Ehteshami-Afshar S, Behzadnia N, Masjedi MR. Chest  
27 physicians' knowledge of appropriate thromboprophylaxis: insights from the PROMOTE study. *Blood*  
28 *Coagul Fibrinolysis*. 2011;22(8):667-72.
- 29 35. de Franciscis S, Agus GB, Bisacci R, Botta G, Gasbarro V, Domanin M, et al. Guidelines for  
30 venous thromboembolism and clinical practice in Italy: a nationwide survey. *Ann Vasc Surg*.  
31 2008;22(3):319-27.
- 32 36. Ackermann E. Barriers to "appropriate care" in general practice. *Med J Aust*. 2012;197(2):76.
- 33 37. Scott IA, Del Mar CB. A dog walking on its hind legs? Implications of the CareTrack study.  
34 *Med J Aust*. 2012;197(2):67-8.
- 35 38. Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, et al.  
36 CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust*.  
37 2012;197(10):549-50.
- 38 39. Dresselhaus TR, Luck J, Peabody JW. The ethical problem of false positives: a prospective  
39 evaluation of physician reporting in the medical record. *Journal of medical ethics*. 2002;28(5):291-4.
- 40 40. Luck J, Peabody JW. Using standardised patients to measure physicians' practice: validation  
41 study using audio recordings. *Bmj*. 2002;325(7366):679.

## STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation	
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	We have described a retrospective medical review in the Methods of the Abstract.
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	The abstract outlines the key definition of the dependent variable used, the indicator review process, sampling aim, medical record review, data collection timeframe; and the abstract results outlining the quantum of data collected, overall result and range.
<b>Introduction</b>			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	See Introduction with particular attention to the third paragraph.
Objectives	3	State specific objectives, including any prespecified hypotheses	See last paragraph of the Introduction.
<b>Methods</b>			
Study design	4	Present key elements of study design early in the paper	See Methods section including sub-sections Development and ratification of indicators, Recruitment of participants and healthcare providers, Review of medical records, and Statistical analysis. More detail is provided in the referenced protocol paper and main CareTrack Australia results paper (references 19 and 20).
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	Settings, locations, and relevant dates – see sub-section Recruitment of participants and healthcare providers in the Methods. Data collection – see Review of medical records in the Methods. More detail is provided in the referenced protocol paper and main CareTrack Australia results paper (references 19 and 20).
Participants	6	(a) <i>Cohort study</i> —Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up (b) <i>Case-control study</i> —Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of	Cross-sectional study – the eligibility criteria, sources and methods of selecting participants is outlined in the sub-section “Recruitment of participants and healthcare

		cases and controls <i>Cross-sectional study</i> —Give the eligibility criteria, and the sources and methods of selection of participants	providers” in the Methods. More detail is provided in the referenced protocol paper and main CareTrack results paper (references 19 and 20).
		(b) <i>Cohort study</i> —For matched studies, give matching criteria and number of exposed and unexposed <i>Case-control study</i> —For matched studies, give matching criteria and the number of controls per case	Not applicable
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	See Table 1 for descriptions of the indicators used.
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	The sub-section Development and ratification of indicators in the Methods outlines the process for developing the indicators. The sub-section Review of medical records in the Methods outlines the assessment method.
Bias	9	Describe any efforts to address potential sources of bias	Potential sources of bias are outlined in the Strengths and Weaknesses section of the Discussion. Weighting is discussed in the sub-section Statistical Analysis in the Methods.
Study size	10	Explain how the study size was arrived at	See first paragraph of the sub-section Review of medical records in the Methods. More detail is provided in the referenced protocol paper.
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	See third paragraph of the sub-section Review of medical records in the Methods for explanation of how the variables were aggregated. These variables are reported in Table 1.
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	See Statistical Analysis in the Methods.
		(b) Describe any methods used to examine subgroups and interactions	Not applicable.
		(c) Explain how missing data were addressed	See second paragraph of the Results.

		<p>(d) <i>Cohort study</i>—If applicable, explain how loss to follow-up was addressed</p> <p><i>Case-control study</i>—If applicable, explain how matching of cases and controls was addressed</p> <p><i>Cross-sectional study</i>—If applicable, describe analytical methods taking account of sampling strategy</p>	<p>See Statistical Analysis subsection in the Methods for weighting process. See Appendix 2 of the CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.</p>
		<p>(e) Describe any sensitivity analyses</p>	<p>See Statistical Analysis subsection in the Methods for weighting process. See Appendix 2 of the main CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.</p>

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Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	See first two paragraphs of the Results section. More details are available in the Results section of the CareTrack Australia study (reference 20).
		(b) Give reasons for non-participation at each stage	See first paragraph of the Results section. More details are available in the Results section of the CareTrack Australia study (reference 20).
		(c) Consider use of a flow diagram	Flow diagrams are provided in the protocol paper (reference 19) regarding stage design and the CareTrack Australia study (reference 20) for non-participation.
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	See first paragraph of the Results section.
		(b) Indicate number of participants with missing data for each variable of interest	Not applicable
		(c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)	Not applicable
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time	Not applicable
		<i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure	
		<i>Cross-sectional study</i> —Report numbers of outcome events or summary measures	See Results.
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	See Results.
		(b) Report category boundaries when continuous variables were categorized	Not applicable
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	Not applicable
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	See Statistical Analysis sub-section in the Methods for weighting process. See Appendix 2 of the CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.
Discussion			
Key results	18	Summarise key results with reference to study	See first paragraph of the Discussion.

		objectives	
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	See Strengths and Weaknesses sub-section of the Discussion.
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	See first paragraph of the Results and the Conclusion for interpretation of results; in the second, third, and fourth paragraphs of the Discussion, our results are compared with other Australian studies and potential reasons for differences.
Generalisability	21	Discuss the generalisability (external validity) of the study results	Firstly, we have compared at indicator or aggregated indicator level, our results with other Australian results in the second, third, and fourth paragraphs of the Discussion; we have discussed broader policy developments and their limitations related to our results in the fifth paragraph of the Results. Despite our sample being collected from a large number of hospitals (27), we have been cautious in generalising to the wider population.
<b>Other information</b>			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	See Funding section.

