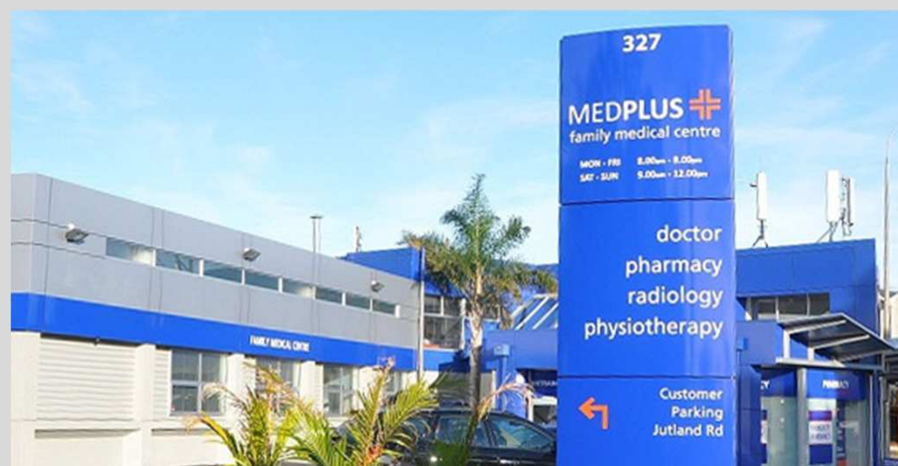
Learning Session 2



The Medplus Warfarin Experience

PHO + facilitator:

Waitemata PHO – Rosey Buchan

The team:

Dr Thomas Herd, Moira van Roekel(RN), Andrea Lawson

Measures Summary

Is there evidence that the last advice on Warfarin dosing given to patient followed current local guidelines or used computer assisted decision making?

100% 80% 60% 40% 20% 0%
Jul 2016 Sep 2016 Nov 2016 Jan 2017 Mar 2017 May 2017

Is the target INR and duration of treatment clearly documented in the notes?

100% 80% 60% 40% 20% 0%
Jul 2016 Sep 2016 Nov 2016 Jan 2017 Mar 2017 May 2017

Since the last blood test, has the patient been taking the correct dose as ordered by the treating GP?

100% 80% 60% 40% 20% 0%
Jul 2016 Sep 2016 Nov 2016 Jan 2017 Mar 2017 May 2017

Has the INR been taken within 7 days of the planned date?

100% 80% 60% 40% 20% 0%
Jul 2016 Sep 2016 Nov 2016 Jan 2017 Mar 2017 May 2017

Is it recorded that the patient has received education about warfarin in the last 12 months?

100% 80% 60% 40% 20% 0%
Jul 2016 Sep 2016 Nov 2016 Jan 2017 Mar 2017 May 2017

Warfarin Management Overall Compliance

100% 80% 60% 40% 20% 0%
Jul 2016 Sep 2016 Nov 2016 Jan 2017 Mar 2017 May 2017

We are so proud of the improvements achieved

Key Ideas Tested

	Idea tested	Outcome (success or failure)	Advice/message for other practices
1	Standardised classification entered for all patient to ensure INR information clearly available for all providers in patient notes	Successful outcome – Q2 moves from 25%- 100% - information available instantly	Implementing standardisation has ensured that everyone is able to access the info quickly in patient notes. Using Red for the classification helped make it easier to see within the classification list
2	Column added to patient record sheet to record that agreed guidelines had been followed	Successful outcome – Q1 moves from 0 – 100%	With a manual system of dose calculation devising a method to prompt staff to use the agreed guidelines also provides the evidence that this has been done. Provides certainty for staff
3	INR patient survey –we implemented a Q+A with patients to see how they found the INR process and what they needed to know	Contributes to Q4 – has lead to in-practice C+ appts with INR patients to discuss	You cant assume that long term INR users have knowledge of the process (and remember it) and will ask for information. We were surprised at what some didn't know or remember

Highlights and Lowlights

- Good input and discussion amongst all clinical staff after initial apathy
- GP and Nurse team all compliant with standardisation of methods (no rogue actions)
- Nurse satisfaction raised due to improved patient involvement and outcomes and greater safety
- Signs of improved patient involvement beneficial to the practice
- The only identified lowlight is continuation of a manual system due to PMS constraints

Trigger Tool

Trigger tool was completed during a clinical staff meeting (GP and nurse teams)

The team was divided into smaller groups, and each group looked at 5 patient records

After completing review of 5 records each, the team came back together to discuss findings

A spokesman for each group reported on the patient records reviewed. No real incidences of harm were identified, but possible improvements to documentation were discussed, in particular with results management. PMS constraints were a factor. Results management to be considered as next bundle.

Communication in the records reviewed was good and the team were able to enjoy this positive result.

Many comments were made after the trigger tool session about how interesting and useful it had been. A small quality team will now look at how this can become a regular occurrence and how to manage findings

Safety Climate Survey

All staff completed the survey. It was undertaken during a period of change process with some uncertainty in the practice.

Leadership was identified as a least positive attribute

- Identified opportunity for one on one discussions with HR partner for staff

Workload was identified as a least positive attribute

- Identified opportunity to re-define roles to more clearly identify what each staff member is responsible for

Safety was identified as the most positive attribute

Plan to re-run the staff climate survey post change process, and then facilitate a practice session.