THROMBOPROPHYLAXIS POLICY
FOR ADULT PATIENTS ADMITTED AS INPATIENTS

Reference No: 362
Version No: 2
Previous Trust / LHB Ref No: 362

Documents to read alongside this Policy, Procedure etc (delete as necessary)
- Patient Identification Policy
- Anticoagulation Policy
- Medicines Management Policy
- Making decisions on individual requests for treatment
- Patient Handover Policy
- Single Nurse Administration of Drugs in Hospital
- Writing Prescriptions Policy

Classification of document: Clinical
Area for Circulation: UHB Wide
Author/Reviewee: Consultant Haematologist
Project Support Officer
Executive Lead: Executive Medical Director
Group Consulted Via/Committee: Thrombosis and Anticoagulation Group
Approved by: Quality and Safety Committee
Date of Approval:
Date of Review: February 2015
Date Published:

Disclaimer
When using this document please ensure that the version you are using is the most up to date either by checking on the UHB database for any new versions. If the review date has passed please contact the author.

OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON
<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date of Review Approved</th>
<th>Date Published</th>
<th>Summary of Amendments</th>
</tr>
</thead>
</table>
| 2              | To be inserted on approval | To be inserted | Review of Trust Policy to inform UHB format with amendments to include:  
|                |                         |                | Update to information in introduction and background based on developments since initial publication  
|                |                         |                | Updated Risk Assessment tools under Clinical Policies and Procedures  
|                |                         |                | Update to Audit Proforma |
THROMBOPROPHYLAXIS POLICY

1. Introduction and Background 4
2. Policy Statement 4
3. Aims and Objectives 4
4. Scope 5
5. Thromboprophylaxis 5
6. Methods of Prophylaxis against VTE 7
7. Process 9
8. Roles and Responsibilities 9
9. Resources and Training 10
10. Implementation and Distribution 10
11. Further Information and references 11
13. Equality 12
14. Audit 12
15. Review 12

Thromboprophylaxis Policy
For Adult Inpatients

Reference No362:
Version No:2
1. INTRODUCTION AND BACKGROUND:

It is estimated that venous thromboembolism kills more than 25,000 people a year, which is 10,000 more than the combined figures for breast cancer, road traffic accidents and AIDS (House of Commons Health Committee, 2005).

Venous thromboembolism (VTE) is often termed ‘the silent killer’ because the diagnosis is frequently made post-mortem, with the patient having had little or no warning about the condition prior to the fatal event. It involves the development of a deep vein thrombosis (DVT) and its subsequent embolism to the pulmonary vasculature (known as a pulmonary embolus [PE]).

In 2005 the Heath Select Committee produced a report concerning the prevention of VTE in hospitalised patients, stating that hospitals in the UK were in general failing to institute adequate measures to reduce the incidence of hospital-acquired venous thrombosis. In 80% of cases patients who suffer from VTE usually have at least one risk factor such as immobilisation, obesity and older age. It was reported that as few as 20% of ‘at-risk patients’ received adequate thromboprophylaxis (mechanical and/or pharmacological measures aimed at reducing the risk of venous thromboembolism).

An expert working group was established by the Chief Medical Officer to determine the best approach to address these failings. Their report was published in 2007 stating that every hospital patient should be individually assessed for their risk of VTE. An ‘implementation Working Group’ developed a national risk assessment tool to allow a uniform approach within the NHS. Health Boards and Local Trusts are responsible for the introduction and implementation of local risk assessment tools that follow the national approach.

NICE Clinical Guideline (CG) 92 replaced NICE Clinical Guideline 46 in January 2010. This guideline mandates that ALL patients admitted into hospital must be fully assessed for their risk of venous thromboembolism within 24 hours of admission. The guidance also recommends that patients are re-assessed for their risk of VTE with 72 hours of admission.

2. POLICY STATEMENT

It is the policy of Cardiff and Vale University Health Board (UHB) that all adult patients admitted to hospital are assessed, using the UHB Risk Assessment tool within 24 hours of admission, and that appropriate preventative measures instituted as a result.

3. AIMS AND OBJECTIVES

- To introduce a Risk Assessment Tool into specialities across the UHB
- To provide equality of care for all patients admitted to the UHB with regard to VTE prophylaxis
- To ensure that Directorates develop and implement specific guidelines in order to reduce the risk of VTE in the clinical conditions that they
Cardiff and Vale University Health Board

manage. Guidelines are based on a consensus view of the evidence base within a speciality area and not on clinical preference

• To ensure that all patients are assessed for their individual risk of VTE and that the outcome is documented with regard to appropriate risk-reduction measures.
• To ensure provision of appropriate risk reduction measures including adequate information to staff and patients

4. SCOPE

4.1 Groups that will be covered;
   a) Adults (18 years and older) admitted to hospital as inpatients or formally admitted to a hospital bed for day-case procedures
   b) Pregnant women admitted to hospital have been identified as a group requiring special consideration.
   c) During the review of the evidence, any additional groups that are shown to have particular clinical needs will be given special consideration.

