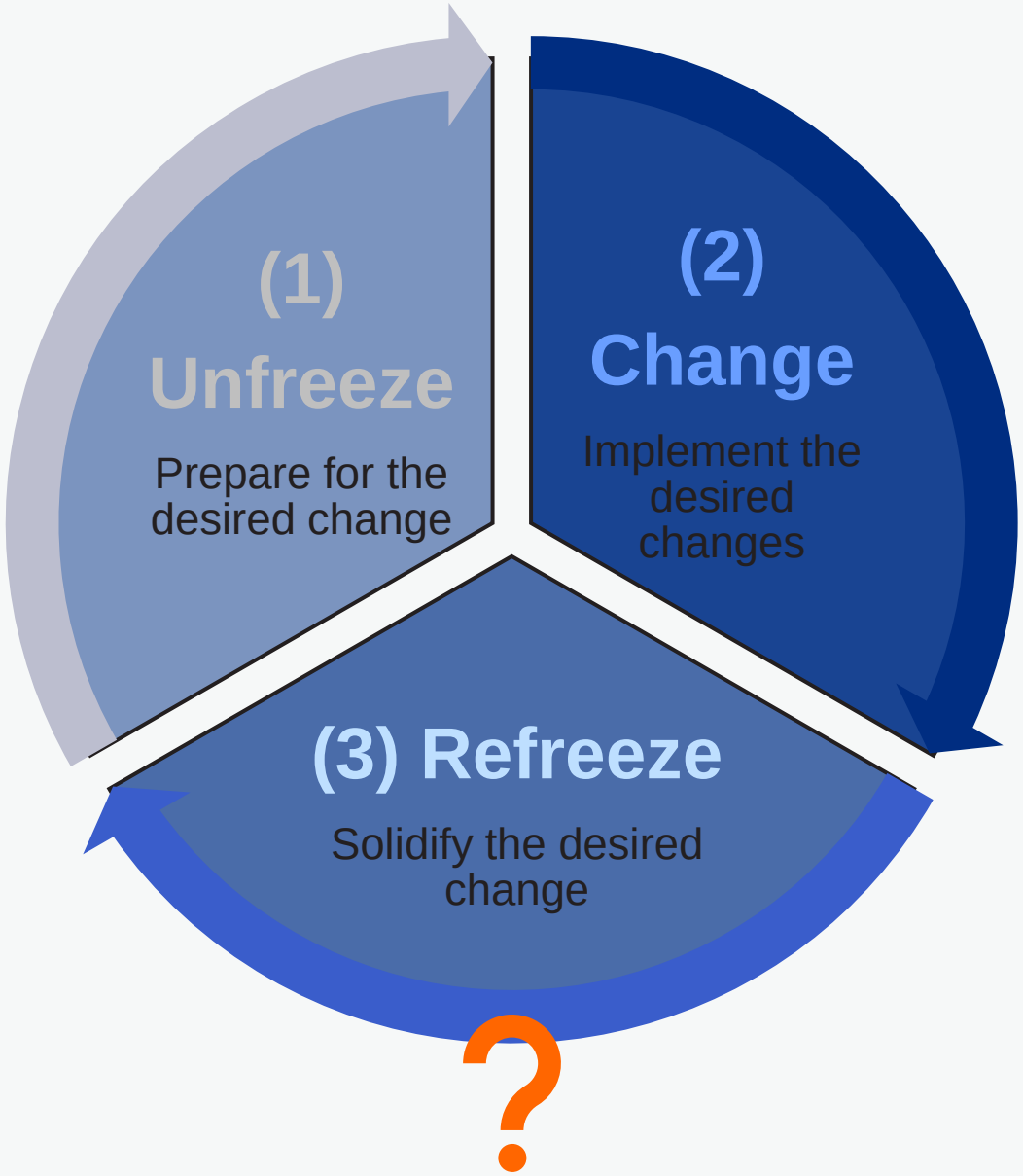
Impact

One life will be saved or major bleed prevented for every 25 patients on an DOAC whose dose is corrected.

National picture

- Over 2022/23 an estimated additional 300,000 patients had the monitoring they needed completed.
- Dose adjustment also improved with modelling suggesting that this saved 68 lives and 680 major bleeding events over 12 months.
- Since national focus has moved away, we have seen regression in monitoring levels

- ✓ Research and made the case for change
- ✓ Agreement as a priority within your organisation
- ✓ Undergone some competence and capability building
- ✓ Brief stakeholders
- ✓ Assemble a team
- ✓ …etc



- ✓ Created system searches
- ✓ Identified patients for review
- ✓ Undertaken reviews, monitoring and dose checks/ adjustments
- ✓ Counselled patients
- ✓ Update notes
- ✓ Collated measures of success
- ✓ Fed back to the organisation

? Can you and your team identify what lead to the current problem?

? For example –applying Human Factors to understand the problem and design solutions?

RPS webinar on 26th November Exploring Human Factors in Medicines Safety

Kurt Lewin's 3 step change model

Quality Control

Vigilance to ensure the system continues to hold the gains made through improvement

Key steps:

- Identify and agree clear standards of quality that can be monitored over time.
- Identify and agree what data sets you will use to monitor this going forwards.
- Identify who will be responsible for monitoring this going forwards and at what time intervals
- Create a plan of corrective action that will be taken when appropriate and by whom
- Plan the escalation route when corrective action doesn’t bring the system back under control