# QI Boxset

## Podcast transcript: Getting the team on board

### Louise Northway RVN

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

**Pam Mosedale:**

Hi everyone. Today, I'm going to talk to Louise Northway. Lou is a two times winner of the RCVS Knowledge champion awards for her work on clinical audit. So I'm hoping she'll be able to share some tips with us. Hi Lou.

**Louise Northway:**

Good morning. Hello Pam.

**Pam Mosedale:**

How are you today?

**Louise Northway:**

Yes, I'm good. Thanks. Really excited to tell you about what I've been up to.

**Pam Mosedale:**

Excellent. So, what got you started in clinical audit? Why did you start getting interested in clinical audit?

**Louise Northway:**

So clinical audit for me actually came about around the time of when we had one of our RCVS Practice Standards inspections. My practice manager suggested that we had really good time to get cracking with that. So, that was how it all began and our vet lead at the time introduced me to the national small animal audit. So, I got cracking with that and that involved auditing all of our neutering patients for postoperative complications and it was a massive eye opener. So that was the start of many different audits than I've since completed in practice, but that's how we, how it all started.

**Pam Mosedale:**

Excellent. And how did you actually get the knowledge to know how to start apart from looking at the national audit? Is there anywhere else you got your knowledge from?

**Louise Northway:**

To be honest, if I am honest, is I just had a go to start with, started collecting data, and then I had to look towards the RCVS Knowledge website and there became more and more useful guides and

information there to help me manage all this data that I then had and how to sort of use it and reflect upon it. And then at the end of, I think it was the first year I submitted our data to the national database and waited for this sort of report to come out on how everyone else was doing as well. And then we had a massive eye opener, because we realized that actually we weren't doing as well as what we thought what we were comparative to other practices. And we then realized there was a lot of work to be done. And that was a massive surprise, I think to everybody because we all thought we were doing just fine, but actually there was a lot of work to be done.

**Pam Mosedale:**

And I think that's common. Don't you think in practices that we all assume that we are doing fine and sometimes we don't realize we're not doing fine until something goes badly wrong. So I think all it's a really good way of finding that out before you have a tragedy.

**Louise Northway:**

Yeah, no, I completely agree. And when you work in a busy practice and you are all consulting, so there can be three vets and one or two nurses consulting each day. If each of us have one patient back with a postoperative complication to that one person, it's just one in a day. Wasn't that serious, not going to think twice about it. But actually then when you collate those abnormalities over the course of the month and you realize actually, oh no, that was 50 patients in total over that month or sometimes more, then you think, oh, that is something we need to address because if we can even just bring it down by five patients a month or ten patients a month, then we should be. So yeah, it's really interesting.

**Pam Mosedale:**

That's the beauty of audit, isn't it about making the changes. So once you've collected your data, how did you go about making your changes?

**Louise Northway:**

Yeah, so it was very reflective to start with. So just thinking about all the mitigating factors as to why we were having the problems that we were having. So, just talking or focusing on the neutering one, there were complications surrounding the postoperative wounds. So infections, breakdown, interference, clipper rash, erythema, things like that. And then there were gastrointestinal complications. So some patients coming back with vomiting and diarrhea. So then we were thinking, is this in relation to our nonsteroidals? Are they dosing appropriately, following instructions, are we giving information correctly to them in a way they understand? Are owners actually reading the post-op forms and making sure the nonsteroidals are given with food? And once you start like a catalyst of what-ifs, but that's only part of the picture. So once you have those thoughts in your head, it's then looking towards the evidence. So like dosing our nonsteroidals, are we following the data sheet? What does the evidence show? Is this the most appropriate sort of protocol for our patient and things like that. So using your experience, but then also using evidence as well and not just sort of using your own opinions, because we all have a lot of opinions, but evidence is important.

**Pam Mosedale:**

And audit is a way to have some facts rather than of just opinions, isn't it? And that's great. You find out all these things out, but then I presume you just discuss these with the team involved. And how did you find getting the team on board for having those discussions?

Louise Northway:

Yeah, so initially, because audit was all very new, I did a lot of the groundwork to start with. So it was collating the data, writing reflective summary, gathering evidence and then sending out a report. It was through our internal email system and I think including the results alongside thoughts, got other people thinking too. And then every morning in the practice we have clinical rounds. So that involves discussing inpatients and day patients. But then we've often got about 10 minutes left at the end. And then at those points we often had the opportunity to raise whatever it is we're going to talk about and others could bring their views forward then at that point too.

