



Venous Thromboembolism Prevention Policy

1. Purpose

This policy aims to reduce avoidable death or disability caused by hospital-acquired venous thromboembolism (VTE) in accordance with the Australian Commission on Safety and Quality in Health Care (ACSQHC) [Venous Thromboembolism Prevention Clinical Care Standard](#), by establishing the minimum practice standards for the identification of patients who are at risk, assessment of VTE and bleeding risk, and appropriate use of VTE prevention methods (pharmacological and mechanical prophylaxis).

The scope of this policy excludes:

- outpatients including ambulatory cancer patients receiving chemotherapy as day procedures
- treatment of VTE.

2. Policy

The following patients should have a VTE risk assessment:

- all patients admitted to an inpatient ward, mental health inpatient units, subacute/rehabilitation care, Hospital in the Home, and palliative care
- all patients undergoing day surgeries or procedures under general and prolonged anaesthesia with significant reduction in their mobility
- pregnant and post-partum women (<6 weeks postpartum and receiving perinatal care)
- ambulatory patients with isolated injury who will require temporary lower limb immobilisation (including those discharged from Emergency Departments).

The following patients **do not** routinely require VTE prophylaxis (and therefore do not require a VTE risk assessment):

- day surgery or procedure patients where procedures are carried out under local anaesthesia without any limitation of mobility
- all patients discharged home from the Emergency Department other than those with lower limb immobilisation.

2.1 Assess and document VTE risk

Pre-admission screening for elective procedures

At the pre-admission appointment, conduct preliminary risk assessments to allow for VTE prevention planning prior to admission for an elective procedure in accordance with this policy.

Refer to the [Guidelines on Periprocedural Management of Anticoagulant and Antiplatelet Agents](#) for clinical practice guidance.

VTE risk assessment

Assessment and documentation of VTE risk and bleeding risk must be completed as soon as practicable and within 24 hours of admission.

Adults (excluding perinatal women)

Validated VTE risk assessment tools should be used to support clinical decision-making.

Recommended tools include:



Surgical (including orthopaedics) – ‘[Caprini Score for VTE](#)’ online via [MDCalc.com](#) or via the QR code.



Medical – ‘[Padua Prediction Score for Risk of VTE](#)’ online via [MDCalc.com](#) or via the QR code.

VTE risk assessment for adults must be documented using the ‘VTE risk assessment/Anticoagulation’ section of the WA Hospital Medication Chart (WA HMC). If the risk changes, the new outcome is to be documented on a separate WA HMC.

Palliative patients

For palliative patients that are near the end of life, patients and staff must balance symptom burden, greatly elevated thrombosis and bleeding risks, competing comorbidities and medications, and changing goals of care over time.¹ The recommended primary guidance for VTE in palliative care are the [Therapeutic Guidelines](#).

A secondary reference for additional information is the American Society of Hematology [Anticoagulation at the End of Life: Whether, When, and How to Treat](#). This provides a framework for individualised decision-making on starting, continuing, or stopping anticoagulation in patients with limited life expectancy.

Perinatal women

For perinatal women, staff are to refer to and apply Women and Newborn Health Service [Venous Thromboembolism \(VTE\): Prevention and Management Clinical Practice Guideline](#) and document the risk assessment in the relevant WACHS antenatal and postnatal risk assessment forms:

- [MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis](#)
- [MR80A.2 WACHS Postnatal Risk Assessment for VTE Prophylaxis](#).

Children and young people

The indication for VTE prophylaxis in children and young people is a specialised area of practice where evidence is limited. Decisions must be informed by specialist paediatric guidance and individual patient risk assessment.²

The Perth Children’s Hospital [Venous Thromboembolism \(VTE\) Primary Prophylaxis Guideline](#) is to be consulted for the latest information on risk assessment and prophylaxis.

2.2 Develop a VTE prevention plan

Assess for contraindications to pharmacological and mechanical VTE prophylaxis

Consideration should be given to:

- reason for admission
- patient-related factors
- comorbidities
- medication history.

