

Eliminate medication errors from failed TTA processes

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Background

- Concern about errors in medication after discharge
- Limited understanding of where the problem lay

Aims:

- To eliminate meds errors post discharge
- To increase reliability of TTA documentation reaching GP (TTA receipted/TTAs sent)

Aims:

Primary Drivers

Secondary Drivers

Change ideas

Leadenhall
TTA project

Method of
communication

Reliability of faxes

Possible use of email

Email TTA to GP

Response /
receipt

No way of knowing if GP has
received

Ask GP to receipt fax

Pt participation
in the process

Pts and families not
understanding the TTA meds

Pt and carer education /
medication counselling pre-
discharge

Pharmacy
involvement

Involved in preparing TTA

Medicine reconciliation post
discharge

Communicate with community
pharmacy

Admin process

Involved in faxing form to GP

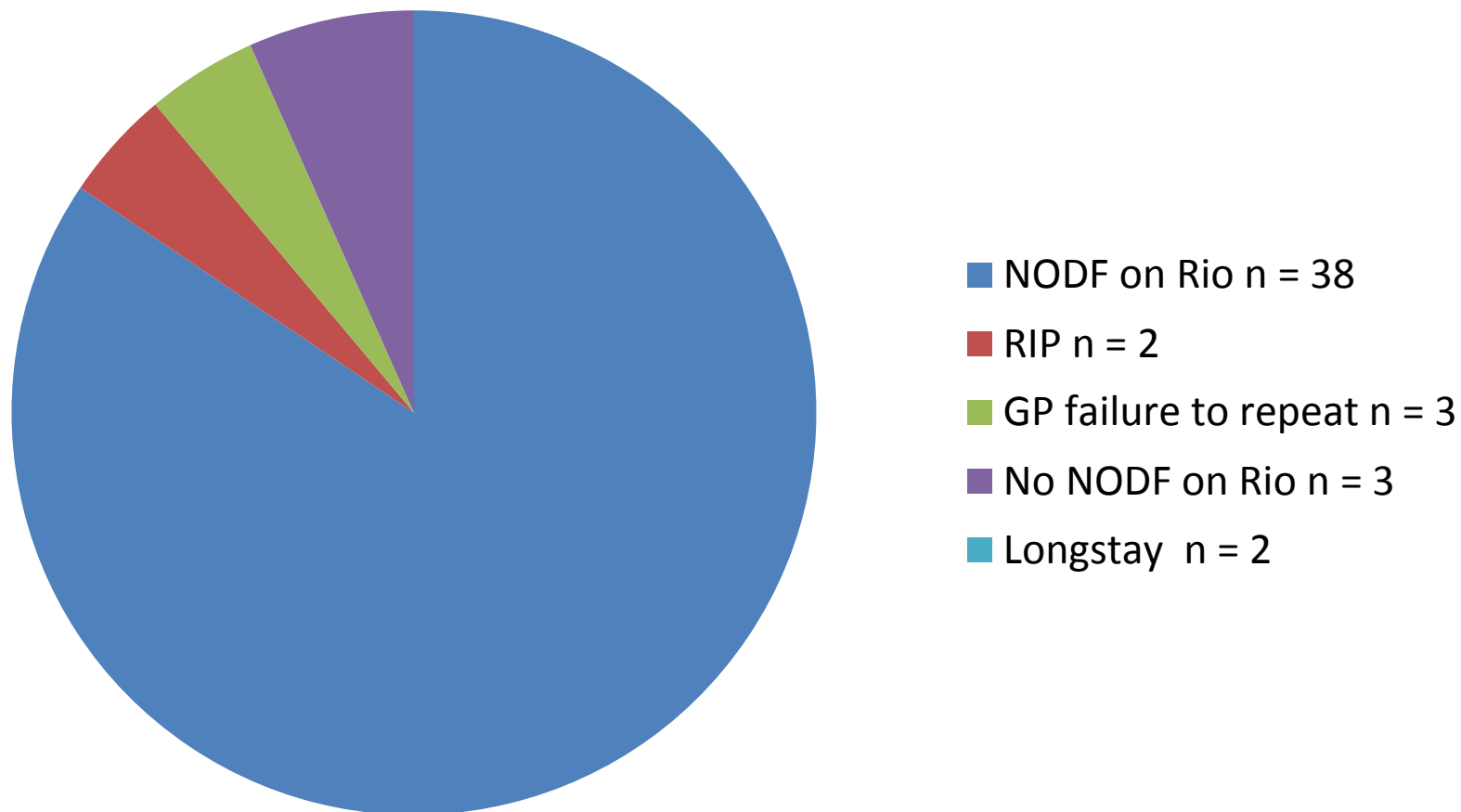
Process map admin process

Eliminate
medication
errors from
failed TTA
processes

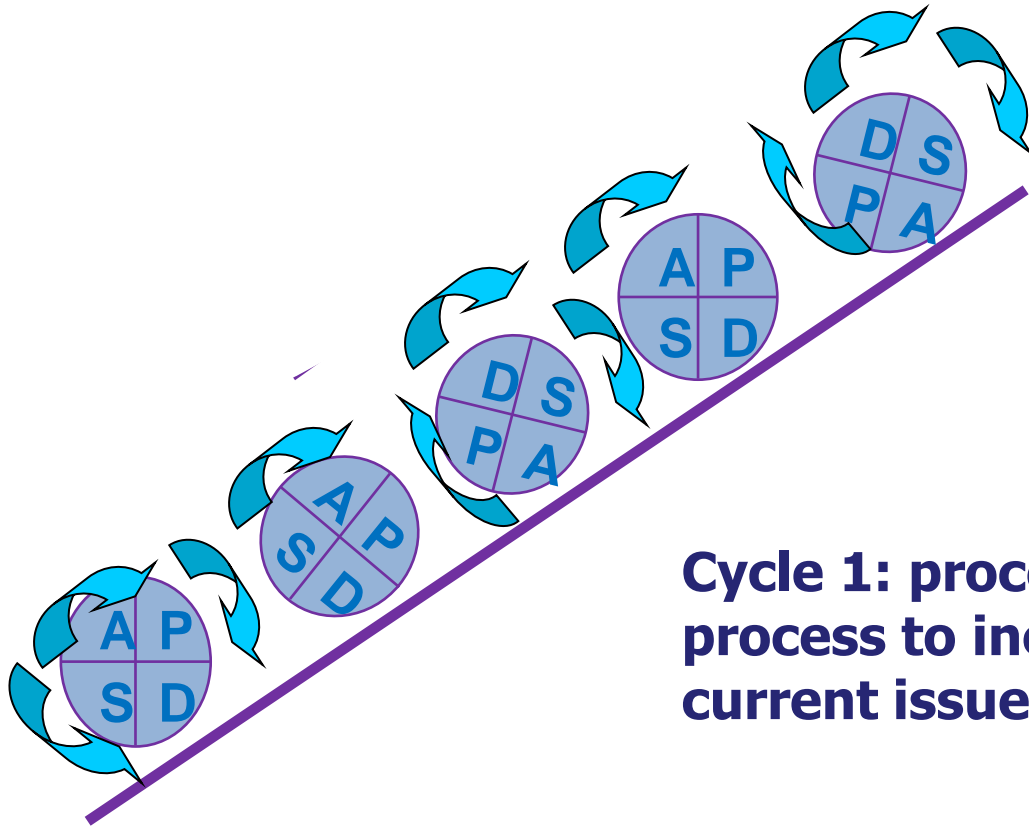
Increase
reliability of
documentation
reaching GP

(Numbers of TTA
received)

