# Policy for Venous Thromboembolism Prevention and Treatment

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<th><strong>Start date:</strong></th>
<th>May 2013</th>
<th><strong>Next Review:</strong></th>
<th>May 2015</th>
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<tbody>
<tr>
<td><strong>Committee approval:</strong></td>
<td>Thrombosis and Thromboprophylaxis Steering Committee</td>
<td><strong>Date:</strong> 22nd May 2013</td>
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<td><strong>Endorsed by:</strong></td>
<td>Trust Executive Quality Committee</td>
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<td><strong>Distribution:</strong></td>
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This document should be read in conjunction with:
- Guidelines for Peri-Operative Venous Thromboembolism (VTE) Prophylaxis in Adults
- Guidelines for venous thromboprophylaxis for acutely ill medical patients
- Thromboprophylaxis management of patients with a lower limb plaster cast in the urgent care centre/emergency department
- Prevention and treatment of venous thromboembolism in pregnancy
- Good practice guidelines for the management of patients wearing anti-embolism stockings
- Protocol for the investigation of suspected pulmonary embolism (including pregnant patients)
- Protocol for the investigation of suspected deep vein thrombosis (DVT) (excluding pregnant women)
- Guideline for the management of deep vein thrombosis (DVT) and non-massive pulmonary embolism (PE) (excluding pregnant women)
- Guidelines for the management of acute massive pulmonary embolism
- Guideline for adult patients requiring anticoagulation with warfarin

**Author/Further information:**
- Dr Helen Yarranton, Consultant Haematologist
- Sheena Patel, Specialist Anticoagulation Pharmacist

**Version:** 4

**Stakeholders involved:**

**Applicable to:** Trustwide

**Directorate responsible for the document:**
- Medicine – Haematology (Thrombosis and Thromboprophylaxis Committee)
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<td>May 2013</td>
<td>4</td>
<td>Helen Yarranton, Sheena Patel</td>
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Date Expired
POLICY FOR VENOUS THROMBOEMBOLISM PREVENTION AND TREATMENT

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1 DEFINITION OF VENOUS THROMBOEMBOLISM
Venous thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE).

2 PURPOSE OF POLICY
The purpose of this policy is to:

• prevent hospital associated venous thromboembolism (VTE) in accordance with the recommendations of NICE Clinical Guideline 92 (January 2010): Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital
• manage VTE appropriately once the diagnosis has been made

2.1 Rationale for thromboprophylaxis

2.1.1 There is a high prevalence of VTE in hospitals
• Almost all hospitalised patients have at least one risk factor for VTE
• DVT is common in many hospitalised patient groups
• Hospital–associated DVT and PE are usually clinically silent
• It is impossible to predict which at risk patients will develop symptomatic thromboembolic complications

2.1.2 There are adverse consequences of unprevented VTE
• An estimated 25,000 people a year die from hospital-associated VTE in England and Wales
• 25 times more people die of VTE than hospital acquired infection
• There are significant costs of investigating symptomatic patients
• Many patients with VTE will suffer chronic problems such as post-thrombotic syndrome and chronic thromboembolic pulmonary hypertension
• There is a 30% recurrence rate for VTE at 10 years

2.1.3 Thromboprophylaxis is effective and efficacious
• Thromboprophylaxis is highly efficacious at preventing DVT and PE
• The majority of deaths from VTE are preventable
• Cost-effectiveness of thromboprophylaxis has repeatedly been demonstrated

2.2 Rational for the appropriate management of VTE once the diagnosis is made
Under-anticoagulation in the treatment of DVT may lead to the extension of DVT or risk of PE. Under-anticoagulation in the treatment of PE may be fatal.
Over-anticoagulation in the treatment of DVT or PE may lead to haemorrhage that may be major or fatal.
Patients who do not wear anti-embolism stockings are at a higher risk of developing post-thrombotic syndrome.