Refer to the Queensland Health [Guideline for the Prevention of Venous Thromboembolism \(VTE\) in Hospitalised Adult Patients](#) for clinical practice guidance.

If VTE prophylaxis is not required or if contraindicated, document on the appropriate medication chart by ticking the appropriate box and ensure the relevant section is signed and dated to indicate that the risk assessment is complete.

Consider bleeding risk

Apply the [best possible medication history](#) to identify medicines the patient might be taking (including complementary and over-the-counter medicines) that increase the risk of clotting or bleeding – refer to the WACHS [Medication Review Procedure](#).

Clinicians must consider bleeding risk and relevant contraindications when determining the appropriateness of pharmacological VTE prophylaxis in comparison to mechanical prophylaxis. General guidance to inform decision making for bleeding risk assessment is outlined in the Table 1.

Table 1: Bleeding risk assessment^{3,4,5}

Contraindications to anticoagulants	Notation
• Current significant bleeding • Platelets < 50 x 10⁹/L • Lumbar puncture, epidural or spinal anaesthetic planned in next 12 hours or completed in the last 4 hours	Avoid anticoagulants unless directed by specialist in exceptional circumstances
Major bleeding risk factors	Notation
• Active gastrointestinal ulceration • Major bleed in last 1 month • Intracranial, spinal or intraocular bleeding in last 3 months • Recent procedure with high bleeding risk • Inherited bleeding disorder (untreated) • Neurosurgery, spinal or eye surgery in last 2 weeks	To justify anticoagulation, there must be major/multiple thrombosis risk factors to outweigh bleeding risk
Moderate bleeding risk factors	Notation
• Age ≥ 85 years • Liver disease or coagulopathy with INR > 1.5 • Renal failure with eGFR < 30 mL/minute • Antiplatelet prescribed (e.g. aspirin, clopidogrel, ticagrelor)	If two or more, the risk of bleeding might outweigh the benefit of anticoagulation

2.3 VTE prophylaxis selection

Inform and partner with the patient

Patients are to be provided with information and education to support their active involvement in VTE prevention tailored to their risk and needs. The patient should be involved in shared decision making regarding their VTE prevention plan including medicines and/or mechanical prophylaxis methods offered taking into consideration the patient's clinical condition and their preferences.

The ACSQHC [Quick Facts for Consumers](#) resource is a useful tool to support shared decision-making.

Pharmacological prophylaxis

Decisions regarding pharmacological VTE prophylaxis must be individualised, balancing the patient's risk of thrombosis against the risk of bleeding, and guided by current evidence-based clinical guidelines, including (but not limited to):

- [Therapeutic Guidelines](#)
- [Australian Injectable Drugs Handbook](#)
- [Australian Medicines Handbook](#)
- [Guidelines on Periprocedural Management of Anticoagulant and Antiplatelet Agents](#).

Where pharmacological prophylaxis is indicated, it must be prescribed on the [MR170C Anticoagulant Medication Chart](#).

Mechanical prophylaxis

When developing a plan that includes mechanical prophylaxis, consider the following:

- specialist vascular advice if prescribing in peripheral arterial disease (or if suspected)
- consideration of foot impulse technology as first preference in patients with peripheral arterial disease if mechanical compression is required after a vascular assessment.

For children and young people, there is limited evidence to support routine use of graduated compression stockings and pneumatic compression devices.² They should, however, be routinely considered in young people (more than 12 years old) or weigh more than 50 kg having surgery, as they are at higher risk for VTE.²

If mechanical prophylaxis is indicated it should be commenced as soon as possible after the completion of the VTE risk assessment. Generally, mechanical prophylaxis will be required until mobility has returned to an anticipated or clinically acceptable level or when the patient is discharged from hospital.

Mechanical VTE prophylaxis devices must be selected, fitted and applied by staff who are trained and competent in their use.⁴ The plan of care for mechanical prophylaxis must be documented in the healthcare record.

