Learning Session 3

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Warfarin

Aim:to maintain INRs within a specific therapeutic range for each individual patient therefore reducing the risk of complications from being ether under OR over anti-coagulated.

To ensure each individual patient has a good understanding regarding aims of treatment, the increased bleeding risk and signs and symptoms of this, interactions of warfarin with some dietary factors and other medications, also the importance of regular testing/monitoring.

Change Ideas

Driver Diagram

1/ Simplify Warfarin dosage regime

2/ Improve Recall System

3/ Standardising Education Practice

Change Package

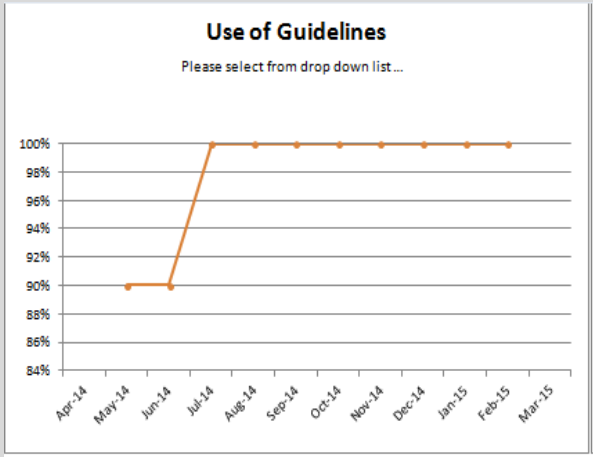
	Change Tested	Outcome / Evidence of Improvement
1	Simplify Warfarin dose	More stable INR results Longer retesting periods (more stable)
2	Recall system	Clear staff responsibility Every patient on a recall Tracking of daily results
3	Standardising education	New Policy with agreed education resources Testing knowledge regularly

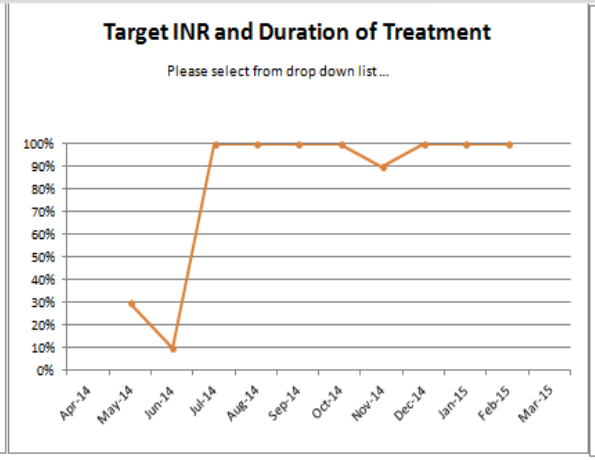
PDSA Cycles

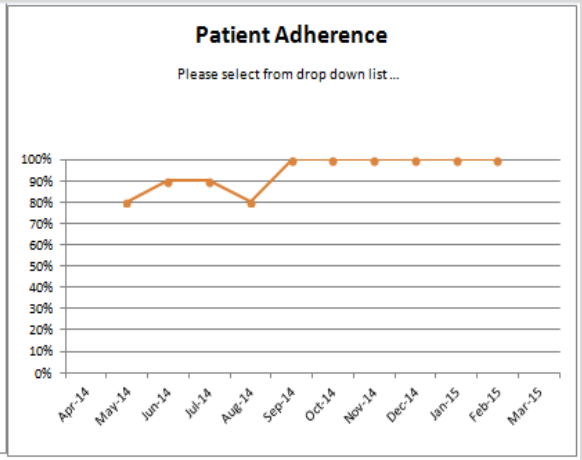
The simplifying dose advice has been the most successful based on INR stability and longer testing intervals

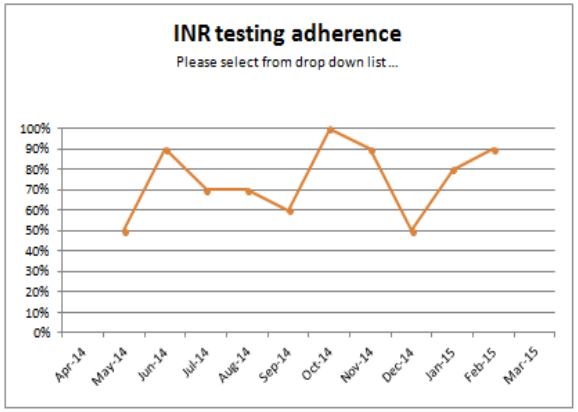
The recall system now captures all DNAs and we track all patients to contact when overdue, learning was the extent of overdue INRs

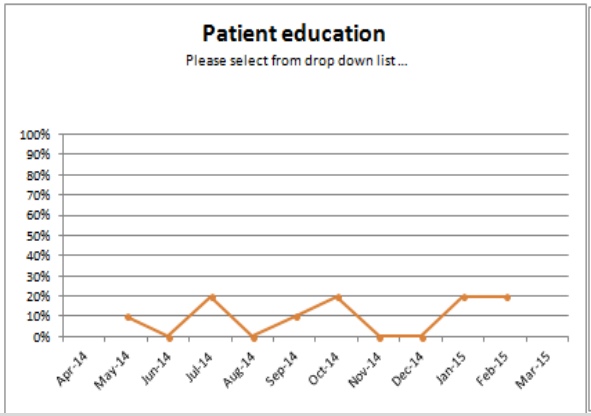
Measures Summary

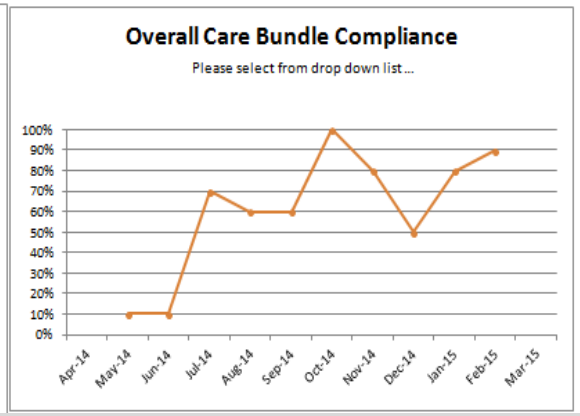












Achievements to date

Do you have an

- agreed aim- Yes
- a change package-Yes
- measurement plan-Yes

We have written a complete new Policy that describes agreed standardised education, when delegated authority is appropriate, and how to manage warfarin/INR with clear limits and accountability

Trigger Tool

1/ Need a longer period than 3 months for each patient

2/ Appeared very difficult but much easier once familiar with assessing notes

3/ Triggers are not detecting a significant number of harms, need to be alert to other potential harms as well as triggers

Safety in Practice

Any other achievements?

Despite being funded it is very difficult to complete this work within normal working hours.

Expecting current staff to work longer or extra hours to do this is difficult for staff, who already are working to their capacity.

Highlights and Lowlights

- Satisfaction in improving a process we thought we did well with improved results
- Struggling to fit an increased workload into a team already working at full capacity
- Safety has tangibly improved and we feel we have achieved this with this programme, ie a culture change may have begun