Groups that will not be covered;
   a) People younger than 18 years.
   b) Elderly or immobile people cared for at home, or in external residential accommodation, unless admitted to hospital.
   c) Patients admitted to hospital with a diagnosis of, or suspected diagnosis of, deep vein thrombosis or pulmonary embolus who will require specific assessment and treatment.

5. THROMBOPROPHYLAXIS

Venous thromboembolism (VTE) accounts for 10% of all hospital deaths. However, this is likely to be an under-estimate as many hospital deaths are not followed by post-mortem examination. The total cost of managing VTE in the UK is estimated to be around £640 million per year. Around 25% of patients treated for deep vein thrombosis (DVT) subsequently develop debilitating venous leg ulceration, treatment of which is estimated to cost £400 million in the UK.

The most serious complication of VTE is pulmonary embolism (PE) which, untreated has a mortality rate of 30%. However, with appropriate treatment this figure is reduced to 2% (House of Commons Committee, 2005). Unfortunately, this diagnosis of VTE is often delayed until the development of a sometimes fatal PE.

Without prophylaxis, 45-51% of orthopaedic patients develop DVT and it is estimated that in Europe around 5,000 patients are likely to die per year of VTE following hip or knee replacement when prophylactic treatments are not prescribed.
About a third of all surgical patients developed VTE before the introduction of prophylactic treatments. The routine implementation of venous thromboprophylaxis guidelines (issued by the Royal College of Obstetricians and Gynaecologists) for women undergoing caesarean section has seen a substantial fall in morbidity and mortality from VTE (House of Commons Health Committee, 2005). However, VTE is still a leading cause of maternal morbidity and mortality and ongoing Risk Assessment of a woman’s risk of VTE throughout pregnancy is essential for unnecessary deaths to be avoided.

Table 1 depicts the incidence of DVT from prevention of venous thromboembolism in hospitalised patients (House of Commons 2005)

<table>
<thead>
<tr>
<th>Speciality</th>
<th>DVT % (weighted mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>25</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>45-51</td>
</tr>
<tr>
<td>Urology</td>
<td>9-32</td>
</tr>
<tr>
<td>Gynaecological Surgery</td>
<td>14-22</td>
</tr>
<tr>
<td>Neurosurgery including stokes</td>
<td>22-56</td>
</tr>
<tr>
<td>Multiple trauma</td>
<td>50</td>
</tr>
<tr>
<td>General Medicine</td>
<td>17</td>
</tr>
</tbody>
</table>

It is clearly established that hospitalisation is associated with an increased risk of VTE, with an incidence 135 times greater in hospitalised patients than in the community. It is estimated, that 70-80% of hospital-acquired VTEs occur in 'medical' patients (House of Commons Health Committee, 2005).

The aetiological of VTE is multifactorial and risk factors associated with its development are clearly identified. Hospitalised patients with stroke, myocardial infarction, severe heart failure, chronic respiratory disease, active cancer or those receiving cancer therapy are at greater risk of developing VTE which, for example; may occur in up to 50% of patients with stroke/MI. The incidence of VTE after 14 days hospitalisation is estimated to be 15% in patients considered to be at moderate risk of developing VTE (House of Commons Health Committee 2005).

Patients with a personal or family history of venous thrombosis are at risk of developing VTE whilst in hospital.

The risk of VTE increases with age, particularly in patients over 50 years. Other “acquired” risk factors include:
- Recent surgery, especially orthopaedic or neurosurgery
- Pregnancy
- Obesity, BMI >30kg/m²
- Oestrogen-containing drugs, such as the combined oral contraceptive pill and hormone replacement therapy
- Kidney disease, such as nephrotic syndrome and myeloproliferative disorders
Low Molecular Weight Heparins (LMWH) have been shown to be effective in many clinical settings e.g. general surgery, obstetrics, orthopaedic surgery and general medicine in reducing the incidence of VTE. For example, the use of thromboprophylaxis in hip replacement surgery can reduce venographically confirmed DVT from approximately 50% to 10-15% (House of Commons Health Committee, 2005).

A meta analysis, which included 9 studies (n = 19,958) involving hospitalised medical patients showed treatment with prophylactic doses of LMWH significantly reduced the risk of PE (relative risk 0.43, CI 0.26-0.71), with absolute risk reduction of 0.29% (Dentali et al, 2007). The incidence of fatal PE was also reduced (relative risk 0.38, CI 0.21 – 0.69; absolute risk reduction 0.25%).

Clinical guidelines for thromboprophylaxis have been published by some specialties in the UK and also in other countries. These include the guidelines published by the Royal College of Obstetricians and Gynaecology, the 7th American College of Chest Physicians (ACCP) and the Scottish Intercollegiate Network (SIGN) as well as the most recent NICE CG92.

Cardiff and Vale University Health Board is committed to thrombosis prevention and has introduced venous thromboprophylaxis in all specialties in order to prevent unnecessary morbidity and mortality from VTE. Both clinicians and the general public require ongoing education to increase awareness of the problem and effective audit cycles instituted in all specialties to review the safety and compliance with relevant protocols.