2.4 Reassessing risk, monitoring and updating the VTE prevention plan

Reassessing risk

Patients should be reassessed for risks of VTE and bleeding:

- at intervals no longer than seven days
- whenever there is a change in the patient's clinical condition or goals of care
- on discharge (including interhospital patient transfers).

Monitoring

It is essential that patients are encouraged to mobilise and ensure adequate hydration (unless clinically contraindicated).

Patients are to be monitored daily for³:

- early recognition of VTE-related complications (e.g. thrombosis or bleeding)
- early recognition of medicines-related complications (e.g. erroneous concomitant prescribing of VTE prevention medicines or drug interactions).
- skin integrity checks of lower limbs and pressure areas for patients with mechanical prophylaxis. Ensure correct fitting and adjust if indicated (e.g. if patients develop oedema or postoperative swelling).

Update VTE prevention plan

If VTE risk or bleeding risk changes during the admission, review VTE prophylaxis and adjust in line with a current, locally endorsed, evidence-based guideline and the patient's preference.

2.5 Transition from hospital and ongoing care

VTE risk and prevention requirements must be considered at the time of discharge and clearly documented in the patient's healthcare record, including the discharge summary, where applicable.

Prior to discharge, any plan to continue VTE prophylaxis must be communicated with patients and their carer, including how to use the prophylaxis. The plan is to be communicated to the general practitioner (GP) or ongoing clinical provider within 48 hours of discharge to continue ongoing care to prevent VTE.

To support safe and effective transition from the hospital setting to the community the following must be considered in the rural and remote context:

- confirming transport and pharmacy access
- capacity to attend follow-up
- access to a GP or local health service
- ability to store and administer medicines safely
- whether the patient would like family/carers or Aboriginal Health staff included in discharge education.

Written information should be provided where available. Examples of resources include:

- ACSQHC [Quick Facts for Consumers](#)
- Healthy WA [Deep Vein Thrombosis](#)

- [Living with a Direct-Acting Oral Anticoagulant \(DOAC\)](#)
- [Living with Warfarin.](#)

3. Roles and Responsibilities

District Director is responsible for ensuring:

- District governance arrangements support implementation of this policy, including alignment with district clinical governance, safety and quality systems.
- Monitoring of compliance and performance related to VTE risk assessment and prophylaxis occurs through established audit, quality and safety reporting processes.
- Assurance regarding compliance with this policy is provided through routine reporting to executive and Board-level governance structures, as required.

Director Medical Services is responsible for ensuring:

- Medical practitioners are aware of, and supported to comply with, requirements for VTE risk assessment, prescribing and documentation.
- Clinical advice and escalation are provided to the District Director and multidisciplinary team on emerging risks, variation in practice or gaps in compliance related to VTE prevention.
- Medical workforce capability is supported through education, supervision and reinforcement of best-practice guidance relevant to VTE prevention

Director Nursing and Midwifery is responsible for ensuring that:

- Nursing and midwifery practice across all district health services aligns with requirements for timely VTE risk assessment, reassessment, prevention and documentation in accordance with this policy and relevant clinical guidelines.
- Nursing and midwifery workforce capability to implement this policy is supported through appropriate education, supervision and professional development activities.
- Clinical advice and escalation are provided to the District Director and the multidisciplinary team on emerging risks, variation in practice or gaps in compliance related to VTE prevention.

Treating Medical Team are responsible for ensuring:

- VTE and bleeding risk assessments are completed, documented and reviewed within required timeframes
- Appropriate prophylaxis is prescribed (for pharmacological) and a plan of care is documented (for mechanical) when indicated
- Plans for ongoing VTE prevention at discharge are documented and communicated.
- They actively participate in clinical audit and reviewing practice.

Nursing, Midwifery and Allied Health Staff are responsible for ensuring that:

- Consumer education is provided regarding the general prevention of VTE
- Pharmacological and/or mechanical prophylaxis is administered and/or used as prescribed.
- Where credentialed to prescribe, nurses and midwives work within their scope of practice and WACHS policy guidance.

