Tuesday Teatime Takeover- Clinical Audit

Video transcript

Louise Northway RVN

Amelia Poole DipAVN (small animal) RVN

Amelia Poole:

Yeah, we are live.

Lou Northway:

Okay, we are live. Is this working? What's this down here? We're just going to see if we can make sure everyone can hear us. If you can hear us, can you write a message and let us know that you're here? I'm going to try and do the same with my iPad just to make sure we are actually talking to people and not to ourselves.

Amelia Poole:

We have a little bit of technical issues.

Lou Northway:

We're just going to make sure it's working.

Amelia Poole:

Hopefully, fingers crossed, we can get them ironed out and continue the talk about audit.

Lou Northway:

Okay.

Amelia Poole:

Well, I think it's still saying live, so I think we should just go ahead.

Lou Northway:

So Leon, can you hear us nice and clearly? Just to make sure, we've got one person saying hello so far, but can you just confirm that you can hear us okay?

Amelia Poole:

Oh, hello.

Lou Northway:

Hello. Hi there, great.

Amelia Poole:

More people, yay.

Lou Northway:

Yah, we're not talking to ourselves. That's fantastic. So, welcome to the first RCVS Knowledge Tuesday Teatime Takeover. I am very excited to be doing the first one, and I am joined this evening by Amelia Poole, who is an RCVS Knowledge member of the team. So yeah, we're going to talk about clinical audits in practice, and we're going to be answering any questions that you may have as well.

Amelia Poole:

Brilliant. So just to start off with, well, thank you everyone who's saying hello and that they can hear us loud and clear. Thanks all for the feedback. And just to let you know a little bit about what RCVS Knowledge does, so we are the charity partner of the RCVS and we have a mission statement which is to advance the quality of veterinary care for the benefit of animals, the public and society. So I work in the quality improvement part of RCVS Knowledge, and quality improvement is all about improving ourselves and improving our care for the benefit of ourselves and our patients.

I am from exactly the same background as all of you. I'm a veterinary nurse. I've been qualified 11 years, worked in practice for 11 years before I came to RCVS Knowledge, so that's my background. I'm here to, well, get Lou to talk to all of you about why you should all be doing clinical audits in practice, and why they are the best. I'm just going to read one comment that says, "Lou has the best teapots."

Lou Northway:

Oh, I know. Thanks.

Amelia Poole:

She does indeed.

Lou Northway:

Yeah, you can't even see the full collection, but yeah. So yeah, we're actually filming live tonight from my house, because it's a teatime takeover, so hence the teapots and the mugs.

Amelia Poole:

Teacups.

Lou Northway:

Yeah, as Amelia was saying, clinical audits are really important. I know when you first hear the word clinical audit you think, "Oh my gosh, that sounds so dry and boring," but it really isn't. I started doing audits in practice ... Head of our practice started inspection about three years ago now. At first, like all of you probably right now, I thought, "Oh, gosh. I don't know what this is. I don't know where to start. I don't know what to do." So one of my colleagues suggested I had a look on the Royal College website, and that was my first learn about vet audit.

So this is an online audit which you can download from the RCVS Knowledge website, which is all about auditing your post-op neutering complications, and it's really straightforward. So at the end of every week, I would go to all of our patients 10 days post-procedure and look for complications,

basically. And then at the end of each week or each month, I would report an issue to the team, issue a report rather to the team just saying, "These are the complications, and where should we go from here? What do you think?" And yeah, the amount of things it's highlighted is really, really surprising.

So for example, if you work in a busy practice like me, each person in your team might see one complication a day. So at first you might think, "Oh, I've only seen one thing today that's not been 100%. That's fine." But actually if you're auditing and you get to the end of your week, you will see that you have seen a lot of complications. And when we say complications, it's not things are dying, or there's catastrophic complications.

Amelia Poole:

Surgeries.

Lou Northway:

Yeah, it can be just something simple like dog castrate has licked his wound, so therefore now he has a wound infection. So not ideal, and we need to be thinking of ways of preventing this happening again in the future. So, what went wrong and what can we do to make it better? So yeah, that's probably the first audit I would recommend you start doing in practice, to get familiar with sort of how it works. All of the support materials you need for that are on the RCVS Knowledge website, so yeah.

