QI Boxset

Podcast transcript: Communication in practice

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RCVS Knowledge:

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

Pam:

Hi everyone. Today I'm very lucky to be talking to one of my veterinary heroes, someone who got me out of so many situations when I was in practice, always at the end of the phone with really good advice. Professor John Williams, who's National Surgical Lead at Vets Now and works in the Vets Now hospital, Manchester. And I'm going to talk to John about meetings and communication in practice. John, Vets Now Manchester is, I know, is a very large referral hospital with an overnight 24/7 overnight service as well. How do you organise talking about clinical cases and having meetings in a situation like that?

John:

Okay. We do that in a number of ways, I guess. We do, during the daytime we do a very formal ward round, first thing in the morning about nine o'clock. But prior to that there are smaller group meetings. There's nurse to nurse meetings and vet to vet meetings, which start at the beginning of each shift. So every shift change there is a proper handover. It's quite a formalized process, it's recorded. Pre COVID, we did this on paper but just before the COVID lockdown, we started using SmartFlow for exactly the same thing that we record the same data. But now it's just on a PDF on a tablet and it's attached it's automatically attached to the patient file. It's based on a number of human systems for communicating handovers, because it's been shown that in people, I think something like 20 to 30% of patient harm occurs due to poor handovers.

John:

And we decided as we have such a busy practice both in Manchester and in Glasgow that the sensible thing to do is to try and formalize that with the hope that we would reduce risk of harm or incidents happening because of miscommunication about patient care. And as far as we can tell, it works really well. We've had the paper system in place probably for about two

and a half, three years. It's gone through several iterations to try and make it as seamless and less clunky, for want of a better way of putting it because certainly people don't want to spend their whole life paper filling when there's 20 or 30 inpatients. So, the great advantage I must admit of the SmartFlow system is that it self-populates a lot of the data. And the stuff that's been recorded previously is still in the system.

John:

Whereas with the paper system you do, sometimes have to repeat what you're doing. But that's worked really well. And we also found by doing a very simple audit early on, that there was a huge difference in the information being gathered by the vets and the nurses. The vets were very fact driven, I guess. Whereas the nursing side of it was very much about the care of the patient. And initially we used to have like a joint meeting with vets and nurses and the same discussing the same patient. And when you looked at what they recorded, it was very marked the difference in what they took from those meetings. And I think that's why it's really important to remember there is two sides to it. There is the, I suppose, veterinary clinical side and also the nursing care side.

John:

And it's important that all that detail crosses over because sort of things that I guess vets perhaps forget about is what was it fed that morning? What does it, what does it eat? You know, the sort of thing that maybe not that it doesn't interest us, it's not that it's not important, it's just that it's important in a very different way. So that I think has worked really, really well. And the SmartFlow system has allowed us to sort of work through the COVID period as well. Because it's meant that everything does get recorded. We've been able to do it with small groups of people, in fact not having to be in the same room to do the handovers, which is a bit weird. But it does seem to...

Pam:

Oh right yeah that's interesting...

John:

Well, we haven't... Because we worked in a system of teams and certainly when one team switched over to the other team, we couldn't have any personal crossovers, so it had to be done sort of remotely. So that, but that's, again, seemed to have worked quite well in our situation. But yeah, being a big hospital, certainly going... In the old normal since this sort of communication thing did work really, really well.

Pam:

Excellent. Yeah. I think that's such a good point about handovers because probably often you have somebody who's, you know, been working all night and is very tired and wants to get

away and someone who's coming in, who's very stressed because everybody's telling them everything at once and there's lots of potential there. Isn't there, without a system.

John:

Yeah. I mean, there's so many factors which affect concentration for want of a better word. You know, the fact that you want to go home, you are tired. Or you're thinking that, you know, I haven't eaten properly for the last five, six hours or whatever, and I need some food. Or your worried about the journey home cause you're going to start hitting rush hour traffic and all that sort of stuff. All those things make you forget to tell people small things. Whereas if it's all formalised, then it's easier to remember because if there are trigger points within the forms to try and make sure that you don't forget that, you know, his potassium was low or, you know, you have run bloods or you haven't run bloods, but somebody needs to run bloods in the next half hour, or whatever. So that, you know, there's all these things which, which affect communication. You know the non-verbal part of the communication process, which is key.

Pam:

Yeah. That's really interesting. The number of times I've driven away from somewhere and suddenly thought, Oh, I forgot to tell somebody this and phoning in... And so having a good system to record that or to remind people, it's a checklist really isn't it, it's a checklist.