\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at [www.strobe-statement.org](http://www.strobe-statement.org).

# BMJ Open

## Assessing the appropriateness of prevention and management of venous thromboembolism in Australia: a cross-sectional study

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# Full title: Assessing the appropriateness of prevention and management of venous thromboembolism in Australia: a cross-sectional study

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**Word count:** 2,279 (not including title page, abstract, references, figures and tables)

**Abstract word count:** 290

## ABSTRACT

### Objectives

The prevention and management of venous thromboembolism (VTE) is often at variance with guidelines. The CareTrack Australia (CTA) study reported that appropriate care (in line with evidence- or consensus-based guidelines) is being provided for VTE at just over half of eligible encounters. The aim of this paper is to present and discuss the detailed CTA findings for VTE as a baseline for compliance with guidelines at a population level.

### Setting

The setting was 27 hospitals in two states of Australia.

### Participants

A sample of participants designed to be representative of the Australian population was recruited. Participants who had been admitted overnight during 2009 and/or 2010 were eligible. Of the 1,154 CTA participants, 481(42%) were admitted overnight to hospital at least once, comprising 751 admissions. There were 279 females (58%), and the mean age was 64 years.

### Primary and secondary outcome measures

The primary measure was compliance with indicators of appropriate care for VTE. The indicators were extracted from Australian VTE clinical practice guidelines and ratified by experts. Participants' medical records from 2009 and 2010 were analysed for compliance with 38 VTE indicators.

### Results

Of the 35,145 CTA encounters, 1,078 (3%) were eligible for scoring against VTE indicators. There were 2 - 84 eligible encounters per indicator at 27 hospitals. Overall compliance with indicators for VTE was 51%, and ranged from 34 - 64% for aggregated sets of indicators.

## Conclusions

The prevention and management of VTE was appropriate for only half of the at-risk patients in our sample; this provides a baseline for tracking progress nationally. There is a need for national and, ideally, international agreement on clinical standards, indicators and tools to guide, document and monitor care for VTE, and for measures to increase their uptake, particularly where deficiencies have been identified.

## ARTICLE SUMMARY

### Strengths and weaknesses of this study

- The study is designed to be representative of the Australian population rather than a convenience- or purposive-based sample.
- The review of medical records, while costly and difficult, allowed compliance to be measured in a real world setting.
- Numbers of participants and/or eligible encounters are low for some indicators.
- There was a high rate of attrition of potential participants and several sources of possible bias. However, weighting using two methods and five different options made no significant difference to the compliance percentage.

## INTRODUCTION

Each year in Australia about 1 in every 1,000 people develop a first episode of venous thrombo-embolism (VTE), manifesting as deep venous thrombosis (DVT) and/or pulmonary embolism (PE).(1, 2). This amounts to about 20,000 cases, of which 80% occur during or soon after an admission to hospital.(1, 2) Including loss of productivity, total costs amount to well over AUS\$1 billion per year.(3)

There is evidence that the appropriate use of pharmacological and mechanical prophylaxis in orthopaedic, general surgical and medical patients can reduce the incidence of VTE,(4-6) although a recent paper has questioned use of pharmacological prophylaxis in lower risk medical patients.(7) Clinical practice guidelines (CPGs) have been developed, in Australia(8, 9) and elsewhere,(10, 11) to prevent VTE and to standardise the management of DVT and PE. Several initiatives have been undertaken to promote and facilitate their uptake, including implementation guides,(12) templates,(13) learning modules,(14) hospital medication self-assessments,(15) and patient information pamphlets.(16) However, despite these initiatives and the considerable harm from VTE, much of the care provided for VTE is not in line with CPGs (17) in both the developed (18) and developing worlds (19).

As healthcare is facing an affordability crisis, there is an urgent need to move towards being able to monitor the appropriateness of care (“care in line with evidence- or consensus-based guidelines”).(20) The CareTrack Australia (CTA) study was designed to establish baseline estimates of the appropriateness of care delivered, at a population level, by a range of practitioners in real-world settings, and to determine what would be needed to monitor the ongoing appropriateness of care.(21) CTA showed that adult Australians received appropriate care for 22 common conditions at 57% of eligible healthcare encounters during 2009 and 2010; VTE compliance was reported at 58%.(22) The aim of this paper is to present and discuss the detailed CTA findings for VTE as a baseline for

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3 compliance with guidelines at a population level, from which to track progress resulting from  
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5 future interventions.  
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## 7 8 **METHODS** 9

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11 The CTA methods have been described in detail elsewhere.(21, 22) Some aspects of  
12  
13 relevance to VTE are summarised here.  
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### 15 16 **Development and ratification of indicators** 17

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19 An initial list of 15 indicators (with 54 sub-criteria) was sourced from  
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21 recommendations within the National Health and Medical Research Council guidelines(8, 9)  
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23 and sent to three practising specialist haematologists who were Heads of Departments,  
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25 asking them to comment on and rate each on a scale of 1 to 9 for appropriateness(23) in the  
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27 Australian context during 2009 and 2010. A two-round review process was used and a  
28  
29 formal process was employed for managing discrepancies between specialists.(21) Opinions  
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31 of other specialists were not canvassed for logistical reasons. This resulted in 39 indicators  
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33 being accepted as appropriate: 31 relating to pharmacological and mechanical prophylaxis  
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35 and eight to risk assessment, discharge care and management of DVT or PE (see Table 1).  
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### 39 40 **Recruitment of participants and healthcare providers** 41

