

## Safety in Practice



# Manukau City Accident & Medical Centre (Procure)

## Warfarin Improvement

Dr Cliff Ah Kit - Director

Audrey Cassidy – General Manager

Sandra Hewlett – Charge Nurse

## *Safety in Practice*

# Engagement of Team

## First steps and getting buy in from the team

- **Attended the initial Safety in Practice Training Session (March 2014)**
- **Selected appropriate Care Bundle according to practice need – Warfarin**
- **Identified key personnel and assigned roles accordingly**
- **Consulted with team at MCAM and explained the project**

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# Safer Warfarin – what changes did we make?

## Improvements made and changes to processes

1. Audited the existing paper file and got rid of paper system
2. Created a spreadsheet of remaining patients
3. Entered an alert on Medtech for all Warfarin patients
4. Entered all Warfarin patients on screening/recall
5. Wrote to the patients explaining the new process
6. Began nurse led management of warfarin using Standing Orders and BPAC guidelines
7. Checked daily recall lists to ensure all patients tested or reminded
8. Started sending out dosage calendars and phoning patients with results
9. Trained nurses in the use of BPAC and Warfarin Standing Orders
10. Linked with anti-coagulation nurse practitioner at MMH

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# Safer Warfarin - Progress to date

## Successes and engagement

- Able to establish closer contact with our patients to discuss any variance in results
- Sent out fridge magnets and stick on pens to our patients so they could put them on fridges etc. and mark off when they have taken medication
- Have extended the time between tests for many of our more stable patients
- Sent out a survey to patients asking for feedback and critique of new system
- Sought education from Hematology Dept. MMH – established link with anticoagulation nurse
- Able to quickly identify non compliant patients and remind them to take tests using recall system



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# Safer Warfarin – Progress to date

## Patient Challenges

- Educate patients that it was safe to extend the time between tests

## Interface Challenges

- Getting the EDS in appropriate time
- New patients transferring in
- Patient discharged from hospital then turning up at clinic for results
- Required internal systems being set up

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# Safer Warfarin – Early results

## What's happening now

- Some patients are now being tested either monthly or 6 weekly
- Four patients have been started on Pradaxa
- Greater compliance
- More patients have become stable
- Less time taken to do INR follow-ups
- INR results early
- Dosage calendar has been a great success with excellent feedback from patients
- No complaints
- We have not had to use outreach for non - compliance

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# Safer Warfarin - Tips & Tricks

### Our advice

- ✓ **First thing to do is audit your existing system**
  - check for patients who are non-compliant, no longer on warfarin, have transferred out, passed away etc...
- ✓ **Let patients know you are going to change the system and how it will affect them before you do it and why you are changing it**
  - Phone call or letter
- ✓ **KISS – Keep It Super Simple**
  - keep your new system simple
- ✓ **Create a separate spreadsheet to manually update each time you give INR results and also to put notes such as;**
  - Duration of treatment
  - away on holiday etc...

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# Safer Warfarin – Our way forward

## Where to from here

- ✓ Possibility of on site testing with coagulation check meter being considered

## Advantages

- Instant results and dosage calendar
- No need for further follow up until next test
- No need to rely that patient has gone to get blood tests
- Reception given list of all patients due that week
- No waiting – send directly to nurse for test
- Text messaging for reminders for testing from recall system