6. METHODS OF PROPHYLAXIS AGAINST VENOUS THROMBOEMBOLISM

These examples are examples of preferred interventions at Cardiff and Vale University Health Board

6.1 PHARMACOLOGICAL PROPHYLAXIS

6.1.1 HEPARINS

Lower Molecular Weight Heparin

a: Enoxaparin: is the preferred low molecular weight heparin (LMWH) for indications for which it is licensed.

Contradictions for use of prophylactic heparins

Active bleeding, hypersensitivity to heparin, coagulopathy, acute renal failure, chronic renal disease (eGFR <30ml/min), endocarditis, history of heparin induced thrombocytopenia (HIT), lumbar puncture or neuroaxial anaesthesia within 12hrs, recent intraocular or intracranial surgery. Caution in uncontrolled hypertension.
The use of LMWH should be re-assessed where there is chronic renal disease (eGFR <30ml/min) or evidence of acute renal failure. In these circumstances consider the use of subcutaneous unfractionated heparin 5000u bd.

This list is not exhaustive and a Risk Assessment should take place for each patient.

Aspirin is not recommended for VTE prophylaxis and should only be used as part of a speciality – specific guideline.

6.2 MECHANICAL METHODS OF PROPHYLAXIS

These examples are examples of preferred interventions within Cardiff and Vale University Health Board

6.2.1 Anti-embolism stockings (AES)

Anti-Embolism Stockings (AES) are an adjunct or alternative to pharmacological prophylaxis where there is an increased risk from heparin use due to patient or procedure related factors. AES’s may be used with pharmacological prophylaxis when risk of VTE is high. There is an All-Wales guideline and a local UHB guidance for the use of AES’s

Cautions for use of AES
Peripheral vascular disease, longstanding diabetes, ulcers, trauma, infection, recent skin grafts, massive oedema, pulmonary oedema, present or previous pressure damage to heels, sever leg deformities. Pulse palpation and arterial doppler assessment are not reliable assessments of skin perfusion and regular inspection if there is suspicion or risk of vascular compromise.

6.2.2 Other mechanical devices

Intermittent Pneumatic Compression (IPC) Devices
Mechanical Foot Pumps

These are suitable alternatives to AES. However, they are not widely available in the UHB and should be used as part of a local specialty specific thromboprophylaxis protocol, ratified by the Thrombosis and Anticoagulation Group (TaAG). Contraindications to their use are as for AES.

6.3 PATIENT EDUCATION

Patients should be made aware of the increased risk of venous thromboembolism associated with hospital admission. In specialties where extended thromboprophylaxis is required, involving the administration of subcutaneous low molecular weight heparin, the patient should be advised, in advance of the procedure, that they will be trained to self administer the medication at home.
The UHB has designed “in-house” patient information leaflets. These should be given to patients in the pre-operative assessment area and on admission to all adult wards where possible.

Patient line and plasma screens are used to increase patient awareness; thrombosis prevention campaign material is regularly updated and displayed.

7. PROCESS

7.1 On admission all patients will be assessed for their risk of venous thromboembolism. The outcome of this assessment should be documented in the medical notes (e.g. using a Risk Assessment Proforma).

Risk Assessment Tools for each specialty are included in Appendices 1, 2, 3, 4 and 5. Any modification by individual directorate should be approved at Directorate Level and ratified by the Thrombosis and Anticoagulation Group (TAaG).

8. ROLES AND RESPONSIBILITIES

8.1 Thrombosis and Anticoagulation Group (TAaG)
It is the responsibility of TAaG to guide the UHB on the content of this Policy and through its group monitor adherence to it. This is to be supported by audits across the UHB, with results reported to TAaG and at specialty and Directorate level. The Medical Director (or delegated representative) will be Chairman of this group and be responsible for reporting to the Quality and Safety Committee.

8.2 Divisional Directors
It is the responsibility of Divisional Directors (or their equivalent) to ensure where appropriate that the requirements of this Policy are implemented within clinical areas for which they hold responsibility and where employed UHB staff and inpatients of the Health Board are being treated.

8.3 Clinical Multidisciplinary Teams
It is the responsibility of all members of the clinical and multi-disciplinary teams to ensure that they are conversant with this policy and the particular role that they play in ensuring appropriate risk assessment takes place. Measures should be in place to ensure that all patients remain well hydrated and are encouraged to mobilise as soon as practically possible.

8.4 Prescriber
It is the responsibility of the admitting clinician to assess each patient using the risk assessment appropriate to the speciality and to document the outcome of that assessment in the medical notes. Adherence to the speciality-specific guidelines will enable the clinician to prescribe the correct thromboprophylaxis. An explanation for any deviation from the recommendations should be documented in the notes.
8.5 Registered Nurses & Midwives
Ensuring quality and safety standards which are defined by the UHB are the responsibility of all registered nurses and midwives. Registered nurses and midwives should ensure that patients in their care have been assessed for their risk of thrombosis within 24 hours of admission. Where thromboprophylaxis is prescribed (in the form of AES or LMWH) then, prior to administration, the nurses or midwife should check whether a risk assessment has been documented, and if not, bring this to the attention of a member of the medical team.

The registered nurse or midwife is responsible for the accurate administration of prescribed thromboprophylaxis.

