





Learning Session 3

Otara Family and Christian Health Centre Warfarin Management

Siniva Tuato, (Practice Nurse) Lapulou Ikavuka (Practice Nurse) Mark Arbuckle (GP)

ProCare: Nicki Brentnall



















Safety in Practice

C O U N T I E S MANUKAU Safety in Practice Measures Summary April

Waitemata

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



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



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



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























AUCKLAND
DISTRICT HEALTH BOARD
To Toka Tumai

Measures Summary



Is it recorded that the patient has received

Warfarin Management Overall Compliance



Aug 2017

Sep 2017



















Safety in Practice





Learnings & Change Package

- How did your results change from the beginning to the end of the year?
 - Consistent dosage advice, recording of results and education were all markedly improved?
 - The main limitation was patient compliance for taking pills and testing in time.

- How did you achieve this improvement?
- Using a fully computer based system in My Practice and losing the dreaded blue folder.
- Empowering the nurse team with minimal GP input.





















Safety in Practice



Learnings & Change Package

Best Change Idea
 Empowering the nurses

We need to now move stable patients to pharmacy testing or dabigatran whichever is clinically appropriate.

Helpful to know

The change has reduced nurse workload as well as decreasing GP involvement.

It is still a challenge to change the behaviour of noncompliant patients.























Other Thoughts

Initially the SIP programme appeared daunting but with teamwork and support from our PHO(thanks Nicki)it has been time well spent.

The safety climate survey was interesting providing generally positive feedback and we were on a par with other practices. The team appeared to be happy but at times felt overloaded and sometimes not well supported with difficult patients.

The trigger tool showed some failings in reconciling discharge medications, actions to be done and new diagnoses. This will be our next focus.

























Highlights

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

C O U N T I E S MANUKAU

Safer handing of warfarin patients, less worry and reduced workload!