42  
43 A sample designed to be representative of the Australian adult population was used.  
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45 Households were randomly selected from a phone directory (the Telstra White Pages) from  
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47 defined regions within New South Wales and South Australia and contacted using a  
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49 Computer-Assisted Telephone Interview (CATI).(21, 22) One adult was randomly selected  
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51 from each household and was asked to participate. Those who agreed were sent a mail  
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53 package containing information about the study and a consent form to allow access to their  
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55 medical records. Participants who provided consent were called back and asked if they had  
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57 been admitted overnight to a hospital or had one or more of the CTA conditions, and which  
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3 healthcare providers they had seen for these in 2009 and 2010. Hospitals identified by the  
4 participants were contacted and asked to provide their consent for medical record access.  
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6 Human Research Ethics Committee (HREC) approval was obtained from Hunter New  
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8 England Local Health District as the lead HREC and other relevant bodies and local  
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10 sites.(22)  
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## 12 13 14 **Review of medical records**

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17 Medical record reviews were undertaken for the 1,154 consenting participants whose  
18 healthcare providers had also provided consent. Healthcare encounters were deemed  
19 eligible for scoring of VTE indicators if a participant had been admitted overnight during 2009  
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21 and/or 2010.  
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26 Experienced registered nurses were recruited and trained as surveyors to conduct  
27 the medical record reviews using a web-based tool for on-site encrypted data collection.  
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29 They were provided with formal training and received a manual with detailed criteria for  
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31 inclusion, exclusion and scoring of indicators.  
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36 Estimates of compliance were measured as the percentage of eligible encounters for  
37 the VTE indicators that were answered 'yes'.(21, 22) The inclusion criteria for the indicators  
38 for VTE prophylaxis were specific to particular types of surgery (e.g. hip fracture surgery or  
39 abdominal surgery) or medical conditions (e.g. decompensated cardiac failure or acute on  
40 chronic lung disease).(8, 9) As the CTA study was designed to measure the overall  
41  
42 appropriateness of the healthcare delivered for 22 conditions and was not powered for  
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44 significant results at indicator level, the number of eligible encounters for many indicators  
45  
46 was low. To address this, indicators were aggregated into broader, clinically meaningful  
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48 categories. For example, orthopaedic conditions with pharmacological prophylaxis  
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50 (indicators 45-48) were grouped and included hip arthroplasty, hip fracture surgery, knee  
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52 arthroplasty, and lower limb fractures (see Table 1).  
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3 Data relating to documentation of VTE risk assessment (indicator 42) was not  
4 included in the analysis reported here, as a review of surveyor practices revealed that some  
5 had assumed that a risk assessment had been carried out whenever appropriate prophylaxis  
6 had been prescribed, whether or not explicit documentation of an assessment was found.  
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8 This was in breach of the criteria for this indicator, and these data were thus excluded.  
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## 13 **Statistical analysis**

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15 Mean compliance and associated 95% confidence intervals (using a modified version  
16 of the Clopper–Pearson (exact) method) were obtained using the SURVEYFREQ procedure  
17 in SAS version 9.3 for Windows (SAS Institute, Cary, NC, USA). To address biases arising  
18 from the study design (including adjustment for non-response), two different weighting  
19 options and five versions of weights (three based on approaches used in the similar US  
20 study(23)) were used to generate weighted estimates of compliances. These were not  
21 significantly different to unweighted compliances overall or for any condition (including VTE).  
22 Hence, unweighted compliances were used for this analysis.(22) Appendix 2 of the CTA  
23 study outlines the detailed methodology and overall results.(22)  
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## 36 **RESULTS**

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38 Of the 1,154 CTA participants, 481(42%) were admitted overnight to hospital at least  
39 once, with a total of 751 admissions eligible for assessment against the VTE indicators.  
40 There were 279 females (58%), and the mean age was 64 years (6% were aged 18 – 39,  
41 17% 40 – 54, 56% 55 – 74 and 21% were over 70 years of age).  
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49 Of the 35,145 CTA encounters (with duplicates and the risk indicator removed),  
50 1,078 (3%) were eligible for scoring against VTE indicators; the number of eligible  
51 encounters per indicator ranged from 2 - 84. Records were reviewed at 33 hospitals, with 27  
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3 Overall compliance with the VTE indicators was 51% (CI 95%: 47-54%), with results  
4 for aggregated sets of indicators ranging from 34 - 64% (Table 1). Omission of the risk  
5 assessment indicator from the overall score reduced compliance from the 58% reported  
6 originally(22) to the 51% reported here. For the eight hospitals with 50 or more eligible  
7 encounters, compliance ranged from 45 - 70%.  
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Table 1: CTA indicators (and aggregated sets of indicators) by compliance

Indicator Number	Indicator and sets of indicators	Eligible encounters (N)	Compliant encounters (N)	Compliance* (%)	95% confidence limits† (%)
45-48	Patients undergoing certain orthopaedic procedures or care received appropriate pharmacological anticoagulant therapy	55	34	62	48 - 75
45	Patients who had a hip arthroplasty have received anticoagulant therapy for up to 35 days‡	22	12	Insufficient data to report	
46	Patients who had hip fracture surgery have received anticoagulant therapies for up to 35 days§	2	2	Insufficient data to report	