Amelia Poole:

So just to clarify the support ... Oh, sorry about that ... Support materials. You can tell I'm really good when it's going live. So we basically supply a spreadsheet. Don't be worried when I say the word spreadsheet. It is the easiest spreadsheet to use. Basically you put your patient ID. That can be just the patient's name or anything that you want. It doesn't have to be anything technical for GDPR or anything like that. You basically just write whether it was a dog spay or castrate, cat spay, cat castrate. And then the options for complications are that there is no complication, or there is a complication that didn't require any sort of medication, complication that just required medication, complication that required surgery, or complication that ended up in the patient's death. So you don't need to go into any more detail than that, and it's completely confidential. Basically that gives you all the numbers that you then need, and once you fill out a little bit, voila. That's your first audit, done and dusted.

Lou Northway:

Done, yeah. It's literally as straightforward as that. So the audit, the neutering one probably would take you about 20 minutes a week probably, depending on how busy your practice is, if you keep up to date with inputting your patient details. I think probably one of the other things that just flattens my head from doing the neutering audit is that when ... Although at the beginning, it's nonspecific when you're looking at your complication. It's just they were normal, abnormal no treatment, abnormal medical treatment, abnormal surgical treatment. You do have to sometimes take it down ... Well, up a notch and look at what those complications were.

So at first, so we mentioned it might be that lots of your patients are interfering with their wounds. Perhaps we're not explaining ourselves properly to owners of how important it is to prevent licking. But a lot with dog neutering, especially I've found that a lot of dogs or quite a few often have diarrhoea for a day, or a day or two after surgery. Now, there are many reasons why this could happen but it is something that I have noticed over the three years that I've been doing audits, often worse in the summer months than the winter months. So you think environmentally there are more bugs in the environment. What's going on? But it really starts almost a spider web of things to think

about, and you can start off with a very simple audit and mission, and make it quite sort of intense. There's lots of different avenues you can come off on, but it makes it really, really interesting.

Amelia Poole:

Also just off on that, means that I think when you see massive big audits you shouldn't look at them and get scared about it because however ... You get out what you put into it, really. You can just monitor the basic things and go really slowly, just to try and get your team on board, or you can do what I'm going to call is a full-on Lou and just-

Lou Northway:

Look at everything. Look at everything, yeah.

Amelia Poole:

Look at absolutely everything. So that's a bit of an introduction into kind of a vet audit. I've got a question for you, Lou.

Lou Northway:

Okay.

Amelia Poole:

Why should we audit?

Lou Northway:

Because you just don't know how well you're doing unless you're looking at how you're doing. You think you know how you're doing, but actually most of the time I find that you're perhaps not doing as great as you think. Sometimes we are, don't get me wrong. But it's like monitoring standard of care, and how do you do that? Well, you can do that by doing an audit. And I think nursing is a very reflective discipline. We should always be thinking about what we're doing and how it's gone, and this is the way of doing that.

Amelia Poole:

Yeah, and I think all of us really, we got into the job because we care about animals, because we constantly want to improve the care that we give them. Audit just gives you essentially the numbers so that you can work from that. So we've got a couple of other questions that were sent to us beforehand, but if anything crops up during the meantime please feel free to ask questions throughout and we will do our best to answer them. And so one of the questions I've got here, and sorry I don't have any names as to who asked them. But the first one is, "How often do you do an audit? And if there is any fails in the audit, how do you address them?"

Lou Northway:

Yeah, so I would probably automatically say try to avoid the word fail, because it's really negative. If you are going to blanket not getting great stats as a fail, it's just really, really negative. So it's, I would think suboptimal would be a better word. So in my practice now, initially I was just doing the vet audit spreadsheet. Now I audit everybody, so every dog, cat, rabbit, any species of animal that comes in for general anesthetic or sedation is audited, so for complications during and also post-op. And that is something I do at the end of every week. Now, if we do have serious complications occur, so complete wound breakdowns, animals that have diarrhea that then needed to be hospitalized, patient deaths, anything that's really severe, then we do what we call a significant event audit.

So that is a team task, so we stand together. I mean, it's basically like a debrief but it just works through what didn't go so well. We action plan to talk about how we can make things go better in the future. What were the factors that made that day not go so well? And that's really sort of helped to change the culture. I think maybe in the past, everyone's been a bit scared of admitting when things don't go so well. But you know what? We actually do have to take responsibility for that and move forwards. I feel like I've gone off on a tangent there from the question, haven't I?

