Author response. Thank you for your thoughtful comments. Having spent more than 36 years in clinical practice, I am aware of and understand the barriers that arise when perioperative nurses and others attempt to implement best practices. The recommended practices implementation guides being published in the AORN Journal are designed to assist perioperative nurses with implementing AORN recommended practices in diverse settings. Your comment regarding the importance of proper and thorough assessment of risk factors and the usefulness of an algorithm or checklist is right on point. I would encourage you to consider developing this kind of assessment tool. As stated in the article, “Many health care organizations are willing to share the documents they have developed and are currently using. Teaching universities (even if not close by) are excellent resources.”\(^1\)

I also agree with your statement about the need for access to proper measuring devices to ensure proper fit of graduated compression stockings. As stated in the article, decreasing the potential for complications when the patient is receiving mechanical prophylaxis “will be much easier if there are sufficient sizes and quantities of devices, measuring tools, and any other supplies that may be required. These items must be conveniently located to allow for ease of application and use.”\(^1\)

One of our most important tasks as nurses is patient education. Each encounter with a patient provides an opportunity for teaching, and as you have stated, providing education regarding thromboembolism prophylaxis on the day of surgery may be too late. As stated in the article, Patient education and discharge planning for surgical procedures begins in the preoperative phase of care with the initial visit to the physician’s office and continues throughout the scheduling procedure, diagnostic testing, the preadmission interview, and the preanesthesia assessment.\(^1\)

I would add that patient and family member education should continue until the patient is discharged and also during the postoperative recovery period.

Implementing the AORN recommended practices for prevention of DVT presents a unique opportunity to build collaboration within and beyond the facility setting and to make certain that evidence-based practices are understood and followed by all clinical practitioners. Perioperative RNs can take an active role in DVT prevention by providing a careful and thorough preoperative assessment, advocating for patients through collaboration with professional colleagues, and educating patients as to the necessity of compliance with prophylactic treatments.

Continuous application of intermittent pneumatic compression devices

I was delighted that you chose deep vein thrombosis (DVT) prevention to kick off your new series of recommended practices summaries\(^1\) and implementation guides.\(^2\) I would like to see more information on the need for continuous intervention throughout the hospital stay, particularly as it concerns intermittent pneumatic compression (IPC) devices. I believe that

Reference
we should strive to maintain continuous application of IPCs from the OR to the postanesthesia care unit (PACU) to the short-term postoperative location, be that the hospital or home. Although we’ve had access to this technology for decades, a 2010 study by the Agency for Healthcare Research and Quality verified that pulmonary embolism, a consequence of DVT, remains the most common preventable cause of hospital death in the United States.\(^3\) In many hospitals, IPCs are properly placed before induction of anesthesia but, at the end of surgery, the IPCs are discontinued for periods of minutes to hours while the patient makes his or her way through recovery and to the acute care ward.

As your excellent author, Sharon Van Wicklin, MSN, RN, CNOR, CRNFA, CPSN, PLNC, has noted in a previous publication, about half of health care-associated DVTs begin in the OR itself, and the vast majority form within two days after surgery.\(^4\) Patient and family education can address patient compliance with IPC use when the patient is alert and oriented, but we in the perioperative arena must be their advocates until that time. I worry that we have become overconfident in the efficacy of pharmacologic prophylaxis; studies show that this is effective no more than two-thirds of the time\(^5\) and can lead to increased bleeding while affecting only one limb (ie, hypercoagulability) of Virchow’s triad. It requires little of us to address the other two limbs of the triad (ie, venous stasis and vessel wall damage) by ensuring continuity of IPC use, which keeps blood in motion, stimulates endogenous fibrinolysis, and causes an increase in circulating tissue plasminogen activator without causing an increase in surgical and postoperative bleeding.\(^6\)

Given that IPCs should not be used for patients with existing DVTs, that up to 90% of DVTs are clinically silent,\(^4\) and that DVTs can form in minutes, by discontinuing and reinitiating IPCs between the OR and PACU, and between the PACU and the next destination, we are potentially setting up our patients for showers of clots. I would be delighted to see more research in this area and to see AORN incorporate guidelines addressing this concern in future recommended practices. AORN

DOUGLAS BURNS
BSN, RN, CNOR, CRNFA
CLINICAL MANAGER OF SURGICAL SERVICES
ST DAVID’S SOUTH AUSTIN MEDICAL CENTER
AUSTIN, TX
doi: 10.1016/j.aorn.2012.03.003

References

Resources
Summerfield DL. Decreasing the incidence of deep vein thrombosis through the use of prophylaxis. AORN J. 2006;84(4):642-645.


Author response. Thank you for your insightful comments regarding the recommended practices implementation article.¹ The hospital patient scenario was included in the article to address the need for nurses to provide patient and family member education as a means to prevent situations wherein IPC devices are disconnected for periods of time. As patient advocates, perioperative RNs should ensure that IPC devices are used continuously from induction until the patient is alert and ambulating.

SHARON A. VAN WICKLIN
MSN, RN, CNOR, CRNFA, CPSN, PLNC
PERIOPERATIVE NURSING SPECIALIST
AORN, INC
DENVER, CO
doi: 10.1016/j.aorn.2012.03.004

Reference

The AORN Journal welcomes letters for its “Letters to the Editor” column. Letters must refer to Journal articles or columns published within the preceding six months. All letters are subject to editing for length and clarity before publication. Authors of articles or columns referenced in the letter to the editor may be given the opportunity to respond.

Letters that are included in the “Letters to the Editor” column must contain the writer’s name; credentials if applicable; position or title; and employer’s name, city, and state.

Please submit letters by e-mail to aornjournal@aorn.org and reference “Letter to the Editor” in the subject line, or submit letters by mail to AORN Journal, Letters to the Editor, 2170 S Parker Rd, Suite 400, Denver, CO 80231-5711.