Learning Session 2

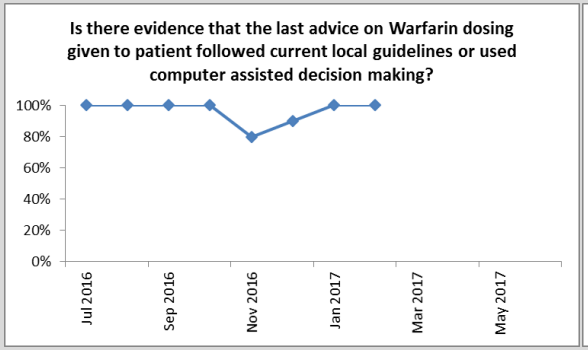
Medical Centre @ Apollo

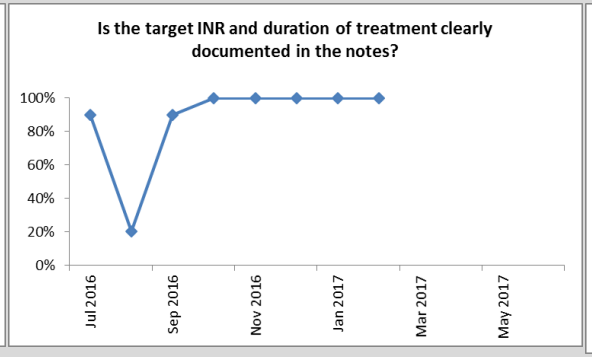
Warfarin SIP

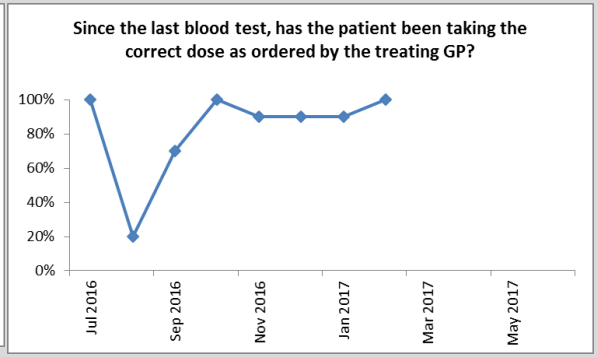
PHO and Facilitator: Procare, Nicki Brentnall

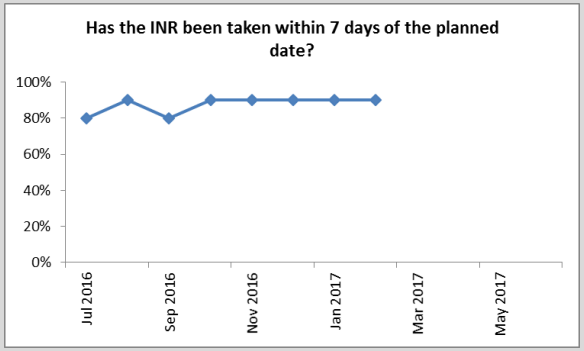
Team members: Rebecca Baldwin (Medical Assistant), Veronica Smith (RN), Esme David (GP)

