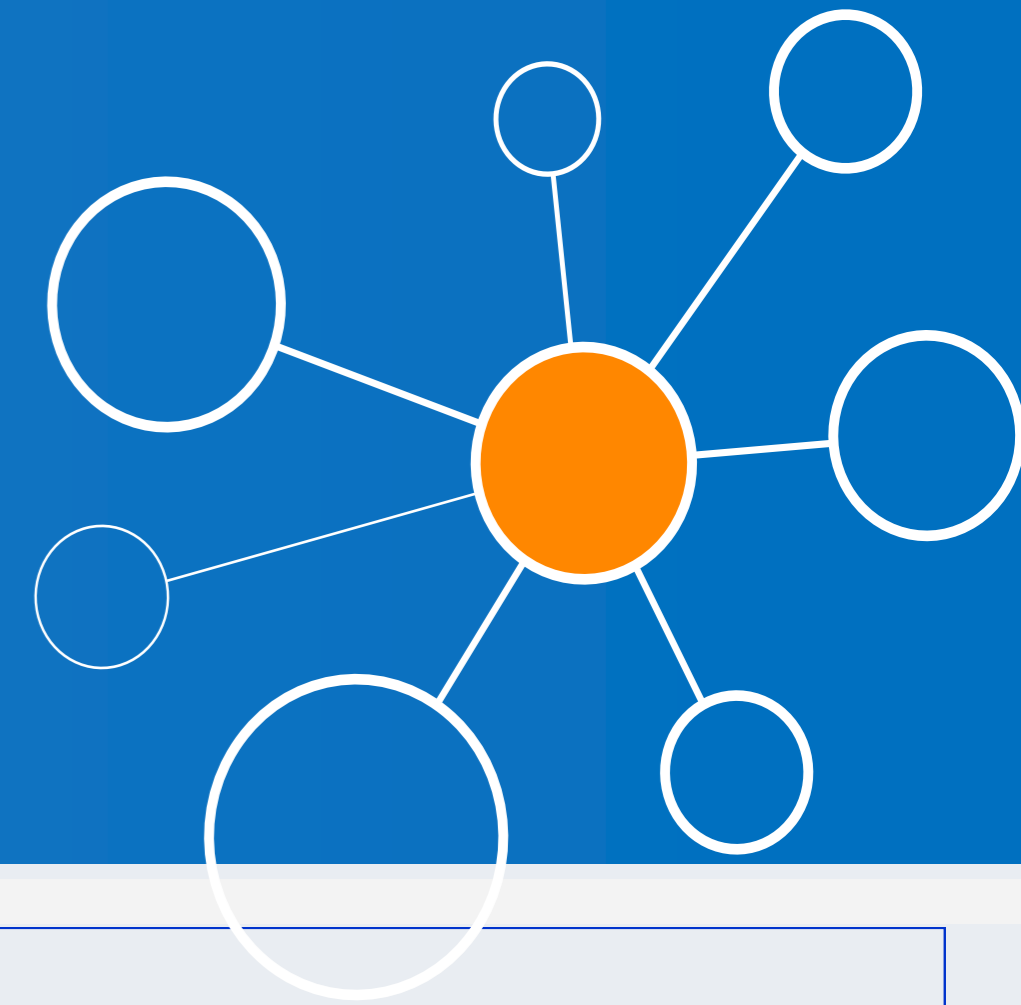


# A service improvement project on increasing documentation of the indication for newly prescribed medicines on discharge paperwork

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## Introduction

*‘Managing medicines when a patient is transferred from one setting to another is central to safe, high quality care’*

–Care Quality Commission (CQC) (1)

If hospitals fail to share correct information with patients’ GP about changes to medication, it can potentially increase the risk of the GP prescribing incorrect medication after discharge. (1) When a patient is eligible for discharge at GHNHSFT the doctors will electronically produce a discharge summary and prescription called a To Take Out (TTO), listing their medication.

