

IPC Training and Implementation

Frances Harrington

Stroke specialist consultant at Royal Cornwall Hospitals NHS Trust

The Stroke Team at RCHT participated in CLOTS 1 and 2, though not CLOTS 3. After hearing results of CLOTS 3 at the European Stroke Conference in 2013, we decided to introduce this service on our acute stroke unit. We wrote draft guidelines and started using IPC in late 2013.

The NHS Improving Quality Programme and SW strategic network obtained pump priming funding for IPC for all SW stroke units. This allowed us to expand provision to our 2 community rehabilitation units.

An audit in December 2013 found 73% had IPC prescribed. Reasons for lack of prescription included patient refusal, lack of equipment and end of life care. Nurses' main concerns included poor patient tolerance especially in confused patients.

A tick on the prescription chart does not mean good concordance. Our audit in 2015, showed IPC prescribed in 91% (acute unit) and 75% (community) but in place and working in 41% and 10%. We found IPC not reapplied after therapy or personal care and staff fatigue after repeated patient intolerance. We trained all staff using the STARS Module (Reducing the Risk of VTE). Root cause analysis in cases of Hospital Acquired Thrombosis (HAT) was introduced.

IPC boots are now part of our acute stroke protocol. Our new acute stroke nursing service provides 24/7 care to patients arriving via ED. They prescribe IPC electronically and fit IPC on arrival. We have an IPC patient information leaflet.

Our latest audit shows 100% prescription and concordance in patients with indication for IPC. About half had IPC, the rest had valid exclusions -peripheral vascular disease, anticoagulated for AF, high falls risk, end of life care or normal mobility.

We still face challenges. IPC are not always put on properly or the wrong size is used, they can be left off after care. The tubing is often discarded when the sleeves become dirty, so we run out of equipment at times. Some patients do not like the boots, despite explanation of benefits, especially overnight and they can be a tripping hazard in confused patients. We use IPC for the length of the hospital stay if patients remain immobile, rather than stop at 30 days as per CLOTS 3.

Our top tips

Incorporate IPC into local guidelines

Spot audits to monitor compliance

Regular training for all staff - STARS Advancing Module (Reducing Risk of VTE)

Electronic prescribing

Feedback from root cause analysis for HAT

RCHT Use of Intermittent Pneumatic Compression in Stroke Patients

