

## Appendix 1 Adult Inpatient Drug Chart

### Risk Assessment for Venous Thromboembolism (VTE) for ALL adult patients admitted to hospital

(For pregnancy related admission see separate guidelines) **Risk assessment completed at Pre-assessment**

	Assess mobility for all patients admitted to hospital - tick one box	✓	Action
Step 1	Surgical patient		Assess for thrombosis risk and bleeding risk (Step 2 and 3)
	Medical patient expected to have ongoing reduced mobility relative to normal state		
	Medical patient <b>NOT</b> expected to have ongoing reduced mobility relative to normal state		VTE prophylaxis not required <span style="color: red;">Go to Step 4</span>

Assess thrombosis risk - tick all that apply (✓) Any tick should prompt thromboprophylaxis							
Step 2	Patient related		First	72hr		First	72hr
	Active cancer or cancer treatment				Use of hormone replacement therapy		
	Age >60				Use of oestrogen-containing contraceptive therapy		
	Dehydration				Varicose veins with phlebitis		
	Known thrombophilias				Critical Care admission		
	Obesity (BMI >30kg/m <sup>2</sup> )				Significant medical comorbidities (eg. heart disease, metabolic, endocrine or respiratory pathologies; acute infectious disease; inflammatory conditions)		
	Personal history or first-degree relative with a history of VTE						
	Admission related						
	If total anaesthetic + surgery time > 90 minutes				Significant reduction in mobility for 3 days or more		
	If surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 minutes				If acute surgical admission with inflammatory or intra-abdominal condition		

Assess bleeding risk (re-assess regularly) - tick all that apply (✓)							
If bleeding risks identified pharmacological prophylaxis may be contra-indicated, discuss with senior doctor before prescribing							
Step 3	Patient related		First	72hr		First	72hr
	Active bleeding				Thrombocytopenia (platelets < 50x10 <sup>9</sup> /l)		
	Acquired bleeding disorders (e.g. acute liver failure)				Uncontrolled systolic hypertension (≥ 230 mmHg)		
	Concurrent use of anticoagulants (e.g. warfarin with INR > 2, therapeutic dose of enoxaparin or rivaroxaban)				Untreated inherited bleeding disorders (such as haemophilia or Von Willebrand's disease)		
	Acute stroke (< 3 months ago or risk of CNS bleeding)						
	Admission related						
	Neurosurgery, spinal surgery or eye surgery (except cataract surgery)				Lumbar puncture/epidural/spinal anaesthesia within the previous 4hrs or expected within the next 12hrs (if pharmacological prophylaxis is indicated clearly document timing of dose and/or start date)		
	Other procedure with high bleeding risk						

Assessment completed by (can be any trained healthcare worker)						
Step 4	Assessment	Signature	Name (PRINT)	Grade	Bleep	Date
	First					
	72 hour					

Consider contra-indications tick if present (✓)					First	72hr	
Step 5	Contra-indications to pharmacological prophylaxis (consider anti-embolism stockings)						
	Contra-indications to anti-embolism stockings (see below)						
	Peripheral arterial disease	Peripheral arterial bypass grafting	Recent skin graft	Cardiac failure	Known Allergy		
Peripheral neuropathy	Severe dermatitis or gangrene	Severe leg oedema	Leg deformity				

Guidelines used to risk assess: Surgical <input type="checkbox"/> Orthopaedic <input type="checkbox"/> Obstetric <input type="checkbox"/> Other.....(specify)						
Step 6	Record treatment decisions tick all that apply (✓)					
	None - cross off enoxaparin from chart (drug 1)	First	72hr	Unfractionated Heparin (UFH)	First	72hr
	Enoxaparin			Rivaroxaban		
	Intermittent pneumatic compression or footpumps			Anti-embolism stockings		

Step 7 Write prescription	
Ensure selected thromboprophylaxis is prescribed at an appropriate dose for the patient	
Consider eGFR and body weight if applicable (see 'Enoxaparin VTE Dosing Guidance' on opposite page)	

Monitoring patients on enoxaparin	
<b>Heparin Induced Thrombocytopenia (HIT):</b> For inpatients check baseline platelet count and then every 2-4 days until day 14. As a minimum for extended prophylaxis post-discharge check once between 4-7 days and again after 10-14 days of enoxaparin treatment. If platelets fall by more than 50% of baseline stop enoxaparin and discuss with haematology.	
<b>Hyperkalaemia:</b> monitor serum potassium in at risk patients (those with diabetes mellitus, chronic renal failure, pre-existing metabolic acidosis or taking potassium sparing drugs) before starting treatment and recheck regularly	

All patients to be periodically reassessed during inpatient stay as risk factors or contraindications may change.  
**Review assessment at 24 hrs then reassess every 72 - 96 hrs or, as or when patient's condition changes.**