QI Boxset: Involving the team in Significant Event Audit.

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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 Mosedale:

Hi everyone. Today I'm going to talk to Kathrine Blackie. Kathrine is Quality Improvement Manager at Linnaeus. Hi Kathrine.

Kathrine Blackie:

Hi Pam.

Pam Mosedale:

Hi. I thought we're going to talk today about, a little bit about errors because they happen in veterinary practice, don't they? However hard we try and reduce them and I know that you have a lot of practices that you help with quality improvement. Why do you think the way practices deal with errors is so important?

Kathrine Blackie:

As you said, things do go wrong in practice even with everyone's best efforts and when they do go wrong, then we have the opportunity to take that in one of two ways. You know, we can go in two different directions and it tends to be that people either end up blaming and punishing somebody for the thing that's gone wrong, or we can go the in the other direction and we can use that as an opportunity to learn something and improve what we do. What we can't do is do both of those things. So we have to sort of make a conscious decision that we're going to use that as a chance to learn.

Pam Mosedale:

Yeah. And it can be so negative, blaming people for things that are genuine errors which should never be a source of blame, should they?

Kathrine Blackie:

Absolutely. 're all going to do things wrong sometimes. T's not that people come into work thinking, 'Oh, I'm going to do a really bad job today'. They come into work trying to do their best, but despite that, sometimes, you know, we make mistakes and that can end up having a bad outcome for our patients. Ut when that happens, you know, the first reaction of a lot of people is that they feel like it's their fault. They want to sort of beat themselves up over it. They feel really bad. But if we can try

and frame it a different way, then it becomes a chance to get better. And that means that something good has come out of what is sometimes a negative event.

Pam Mosedale:

And how do you suggest that practices actually do this, from a practical point of view?

Kathrine Blackie:

There are a few things that need to happen, but the very first thing is that we have to know what is happening. Sometimes, it'll be very obvious, you know, the whole team's there, you know, something goes wrong. But other times you maybe find out later that there's been a mistake or maybe only one or two people are present when it happens. And so the first stage is to know what's going on, is to capture that information. Nd that can be done in various different ways. Lots of practices will have a system for this sort of thing, whether it's paper-based in a notebook, really old school, whether they scribble it on a whiteboard or they have some you know, a spreadsheet in their computer you know, maybe like us they use Vetsafe, which is the VDS system for capturing adverse events of this sort.

Pam Mosedale:

Okay. And once they've decided that something's happened and what do they do next, what's the next step?

Kathrine Blackie:

I think it's really important that they just understand exactly what did happen and think about why it might have happened. So rather than just sort of saying, 'Oh, you know, I'm an idiot, I made a mistake, that's why it happened', to just kind of damp that impulse down and from you know, the other people around as well. You know, so if a colleague makes a mistake, don't just sort of roll your eyes and think, 'Oh, you know, their brain wasn't on the right planet today.' But just think, 'Oh, hang on, what else was happening when that went wrong?' Or when they made that mistake, or when they got the wrong drug dosage. What else was going on? And think about all the circumstances surrounding it because the things we do, the way we behave, and the decisions we make all happen in a context.

And that is the most important factor in why things make sense when you do them. You know, it may be as simple as they were massively distracted by people asking questions while they were drawing up that drug. Or, you know, maybe they've come into work and you know, they're really tired because they've been up all night, something like that. And you just don't always know what else is going on. O that's really important that we know that first. And I think the way that everyone responds in the moment that something goes wrong is terribly important as well. And particularly for leadership, because if you are a leader in a practice, then your opinion has great weight in how you respond to failure, to things going wrong, that matters a huge deal. And that really sets the tone for the practice. So it's very important that when something goes wrong, there isn't that sort of, 'Oh my goodness, how could you be so silly?' you know, 'How could you do something like that?' That you don't say something like that, but that, you know, people respond in a way that is trying to understand rather than thinking you already know.

Pam Mosedale:

So that's how to respond at the time it happens. But then what happens sort of after that may be a little bit further down the road.

