Knowledge Awards 2020 podcasts: Aural cytology audit

Podcast transcript: Amelia Poole RVN, Project Officer at RCVS Knowledge, speaks with Meghan Conroy RVN about her case example, auditing ear cytology.

This audit was awarded Highly Commended in the Knowledge Awards 2020.

Amelia Poole:

Hello, and welcome to this podcast from RCVS Knowledge. My name is Amelia Poole, and today we're coming to you from lockdown and chatting to Meghan Conroy, RVN about her highly commended case example for the 2020 Knowledge Awards about auditing ear cytology. Meghan Conroy is an RVN and head nurse of a group of practices in Southampton. Her passions include medical nursing, emergency and critical care and raising clinical standards for general practice nurses. So to start off with, I really enjoyed your case example and mainly because it was, it was really different. We get a lot of audits in but not often ear cytology. And I liked the fact that it contained a bit of everything. It started off with what patients are having cytology before antibiotics after antibiotics and including the training. So, I must admit my nurse geekiness was in an overdrive (laughs) when I read it, because I thought it was really interesting. So how did you decide on what topic to cover, why ears?

Meghan Conroy:

So I think, I myself in last couple of years have only started to get into cytology again, I think it's something that a lot of us learn at college or university and unless you're really keen on it, we tend to learn those skills and forget about them. But actually in the last couple of years we had a new clinical director from South Africa. And he worked with a different pool of clientele, and some of them have very limited funds. Therefore in-house cytology is an essential piece of kit. I think it really kind of opened my eyes up of how, how we devaluing or deskilling ourselves by not using it. And actually this is an amazing service we can provide. So that's how I got my appetite for it. I thought, actually this would be really interesting to see because I could see the different confidence levels within the team. Some of them loved the idea and were like, "yeah, I want to throw myself into this" and the others weren't and therefore weren't doing it because of anti-microbial stewardship at the moment is so important and at the forefront of most things, I felt it was a good area for us to focus on and like yourself, I really liked looking at the reports and I love doing audits on consultations and things like that. So yeah, I think that's really what gave me the appetite for it.

Amelia Poole:

I think it's also really good as well because just from an in-practice basis, ears is something that can either take forever and ever to treat and clients get quite frustrated, and it can also be something that actually really gets quite expensive as well. So, I think it's a great idea. So you started by doing an audit of how many consults came in for ear problems and actually had swabs taken. Was that right?

Meghan Conroy:

That's right. So the first one where, so I have a number of practices that I look after as Head Nurse. So I looked at each individual practice and each vet, and so who was doing ear cytology at the first presentation. Now one of my vets was actually sending everything away for culture and sensitivity, which is almost the other extreme. It's almost too much the other way because actually, unless you're seeing rods there's really no indication or unless it's persistent, to do that straight away. We've got reports on Robovet, for anyone out there that uses it, that we can run. So we looked at the consultations for ears specifically and looked at a period of three months and then saw the percentage that were having ear cytology or the percentage that were having anti-microbials prescribed to them without ear cytology.

Amelia Poole:

Okay and after that how did you get the team on board to really make the changes that you wanted in practice? Was that quite, was it difficult?

Meghan Conroy:

I'm not gonna lie it was not an easy process and it was not a fast one. In terms of clinical governance, unless you are a real geek about it and you've caught the bug, it can be a really intimidating it can be an intimidating word. It can be an intimidating subject for people because they immediately think governance or quality improvement means that you're doing something wrong. Where actually it's about looking at what we're doing and evaluating ourselves and constant reflection. And it doesn't need to be a scary thing. So I was trying to change the culture and we had monthly clinical governance meetings where we would discuss cases and M&Ms and bits and pieces like that. So they were already used to my audits, but they were very much nurse related before that, where this was certainly a more team based audit. So they were responsive in that respect. They were also pretty surprised at how little they were doing, and also just a bit scared really of using the microscope.

Amelia Poole:

I can completely understand.

Meghan Conroy:

She was 25 years out and she said, "I haven't used a microscope since I left vet school, so I'm terrified". But actually what that opened up was a conversation between us and implore her honesty because actually when somebody then says, "oh I don't know how to do this" or, "I don't have the confidence, that's why I don't charge for things like this" Well, that that's a great learning opportunity, not just for her but for everyone. And now it's been over a year and we're still not a hundred percent all the time. But we're kind of 80% there and Naziema, the vet I was talking about and she's done like little testimonials for me. But for other vets at other CVS practices because she's had such a turnaround in all of her cases now she does aural cytology. It's been amazing and she's now moving onto haematology slides and other cytology bits as well. So yeah, I think the whole team, the majority of them really took it on board, but QI, it makes us look at ourselves. Sometimes that can be a little bit difficult, to look at.

