Knowledge Natter: Post-operative pain scoring bitch spays: A Clinical Audit by White Lodge Veterinary Surgery, CVS

Lou Northway and Dr Paul David Stanley, BVM&S PGCertSAM MRCVS

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 (QI) in their work. Whether you're 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. Welcome to this RCVS Knowledge Natter. My name is Lou Northway, Quality Improvement Clinical Lead here at RCVS Knowledge. Today I'm talking to Paul Stanley, from White Lodge Vets, which is part of CVS, about his second RCVS Knowledge Award.

Welcome, Paul.

Paul Stanley:
Thank you. Thank you very much for having me.

Lou Northway:
Well, welcome back. Absolutely amazing that this year, you've received your second RCVS Knowledge Award. Today we're going to be talking to you about it.

Before we get going, for those listening that haven't met you already, could you introduce your team and yourself to us?

Paul Stanley:
My name is Paul Stanley. I'm the head of QI at White Lodge, which is a small animal first opinion practice in Exmouth. I'm the advanced practitioner in small animal medicine, and have an interest in QI and research.

Lou Northway:
Thank you, Paul. Last year, you won your RCVS Knowledge Award for reducing antibiotic use in cat bite abscesses. This year, your project has taken a completely different path. Where did your inspiration for this year's project come from?

Paul Stanley:
Yeah. This year's project ... Well, it wasn't this year. We started actually in 2001... Was on reducing our post-operative pain scores. This all started at a practice meeting where the nurses in particular were raising a concern about the comfort and pain management in some our patients post-operatively. What we did with the team is basically design an audit to find out if there is a problem. And if so, what it is and how we can fix it, and see if that's successful.

Lou Northway:
I bet that was really empowering for the nurses to be listened to, and to have a project that you could all work on together to improve welfare for your patients.

Paul Stanley:

Yeah. Well, these things don't work unless you've got a whole team involved. Particularly when it is something like post-operative pain scoring that the nurses are doing anyway. They're quite passionate about the welfare of animals. You need to make sure that they're, one, on board with the project. But two, happy with, particularly if you want to collect a bit of extra data, you want them to fill in an extra form, you want to make sure that everyone's designed in that, so it's as least effort as possible. They're very, very busy doing lots of important jobs. A lot more than us vets probably understand or know. Having them involved, and on board, and happy to do it is really key to the success, really. If someone's not happy or if it's too much of a fuss, you're going to get less uptake, less useful information. You're not going to get the results you hope for, really.

Lou Northway:
How did you streamline your data collection? Because you just alluded to the amount of paperwork that we complete in practice and there can be a lot to do. How did you make it easier for your nursing team to partake in the audit and collect that data?

Paul Stanley:
A lot of it, and particularly as time has gone on, records have been improved that we could try to get from the practice management system. Anything that we couldn't, we tried to include a little slip that could be attached to all the anaesthetic forms the day before. These slips were designed as it's minimal writing. It was all tick boxes. Everything was there so you just go

through and tick it. It was pre-checked with them first that they were happy, and then if they have any suggestions how we could streamline it, make it easier for them, what they want on it.

Essentially, the less input they have to do, just ticking a box, is much less than writing out all the information. The other advantage of just having things like tick boxes is that it also unifies the data you're getting. You can sort into categories much easier than handwritten, where there can be variation. Whereas you put in three sentences, categories that you can then look at.

Lou Northway:
Yeah.

Paul Stanley:
It's those little slips, just simplifying the input that we needed.

Lou Northway:
Were these slips then scanned onto the patient records? Or did you collect them up at the end of the day and then go through them? How did you organize your data?

Paul Stanley:
We had a tray that they were then placed in. The anaesthetic forms, it's normal, we always scanned on the records. Then those slips would be then handed to myself, I'd collect them to the tray, and then I'd add them to a very large spreadsheet so that it could be analysed later. There was always a place that they could go, I could then get the slip, pair it up with the records that are scanned on, and then put all the data into the spreadsheet that we needed.