Kathrine Blackie:

Yeah. So once we sort of know what's happened, and we have that information, the next thing that a team in a practice needs to do is to talk about it. You know, this can't just be one person looking at that event and thinking, 'Well, I know what we need to do to deal with this'. There needs to be a conversation happening. And, ideally, it needs to happen quite quickly while everyone still remembers what was going on and can sort of think through, 'Ah, yes, this was, you know, this was happening as well', or this might be a reason why it happened. I think, you know, before you get into sort of how you might prevent something happening, again, you've got to think about what you need to do immediately. If a patient's been harmed in some way, you need to think, you know, what do we need to do to mitigate that?

How can we, you know, fix the problem or mitigate the problem or, you know, help that patient? And, you know, usually they come attached to an owner as well and your client also deserves to know what's happened and to have an explanation and perhaps an apology if a mistake has been made. And then once that part's been done, you know, as a team, you need to talk about what happened and why it happened, and whether there's something about the way your system works in your practice that has made this more likely and what you might do to fix it. For me, the really important part with this is that you involve lots of different people, anyone who might be involved in that system of work. So for example, if there's been a serious dispensing error, you don't just want the vet team to sit down and try and figure this out.

You need everyone who's involved in that whole process. You need your veterinary nurses and probably your reception staff as well to be involved because they are all part of that process. And you might be missing out on somebody's really brilliant insight into why something happened. And I've certainly come across that from practices that I've spoken to where, you know, for example, the receptionist said, 'Well, you know, obviously that's why we've had these dispensing mistakes because the number of tablets in the box is printed on the label as well as the strength. So when it says 50 milligrams, 500, you don't know whether they're fifties or five hundreds, no wonder we've been dispensing the wrong size' and nobody else had noticed. So getting everyone's voice heard is very important. And they'll only do that if they feel safe to speak up.

Pam Mosedale:

Oh, I totally agree. I think the whole team is the way to go, isn't it? And would you do that for anything, not just for the dispensing errors? Do you think it's a good idea to have the whole team involved in lots of these different things?

Kathrine Blackie:

Yeah, I absolutely do. I think, you know, in a veterinary practice, obviously, you know, they come in all shapes and sizes, but in a lot of them, everyone, no matter their role works very closely together, and I think, even if, you know, whatever happened was maybe sort of an anaesthesia or a surgical thing, the rest of your team have still been involved in that whole process. You know, they know the client, they speak to them, maybe they sort of have chatted through the consent form with them. So it, you know, leaving say a nurse out of the conversation that had that initial conversation and got the form signed with the client, you are missing part of that process and the big bigger picture there.

Pam Mosedale:

Absolutely. So would you want the whole practice team or would you just want representatives of each of the different roles in practice?

Kathrine Blackie:

In most cases, representation is probably the way to go because if you have too many people there, it starts to get a bit overwhelming, particularly in a big practice. If you've got a small branch surgery, then yeah, maybe there's only sort of five of you there. And having all of you talk about it is probably a great idea. But if we're talking, you know, a big hospital, then it's not going to be realistic. You know, you've got people on all sorts of different shifts. You've got, you know, potentially tens or even over a hundred people working there, they're not all going to get together for a meeting. But if say for example, you know, your reception team, they'll maybe have a representative that could go to a meeting and that person could then gather opinions or feedback from their own team and bring that along to the meeting.

Pam Mosedale:

And these meetings are generally face-to-face meetings, are they?

Kathrine Blackie:

Well, I think face-to-face works best, but given the way things have been over the past couple of years, we've all got a lot more comfortable with doing things, you know, on Teams or Zoom or whatever. And that can work really well too. And I think particularly for practices that are multi-site where they, you know, have maybe had similar things go wrong at different branches, and they perhaps want to get the whole team together from the different sites to sort of discuss how they want to change things as a whole practice so that that can be a good way as well. It's much better to do it virtually than to not do it at all.

Pam Mosedale:

Yeah. And to do it in a timely manner if that means doing it virtually. Yeah, exactly. And once they've discussed it, what's the next stage?

Kathrine Blackie:

The aim of the whole meeting is to learn something in terms of why the event happened and to think about what they might do to prevent it from happening again in the future. Not necessarily even just that very specific event prevention, but if they've discovered some weakness in their systems of work, then think about how they might make that better. And that's where everybody's suggestions are going to be really, really important. They are the people who do the work. That's who you want to, you know, to be coming in here and saying, you know, this is the thing that isn't working very well. This is what we need to fix, otherwise either this is going to happen again, or something else in this process is going to go wrong. Maybe not to the same person, because presumably, you know, they're thinking, 'Oh my goodness, I'll never do that again'.

