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Midlands Trauma Networks
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This policy is now built into PICS thrombosis assessment

- ALL lower limb/pelvic/abdo/chest/spine/head admissions should receive antiembolism stockings (GECS) unless contra-indicated. These should be applied certainly to the "good" leg(s) and to the "bad" leg if the injuries permit this to be done safely. If contra-indicated or the patient refuses then this MUST be recorded in the notes.
- ALL lower limb/pelvic/abdo/chest admissions should receive 40mg enoxaparin subcut once daily unless contra-indicated. If contra-indicated or the patient refuses then this MUST be recorded in the notes.
- Spinal and head-injured patients will need special consideration, preferably in consultation with the neuro/spinal surgeons, but should receive 40mg enoxaparin subcut once daily unless contra-indicated. If contra-indicated or patient refuses then this MUST be recorded in the notes.
- ALL upper limb patients will need at the least an assessment of risk. If in doubt they should ALL receive GECS. If there is particular risk, especially if they are immobile (e.g. following a flap reconstruction) they should receive 40mg enoxaparin subcut once daily unless contra-indicated. If contra-indicated or the patient refuses then this MUST be recorded in the notes.
- Where enoxaparin is contra-indicated by active bleeding or a high risk of bleeding (e.g. conservatively managed solid organ injury) or another reversible reason the contra-indicating risk MUST be reviewed regularly and frequently so that enoxaparin can be started as soon as safely possible.

- In some high-risk patients where enoxaparin is contra-indicated a caval filter may be appropriate. This is a decision that needs to be made at a relatively senior level. Make sure that VTE prohylaxis is something you discuss on your ward rounds.
- Enoxaparin should be stopped 12 hours before surgery and restarted 6—12 hours post surgery. **If a patient is postponed for theatre then this requires an active decision to give any dose that would otherwise have been omitted.**
- Hip fracture patients require their enoxaparin continued to 35 days post-surgery EVEN IF THEY GO HOME rather than to a rehab unit. Please ensure this is made to happen at discharge.
- Make sure that, as with any decision about patient management, decisions about VTE prophylaxis are recorded in the notes.

No trauma/orthopaedic patients should receive 20mg enoxaparin (unless dose reduced for renal impairment), so if you see this change it. Almost all trauma patients should be wearing GECS until fully mobile, so if you see someone without GECS question it and prescribe them if appropriate.