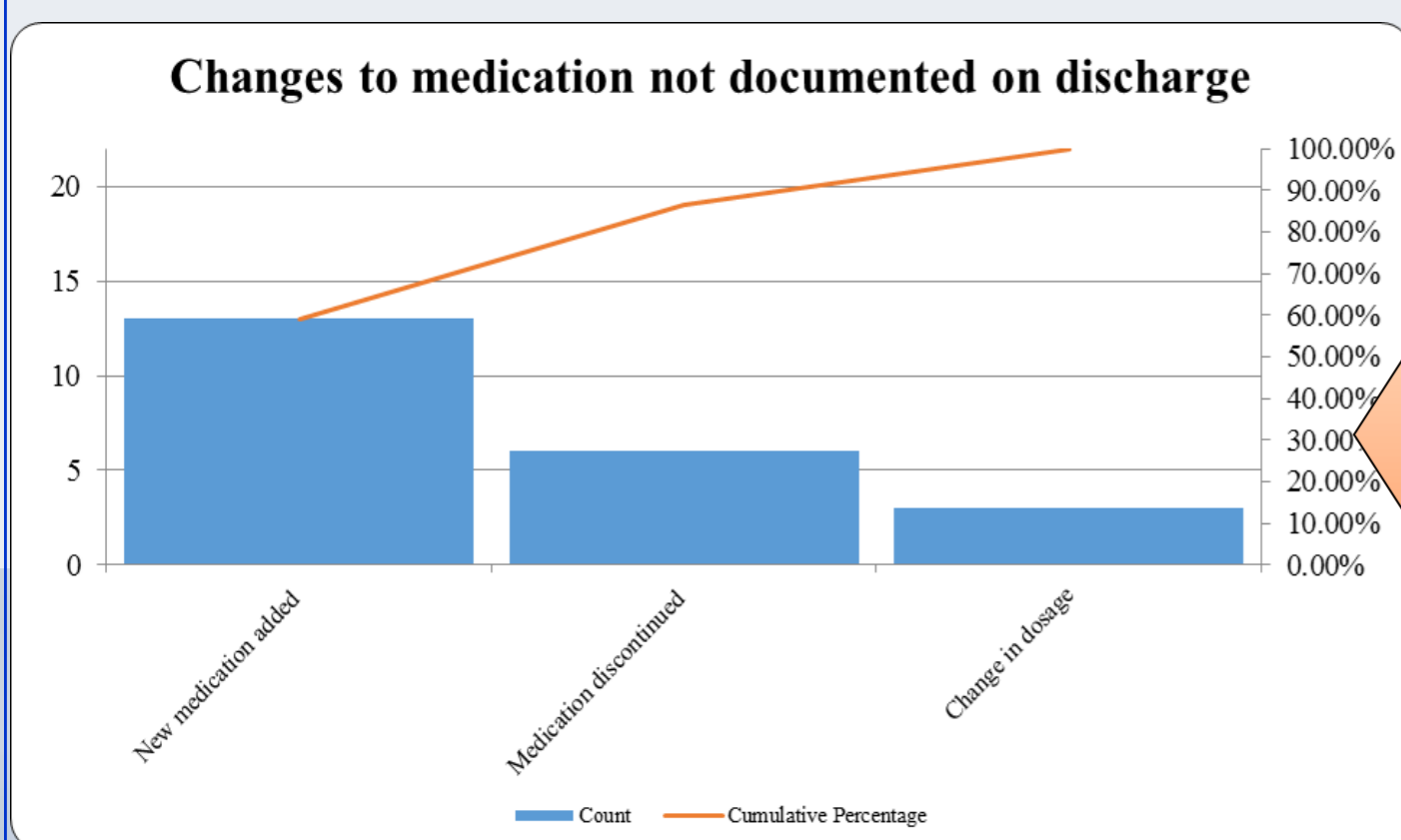
**PDSA Cycle 1:** Handwriting the indication for newly started medicine next to N for new section of the drug chart

Medicine	APPROVED NAME PLEASE PRINT	N	06.00	Atrial Fibrillation
Rivaroxaban		M	08.00	
DOSE	Other e.g. mL	Directions	Additional Instructions	
20		OD		
microgram		Route	with food	
		PO		
Start Date	Signature	GMC No.	Bleep	
25/11/16	A. Doxer	1284	4321	
Pharmacy supply annotations		Clinical check		
(sp) CSP 25/11/16		AP		

