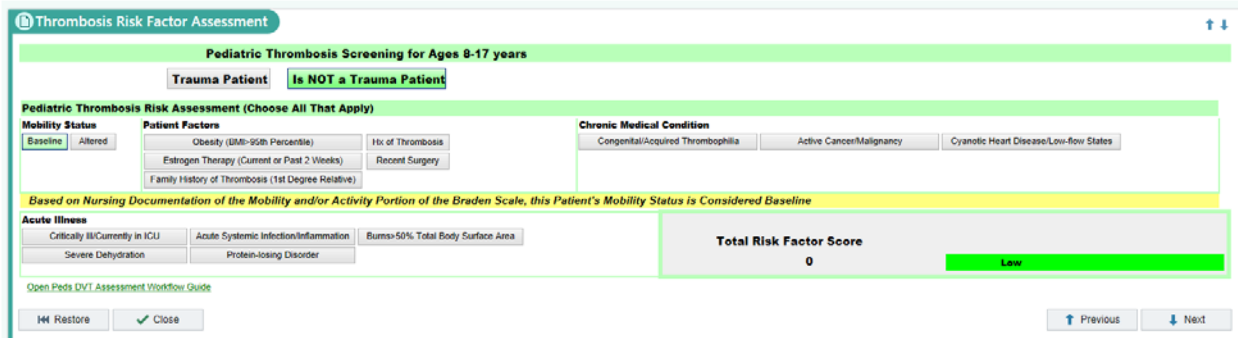
UPSTATE Golisano Children's Hospital | Pediatric Trauma Center

Pediatric VTE Guideline

VTE Risk Screening for Med/Surg Pediatric Patients age 12 & Up:



This screening tool is in the admitting resident's workflow, and can be easily accessed at any time from the clinical overview screen. The screening questions will assess the patient risk based on the logic below, which is from the Children's Hospital Association Solutions for Patient Safety VTE prevention bundle.

VTE Prevention Intervention Based on VTE Risk Assessment

	Low Risk	At risk		High Risk
Mobility Status	Baseline	Baseline	Altered	Altered
Number of VTE Risk Factors	0	1 or more	0-1	2 or more
Interventions: *with no contraindications present*				
○ Encourage highest degree of mobility	Yes	Yes	Yes	Yes
○ SCD	-	Yes	Yes	Yes
○ Anticoagulation	-	-	-	Yes

Based on VTE Risk the admitting resident places orders for encouraged mobility, SCDs, or anticoagulation if appropriate. No level of risk automatically warrants prophylactic anticoagulation in the Peds Med/Surg Patient, so the resident will not be automatically directed to place anticoagulation orders at any time, but may do so if the clinical team decides anticoagulation is indicated.

SPS Standard Interventions

- **Mobility**: encourage highest degree of mobility, ideally ambulation, for patients >/= 3 times a day
- **Sequential Compression Devices (SCD)** unless contraindicated
    1. While in bed
    2. Prior to the induction of general anesthesia and for the duration of a procedure/surgery if anticipated to be greater than 1 hour.

SPS Recommended Interventions

- **Anticoagulation**: Strongly consider prophylactic anticoagulation of high risk patients if the patient has altered mobility and 2 or more VTE risk factors present (see VTE intervention based on risk assessment unless contraindicated).

  Prophylactic anticoagulation: utilize a form of low molecular weight heparin or subcutaneous unfractionated heparin. If a patient is already on other forms of anticoagulation (i.e. warfarin or direct oral anticoagulants) no additional prophylactic anticoagulation is needed. Aspirin or other antiplatelet therapy is not considered VTE prophylaxis.

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For Pediatric Trauma Patients:

Thrombosis Risk Factor Assessment

Pediatric Thrombosis Screening for Ages 8-17 years

Trauma Patient | Is NOT a Trauma Patient

Pediatric Trauma Thrombosis Risk Assessment (Choose All That Apply)

Patient Factors

Intubation | Admission to ICU
Major Surgery | Transfusion of Blood Products
Female | Central Venous Catheter Placement
Pelvic Fracture | Lower Extremity Fracture

Age

Age <1 | Age 1-9 | Age 10-12 | Age 13-15
Age 16-17

GCS Score

!! The GCS score has not been documented in the past day; Please document now.

Eye 1 2 3 4
Verbal 1 2 3 4 5
Motor 1 2 3 4 5 6
Total Score 15

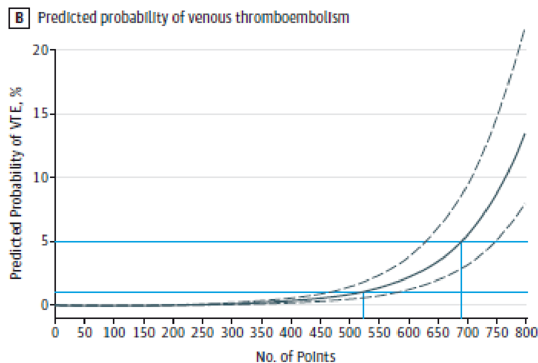
Total Risk Factor Score
185 Low

Open Peds DVT Assessment Workflow Guide

Restore | Close | Previous | Next

This screening tool is in the admitting resident's workflow, and can be easily accessed at any time from the clinical overview screen. The screening questions will assess the patient risk based on a clinical predictive model published by the Pacific Coast Surgical Association and approved by the Pediatric & Adult Trauma QI Teams.

Connelly, CR et al "A Clinical Tool for the Prediction of Venous Thromboembolism in Pediatric Trauma Patients" *JAMA Surg*. 2016;151(1):50-57. doi:10.1001/jamasurg.2015.2670



Averaged over facilities, model 3 scores of 0 to 523 correspond to low risk (<1%) of VTE, scores of 524 to 688 correspond to medium risk (1%-5%), and scores of 689 to 797 correspond to high risk (>5%). The predicted probability averaged over facilities (ie, zero intercept) is shown as a dark blue line. The 95% CI band, shown as a set of solid light blue lines, represents variability in the predicted probabilities over facilities. Cutoff values for risk categories averaged over facilities are shown as dashed lines. GCS indicates Glasgow Coma Scale; ICU, intensive care unit; and NA, not applicable.

Based on VTE Risk the admitting resident places orders for encouraged mobility, SCDs, or anticoagulation if appropriate. No level of risk automatically warrants prophylactic anticoagulation in the Pediatric Trauma Patient, so the resident will not be automatically directed to place anticoagulation orders at any time, but may do so if the clinical team decides anticoagulation is indicated.
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