Knowledge Natter transcript: Huddle up for safer care (HUSH) Huddles, by Paragon Veterinary Referrals

Lou Northway and Helen Garbett, RVN

RCVS Knowledge:

Welcome to this Knowledge Natter, by RCVS Knowledge. Here, we have friendly and informal discussions with our Knowledge Award champions, and those who are empowered by Quality Improvement in their work. Whether you are a veterinary surgeon, veterinary nurse, receptionist or member of management, Quality Improvement will and can positively impact your everyday life. Listen and be inspired.

Lou Northway:

Hello everyone, my name is Lou Northway. I'm Quality Improvement Lead RVN here at RCVS Knowledge and I'm here today to talk with one of our amazing RCVS Knowledge award winners, Helen Garbett from Paragon Referrals. Hello Helen!

Helen Garbett:

Hi!

Lou Northway:

Thank you so much for joining me on this very busy morning in practice, I'm sure. So before we dive in and we find out all about your project, can you tell me a little bit about you, your career history, and most importantly, all about Paragon and your team?

Helen Garbett:

Yeah, so I, as you mentioned, Helen Garbett, I'm the learning and development team lead at Paragon Referrals. I have been at Paragon for five years now. I qualified 15 years ago. Prior to coming to Paragon, I'd never worked in referrals before. It was quite a big jump at what I felt was late on in my career.

But yeah, previous to that, I've been a Head Nurse in A hospital, locum a bit, so, yeah, I've been around. I've seen the good, the bad and the ugly of the veterinary world, I guess.

Lou Northway:

And I imagine got a lot of inspiration for things we're going to be talking about today as well.

Helen Garbett:

Yeah, definitely.

Lou Northway

And tell the listeners, what does Paragon look like day to day.

Helen Garbett:

Oh, so it's quite busy. We're a multidisciplinary referral site. We have a lot....we've got medicine, neurology, dermatology, cardiology, soft tissue surgery, orthopaedics. Oh, I don't know if I've missed anyone out, quite probably. There's a lot going on. We're kind of on two floors so we run our surgical department upstairs and our diagnostic imaging downstairs. So yeah, as I said it's quite busy and our team's kind of...I guess the beauty of being multidisciplinary is that quite often our patients need more than one clinician involved. They might come in for one problem and then we find another so internally we can refer to different departments, so the patient gets the best of care.

Lou Northway:

I bet that really helps with teamwork and communication and collaboration as well, doesn't it?

Helen Garbett:

Yeah, absolutely, yeah.

Lou Northway:

And your Quality Improvement team, how did QI come into Paragon? How did it all start?

Helen Garbett:

A group of us got together and said 'okay, we have the capability, the facilities to do a lot of things and our main driving force is that we want to provide the best standard of care we can for our patients. So how can we improve on that? How can we better that?' A group of us

formed the Quality Improvement team so that we could really analyse…'okay, this didn't go so well in this instance, how can we make it better?'

So, we used VetSafe reporting, which now, as we are part of Linnaeus' The Mars Halo [system]. We really encourage everyone to submit anything on there that maybe they felt could have gone better or wasn't quite right and we analyse those quite regularly, put some actions in place, and then there's other things that maybe need a bit more discussion, a protocol change, to look at how can we make this better? And it's a constant kind of cycle.

Lou Northway:

And to start with, you were using VetSafe and then Halo and reporting, and you found that engagement at the beginning of sort of like this QI journey, it wasn't as good as you'd hoped. Then you decided to change it up a bit, and this is when this initiative came into play. Can you start telling us about the journey with your Knowledge Award?

Helen Garbett:

Yeah, so we're getting constant reports on the reporting system, VetSafe and Halo, of medication incidents or medication errors. And that could be anything from…our protocol is that all medications have to be double signed. So sometimes it'd be that it was on a single signed and checked right through to a patient might have received an incorrect dose or incorrect frequency. We recirculated protocols and we put meetings in to give more awareness. We tried a lot of different methods to try and reduce that really. The number of medication errors we were seeing on our reporting system was about 50% of all reported incidents.