Audit of 48 Leadenhall Discharges 2014 -2015

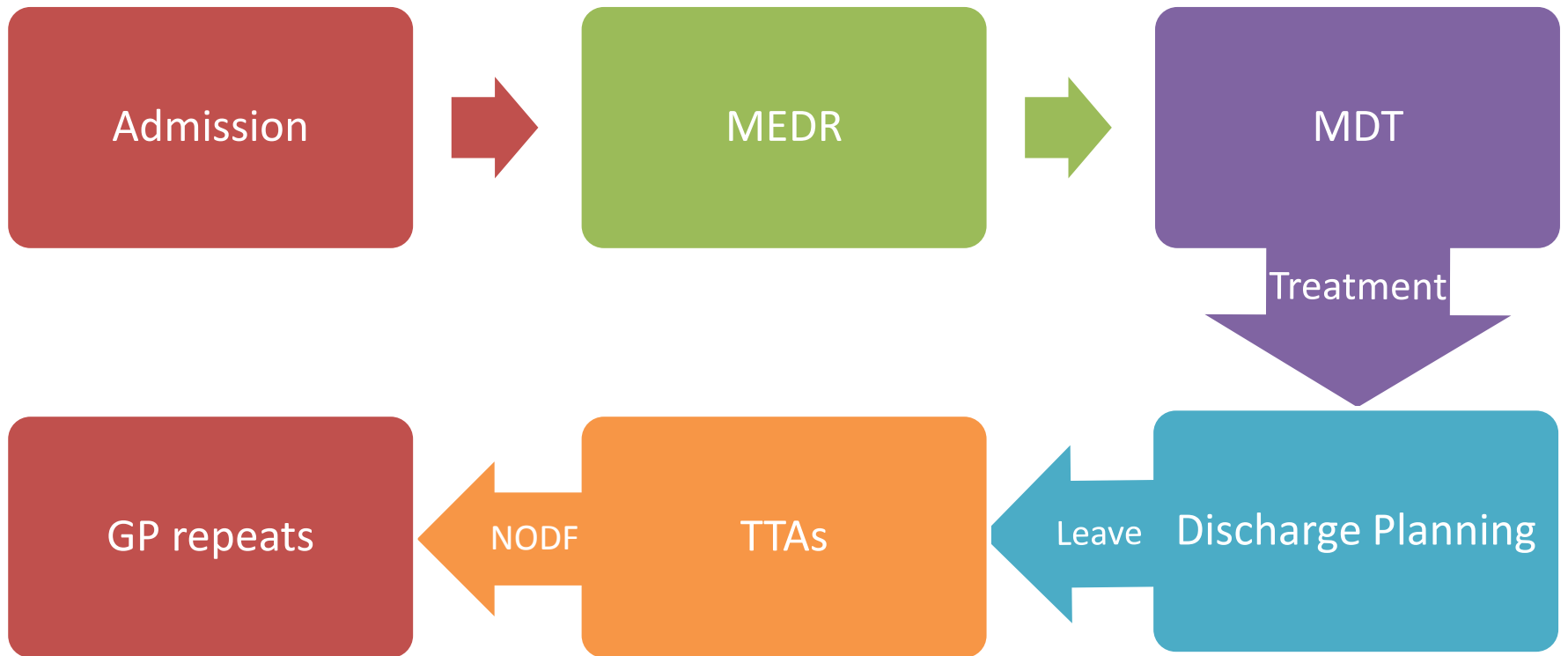


Sequence of PDSA's



Cycle 1: process mapping of admin process to increase understanding of current issues

Discharge process map



Learning

- Medicine education not always given.
- Ward Administrator not fulltime and delays sending NODF.
- No evidence GPs receive NODF/No fax receipt.
- Some patients let the TTAs run out/No GP contact post discharge.

Change Ideas

- Medicine education routinely given by doctor and named nurse.
- Ward Administrator keeps spreadsheet of NODF date sent and GP fax receipts.
- NODF now electronic.
- To liaise with CCG to help GPs accept email NODF