John:

It is a sort of checklist. Yes. Yes. ...because it is, as you say, it just formalizes the whole thing without hopefully making it too onerous because obviously if you've got, I think it's been shown with checklists, if you've got more than nine things in the checklist that people lose focus on it and don't concentrate on it. The principle is exactly the same that you try very hard to just... Poke people's minds and say, you need to remember to do this bit. So, yeah, I think it's one of the things that, it didn't transform how we did things, but I think it's really, really helped and made the system more robust. And really helped as well, if you've got new staff and you've got locums coming in, there's a system in place that everybody can buy into. It is not sort of hoping that, you know, Hey, we'll talk to B and remember to tell them things, you know, and you know that you can't leave the building until you've done a handover. You know, that's one of the other key things, you know, ‘cos you've reached the end of your shift. You want to go home, but you know, actually I do have to come and talk to this person. I have to talk through everything.

Pam:

I think systems are the key, aren't they? I mean, there's so many, you know from human healthcare, I mean, we're all human and we can all make mistakes. And you know, we have to think about the human factors, but if we have good systems of work that work for the people on the ground, that's the important thing and that they've been involved in. And presumably did you involve your team when you were getting this going?

John:

We did. We probably spent the best part of a year, I think going through various iterations of it. And initially we just we involved some key stakeholders from our sites in Swindon, Glasgow, and Manchester. And we designed a form by committee, which perhaps didn't quite work initially. So then we sort of, we trialled it, we did a survey monkey, we changed the form retrialled it, did another survey monkey to see what worked, what didn't work. And then eventually we settled on the form, which we thought was a good compromise between what everybody else wanted and what we thought would actually work on the ground. But yeah, I think with introducing that, the key thing was the fact that we involved everyone, everyone had an opportunity to have a say, nurses and vets as to what they felt was important and not important in that form. Because I think if we hadn't done that, we hadn't had everybody on board you know, just try to introduce it from the top down, just wouldn't have worked. You know, 'cos when you've got people who are, I suppose vets are relatively independent people.

Pam:

Yeah. We can say that [laughs]

John:

In the way that they like to work, and to try to get everyone to work in the same way, it's a little bit like herding cats at times, but I think it did work out because we just involved everyone in the whole process. And I think, and as I said, and then transferring it from a paper form to an online or at least a SmartFlow form has made a bigger difference as well. 'Cos people don't like filling in the patient's name, the patient's details every time when you get it. And also, there's obviously the waste of paper as well.

Pam:

And you could, you could lose paper presumably…

John:

Yes, we've had that as well. You know, but usually what's meant to happen is then meant to be attached and was always meant to be attached straight to the patient's file as soon as and then scanned into the system. Whereas certainly with using a tablet system, you press a button and it automatically gets attached.

Pam:

Oh, so I'm sure your receptionist and admin staff prefer the fact they don't have to be scanning stuff onto...

John:

...Absolutely. I mean, scanning, I think it was the bane of most receptionists' lives. Because you generate so much paperwork, between consent forms, anesthetic forms, checklists, handover forms, various other forms that we do, nursing care forms. All these things, then, there's this big pile of paper which then needs to be scanned.

Pam:

It's not good for sustainability either, is it?

John:

Absolutely not, absolutely not. So, you know, certainly, I'm not trying to be an advocate. Other systems do exist...

Pam:

An online system, a digital system.

John:

A digital workflow system, which allows us just to attach everything to the system. And it works, it seems to work, very well very well for us.

Pam:

When I came along to, your practice to do the Practice Standards Assessment a few years ago. And I was impressed by all of the practice. It was, it was great. But what really, one thing really impressed me was in the afternoon a bell rang and everybody stopped what they were doing, and all came together for a short stand up meeting for about 10 minutes to just to discuss things. I think, a sort of a huddle. How did you, are you still doing those or?

John:

Well, we do the huddles... Well pre-COVID, COVID has changed everything, but pre-COVID we, we still huddled in the morning for want of a better way of describing it. We unfortunately had to stop the afternoon one purely on logistic base because we'd reached the point because I think when we did the original practice standards, it was in our early days of, we were still growing. Probably the last, I think we're... trying to think when we dropped it, probably dropped it in the last six to nine months. Purely because it was impossible to get everyone to stop doing what they were doing because there were lots of procedures going on. You can't stop scoping; you can't stop in theatre or stop the CT scan or whatever. And it just, unfortunately just no longer fitted into the day. And again, it sort of reinforced to me how important the handover process was because that's really, the beginning and end of the shift, that's when the most information transfer happens.

