

*Safety in Practice*

# Storyboard

- Mt Wellington Integrated Health Centre
- 1/627 Mt Wellington Highway, PO Box 62-176,
- Sylvia Park, Telephone: 09-2768640, Facsimile: 09-2769849
- PHO, Alliance Health+ Trust



17 March 2015

*Safety in Practice*

# Collaborative Team



***Working Group :***

- Clinical Leader : *Dr Minnie Strickland*
- Nurse Leader: *Naomi Toalii*
- Practice Administrator: *Toka Bates*

***Invited support members:***

- *Vanita Hira & Philippa Little*  
(PHO Manager & Practice Advisor)

## *Safety in Practice*

# Aims and Measures

### *Aim statement:*

- *To ensure patients on warfarin management understand and received the right medication at the right time and in the right dose.*

### *Goals :*

- Standard guidelines are used to prescribe Warfarin
- Good documentation to guide target INR and duration
- Patients are provided with information in a manner that that understand
- Blood testing and medication timeframes are in alignment

## Safety in Practice

# Warfarin - Bundle

### What are we trying to accomplish?

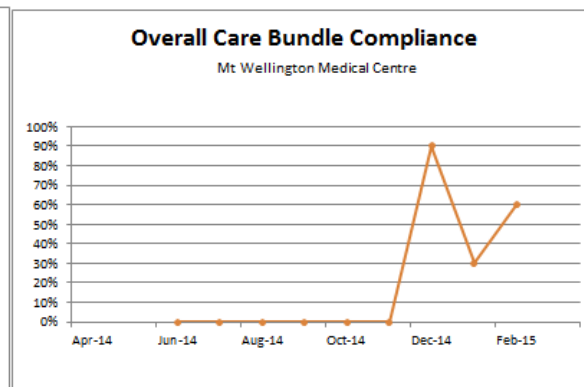
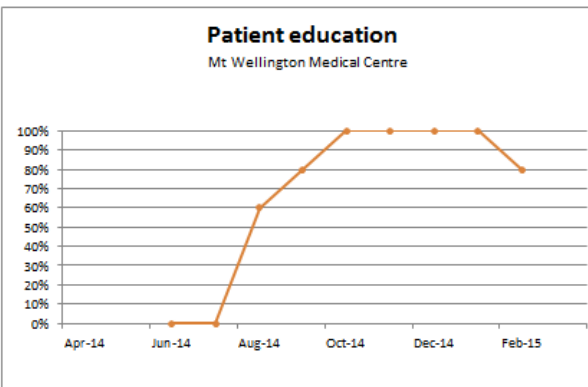
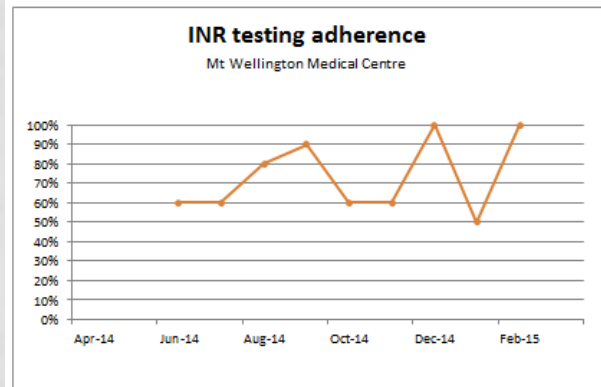
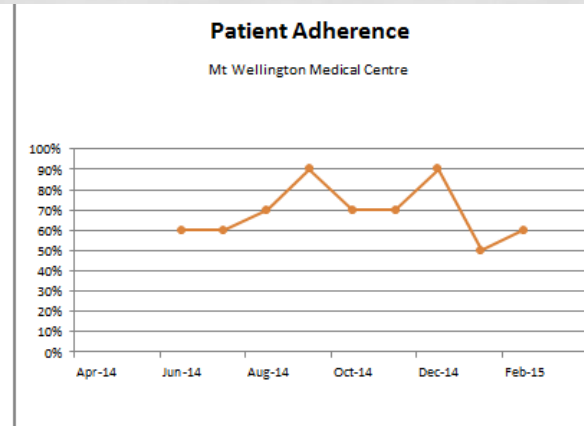
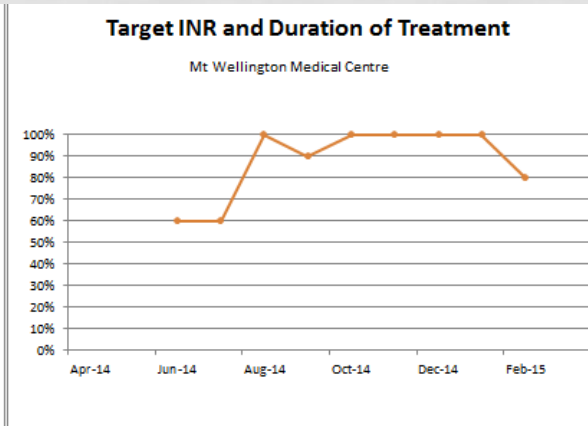
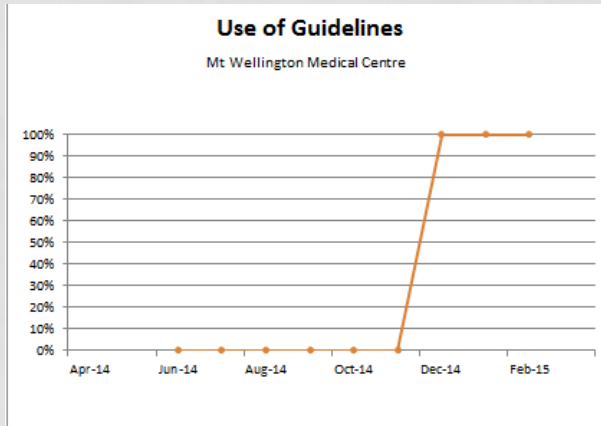
- *Better understanding of where and why harm might occur allowing for the design of :*
  - *Improved & more efficient practice processes*
  - *increased skills*
  - *less stress amongst staff*
  - *enhance patient experience*
  - *Improved medication safety*
- *To identify a clear streamlined process for all staff to follow*
- *Move from a paper based process to electronic mapped patient records in Medtech*