**Louise Northway:**

And then also we could plan, so what are we going to change? What are we going to do? And you know, one of the biggest, most beneficial changes was something like moving away from Buster collars to the sort of medical clothing, I was going to say brand then, which I'm not allowed to do. Because they're much better tolerated by the patients, especially dogs and that made a massive difference. So, that was then all of a sudden included in the cost of the neutering. So it wasn't no, oh, and you can have this because sometimes the pet owners don't want to pay another £15 for another item. So if you include it, you've covered all bases and yeah, it's better for the patients.

**Pam Mosedale:**

And better for the owner when the Buster collar isn't constantly banging into their legs.

**Louise Northway:**

Oh gosh. Yeah. Well it's so painful and I really don't like them myself either. So if on my dog I always go to try and use something else I'm not going to then stand there and forcefully tell that pet owner that they need to do that with their crazy bounty Labrador. That's like a, I can't even think of something crazy to describe, but there we go.

**Pam Mosedale:**

Did you have any of the team members that were a bit resistant to the idea or anybody who was worried that they were being checked up on by this audit?

**Louise Northway:**

Yeah, I mean, I think my role in practice to start with, as it developed, because it's sort of a bit like surveillance, but friendly and informed surveillance. It's like, oh, well yeah, we are having some problems, but they're not really serious, are they? So do we need to make a change there? Or if we do this, it's going to for example, like what I've just mentioned, if we include that in the cost than revenue of the procedure reduces and it's like, yes it does. But ultimately it's better for the patient.

**Pam Mosedale:**

And then you're not having to see them back at 3, 5, 7, 10 days to then treat their infected wound. So longer term has big benefit, but I think it's about inclusivity. So making sure that everyone has the chance to speak, not everyone often has a view and that's absolutely fine, but it's getting everyone on board to feel like their part of the movement and their views matter. So, sometimes I'll suggest something and they'll be like, oh, no Lou, that's really not a good idea. Or I don't think that would work. Have you thought about this? And of course then we may try what they suggest and say, and that's the way it should be. It should be a team thing.

**Pam Mosedale:**

When you say team, are you including vets, nurses, and reception team in these discussions?

**Louise Northway:**

Mainly, so far with what I've done, it has been vet and nurse focused, but reflecting, I've had a lot of time to reflect on the last year, there are things now I can think even back to like the neutering audit that the clinical, the front of house team should be involved in as well. So especially around things like advice. So we don't want the front of house team to be recommending still going ahead with Buster collars and not talking to owners about the other options, which what we are pushing is completely different. So it is making sure that instructions and guidelines are followed by everybody. Otherwise, you get mixed information from different teams and it then just looks really unprofessional to the client. That's really important. So yeah. And dispelling myths. So with clients as well, for example they'll often say, "oh, well, my dog's saliva is antiseptic, isn't it, it's okay if they lick their wounds." So making sure you dispel that myth during the consult and then it's reiterated at the front desk is a really good idea.

**Pam Mosedale:**

Yeah, no, I agree with you totally. And I think it's really important that even that the reception team are included or included when you're discussing results and included in knowing what's going on behind the scenes, because they can reassure clients when clients are nervous about what's happening. They can reassure clients. Yeah, know in this practice we do monitor these things.] And the other place I think it can be really useful is around informed consent.

**Louise Northway:**

Yes. Yeah. No, absolutely. Because I think, again, when you're in the job a long time, you just assume the client knows what consent is and what it is you're giving to them and everything around that. So no, I think that's really important. And also one thing we did adapt was our postop form slightly just to include a little bit more information, but to also change the language a bit that we were using, because again, even simple veterinary terms that are simple to us and not clients. So yeah. It's just making sure we are very human in how we approach dealing with them.

**Pam Mosedale:**

Yeah. And including clients in the whole thinking about all this is important, I think. One of the main barriers when we did the survey, one of the main barriers to, to a lot of quality improvement activities, clinical audit included was having enough time to do it. How did you find the time or how did the rest of your team members find the time?

**Louise Northway:**

Yeah, I can definitely relate to that. And I would say that is probably still an issue probably more so actually in the last year because of team shortages and things like that. But it's emphasizing the importance of what you are doing to your line managers and your management and then being allocated time to do it. So I was given a half day, I think in the end it was normally once a week, at least, or once every other week. And that would be an afternoon really for me, a data collection. Now that might sound boring. Because it did involve me sitting in front of a computer, but the practice management software that we had at the time, it didn't really help me extrapolate the data. So I would have to go in one patient at a time and pull my data across, which is fine. I enjoyed it.