3 POLICY AIM
To enable healthcare professionals to identify patients at risk of developing VTE, select appropriate pharmacological and mechanical thromboprophylaxis and offer patients information to reduce the morbidity and mortality associated with VTE.

To enable healthcare professionals manage patients with newly diagnosed VTE by treating with adequate anticoagulation unless contraindicated and arranging future monitoring of anticoagulation, providing low compression anti-embolism stockings unless contraindicated and informing patients and their GP to obtain high compression anti-embolism stockings.
4 PROCESS FOR PREVENTING VTE

4.1 Which patients need to be risk assessed?

- All adult patients (aged 18 and above) admitted to hospital including day case patients
- All patients seen in the Emergency department or the Urgent Care Centre with limb immobilisation with plaster casts, back-slab or walking or air boot
- All antenatal patients at booking clinic appointments

*Note: Patients admitted and discharged from the Emergency Observation Unit will not require a VTE risk assessment – these patients are at low risk of VTE and mobile*

4.2 When do patients need to be risk assessed?

4.2.1 Patients undergoing surgery seen in the surgical pre-assessment centre

- Should be risk assessed in the pre-assessment centre
- On the day of surgery the risk assessment does not need to be repeated unless there has been a clinical change or the risk assessment was completed more than 3 months previously
- The patient should be reassessed within 24 hours of admission and again whenever the clinical situation changes

4.2.2 Patients undergoing surgery not seen in the surgical pre-assessment centre (including emergency admissions)

- A risk assessment should be completed on admission to hospital
- For low risk day cases receiving surgery under local anaesthetic (see Appendix 1), the risk assessment will be completed at the mobility screen of the electronic VTE risk assessment
- The patient should be reassessed within 24 hours of admission and again whenever the clinical situation changes

4.2.3 Patients seen in the Emergency department or the Urgent Care Centre with limb immobilisation with plaster casts, back-slab or walking or air boot

- Should be assessed when they are seen in the department

4.2.4 All other patients

- A risk assessment should be completed on admission to hospital

4.3 Who is responsible for undertaking and documenting risk assessments?

Staff responsible for completing the VTE risk assessments are listed in the table below:

<table>
<thead>
<tr>
<th>Directorate/Department</th>
<th>Staff Responsible for Completing VTE RA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine and Emergency Medicine</td>
<td>Doctors</td>
</tr>
<tr>
<td>Inpatient wards</td>
<td>Doctors</td>
</tr>
<tr>
<td>Medical day unit</td>
<td>Nurses</td>
</tr>
<tr>
<td>Emergency observation unit</td>
<td>Doctors or nurses</td>
</tr>
<tr>
<td>/urgent care centre – patients</td>
<td></td>
</tr>
<tr>
<td>admitted and transferred to</td>
<td></td>
</tr>
<tr>
<td>inpatient ward</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>Doctors</td>
</tr>
<tr>
<td>Inpatient wards</td>
<td>Doctors</td>
</tr>
<tr>
<td>Treatment Centre</td>
<td>Nurses</td>
</tr>
<tr>
<td>Preoperative Assessment Centre</td>
<td>Nurses</td>
</tr>
<tr>
<td>Surgical Admissions Lounge</td>
<td>Nurses</td>
</tr>
<tr>
<td>HIV&amp; Sexual Health</td>
<td>Doctors or nurses</td>
</tr>
<tr>
<td>Ron Johnson ward</td>
<td>Doctors</td>
</tr>
<tr>
<td>Kobler day care</td>
<td>Nurses and Doctors</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Doctors</td>
</tr>
<tr>
<td>Dermatology inpatients</td>
<td>Doctors</td>
</tr>
<tr>
<td>Dermatology day cases</td>
<td>Nurses</td>
</tr>
</tbody>
</table>
4.3.1 *Patients seen in surgical pre-assessment centre*

The nurse assessing the patient is responsible for undertaking and documenting the risk assessment on Lastword® and record the completion. If both a thrombotic and a bleeding risk are identified then the pre-assessment nurses will record this on the electronic surgical pre-assessment communication notes.