But if they were able to do it, someone else is going to be entirely capable of making the same error. So it's about sort of getting everyone's thoughts about what they can improve. The only thing I'll say there is that you have to be realistic about what's in your power to change.

You know, it's all very well saying, 'Ah, well, you know, this thing happened because it would be much better if we had three nurses on during this shift than just one.' But, you know, with the recruitment situation as it is at the moment, that's saying, 'Oh, you know, we need to hire two more nurses'. You know, even if you could manage to do that you're going to struggle to find those people in a reasonable time scale. So you've got to think about how can we make a system that is going to be strong enough to cope, even though we are probably going to be short-staffed for a while now.

So you really need to think about what you can control and what you can't. And also into that category might fall things like equipment design issues or medication packaging. You know, you might have two products that people have mixed up on several occasions because they look so

similar, but you don't have a lot of influence with the manufacturers to get that changed quickly. You might report it as part of an adverse event report for a medicine, but you know, that's not going to imminently change. So what can you as a practice do to help that? You know, maybe you look at those products and you put a big fluorescent sticker on one of them, or you put them in completely different bits of your dispensary. So it's what can you do?

Pam Mosedale:

So once the team have discussed this, presumably they need to make sure that the rest of their practice knows what's been decided and what changes are going to be made.

Kathrine Blackie:

Absolutely. Because I think if you have something happen, something goes wrong, and you report it in whatever way your practice does, then you want to know that something's going to be done about it, that someone is going to notice that that's happened and find out and change something. Because as you can imagine, if you report things and nothing changes, that's pretty demotivating and you're probably going to stop ever piping up when anything happens. So it's really important that that change gets communicated, that people get that feedback about what they've contributed. And there's lots of different ways to do that. In a small practice, it might just be that you gather the team around and you go, 'Right, this is the result of this thing that happened. We've decided to change our record sheets and include this information. Let's see how that goes'. In a bigger practice, that's a bit more tricky. We do... You know, our practices do various things. We have people who sort of send out email updates when they've had a meeting of this sort just to sort of say what's been discussed and what improvements have been made as a result. And we have big referral hospitals, which issue a monthly newsletter, literally just on this subject of all the different things that have been reported. Because as you can imagine in a big multidisciplinary centre, you get an awful lot of reports and, you know, they'll often fall into different categories so that they've got plenty to put into a newsletter.

Pam Mosedale:

And does any of this information spread throughout your group? Are there things that you might alert the whole group to if they commonly happen?

Kathrine Blackie:

Yes, absolutely. So although the discussion and the changes and the improvements at a local level are really the most important aspect of this process, it can also be very helpful to look at the data at a bigger scale and see what sort of issues are coming up everywhere. And we do notice themes and there's a few different types. We have the things that are common, that are common everywhere.

Medication errors of various kinds, both in terms of sort of administration of medicines in hospitals, but also dispensing errors. And those crop up in every single type of veterinary practice that you can possibly imagine as do, you know, issues with inpatient care errors, you know, things not being done at the right time, patients being mixed up with each other, those types of things. One example I can share with you is that we noticed that quite a regular report that was coming up was patients leaving our practices with IV catheters still in place.

And actually what we did here was we learned from the practices where this never happened and we learned what they did, which was put... In the case of the one we talked to... Put a red bandage on when a patient has an IV. Nd we sort of started a campaign, we made some posters, we shared this information around and various practices were already doing it. And they've thought, 'Yeah, well obviously you would do this', but for the ones that weren't already doing it, it was an amazing

change. It was a sort of, 'Oh wow, what a great idea. Let's, yeah, let's start doing that'. And the number of reports we had fell dramatically, and that was against the background of increasing reporting generally. So we can be pretty sure that that's been a very successful campaign.

