QI Boxset: Clinical audit and the Practice Standards Scheme

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RCVS Knowledge:

Welcome to the Quality Improvement Boxset by RCVS Knowledge. A series of webinars, podcasts, video interviews for practices and practitioners.

Pam Mosedale:

Hi everyone. Today, I'm talking to David Ashcroft, who is the lead assessor of RCVS Practice Standards Scheme. Hi David.

David Ashcroft:

Hi Pam. Nice to talk to you.

Pam Mosedale:

Nice to talk to you too. I wanted to talk to you today a little bit about some changes at Practice Standards. I've heard that standards are changing a bit. How will that affect the clinical governance module?

David Ashcroft:

Yes, there's been quite a few changes and they've actually been published now so people can review them and read the changes already. There were released in May. And we are hoping to be able to assess to the new standards from October, when we're back in in-person assessments.

David Ashcroft:

One of the bigger changes is involved in clinical governance. There's basically three main areas, veterinary nursing roles, team welfare, vet mental health, and the big one being the changing around of the clinical governance module, which has made some very significant changes. Which will hopefully improve practice's ability to help with monitoring what we're doing.

Pam Mosedale:

That's great. Of course, these things do have to change, don't they? The standards can't stay the same all the time, can they, as time moves on?

David Ashcroft:

No, the profession is evolving all the time. And a lot of these changes, I think, also do reflect, to a degree, what practices are already doing. And it's acknowledging the fact they are doing it as well, rather than making them do it. It's good that these things do... What they often do is alter the levels.

David Ashcroft:

So what was in hospital before, or wards that was before, it's now become a general practice. And some things sometimes go down from general practice to core standards. It's all based on trying to reflect the profession, how it's changing and recognizing and acknowledging how well people are doing when they do things like this. It's good that it has this ability to also... It spikes every five years on a major review, and this has just been the 2020 review. It's been delayed, obviously for the well-known reasons we've all had to suffer, unfortunately.

Pam Mosedale:

Like everything. Like the football. It's the 2020 in 2021. Clinical audit then, it's moved down to GP level. Is that right?

David Ashcroft:

Clinical audit, previously, was only in hospital level or a ward level. Obviously GP practices can get awards without being hospitals. Some of the new GP level requirements were either, in hospital or in ward level beforehand, and clinical audit is one of those. The previous GP levels was really more just about monitoring outcomes and discussing cases and maybe having journal clubs and this sort of thing.

David Ashcroft:

The level now, is based on having evidence of either, clinical audit or significant event audit, or mobility and mortality meeting. So we're now asking that within GP there's evidence of at least one of those as a specific event. And let's say they were previously on either hospital or a ward level. So these are things that practices, particularly clinical audit side, often are doing. And they are sometimes asked for in separate areas of the standards as well. But some of the process and outcome audits are something that we're trying to improve and encourage, and we'll help advise and support on how to do this.

Pam Mosedale:

Excellent. As you know, I'm really keen on clinical audit. So I'm absolutely thrilled to see that it's going to GP level, because most practices in practiced under scheme, the biggest number of practices are at GP level, general practice?

David Ashcroft:

Most practices now actually obviously in practice standards. So it is something that will be throughout the profession a significant development. And it will be something that we're all on the same side, trying to improve standards overall for our patients and clients. And this is what this will help towards and also the team input. It tends to improve team morale, to know that they're doing things the best they can. They know that they're monitoring outcomes. And they know that they can monitor change as well.

David Ashcroft:

What we're also encouraging along now is the whole audit cycle, where we see the reviews and the improvements that have been made and the way practices are altering to this. So it's great to see a

change in a process or how something is done as a result of the audit that performed. And go back and say, yes, we're doing this better than we were, which is lovely.

Pam Mosedale:

That's music to my ears, absolutely. And I totally agree with you that there was no point to... We don't want people, you don't want people, I'm sure, doing audit just to tick your box. If they're not going to act on it and make some changes that make a difference to what they're doing.