8.6 Pharmacists
Pharmacists for each speciality have a responsibility for ensuring that prescribing of pharmacological thromboprophylaxis is appropriate. Pharmacists are responsible for monitoring the documentation of administration of the prescribed thromboprophylaxis and should highlight the need to review / reassessment as the patient’s clinical condition alters.

8.7 Physiotherapists and Occupational Therapists
The physiotherapy or occupational therapy team are in a position when assessing the patient to establish risk for thromboprophylaxis. They should be conversant with this policy and must be aware of the risk factors associated with their speciality. Patients found to be at risk must be highlighted to the admitting clinician in order that appropriate thromboprophylaxis is prescribed.

9. RESOURCES AND TRAINING

9.1 Printed risk assessment tools and patient information leaflets are required for each specialty. The cost for printing will be carried by individual directorates.

9.2 Ongoing training of all Doctors and Nursing staff is essential to ensure success and to ensure evidence based practice. This is incorporated into Divisional Quality and Safety Meetings, Grand Rounds and Registered Nurses Educational Programmes and Induction Programmes.

10. IMPLEMENTATION AND DISTRIBUTION

10.1 The policy will be published on the intranet, clinical portal and UHB Internet site.

10.2 This policy will be circulated to the Executive Medical Director, Executive Nurse Director, Executive Director of Therapies and Health Sciences, Divisional Directors, Managers and Nurses, Lead Nurses,
Heads of Therapies, Clinical Directors, Directorate Managers and Senior Nurses.

10.3 Amendments to the Risk Assessment Tools should be ratified by the Thrombosis and Anticoagulation Group (TAaG). Implementation of the policy will be monitored through regular audit and reported via TAaG.

11. FURTHER INFORMATION AND REFERENCES


12. CLINICAL POLICIES AND PROCEDURES

Each patient admitted to the hospital should have a risk assessment completed and appropriate measures prescribed and documented in their notes.

See appendices for Risk Assessment Tools
13. EQUALITY

Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies, our service standards and our Single Equality Scheme-FAIR CARE. The responsibility for implementing the scheme falls to all employees and UHB Board members, volunteers, agents or contractors delivering services or undertaking work on behalf of the UHB.

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned. Where appropriate we have taken or will make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

13.1 The tool is included in appendix 6

14. AUDIT

14.1 TaAG will monitor the development of and adherence to the use of associated Risk Assessment Tools and Audit

14.2 Regular audit of all adult, admissions will determine whether patients are being assessed for their risk of VTE and that appropriate preventative measures are in use. Each Division/Directorate will add this to their clinical audit plans. All outcomes of these audits should be fed back to TAaG (see Appendix 6 for suggested audit tool).

14.3 An audit of patients re-admitted with post-operative deep vein thrombosis or pulmonary embolism will also be collected. This will be fed back to individual speciality groups so that cases can be reviewed.

15. REVIEW

This Policy will be reviewed every 3 years or sooner if appropriate as decided by TAaG
## Appendix 1

### Medical Admissions Risk Assessment Tool

**Patient details**

- **(affix addressograph)**

**GIG**

**Cardiff and Vale University Health Board**

---

**Weight:** ........................................ kgs  
**Date weight recorded:** ........................................

---

**Thromboprophylaxis Adult Medical Admissions**

**UNLESS CONTRAINDICATED:** Prescribe pharmacological thromboprophylaxis for all patients who are non-ambulant with an acute medical illness or  
≥1 risk factor for venous thromboembolism

**If pharmacological thromboprophylaxis is contraindicated:** consider anti-embolism stockings

### Does the Patient Have Risk Factors for Venous Thromboembolism? (VTE) (√)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute or exacerbation of heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute respiratory failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute exacerbation of COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age ≥ 60 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active cancer or cancer treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical care admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute medical admission for sepsis, pneumonia, inflammatory conditions e.g. Ulcerative Colitis/Crohn’s, Rheumatoid Arthritis/SLE, diabetic ketoacidosis/hyperosmolar nonketotic acidosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Does the Patient Have a Contraindication to:

#### Pharmacological Thromboprophylaxis?

- Arterial insufficiency (suspected or proven):
  - absent or weak foot pulses
  - intermittent claudication
  - slow capillary filling (pinched nailbed/toepad that takes >3 seconds to return to normal colour)

#### Mechanical Methods?

- Known thrombophilia
- Obesity (BMI > 30kg/m²)
- Personal or first degree relative with history of VTE
- Pregnancy or ≤ 6 weeks post partum
- Use of hormone replacement therapy
- Use of oestrogen-containing contraceptive therapy
- Varicose veins with active phlebitis

### Completing the Risk Assessment

**Patient Age:**

- If patient > 70 years old request an eGFR since they may have undiagnosed renal impairment

**Thromboprophylaxis Indicated?**

- Y/N

**Sign**

**Name**

**Date**

### Thromboprophylaxis Policy

**For Adult Inpatients**

**PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART**

**N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes**

### On Admission

**Consultant:**

**Enoxaparin (Clexane)**

- **sub-cutaneously**
- **Weight** (Kg)
- **Dose**
- **Anti-embolism stockings if Enoxaparin contraindicated**