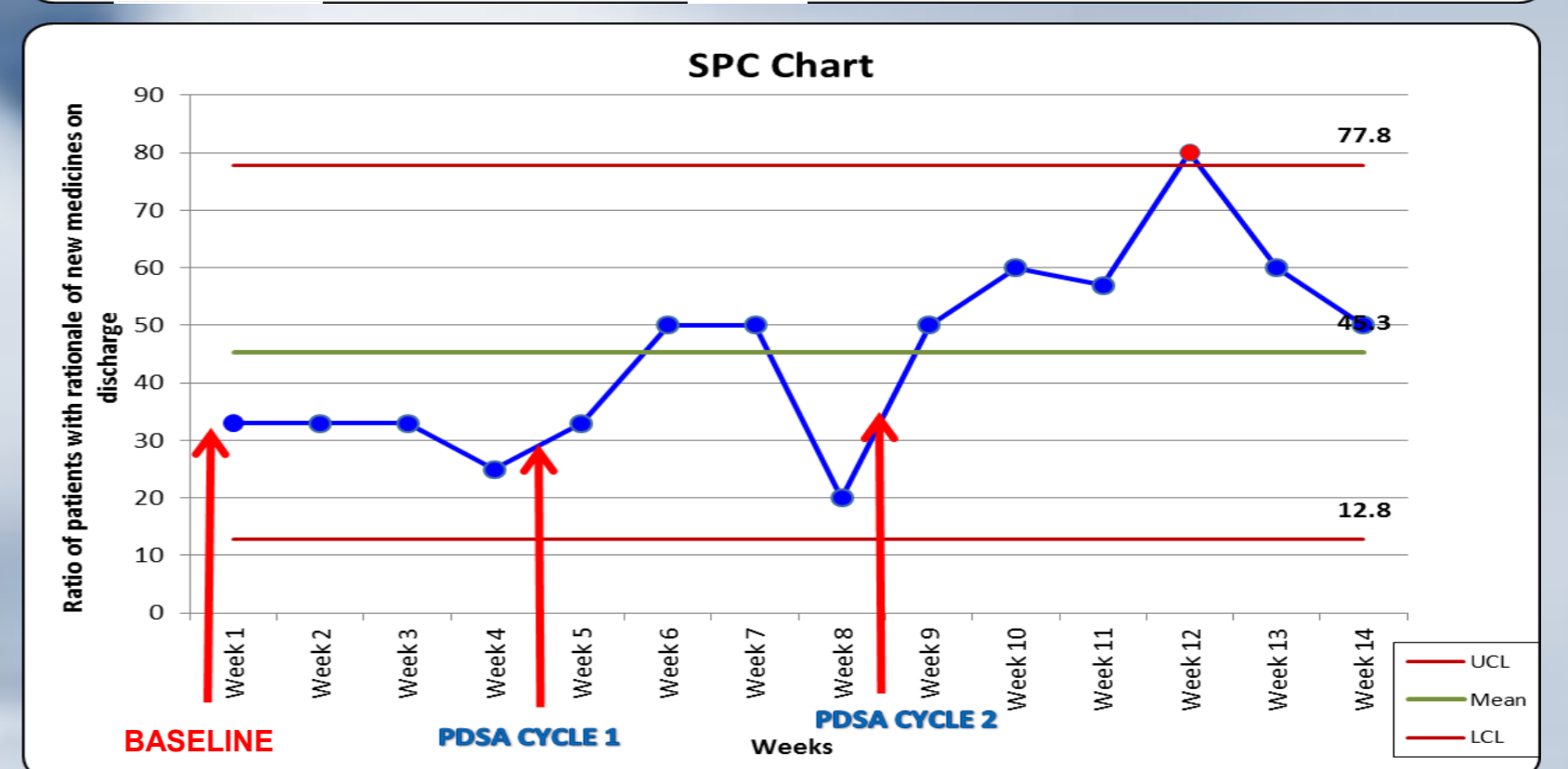
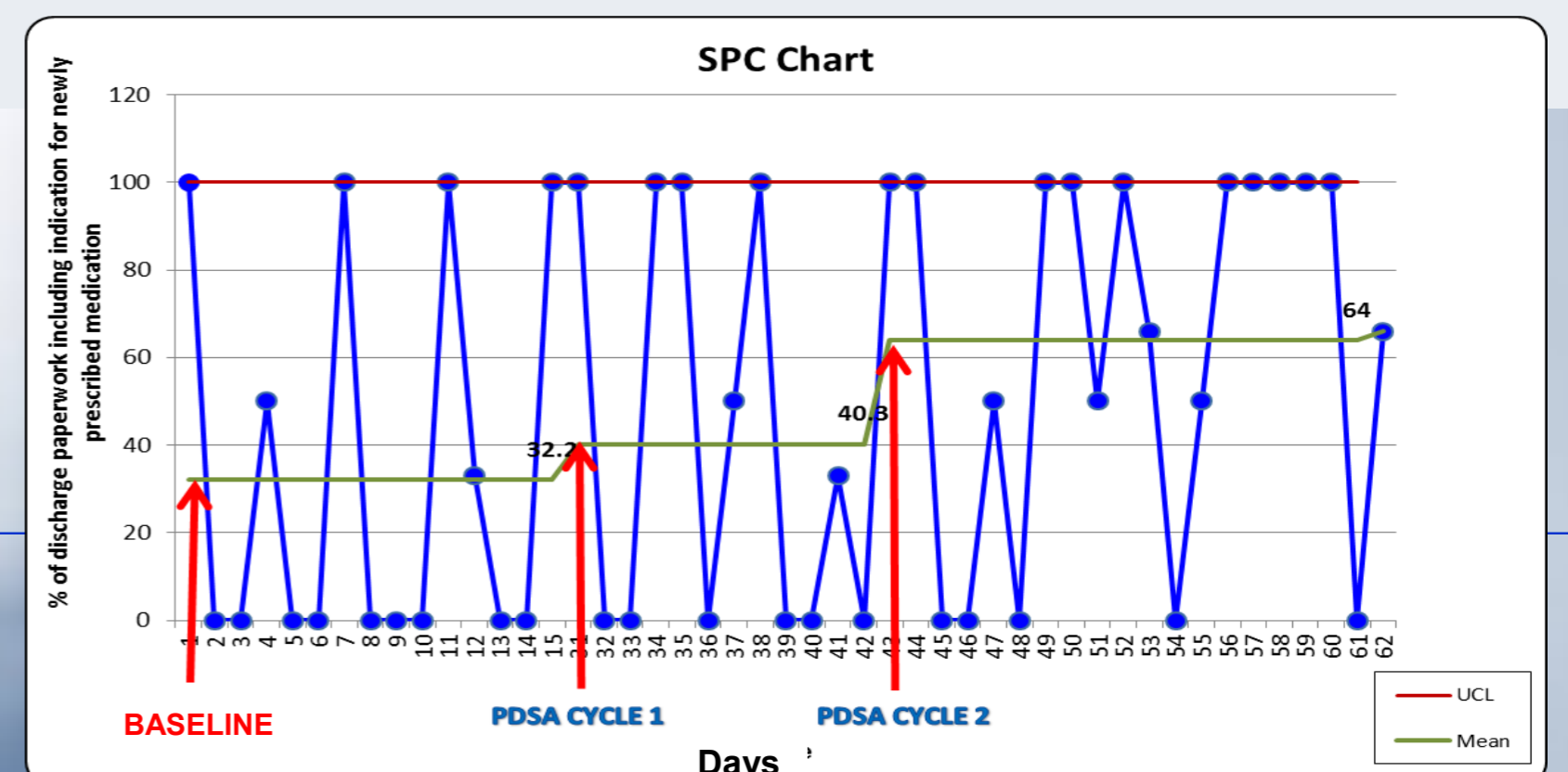
**PDSA cycle 2:** Placing sticker with the indication written on next to the prescribed drug on the drug chart.

