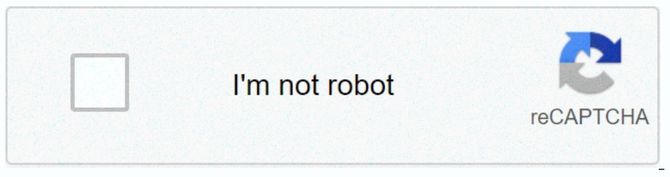

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Warfarin dosing guidelines nhs

Skip to the main contents of the Menu Back to Drugs A through Z This site provides advice on managing patients taking warfarin in primary care during pandemic Covid-19 Drug Monitoring Advice for other drugs during Covid-19 there is a common practice to monitor INR up to a maximum of every 12 weeks during the Covid-19 pandemic, recommendations to help minimise attendance include the following 1) In patients with previous DVT or PE and where the risk of recurrence is now low, consider stopping warfarin 2) In other patients, consider switching to DOAC; However, DO NOT switch if the patient: has a prosthetic mechanical valve; Consult a cardiologist has moderate to severe mitral stenosis, has antiphospholipid antibody syndrome (APLS) is pregnant, breastfeeding or pregnancy planning requires a higher INR than the standard inr range of 2.0-3.0 has severe kidney damage (creatinine clearance < 15ml/min) takes interacting medicines such as some HIV antiretrovirals or hepatitis antivirals (control of HIV drug interactions) 3) If the patient is in the category below, seek expert advice against coagulation before switching to DOAC: has active malignancy and/or chemotherapy takes phenytoin, carbamazepine, phenobarbiton or rifampicin has venous thrombosis in unusual places is on triple therapy, i.e. If in the entire cohort of patients considering switching to DOAC, take a gradual approach during the 12-week cycle to protect the supply chain for all patients Consider prioritising patients (i.e. first change) with poor control of their INR , as this cohort will require the most frequent INR checks. 5) If warfare remains necessary, there are a number of options to help minimise the attendance of monitoring inr Advice on extending inr testing intervals As many stable patients as possible should continue to be monitored inr at least every 12 weeks as these are international guidelines. Self-monitoring and community INR monitoring are options to reduce traffic; However: If patients usually have inr monitored more than 12 times a week, consider switching to 12 per week where it is safe Patients should be advised to contact their INR monitoring service by phone if they experience symptoms of COVID-19. If patients show symptoms of COVID-19, it is not advisable to extend the INR monitoring interval. Monitor INR patients within 1-7 days, the exact timing of the INR should take into account relevant factors, including: whether the patient has symptoms of bleeding, takes antibiotics or other new interacting drugs, does not feel well, has a reduced food intake, has recent alcohol consumption. See options below Increasing custom monitoring can help reduce both traffic and inr monitoring load throughout the system. Consider: Patients or family members should be carefully selected for the use of CoaguChek, their manual skill, cognitive function, vision and ability to use technology. Patients or family members who live with them will need to learn to test their own inr using the CoaguChek machine (assuming this can be obtained) and make phone calls in the results. Implementation is associated with problems: for example, the purchase of equipment, the provision of test strips, patient training and the implementation of quality assurance checks. Further advice on self-ness can be found in NICE in their DG14 diagnostic guidelines. Community monitoring through patient visiting teams Continuing safe INR monitoring of patients in the community who have long been isolated during COVID-19 is essential. Home visitor plepbotomy services associated with INR monitoring services (e.g. GP surgeries or community trusts) will be key to continuing to safely monitor patients on warfarin during COVID-19. Services monitoring patients with suspected COVID-19 should pay particular attention to the timing of the blood test (i.e. they must be arranged at the end of the pchedotomy/nursing shift) and should follow local blood test guidelines for suspected/confirmed positive COVID-19 patients. Further guidance can be found in NHS England and NHS Improvement advice on COVID-19 Prioritisation within the Community Health Services (see section 45 of the Adult and Elderly People Services section) For other patients for whom DOACs are not an option, consider low molecular weight Heparin (LMWH) if the patient can be instructed to self-inject or a family member living with them can inject. As a last resort, in individual patients who cannot be tested for INR and therefore warfarin cannot be safely ed, warfarin treatment could be temporarily stopped. Any decision to stop must take into account the balance of benefits and risks for the individual patient and should include a discussion with both the patient and the advice required from the anticoagulant clinic. A regular review should be carried out to restore warfarin as soon as safely possible. Please note that patients with in situ mechanical valves must continue to use warfarin at all times and should seek a cardiologist if regular INR testing cannot be performed. This site was developed in collaboration with Helen Williams, consultant pharmacist for cardiovascular disease and clinical director for atrial fibrillation, Southwark CCG and Health Innovation Network, South London and Dr Frances Akor, Consultant Pharmacist, Anticoagulation, Imperial College Healthcare NHS Trust. This council was drawn up quickly in response to the COVID-19 pandemie; If you notice anything that's wrong, report it to us. Skip to main menu content Back to Drugs A through Z Z