Amelia Poole:

I think as well, especially if you were looking essentially at people doing a certain skill, and like you say, nobody really wants to admit that they are not confident in something or can't do something. But that's often the reason things aren't done is because you're just not confident at doing it. I'm going to admit now I wouldn't have a clue where to start with ear cytology, but, you know, give me some urine and I'm there (laughs). So it's just a matter of just kind of getting people to share what they're comfortable with doing. And if you find someone that is really passionate about certain subject they're often the best to actually teach others and kind of spread that passion around the practice.

Meghan Conroy:

That's it. And it's a pretty mundane thing, you know, ears, we see a lot of cases and you get the odd one that is just awful and has like Repeat pseudomonas and whatever, and it eventually needs TECA (Total Ear Canal Ablation), but actually the vast majority are pretty simple to treat. And when we look at the anti-microbials that we were prescribing in terms of treatment and what we should be going for, the vast majority of our cases only need a good cleaner to get rid of malassezia and then actually they're okay. So I think, there's so much to be learnt and so much that we can do for our clients and actually the aural cytology, they're making the most of that consult and everything in-house, they're getting a diagnosis on the day, we're treating something specific. So in terms of their expectation, I think we're really meeting it and providing them a good service.

Amelia Poole:

So have you had much feedback from clients about the case? Have you had any long-term ear clients that have noticed a change or is it mainly in-house that you've noticed the change?

Meghan Conroy:

So I think in terms of their expectation now, especially before lockdown, when they were obviously still in the building with us we would often take pictures and show them what we've seen down a microscope. And we'd say, look, we're just taking these swabs. And maybe some of our nurses have collected the samples, prepared them, have a look down and said, oh yeah, you've definitely got cocci or whatever down there. Then the vet comes double checks and then goes, yep, that's what we'll do. And we'll often take pictures and show the clients and they're kind of fascinated by it. Also they, I think a lot of them were just used to, oh, here's a bottle there you go. But actually now it's a little bit more intense, you know, after a week we want to get them back. We want to re-check, we want to make sure it's working and actually we want to make sure we've got rid of everything rather than what potentially happened in the past, which was you know, they were given something they didn't come back to see if it resolved and it never completely went away. And then six months down the line we're in the same issue again.

Amelia Poole:

I also liked you specifically said in your case example, that you've had some exclusions in your audit, so any care kind of patients and things like that. And I think that was really important to point out because I think sometimes people get caught up on the, you know, we're auditing this, so we have to do this certain thing. So we have to do cytology. And then, because they're thinking that all the time, they kind of forget that actually is also on a case by case basis. And as long as you can justify what your reasons are, and then that's okay. So I quite like the fact that you specifically said, you know what, we had some exclusions and that was that really because of the benefit of the patient.

Meghan Conroy:

Absolutely. You know, there are times when you have, you know, and a care patient obviously is not just aggressive or whatever, but those are really petrified and they're just not used to having their ears handled. We don't want to exasperate that problem for the owner. And actually what we have done is we've got owners to collect sample for us, and they'll do the swabs for us and they'll just hand it over. And that's been really good as well because it means that that doesn't interfere with their, you know, their process of treatment for that patient. And I think that's really important because there was a few years where he veterinary world got a bit, you know, hung up on the terminology of gold standard and it's something that can really get people's backs up actually. And I found out it does get people's backs up. And yes there will always be, you know, an ideal way of doing things, but we don't live in an ideal

world and veterinary practice is certainly not ideal. So we have to take each base. There, there are certain standards and certain expectations, but we have to do it on a case by case basis and give it the credit that it's due rather than it just being an analytical data analysis, which sometimes it can be.