Amelia Poole:

No, no, no. I think that the fail in it threw you, and I definitely second that. I think as long as you're doing an audit and you're looking at yourself, even if the results aren't what you think, I wouldn't call it a fail. Because you're on the first step to trying to improve things by auditing, so I wouldn't call anything a fail. There are some times when you didn't do as well as you thought, but that's absolutely fine because like Lou said, you should just look at why you didn't do as well as you thought. It could be, like when you say looking at the factors, it could be that you have done absolutely everything right but it just so happened that you haven't done well. Or it may be, we had six weeks of rain and mud and that has affected post-op complications, because the owners have found it really difficult to keep their animals clean afterwards.

That's something that you can't control. That's something that the owners are trying their best to control, and I think you can take those factors into account. As long as you don't get a bit blasé with it and go, "Oh, we can't control that. That's fine." But I would try and stay away from the word fail, because as long as you're looking at what you're doing and trying to improve it, you are absolutely not failing at all.

Lou Northway:

Absolutely.

Amelia Poole:

And I'm a big believer in we ... Well, nurses and anyone in the veterinary industry work so hard that nothing you do is really failing, because you're amazing.

Lou Northway:

Yes, love it. Absolutely.

Amelia Poole:

And we definitely got off on a complete tangent there. So how often do you do an audit? I think that really depends on what you're doing and how busy you are. I mean, you could take some measurements every couple of months, or you could do it every week, just whatever that helps to get your team engaged.

Lou Northway:

Yeah, like post-op temperatures, that's an easy one. Post-op temperatures; if you follow my Facebook page, you'll know I go on about hypothermia and why we should all be trying to avoid it to the Nth degree in our anesthetized patients. Well, what temperature are your patients coming back to bed with? So let's take the first reading when they get back to the kennels. Are they cold, or are they a nice temperature? If the majority of your patients are coming back to bed cold, action plan as a team, what are you not doing or what could you do better? And then you can do that audit week to week, or maybe quarter to quarter.

So season to season, in the winter months, if you work in a practice that's old-fashioned and doesn't have modern heating, then in the winter months it's going to be extremely challenging to try to keep

your patients warm. But in the summer months, it's going to be much easier. So I think yeah, maybe post-op temperatures would be a good first audit to try doing in practice, alongside maybe the post-op neutering, because that's quite an easy one. Not an easy area, but a good area to work on which everyone will see the benefits of warm patients.

Amelia Poole:

Yeah, and we were talking earlier about post-op temperatures, especially when it's coming to winter. A lot of practices keep their oxygen outside, and the air that comes through then is freezing. So comparing that with your summer, whether it actually makes a big difference? Do you need to invest in actual warming devices that warm up the oxygen before they go into your patient? All that sort of thing can be answered with audit. It's the answer to everything.

Lou Northway:

It is. You'll get addicted, like me.

Amelia Poole:

So this is a good one. "Should this be the whole team's responsibility, or one designated person?"

Lou Northway:

I think it really depends on what your team is like and how big your team is. I would say it's probably a good idea to hand the task to one person, but I do think it's important to collectively let the team know what's going on and what you're looking at, and not to always make them aware of when maybe you're auditing. Because sometimes for example if you're doing an infection control audit, that week everyone might work a little bit harder. So when you look at your results, they're really, really good. But if you did it another week when people are doing things as we do day to day normally, they may not be where you want them.

But I do think it's important to get everybody on board, but personally I do all the audits myself in practice, but then I feed back the information to everybody. So there's an end-of-month report offered saying, "This is what our stats are doing this month compared to last month," and then some reflective thoughts over why I feel they may be that way. Some months are not as good. Some months are amazing. It really depends. And then obviously everybody can have their say as well in feedback to me. "Oh well, Lou, I think this is a good idea," or, "Perhaps we could try this." And yeah, you can't have too many good opinions, in my opinion.

Amelia Poole:

Yeah, yeah. That's a good one. Also, I think when you do have one designated person for audits, it doesn't have to be the same person all the time. If you're really passionate about post-op temperatures, one person could take the lead on that audit and get everyone else really just excited for it. But another person might just be really into kind of client waiting times and things like that. If someone has got their niche in practice, to steal Lou's words there, then let them go for it, really. Because if that's what they're passionate in, they're much more likely to spread that passion around to other people.

