As vets look beyond Covid-19, QI is more important than ever.

Nicky Paull, Chair of the VDS Board.

Lizzy Whiting, BVSc CertAVP MRCVS, Member of the QIAB.

Pam Mosedale, QI Clinical Lead BVetMed MRCVS, Chair of QIAB.

Nicky Paull:

Well, hello and welcome. So, the question today is, what is QI? For many it's just a quiz show chaired by Sandi Toksvig on BBC Two, but in the veterinary world, QI is taking on the recognised and growing importance in day to day working. And I'm really pleased to get the opportunity to chat to vet, Pam Mosedale, a long-standing friend, who is Chair of the Quality Improvement Advisory Board set up by RCVS Knowledge. And also, Lizzy Whiting, a young vet colleague from Cornwall, who also sits on the QIAB. She's actively embedding QI in the vet team that she works with but is also working to widen the understanding and benefits of QI as a QI ambassador. So, Pam, can you give us a quick definition of what is QI?

Pam Mosedale:

Quality Improvement, QI, might seem new. It isn't new, it's stuff that you and I, as we say, can go back a long way as vets and it's stuff that we've always done. Looking at cases, seeing how we can improve. The difference now is that Quality Improvement is more of a structured approach and it's everyone working together in the practice to make changes, to improve patient outcomes, to improve care, to improve systems within the practice, which leads to better care, and to improve learning and professional development and the way the team works together.

Nicky Paull:

So, we're looking at something old, but almost with a new name and a more formal process to it, perhaps. Can you tell us what it looks like in practice, maybe give us some examples?

Pam Mosedale:

Yeah, certainly. Practices that are involved in continuous Quality Improvement because it has to be continuous. They have meetings. They involve everybody. They listen to everybody on the team. Everybody feels they've got a voice and can speak up. They're probably doing some clinical audits, and more importantly, when they've done the clinical audits, they're acting on the results and changing things as a result and following that through and making other changes if they need to and repeating the audit.

They're drawing up guidelines or protocols, which is something I know Lizzy's been involved in a lot. And when they're doing that, they're doing it with the team all on board and the team able to contribute from the beginning and looking at the evidence base and letting everybody input into it, so everybody can take ownership of them. They're looking at those things, which unfortunately we

all have, where things don't go too well. Client complaints, significant events, having a look to see what they might have been able to do differently and what they might do to try and prevent it happening. Or not prevent, we can never prevent, but to try and make it less likely for it to happen again.

But the important thing there is that they're making sure their team knows that they're doing this to improve systems, not to blame individuals. I don't think it's easy to implement Quality Improvement in a practice where the culture means that people are too worried to speak up or to make suggestions because they think they won't be heard or listened to. It's all a very joined up process. If you once get involved in one of them, if you start using a checklist, then you might want to audit the use of the checklist. If you start drawing up a guideline, you might want to audit that, or an audit might lead you to drawing up a guideline. So, it's all very joined together. When practices start, hopefully they get enthusiastic and then they move on from doing one small thing to doing a combination of things.

Nicky Paull:

If you were going to pitch this to a practice as to why they ought to embed QI in their day-to-day work, I mean, one of the questions is going to perhaps come back to you from the practice is, "How will the practice benefit and also how will the clients and animals' benefit?" Maybe you could try and sum that up for us.

Pam Mosedale:

Yeah. Okay. I'll try. I'd say they'd have a smoother running practice. They'd have better patient outcomes. They'd provide better care for the animals. Therefore, they'd have happier clients, and they'd have happier team members and they're more likely to retain team members if they felt they were part of a team that were improving in a continuous manner.

Nicky Paull:

Right. Lizzy, can I bring you in now? How did you first become aware of QI and what made you keen to become further involved by joining the RCVS Knowledge QI Advisory Board?

Lizzy Whiting:

I first became aware of QI when Jill Nute was RCVS president, and she was involved in getting the ball rolling on QI becoming more of a formal procedure and something supported by the RCVS. So, she brought it back to her practice, Nute's Vets in Wadebridge, where I worked at the time. So, we would hold monthly ish meetings, and we'd have some lunch and what have you. Things that we didn't know the other vets did, so for instance, we picked up that one of the vets always checked female dogs for mammary masses, whether they'd been spade or not. It was just a little thing that he added to his clinical exams. "Oh, that's a good idea." And then we all started picking up good ideas from the other members of the team. If there was a problem, we could talk about it, as Pam has discussed.