4.4 **Who is responsible for selecting and prescribing prophylaxis treatments?**

The admitting doctor who has carried out the risk assessment is responsible for prescribing prophylaxis (pharmacological prophylaxis and mechanical prophylaxis) according to Trust guidelines.

For patients with limb immobilisation in plaster casts, back-slab or walking or air boot seen in the Emergency department or the Urgent Care Centre, the nurse practitioner (if a qualified prescriber) or the doctor assessing the patient should prescribe thromboprophylaxis according to the Trust guidelines.

4.5 **Who is responsible for administering pharmacological prophylaxis and who is responsible for administering mechanical prophylaxis?**

The nursing staff are responsible for administering pharmacological prophylaxis and mechanical prophylaxis as prescribed.

4.6 **What VTE risk assessment tools are used and where can they be found?**

There are two VTE risk assessments (*see Appendix 2*) used in the Trust for patients admitted to hospital. The first is based on the Department of Health’s risk assessment for venous thromboembolism and the second is for pregnant women. The risk assessments are in electronic format and the appropriate risk assessment will appear according to the department the patient is admitted to.

There is a further paper VTE risk assessment tool specifically for patients seen in the Emergency department or the Urgent Care Centre with lower limb immobilisation.

4.6.1 **Completing the risk assessment**

The first part of the risk assessment is to assess the mobility status of the patient. If the patient is not expected to have significantly reduced mobility relative to their normal state, this should be documented and the risk assessment is completed at this stage. If the patient is expected to have ongoing reduced mobility relative to their normal state (the majority of patients admitted overnight) then the assessment requires the documentation of thrombotic risk. If thrombotic risk factors are documented an assessment of bleeding risk is required.

4.6.2 **Mandatory alerts**

When an admitted patient is activated on Lastword® by staff in the doctor or nurse user groups, a VTE risk assessment alert will appear on admission and again within 24 hours of admission. These alerts will continue to appear until the risk assessments are completed. The alert will direct the user to the VTE risk assessment.
4.6.3 **Performing the VTE risk assessment when the mandatory alerts do not appear**

*For example if the patient has already had a risk assessment completed on admission and were reassessed within 24 hours.*

A risk assessment can be completed at other times on Lastword® by selecting "VTE Risk Assessment Entry" in the Lastword® base screen under the “PATIENT OPTIONS” tab. Alternatively type “vte” in the command field.

4.6.4 **Cancelling the mandatory alerts**

The mandatory alert can be inactivated by selecting one of the override reasons in the drop down list on the mandatory alert (see table below). Override reasons should NOT be used inappropriately and their use will be monitored.

<table>
<thead>
<tr>
<th>Override reasons</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Patient requiring urgent attention</td>
</tr>
<tr>
<td>B</td>
<td>Reviewing results only</td>
</tr>
<tr>
<td>C</td>
<td>VTE risk assessment in preop OP &amp; No change</td>
</tr>
<tr>
<td>D</td>
<td>Not admitting Dr/nurse</td>
</tr>
<tr>
<td>E</td>
<td>Not named team</td>
</tr>
<tr>
<td>F</td>
<td>Not trained to perform task</td>
</tr>
<tr>
<td>G</td>
<td>Patient activated in error</td>
</tr>
</tbody>
</table>

For inpatients, nurses should be selecting option F – *Not trained to perform task* if an alert appears when a patient is activated and should encourage the doctors to complete the VTE risk assessment.

The mandatory alert will appear again when a different user activates the patient record.

4.6.5 **Viewing a list of patients who have not had a risk assessment on admission or have not been reassessed within 24 hours of admission**

A list of patients who have yet to have a VTE risk assessment completed can be found by typing “vta” in the command field. Patients whose risk assessment is overdue are highlighted in black.

4.6.6 **Viewing a risk assessment**

Previous VTE risk assessments can be found under “VTE risk assessment viewer” on Lastword® on the base screen under the “RESULTS” tab.