John:

But what we do do in the mornings, we have a big huddle for want of a better way. We have a big ward round where, it's nurse led, we discuss initially all the cases that are in the hospital and all the inpatients and go through their plan for the day. And once we've done that, we then break into I think I was going to say species specific... I didn't mean species, discipline specific groups: medicine, surgery, soft tissue surgery, orthopedics and critical care. And in those groups, there will be a vet and a nurse and an animal care assistant. And in that small group, we will discuss the plan for the day. We will discuss which cases are coming in. Also, the inpatients, which belong to that little group as well and more extra things we may or may not want to do to those.

John:

But also, what we're going to do with those patients that are actually coming into the building on that day as well. So, everyone in that little mini huddle is fully aware, aware of how we want to work, the floor is run by one of the senior nurses. And so the overall, she has overall vision of what was happening during the day. But then within our little mini groups, we then sort of plan exactly how we want those groups to work out through the day. You know, if something comes in to see me, may need blood sampling, it may need x-rays or a CT scan, or we may just need to go straight to surgery. It just very, it's very variable, but we tried very hard to, to make sure that everybody in the team is fully aware. Sometimes obviously there's crossover, particularly between medicine and surgery or medicine and the critical care team. And again, we will have involved them in our huddle discussion as well to make sure that certainly the beginning, plans will obviously change as is always the case, best laid plans and all that. But we try very hard at the beginning of the day to make sure that at least we have some structure so that everyone's aware of what we want to try and achieve during the day. And yet there has to be some flexibility because we see a lot of emergency cases, but at the beginning, by doing those little huddles, we involve everyone. Everyone has a say. And so we know then what's going to go on, we try very hard not to be hierarchical in it as well.

Pam:

And when you say everyone, you mean, you mean the vets and the nurses, but you also mean receptionists and practice managers?

John:

No, they don't tend to get involved. Some receptionists do join the original ward round, the big, the bigger ward round that we have. Some of the admin staff do as well to see exactly so that everybody knows who's in hospital. And what's actually going on in general during the day. But they don't then get involved in the little mini huddles that we do. That's very much a clinically driven, as I said, it's nurses, vets and the animal care assistants in those mini huddles. Because obviously with, it's not just the vets and the nurses, we need, the animal care assistants are key. And certainly in theatre, we use them a lot sort of to facilitate how we work in theater. It's important that they know how we want to book the day as well.

Pam:

And I think the, it'd be important for having the receptionist in the morning case handovers, because then they're aware. It's nothing worse, isn't it, when you have people ringing up about their animal and they speak to somebody, who's got no idea what they're talking about.

John:

I know, and again, it does help because it does give them a handle on what's going on during the day. So they get at least have a mini oversight of what's going on with each case. You know, the amount of detail they probably take on board is not huge, but it's enough to allow them to say that, you know, Fred is doing quite well.

Pam:

At least, you know, 'Oh, yes, I know who Fred is' when the owner rings up.

John:

Exactly. Because I think that's with all practices, always an issue when somebody phones in and it's said 'oh don't know anything about Fred' or the vet will phone you back in an hour but the client's obviously concerned now, which is why they phoned. So it was always useful to have that sort of thing. So they have that information and they can pass that on as well. Say you know 'Fred's had a comfortable night etc. and someone will phone you back as soon as possible.'

Pam:

Excellent. So sounds like you have a really good system there. And apart from the day-to-day meetings, presumably you have some other, do you have, do you do journal clubs and do you do M&Ms or significant events?

John:

We do M&Ms, again COVID has put a big spanner in the works on M&Ms. We do a fairly formal M&Ms once a month we record it and we actually share it on our company-wide intranet.

Pam:

That's a very good idea.

John:

But we do it as a, we encourage people to do them as a PowerPoint presentation. And then to share it sort of more widely within the Vets Now community. Again, it's one of those things that's taken a big hit from COVID because we just haven't, we're just not in a position to do that.

Pam:

Hopefully things will get back to...

John:

Yes. Yeah. I mean, once, once everything sort of starts to settle back and we start to work as a complete unit again, I think it will make life easier. We also do because part of our intern training is slightly different, I suppose, but we do joined up webinars, seminars with the interns on both sites using TEAMS. We been doing that for about two years now, just using the internet to allow consolidation, I guess, and make it easier to teach across both sites. The other sort of meetings, you have occasional journal clubs M&Ms, management meetings. And we do have discipline specific meetings. It would be a referral clinician meeting as well to discuss relatively informally, maybe sort of two or three times a year to discuss in general how we working and how we want to things to move forward.