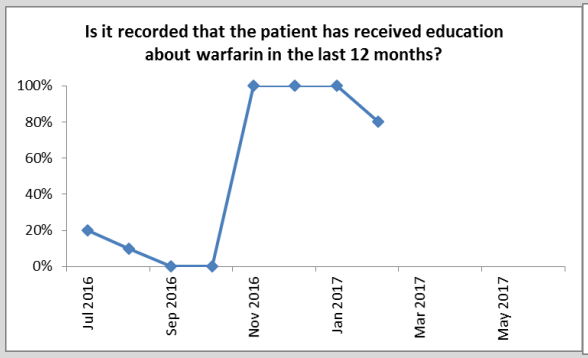
Measures Summary

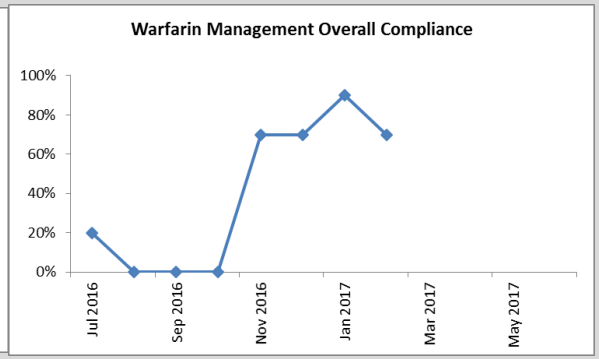












Key Ideas Tested

	Idea tested	Outcome (success or failure)	Advice/message for other practices
1	To process all INRs during normal hours (i.e. not on urgent care/UC queue), unless significantly out of range	Have not audited yet, however seems to be less INRs processed in UC	For large practices, to have small dedicated team of nurses & doctors managing most INRs. Leads to more consistency.
2	Letters sent to patients advising about pharmacy point of care testing (POC)	Audit – 5% more patients opted for POC. Total pts in POC 16%.	Unfortunately pharmacy on our site does not offer POC – likely more patient's would engage if did.
3	To reduce frequency of INR testing when INR results out of range opted to use BPAC calculation, as well as manual calculation (using Healthpathways guide), then nurse/Dr agree on next dosage & test date	Not yet audited, however hopefully reducing reflex 'next day' testing for out of range INRs.	Have clear protocols in place for out of range warfarin dosage calculation & repeat INR testing

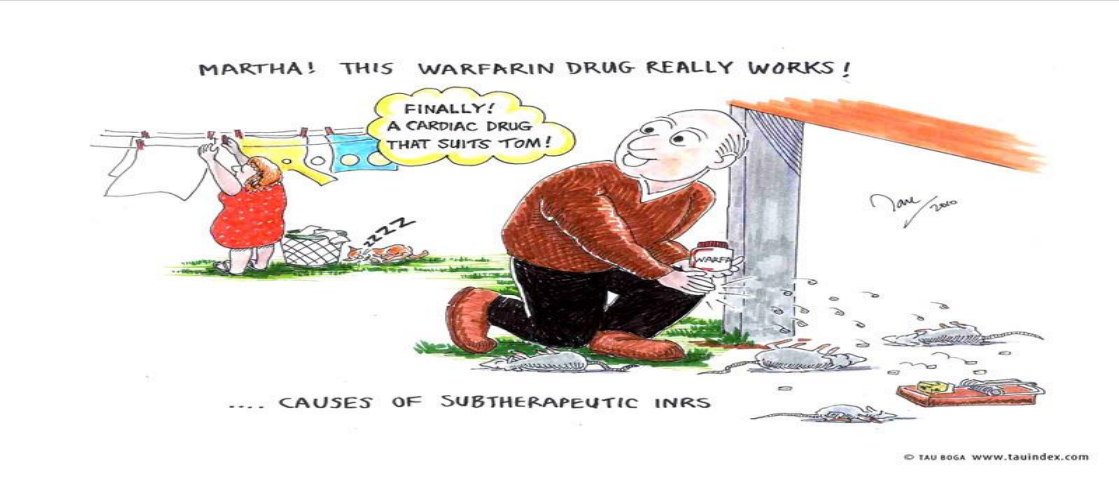
Highlights and Lowlights

"Highs"

- Slowly becoming more streamlined, more consistent with result management.
- Appears to be less INRs on UC queue/needing to be dealt with 'out of hours'.
- Hopefully increasing safety – mini Feb audit -1.5% of patient's INRs out of range, 3% patients overdue for INR.
- Developed warfarin education reminder leaflets in English, Chinese & Korean, which have now been distributed to patients.

"Lows"

- Time a big factor – takes time out of consulting/usual work commitments.
- Difficult to find enthusiasm across all team regarding warfarin management.
- Changing behaviour – both Drs & patients challenging.



Trigger Tool

- Looked at: **Patients 75yrs. or older and on 6 or more long term medications.**

- Time consuming, however did identify few potential safety areas, that provided further discussion & review of guidelines/recommendations.

- Safety areas identified included:
  - Use of dual antiplatelet therapy in patient at high risk of bleeding - reviewed guidelines on use of combination dual anti-platelet therapy; discussed with GP.
  - Identified area for improvement with updating long term medications & 'de-highlighting' previous medication, to avoid prescribing errors – patient's notes updated; practice continues to be involved in medications reconciliation & repeat prescribing audits.
  - Use of liquid nitrogen in diabetic patient with known high foot risk – reviewed articles & Dermnet LN recommendations, discussed with clinical director, aim to review liquid nitrogen protocol.

Safety Climate Survey

- Practice has been involved with 2 past surveys, so aware of process.
- Survey helpful as a prompt for further discussion, especially in areas where score lower than expected.
- Percentage of team members engaging would be good to know.
- As large practice would be more beneficial to have survey results divided into individual groups – admin team/ receptionists/nurses/GPs – could then address relevant issues within specific teams.
- Would be better to compare results with other practices of similar demographic & size.
- Comparing our individual practice year on year results may be valuable.

Aim:

- Results will be discussed with team at next Quality Improvement meeting.
- Identified potential for improvement with communication across team.