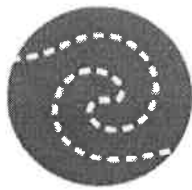


General Practice PDSA Plan

START DATE	17 August 2022	END DATE	
PURPOSE OF PLAN – What are you trying to accomplish?	To ensure EEN's are aware of the importance of complying with medication administration, in particular the 5 rights of medication administration, second checks and documentation.		

PLAN – Write concise statements about what you plan to do and the steps involved:		
WHAT DO YOU PLAN TO DO?	Deliver a short refresher training session on Medication Safety/Administration and documentation.	
WHAT DO YOU HOPE TO ACHIEVE? (Include measurement/outcome)	A baseline pre session quiz will identify any knowledge/skills gap, these will then be discussed, and quiz repeated. This will enable the staff involved to be pro active in their efforts to ensure compliant safe medication administration.	
HOW ARE YOU GOING TO DO THIS? (list the steps to be implemented)	BY WHO?	BY WHEN?
Individual sessions	RN RH	EEN MS 24/8/21 EEN ES 23/8/21
Reflect on process/findings and report back to PM	RN RH	31/8/21

DO – Implement your plan and write the observations you have during your implementation. This may include how the patients react, how the doctors react, how the nurses react, how it fits in with your system or flow of the patient visit. Ask yourself, "Did everything go as planned?"	
What did you observe?	ES – • in the pre quiz showed sound knowledge of most of the obligations of a nurse when administering medications. • Discussion after the pre quiz facilitated ES in identifying ways in which she can alter practice to improve medication safety.

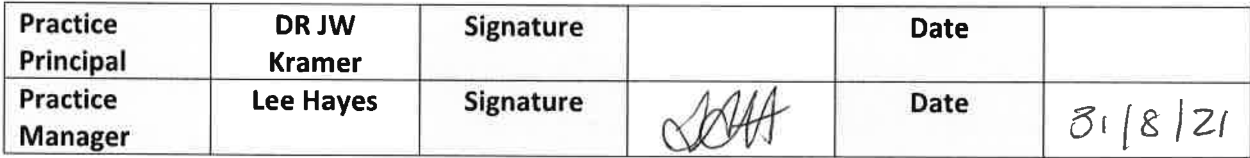
	MS – • in the pre quiz showed sound knowledge of most of the obligations of a nurse when administering medications. • in the **post quiz** MS identified that in the context of BSFP, the predominant obstacle preventing her from obtaining valid orders as – "habit – orders are not performed @ practice".
Where there any unexpected events?	ES – • yes - although ES is aware of her obligation and responsibilities when administering medications, as well as indicating on the **pre quiz** that there were no barriers stifling her ability to obtain valid orders at BSFP that she doesn't routinely request/facilitate orders. MS – • MS believed that limited access to busy Dr's prevented her from obtaining second checks. During discussion on the topic, it became evident that somehow MS was under the opinion that at BSFP, Drs were the only people that could do a second check. MS now understands that second checks can be performed by nursing staff – in the first instance MS should try to have second check performed be an RN if not available then an EN can perform and of course a Dr can perform second check. The most important thing is that the checks are performed (correctly) and documented accordingly. Both ES & MS were of the opinion that critical processes including second checks and valid orders, weren't important/didn't apply at BSFP. Both ES & MS identified that documentation was an important responsibility for all clinicians and identified ways in which they can improve their practice – particularly ways in which the obstacles that prevented them from obtaining valid orders can be overcome.

STUDY – After implementation, take time to study the results and record how well it worked, if you met your goal and document areas of improvement. Ask yourself, "Do I need to modify the plan?"	
What did you learn?	Even when clinicians understand their responsibilities and what is required of them, poor practices find their way into the workplace. There seems to be a mindset that Incident reporting/managing is a punitive process rather than being viewed as an opportunity to improve practice and more importantly patient safety; changing this mindset would be beneficial to the clinicians, BSFP and most importantly to patient safety. The mindset/attitude of participants is an important factor influencing how they engage in opportunities for learning and improvement and ultimately what they gain from the process. When these types of issues are brought into the open, analysed and addressed, change can be facilitated. ES & MS both identified ways in which improvements in practice can be made that will help them meet their responsibilities and improve patient safety/outcomes.

	• The quizzes identified that ES & MS know that the nurse administering a medication is responsible for obtaining valid orders, prior to administering. It was acknowledged that the practice of providing valid orders by Drs (in general practice) is not likely to change. However, they did acknowledge that by gathering the information required to complete a valid order, documenting the information in the patients' notes, then calling the Dr concerned to verify the order and noting the same in the notes – that in effect they have obtained an order that at least shows a duty of care and improves patient safety. • The quizzes identified that ES & MS know that the nurse administering a medication is responsible for documenting the event, both were able to identify times when this doesn't occur and are capable of making minor adjustments to their practice to meet this requirement. • The quizzes identified that neither ES nor MS had a sound understating of how second checks are to be performed. After some discussion they were both able to identify components of obtaining a second check. Both are aware that failure to obtain second checks can be a cause of adverse events for the patient.
Has there been an improvement?	Too early to say, however both ES and MS have identified ways in which they can alter their practice to assist them in meeting their responsibilities. ES & MS were assured that the problems addressed in this process are certainly not limited to their practice, we all have room for improvement, and this was an opportunity for them to be seen as leaders in practice improvement and patient safety.
Did you meet your measurement goal?	Mostly – both nurses were able to identify ways in which they will alter their practice, to improve medication safety and meet their responsibilities.
What could be done differently?	The process around setting up the training/change could be formalised, e.g. Practice management and whomever is tasked with the training, should consult on what the objective/s is/are and how it will be achieved. Once this has been decided the PM could send a message to the participants letting them know the training sessions have been arranged as a professional development/CPD opportunity, allocating a time frame for completion. The quiz used would benefit from a review, this became evident during the analysis stage.

ACT – Write what you came away with after this implementation, whether it worked or not. If it did not work, what can you do differently in your next cycle to improve the outcome? If it did work, are you ready to spread it across your entire practice?	
What did you conclude from this cycle?	Even with sound clinical knowledge, poor practices that can be detrimental to patient safety creep in over time.

	A positive that can be taken from this exercise is that with some revision of why certain processes are important, they can be reinstated in everyday practice with a little effort.



Practice Principal	**DR JW Kramer**	**Signature**		**Date**	
Practice Manager	**Lee Hayes**	**Signature**	[signature]	**Date**	31/8/21