And despite what we were doing, it didn't really seem to alter too much. We kind of thought that off the back of that, this needs a big change. It needs something completely different. We're doing huddles, we're doing meetings, we're recirculating protocols and it's not changing. This needs something different. Then Sophia Ramantos, our clinical director, she was researching or having a look at other industries really and what they use to reduce incidents, accidents, that kind of thing. I think she initially started looking in sort of construction, aviation and then happened upon the Improvement Academy which is a human healthcare-based initiative of improvement scientists and patient safety experts, and they work, as I say, within the NHS. And I think it struck a chord with her because they're Bradford-based in Yorkshire, which is not too far from us. We're like, 'hey, they're from Yorkshire, we're from Yorkshire, maybe we could team up with them'.

Lou Northway:

Yeah, it's really interesting, like cross-section, know, human versus veterinary learning, like it's happening more and more, isn't it?

Helen Garbett:

Yeah, definitely. And I think it's nice because, you know, historically, the veterinary world has been quite far behind the human health care system. And it'd be nice to reduce that so that we are getting the latest information techniques, that kind of thing. So hopefully this is bridging that gap a little bit as well.

Lou Northway:

The initiative that you learned about was HUSH, the HUSH huddles. What does HUSH stand for?

Helen Garbett:

HUSH stands for 'Huddle Up for Safer Healthcare'.

Lou Northway:

And how do you go around doing a HUSH huddle?

Helen Garbett:

I mean, there's a lot more to it than the HUSH huddles, but the team that are day-to-day working, that's all that they see as part of this initiative, which is great because for them, it's 5 minutes of their day. A HUSH huddle is just a small little huddle. As I say, it lasts 5 to 10 minutes, ours generally about 5 minutes.

They're led by the most suitable person, so that's not necessarily a lead or the most senior person, it's the most suitable person to lead that. The idea is that you have all team members present, even those that are non-clinical, just to get everyone kind of on board and excited by it. And by tagging in as many people as possible, you can explore better how the errors did occur and get proactive suggestions to prevent them. Everyone sees things from different perspectives.

The huddles are focused, so ours, what we wanted them for was to prevent medication administration and dispensing errors. We identify patients that are at high risk of a medication error and discuss ways of mitigating that before it's actually happened.

Lou Northway:

Who would that be? What would you define as a patient with like a high risk of making an error?

Helen Garbett:

I think that depends on what you're trying to target. For us, when we started the huddles, we noticed that patients that were on four or more medications, especially if they were different frequencies, so if you had a once a day, a twice a day, three times a day, the frequency sometimes got a bit mixed up. For us, our targets initially were high risk patients on four of our medications. Patients that we had switched opioids, so buprenorphine to methadone, methadone to buprenorphine. And patients with the same name. We have a lot of, we do a lot of orthopaedics, we have a lot of black labradors in for TPLOs, they are probably our most represented. A lot of them, you know, 'Max', 'Lola', 'Luna', you get a lot of, similar names in similar looking patients. So that was also a big one for us to target because we noticed that 'Max', for instance, was getting his medication mixed up with another Max and they could be different weights.

Lou Northway:

Yeah, it's so easily done, isn't it? From where I am in practice, our clinic is Cockapoos. They're probably the most popular. It's like go and get the Golden Cockapoos. And you're like, 'well, there's four in there today'. So yeah, that's really, it's really interesting that you can totally relate to that.

Also about medicines and how they change day to day. One of the things when you were just talking then that really sort of came into my head was the use of like certain non-steroidal medicines which start at a starting dose and then there's a lower dose on day two and it's how often does that actually get reduced on day two and I'm sure that's a complication or a drug dosing error that many listening will also encounter in practice.

One of the things that stands out from your project which I really love is that with the progress that you've made. Now with your reporting you only really see new problems. You don't have the same sort of errors reported again and again and again because your systems have changed and that's fantastic and I think that's amazing evidence that what you're doing is working.

Helen Garbett:

Yeah, thanks. It's something that we didn't... It only got kind of so far down the line when we realised that, that once we'd discussed how they were occurring once in the huddles and mitigated them, then it was something else. Although we've reduced our errors quite significantly, we are still seeing them, but it's different ones or they've occurred differently. It's just something else to tackle.