David Ashcroft:

No, that's right. And there's several easy examples people have been doing. Some of these you can also contribute to national databases by submitting evidence. The classic ones, being things like surgical complications or wound infections and those sorts of things. Which, once you get the systems in place, they're very easy to set up and very easy to do. Involve the whole team is the secret, I think, and not try and do it all by one person. Trying to get everybody involved at different levels, or the nurses involved particularly love doing this. Nurses are very keen to driving the vets to complete the forms and make sure they're doing it well. So we're always keen to involve the whole team and make sure the nurses who do nag the vest to get involved as well. That tends to work better than anything really.

Pam Mosedale:

Absolutely. I agree with you. I think nurses are better at caring clinical audits through. We might come up with some ideas, but nurses are much better at also coming up with ideas, but also carrying them through. And that's great. So yeah, they could be great for them to submit their data to the national audit. And this applies, not just to smaller more practices, does this apply in farm and equine as well, GP level?

David Ashcroft:

Yes, it does, absolutely. And again, there's several good examples there where you can do fairly simple analysis of outcomes, how they respond to treatments and just things like cow cesareans or cow castrations, how they are made a complication with those. Just keeping information and monitoring any changes. Again, anything you alter as a result of recognizing complications, how you then have made the difference. And then reorder it and see if the changes have quantified into something better. And then you've got that information to hand to share as well.

Pam Mosedale:

And so those are outcome audits of those surgical procedures-

David Ashcroft:

Yes.

Pam Mosedale:

And pretty much any surgical procedure you can outcome audit. But what about audits of processes. You have any good examples of those?

David Ashcroft:

Process audits are equally important. And they're also equally good to try and get the team involved with doing. One of the specific ones that we do ask for in the standard generally is about cleaning schedule audits, how often they are performed, how often they're reviewed, that they are actually being completed. But just things like, how often is a consent form completed properly. How often are pre-anesthetic checks done. And is there is heart rate monitored before and during surgery. So there's lots of things that are done order everyday really, that are very good to be subject to this sort of auditing an investigation.

David Ashcroft:

And it doesn't have to go into particularly complicated. It can just be things that they're doing every day. How quickly the phone answers, those things the reception can do. There's all sorts of different things in different areas, which again, is good for whole team involvement. And then you'll sometimes see there's a reason to change something. And then again, as you say, go back and Thea it and see the benefits. And it's good if people know this things are being audited. It encourages people to do things, I think, more thoroughly if they know there's an audit in place. But it's great to see the results as they improved with not having that process there.

Pam Mosedale:

I'm glad to hear you say about the whole team, because I think it's great for it to be a whole team activity and involving nonclinical team members too. Because because often what they do can have an impact on the clinical. Reception team, as you say, could audit waiting times or they could audit that they were touching history, smaller practices to the records correctly, because if that's not done, then that can impact on the clinical care too. So I think that's really important.

David Ashcroft:

I think we've always suggested to try and make it something relevant to your practice, rather than try and do just as a general list that we provide. So different practices have different strengths of areas where they want to know more about certain things. And if they can tailor it to what they're doing and make it the most useful to their individual situation, there's a lot more benefit to be gained from it, I think. So it's just how certain referral practices say, as opposed to consulting on the branch has different things to look at in different places. And people will do that according to their needs and what they feel will help their clients and patients best, I think.

Pam Mosedale:

Yes, that's right. Personalized, I think that's important. You mentioned earlier the national audit for neutering, which can then come up with some national benchmarks that practices can compare themselves to. And I know that you're an orthopedic surgeon too. So, we've got this canine cruciate registry coming up too.

David Ashcroft:

I've registered to attend that already. So that will be good. And again, if you get 10 orthopedic surgeons in a room, you'll probably have 20 different crucial techniques, and every one of them is perfect. So to actually get some quantification behind this, it will be wonderful to know it's such a common condition. It's such a common area that is involved. Everybody's doing it, not just specialist surgeons, general practice clinicians giving input as well.

David Ashcroft:

And it's something that we're trying out for. I know there's been one on hip replacements, which has been from the specialist side, but to actually get full input from general practitioners to increase in surgery as well, will be wonderful. It would be really informative. There's so many different techniques. And even if we find out they all are equally good, that would be a great thing to know. I could talk about this forever so...

