St John’s Hospital

Dialysis Unit

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**Prescribing Warfarin in the Outpatient Dialysis Unit**

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| DESIGNATED PRESCRIBERS for routine prescriptions |
| 1st contact | 2nd contact (only if 1st contact unavailable) |
| Dr Michaela Petrie | **Dr Fiona Duthie** | Renal Registrar on-call via RIE switchboard |

* INRs should only be checked on a Monday or Tuesday unless there are clinical concerns *(eg: unusual bleeding at fistula site, prolonged nose bleeds, unusual extensive bruises, malaena etc)* or when instructed by a prescriber
* Prescriptions should be completed and communicated to patients according to the following timings:

|  |  |  |  |
| --- | --- | --- | --- |
| HD Day | Session | INR reporting to prescriber | Time to contact patient |
| Monday | Morning | Monday morning | Monday morning/afternoon |
|  | Afternoon | Tuesday morning | Tuesday morning/afternoon |
|  | Twilight | Tuesday morning | Tuesday morning/afternoon |
| Tuesday | Morning | Tuesday morning | Tuesday morning/afternoon |
|  | Afternoon | Wednesday morning | Wednesday morning/afternoon |
|  | Twilight | Wednesday morning | Wednesday morning/afternoon |

* The Yellow Warfarin book **MUST** be made available to the prescriber completing the prescriptions - understanding the patient’s anticoagulation history is key to safe prescribing
* All enquiries to Renal SpR on-call during the out-of-hours period or in the weekend **MUST** be done via the Nurse In-charge of the Dialysis Unit at the time. The on-call registrar should **NOT** be routinely contacted for warfarin prescriptions except in unsafe situations as below:
* INR >4
* Active bleeding
* For subtherapeutic INRs, please follow steps above except in the following situations where the prescriber should be contacted:
	+ Patients with a metallic heart valve when INR is <2.0
	+ Patients with lupus anticoagulant when INR is <1.5
	+ Patients with venous thromboembolism (PE/DVT) when INR is <1.5
	+ Patients with stable INRs will require less frequent monitoring. They should continue their usual warfarin dose unless it is unsafe (as described above)
	+ Unnecessary INR monitoring and frequent dose changes will lead to erratic anticoagulation which may be harmful to the patient