<table>
<thead>
<tr>
<th>&lt; 50</th>
<th>50 - 100</th>
<th>40mg od</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek advice</td>
<td>Calf length anti-embolism stockings</td>
<td></td>
</tr>
</tbody>
</table>

**Enoxaparin (Clexane)**

- **sub-cutaneously**
- **Weight** (Kg)
- **Dose**

<table>
<thead>
<tr>
<th>&lt; 50</th>
<th>50 - 100</th>
<th>40mg od</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek advice</td>
<td>Calf length anti-embolism stockings</td>
<td></td>
</tr>
</tbody>
</table>

**Anti-embolism stockings if Enoxaparin contraindicated**

**Anti-embolism stockings if Enoxaparin contraindicated**

**Anti-embolism stockings if Enoxaparin contraindicated**

**Anti-embolism stockings if Enoxaparin contraindicated**

**Seek further advice from coagulation registrar/patient’s consultant**

---

**Reference No362:**

**Version No: 2**

---
### Thromboprophylaxis Policy
**For Adult Inpatients**

#### Thromboprophylaxis Policy

<table>
<thead>
<tr>
<th>Dosage</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>101 - 150</td>
<td>40mg bd</td>
</tr>
<tr>
<td>&gt; 150</td>
<td>60mg bd</td>
</tr>
</tbody>
</table>

**Contraindication**
- Contraindication present

If no contraindications exist and thromboprophylaxis is not prescribed state reason:

<table>
<thead>
<tr>
<th>Sign</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

**PRESCRIBING ADVICE**

- **TIMING** of enoxaparin administration: administer no later than 18:00hrs
- **Heparin induced thrombocytopenia (HIT):** medical patients do not need monitoring for HIT

---

*Thromboprophylaxis Policy*

*For Adult Inpatients*

*Reference No. 362:*

*Version No. 2*
THROMBOPROPHYLAXIS FOR ADULT SURGERY ADMISSIONS

UNLESS CONTRAINDICATED: Prescribe both pharmacological and mechanical thromboprophylaxis for all patients:
- who are non-ambulant with an acute surgical illness who have ≥1 risk factor for venous thromboembolism
- undergoing surgery who have ≥1 risk factor for venous thromboembolism
- undergoing surgery where duration of anaesthesia & surgery ≥ 60 minutes (pelvic surgery) or ≥ 90 minutes (non-pelvic surgery)

DOES THE PATIENT HAVE RISK FACTORS FOR VENOUS THROMBOEMBOLISM? (VTE) (√)

- Acute or exacerbation of heart failure
- Acute respiratory failure
- Known thrombophilia
- Acute exacerbation of COPD
- Obesity (BMI > 30kg/m²)
- Age ≥ 60 years
- Pregnancy or < 6 weeks post partum
- Active cancer or cancer treatment
- Critical care admission
- Dehydration
- Varicose veins with active phlebitis
- Hip fracture

Risk identified? Y/N
Thromboprophylaxis indicated? Y/N
Sign Name Date

PATIENT AGE: If patient > 70 years old request an eGFR since they may have undiagnosed renal impairment

DOES THE PATIENT HAVE A CONTRAINDICATION TO:

- pharmacological thromboprophylaxis? ✓
- mechanical methods? ✓

Assessment 1 2
Currently receiving therapeutic anticoagulation
Uncontrolled systolic hypertension > 180mmHg
Thrombocytopenia: platelet count < 70 x 10⁹/l
New-onset stroke, intra-cerebral haemorrhage or untreated sub-arachnoid haemorrhage
Severe liver disease
Known bleeding disorder *
Renal impairment with eGFR < 30ml/min *
Active bleeding or at risk of bleeding
Known heparin allergy
Admitted for terminal care or end of life pathway
Previous heparin induced thrombocytopenia *
Lumbar puncture/epidural/spinal anaesthesia within past 4 hours or expected in next 12 hours

Contraindication present? (√ / x)

* seek further advice from coagulation registrar/patient’s consultant

PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART
N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes

On admission Consultant: Post-operatively Consultant:

Enoxaparin (Clexane) sub-cutaneously
- Weight (Kg) Dose
- select one mechanical method
- Weight (Kg) Dose
- select one mechanical method

≤ 50 Seek advice *
< 50 Seek advice *
50 - 100 40mg od
50 - 100 40mg od
101 - 150 40mg bd
101 - 150 40mg bd
> 150 60mg bd
> 150 60mg bd
Contraindication present
Contraindication present

If using bd dose omit a.m. dose on day of surgery
If using bd dose omit a.m. dose on day of surgery

Thromboprophylaxis Policy
For Adult Inpatients

Reference No362: Version No:2
Prescribed state reason:

<table>
<thead>
<tr>
<th>Sign</th>
<th>Name</th>
<th>Date</th>
<th>Sign</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

**PRESCRIBING ADVICE**

**TIMING of enoxaparin administration:**
- if given day before surgery: administer **no later** than 18:00hrs
- day of surgery: administer at 18:00hrs OR 6 hours post-op for afternoon cases (d/w consultant surgeon/anaesthetist)
- subsequent post-op days: prescribe at 18:00hrs

**Following surgery under spinal/epidural anaesthesia:** Wait at least 4 hours before giving enoxaparin

**Patients with epidural analgesia post-op:** Do not remove epidural catheter within 12 hours of enoxaparin

Following removal of epidural catheter wait 4 hours before giving next dose of enoxaparin

**Heparin induced thrombocytopenia (HIT):** Check platelet count before commencing and following 5-7 days of treatment

**Patients having abdominal/pelvic surgery for malignancy:** consider **extended thromboprophylaxis** for up to 28 days
Thromboprophylaxis for Trauma Admissions

Prescribe both enoxaparin and below-knee anti-embolism stockings for all patients who are not walking OR undergoing surgery.