Moved down to Truro and because I had done a lot of QI stuff, the team at City Road were quite keen to implement that into their practice. So, we've started from scratch really on doing that. They had some protocols in place but hadn't quite taken off. It's much more part of the culture at the practice now. They were certainly aware of it, but to give it a structure and a practical application, I think was where I helped them. So, quite simple things like setting up a client card, that's called Quality Improvement, and it has different animals, for want of a better word. So, you enter an animal as say, near misses, you enter one as adverse events, we enter one as just general small animal stuff.

So, when something comes up, as it occurs to any of the members of staff, they can go onto that client screen, they can type it in and then when it comes, usually the week before a meeting, I'll collate all the information that's just been jotted down there, and we discuss that in the meeting. So, it might just be something simple like, "Blue ET tube cuff inflation." Or, it might be, "Old cat testing guidelines." Or something like that. So, some of the things will be big and some of them will be just little snippets. When people have been on CPD, they can put down, "Ooh, I learned X, Y, and Z." And then they can present that to the rest of the team. So, it is literally note format.

By applying it that way, it makes it more practical and then because they were keen to implement it, it then meant that the practice manager was able to say, "Right, we're going to put aside this hour and a half period of time every month to six weeks, to have the meeting." And that's really important as well to get the support from that front, because trying to get all the vets together at the same time, as you can imagine, can be quite difficult. But if it's like, "No, it's in the diary. This is meeting time. This is what's going to happen." And if we had agreed on a guideline, I'd write it up, print it up, give it to everyone, laminate it, put in the rooms, whatever needed to be done to get that system implemented, and then take it back to the subsequent meeting and we'd follow up, "Is this working, does it need to be altered? How do you feel about it? Is everyone happy with it?"

Nicky Paull:

So, have you applied these same principles post-COVID, with the start of COVID and into COVID planning?

Lizzy Whiting:

Yeah, I think so because we are used to speaking to one another to solve problems. The fact that we have that background, I think has helped with the big changes that we've had to make to the practice. Things like collecting medicines. I think when we had our first meeting, we said, "Well, we have a window at the reception, so we'll pass things through the window, so people aren't coming into the practice." So, that was great, but then we realised, or I think one of the vets who was on duty realised that the people were leaning through the window. So, we modified that to a chair outside and then we've added hand sanitizer onto the chair.

So, it's been a bit of an evolving process, but that initial, "Right, the problem here is we need to not have clients coming into the practice. How can we solve it?" So, it's a bit of problem solving, a bit of process, and then that whole key thing, communication. And I think the fact that we already had good communication systems has really helped.

Nicky Paull:

Lizzy, I've worked with lots of vets over a long period of time, some love protocols and structure and they'd like one just for even getting out of bed in the morning. And then, I've worked with others who see the whole protocol-driven move as an attack on their own professional judgment and independent thinking. Have you come across that in any of the teams that you implemented QI in? And how do you deal with it when challenged on this interfering with clinical judgment question?

Lizzy Whiting:

Well, I very much try not to say, "This is the protocol, and this is what we're doing." Because that instantly gets the reaction, "Oh no, we're not." But I don't like the word protocol. That's fine for cashing up, but not for clinical stuff. It's a guideline. It's a suggested route, because we always have client issues, patient issues, money issues, all these different things come into it, so you can't always do perfectly what to do every time.

But I think the key bit is to get everyone engaged in that first discussion, "Right. Let's talk about diarrhoea in dogs. How do you treat it?" "Oh, that's interesting. How do you treat it?" "Oh, do you

do that? Oh, that's cool. Why do you do that?" And getting all the different ideas and pooling together what we feel works best. And then if we have got the access to evidence for doing it in a certain way, then we use the evidence.

The RCVS have produced Knowledge Summaries [RCVS Knowledge's *Veterinary Evidence* journal], which are a one or two sides of A4, with a review of the current literature on various subjects. So, there's a nice review of each paper and then at the bottom, the suggested evidence for the best practice in for example, diarrhoea in dogs or luxating patella's in dogs, or various different subjects that are out there. So, those are really, really handy, because the time it takes to go and seek the evidence and review it and put it all together is quite a considerable amount of time. So, the fact that the RCVS Knowledge have those summaries is really helpful for practitioners.

Nicky Paull:

Thanks Lizzy. Pam, can I come back to you on this idea of fear of group thinking impacting on individuals' clinical judgment and balancing what can be perceived as the old name protocol being rather restrictive to what people can do?

