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Warfarin safety and monitoring Initial assessment

Pharmacology-related Cases | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

68-year-old woman taking prescribed warfarin. Care stage: At the first supervised assessment.

Medical history: Warfarin is prescribed for atrial-fibrillation-related stroke prevention in this fictional case. New bruising and a proposed herbal product prompted interaction and INR review. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Noticed bruising and is unsure about a new herbal product.

Objective findings and required checks: Bleeding assessment, INR history and interaction review are needed.

Physical examination and investigations: Review INR, blood count when indicated, bleeding symptoms, indication, medicine list and dietary consistency.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Warfarin safety and monitoring: Vitamin-K-dependent coagulation is reduced; interactions and variable effect can alter bleeding/thrombosis risk.

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Medical / surgical management

Escalate suspected bleeding, verify the current dose plan and coordinate anticoagulation/pharmacy review.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Warfarin	Prevent or treat the prescribed thromboembolic indication	Check INR plan, bleeding and interactions
prescribed reversal treatment if indicated	Manage clinically significant over-anticoagulation	Use the specialist protocol, never self-reverse.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Noticed bruising and is unsure about a new herbal product. Bleeding assessment, INR history and interaction review are needed. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize bleeding or vulnerability to further blood loss; possible treatment-related harm requiring prompt assessment; difficulty sustaining the agreed treatment plan; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Escalate suspected bleeding, verify the current dose plan and coordinate anticoagulation/pharmacy review. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met

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using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about bleeding, dizziness, bruising and relevant medicines. Assess: Assess blood loss, circulation, consciousness and ordered coagulation or blood counts.	Bleeding or vulnerability to further blood loss. Possible factors: tissue injury, altered coagulation or treatment effects. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Blood loss is recognized promptly and circulation is supported by the emergency or treatment plan. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies bleeding warning signs and medicine-related precautions.	1. Quantify visible loss where possible and escalate active significant bleeding immediately. Rationale: Underestimating blood loss can delay life-saving care. 2. Prepare ordered access, investigations and treatment while monitoring perfusion. Rationale: Coordinated response supports rapid stabilization. 3. Avoid unnecessary traumatic procedures and apply appropriate bleeding precautions. Rationale: Reducing additional injury limits preventable blood loss. 4. Escalate suspected bleeding, verify the current dose plan and coordinate anticoagulation/pharmacy review. Rationale: Vitamin-K-dependent coagulation is reduced; interactions and variable effect can alter bleeding/thrombosis risk. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about medicine names, timing, symptoms and non-prescribed products. Assess: Review observations, medication record and relevant drug-specific investigations.	Possible treatment-related harm requiring prompt assessment. Possible factors: adverse medication effects or an administration problem. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: The suspected adverse event is escalated and no further avoidable exposure occurs. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the revised medication plan and warning symptoms before discharge.	1. Assess airway, breathing, circulation and the time course of symptoms. Rationale: Serious adverse reactions require immediate stabilization. 2. Escalate suspected toxicity and follow the authorized hold, monitoring or antidote instructions. Rationale: Treatment decisions depend on the drug and clinical severity. 3. Document and communicate the reaction and reconcile the medicine list. Rationale: Accurate records reduce repeat exposure and support pharmacovigilance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: After the first indicated intervention, at the	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach INR attendance, consistent diet, interaction checking and urgent bleeding precautions. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach INR attendance, consistent diet, interaction checking and urgent bleeding precautions.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Significant bleeding, head injury, black stools, severe headache or new neurological symptoms needs urgent assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Vitamin-K-dependent coagulation is reduced; interactions and variable effect can alter bleeding/thrombosis risk.

- Priority concerns: Bleeding or vulnerability to further blood loss; Possible treatment-related harm requiring prompt assessment; Difficulty sustaining the agreed treatment plan; Learning needs about the condition and care plan.

- Significant bleeding, head injury, black stools, severe headache or new neurological symptoms needs urgent assessment.

- Teach INR attendance, consistent diet, interaction checking and urgent bleeding precautions.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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