47	Patients who had a knee arthroplasty received anticoagulant therapies for up to 28 days	24	16	Insufficient data to report	
48	Patients who had a lower limb fracture received anticoagulant therapies for at least 5 days or until fully mobile§	7	4	Insufficient data to report	
<b>62, 68-70, 73-75</b>	<b>Patients undergoing certain orthopaedic procedures or care received appropriate mechanical anticoagulant therapy</b>	<b>104</b>	<b>49</b>	<b>47</b>	<b>37 - 57</b>
62	Patients having a total hip replacement have been prescribed graduation compression stockings	20	19	Insufficient data to report	
68	Patients having a total hip replacement have been prescribed an intermittent pneumatic compression device	18	11	Insufficient data to report	
69	Patients having hip fracture surgery have been prescribed an intermittent pneumatic compression device	3	1	Insufficient data to report	
70	Patients having a total knee replacement have been prescribed an intermittent pneumatic compression device	21	15	Insufficient data to report	

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73	Patients having a total hip replacement have been prescribed a foot pump	18	1	Insufficient data to report	
74	Patients having a total knee replacement have been prescribed a foot pump	22	2	Insufficient data to report	
75	Patients having hip fracture surgery have been prescribed a foot pump	2	0	Insufficient data to report	
<b>49-54</b>	<b>Patients undergoing non-orthopaedic surgical procedures (general, gynaecological, abdominal, cardiac, thoracic or vascular, trauma or spinal surgery) or who had cancer and underwent surgery received appropriate pharmacological anticoagulant therapy</b>	<b>226</b>	<b>76</b>	<b>34</b>	<b>27 - 41</b>
49	Patients who had a general surgical procedure received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile	55	19	35	22 - 49

50	Patients who had gynaecological surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	26	5	Insufficient data to report	
51	Patients who had abdominal surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	61	29	48	18 - 78
52	Patients who had cardiac, thoracic or vascular surgery received anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶	31	12	39	16 - 66
53	Patients who had trauma or spinal surgery received anticoagulant therapies commenced after primary haemostasis was established (unless contraindicated) until hospital discharge or fully mobile¶	18	0	Insufficient data to report	
54	Patients who have cancer that underwent surgery received one	35	11	31	5 - 74

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	of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile¶				
<b>63-67, 71-72</b>	<b>Patients undergoing non-orthopaedic surgical procedures received appropriate mechanical anticoagulant therapy</b>	<b>294</b>	<b>176</b>	<b>60</b>	<b>52 - 67</b>
63	Patients having general surgery have been prescribed graduated compression stockings	72	63	88	78 - 94
64	Patients having gynaecological surgery have been prescribed graduation compression stockings	28	21	Insufficient data to report	
65	Patients having abdominal surgery have been prescribed graduation compression stockings	66	48	73	46 - 91
66	Patients having cardiac, thoracic or vascular surgery have been prescribed graduation compression stockings	52	17	33	2 - 85
67	Patients having neurosurgery have been prescribed graduation compression stockings	13	11	Insufficient data to report	

71	Patients having cardiac, thoracic or vascular surgery have been prescribed an intermittent pneumatic compression device	50	7	14	2 - 41
72	Patients having neurosurgery have been prescribed an intermittent pneumatic compression devices	13	9	Insufficient data to report	
<b>55-61</b>	<b>Medical patients admitted to hospital with certain conditions received appropriate pharmacological anticoagulant therapy</b>	<b>167</b>	<b>77</b>	<b>46</b>	<b>36 - 57</b>
55	Medical patients admitted to hospital with ischemic stroke received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	5	1	Insufficient data to report	
56	Medical patients admitted to hospital with myocardial infarct (where full anticoagulant is not in use) received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge <sup>††</sup>	15	6	Insufficient data to report	

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57	General Medical patients admitted to hospital assessed as being at risk of VTE received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	84	43	51	40 - 62
58	Medical patients admitted to hospital with active cancer received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	23	8	Insufficient data to report	
59	Medical patients admitted to hospital with decompensated cardiac failure received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	7	3	Insufficient data to report	
60	Medical patients admitted to hospital with acute on chronic lung disease received anticoagulant therapies until resolution of the acute medical illness or until hospital discharge††	31	15	48	30 - 67
61	Medical patients admitted to hospital with acute on chronic inflammatory disease received anticoagulant therapies until	2	1	Insufficient data to report	

	resolution of the acute medical illness or until hospital discharge††				
<b>76-80</b>	<b>Patients with suspected PE/DVT were managed with appropriate investigations, or had anticoagulant therapy commenced as soon as clinically suspected; or if PE/DVT confirmed, were managed appropriately</b>	<b>89</b>	<b>57</b>	<b>64</b>	<b>51 - 76</b>
76	Patients with a suspected DVT had a venous duplex ultrasound performed	12	10	Insufficient data to report	
77	Patients with a suspected PE had investigations performed††	21	17	Insufficient data to report	
78	Patients with a suspected DVT or PE where ultrasound was delayed, had anticoagulant therapy commenced (unless contraindicated) as soon as clinically suspected	10	8	Insufficient data to report	
79	Patients with a confirmed DVT / PE received anticoagulant therapies <sup>A</sup>	6	3	Insufficient data to report	

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80	Patients who were administered heparin therapy had it continued until the <i>International Normalized Ratio</i> (INR) had been therapeutic for 48 hours (INR range 2.0 - 3.0)	40	19	48	26 - 70
<b>Patients discharged on anticoagulant therapy have an appropriate documented care plan including details on the intended duration of treatment AND a review date<sup>B</sup></b>		70	32	46	31 - 61
43	Patients who are discharged on anticoagulant therapy have a documented care plan that includes details on the intended duration of treatment	73	43	59	46 - 71
44	Patients who are discharged on anticoagulant therapy have a documented care plan that includes a review date	70	35	50	29 - 71

Footnote:

† compliance and % compliance were not calculated for <30 encounters

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5 ‡ enoxaparin 40mg/day; dalteparin 5000u/day; low dose unfractionated heparin (LDUH) 5000u TDS; fondaparinux 2.5mg/day [commenced 6 –  
6 8 hours post op]; rivaroxaban[PO]; dabigatran [PO]  
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9 § enoxaparin 40mg/day; dalteparin 5000u/day; LDUH 5000u TDS; fondaparinux 2.5mg/day [commenced 6 – 8 hours post op]  
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11 || enoxaparin 40mg/day; dalteparin 5000u/day; LDUH 5000u TDS; fondaparinux 2.5mg/day [commenced 6 – 8 hours post op]; rivaroxaban[PO];  
12 dabigatran [PO]  
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14 ¶ enoxaparin 20mg/day; dalteparin 2500U/day  
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17 †† enoxaparin 40mg/day; dalteparin 5000U/day; LDUH 5000U BD or TDS; assumed implicit and explicit risk assessments included.  
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19 ‡‡ One of: ventilation perfusion scan; CT angiography; pulmonary angiography  
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21 A heparin administered together with warfarin for at least 5 days; unfractionated heparin IV (Activated Partial Thromboplastin Time (APTT)) or  
22 subcutaneous (dose/kg); Low Molecular Weight Heparin (LMWH) subcutaneously at least once daily.  
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24 B Compliance for this aggregated indicator was both indicators 43 and 44 were compliant for a participant in an episode of hospitalisation. In  
25 other aggregated indicators, compliance was measured by adding each individual encounter as each episode of hospitalisation was an  
26 independent event.  
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## DISCUSSION

Our analysis of CTA data has shown that a sample of 481 Australian adults in 27 hospitals received appropriate care for VTE during 2009 and 2010 at only 51% of eligible healthcare encounters, in spite of considerable efforts to promote and facilitate the uptake of CPGs in Australia.(12-16) Thus despite the prevalence, cost, morbidity and mortality associated with VTE and PE, prophylaxis and treatment are still in line with CPGs only half the time. This continues to be a problem in both the developed and developing worlds.(17-19)

CTA patients who had surgery received appropriate pharmacological or mechanical anticoagulant therapy on only 39% and 57% of occasions respectively (aggregations from Table 1). The ENDORSE study, a multi-national cross-sectional survey, also examined the proportion of at-risk patients who received effective prophylaxis.(17) It found, for 804 patients from eight Australian hospitals studied in 2006-07, that 82% of at-risk surgical patients received appropriate prophylaxis. This study did not separate pharmacological and mechanical prophylaxis.(17) Baseline (pre-intervention) compliances for surgical patients were also higher than CTA compliances in two single hospital studies (65 and 74% for pharmacological prophylaxis and 89 and 64% for mechanical prophylaxis).(24, 25) Possible reasons for the lower CTA compliances are that CTA was a population-based study at 27 hospitals which were effectively randomly selected, whilst ENDORSE mainly collected data from prominent teaching hospitals, and the two single hospital studies were about to start an intervention for VTE prophylaxis, and had possibly raised awareness of the problem.

In contrast, the CTA compliance for at-risk medical patients at 46% (aggregations from Table 1) was similar to those in the eight Australian ENDORSE hospitals and a regional hospital (51%, and 64%, respectively).(17, 25) Lower compliances for medical than surgical patients in the ENDORSE study and the regional hospital are consistent with the more

1 complex indications in medical patients, and have been noted elsewhere.(26) No equivalent  
2  
3 Australian studies could be found for indicators associated with management of suspected  
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5 or confirmed DVT or PE (CTA compliance 64%), or patients with a documented discharge  
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7 plan and a date for cessation of treatment (CTA compliance 46%), but it would seem  
8  
9 reasonable to conclude that both of these areas of practice also require attention.  
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12 The risk assessment indicator was studied in two Australian single-hospital studies  
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14 which both found 0% compliance at the pre-intervention stage, with modest post-intervention  
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16 compliances of 28 and 36%.(24, 27)  
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19 The poor compliances with VTE indicators in Australia are consistent with the lack of  
20  
21 a system-wide approach. Compliance measures or outcomes are not publicly reported at  
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23 hospital level,(28) VTE is not included in national standards,(29) nor is it a national health  
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25 care goal.(30) Australian clinicians have identified that setting agreement on clinical  
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27 guidelines and standards (agreement on risk categories, risk assessment tools, mandatory  
28  
29 actions and protocols, provision of summaries), decision-support tools, and reporting results  
30  
31 are enablers to delivering appropriate VTE care.(31, 32) The fact that compliance ranged  
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33 from 45% to 70% between hospitals suggests that some facilities are faring better than  
34  
35 others at managing VTE appropriately.  
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## 38 **Strengths and weaknesses**

