Affix Patient Label here or record:

Name: _____

NHS No: | | | | | | | | | | |

Hosp No: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y Male ☐ Female ☐

WARD: CONS:

NHS
Worcestershire Acute Hospitals
NHS Trust

VENOUS THROMBOEMBOLISM
(VTE) RISK ASSESSMENT all patients ≥16

Person Completing the Risk Assessment						
	Date	Time	Name	Prof. Reg. No.	Job Title	Signature
Initial (<12Hr)						
24Hr (18 - 36Hr)						

Step One - Assess Mobility. Tick one box.					
Surgical Patients	☐	Medical patient expected to have ongoing reduced mobility relative to normal state	☐	Medical patient NOT expected to have significantly reduced mobility relative to normal state	☐
Assess for thrombosis and bleeding risk below.				**Risk assessment now complete.** Sign below.	

Step Two – Assess Thrombosis Risk. Thromboprophylaxis indicated if one or more boxes are ticked					
Patient Related (Tick if present)	Initial	24Hr	Admission related (Tick if present)	Initial	24Hr
Active cancer or cancer treatment			Significant or likely reduced mobility for >3 days		
Age>60			Surgery with significant reduction in mobility		
Dehydration			Total anaesthetic + surgical time >90 minutes		
Known thrombophilia			Hip or knee replacement within last 12 weeks		
Obesity (BMI >30kg/m2)			Hip fracture within last 12 weeks		
One or more significant medical comorbidities e.g. cardiac, metabolic, endocrine, respiratory, acute Infectious, inflammatory conditions)			Surgery involving the pelvis or lower limb with total anaesthetic + surgical time >60 minutes		
Personal history or first-degree relative with a history of VTE			Acute surgical admission with inflammatory or intra-abdominal condition		
Use of systemic hormone replacement therapy			Critical care admission		
Varicose veins with phlebitis			Pregnancy or <6 weeks post-partum		
Use of oestrogen-containing contraceptives			Any additional VTE risks considered significant by clinicians		
None of the above apply	☐	☐		☐	☐

Step Three - Assess Bleeding Risk. Relative contraindication to pharmacological thromboprophylaxis if one or more of these boxes are ticked. See over for action*					
Patient Related (Tick if present)	Initial	24Hr	Admission Related (Tick if present)	Initial	24Hr
Active bleeding			Neurosurgery, spinal or eye surgery		
Acquired bleeding disorders			Other procedures with high bleeding risk		
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands disease)			Lumbar puncture/epidural/spinal anaesthesia expected in the next 12 hours or performed in the previous 4 hours		
Acute stroke			Concurrent use of anticoagulants		
Thrombocytopenia (platelets <75x10^9/L)			Uncontrolled systolic hypertension(230/120mmHg or higher)		
			Any additional bleeding risks considered significant by clinicians		
None of the above apply	☐	☐		☐	☐

Clinical decision regarding Thromboprophylaxis	Initial	24Hr
No Thromboprophylaxis prescribed (Based on senior clinical advice or speciality specific pathway e.g. in gynaecology).		
Enoxaparin		
Alternative anticoagulant		
Mechanical thromboprophylaxis (See over for contraindications for mechanical thromboprophylaxis)		

***Reassess the risks within 24 hours, once every week & if significant change occurs to the clinical condition**

Venous Thromboembolism Risk assessment (Initial & 24 hours)

Affix Patient Label here or record

NAME: . . . . . .

NHS NO: | | | | | | | | | | |

HOSP NO: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

Venous Thromboembolism (VTE) FAQ

Which patient needs VTE risk assessed / re-assessed?

All patients, older than 16 years, who are admitted require VTE and bleeding risk assessment on admission, within 24 hours of admission and whenever the clinical situation changes. The risk should be reassessed at least once every week thereafter, where applicable using a new form, by writing the number of days from admission (e.g. day 7) in the box where it says 'initial'.

This form should be used on all patients except pregnant patients then use form WR2068

Who can carry out VTE risk assessment & complete this form?

A qualified medical professional or qualified prescriber (nurse/pharmacist/other) can carry out VTE Risk assessment using this form.

What is used for pharmacological prophylaxis?

The standard pharmacological prophylaxis is enoxaparin subcutaneously:

Weight	<50kg	50-100kg	100-150kg	>150KG
Enoxaparin dose	20mg OD	40mg OD*	40mg BD*	60mg BD*

*If renal function is normal.

If Creatinine Clearance<30ml/minute use

Creatinine clearance 15-30ml/minute	enoxaparin 20mg subcutaneously OD
Creatinine clearance <15ml/minute	Unfractionated Heparin calcium 5000units subcutaneously BD while inpatient (If require on discharge discuss with a consultant haematologist).

If Heparin contraindicated use

Due to religious reasons	fondaparinux 2.5mg OD subcutaneously
Due to allergic reasons or needle phobia in adults aged >18 years**	rivaroxaban 10mg OD

If a patient is already on, or is started on an alternative anticoagulant*, then they do not require additional pharmacological prophylaxis.
* apixaban, edoxaban, rivaroxaban, dabigatran, fondaparinux, danaparoid or therapeutic warfarin.
** in patients <18 years age, discuss with a haematologist

What should be done if there is relative contraindication to pharmacological thromboprophylaxis in view of the bleeding risk?

In presence of a bleeding risk factor a decision to start/withhold thromboprophylaxis needs to be made following a discussion with a senior medical staff and a risk-benefit analysis.

Prescribing in patients under the age of 18 years

LMWH, fondaparinux and rivaroxaban are not currently licensed for use in under 18s. The prescriber should follow the relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented.

What is used for mechanical prophylaxis?

The standard mechanical prophylaxis is below knee graduated compression stockings, these should be prescribed on the drug chart.

In which patients below knee compression stocking may be contra-indicated?

- Peripheral vascular disease
- Infection in the limb
- Peripheral sensory neuropathy
- Leg ulcers
- Severe limb oedema
- Unusual shape/size or deformity
- Known allergy to the material of manufacture
- Local condition where the stockings may cause damage, such as paper thin skin, dermatitis, gangrene or recent skin graft
- Acute stroke patients (consider use of intermittent pneumatic compression device instead)
- Uncontrolled heart failure

These patients may require specialist stockings or intermittent compression devices (refer to guidance).

How should procedures be managed in patients on prophylactic enoxaparin?

- Lumbar puncture/epidural anaesthesia (insertion and removal) – delay procedure until >12 hours since last dose and delay next dose until 4 hours after the procedure.
- Procedure with high bleeding risk – delay procedure until >12 hours since last dose and delay next dose until haemostasis is secure (at least 4 hours post-operatively).
- Procedure with normal/low bleeding risk - delay procedure until >6 hours since last dose (ideally 12 hours) and delay next dose until haemostasis is secure (at least 4 hours post-operatively).

Who should receive extended prophylaxis?

On discharge all patients should be assessed if they have significantly reduced mobility compared to normal and if they are at an increased risk of VTE. If they are then consideration should be made for VTE prophylaxis (either or both mechanical or pharmacological). For certain operations or treatments all patients receive extended prophylaxis (refer to guidance).

For further guidance refer to

- Treatment Pathway for WAHT Venous thromboembolism (VTE) risk assessment and thromboprophylaxis in adults http://www.treatmentpathways.worcsacute.nhs.uk/clinical-support/haematology/
- Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE guideline (NG89) Published March 2018