**DOES THE PATIENT HAVE RISK FACTORS FOR VENOUS THROMBOEMBOLISM? (VTE) (✓)**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt; 60 years</td>
<td>✓</td>
</tr>
<tr>
<td>Spinal patient for surgery, bed-rest, brace, halo or hard collar</td>
<td>✓</td>
</tr>
<tr>
<td>Pelvic surgery, stable pelvic fracture or pubic ramus fracture</td>
<td>✓</td>
</tr>
<tr>
<td>Intracapsular and two-part trochanteric hip fracture</td>
<td>✓</td>
</tr>
<tr>
<td>Prolonged (&gt;90 minutes) lower-limb surgery</td>
<td>✓</td>
</tr>
<tr>
<td>Long-leg cast, brace, or traction</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Other (specify)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**DOES THE PATIENT HAVE A CONTRAINDICATION TO:**

<table>
<thead>
<tr>
<th>Contraindication to</th>
<th>List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enoxaparin?</td>
<td>✓</td>
</tr>
<tr>
<td>Below-knee stockings?</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Assessment**

- **1**
- **2**

**Thromboprophylaxis Indicated?**

- **Y/N**

**Sign**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

**Contraindication Present?**

- **Y/N**

**Thromboprophylaxis Policy**

For Adult Inpatients

N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes.

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

If using b.d. dose omit on the day of surgery.

**Other (specify)**

- **Y/N**

**Other (specify)**

- **Y/N**

**PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART**

**Thromboprophylaxis Policy**

For Adult Inpatients

N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes.

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

If using b.d. dose omit on the day of surgery.

**Other (specify)**

- **Y/N**

**Other (specify)**

- **Y/N**

**PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART**

**Thromboprophylaxis Policy**

For Adult Inpatients

N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes.

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

If using b.d. dose omit on the day of surgery.

**Other (specify)**

- **Y/N**

**Other (specify)**

- **Y/N**

**PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART**

Thromboprophylaxis Policy

For Adult Inpatients

N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes.

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

If using b.d. dose omit on the day of surgery.

**Other (specify)**

- **Y/N**

**Other (specify)**

- **Y/N**

**PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART**

**Thromboprophylaxis Policy**

For Adult Inpatients

N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes.

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

**Enoxaparin (Clexane)**

- **Weight (Kg)**
  - < 50: Seek advice**
  - 50 - 100: 40mg od
  - 101 - 150: 40mg bd
  - > 150: 60mg bd

- **Mechanical prophylaxis**
  - Calf length anti-embolism stockings

If using b.d. dose omit on the day of surgery.
### Thromboprophylaxis Policy

**For Adult Inpatients**

Reference No 362:

Version No: 2

---

<table>
<thead>
<tr>
<th>If no contraindications exist and thromboprophylaxis is not prescribed state reason</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign</td>
<td>Name</td>
</tr>
</tbody>
</table>

### PRESCRIBING ADVICE

**TIMING of enoxaparin administration:**
- **if given day before surgery:** administer **no later** than 18:00hrs
- **day of surgery:** administer at 18:00hrs OR 6 hours post-op for afternoon cases (d/w consultant surgeon/anaesthetist)
- **subsequent post-op days:** prescribe at 18:00hrs

**Following surgery under spinal/epidural anaesthesia:** Wait at least 4 hours before giving enoxaparin

**Patients with epidural analgesia post-op:** Do not remove epidural catheter within 12 hours of enoxaparin

Following removal of epidural catheter wait 4 hours before giving next dose of enoxaparin

**Heparin induced thrombocytopenia (HIT):** Recheck platelet count following 5-7 days of treatment
# Critical Care Admissions Risk Assessment Tool

**Appendix 4**

**Weight:** ………………………………………………………………kgs

**Date weight recorded:** …………………………………………………

**COMPLETE AND FILE IN PATIENT’S NOTES**

## Thromboprophylaxis for Adult Critical Care Admissions

**FOR ALL ADMISSIONS:** UNLESS CONTRAINDICATED, PRESCRIBE

Enoxaparin 40mg s.c. o.d at 18:00hs AND below-knee anti-embolism stockings

**RENAL FAILURE**

- eGFR <30ml/min: prescribe Enoxaparin 20mg s.c. o.d.
- CVVH: assume normal clearance; prescribe Enoxaparin 40mg s.c. o.d

Assessment 1 to be done at admission, timing of assessment 2 to be specified at bottom of page