### Ideas for Change

- *Educate & give handouts to patients with INR guidelines*
- *Introduction of INR screening form for nurses to collect INR data*

# Safety in Practice

## Audit Results to Date



# OUTCOMES

- *Measures:*
- *Stable INR's*
- *Patients understand their medication regime*
- *Less frequent blood testing*
- *All clinical staff used standardized guidelines.*

***CQI : Evaluate outcomes/improvement and identify areas for further improvement***

## ***HIGHLIGHTS***

**&**

## ***LOWLIGHTS***

- *Move to an electronic system*
  - *Development of resources*
  - *Cycle of education leading to patients involvement and better compliance*
  - *The level of compliance & the effort put in by Doctors and Nurses to provide a safer warfarin management for our patients.*
- *Not all staff enthusiastic moving to electronic system*
  - *Reluctance to change from some staff*
  - *Difficulties in coordinating practice wide meetings*
  - *Data identified regular non-compliant patients.*

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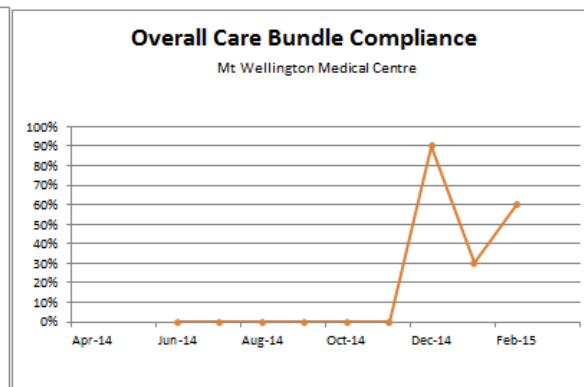
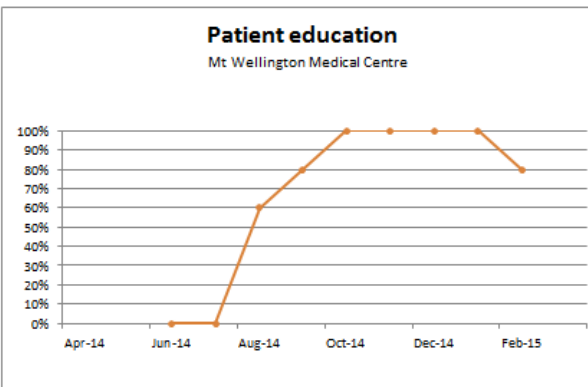
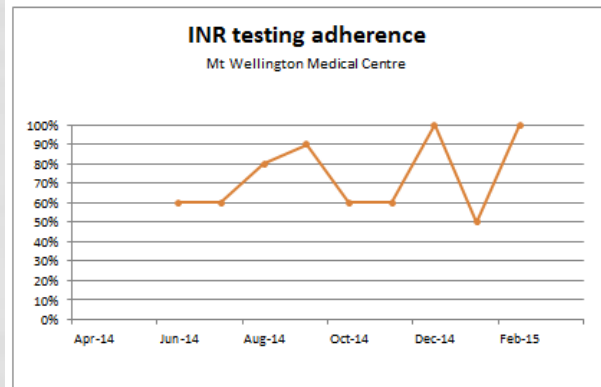
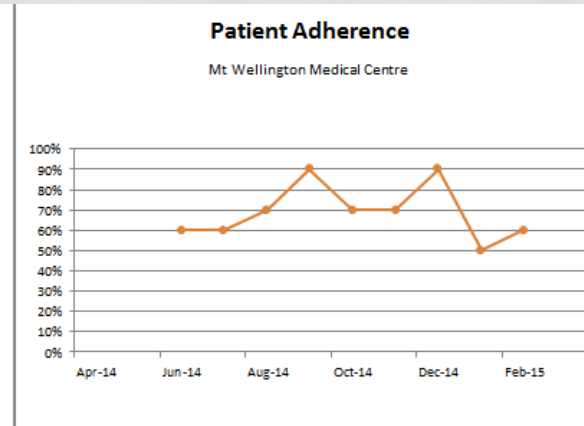
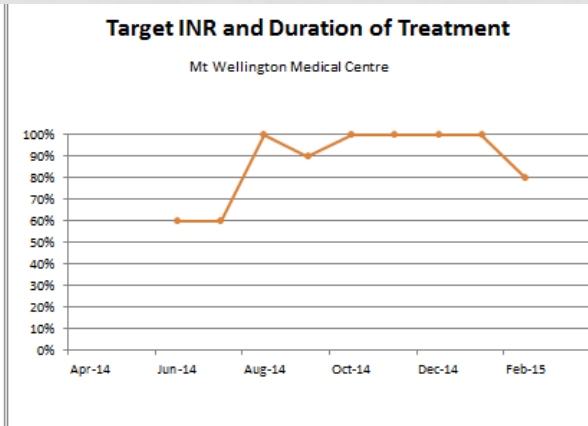
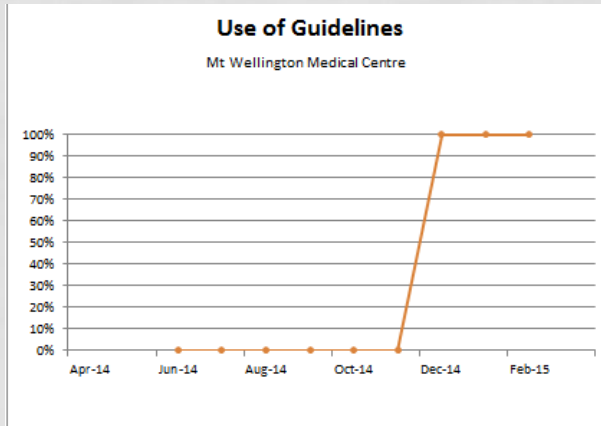
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