Safety in Practice

Crawford Medical Centre

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EastHealth

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Organisational "Buy - In"

Aim: Safe management of warfarin dosing by practices nurses.

Buy-in

- Warfarin dosing decision by nurses based on algorithm.
- Benefit to patients:
  - Ensure more stable INR results.
  - Reduce the frequency of testing.
  - Increase patient knowledge and self management.
- Benefit to practice:
  - Reduce time spent on results handling and dosing.

The plan:

First:

- Development of simple effective algorithm that could be used for nurse led warfarin dosing.

Then we also decided to:

- Utilise a warfarin trouble shooting checklist (CMDHB) to be used with annual review chronic care visit – adapted into screening template.
- Consider of using Pharmacy INR testing - and investigated if we could offer practice based testing

What Changes have you tested?

	Change Tested	Outcome
1	New simple effective algorithm	• Simplified April 2014 • Modified dosing August 2014 recommendation for INR's just out of range to avoid over/undershooting • Use of the algorithm was 100% for 3 months until Sept 14
2	Patient education and warfarin review	• New warfarin annual checklist Development of a screening/education template with auto annual recall. • Still being implemented- Will take time to see effect on the monthly audit

Most Successful PDSA Cycle(s)

1. Recognition of lack of documentation on warfarin review and ongoing education in the electronic record – response is a screening template for education and auto recall.

2. A process of change and review of algorithm to a very workable version, clear and simple.

Measures Summary

1. Use of guidelines = correct use of algorithm by the practice nurse/GP. Our aim was to have a standing order for safe nurse prescribing of warfarin dose.
2. Ongoing work required to meet expectation of annual review and education intervention for patients.
3. However “bundle compliance” has depended on who performed the audit (September were patients of a specific GP). The bundle is not necessarily reflecting progress. (10/approx. 110 patients on warfarin)

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Safety in Practice

COUNTIES MANUKAU HEALTH

Safety in Practice

Waitemata District Health Board Best Care for Everyone

Use of Guidelines

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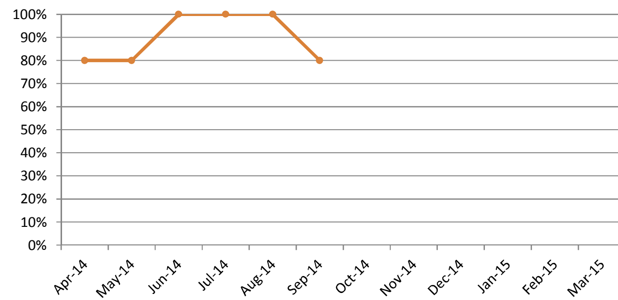

Target INR and Duration of Treatment

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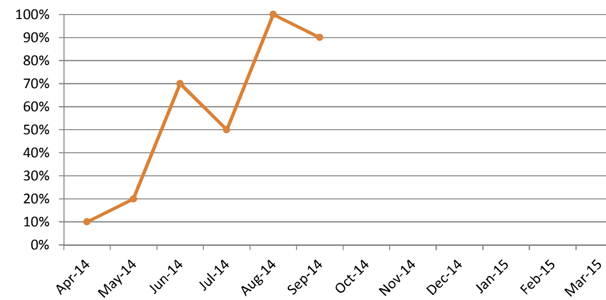

Patient Adherence

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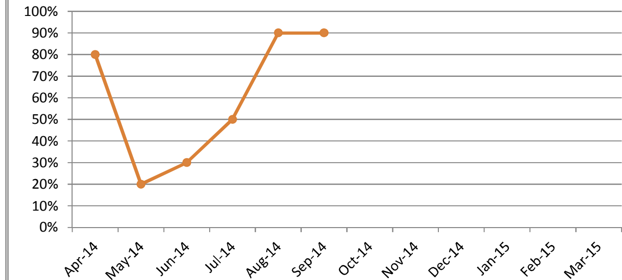

INR testing adherence

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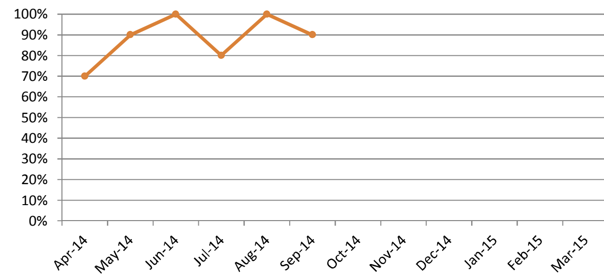

Patient education

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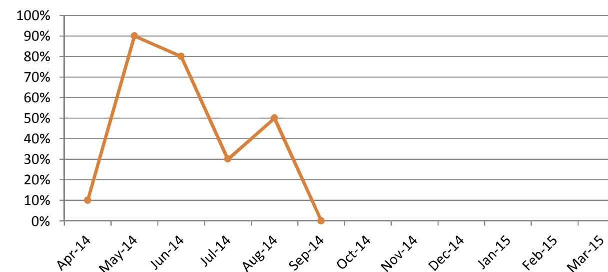

Overall Care Bundle Compliance

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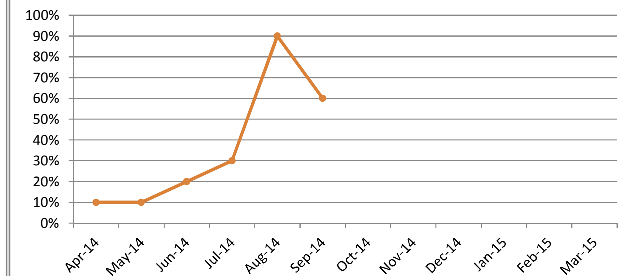

KO AWATEA HEALTH SYSTEM INNOVATION AND IMPROVEMENT | ALLIANCE HEALTH+ | AUCKLANDPHO | EAST HEALTH TRUST primary health organisation | ProCARE | National Hauora Coalition | comprehensive care | waitemata pho

Highlights and Lowlights

- Improved awareness of the doctors and nurses of following an algorithm.
- The vast majority warfarin dosing is prescribed by the nursing staff.
- Lowlights – some problems with managing pharmacy based INR testing – now sorted after meeting and discussing processes and expectations.

Achievements to date

Do you have an

- agreed aim – yes Nurse prescribing of dose of warfarin.
- a change package – yes, a fine tuned algorithm.
- measurement plan- yes, monthly audit. But do we need to measure other outcomes such as reduced freq. of testing?
- Do people on your team know what their responsibilities are and what is expected of them? Yes

What has changed and what difference have the changes made: Significantly reduced GP prescribing of warfarin. Improved warfarin education and a structured annual screening template.