Can patient receive anticoagulation?

- Yes
  - Is there any contraindication to heparin (e.g., HITT syndrome)?
    - No
      - Continue heparin via CRRT circuit. Continue subcutaneous DVT prophylaxis.
    - Yes
      - Systemically anticoagulate with non heparin (if AC required for HITT)

- No
  - Is patient systemically anticoagulated?
    - Yes
      - Standard flow rates with NO added CRRT anticoagulation. Reassess when systemic AC discontinued.
    - No
      - Does anticoagulation need to be stopped? (e.g. for invasive procedure, bleeding)?
        - No
          - Continue heparin via CRRT
        - Yes
          - Stop AC and change to high predilution hemofiltration

Initiate HIGH FLOW HEMOFILTRATION (pre 2-2.5 L/h and post 500 ml/h)
- If no HITT, prime with heparin followed by saline rinse
- If HITT suspected/confirmed, prime with 2 L saline and NO heparin
- Increase blood flow if access/return pressures tolerate to 250 ml/min

Is filter lasting > 12 hours
- Yes
  - Continue with high flow hemofiltration
    - Optimize blood/predilution rates
    - Reassess AC readiness
    - Consider citrate AC (rule out liver failure)
    - Consider Oxiris filter (review with CE/CNS)
- No
  - Standard flow rates with NO added CRRT anticoagulation. Reassess when systemic AC discontinued.

Systemically anticoagulate with non heparin (if AC required for HITT)

Is patient systemically anticoagulated?