Always follow local guidelines and discuss with Haematology or Senior if unsure

VTE RISK ASSESSMENT

Department of Health

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

Mobility – all patients (tick one box)	**Tick**		**Tick**		**Tick**
Surgical patient		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**	

Thrombosis risk			
Patient related	**Tick**	**Admission related**	**Tick**
Active cancer or cancer treatment		Significantly reduced mobility for 3 days or more	
Age > 60		Hip or knee replacement	
Dehydration		Hip fracture	
Known thrombophilias		Total anaesthetic + surgical time > 90 minutes	
Obesity (BMI >30 kg/m^2)		Surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 minutes	
One or more significant medical comorbidities (eg heart disease;metabolic,endocrine or respiratory pathologies;acute infectious diseases; inflammatory conditions)		Acute surgical admission with inflammatory or intra-abdominal condition	
Personal history or first-degree relative with a history of VTE		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing contraceptive therapy			
Varicose veins with phlebitis			
Pregnancy or < 6 weeks post partum (see NICE guidance for specific risk factors)			

Bleeding risk			
Patient related	**Tick**	**Admission related**	**Tick**
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorders (such as acute liver failure)		Other procedure with high bleeding risk	
Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR >2)		Lumbar puncture/epidural/spinal anaesthesia expected within the next 12 hours	
Acute stroke		Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Thrombocytopaenia (platelets< 75x10^9/l)			
Uncontrolled systolic hypertension (230/120 mmHg or higher)			
Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease)			

Any tick for **Thrombosis risk** should prompt thromboprophylaxis

Any tick for **Bleeding risk** should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention

There are no specific cut-offs - Discuss with Senior if unsure

TYPES OF VTE PROPHYLAXIS

Mechanical Prophylaxis:
- Correctly measured and fitting Compression stocking
- Flowtrons

Chemical Prophylaxis:
- Generally given in the form of Heparin
  - Use Low molecular weight heparin (LMWH) unless renal function is low enough to necessitate unfractioned heparin
- Discuss with Haematology if patient has allergy to Heparin

LMWH

Enoxaparin

Dalteparin

Tinzaparin

Consult local guidelines regarding dose
Consider body weight / renal function

UNFRACTIONATED HEPARIN

Medical Patient	• 5000 units every 12 hours
Surgical Patient	• Post-surgery: 5000 units every 12 hours ◦ Always check post-op plan

MONITORING

Heparin-Induced thrombocytopenia
- Monitor Platelet count for patient
- Check prior to starting and at least 1 x weekly
- Especially if treatment for > 4 days

Hyperkalaemia
- Monitor Serum Potassium
- Check at least 1 weekly
- For patient at risk of Hyperkalaemia check more regularly
- Especially if treatment for > 7 days

Always consult BNF for dose / administration and contraindications for all above medications