Pam Mosedale:

I know! But I think that this is the whole point of audit. There's a quote from Deming, which is, without data, you're just a person with an opinion. And I think that's what it is. We all have our opinions, whether it be about cruciate surgery or anything else in veterinary practice. And we all think that our opinions are probably right, but if you actually start to measure things, that's when you can improve them, if you need to. And as you say, it can be quite positive. You can audit and find that actually you're doing a grand job, but if they do audit it and find that they're doing a great job, is that the end of the story for them, do you think?

David Ashcroft:

No. Keep on going. Just keep checking, make sure things are right. I, again, just go back to my personal appearance slightly. At one stage, I was actually asked by a client ringing round what my complication rates were, which I thought was interesting, that it got through to clients, on the basis of what's happening in the health service. They are now choosing surgeons by data and by results and by reported complication rates.

David Ashcroft:

So I think that's coming our way as well. I think clients are getting more perceptive and they are wanting to know how practices are dealing with these issues. So it will come. It will become more of a standard thing to be able to show what you're doing and justify how you're dealing with things, I think.

Pam Mosedale:

Yes. And that's really useful, when it comes to informed consent, I think. Because when clients ask us, what are the complications or what rate, or what's your anesthetic complications rate? And we've always given them maybe a slightly vague answer, or these things can happen. But to actually be able to give figures, I think is very powerful, isn't it?

David Ashcroft:

Yes. Especially when there are benchmarks who compare your own situation with. Obviously submitting evidence whenever we can to the national benchmarks is all contributing towards this, but then at least you've got something to compare your practice with, how you're doing. And then again, looking at what changes you might be able to make, to make things improve for everybody.

Pam Mosedale:

And I was really interested in your comment about team morale, because again, I think that's really important for teams staff realizing that they are doing well, or find out they're not doing so well, but make some real improvements on the ground and do better. It's great for team morale, isn't it?

David Ashcroft:

It is absolutely. And again, once people get in the routine of it, I think the hard part is getting started. But once you get started and you get team involvement and people will really get enthusiastic about it. And again, if something has changed with a noticeable and recordable improvement, it really just escalates. Once people get the hang of seeing the outcome improvements, they will really, what can we do next? We've done these, what can we look at next and keep it going?

David Ashcroft:

And it becomes part of the daily routine, rather than being a chore, or be something just to complete, it becomes a real positive boost for everybody to see the results. And we just encourage it on that basis that yes, it's a requirement in practice standards, but it's a requirement for the right reasons. And most of the things in standards now are based on a framework for good practice. And this is just a perfect example of that really.

Pam Mosedale:

That's right. It's getting away from just checking bits of kit and buildings. It's more about what's really happening in the practice. When they did some research, they found the two main barriers for them to audit were, what you just said, not knowing where to start and time. So, would you have any advice for practices on either of those two barriers?

David Ashcroft:

Ongoing. Little and often. Don't make it a project someone has to do once a week or anything, just try and get a system in place where things are available. We've always talked about keeping record cards on the PMS everybody can access easily to add data to. So you're not searching around for something , like 'Wheres the file gone'. So just make it... it's about sort spreading information. Make sure everybody knows where to enter data, how they do it. A lot of the peer masses now do have coded systems for follow-up on complications. So literally just adding in a different code at the post-op checks and things.

David Ashcroft:

So there's ways that these can be made very much part of daily routine. And plus, I think we go back to what I said about trying to make sure everybody does something, rather than leave it all to one person. If you spread the load out in different areas of the team, you'll get different areas investigated and you'll get a lot of interesting information.

Pam Mosedale:

Great. So, that's addressed the time barrier. What about the barrier of not knowing where to start? How would you suggest practices address that one?

David Ashcroft:

We work really closely and standards with yourselves at RCVS Knowledge. There's loads of links available to different areas of that. We've always said the two areas are interlinked and we are absolutely happy to suggest RCVS Knowledge is our first point of call when people want to know where to begin. We've used it ourselves a lot in our own practices over the years. And we've found, it just gives you that framework to work to. And again, with a lot of new information available now about evidence-based medicine as well. It's all in one place to go to, so we can't recommend it enough really. It just seems to

be one of these things which has been missing maybe 10 years ago, where we all thought, oh, we should start looking at outcomes a bit more. And how do we do it and know where to go. Now we can. And it just makes it so much easier. As I said, they're all direct links through from the practice standards from the PDFs and from Stanley. So we just say, have a look, find something that suits you and your practice and work with it.