39  
40 The key strength of the CTA study is that it is designed to be representative of the  
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42 Australian population to minimise selection bias, rather than a convenience- or purposive-  
43  
44 based sample. However, an unavoidable consequence of this strategy, coupled with finite  
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46 research funds, is that the numbers of participants and/or eligible encounters are low for  
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48 some indicators; 25 of 38 had insufficient data to report. Findings for these must be  
49  
50 disregarded or interpreted with caution. The review of medical records, while costly and  
51  
52 difficult, allowed compliance to be measured in a real world setting and avoided the  
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54 limitations inherent in asking health care providers to respond to clinical vignettes(33, 34) or  
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1 questionnaires.(35) Errors arising from measurement (information bias) were within  
2  
3 acceptable limits for implicit review.(36-38) Accordingly CTA provides some baseline  
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5 estimates for compliance against which progress on the provision of appropriate care for  
6  
7 VTE could be compared and tracked.  
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10 The approach used was associated with a high rate of attrition of potential  
11 participants and several other sources of possible bias. Although it was not logistically  
12 feasible to design sampling so as to eliminate all possible confounders (confusion bias) or  
13 have the sample characteristics to exactly match the Australian population, weighting using  
14 two methods and five different options made no significant difference to the overall  
15 compliance percentage, or that for VTE;(22) this is consistent with providers not altering their  
16 clinical practices for patients of different ages, gender, or socio-economic or health literacy  
17 status.  
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27 Commentators have raised issues with respect to the levels of evidence for and  
28 choice of indicators, effects of comorbidities, inter-rater reliability, and the possibility of care  
29 having been provided but not recorded.(36, 37) These have all been addressed:(22, 38)  
30 compliance was shown to be no different for consensus-based and evidence-based  
31 recommendations; the CTA indicators were designed to be clinically relevant but not affected  
32 by comorbidities; inter-rater reliability was moderate, but was in line with other studies using  
33 implicit medical record review;(38) and the effect on overall compliance of care received but  
34 not documented is thought to be no more than 10%.(23, 39, 40)  
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## 45 CONCLUSION

46 Our analysis of the VTE indicators from the CTA study show that compliance is  
47 modest at 51%, despite resources and guidelines being available, and the high associated  
48 cost and burden of disease. This is consistent with the lack of a system-wide focus on VTE  
49 in Australia as is the case in most of the rest of the world. In line with recommendations  
50 arising from the overall CTA study and feedback from clinicians, the challenge is to now  
51 move towards agreement on national clinical standards and on the development of  
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1 indicators and tools to guide, document and monitor the appropriateness of care for VTE. An  
2 inclusive, national wiki-based process for achieving this has been proposed.(20) VTE data  
3 could then be monitored at hospital level and the data aggregated at national and, potentially  
4 at international levels to track progress and inform policy.  
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## 10 **ACKNOWLEDGEMENTS**

11 We thank the participants, healthcare providers, practice managers, medical records  
12 staff and expert reviewers who generously gave their time and expertise.  
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## 18 **CONTRIBUTORSHIP STATEMENT**

19 I confirm that all listed authors have contributed substantially to the conception and  
20 design of the study, or acquisition of data or analysis and interpretation of the finding. All  
21 have also been actively involved in either the drafting of the manuscript or revising it critically  
22 for important intellectual content; and have given approval for this version to be published.  
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29 Peter D Hibbert was Program Manager for the NHMRC Program Grant who also  
30 assisted with the analysis and interpretation of findings and made a substantial contribution  
31 to review the literature, synthesising results and findings from other relevant studies, and the  
32 drafting of the manuscript.  
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38 Natalie A Hannaford was responsible for the selection, development and ratification  
39 of all the indicators used in the study and assisted Tamara Hooper with surveyor recruitment  
40 and training. She also contributed to the revision of the manuscript.  
41  
42  
43

44 Tamara Hooper was the Project Manager for CareTrack and coordinated the data  
45 collection for the entire study including the extraction of patient medical records. She also  
46 coordinated all the necessary approvals and managed the training and performance of  
47 surveyors and contributed to the revision of the manuscript.  
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52 Diane M Hindmarsh was the main Statistician for CareTrack and undertook analysis  
53 of the CareTrack. She also contributed to the interpretation of the statistical information  
54 included in the manuscript.  
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1 Jeffrey Braithwaite was involved in the design and conception of CareTrack Australia  
2 as the Chief Investigator-A of the NHMRC Program Grant, and extensive editing and  
3 revision of the manuscript.  
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5  
6

7 Shanthi Ramanathan developed the initial sampling plan for CareTrack Australia;  
8 provided advice for the process of recruiting participants and organised and managed  
9 telephone recruiters.  
10  
11  
12

13 Nicholas Wickham was involved as a CareTrack Australia clinical expert, assisted in  
14 the ratification of the SSI indicators and provided clinical input into the editing and revision of  
15 the manuscript.  
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19 William B Runciman was the primary instigator of CareTrack and responsible for its  
20 conception and design. He was also involved in all aspects of the project from data collection  
21 to analysis and interpretation of findings. He has been heavily involved in the editing and  
22 revision of the manuscript providing invaluable advice and guidance to the corresponding  
23 author.  
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## 30 **COMPETING INTERESTS**

31 The authors have no competing interests.  
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37  
38

## 39 **DATA SHARING STATEMENT**

40 There are no additional available data to be published  
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## 44 **REFERENCES**