## Does the Patient Have a Contraindication to Pharmacological Thromboprophylaxis?

### (a) All Patients

<table>
<thead>
<tr>
<th>Assessment (✓)</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently receiving therapeutic anticoagulation</td>
<td>Known Bleeding disorder</td>
<td></td>
</tr>
<tr>
<td>Lumbar puncture/epidural/spinal anaesthesia within past 6 hours or expected in next 12 hours</td>
<td>Heparin Induced Thrombocytopenia (discuss with Coagulation registrar)</td>
<td></td>
</tr>
<tr>
<td>Uncontrolled systolic hypertension &gt; 180mmHg</td>
<td>Active bleeding/ DIC</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia: platelet count &lt; 30 x 10⁹/l</td>
<td>Heparin allergy</td>
<td></td>
</tr>
<tr>
<td>Severe Liver Disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### (b) ICU Specific Patient Groups:

<table>
<thead>
<tr>
<th>Assessment (✓)</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>Long term ventilated / tetraplegic pts</td>
<td></td>
</tr>
<tr>
<td>Within 24 hours of surgery</td>
<td>In the absence of acute illness thromboprophylaxis is not required. Reassess in the event of change in clinical condition. Maximum duration of treatment with enoxaparin is 3 months.</td>
<td></td>
</tr>
<tr>
<td>Unruptured aneurysm/unsecured/AVM *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due for surgery within 12 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New haemorrhagic intracerebral bleed *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal</td>
<td>Activated Protein C</td>
<td></td>
</tr>
<tr>
<td>Within 24hrs surgery</td>
<td>Not for enoxaparin for duration of APC infusion</td>
<td></td>
</tr>
<tr>
<td>Surgery due in next 12-24hrs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Does the Patient Have a Contraindication to Anti-Embolism Stockings?

### Assessment (✓)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial Insufficiency (suspected or proven)</td>
<td></td>
</tr>
<tr>
<td>- Weak or absent foot pulses</td>
<td></td>
</tr>
<tr>
<td>- Capillary refill time &gt; 3 secs</td>
<td></td>
</tr>
<tr>
<td>Peripheral Neuropathy</td>
<td></td>
</tr>
<tr>
<td>High dose Noradrenaline &gt; 0.1mcg/kg/min *</td>
<td></td>
</tr>
<tr>
<td>Known allergy to material</td>
<td></td>
</tr>
</tbody>
</table>

Use of Vasopressin & Noradrenaline

Pedal venflons

Severe oedema of legs

## Prescribe Enoxaparin Subcutaneously

<table>
<thead>
<tr>
<th>Assessment 1</th>
<th>Assessment 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (Kg)</td>
<td>Dose</td>
</tr>
<tr>
<td>&lt; 50</td>
<td>20mg od</td>
</tr>
<tr>
<td>50 - 100</td>
<td>40mg od</td>
</tr>
<tr>
<td>101- 150</td>
<td>40mg bd</td>
</tr>
<tr>
<td>&gt;150</td>
<td>60mg bd</td>
</tr>
</tbody>
</table>

**Thromboprophylaxis Policy**

*For Adult Inpatients*

Reference No: 362

Version No: 2
<table>
<thead>
<tr>
<th></th>
<th>eGFR &lt;30ml/min</th>
<th>CVVH</th>
<th>eGFR &lt;30ml/min</th>
<th>CVVH</th>
<th>20mg od</th>
<th>40mg od</th>
<th>20mg od</th>
<th>40mg od</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20mg od</td>
<td></td>
<td>20mg od</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CVVH</td>
<td></td>
<td>CVVH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Measure and fit embolic stockings**

<table>
<thead>
<tr>
<th>Calf Measurement (cm)</th>
<th>Ankle measurement (cm)</th>
<th>Size used (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>Left</td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>Left</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment 1</th>
<th>Sign</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of next assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment 2</td>
<td>Sign</td>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Thromboprophylaxis Policy**

*For Adult Inpatients*

Reference No: 362

Version No: 2
## Elective Admissions Risk Assessment Tool

### Appendix 5

**Cardiff and Vale University Health Board**

**Weight:** …………………………kgs

**Date weight recorded:** …………………

**COMPLETE AND FILE IN PATIENT’S NOTES**

---

### THROMBOPROPHYLAXIS FOR ELECTIVE ADULT HIP/KNEE REPLACEMENT SURGERY

**UNLESS CONTRAINDICATED:**

All patients admitted for elective hip or knee replacement surgery should receive combined thromboprophylaxis with **MECHANICAL METHODS** from admission, until mobile

**AND**

**RIVAROXABAN** starting 10 hours after surgery

- Knee replacement surgery: continue for 14 days post surgery
- Hip replacement surgery: continue for 35 days post surgery

**PATIENT AGE:**

<table>
<thead>
<tr>
<th>If patient ≥ 70 years old request an eGFR since they may have undiagnosed renal impairment</th>
</tr>
</thead>
</table>

