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** ☐

Step 1

Assess mobility for all patients admitted to hospital - tick one box	✓	**Action**
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 **NOT** expected to have ongoing reduced mobility relative to normal state		VTE prophylaxis not required Go to Step 4

Step 2

Assess thrombosis risk - tick all that apply (✓) **Any tick should prompt thromboprophylaxis**	First	72hr		First	72hr
Patient related					
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/m²)			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		

Step 3

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	First	72hr		First	72hr
Patient related					
Active bleeding			Thrombocytopenia (platelets < $50x10^9$/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					

Step 4

Assessment completed by (can be any trained healthcare worker)

Assessment	Signature	Name (PRINT)	Grade	Bleep	Date
First					
72 hour					

Step 5

Consider contra-indications tick if present (✓)	First	72hr
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		

Step 6

Guidelines used to risk assess: Surgical ☐ Orthopaedic ☐ Obstetric ☐ Other.....(specify)

Record treatment decisions tick all that apply (✓)	First	72hr		First	72hr
None - cross off enoxaparin from chart (drug 1)			Unfractionated Heparin (UFH)		
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

Heparin Induced Thrombocytopenia (HIT): 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.
Hyperkalaemia: 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.