- 45 1. Heit JA. The epidemiology of venous thromboembolism in the community: implications for  
46 prevention and management. *J Thromb Thrombolysis*. 2006;21(1):23-9.
  - 47 2. University of Western Australia. The incidence and risk factors for venous thromboembolism  
48 in hospitals in Western Australia 1999–2001. National Institute of Clinical Studies; 2005.
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3. Access Economics. The burden of venous thromboembolism in Australia. Report for the Australia and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism; 2008.
4. Palmer AJ, Kopenhagen K, Kirchhof B, Weber U, Bergemann R. Efficacy and safety of low molecular weight heparin, unfractionated heparin and warfarin for thrombo-embolism prophylaxis in orthopaedic surgery: a meta-analysis of randomised clinical trials. *Haemostasis*. 1997;27(2):75-84.
5. Palmer AJ, Schramm W, Kirchhof B, Bergemann R. Low molecular weight heparin and unfractionated heparin for prevention of thrombo-embolism in general surgery: a meta-analysis of randomised clinical trials. *Haemostasis*. 1997;27(2):65-74.
6. Kanaan AO, Silva MA, Donovan JL, Roy T, Al-Homsi AS. Meta-analysis of venous thromboembolism prophylaxis in medically ill patients. *Clin Ther*. 2007;29(11):2395-405.
7. Flanders SA, Greene M, Grant P, et al. Hospital performance for pharmacologic venous thromboembolism prophylaxis and rate of venous thromboembolism : A cohort study. *JAMA Internal Medicine*. 2014.
8. The Australian and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism. Best Practice Guidelines for Australia and New Zealand Health Education and Management Innovations. 4th Edition. 2007.
9. National Health and Medical Research Council. Clinical practice guideline for the prevention of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to Australian hospitals. Melbourne: National Health and Medical Research Council, 2009.
10. National Institute for Clinical Excellence. CG92 Venous thromboembolism - reducing the risk: full guideline. NICE; 2010.
11. Hirsh J, Guyatt G, Albers GW, Harrington R, Schünemann HJ. Antithrombotic and thrombolytic therapy\*: American college of chest physicians evidence-based clinical practice guidelines (8th edition). *CHEST Journal*. 2008;133(6\_suppl):110S-2S.
12. National Health and Medical Research Council. Stop the Clot: Integrating VTE prevention guideline recommendations into routine hospital care. Melbourne: National Health and Medical Research Council, 2011.
13. Australian Commission on Safety and Quality in Health Care. Template for hospital venous thromboembolism prophylaxis policy. Sydney: ACSQHC, 2011.
14. National Prescribing Service. QUM for health professional students learning objectives 2013 [cited 2013 6th May]. Available from: <http://www.nps.org.au/health-professionals/professional-development/online-learning/qum-for-health-professional-students-learning-objectives>.
15. Clinical Excellence Commission. Medication Safety SELF ASSESSMENT for Antithrombotic Therapy in Australian Hospitals. Sydney: New South Wales Therapeutic Advisory Group, 2007.
16. National Health and Medical Research Council. Blood Clots: reducing your risk. In: NHMRC, editor. 2010.
17. Cohen AT, Tapson VF, Bergmann JF, Goldhaber SZ, Kakkar AK, Deslandes B, et al. Venous thromboembolism risk and prophylaxis in the acute hospital care setting (ENDORSE study): a multinational cross-sectional study. *Lancet*. 2008;371(9610):387-94.
18. Golian M, Moussa M, White C, Aletta G, Koley L, Seifer C. Venous Thromboembolism Prophylaxis on a Cardiology In-Patient Unit: A Surprising Result? *The Canadian journal of cardiology*. 2015.
19. Atmakusuma TD, Tambunan KL, Sukrisman L, Effendi S, Rachman A, Setiawati A, et al. Underutilization of anticoagulant for venous thromboembolism prophylaxis in three hospitals in Jakarta. *Acta medica Indonesiana*. 2015;47(2):136-45.

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20. Runciman WB, Coiera EW, Day RO, Hannaford NA, Hibbert PD, Hunt TD, et al. Towards the delivery of appropriate health care in Australia. *Med J Aust*. 2012;197(2):78-81.
21. Hunt TD, Ramanathan SA, Hannaford NA, Hibbert PD, Braithwaite J, Coiera E, et al. CareTrack Australia: assessing the appropriateness of adult healthcare: protocol for a retrospective medical record review. *BMJ Open*. 2012;18(2):2011-000665.
22. Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, et al. CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust*. 2012;197(2):100-5.
23. McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348(26):2635-45.
24. Duff J, Walker K, Omari A. Translating venous thromboembolism (VTE) prevention evidence into practice: a multidisciplinary evidence implementation project. *Worldviews Evid Based Nurs*. 2011;8(1):30-9.
25. Liu DS, Lee MM, Spelman T, MacIsaac C, Cade J, Harley N, et al. Medication chart intervention improves inpatient thromboembolism prophylaxis. *Chest*. 2012;141(3):632-41.
26. Pow RE, Vale PR. Thromboprophylaxis in patients undergoing total hip and knee arthroplasty: a review of current practices in an Australian teaching hospital. *Intern Med J*. 2015;45(3):293-9.
27. Li F, Walker K, McInnes E, Duff J. Testing the effect of a targeted intervention on nurses' compliance with "best practice" mechanical venous thromboembolism prevention. *J Vasc Nurs*. 2010;28(3):92-6.
28. National Health Performance Authority. My Hospitals 2013 [cited 2013 15th August]. Available from: <http://www.myhospitals.gov.au/>.
29. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: ACSQHC, 2011.
30. Australian Commission on Safety and Quality in Health Care. Overview of the Australian Safety and Quality Goals for Health Care. Sydney: ACSQHC, 2011.
31. National Health and Medical Research Council. Venous Thromboembolism Prevention Policy Summit May 2010: Summary Report. Melbourne: National Health and Medical Research Council, 2011.
32. National Health and Medical Research Council. Preventing Venous Thromboembolism in hospitalised patients. Summary of NHMRC Activity 2003-2010. NHMRC, 2011.
33. Johnson MJD, Sheard LD, Maraveyas AD, Noble SD, Prout HM, Watt IP, et al. Diagnosis and management of people with venous thromboembolism and advanced cancer: how do doctors decide? a qualitative study. *BMC Med Inform Decis Mak*. 2012;12(1):75.
34. Bikdeli B, Sharif-Kashani B, Raeissi S, Ehteshami-Afshar S, Behzadnia N, Masjedi MR. Chest physicians' knowledge of appropriate thromboprophylaxis: insights from the PROMOTE study. *Blood Coagul Fibrinolysis*. 2011;22(8):667-72.
35. de Franciscis S, Agus GB, Bisacci R, Botta G, Gasbarro V, Domanin M, et al. Guidelines for venous thromboembolism and clinical practice in Italy: a nationwide survey. *Ann Vasc Surg*. 2008;22(3):319-27.
36. Ackermann E. Barriers to "appropriate care" in general practice. *Med J Aust*. 2012;197(2):76.
37. Scott IA, Del Mar CB. A dog walking on its hind legs? Implications of the CareTrack study. *Med J Aust*. 2012;197(2):67-8.