**DOES THE PATIENT HAVE A CONTRAINDICATION TO:**

**pharmacological thromboprophylaxis?**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently receiving therapeutic anticoagulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncontrolled systolic hypertension &gt; 180mmHg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia: platelet count &lt; 70 x 10⁹/l</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New-onset stroke, intra-cerebral haemorrhage or untreated sub-arachnoid haemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known bleeding disorder *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal impairment with eGFR &lt; 30ml/min *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active bleeding or at risk of bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lumbar puncture/epidural/spinal anaesthesia within past 6 hours or expected in next 12 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contraindication present? (✓ / x )**

* seek further advice from coagulation registrar/patient’s consultant

---

**PRESCRIBE THROMBOPROPHYLAXIS, ACCORDING TO RISK ASSESSMENT, ON DRUG CHART**

**N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes**

**Post-operatively**

**Consultant:**

**Reassessment at 24 hours post-op**

**Consultant:**

<table>
<thead>
<tr>
<th>Rivaroxaban 10mg po od</th>
<th>Select one mechanical method</th>
<th>Rivaroxaban 10mg po od</th>
<th>Select one mechanical method</th>
</tr>
</thead>
<tbody>
<tr>
<td>see BNF/SPC for specific contraindications/precautions</td>
<td>Calf length anti-embolism stockings</td>
<td>see BNF/SPC for specific contraindications/precautions</td>
<td>Calf length anti-embolism stockings</td>
</tr>
<tr>
<td>Foot impulse devices</td>
<td>Intermittent pneumatic compression devices</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contraindication present?**

**Contraindication present?**

**Rivaroxaban administration:**

- a) day of surgery: 10 hours post-op (discuss with consultant surgeon/anaesthetist)
- b) subsequent post-op days: 08:00hrs or 18:00hrs according to timing of first dose

**Sign**

**Name**

**Date**

**Sign**

**Name**

**Date**

**If Rivaroxaban is specifically contraindicated or not tolerated, but thromboprophylaxis is indicated, consider prescribing EITHER**

**Dabigatran Etxilate:**

- a) Age75 yrs or less, AND eGFR >50ml/min: day of surgery: 110mg po od, administered 1-4 hours post-op
- b) subsequent post-op days: 220mg po od, administered at 18:00hrs

---

**Thromboprophylaxis Policy**

**For Adult Inpatients**

**Reference No362:**

**Version No:2**
b) Elderly patients (>75 years) or eGFR 30 - 50 ml/min: Dabigatran 75mg orally 1-4 hours after surgery then 150mg once daily
Please refer to current BNF/SPC for specific contraindications/precautions and further prescribing information

OR

Enoxaparin:
refer to Adult Elective Orthopaedic surgery (exc hip/knee replacement) assessment form for further prescribing advice

Duration of treatment with either dabigatran or enoxaparin: Knee replacement surgery: continue for ≥ 10 days post surgery
Hip replacement surgery: continue for ≥ 28 days post surgery

If no contraindications exist and thromboprophylaxis is not prescribed state reason:

PRESCRIBING ADVICE

Following surgery under spinal/epidural anaesthesia: Wait at least 6 hours before giving Rivaroxaban or Dabigatran
Patients with epidural analgesia post-op: Do not remove epidural catheter within 18 hours of Rivaroxaban or Dabigatran. Following removal of epidural catheter wait 6 hours before giving next dose of Rivaroxaban or Dabigatran

Aspirin is not recommended for thromboprophylaxis
## Appendix 6

### Thromboprophylaxis Audit Tool

Audit to be undertaken on __________. Select the last 5 patients to be admitted, AT LEAST 24 HOURS previously.

<table>
<thead>
<tr>
<th>1 Name of Auditor (Print)</th>
<th>Date</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 Consultant</th>
<th>Admission (decision to admit) date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Please tick which Risk Assessment Tool Used:</th>
<th>Trauma</th>
<th>Spinal</th>
<th>Electronic orthopaedic (other)</th>
<th>Elective Hip/knee replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Surgery</td>
<td>Critical Care</td>
<td>Adult Medicine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 Was the risk assessment 1 completed in full</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the risk assessment 1 partly completed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was patient deemed at risk of VTE on the risk assessment form?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Relevant was risk assessment 2 completed in full</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5 If risk of VTE were there any contraindications to:</th>
<th>Assessment 1 (48 hours of DTA)</th>
<th>Assessment 2 (48 hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacological thromboprophylaxis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mechanical thromboprophylaxis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>weight adjusted LMWH</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>mechanical TP</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6 If patient at risk of VTE and no contraindications existed, was thromboprophylaxis (TP) recorded on the tool weight adjusted LMWH</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>mechanical TP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If TP indicated and no contraindications existed, but TP not given was reason stated</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7 Prescription Chart (Note to auditor: check the drug chart irrespective of whether risk assessment completed)</th>
<th>Weight</th>
<th>Risk of VTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the LMWH prescribed on the drug chart</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were antiembolism stockings prescribed on the drug chart</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8 If the Risk Assessment Tool was not completed in full which sections were incomplete (please tick)</th>
<th>Contraindications</th>
<th>TPx prescript</th>
</tr>
</thead>
</table>

---

**Thromboprophylaxis Policy**

*For Adult Inpatients*

---

Reference No362:
Version No:2