Pharmacists are responsible for ensuring that:

- VTE risk assessment and prophylaxis are considered when undertaking medication review for patients. This includes confirming that the choice of prophylaxis medicine, its dosing, frequency and duration are appropriate for the patient.

4. Monitoring and Evaluation

District Directors are responsible for monitoring compliance with this policy through established clinical audit and quality assurance processes comprising:

- Audit of VTE risk assessment and prophylaxis documentation via the WACHS Combined Bedside Risk Assessment (CoBRA) audit tool.
- Monitoring of the Health Service Performance Report (HSPR) Indicator P2-26d Rate of Hospital acquired complications: Venous thromboembolism.

5. References

1. Parks AL. [Anticoagulation at the End of Life: Whether, When, and How to Treat](#) [Internet] Hematology Am Soc Hematol Educ Program (2024) 2024 (1): 348–354 [Cited 17 July 2026]
2. Government of Western Australia, Child and Adolescent Health Service [Intranet] [Venous Thromboembolism \(VTE\) Primary Prophylaxis Guideline](#). Perth Children's Hospital; 2025 May [cited 17 July 2026]
3. Queensland Government, Queensland Health [Guideline for the Prevention of Venous Thromboembolism \(VTE\) in Hospitalised Adult Patients](#) [Internet]. 2025 [cited 28 July 2026]
4. Government of Western Australia, South Metropolitan Health Service [Intranet] [Venous thromboembolism \(VTE\) prevention policy and procedure](#) Fiona Stanley Fremantle Hospital Group; 2025 Feb [cited 17 July 2026]
5. Agency for Healthcare Research and Quality [Chapter 4. Choose the Model to Assess VTE and Bleeding Risk](#) [Internet] 2022 Oct [cited 17 July 2026]
6. Australian Commission on Safety and Quality in Health Care. [Venous Thromboembolism Prevention Clinical Care Standard](#) [Internet]. 2020 [cited 17 July 2026] [Accessed: 2026 July 17]
7. Guyatt GH, Eikelboom JW, Gould MK, Garcia DA, Crowther M, Murad MH, et al. [Approach to outcome measurement in the prevention of thrombosis in surgical and medical patients: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines](#). Chest [Internet]. 2012 Feb;141(2 Suppl):e185S-e94S [Accessed: 2026 July 17]
8. [Australian Medicine Handbook](#) [Internet]. AMH Pty Ltd. 2022 July [Accessed: 2026 July 17]
9. Agaba P, Kildow BJ, Dhotar H, Seyler TM, Bolognesi M. [Comparison of postoperative complications after total hip arthroplasty among patients receiving aspirin, enoxaparin, warfarin, and factor Xa inhibitors](#). Journal of Orthopaedics [Internet]. 2017 Dec;14(4):537-43 [Accessed: 2026 July 17]
10. Faour M, Piuze NS, Brigati DP, Klika AK, Mont MA, Barsoum WK, et al. [Low-Dose Aspirin Is Safe and Effective for Venous Thromboembolism Prophylaxis Following Total Knee Arthroplasty](#). The Journal of arthroplasty [Internet]. 2018 March;33(7s):S131-s5 [Accessed: 2026 July 17]
11. Freeman AL, Pendleton RC, Rondina MT. [Prevention of venous thromboembolism in obesity. Expert review of cardiovascular therapy](#) [Internet]. 2010 Dec;8(12):1711-21 [Accessed: 2026 July 17]

6. Definitions

Term	Definition
Best possible medication history	Best possible medication history (BPMH) refers to a list of all medicines a patient is taking prior to admission. The list should include prescribed, 'over the counter' and complementary medicines. The list should be confirmed with at least two sources (if second source deemed unnecessary, this must be explicitly documented). It includes recording previous adverse reactions to medicines and allergies and any recently ceased or changed medicines. ⁴
Mechanical prophylaxis	A physical agent that is used, in this context, to prevent thrombosis. Mechanical methods of VTE prophylaxis include graduated compression stockings (GCS), intermittent pneumatic compression (IPC), and foot impulse technology (FIT), also known as venous foot pumps or foot impulse devices (FID) ⁴
Pharmacological prophylaxis	A pharmacological agent that is used, in this context, to prevent thrombosis.
Venous thromboembolism	The blocking of a blood vessel by a clot that has broken away from its site of origin. A collective term for deep vein thrombosis and pulmonary embolus. ⁴