I think the major problem areas we've sorted out. So now we're getting on to the other ones that we didn't even know existed because we hadn't uncovered them yet.

Lou Northway:

Yeah, no, and I think it's really interesting when you start learning about the things that happen in practice and when if you do have things that repeat again and again. I just think it's so interesting.

Also to normalise making mistakes and to appreciate that we're all going to make them. So how can we work together to one, normalise it and two, collectively feel empowered to make those changes? Because like your team culture and everything's really improved as a result, hasn't it as well?

Helen Garbett:

Yeah, I think we have always had like a pretty good culture and I'm very much someone that advocates, like everyone makes mistakes, it is going to happen. But how do we reduce that going forward and how do we reduce the... I guess the impact of that on the person who's made it and the practice and the patients. What was the surprising thing for me is that doing these huddles and openly discussing errors at first. Ironically, the first person to make a drug error when this project was released was me. And I'm very open about mistakes. I said, 'Oh guys, that was me. I'm really sorry', and discussed it. And maybe that was a good thing because I am quite open, but people saw that. It has created a psychologically safe environment, which I just didn't really contemplate it would. Now people do say, 'I did that, I'm really sorry guys, we're back to zero on the errors'. But the support they get from the group is great. But what happened at that time? How could we have helped reduce it? Is it anything that anyone else could have done? What would have helped? And the support is really, really good.

Lou Northway:

Yeah, I mean, it's amazing to hear and we always say at Knowledge, learn from everything. And there's loads of motivational quotes in there about learning from mistakes and everything. And, you know, that's so lovely to hear that everybody is really forthcoming when they make a mistake, they're not worried that they're going to lose their job or, you know, they're going to get the sack or be penalised or told off for it. Because ultimately, when we stand still and we reflect on what's just happened, most of the time I think you can think, 'well, it's happened to me and unless something changes right now, it's going to happen to someone else.' Or sometimes I think you think, 'wow, how has this not happened already?' Or maybe it has and just no one said anything, but yeah, it's absolutely fascinating.

Let's get down to the numbers, HUSH Huddles came into force. The team engaged, the amount of reporting increased and then the amount of errors reduced. Tell me, what happened over the course of time.

Helen Garbett:

We obviously collect our data through Halo and then we send it off to the Improvement Academy. They do kind of all our analysis. They use statistical process control charts and then we get the results of that every two months.

The data showed that we got 10 error free weeks in 5 months since starting the huddles compared to 10 error free weeks in a year before the huddles. We started the HUSH Huddles officially in August 2024 and we got a 10% reduction in total medications from August to December 2024 compared to August to December the previous year 2023.

Lou Northway:

Wow, I mean, that's amazing. And what was the team's response to that when they get fed back that information?

Helen Garbett:

They were really happy. I think that because we as part of the HUSH Huddles, we have a board downstairs and we display the days between errors. When we're at the HUSH Huddle, we hadn't had an error, the number goes up by one each day. They just see that number go up. But they really celebrate that number like, 'we want to get to 10, we want to get to 20', and we can't give certificates. They see that number going up. But I don't think they realise the overall impact that that had had on the reduction in medication errors.

Lou Northway:

Yeah, absolutely. And do you think it slowed the team down when they're handling medicines to really try and be in the moment and touch base with others to make sure that the medicines in front of them are the right ones, the right dose, the right patient, all of those types of things?

Helen Garbett:

Absolutely, they definitely concentrate a lot more because through hearing other people make errors in the huddles you realise how easily they're made. It can take one barking dog that distracts you or a really busy ward, so it's made them really concentrate and take a bit more... I'm not going to say care because everyone takes care but I think they recognise the distractions that so easily happen.

Lou Northway:

Absolutely, yeah, like you say, you're a bit fatigued, there's lots going on, you only have to mishear someone or misread someone's notes on a hospital sheet and it's very easy to make a mistake, isn't it? Can you think of some of the sort of drug dosing errors you've encountered in practice and then some of the changes you made as a result that you could share?