Lou Northway:
That sounds like a really nice, simple way of doing things. For those of you listening, Paul's little slips that he made for his team to use in practice are available to use as part of his case example, to get some inspiration from. Make sure you have a look at those.

Along the way, Paul, your team, were they very engaged? Were they wanting to know the results before you got to the end of the first cycle? How did it all go?

Paul Stanley:
Yeah. Everyone was engaged. I think reporting the results back regularly gets more feedback. It's interesting, several things that we found throughout the audit.

I think when you do these things, sometimes you find unexpected results that also might be sometimes slightly uncomfortable. I think one of the examples that we found is that some of

our animals were over... we use the Glasgow Pain Scoring chart... were over the threshold but not getting analgesia. We had a chat with the team about these cases. It wasn't that they weren't doing it or ignoring it. It actually came out from a concern about opioid dysphoria. They thought that that might be elevating their pain scoring result, which might be the case. But we had a good chat about it at the time and said, "Well, we don't if that's for sure." We talked about alternative options of pain relief.

Lou Northway:
Yeah.

Paul Stanley:
Then just we'd keep looking at the results and see if there was anything like that, that could pop up unexpected. Then we're also getting the team involved in the solutions, because it can identify the areas, and then you need to speak to the people to find the barriers. Then you need to come up with a decision together on how to overcome them, because it's all fine if I come up with one decision, but if most of the people doing it aren't happy to do it, it's not going to get done. It needs something that everyone's happy with, really.

Once we did the first stage of the audit, we reported all the results. Should I go into the results, is the best thing?

Lou Northway:
Yeah, let's dive in there. Yeah.

Paul Stanley:
Results after the first phase of the audit showed that our bitch spays and abdominal surgeries, a lot more of them had a higher pain score post-operatively. In fact, bitch spays in particular, we found that 24% of them needed rescue analgesia. Once we found this from our results, we reported it back to the team.

Then we organized a CPD day. We'd got in a professional who's a diplomat in veterinary anaesthesia and analgesia. She very kindly ran CPD in the practice for the day, based on our protocols. Had a look, and we came up with something that we were all comfortable on and did the training, so everyone could do it as well. Then we essentially repeated the audit, this time just focusing on the bitch spays. We managed to get it down, in the end, from 24 to 10 percent.

Lou Northway:
Wow. It's a big improvement there. It's really fantastic. And really inspiring, also, just to hear about what an impact having some whole team training has had on improving team confidence. I bet the team really enjoyed that day, didn't they?

Paul Stanley:
Yeah, they really enjoyed it. It was quite nice having it in the practice. One, people don't have to travel, or go out of hours, or go after work, or anything like that. But two, it was tailored to our specific needs, which is quite nice. We could ask questions, because what will work in our practice may not work in another practice. Or what our surgeons and nurses are comfortable with using may not be comfortable elsewhere, and vice versa. I think they really appreciated it.

I think coming to a decision together ... I think I've said it once earlier before, but it's making sure that everyone's comfortable, you're going to be more likely to get that change on board if it's their decision. Then obviously, the results, you also get to share with the team that it's worked, which is also quite nice to be able to share.

Lou Northway:
Yeah. Very motivating and empowering. When you had the specialist come out to the practice, and you were looking at you guys were doing every day, what were the changes that you came up with as a team, alongside the specialist?

Paul Stanley:
We started adding lidocaine to all our neutering. Typically, using splash blocks. That was a major difference to what we were doing previously. Being someone who likes the numbers, ideally I would have liked ideal numbers from the first stage of the audit to the second stage of the audit. I think too much keenness was introduced to the surgeons, and they decided halfway through they also wanted to change technique to ovariectomies because they'd been reading some papers. Which then improved it further.

Lou Northway:
Good.

Paul Stanley:
Which was good. That was also one other change at a later stage. But we saw an improvement by just adding the lidocaine. Then we saw an improvement again by changing technique and adding the lidocaine.