Pam Mosedale:

Protocols are certainly appropriate for some things, for instance, you would have a protocol for how you recorded controlled drugs in your controlled drug register. That's something everybody has to do and there is a right way to do it. Guidelines are much more, as Lizzy just said, about being collaborative, but yes, there is a feeling that, yes, this can restrict my clinical freedom. You shouldn't deviate from a protocol, but anybody can move away from a guideline as long as you've thought about it. I think that's the important thing, to have thought about what you thought was the best practice idea and then mentally to have thought, "Yes, but we can't do that because the client won't bring the cat back." Or "They can't afford this." Or it's just not appropriate in this particular case for whatever reason.

And of course, the other issue with guidelines is that where there's comorbidity, so start getting a little bit more complicated. They need to be altered and checked and are reviewed every, probably six months to a year or whatever. When people have been on CPD, they may come back with new ideas. A guideline is not for life.

Nicky Paull:

Thanks, Pam. So, as chair of the QAIB what is your vision for the future and how as a group, do you think you'll be able to measure your success?

Pam Mosedale:

Well, my vision for the future ... That sounds very grand, doesn't it? But my vision for the future is that QI is part of normal veterinary life. That it's just something we all do like everything else in amongst the day. I do think that practice teams need time to do it and I think that practice businesses need to acknowledge that teams do have time, and it needs to come from above.

And also going forward, I think there's going to be quite a lot more benchmarking. RCVS Knowledge Quality Improvement, we're involved in this. We already have the National Small Animal Neutering Audit and there's moves to move that into some other surgical procedures. We're going to have the Canine Cruciate Registry where any vet, don't have to be a referral specialist, any vet who's doing cruciate surgery can submit their data. And all these things are going to give us some benchmarks across the profession, which I think is exciting for the future.

Nicky Paull:

Lizzy, how do you see the future of practice working with embedded QI?

Lizzy Whiting:

Just getting people enthusiastic about it, because you say the word QI, it sounds a bit dry and dusty, where actually when you realise what it is and what it does for your patients, that's what excites me. And I would love at least one other person in every practice to be as excited about it and as driven to be, "Yeah, we can make our patients' lives better. We can make our own lives better. We can provide a better service. We can have a happier running practice." And it all starts with that collaborative approach. It's the ethos of the practice and that willingness to learn, change, develop, which I would love it if every practice could do that.

Nicky Paull:

Cornish practices got together recently and looked at the RCVS BVA COVID guidelines and wanted to look at how we could produce something for Cornwall. How did you implement that? Because you were very much involved in that, using your QI structure to try and develop something for Cornwall. And out of interest, is that still holding up?

Lizzy Whiting:

Yeah. So, when the BVA guidelines came out, there was many, many different ways that they could be interpreted. As a practice, we came up with our interpretation and then thought it would be a good idea to involve other practices as well, to try and get a consensus across the county. So, the same approach as in our normal QI meetings, see where are we starting from? What's everyone else's opinions on these guidelines? Where do they think that they sit within those guidelines? Some practices were thinking about offering more, some practices were thinking about offering less than the guidelines. And just trying to let everyone have their say as much as possible, but then to bring it back round to, "Right. Well, this is our baseline. Let's add this bit. Let's take this bit out. Have we got a general agreement that this is more or less what everyone is happy with and is a sensible way forward?"

And it still complies to the RCVS guidelines, it still fits in with the BVA guidelines, but we all have a cohesive structure going forwards. And as time has gone on, I think we've more or less been stuck to as far as I can tell. We've had a few questions recently. I think rules are going to be changing this week, potentially, from the government. We'll probably have to adapt what we're offering and what we're talking about, but we have the communications systems in place. We have our WhatsApp group; we have the Facebook groups, and we can talk to one another. So, hopefully the people that were on board on that first weekend are going to stay on board and we can have further discussion, further refinement of the principles in exactly the same way we do for clinical QI guidelines in practice.

Nicky Paull:

Well, thank you very much, Pam and Lizzy, your enthusiasm is infectious. If anybody wants to get up to speed with this then the best place to look is on the RCVS Knowledge website. Look under the QI resources where you'll find the templates, the Knowledge Summaries, lots of case examples, and also, I understand there's quite a lot on COVID advice and a very good infection control webinar. So, that's on the RCVS Knowledge website. And thank you both again.