**Louise Northway:**

But it's yeah, it is. It's getting your bosses on board to enable you to do it because it's not just when your RCVS inspection is taking place that you should be doing it. It's a continuous process and yeah, I've been doing them now, well minus the last year, because I've been off but three full years and I just then started collecting more and more information. So when I go back into practice, I'm still

going to be doing the neutering audit, but I'm also going to be looking at postop temperatures ongoing and things like that. So yes, I don't know if I've answered your question. I do think time is a problem because we are very busy, but it's making it part of your day because that's your role. So it's not just a fancy, add-on, it's an important part of your clinical week.

**Pam Mosedale:**

I think that's really important. And for people who are maybe not as lucky as you and your practice where they perhaps don't have the half day a week or every other week protected time, I think you are right. Making that there's little bits of time during the day where they can do just bite size.

**Louise Northway:**

Oh, absolutely. Yeah. Because with the nutrient one, for example, the Excel spreadsheet, which you can down load to use, it's very easy to complete. And if you just did that at the end of every day, before you go home, it would take a matter of probably five minutes depending on how many patients you have in a day. And then yes, that will save you then having to sit there for hours at a time, once a month or once a week, for example. So, yeah, that's a good idea too.

**Pam Mosedale:**

And since you've been doing this, have any of your other team members come up with ideas for audits?

**Louise Northway:**

Yes they have. And it's actually, it's come off of primary audits that we've already done. So for example, we had a run of postop, gastrointestinal complications in canine patients. So we had to think about the influencing factors and one of them was an infection control review. So two of the nurses had a review of what we were doing and how we were doing. We did swab to the practice.

**Louise Northway:**

They actually went on training as well, following on, I think it was about a month later after we had our mini outbreak and yeah, a lot was changed and then ongoing it's sort of looking at how well or how often cleaning procedures are being performed. And if they're done being done correctly, because when it's quick and we're busy, it's easy just to splash and disinfectant into a bucket, but if it's not the right concentration, then it's not going to be effective or it may not be as effective. Oh, there's just so much to think about as I'm sat here, I struggle to keep on track because that's just what clinical is to me, it's like one thing, but then it goes 'woosh'.

**Pam Mosedale:**

And this masses of potential within infection control to audit.

**Louise Northway:**

Yeah. It's like gloves, washing hands between patients, the dogs that come in with, just vomiting and no diarrhea. It was where they were being put in the practice. Were they being put in kennels with day patients or should they be going straight to isolation? And it's just things like that. If you don't have a purpose built practice, we don't, unfortunately then it can be very busy and you can't always put patients where you want to. So, how are we going to barrier nurse them better? How are we going to change traffic through the practice? Is reception being cleaned appropriately? Because that was another big consideration because your healthy patients come into reception, and so do your poorly ones. So whilst you may do your best to barrier nurse them out the back, it's actually making

sure what happens in receptionist is controlled as well. And maybe they shouldn't be coming in and should be waiting outside. So, yeah. Sorry, take it. I'll take a breath now.

**Pam Mosedale:**

No, that's fine. But yeah. So infection control, I mean, there's lots of preventatives audits. You could do that or just process audits of how cleaning's happening. And as you said, hand washing audits, et cetera, and RCVS Knowledge, have some great infection control webinars. If anybody doesn't know, there's a series of webinars, infection control, from the organisms to the disinfectants to how audit. So, yeah. And they're all free on, on the Knowledge website too. So all in all, Lou, what would be your top tip for audit someone who's thinking of getting started.

**Louise Northway:**

My top tips would be to keep it simple and not overthink it because it really isn't as complicated as everyone thinks. So direct yourselves to our RCVS Knowledge website, start with the neutering audit show, how much information it gives you and all the different thoughts that will come from that. And then I guarantee it will lead you onto other things. But yes, just keep it simple and make sure you involve your team. Otherwise, it's a lot of work to do unless you involve everyone and change happens at the other end. So make sure it's a team process.

**Pam Mosedale:**

Absolutely agree. Couldn't agree more. Those are fantastic top tips and yeah. And if you don't, you've got to get a team on board and you've got show some action haven't you from your audits?

**Louise Northway:**

Yeah, absolutely.

**Pam Mosedale:**

Oh, that's amazing. Thank you so much. Hopefully this going to encourage those people. And as Lou said, I totally agree with that. Don't wait to be perfect, just have a go. Just have a try.

**Louise Northway:**

Absolutely.

**Pam Mosedale:**

And as both Lou and I have said, go and have a look on RCVS Knowledge website where there's loads of clinical audit courses, templates, there's walkthroughs, loads of stuff to help you. So thank you very much, Lou, that's been amazing and hopefully we'll get lots of other people getting involved in audit and becoming Knowledge Award champions too. Thank you.

For further courses, examples and templates for quality improvement, please visit our quality improvement pages on our website at rcvsknowledge.org