4.7 **What thromboprophylaxis should patients at risk of VTE receive?**

Patients should be prescribed thromboprophylaxis according to Trust guidelines available on Datix on the Trust intranet*:  
- Guidelines for Peri-Operative Venous Thromboembolism (VTE) Prophylaxis in Adults  
- Guidelines for venous thromboprophylaxis for acutely ill medical patients  
- Prevention and treatment of venous thromboembolism in pregnancy  
- Thromboprophylaxis Management of Patients with a Lower Limb Plaster Cast in the Urgent Care Centre/Emergency Department  

*a shortened form of the guidance is available within the Adult Pocket Guide: Prevention and Treatment of Venous Thromboembolism (also available on the intranet)*
4.8 What factors are used in the categorisation of risk in medical and surgical patients?
Refer to Trust Thromboprophylaxis guidelines

4.9 What recommended treatment options apply to each risk category?
Refer to Trust Thromboprophylaxis guidelines

4.10 What contraindications to pharmacological prophylaxis apply?
Refer to Trust Thromboprophylaxis guidelines

4.11 What contraindications to mechanical prophylaxis apply?
Refer to Trust Thromboprophylaxis guidelines

4.12 What is the timing, dosage and duration of pharmacological prophylaxis?
Refer to Trust Thromboprophylaxis guidelines

4.13 What information should patients be offered on VTE prevention?
Patients/carers should be offered verbal and written information on VTE as part of the admissions process. Information should be provided on:
- the risks and possible consequences of VTE
- the importance of VTE prophylaxis and its possible side effects
- the correct use of VTE prophylaxis (for example, anti-embolism stockings, intermittent pneumatic compression devices or foot impulse devices)
- how patients can reduce their risk of VTE (such as keeping well hydrated and, if possible, exercising and becoming more mobile)

Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process. Information should include:
- the signs and symptoms of deep vein thrombosis and pulmonary embolism
- the correct and recommended duration of use of VTE prophylaxis at home (if discharged with prophylaxis)
- the importance of using VTE prophylaxis correctly and continuing treatment for the recommended duration (if discharged with prophylaxis)
- the signs and symptoms of adverse events related to VTE prophylaxis (if discharged with prophylaxis)
- the importance of seeking help and who to contact if they have any problems using the VTE prophylaxis
- the importance of seeking medical help if deep vein thrombosis, pulmonary embolism or other adverse events are suspected.

4.13.1 What written information on VTE prevention is available for patients?
There are three Trust patient information leaflets:
- Are you at risk of blood clots? Information for patients in hospital or going home from hospital
- Are you at risk of blood clots? Information for patients in A&E (Emergency Department), Urgent Care Centre and Outpatient Clinics
- Are you at risk of blood clots in pregnancy?

4.13.2 Which patients should be offered the “Are you at risk of blood clots? patient information leaflets?”
All patients admitted to hospital and all patients seen in the surgical pre-assessment centre who are to be admitted for a surgical procedure and on discharge from hospital.
4.13.3 Who is responsible for providing patients with the VTE patient information?

- **Patients seen in surgical pre-assessment centre**
  The nursing staff in surgical pre-assessment centre should give the leaflets to all patients and record this in the communication notes via Command TRXALL on Lastword®.

- **Patients admitted to hospital**
  The leaflet should be offered to all adult patients admitted to hospital by any healthcare professional. The leaflets should be visible and on display on all adult wards.

4.13.4 Where can new stocks of the patient information leaflet be obtained?

VTE patient information leaflets can be obtained from Dr Helen Yarranton, Consultant Haematologist or Sheena Patel, Specialist Anticoagulation Pharmacist via Trust email.