Pam:

So I'm sure you have all the same issues that people have in smaller practices, just magnified.

John:

Yes. [laughs] I mean, you know, once you get into sort of large numbers of staff, we have, everyone has ideas. Everybody wants to work slightly, maybe slightly differently sometimes, but getting people to work in systems without the systems, it wouldn't work in a bigger place. It just wouldn't work. You just can't imagine everyone doing their own thing just would make whole thing fall apart. So having those systems in place is really important. Yeah. And it's like, it's like all things, isn't it it's when I was first introduced to checklists, I thought 'why do we need a checklist? You know, I've been doing, I've been operating for a long time. I've never, never had a problem. I've never left a swab in' and all that sort of cocky thinking we surgeons have. And then you realize how important it actually is because it allows people to communicate preoperatively, particularly sort of pre-anesthesia and then immediately pre-surgery and after surgery. So everybody knows exactly what's happening with that patient because that's what we try and use the checklist for. Yes, we do use it as a checklist, but we use it as a means of communicate..., You know, when they say, well, what of these problems do you anticipate? And then said, well, it's probably no major problems, but this, these are the steps we would like you to take this, or this might happen, but hopefully won't. So it just gives everybody an opportunity to...

Pam:

And you probably always, already have always had that in your head, but now you're verbalizing it. And therefore other people know that that might happen and therefore the nurses can have the right equipment there.

John:
Yeah. I mean, you know, there's the classic anecdote from Atul Gawande who wrote the Checklist Manifesto where he, one day just didn't fancy doing the checklist and his nurse forced him to, and Gawande well, he does some laparoscopic adrenalectomy, that's his thing. He said, well, in theory I could cut the vena cava. He'd never, ever cut the vena cava. And because of that, she ordered stored blood into theater. And what did he do? He cut the vena cava, and if they hadn't had the blood there in theater, the patient would have died.

Pam:

Yeah, no, exactly. And it does. I think there's evidence isn't there. If people have vocalized using the checklist, they're more likely to speak up then later on in the op if something happens, because if the people who might be a bit intimidated by surgeons and might not say anything in the past because of the hierarchy, once they've used the check list, they're more likely to speak up and say something.

John:

Yeah. Very much so, because they've very much, you know, certainly with us, they very much question things during checklisting, why are we doing things, so that it's worked really well. I think and now I'm a great advocate of surgical checklists.

Pam:

Well, it's a communication tool isn't it at the end of the day, it's not about being a piece of paper. It's about being a communicator.

John:

Exactly. It's a means of getting people to talk. And I think certainly when you get new members of staff and perhaps new nurses or new younger vets in, it allows them to see that we do talk, they can question, that is not the wrong thing to do to question somebody you know. I keep saying we've just getting a new batch of interns in, cause it's that time of year. One of them said I'm really embarrassed because I keep asking you question. I said, no, no, you have to keep asking me questions. You know, if you don't ask questions one, I don't know if you know what's going on, but two you're never going to learn. 'Cos sometimes, you know, it's good for me as a surgeon to have to think about actually, why am I doing it this way? I've done it like this for a long time, but maybe there are other ways of doing it. So I think, yeah, the, the whole question, the whole communication thing is so, so important.

Pam:

I think it's part of having a learning culture in the practice as well, isn't it. You're all learning from each other and that's what we all want. Isn't it a just learning culture, not a, not a blame culture, I think is so important in veterinary practice.

John:
Because we know we've been running a significant event reporting system for, well, since before I started, and again, that's part of the whole no-blame thing. It's essentially, whenever we look at even the serious things that we look at, even significant events, it's usually a systems failure. Yeah. It's always a systems failure. And then we'd have to readjust the system and think actually if the system didn't work, how did that happen? You need to change the system slightly, very rarely is it that, is there human blame as such? It is nearly always down to a system failure. And that's why we have the reporting system, is to see why we have things that go awry. And I said, most of them, vast majority of them, 99% plus probably down to a system failure.

Pam:

Absolutely. And near misses are gold dust aren't they should discuss them. And...

John:

Absolutely. Yes, yes. I mean the whole idea of the whole significant event reporting is that it's not just the significant event, is those things which get very close to being a significant event, but you've not quite got there, which is good, but it's, again, if people don't flag them. Again, near misses certainly, in my experience again, are nearly always down to system failure.

Pam:

Absolutely. It's been great talking to you, John. And I can see that you've got a really, really great system going on there at the practice you know as, and like we said, communication is at the heart of just about everything in veterinary practice, isn't it communication with client's communication within the team. So, thank you very much for talking to me today.

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