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38. Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, et al. CareTrack: assessing the appropriateness of health care delivery in Australia. *Med J Aust*. 2012;197(10):549-50.
39. Dresselhaus TR, Luck J, Peabody JW. The ethical problem of false positives: a prospective evaluation of physician reporting in the medical record. *Journal of medical ethics*. 2002;28(5):291-4.
40. Luck J, Peabody JW. Using standardised patients to measure physicians' practice: validation study using audio recordings. *Bmj*. 2002;325(7366):679.

For peer review only

## STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation	
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	We have described a retrospective medical review in the Methods of the Abstract.
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	The abstract outlines the key definition of the dependent variable used, the indicator review process, sampling aim, medical record review, data collection timeframe; and the abstract results outlining the quantum of data collected, overall result and range.
<b>Introduction</b>			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	See Introduction with particular attention to the third paragraph.
Objectives	3	State specific objectives, including any prespecified hypotheses	See last paragraph of the Introduction.
<b>Methods</b>			
Study design	4	Present key elements of study design early in the paper	See Methods section including sub-sections Development and ratification of indicators, Recruitment of participants and healthcare providers, Review of medical records, and Statistical analysis. More detail is provided in the referenced protocol paper and main CareTrack Australia results paper (references 19 and 20).
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	Settings, locations, and relevant dates – see sub-section Recruitment of participants and healthcare providers in the Methods. Data collection – see Review of medical records in the Methods. More detail is provided in the referenced protocol paper and main CareTrack Australia results paper (references 19 and 20).
Participants	6	(a) <i>Cohort study</i> —Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up (b) <i>Case-control study</i> —Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of	Cross-sectional study – the eligibility criteria, sources and methods of selecting participants is outlined in the sub-section “Recruitment of participants and healthcare

		cases and controls <i>Cross-sectional study</i> —Give the eligibility criteria, and the sources and methods of selection of participants	providers” in the Methods. More detail is provided in the referenced protocol paper and main CareTrack results paper (references 19 and 20).
		(b) <i>Cohort study</i> —For matched studies, give matching criteria and number of exposed and unexposed <i>Case-control study</i> —For matched studies, give matching criteria and the number of controls per case	Not applicable
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	See Table 1 for descriptions of the indicators used.
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	The sub-section Development and ratification of indicators in the Methods outlines the process for developing the indicators. The sub-section Review of medical records in the Methods outlines the assessment method.
Bias	9	Describe any efforts to address potential sources of bias	Potential sources of bias are outlined in the Strengths and Weaknesses section of the Discussion. Weighting is discussed in the sub-section Statistical Analysis in the Methods.
Study size	10	Explain how the study size was arrived at	See first paragraph of the sub-section Review of medical records in the Methods. More detail is provided in the referenced protocol paper.
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	See third paragraph of the sub-section Review of medical records in the Methods for explanation of how the variables were aggregated. These variables are reported in Table 1.
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	See Statistical Analysis in the Methods.
		(b) Describe any methods used to examine subgroups and interactions	Not applicable.
		(c) Explain how missing data were addressed	See second paragraph of the Results.

		<p>(d) <i>Cohort study</i>—If applicable, explain how loss to follow-up was addressed</p> <p><i>Case-control study</i>—If applicable, explain how matching of cases and controls was addressed</p> <p><i>Cross-sectional study</i>—If applicable, describe analytical methods taking account of sampling strategy</p>	<p>See Statistical Analysis subsection in the Methods for weighting process. See Appendix 2 of the CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.</p>
		<p>(e) Describe any sensitivity analyses</p>	<p>See Statistical Analysis subsection in the Methods for weighting process. See Appendix 2 of the main CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.</p>

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Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	See first two paragraphs of the Results section. More details are available in the Results section of the CareTrack Australia study (reference 20).
		(b) Give reasons for non-participation at each stage	See first paragraph of the Results section. More details are available in the Results section of the CareTrack Australia study (reference 20).
		(c) Consider use of a flow diagram	Flow diagrams are provided in the protocol paper (reference 19) regarding stage design and the CareTrack Australia study (reference 20) for non-participation.
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	See first paragraph of the Results section.
		(b) Indicate number of participants with missing data for each variable of interest	Not applicable
		(c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)	Not applicable
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time	Not applicable
		<i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure	
		<i>Cross-sectional study</i> —Report numbers of outcome events or summary measures	See Results.
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	See Results.
		(b) Report category boundaries when continuous variables were categorized	Not applicable
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	Not applicable
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	See Statistical Analysis sub-section in the Methods for weighting process. See Appendix 2 of the CareTrack Australia study (reference 20) for a detailed description of the methodology and results of the weighting process.
Discussion			
Key results	18	Summarise key results with reference to study	See first paragraph of the Discussion.

		objectives	
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	See Strengths and Weaknesses sub-section of the Discussion.
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	See first paragraph of the Results and the Conclusion for interpretation of results; in the second, third, and fourth paragraphs of the Discussion, our results are compared with other Australian studies and potential reasons for differences.
Generalisability	21	Discuss the generalisability (external validity) of the study results	Firstly, we have compared at indicator or aggregated indicator level, our results with other Australian results in the second, third, and fourth paragraphs of the Discussion; we have discussed broader policy developments and their limitations related to our results in the fifth paragraph of the Results. Despite our sample being collected from a large number of hospitals (27), we have been cautious in generalising to the wider population.
<b>Other information</b>			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	See Funding section.

\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at [www.strobe-statement.org](http://www.strobe-statement.org).