Amelia Poole:

Yeah. And I think the one thing to add on that is, yes, we are looking for kind of the best treatment and the best process, but I think we need to add on the end of the best process for that patient and for that situation. Because, you can have the nicest animal in the world, but you go to touch their ears and they're just like, no getaway. And that's just something that we obviously deal with on a daily basis. So I think that came across really nicely in your case example, was that yes, we're using quality improvement to improve our patient care, but also remembering that each patient is different and that we might not be able to follow through on these guidelines for every single patient. So we are thinking about it and we're processing it. And even if, say for example, one month you might have had lots of, I was going to say lots of low numbers, but that's not very good English (laughs) lower numbers on the audit scale. But again, analysing that, you could see that maybe a lot of these patients were care patients. So that would justify that. And I think it helps teams move away from the whole a low number is a bad number, because it's not a right or wrong way. It's just, do the best you can way.

Meghan Conroy:

Absolutely. You want to look for those trends. And I think that's why it's so important for discussions to be had as well and for us to not focus. It's very easy, especially when you have these reports available to you. I remember when I started to look at the financial side of things, I'd get really caught up in the final figure, whereas actually there were so many contributing factors to that figure. And that's what we have to do. And that's part of understanding how to read and how to perform QI because it's very easy to just go, we're doing it wrong because we have a low number, but actually that might not be the case. So always looking at the history and looking at the overall picture is gonna be your friend really.

Amelia Poole:

Also just getting the entire team involved because there's lots of like sometimes you can sit down and look at a problem and just not figure out how to figure it out and someone else can walk in and just be like, oh, you just do that. And that because they've got different experiences.

Meghan Conroy:

Exactly, everyone has different things to bring to the table. And now that's what I truly believe with QI, and our clinical governance meeting. We have a panel of core people from different parts of the practice. And then we have, well, basically it's free to all. So anybody that can make it is more than welcome to come to them. And I have to say, I think the saddest thing for me of Corona, is the fact that I haven't been able to do what I would normally do, which would be monthly audits and clinical governance meetings and things like that. So I'm working in a new world of how do I incorporate that and how do I do it when I can't get the practices together? You know, do it over teams? Do I do it more individually? You know, how do I kind of incorporate that in and actually is it the best time to be looking at audits?

Amelia Poole:

So how did you find managing the audit over different practices? Was it three different practices?

Meghan Conroy:

Five. So, well, easy in terms of collecting the data, because all you have to do is put in like certain different things and it will bring up individual practices. And I can see everything who went to which

patient went, where, which, whoever. So from that point of view, that wasn't difficult. What was actually difficult was when I was relaying the results, I like our practices to be a little bit competitive with each other, especially the ones that are similar sizes a healthy competitiveness, not you know, finger pointing look how well we do look how badly you do. I think probably in the beginning, it may have looked like that because one of my practices had 150% total, they were coming in, they were having the aural cytology, they were having it re-checked, brilliant.

Meghan Conroy:

And then another one of mine was about 40%. However, they had had a string of locums and no permanent vet there to kind of impress on what we do and the standard of cytology care that we provide. So, you know, again, that's where it comes into breaking it down. And I would always issue a report each month. So it would only be like a page or a page and a half, along with graphs and things like that. And it would show who's improving and where we're going, what's gone well and it would kind of break it down to them so that it didn't feel like they were just constantly being told they're not doing good enough, but was, it was so nice to see those numbers gradually improve and then people's confidence and provide the actual learning for them as well. So doing extra CPD with them getting them to work alongside another vet that's really confident with it. So I mean, I love doing audits for all of them and some of them, they do get quite competitive against each other. Especially things like patient safety checklists and things like that. So I'm almost slightly like big brother, but in a good way, because I can see everything down to their hospital forms, everything. So there's nothing. And like I said, if you haven't written it down, it's not there or it didn't happen. And so that's impressed upon so much as well I think.

Amelia Poole:

It sounds like a good culture there and obviously it's paid off with the ear cytology and things like that. And obviously paying off with your potential future audits that are coming.

Meghan Conroy:

Definitely. I love the ones we've done on patient safety checklist, hospitalization forms GA sheets, ASA risks like that, but this one I liked because I felt like it was a big collaboration because actually the nurses can do a lot of that cytology. And you relay that information back. So it was something that the whole team could do, where some people tend to go, oh, that's the nurses one. I'm like, no, no, no. And that's why we tried to get my patient safety checklist done by the most inexperienced member of staff in that theatre room. So normally a patient care assistant will be a float person. Because it gives them that responsibility and actually they can say, no, you're not going into the theatre because you haven't done X, Y and Z. That's why I think it's so important

Amelia Poole:

Yeah, helps bring everyone onto the same level almost.

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