Helen Garbett:

So quite early on, one of the ones that we've, as I mentioned, focused on was same names. And this was something that I had never even thought of, but we said, okay, we've got two, for example, Max's in today. And we'd noticed that the previous day, those medications had got mixed up. Each patient got the other patient's medication, and it was a slightly different dose. We said to the team, okay, what can we do to prevent this today?

We had two suggestions which were really, really good. We are fortunate enough to have two separate wards. We have a surgical ward for our dogs and a medical ward for our dogs. One option was to completely separate them into different wards so that we have different nurses on each ward, so completely different nurses.

The other suggestion was to colour code them. All our patients come in and we put a collar on them, paper collar, with their name on so we can identify them. And they have different colours. I said, 'OK, let's give this Max a green collar and then we'll highlight his hospital record in green, and all his medications are going to have green stickers on. And this Max is going to be Max Red. We'll do the same for him, but everything is in red'. And that I'd never even

thought of, and it was one of our night nurses who was probably very tired at the time, came up with that. And I was like, ‘what a fantastic suggestion’.

Lou Northway:

Yeah. And it is just like that though, isn't it? Also when you bring in your HUSH Huddles, you have different members of the team, different insights, different views, like admin team as well, engagement with clients, everybody can add really valuable insights that others just may not think of. Because I think we can get stuck in our own fishbowl a bit, can't we, of how we see things? It's really good to come together like that.

And have you changed anything in regards to like drug storage or where drugs live or counter-signing processes or anything like that?

Helen Garbett:

Yeah, we've had a lot of changes that have gone alongside this. We used to have an area where all our patients’ medications were kept and each patient had their own box with the name on. And then we noticed that was one of the big reasons why patients with the same or similar names were getting medications mixed up because you just pop it in the wrong box by accident.

Now we have all our patient medications for that patient on the front of the kennel. Everything is in there. So that's one of the things that we've done. With our kind of dispensing procedures, we notice we get sort of, you know, you have like prednisolone or any drug that has several strengths, they get mixed up. The ones that get mixed up quite frequently we've put in a clip lock box that has a sign on saying ‘this is five milligrams’. It's a physical kind of barrier to ensure that you check what it is. We have rearranged our pharmacy a little bit as well to separate certain drugs. We've got an eye medication and there's two forms of it. It's the same active ingredient but one's got something else added so we've completely separated them and made warnings so that they don't get mixed up.

Lou Northway:

Yeah and it's just those like small changes isn't it that make such a massive impact in the long run and sometimes it's when you stop you think, ‘my gosh, like we've had two drugs that keep getting mixed up and they live next to each other on a shelf… like that's just asking for trouble’, like you say a small change can make such a big difference.

What's next for Paragon? What are you going to be working on going forward to what your goals and ambitions?

Helen Garbett:

Our goals, I mean ambitions, is always to provide the best care to our patients and that's the main thing. We're going to keep going with the medication errors. Since we started the HUSH, it's been quite a while now since, it's been going a year. The last lot of data that we got back, we've actually reduced our errors by 25% overall, which is amazing.

We're keeping going with that, but we are going to use the HUSH huddle concept and use it for something else as well. We're still going to touch on the medication and stuff, but we've noticed that we've reduced our medication errors quite a lot. But now there's other things that we think we can improve on that are getting probably not more frequent, but we're noticing them more because we're getting less of one type of report.

We are in the process of, I guess, changing up our HUSH Huddles and we're going to focus on something else. We're still going to touch on the medication because we don't want to lose sight on that. Although we've made massive improvements, we're not where we want to be. There's still little way to go. But also I don't want the team to get fatigued so by changing it up, having a different main focus and try and reduce those things. We're trying to use it in different, yeah, for different things really.

Lou Northway:

Super inspiring. Well, I hope those that have been listening today have lots of ideas now to take back to their practice and have a chat and maybe start their own HUSH Huddles. We can hope. But thank you so much for spending some time speaking to me, Helen. I wish you and your team all the best for QI projects in the future. I hope to see you guys in the RCVS Knowledge Awards again next year. Thanks so much, Helen.

Helen Garbett:

Thank you.

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