Yeah. I would have liked equal numbers in each, but you can't squash enthusiasm when you see of people trying to improve things.

Lou Northway:
Oh, no. Absolutely. Champion it, full steam ahead. Has it empowered your team now, to want to look at other patient groups in practice as well?

Paul Stanley:
Yeah, most certainly. When we did the first stage of the audit, we looked at all operations. But they've also started using the lidocaine in various other ops to try and improve it. We'll have to audit, and continue the cycle, to see if we're making a difference with those as well.

The good news is it's sorted the problem and everyone's a lot happier now with how the patients are looking post-operatively.

Lou Northway:
Yeah. It's really, really empowering, isn't it? I think the audit is just fantastic because a lot of us in practice want to make change, don't we? Sometimes you have these ideas. You come back from a conference and you think, "Yes, I want to change this, and I want to change that." But unless we stop to pause and actually measure how we're doing at the beginning, it's very hard to then know if we have made a difference at all or if it's just anecdotal.

Your team, I'm sure, very, very keen now and on board the QI bus. Your practice as a whole, hasn't it, from last year's Knowledge Award through to this year's, have been champions consistently. I bet it's a very lovely place to work and very inclusive.

Paul Stanley:
Yeah. I'm very lucky to work with some very enthusiastic and highly skilled people that made the initiatives look really good. Certainly, if it wasn't for them, we wouldn't be here chatting today.

But yeah, with the auditing, as you say, you go with these CPD and you learn all these new skills, and you see all the papers. There's something very powerful about producing the information yourself to show it works.

Lou Northway:
Yeah.

Paul Stanley:
It just gives you that extra sort of confidence and safety net.

Lou Northway:
Yeah. I was really looking forward to talking to you about your project because this is something that I've looked at in my practice over the last year as well. What you said about measuring your own things and it looking different in different practices. In my own, we found that our cat spays were pain scoring higher than our bitch spays, so completely different to you guys.

I don't know. Do you have separate cat and dog wards in your practice?

Paul Stanley:
We do have separate.

Lou Northway:
Yes. You're so lucky. In mine, I don't.

Paul Stanley:
Oh, okay.

Lou Northway:
A lot of what we were wondering was whether our pain scores and things like that were influenced by patient wind-up from the environment that they're in, and things like that. It's opened loads of cans of worms for us, of things to look at, as to the approaches and techniques, and things we're doing as well.

You start looking at one thing, don't you, and you go off in a spider web. Then you have to rein yourself back in again.

Paul Stanley:
I think that's it. Particularly when you do the first stage and you collect all this data. You've got this lovely, large, colourful spreadsheet, which some people might not agree with, but I quite like them. Then you get all this data. Then it's trying to, first, focus in on the question you initially answered.

Lou Northway:
Yes.

Paul Stanley:
But then also, some other things crop up that you weren't expecting. I think the main thing with the QI, is when you find these things is it's not a bad thing. You're not telling people they're doing something wrong, it's "Look, we're doing great, but we can do better". Do you see what I mean? We found these areas and we can learn from this, and really, really excel.

Lou Northway:
Yeah. What you were saying earlier also, I thought was interesting, about identifying some patients requiring rescue analgesia, and then did not have rescue analgesia. This is something that I identified when I audited this in my practice, too. One of the stumbling blocks we found is that communication, so the time it takes to find the vet that operated earlier, to then get consent from them to administer further analgesia, that often could take time. Especially if they go into consults, or they're dealing with other things.

We have a post-op section now, which authorizes the administration of a drug at a dose if the pain score is above X. That was a very easy way for us to improve welfare, and not have to delay the patient in getting more analgesia. It is just stopping and looking at what you and your team are doing, and how things are flowing or not, and what you can do to improve things.