And then you have the things that happen only rarely in a single practice, but crop up everywhere. The big example I have there are burns to patients from warming equipment. So a practice isn't doing this on a weekly basis. It might happen in a single practice once every couple of years, perhaps, or less. But when we see it cropping up in lots of different settings, we realise that we, you know, we maybe have a problem either with the equipment or with the way it's being used or what the sort of management of patient temperature generally is under anesthesia particularly. As a response to that as a group, we have written guidelines on managing hypothermia and keeping patients warm. And they're completely all-encompassing. It's all about, you know, what equipment to choose, here's where to get it from. Here's, you know, how to prevent hypothermia in the first place. Here's how to identify patients that are at risk and so on. And we've assessed the equipment we want to recommend and the things we don't want to recommend. So that has all come from incident reporting and, you know, we've got other projects lined up of the same thing where we're seeing that we've got trends of things happening. And then you get to sort of...sorry, just one more, which is...when the first lockdown happened back in 2020, the one thing I noticed in the incident reporting was a massive jump in patients escaping or nearly escaping. And this is because we were transferring patients in car parks. And so, you know, as a group, we sort of sent out a bit of a safety alert that this was you know, a massive increase in risk and so that practices could be aware of that and to put things in place to try and mitigate that risk before anything really bad happened.

Pam Mosedale:

And those are fantastic practical examples. I mean, that's, you know, why wouldn't practices do this really and learn from things that happen? What about learning from things that didn't happen but might have, the near misses? Would you suggest they discuss those too?

Kathrine Blackie:

Definitely. These are brilliant. You've got a couple of different kinds. You've got your near misses where you think, 'Whew, we got away with that by the skin of our teeth. We were lucky there because just disaster was averted by pure luck'. Those sort of, 'We gave the pre-med to the wrong patient, but luckily, they were both in for a castrate and they're both the same size, so we got away with that one'. Nd then you've got the ones that we like to call a good catch where somebody spotted the problem. I heard of one of these the other day.

A patient care assistant in a big hospital noticed that the tablets she was about to give the patient, that there were two different kinds in the pot. Somehow some of the wrong ones had gotten mixed in with what was supposed to be there.

These are great because that's showing you where your system has worked, where your defence systems have worked, and your double checks and things like that have spotted a problem. Nd that teaches you something about, you know, your systems of work and how they are functioning. So they're all really well worth knowing about and the near misses where you just got away with it, they are your warning sign. You know, they're your free lesson and a chance to learn without any patients being harmed. N the same way that, you know, sharing our stories with each other and hearing about someone else's incident or mistake can make you think, 'Ooh, I wonder if that could happen to us. How, are we going to be sure that that won't happen here?' and you know, it's a chance to learn without making the mistake yourself.

Pam Mosedale:

Oh, I agree. I think near miss is absolute gold dust, you know, perhaps it's just having a near miss or 'whoops, that nearly happened' kind of book in the... I would say in the dispensary because that's

where so many of them finish up happening, but anywhere, I think and you could use the same system to discuss things that have gone really well, couldn't you?

Kathrine Blackie:

Yeah, absolutely. And I think it's really hard for us to do this. You know, it often doesn't stand out when we've done something really well. And the way I sort of try to encourage people to think about this is either with those near misses where something nearly went wrong and someone did something exceptional that managed to sort of save the day. Or those times when you think, 'Oh, things have just been normal today', but maybe they shouldn't have been because you had three emergencies turn up and do you know what, things actually went surprisingly smoothly. Those are well worth talking about, you know whether you report it like this or whether you have a sort of a system where you sort of all debrief at the end of the day, which is a really nice thing to do. You can sort of say, 'Wow, we really stepped up today. We did an amazing job even though those three emergencies rocked up. We got everything done, it all went well. Why was it so good? What particularly happened? What did we do that was sort of at a higher level than normal?' And try and learn from that and incorporate that into what you do.

Pam Mosedale:

Yeah, I think you are, you are right. There are so many possibilities to use this, but the most important thing is to talk about it, isn't it?

Kathrine Blackie:

It is and I think one of the things that I bring in here is that having a system to report when things are happening and a sort of a way of talking about it, and this is just what we do in this practice, the unexpected benefit of that that I've really noticed over the last couple of years in our practices is that it changes the culture. It's almost like you act that way and you start to become it. It makes people more open about everything. Just the fact that maybe, you know, a senior vet in the practice or the head nurse, somebody is standing there talking about something that's gone wrong for them, some mistake that they've made, it affects the culture and it makes people feel that it's okay to talk about their things and that gradually starts to happen and more and more people get involved and you kind of almost reach a tipping point where it's just what they do.