Lou Northway:

Absolutely. It's infectious, definitely.

Amelia Poole:

Yeah, so we've got quite a few questions as well that run along the same sort of route. We've got, "Where do we even start them? I don't know where to start or how to begin a clinical audit, and what even do I audit?" Well, all good questions.

Lou Northway:

Yeah, really good questions. I think, have a chat with your team. Get the nurses involved in your next nurses' meeting. "What do you guys all think we should work on? What areas of practice should we focus on to start with? What are we keen to improve? Some of you may be doing CPD courses and may be learning lots of new information. When you get back to practice you think to yourself, "Oh, actually how are we doing it? I think it's quite old-fashioned. Maybe it could be updated." And then maybe you could do an audit looking at the results of doing it that way, and then try doing it the other way and then compare your results. It is research really, but yeah, I would say definitely have a think about the courses that you go on, because that was the inspiration of one of my audits, which I think we're going to talk about shortly.

Amelia Poole:

Yes, we are.

Lou Northway:

My anesthesia one, so yeah.

Amelia Poole:

So if you do need any more inspiration on our website, which I will try and post a link to, either during this video if I can figure out how to technologically do that-

Amelia Poole:

Or afterwards, I will post a link to. We've got loads of case examples of practices that have done clinical audits, so even reading one of those and stealing the idea, that's absolutely valid because it gets you started. So the case examples that we've got is GA monitoring, hand hygiene, and we've got controlled drugs audits, and we've got CPR. We've got fluid overload and kind of more specialized things like BOAS boxes, whether they're being made and used on a regular basis. So if you do need to steal an idea because you're just having a bit of a brain fart, then that's absolutely fine.

Lou Northway:

Yeah, there's loads of inspiration on there. I always think it's good to look at other practices and see what they're doing because then, "Oh, do you know what? We could do something like that here," so get on there and have a look.

Amelia Poole:

Yeah. We had one specific question about somebody wanting to carry out a handwashing audit. So they're wanting to improve hand hygiene, and they're kind of wanting to know, "How about doing it?" We do have a case example on the website that talks about hand hygiene. I know you asked about, "Is it a case of visually observing?" And in this case example, they did a mix of visually observing. They had people fill out kind of forms after they washed their hands, about whether they had done it in the right way. So definitely go and give that case example a read, because I think that would be really helpful for you and I will post a specific link to that one as well. And so for the moment, we're going to let Lou go ahead and talk. She is one of our ... Talk ... Talk some more.

Lou Northway:

Talk, it's all I do. I talk all the time.

Amelia Poole:

She is one of our Knowledge Award champions, so she won a Knowledge Award for her ... And I love saying this ... Perioperative parameters audit. So I'm going to let her talk a bit about kind of what she did, how she did it, how she got her team involved and the whole process really, to try and inspire you, and so I'll hand it over.

Lou Northway:

Cool. So yes, back in 2017 I completed an anesthesia certificate. During that time, there were lots of things I thought, "Oh, I want to have a look at that. I wonder how we're doing?" Or, "I think we could improve this. Maybe we should look at that." And I thought I would collect loads of data, day to day, week to week, for four whole weeks, looking at intraoperative parameters and complications. So, how often we were encountering problems, also what actions were taken, and then just having a look if there were any links. So to start with, I made an absolutely ginormous spreadsheet, which went on the wall in prep. It was ginormous. When the girls walked down in the morning they were like, "Are you having a giraffe?" Because it was really, really big.

But I wanted to connect lots of information, because I just wanted a really good overview of how we were doing. So the spreadsheet looked at things like the ASA score, so the physical status of the patient. It would look at the pre-med drugs that they had, what complications were encountered? Were they hypotensive? Were they hypoventilating? Were they hypothermic? What was their post-op temperature? Things like that, so at the end of the month I think I had the data of ... Oh, I can't remember now off the top of my head. It was quite a lot of animals.

Amelia Poole:

It was a lot.

Lou Northway:

And then I broke down the data and looked at specifics. And from that though, quite a lot of key learning outcomes. I think the main thing that stood out for me was that at the time of doing the audit, we had very limited monitoring equipment. But of those that had the advanced monitoring equipment, complications were encountered more often than those that did not have any advanced monitoring equipment, because there are some things we simply cannot know. So basically I thought, "Well, if we've got this big pool of patients," and more specifically actually cats often that we were having more complications with, that were having problems like hypotension for example, how about all those ones that weren't having advanced monitoring? Because it's very likely that they too probably were hypotensive or were hypoventilating, but without my advanced monitoring I wouldn't know.