Pam Mosedale:

Lovely, thank you. And we do have, that knowledge, we've got a one hour CPD course, we've got templates for clinical audit. We've got walk-throughs. And what we have got is loads of really good case examples, mostly coming from the award winners. And so people can find a case example relevant to what they want to audit and have a look at that and maybe get some ideas from it. And I think your PSS assessors, when they're out and about, they're going to get lots of ideas. They're going to see what practices are doing. So, do you think they'll be able to spread these ideas around practices when they're visiting other practices?

David Ashcroft:

I think that's one of the pleasurable or parts of the whole job, really. Actually going out and sharing good practice. We're trying to, well, we have a long time, we have moved away from the idea of just being an inspection. It's a way of sharing ideas. It's a way of disseminating what we've learned or other practices. And helping everybody raise their standards as we evolve together. And it's, yes, it's been something that the assessors are very, very keen on finding out what people are doing. There's always something new. Somebody thought of something that nobody else has thought of before. And we just try and collate all this information together. And it will be something that I'm sure there will be a lot of work in that, that we can actually bring all these wonderful ideas together into one place at some point.

Pam Mosedale:

Excellent. So I think that's great. I'm really pleased that audit is gone into general practice level, and that's really, really positive for practices. Great that our resources there, as well as knowledge. So we look forward to patient care and outcomes improving as a result of all this. That's been really, really interesting, David, and I think my message would be just to practice it, to just start and try it. They don't have to be perfect. What would you think?

David Ashcroft:

Absolutely. We don't expect anything to be a hundred percent from day one by any means at all. And that's the whole point of this, is that you're trying to recognise the areas can be improved. It's the whole point the process that you're looking at areas which, can we do something better? And if we can do that by starting, knowing that there may be issues, that's absolutely fine. We respect that the fact it has been done in the first place. So no, nothing has to be a hundred percent from day one. We would never expect that. We're just, we're looking to see the processes are in place and the people are checking, that they're doing something that will ultimately help the patient outcomes, as always.

Pam Mosedale:

Excellent. And these be quite small things that don't have to be huge massive projects?

David Ashcroft:

No, no. Don't take on anything too much to start with. Just find something sensible that you're comfortable with to begin with. As I said, the classic ones tend to be the wound infections, which are fairly easy to do now on a lot of systems, or simple process to audit about consent forms, something along those lines. And just get the feel of how the process works, try and do it so you know, setting a target, ideally, what to aim for. And then, re-auditing, see if you've reached that target. And then go on that cycle.

Pam Mosedale:

And I think discuss with your team, that's a really important bit as well. Make sure the team will actually do it or getting involved in the discussions?

David Ashcroft:

Yes. And actually, I think where we've seen this work best is when everybody's involved, just keeping an eye on, make sure everybody is comfortable with what they're doing and they know how to do things. And it's been enough training on the process in the first place. And once it's in place, it becomes second nature, hopefully.

Pam Mosedale:

And we need to be sure, I think, some people sometimes might think that they're doing this just to blame somebody, maybe they are up a few more post-op infections than anybody else's.

David Ashcroft:

No, again, we will use the phrase a lot now about a no-blame culture. And that couldn't be more true in this situation. It's about trying to help and advise and get the outcomes better for everybody. And I think we're all open to honest evaluation. I think, again, particularly, as a surgeon, if I'm getting infections, I want to know why I'm getting infections. And I would go back and look at that and think, well, what can we do better? See if there's something we can change. And then once you've done that, you'll have the improvements that you want.

David Ashcroft:

So no, it's not about blaming anybody. Absolutely. It's about just trying to improve standards overall. And in generally, most people would want to know if there's an issue. So that's really a benefit. It helps individual people in the team, and it also helps the clients and the patients as everything else.

Pam Mosedale:

And that's the most important thing. At the end of the day, that we have safer processes and that we have better outcomes.

David Ashcroft:

Precisely because what we do the job for.

Pam Mosedale:

Great. Thank you very much for your time, David. Great to speak to you.

David Ashcroft:

It's an absolute pleasure and has been very enjoyable, thank you.

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