5 PROCESS FOR THE INVESTIGATION OF SUSPECTED VTE AND MANAGEMENT OF A PATIENT ONCE A POSITIVE DIAGNOSIS OF VTE HAS BEEN MADE

5.1 What investigations should be arranged for suspected VTE?

Refer to Trust guidelines
- Protocol for the investigation of suspected acute pulmonary embolism (including pregnant patients)
- Protocol for the investigation of suspected deep vein thrombosis (DVT) (excluding pregnant women)
- Prevention and treatment of venous thromboembolism in pregnancy

5.2 Management of patients once a positive diagnosis of VTE is made

If a DVT or PE is confirmed the patient should be anticoagulated with therapeutic doses of low molecular weight heparin initially and warfarin or one of the novel oral anticoagulants (dabigatran, rivaroxaban or apixaban). Refer to Trust guidelines.
- Guideline for the management of deep vein thrombosis (DVT) and non-massive pulmonary embolism (PE) (excluding pregnant women)
- Prevention and treatment of venous thromboembolism in pregnancy
- Novel oral anticoagulants

5.3 Root cause analysis for hospital associated VTE

A hospital associated VTE is defined as occurring during a hospital admission or within 3 months of a hospital admission. Cases will be identified by monitoring radiology reports. All patients with a new suspected hospital-associated VTE diagnosis are reviewed by the Haematology Consultant and the Specialist Anticoagulation Pharmacist who identify when a root cause analysis is required. A root cause analysis should be performed on cases where appropriate thromboprophylaxis was not used.
6 EXPECTED OUTCOMES/MONITORING

6.1 VTE prevention

6.1.1 The VTE risk assessment target for the Trust is that more than 95% of adult patients admitted to Chelsea and Westminster Hospital will be risk assessed on admission. The risk assessment should be repeated within 24 hours of admission. This will be monitored and reviewed at each Thrombosis and Thromboprophylaxis Committee. The reports will be circulated to the Divisional Medical Directors for review and action. A quarterly report will be provided to the Quality committee via the quarterly update on quality objectives. Actions identified will be monitored by the Quality committee until completion.

6.1.2 All patients should receive appropriate pharmacological and mechanical thromboprophylaxis according to Trust guidelines. This will be monitored by monthly audits and will be reviewed by the Thrombosis and Thromboprophylaxis Committee. A quarterly report will be provided to the Quality committee via the quarterly update on quality objectives. Actions identified will be monitored by the Quality committee.

6.1.3 All patients should be offered verbal and written information on VTE prevention. For patients seen in the surgical pre-assessment centre, an annual audit of the nursing communication notes via command TRXALL will be performed and will be reviewed by the Thrombosis and Thromboprophylaxis Committee. The annual audit will be reported to Quality committee. Actions identified will be monitored by the Quality committee.

6.2 Suspected VTE

The procedure to be followed for suspected VTE (either DVT or PE) will be audited as per the audit plan agreed annually by the Thrombosis and Thromboprophylaxis Committee (see monitoring sections of policies referenced in Section 5.1).

6.3 VTE management

6.3.1 Appropriate VTE management will be monitored by annual audits and will be reviewed and actions identified will be monitored by the Thrombosis and Thromboprophylaxis Committee and be reported to the Quality committee.

6.4 Root cause analysis

Completion of root cause analysis will be monitored by the Consultant Haematologist, Specialist Anticoagulation Pharmacist and the risk management team. Failure to complete root cause analysis investigations in a timely manner will be escalated to the relevant Divisional Medical Director.

7 STAFF TRAINING

The organisation's expectations in relation to staff training is identified in the training needs analysis.
8 REFERENCES


• NICE Quality Standards: VTE prevention, June 2010 http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention/

9 APPENDIX

Appendix 1 - Cohorting Arrangements for Low Risk Patients

Appendix 2 – Electronic VTE risk assessments
Appendix 1: Cohorting Arrangements for Low Risk Patients

Ms Heather Lawrence, Chief Executive
Dr Andy Mitchell, SHA Medical Director
Ms Cathy Mooney, Director of Governance and Corporate Affairs
Mr Jeremy Thompson, Divisional Director for Medicine and Surgery
Ms Zoe Penn, Divisional Medical Director Division of Women’s & Neonatal Services; Children’s & Young People’s Services; HIV, GUM and Dermatology
Ms Karen Robertson, Divisional Director Operations Clinical Support and Chief Pharmacist
Dr Helen Yarranton, Chair of the Thrombosis and Thromboprophylaxis committee

