N14 — The Anticoagulated Patient at the Chair **FRONT**

What changes when the patient already takes a blood thinner: heparin, needle sites, bleeding, dose timing, and falls.

When: every treatment for a patient on apixaban (Eliquis), warfarin (Coumadin), rivaroxaban (Xarelto), or another blood thinner. The written order and your unit protocol govern.

Do this

1. **Confirm the drug, the dose, and the last dose** every treatment ("Did you take your blood thinner last night and this morning?"). Apixaban dose: per your nephrologist's order / unit protocol.
2. **Heparin:** per your nephrologist's order / unit protocol. Don't assume the standard bolus and infusion apply; if the order doesn't address the blood thinner, ask before you start.
3. **If a heparin-free run is ordered,** watch for dark streaks in the dialyzer, clot in the venous chamber, or rising venous or transmembrane pressure [3].
4. **Needle sites:** firm pressure without stopping flow (you should still feel the thrill). **Time it and write down the minutes every session** [12].
5. **Warfarin:** draw the INR with pre-dialysis labs as ordered. Call when the INR is outside the range in the patient's order [8].
6. **Ask every week:** black or tarry stools, blood in stool or urine, vomiting blood, nosebleeds, new bruising, any fall, any bump to the head [2][9].
7. **Apixaban on dialysis days:** usual times — no hold before treatment, no extra dose after [5][6]. Missed dose: the label says take it as soon as possible that day; never double [7].
8. **Before a procedure or catheter change:** tell the nephrologist the drug and the last dose. Cannulation needs no hold.
9. **Before the patient leaves:** steady, not lightheaded (N5: Intradialytic Hypotension: Chair-Side Response).

Call the nephrologist when

- **Now** (and follow your unit emergency plan, N12: Chair-Side Emergencies): a fall with a head strike; new headache, confusion, vomiting, weakness, slurred speech, or vision change; vomiting blood; black or bloody stools; bleeding that won't stop with firm pressure; a fast-growing access hematoma.
- **Same day:** the INR is outside the range in the patient's order — **now** if the patient is bleeding.
- **Same day:** the circuit clotted on a heparin-free run; blood in the urine; an unexplained hemoglobin drop (N10: Anemia Protocol: ESA and Iron Hold/Report Rules).
- **Same day:** new aspirin, clopidogrel, prasugrel, ticagrelor, NSAID, "-azole" antifungal, ritonavir, rifampin, carbamazepine, phenytoin, or St. John's wort [7]; taking both warfarin and apixaban; a dose that doesn't match the order; the drug stopped or unaffordable.
- **At rounds:** needle-site bleeding longer than the patient's usual for **three sessions in a row** [12]; a fall without a head strike.
- AF patients: see N1: Potassium Bath Selection for potassium call rules.

Don't

- Don't give a heparin bolus to a patient on a blood thinner unless it is ordered.
- Don't stop, skip, hold, or double a dose on your own — or tell the patient to [7].
- Don't blame all prolonged needle-site bleeding on the drug. Three sessions in a row can mean the access is narrowing (Examining and Cannulating the AVF and AVG).
- Don't give vitamin K or a reversal drug without an order.
- Don't let a patient leave after a head strike without talking to the nephrologist.
- Don't treat a fall as a reason to stop the blood thinner — report it; the physician decides [10].

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BACK

Why

1. In RENAL-AF, 26–32% of dialysis patients on apixaban or warfarin had a major or clinically relevant bleed within a year, versus about 3% with a stroke or embolism [1]. GI bleeding is the most common major bleed on dialysis (2.3 per 100 patient-years) [2].
2. In a randomized crossover trial, 10 patients on oral anticoagulants had 40 treatments with and without added circuit anticoagulation; none ended early [3]. The UK Kidney Association suggests a heparin-free start (grade 2D) [4]. The trial predates wide apixaban use — so watch the circuit.
3. A dialysis session removes about 4% of apixaban, and levels don't depend on dose timing [5][6]. Dose is debated: the label gives 5 mg twice daily unless age 80 or older or weight 60 kg or less [7]; steady-state data show 2.5 mg twice daily on dialysis matches 5 mg exposure with normal kidneys [5]. Even a 48–72-hour pre-procedure hold may be too short [6].
4. In RENAL-AF, warfarin patients were in the target INR range only 44% of the time [1], and in a US dialysis cohort, patients whose INR was not checked in the unit had the highest stroke risk [8]. The UK Kidney Association advises reassessing warfarin when time in range falls below 65% [4].
5. Dialysis patients 65 and older fell 1.6 times per person-year; 19% of falls caused injury [9]. Fall risk alone did not change the best stroke-prevention choice [10], but 1-year mortality after a spontaneous subdural hematoma on dialysis was 45.9% — 81% in those previously on an oral anticoagulant [11].

Go deeper

- Mastery page: Atrial fibrillation and anticoagulation in HD
- All dialysis nursing reference cards

References

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