You know, everyone mentions it, you know, whenever there's been an incident and it's just part of what they do day to day as opposed to a big performance.

Pam Mosedale:

And that's what we want with quality improvement, isn't it? That all of it becomes part of normal every day veterinary life and just slotted into small bite-size bits during the day rather than being something extra special.

Kathrine Blackie:

Yeah. It needs to be part of how we work, and that makes it a much nicer place to come and work. If you don't feel that you have to feel ashamed if you get something wrong, or if you feel you can't speak up if you're not sure how to do something or you didn't hear what that vet said or whatever it was, or you don't want to point out...'Did you want to run those fluids so fast?' Or, you know, 'Should the dog's foot be pointing that way?' That those kinds of things that, you know, if people feel that they've got a culture in that practice where it's going to be welcomed if they speak, that's a much happier place to come and work. And it's going to be a much safer place as well because you all have each other's back. You know, that if you are about to make some colossal mistake, someone will probably tap you on the shoulder and go, 'Oh, is this what you wanted to be doing?' Or, you

know, 'Have you seen that bit on the x-ray?' But if you work in a place where that's not welcomed or someone snaps at you when you make a suggestion, you soon, you know, become quite silent about these things. Nd that's not such a great environment.

Pam Mosedale:

And I've been rescued so many times, by people saying to me, 'Are you sure you want to do that?' Yeah.

Kathrine Blackie:

As have I. I think the 'Should the dog's foot be pointing that way' was one of the better ones of mine. <Laugh>

Pam Mosedale:

<Laugh>. I think mine was, 'Do you really want to give Domitor again or are you meaning to give Antisedan?'<laugh>

Kathrine Blackie:

Oh no, but do you know what, that's a surprisingly common one, I think.

Pam Mosedale:

Yeah, yeah. But, as you say, it's having that culture in the practice, having that safe enough place that you can say those things and we all spend so much time at work that it's a lot more pleasant. But also I think there's evidence too that a lot of the reason people want to change roles is because of not working in a team where they feel part of the team and safe. So it's, I presume, that this is also good for the retention of team members.

Kathrine Blackie:

I think it probably is. 's Something I don't have evidence on, but I can't imagine how that couldn't be the case. Because if you work somewhere where you can feel you are able to turn up and be yourself and speak up and say what you think when you have a concern that’s just going to be a much more comfortable working environment.

Pam Mosedale:

And of course, we do still have to have accountability, don't we? So if people... If anybody was doing anything that was absolutely not the right thing to do or deliberately wrong, that would be different, wouldn't it?

Kathrine Blackie:

Yeah, absolutely. I always hear that mentioned. I've never really come across it, maybe I've been very lucky, but the people I've worked with have always been really dedicated, very keen to come and do a good job. Nd I've never come across sort of that of deliberate wrongdoing. But on the other hand, sometimes you have maybe grey areas where people are, you know, maybe not aware of their own limitations or doing something they're not trained to do those kinds of things. And they, you know, you do need to make sure that you do what you need to do, to keep everybody safe, including all your patients. So there's, there's that. But I think, yeah, if somebody is doing something they know that they shouldn't be doing, cutting corners or whatever, first you do need to look at whether it's just them or whether everyone's doing it and they were just the one that got unlucky.

But you know, if there's a persistent problem with the person that starts to become a, you know, a different type of issue. And then it's about sort of managing their performance and the HR side of things.

Pam Mosedale:

Absolutely. So then the significant event audit wouldn't really be the thing to do. But most of the time, as you say, it's incredibly rare, those things. And most of the time it sounds to me like a significant event audit is the way to deal with these things, to have a happier team and safer patients.

Kathrine Blackie:

Absolutely, and it comes back to that thing, you can either blame people and punish them in whatever way you, you know, you might do or you can forget about all of that to start from the premise that they're coming to work to do a good job. They tried to do their best. They did what seemed to make sense to them when they were doing it. And learn from that and do better in the future.

Pam Mosedale:

Perfect. Thank you very much, Kathrine.

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