25th November 2010

Re: Chelsea and Westminster Hospital Foundation Trust Venous Thromboembolism (VTE) risk assessment; ‘Cohorting’ arrangements, November 2010

At Chelsea and Westminster Hospital I agree to a “cohort approach” to risk assessment using the DH/NICE National Tool for VTE risk assessment for groups of patients undergoing procedures that are considered to be at low risk of VTE using the DH/NICE risk assessment categories and detailed NICE guidance (CG092).

This will apply to the following cohorts of patients attending the treatment centre for day surgery:

1. Non-cancer endoscopy and cystoscopy procedures with local anaesthetic/regional/ sedation and not general anaesthetic
2. Ophthalmological procedures with local anaesthetic/regional/ sedation and not general anaesthetic
3. Non-cancer plastic surgery lasting less than 90 minutes with local anaesthetic/ regional/sedation and not general anaesthetic
4. Non-cancer dental and maxillo-facial surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not general anaesthetic
5. Other similar minor procedures (see appendix 1) lasting less than 90 minutes with local anaesthetic/regional/ sedation and not general anaesthetic.

These patients will be recorded on the Trust Lastword electronic VTE risk assessment as “Day case surgery pt: NOT under GA, NOT to lower limb, non-cancer & NO reduced mobility cf normal”.

This will also apply to the following cohorts patients attending for day case medical procedures:

1. Chemotherapy
2. Dermatology patients receiving phototherapy or dressing or cleaning of skin wounds.

These patients will be recorded on the Trust Lastword electronic VTE risk assessment as “Medical patient not expected to have significant reduction in mobility relative to normal state”.

Please see Appendix 1 for more information.

Dr Mike Anderson
Medical Director
Appendix 1:

Requirements for a VTE risk assessment

**Surgical procedures which require a VTE risk assessment:**

- Surgery lasting more than 90 minutes
- Surgery performed under general anaesthetic
- if suspected to have significant reduction in mobility

**AND**

The following procedures:
- Surgery to the lower limb
- Surgery to abdomen or pelvis
- patients with known/suspected cancer (with the exception of skin cancers and localised TCC bladder)

**Surgical procedures which do not require a VTE risk assessment UNLESS performed under general anaesthetic**

The following are deemed to be low risk and DO NOT require a VTE risk assessment UNLESS performed under general anaesthetic

