

# Anticoagulation - Clinical Protocol

## Assessment and Recognition

1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated; for example, those with a recent history of deep vein thrombosis (DVT), or heart valve replacement, atrial fibrillation, or those who have had recent joint replacement surgery.
  - a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications.
  - b. Assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above-therapeutic level of an anticoagulation medication should be assessed for bleeding).
2. In addition, the nurse shall assess and document/report the following:
  - a. Current anticoagulation therapy, including drug and current dosage;
  - b. Recent labs, including therapeutic dose monitoring;
  - c. Other current medications; and
  - d. All active diagnoses.
3. The staff and physician will identify situations where an individual is not anticoagulated but where anticoagulation may be indicated; for example, new onset deep vein thrombosis (DVT), or new or previously unrecognized carotid artery stenosis or atrial fibrillation.

## Cause Identification

1. The physician will seek or verify underlying causes of conditions requiring anticoagulation (for example, hyperthyroidism or atrial fibrillation related to mitral stenosis related to atrial fibrillation), and identify potentially reversible causes.

## Treatment/Management

1. The physician will prescribe anticoagulation therapy (for example, low molecular weight heparin, warfarin, or other oral anticoagulant) appropriately, consistent with recognized guidelines.
  - a. In general, long-term subcutaneous administration of heparin in chronically bed-bound individuals is not indicated or of proven benefit for long-term DVT prophylaxis.
2. The physician will collaborate with the consultant pharmacist and nursing staff to identify potentially serious medication interactions with anticoagulants; for example, digoxin, dilantin, amiodarone, and many antibiotics.
  - a. The physician should adjust the anticoagulant dose or stop, taper, or change medications that interact with the anticoagulant, and/or monitor the PT/INR very closely while the individual is receiving warfarin, to ensure that the PT/INR stabilizes within a therapeutic range.

## Monitoring and Follow-Up

1. The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example, periodically checking hemoglobin/hematocrit, platelets, PT/INR, and stool for occult blood.
2. If warfarin is used, staff should use a warfarin flow sheet or some comparable means to follow trends in anticoagulant dosage and response in individuals on warfarin.
3. The physician will review the progress of individuals who are being anticoagulated; for example, to see whether recent-onset atrial fibrillation has resolved or to evaluate the status of any deep vein thrombosis.
4. The physician will periodically identify individuals whose anticoagulant can be discontinued or reduced (for example, resolved atrial fibrillation or sufficient time has elapsed since resolution of a deep vein thrombosis), and will document a rationale for continuing anticoagulation over time, including the medication and current dosage.
5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.
  - a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.
  - b. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated.
  - c. In individuals receiving anticoagulation who are bleeding or who have a markedly elevated PT/INR, it may suffice to stop the anticoagulant and recheck the PT/INR if the individual is stable, there is no more than minor bleeding, and the INR is not more than 9. Once Vitamin K is given to try to reverse the effects of warfarin, it can hamper subsequent resumption of anticoagulation for a week or more.

## References

MDS Items (CAAs)	Section I
Survey Tag Numbers	F684; F757; F710
Other References	American Geriatrics Society Clinical Practice Committee. The use of oral anticoagulants (warfarin) in older people. <i>J Am Geriatr Soc</i> 1996;44:1112-1113. Ansell J, Hirsh J, Dalen J, Bussey H, Anderson D, Poller L, Jacobson A, Deakin D, Matcher D. Managing oral anticoagulant therapy. <i>Chest</i> 2001;119(1, Suppl):22S-38S. Hart RG et al. Antithrombotic therapy to prevent stroke in patients with atrial fibrillation: a meta-analysis. <i>Ann Intern Med</i> 1999;131:492-501. Hirsh J, Dalen JE, Anderson DR, Poller L, Bussey H, Ansell J, Deykin D. Oral anticoagulants: Mechanism of action, clinical effectiveness, and optimal therapeutic range. <i>Chest</i> 2001;119(1, Suppl):8S-21S. McCormick D, Gurwitz JH, Goldberg RJ, Becker R, Tate JP, Elwell A, Radford MJ. Prevalence and quality of warfarin use for patients with atrial fibrillation in the long-term care setting. <i>Arch Intern Med</i> 2001;161(20):2458-2463.
Related Documents	PT/INR/Coumadin (Warfarin) Flowsheet (MP5583)
Version	1.2 (H5MAACL0007)