Paul Stanley:
That's a really good idea. Initially, we had a similar complication of everyone's busy. At one point, I think certainly during the first stage of the audit, all of our bitch spays were getting a post-operative pain relief, regardless of their pain score. But then, we found that led to a lot of probably unnecessary meds, and a lot more opioid dysphoria. Then we switched it to finding people. But that's certainly a good idea, to make it ... It's certainly also giving the nurses more control, because they're so qualified. They've already done the pain score, they know it needs pain relief. Certainly, that's really good and empowering them, because they know when an animal's painful and they will come and find you.

Lou Northway:
Yeah. It just takes a step away, doesn't it, of having to interrupt someone when the vet earlier in the day has already said, "Yeah, I'm very happy. I've prescribed this to be given at this dose by this route, if you identify this." Which is exactly how we should be working together, which is great.

I wondered, would you be able to share, Paul, some of your top tips for QI for others listening today?

Paul Stanley:
Top tips?

Lou Northway:
Top tips. Give me your top two.

Paul Stanley:
Okay. The first one I would say, is one to really raise, it doesn't have to be perfect. My first mistake when doing these things is I was trying to create the world's most perfect QI project, with no data gaps. Trying to remove all the variables, and everything like that. So that it's statistically brilliant and no one can question it. But it's just not possible in a first opinion practice. Particularly if you're doing it at individual practice level. If you have that many exclusions, you're never going to get the volume of data you need to even look at it subjectively. I think the first thing I would say is it doesn't have to be perfect. It's just give yourself a break, is what I would say.

As I said, I was guilty of it when I first went into it. It was looking for perfection. That's just not real life. An audit that isn't perfect is a lot more reflective into what actually happens in practice.

Lou Northway:
Yeah. I bet your spreadsheets may be a little bit smaller than how it first started, maybe? Or maybe it's not.

Paul Stanley:
Yeah. But there are a few gaps in it, where we couldn't get a reading here or there. We'll try and cover with one hand, so I didn't see it. But yeah, I'm much more at home with that.

Lou Northway:
I know. I think that's a really good point about, yes, just doing your best. Having realistic expectations and try to keep it simple. Because that's definitely something along the way I went wrong very many times at the beginning, wanting to know everything about anything, and trying to capture everything. But then you forget about what your mission was in the first place. Yeah. Yeah, keep it simple and be realistic, guys.

Paul Stanley:
Yeah. I was going to say one more. That was just to get the team involved, because they're going to be the people doing it. Making them help design it for what is in their workflow and what they're comfortable doing, you're more likely to get uptake in people in the practice doing it. Getting everyone else involved makes a massive difference. Because ultimately, particularly if you want to collected data in a job role that you're not doing, they're going to know how best to do it because they're doing the job. Getting them fully involved would probably be my second tip.

Lou Northway:
I think that's fantastic advice and I completely agree. I bet your team are very empowered to start looking at, or are probably already looking at lots of different things.

What is next for you and your team? What should we expect to see from you next?

Paul Stanley:
We've got one with my main passion, about antibiotic stewardship looking at trying to reduce the use of triple therapies. Using cytology to identify those ear cases that we don't need to use it, because you can go ... A lot of it is about removing the barrier that you can go off-license to avoid unnecessary antibiotic use, which I only found out a few years ago in my ignorance. It's trying to come up with a protocol that we can do as a team to avoid that unnecessary antibiotic use.

The nurses are just starting one looking into hypothermia during operations. That's going to take us a while because we're just in the data collection stage, stage one of that one, of trying to identify which ops and where, and our weaknesses. Then we'll try and see what we can do with that.

Lou Northway:
Fantastic. Well, I look forward to seeing your next Knowledge Award, no doubt.

Paul Stanley:
I'm not sure about that.

Lou Northway:
Oh, I don't know. I think you need to go for a hat trick, if I'm honest. I think, come on, you've got two. Let's go for one more.

Well, thanks so much for your time, Paul. It's been great speaking to you. I'm sure everyone listening has been really inspired, listening to the great work that you and your team have done. We'll pop some resources and links in the show notes, so please do check them out. Thanks again so much, Paul, for your time.

Paul Stanley:
Thank you very much for having me.

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