<table>
<thead>
<tr>
<th>General Procedures</th>
<th>Orthopaedics procedures not involving the lower limbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excision lipoma</td>
<td></td>
</tr>
<tr>
<td>Excision sebaceous cyst</td>
<td></td>
</tr>
<tr>
<td>Excision lymph node</td>
<td></td>
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<tr>
<td>Temporal artery biopsy</td>
<td></td>
</tr>
<tr>
<td><strong>Hand management unit</strong></td>
<td></td>
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<tr>
<td>Nail bed repair</td>
<td></td>
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<tr>
<td>Incision and drainage of abscess</td>
<td></td>
</tr>
<tr>
<td>Removal of foreign body</td>
<td></td>
</tr>
<tr>
<td>Flexor tendon repair (upper limb only)</td>
<td></td>
</tr>
<tr>
<td>Extensor tendon UCL repair</td>
<td></td>
</tr>
<tr>
<td>K wiring of Fractures (upper limb only)</td>
<td></td>
</tr>
<tr>
<td>ORIF (plating) finger fractures</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ophthalmology Procedures</th>
<th>Pain Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataracts</td>
<td>Facet joint injection.</td>
</tr>
<tr>
<td>Ptosis repair</td>
<td>Sacro Iliac joint injections</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Piriforms Injection therapy</td>
</tr>
<tr>
<td>Pterygium</td>
<td>Therapeutic lumbar epidural injection</td>
</tr>
<tr>
<td>Intravitreal injections</td>
<td>Therapeutic Cervical epidurals</td>
</tr>
<tr>
<td>Occuplastic cases these vary according to the patient</td>
<td>Suprascapular nerve block</td>
</tr>
<tr>
<td><strong>Plastic surgery</strong></td>
<td>Trigger point injection to Muscle</td>
</tr>
<tr>
<td>cutaneous and subcutaneous surgery</td>
<td>Radiofrequency/ Pulsed to nerve</td>
</tr>
<tr>
<td></td>
<td>Pulsed RF to Trigger point</td>
</tr>
<tr>
<td></td>
<td>Radiofrequency destruction of nerve root</td>
</tr>
<tr>
<td></td>
<td>Surgical Insertion of spinal cord stimulator,</td>
</tr>
<tr>
<td></td>
<td>(procedure done in two stages)</td>
</tr>
<tr>
<td></td>
<td>Guanethidine block</td>
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<tr>
<td></td>
<td>Lumbar chemical sympathectomy.</td>
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<tr>
<td></td>
<td>Peripheral nerve neuromodulation (PENS)</td>
</tr>
<tr>
<td></td>
<td>Peripheral nerve blocks</td>
</tr>
<tr>
<td></td>
<td>BOTOX to muscle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urology procedures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexi Cystoscopy</td>
<td></td>
</tr>
<tr>
<td>Hydrocele</td>
<td></td>
</tr>
<tr>
<td>Circumcision</td>
<td></td>
</tr>
<tr>
<td>Penile biopsy</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2: Electronic VTE Risk Assessment

#### VTE Risk Assessment

**Select if patient has risk**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Assessment: VTE Mobility Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MORBIDITY RISK - PATIENT RELATED</strong></td>
<td></td>
</tr>
<tr>
<td>Delayed surgery Pt: NOT under 65, NOT to lower limb, non-cancer &amp; NO reduced mobility of normal</td>
<td></td>
</tr>
<tr>
<td>Surgical patient</td>
<td></td>
</tr>
<tr>
<td>Medical patient EXPECTED to have ongoing reduced mobility relative to normal state</td>
<td></td>
</tr>
<tr>
<td>Medical patient NOT expected to have significantly reduced mobility relative to normal state</td>
<td></td>
</tr>
</tbody>
</table>

---

#### VTE Risk Assessment 2

**Select if patient has risk**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Assessment: VTE Risk Assessment 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THROMBOSIS RISK - PATIENT RELATED</strong></td>
<td></td>
</tr>
<tr>
<td>Active cancer or cancer treatment</td>
<td></td>
</tr>
<tr>
<td>Age &gt; 60 years</td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
</tr>
<tr>
<td>Known thromboembolias</td>
<td></td>
</tr>
<tr>
<td>Obesity (BMI &gt; 30 kg/m²)</td>
<td></td>
</tr>
<tr>
<td>Significant heart disease/respiratory pathology</td>
<td></td>
</tr>
<tr>
<td>Acute infectious disease/inflammatory condition</td>
<td></td>
</tr>
<tr>
<td>Significant metabolic or endocrine pathology</td>
<td></td>
</tr>
<tr>
<td>History of VTE in patient or 1st-degree relative</td>
<td></td>
</tr>
<tr>
<td>Use of hormone replacement therapy</td>
<td></td>
</tr>
<tr>
<td>On oral estrogen-containing contraceptive therapy</td>
<td></td>
</tr>
<tr>
<td>Varicose veins with phlebitis</td>
<td></td>
</tr>
<tr>
<td>Pregnancy or &lt; 6 weeks post partum</td>
<td></td>
</tr>
<tr>
<td><strong>THROMBOSIS RISK - PROCEDURE RELATED</strong></td>
<td></td>
</tr>
<tr>
<td>Significantly reduced mobility for 3 days or more</td>
<td></td>
</tr>
<tr>
<td>Hip or knee replacement</td>
<td></td>
</tr>
<tr>
<td>Hip fracture</td>
<td></td>
</tr>
<tr>
<td>Total anaesthetic + surgical time &gt; 90 minutes</td>
<td></td>
</tr>
<tr>
<td>Pelvic/leg surgery &amp; total ones + Op time &gt;30min</td>
<td></td>
</tr>
<tr>
<td>Surgical inflammatory/intra-abdominal condition</td>
<td></td>
</tr>
<tr>
<td>Critical care admission</td>
<td></td>
</tr>
<tr>
<td>Surgery with significant reduction in mobility</td>
<td></td>
</tr>
<tr>
<td>Other THROMBOSIS risk (please specify in notes)</td>
<td></td>
</tr>
<tr>
<td>NO THROMBOSIS RISKS identified</td>
<td></td>
</tr>
</tbody>
</table>
### Electronic VTE Risk Assessment for Pregnant Women:

#### Risk Assessment

- **Select if patient has risk**
  - [x] Thrombosis Risk - Patient Related
  - [x] Age > 35 years or Parity of 3 or more
  - [x] Obesity (BMI >30 kg/m²) at booking
  - [x] Smoker
  - [x] Varicose veins with phlebitis
  - [x] History of VTE in patient or 1st degree relative
  - [x] Known thrombophilia
  - Multiple pregnancy/assisted reproductive treatment
  - Significant heart disease/respiratory pathology
  - Acute infectious disease/inflammatory condition
  - Significant metabolic/endocrine or renal pathology
  - Sickle cell disease or cancer
  - Long haul travel (>4hrs) within last 2 weeks
  - Pre-existing reduced mobility/parencorphic/SPD
  - Hyperviscosity, Dehydration, Ovarian hyperstimulation
  - Severe infections needing hospital admissions
  - Pre-eclampsia or significant proteinuria
  - Prolonged labour >24 hours
  - Elective or emergency caesarean section
  - Mid-cavity rotational operative delivery
  - Any surgical procedure in puerperium
  - FFP/1 litre or blood transfusion
  - Critical care admission
  - Other Thrombosis Risk (please specify in notes)
  - No Thrombosis Risks identified

#### Additional Elements

- Assessed Date/Time: 12Nov2010 /17:32
- Entered By: HENRY, DAVID

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Policy for venous thromboembolism prophylaxis. Version 4.0
July 2013
### VTE Risk Assessment

**Assessment: VTE Maternity Risk Assessment**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>* BLEEDING RISK - PATIENT RELATED *</td>
<td>Uncontrolled blood pressure [200/110mmHg]</td>
</tr>
<tr>
<td></td>
<td>Active bleeding (AHN/abruptio placentae)</td>
</tr>
<tr>
<td></td>
<td>Acute fatty liverHELLP with low platelets</td>
</tr>
<tr>
<td></td>
<td>Active labour/Early labour</td>
</tr>
<tr>
<td></td>
<td>Platelet count &lt; 75 x 10^9/L</td>
</tr>
<tr>
<td></td>
<td>Induction of labour</td>
</tr>
<tr>
<td></td>
<td>Intravital bleeding disorders eg WAD</td>
</tr>
<tr>
<td></td>
<td>Epidural/spinal anaesthesia due in next 12hrs</td>
</tr>
<tr>
<td></td>
<td>Epidural/spinal anaesthesia within previous 48hrs</td>
</tr>
<tr>
<td></td>
<td>Obstetric Cholestasis</td>
</tr>
<tr>
<td></td>
<td>NO BLEEDING RISKS identified</td>
</tr>
</tbody>
</table>

---

*Assessment Date/Time:* 12Nov2010 / 17:32  
*Form VTE Risk Assessment*  
*Entered Date/Time:* 12Nov2010 / 17:32  
*Mode:* A  
*Entered By:* HENRY, DAVID  

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*Policy for venous thromboembolism prophylaxis. Version 4.0*  
*July 2013*