Medicine	APPROVED NAME PLEASE PRINT	N	06.00	
Rivaroxaban		M	08.00	
DOSE	Other e.g. mL	Directions	Additional Instructions	
20		OD		
microgram		Route	with food	
		PO		
Start Date	Signature	GMC No.	Bleep	
25/11/16	A. Doxer	1284	4321	
Pharmacy supply annotations		Clinical check		
(sp) CSP 25/11/16		AP		

## Results



Analysis of discharge paperwork in the trust revealed documentation of new medicines on discharge needed to be improved



## Discussion

### Baseline data

Only 32% of patients newly prescribed a medicine during admission had the indication included on the discharge paperwork.

### PDSA cycle 1

Performance slightly increased to 40.3%. No shift in process or trend in data. Runs above and below mean were within range for common cause variation.

**Observations:** Lack of space to hand write indication on drug charts. Information not obvious/ ignored

### PDSA cycle 2

Performance increased to 64%. 5 consecutive points above mean suggests trend and change was having an effect. Runs above and below mean were within range for common cause variation. Weekly SPC chart 6 consecutive points above mean indicates a shift in the process. Keep measuring to establish performance stability. **Observations:** Sticker stood out and acted as a prompt. Hard for pharmacists to consistently add sticker to chart.

### Key Learning points

Adding indication next to drug on the drug chart increases documentation of the indication on the discharge paperwork

## PROCESS MEASURES

- 100% of new medicines are listed on the TTO letter
- Medicines reconciliation has been completed for 100% of patients

## Method

Change idea introduced via PDSA cycles

Analysis of discharge paperwork against drug chart

Analysis of Results: Abandon, adapt, adopt?

References:  
1. Care Quality Commission national report: Managing patients’ medicines after discharge from hospital. 2009. [Accessed 22 March 2016]. Available from: [http://www.nationalarchives.gov.uk/2010/201001009/http://www.cqc.org.uk/db/documents/Managing\\_patients\\_medicines\\_after\\_discharge\\_from\\_hospital.pdf](http://www.nationalarchives.gov.uk/2010/201001009/http://www.cqc.org.uk/db/documents/Managing_patients_medicines_after_discharge_from_hospital.pdf)