











## COUMADIN ANTICOAGULANT THERAPY FLOW SHEET - MONITORING

### Purpose:

1. To assure ongoing lab monitoring of Coumadin therapy to help assure resident safety while receiving Coumadin.
2. To maximize communication between nursing staff and residents' attending physicians related to Coumadin and PT/INR testing.

### Procedure:

1. All Coumadin will be administered according to physician orders. All orders will be documented on the medication administration record.
2. Upon receipt of orders for Coumadin therapy, the nurse will ask the physician for orders for lab monitoring - PT/INR testing.
3. It is recommended that residents on long term therapy have labs done at least monthly. If adjustments are being made, each time a new Coumadin dosage order is received by the nurse, the nurse must ask the physician for the next date for PT/INR testing.
4. A Coumadin Flow Sheet will be initiated for any resident receiving Coumadin. On this document is recorded the current dose of Coumadin, the date of every PT/INR test, the results, and the new or continuing Coumadin dose. This documentation is done in addition to changes of medication orders on the MAR, and standard nursing notes documenting the issue.
5. When new lab results are received, record them onto the flow sheet and use that document of ongoing information to communicate with the physician, either over the phone, or via fax, whichever is the method of choice of the physician.
6. The current Coumadin flow sheet is to be kept in:
  - a. The front of the physician order section of the chart OR
  - b. In front of the current MAR
  - c. Each facility may decide the location of current Coumadin flow sheets, but then each record is to be maintained in the same manner
7. Completed Coumadin flow sheets are to be filed with MARs in the resident's record.
8. The resident and legal representative will be notified of any order or condition changes.

## **Fall Protocol/Residents Receiving Anticoagulant Therapy**

Purpose: Rule out and or plan treatment for possible hemorrhage in the event of a fall for a resident receiving anticoagulant therapy.

Policy: Resident on anticoagulant therapy that has fallen will receive a physical exam within 24 hours of the fall by physician to rule out or plan treatment of possible hemorrhage.

Procedure:

Resident on anticoagulant therapy who experience a fall:

1. Access resident for extent of injury
2. Treat resident and maintain safety
3. Begin Fall Protocol: Neurocheck Policy
4. Report incident to the Director of Nursing or designee
  - Determination of plan of care
5. Report to resident's Physician
  - Report fall incident and protocol for physician exam need
  - Physician may determine he/she will complete this exam within the next 24 hours or may determine to send to the hospital emergency room for physician exam.
6. Report incident of fall to responsible party with plan of care.
7. If the physician prefers an emergency room visit exam, call ER, explain policy and reason for resident visit.
8. Place physician exam results in the Physician Progress notes section of the resident medical record.
  - Report results to resident's primary physician
  - Report results to resident's responsible party
  - Record and follow physician recommendations.

## Neurological Check

### Purpose:

1. To detect neurological changes
2. To detect signs of CNS deterioration
3. To identify nervous system damage

### Equipment:

1. Penlight
2. Cotton Ball
3. Stethoscope and Sphygmomanometer

### Procedure:

Neurological checks will be performed when a resident has fallen or when a resident sustains a head injury from either known or unknown cause.

### General procedure guidelines:

1. Perform hand hygiene
2. Provide Privacy
3. Explain procedure to resident
4. Apply gloves

### A. Evaluation of Level of Consciousness

1. Evaluate verbal response and level of orientation. Ask name, place, time, date, season, and year.
2. Evaluate ability to understand and follow commands, which require motor response: open eyes, stick out tongue.

### B. Evaluate pupils and eye movement

1. Gently lift upper lid and evaluate pupil for size, shape and compare two pupils for equality and midline position.
2. Darken room, holding eye open, swing pen light from resident's ear to mid-line of face. Shine directly into eye. Normally pupil will constrict, when light is in contact with pupil; dilate when light is removed.
3. Hold both eyes open and shine light in one eye only. Watch for constriction in other pupil as is normal nerve function.
4. Observe lids for ptosis
5. Ask resident to follow your moving finger

### C. Evaluate for accommodation

1. Hold one finger midline to resident's face and several feet away
2. Have resident focus on finger
3. Gradually bring finger to nose, which should cause convergence of eyes and pupil constriction.
4. Hold eyelids open and gently brush cornea with wisp of cotton if comatose. Immediate blinking should occur  
(If unconscious/comatose, nurse can also test for "doll eye" reflex)

1. Hold eyelids open
  2. Quickly, gently turn head side to side
  3. If eyes move in opposite direction from the side turned, reflex is intact.
- D. Evaluation of motor function
1. Test grip in both hands at same time
  2. Ask resident to squeeze your fingers as hard as he can and compare grip
  3. Ask resident to close eyes, extend arms straight out with palms up. See if either arm drifts down or pronates indicating muscle weakness
  4. If unconscious, exert pressure on nail bed with blunt pencil or pen end and compare reaction.
- E. Check pulse respiration and blood pressure. (Widening pulse pressure indicates increasing intracranial pressure.)
- F. Record findings on the Neurological Check Monitor form.
1. Every 15 minutes for the first two hours after the incident
  2. Then every 2 hours for the next 10 hours.
  3. Then every 4 hours for the next 24 hours or the last day of monitoring.
- G. Report all evaluations that present outside of the normal parameters to the resident's physician.





**TOPIC: Anticoagulation Monitoring**

**OBJECTIVE: Educate DON and licensed staff to accurate monitoring and tracking of residents receiving Coumadin in relationship to PT/INR's and reporting and documentation**

**TOPIC OUTLINE:**

- 1. All residents receiving Coumadin will have a Anticoagulation Medication log initiated upon admission or upon initiation of Coumadin. All information will be entered on this log: date, time, current medication, PT/INR results, previous medication, date of next lab draw and the nurses initials who is making the entry. An entry will be made when there is PT/INR results received and or dosage changes. At shift change the on coming nurse will review and sign the backside of each Anticoagulation Medication log, the signature verifies that the nurse is aware of those who are receiving Coumadin and potential complications that may arise. This review is handled in the same manner, as you would complete during narcotic count.**
- 2. On a daily basis the Unit Manager or designee will utilize the daily Coumadin flow sheet log to ensure all components on the Anticoagulation Medication Log are complete. Unit Manager or designee will sign off that the Anticoagulant Medication log was complete.**
- 3. All residents receiving Coumadin will have in place an Anticoagulant POC, notation of the resident being on blood thinners and being at risk for bleeding will also be noted on the STNA ADL POC**
- 4. Ongoing monitoring may be changed to no less frequently than weekly by nursing administrative staff.**





My signature on this form indicates that I am aware of the Residents status regarding Anticoagulation Therapy. As a Nurse I am responsible for following Physician orders pertaining to medication administration and Lab work

<b>Date</b>	<b>11pm – 7am Nurse Signature</b>	<b>7am – 3pm Nurse Signature</b>	<b>3pm – 11pm Nurse Signature</b>

