Learning Session 3

Apollo Medical

Warfarin

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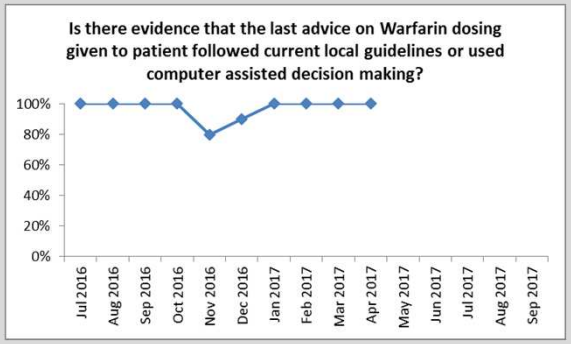
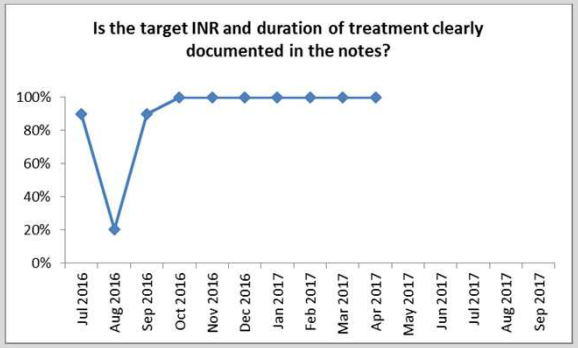
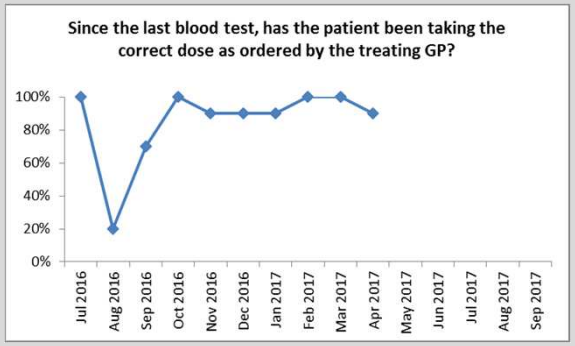
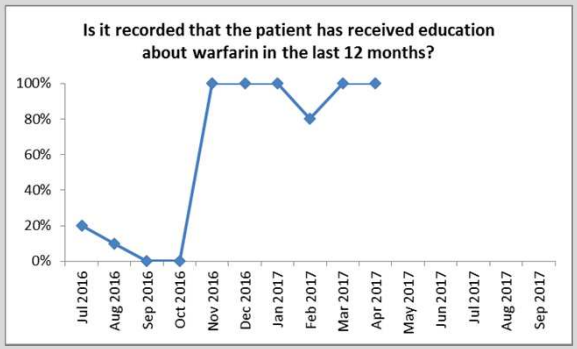
PHO and Facilitator: Procare, Nicki Brentnall

Measures Summary









Learnings & Change Package

<u>How did your results change from the beginning to the end of the year?</u>

- Improvement in recording indication for warfarin, duration of treatment & target range.
- Improved recording of patient's compliance & any new changes that may affect INR.
- Improvement in warfarin patient re-education.
- Improvement using BPAC warfarin module for INR dose calculation & repeat testing. Also attempted to provide more consistency in re-testing INR intervals for INRs out of range.

<u>How did you achieve this improvement?</u>

- Uniformity across team for recording these details in 'Alert' & 'Dashboard'. Consistent format for easy reference.
- "Keyword' created that documents 4 standard questions for nurses to ask when contacting patients, as well as standard documentation of instructions given to patient.
- Created simple, single page warfarin update leaflets in English, Chinese & Korean. These were distributed to all current warfarin patients.
- Warfarin initiation, maintenance dosing & over-coagulation protocols laminated & kept in dedicated area for ease of access to all team members.
- Meetings through year with GPs & nurses to refresh knowledge & advise of practice protocol.
- Maintenance INR dosing nurse lead using BPAC module.
- Designated daily warfarin GP for nurse to liaise with for any out of range INRs.

Learnings & Change Package

Best Change Idea:

- Aim:
  - Reduce INR's being done out of hours by urgent care doctors/nurses.
- Change:
  - Majority of INR blood tests to be done Monday to Thursday (unless otherwise clinically indicated to be done Fri & w/end).
  - INR results processed during designated nurse time on the same or next day of obtaining result.
  - Team education regarding INR retesting intervals (especially out of range INRs), to reduce frequency of reflex next day testing.
  - Use of BPAC module, as well as manual guidelines (Auckland HealthPathways) to guide next test date for out of range INRs.

Helpful to know:

- Formal practice protocol & guidelines provides consistency of warfarin management, especially for large GP practice.
- Nurses better at following the protocol, hence nurse lead management of stabilised patients/ INRs leads to more consistency.
- Changing Drs habits not easy……
- Warfarin initiation & monitoring guidelines are easily accessible on Auckland HealthPathways.

Would be nice…..

- Unfortunately onsite practice pharmacy unable to provide Point Of Care Testing. Access to this would likely be beneficial for both patients & GP team.

Safety in Practice

Other Thoughts

Is there anything else that the team would like to share, either with other practices this year or new practices starting soon?

- Overall SIP improved safety & patient care.
- However it can be time consuming.
- Best to involve several team members from the start – in our large team, it was not easy to find much enthusiasm for auditing & updating warfarin protocols.
- Improving some patient's compliance regarding having INR blood tests on time can be challenging.
- However probably not quite as challenging as changing GP behaviour ☺

Safety in Practice

Highlights

What are your main highlights from your year in Safety in Practice?

- Improved record keeping regarding warfarin.
- Streamlined practice protocols.
- Reduced number of INRs being processed out of standard GP hours.
- Hopefully updated team knowledge & education of warfarin.
- Ongoing team awareness of safety in practice at Apollo Medical – striving for safer practice.
- Survived Auckland traffic & got to Middlemore meetings on time.