7. Document Summary

Coverage	WACHS wide
Audience	All medical officers, nurses, midwives, pharmacists and allied health staff working in inpatient settings.
Records Management	Health Record Management Policy
Related Legislation	Health Services Act 2016 (WA) Health Practitioner Regulation National Law (Western Australia)
Related Mandatory Policies / Frameworks	• MP 0095/18 Clinical Handover Policy • MP 0175/22 Consent to Treatment Policy • MP 0051/17 Language Services Policy • MP 0078/18 Medication Chart Policy • Clinical Governance, Safety and Quality Framework
Related WACHS Policy Documents	• Clinical Documentation Policy • Consent to Treatment • High Risk Medications Procedure • Patient Identification and Procedure Matching Policy • Medication Prescribing and Administration Policy • Medication Review Procedure
Other Related Documents	• ACSQHC Quick Facts for Consumers • ACSQHC Venous Thromboembolism Prevention Clinical Care Standard • ACSQHC Venous Thromboembolism Prevention Clinical Care Standard – Clinician Fact Sheet • ACM National Midwifery Guidelines for Consultation and Referral - 5th Edition (2026) • Healthy WA – Deep Vein Thrombosis • NSW CEC Guidelines on Periprocedural Management of Anticoagulant and Antiplatelet Agents. • PCH Venous Thromboembolism (VTE) Primary Prophylaxis Guideline • Qld Health Guideline for the Prevention of Venous Thromboembolism (VTE) in Hospitalised Adult Patients • Therapeutic Guidelines for VTE in palliative care • WA Health Guidelines for the WA Hospital Medication Chart • WNHS Venous Thromboembolism (VTE): Prevention and Management Clinical Practice Guideline
Related Forms	• MR80A.1 Antenatal Risk Assessment for VTE Prophylaxis

	• MR80A.2 Postnatal Risk Assessment for VTE Prophylaxis • MR170A WA Hospital Medication Chart – Adult Short Stay • MR170C Anticoagulant Medication Chart • MR171 WA Hospital Medication Chart – Adult Long Stay
Related Training	Available from MyLearning: • High Risk Medications: Introduction (HRMINT EL2) • High Risk Medications: Anticoagulants Declaration (HRMA EL2) General information: • ACSQHC Resource hub • CEC Venous Thromboembolism (VTE) prevention
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 5938
National Safety and Quality Health Service (NSQHS) Standards	1.07, 4.15, 5.10, 5.11, 5.13, 5.24
Aged Care Quality Standards	Nil
Chief Psychiatrist's Standards for Clinical Care	Nil
Other Standards (please specify and include link)	ACSHQC Venous Thromboembolism Prevention Clinical Care Standard

8. Document Control

Version	Published date	Current from	Summary of changes
2.00	26 March 2019	26 March 2019	Formal Review
3.00	06 January 2023	06 January 2023	• Desktop review of medications. • Title change to policy (from CPS). • Rivaroxaban to commence post operatively provided haemostasis has been established.
4.00	7 August 2026	7 August 2026	Formal Review • Full rework of the policy to refocus as a high overarching level policy statement • Inclusion of cultural safety considerations • Inclusion of risk assessment and specialty areas (medical, surgical – including advance planning for planned hospitalisation, palliative care patients near end of life, perinatal women, children and young people)

			• Inclusion of new section: monitoring, reassessment and update of VTE prevention plan • Clinician guidance to support decision making linked to established guidelines and tools as recommended by key leads • Roles and responsibilities clearly defined.
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9. Approval

Policy Owner	Executive Director Clinical Excellence
Contact	Director Safety and Quality
Business Unit	Medical Excellence and Medical Services
EDRMS #	ED-CO-15-92917
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