So that gave me quite a strong case to my bosses to request more monitoring equipment, because it seemed bizarre that we would have to prioritize which patient had which bit of kit. I would say that this is still a work in progress in my practice. We're literally at the point now where at Christmas this year, Santa Claus is bringing me a lot of new equipment. So yeah, but you have to really sort of look at how you're doing. And yeah, but the anesthesia one was really eye-opening. Other things as well, drug associations; there are certain pre-med combinations we were finding we would have more instances of hypotension, so certain drugs that were vasodilating our cats. I'll say no more there. So we've adapted and changed our protocols, and since doing that we've had far less problems, so yeah, lots of positives to take from that.

There were some things that weren't so much of an issue, so post-op temperatures in our dogs and cats was actually really good. But the girls were already ... Well, you know what I'm like about

temperatures. They were already on it. They're good at making sure the patients are kept nice and warm. So yeah, but do you want me to talk about how I got to submitting my work?

Amelia Poole:

Yes.

Lou Northway:

Yes?

Amelia Poole:

So, why did you decide to apply for the Knowledge Awards?

Lou Northway:

Yeah, so if I'm honest, to begin with, I hadn't really hard of Knowledge Awards. My practice manager gave me a little nudge and said, "Oh, Lou, you should think about submitting your work here." I was like, "Oh, all right then," so I did. Lo and behold, a few weeks later they were like, "Oh, we really like your work. You're going to be a Knowledge Champion." I was like, "Oh my gosh, really?" But it was a lot of work, like hours and hours and hours of work. But we made some really positive changes that have had a long-term impact from doing it, so it was totally absolutely worth it.

Amelia Poole:

Yeah, so Knowledge Awards is still open for this year. I've got a little flyer right here, if you can see that. But again, I will post a link to it. So really, the Knowledge Awards just basically celebrates any sort of quality improvement in practice. I know we're specifically talking about clinical audit at the moment, but it celebrates guidelines and checklists, benchmarking, anything where you have used quality improvement to make an improvement. So we would really encourage everyone to apply for the Knowledge Awards, and you don't have to have been doing clinical audit for six million years to apply. You could have just started out and apply. Everyone gets feedback on their quality improvement initiative, whether they are successful to the final or not, so I think it's worth it for everyone just to get involved, and just to be able to see how they're doing, really. And like Lou says, it's really opened their eyes on how they're doing and what they're doing. I think it sounds like everyone is working together a bit more?

Lou Northway:

Yeah. Yeah, absolutely. I think everyone's a little bit more aware and sort of reviewing what we're doing, because we are reviewing what we're doing every single day. I think that's the important thing. We sometimes become a little bit complacent, I think, day to day in practice. Especially when you're very protocol-driven, you're doing a task, just do, do, do. You're doing it, but we need to keep stopping and thinking about, "Is this working? Can this be improved?" And yeah, do an audit.

Amelia Poole:

Yeah. So along those lines, another question that we were asked was, "How do you get the whole team engaged with clinical audit?" So, did you come across any problems getting the team engaged?

Lou Northway:

Yeah, I think initially it was a bit like, "Oh, we're doing fine." Like, "We're doing fine. We don't need to. We're not having any problems. Patients aren't dying." And then, that was true. Patients weren't dying. That's great. That's what we want, but quality improvement and clinical audits say much more than just looking at patient deaths. It's improving outcomes, improving patient experience and all

client experience, depending on what you're looking at. So I'm not going to deny, there was a little bit of resistance at first. But once sort of the feedback was coming back to the team, "So this month we had this many complications," they're like, "Really?" And they're like, "Complication?" Because automatically everyone's ears light up ... Not ears light up. Don't know where that's coming from. But you know-

Amelia Poole:

It works. It works.

Lou Northway:

Everyone thinks, "A complication? Oh my gosh, we're having complications?" But yeah, 10 out of the 30 dog castrates this month licked their wounds because their owners didn't think the Buster collars were important. So should we have a look at some other patient experience prevention methods, like medical pet shirts, things like that? Possibly, yes. But then once, yeah, they wanted to know what the statistics were. So each month when the results come through, everyone's quite interested now. I think that really helps, because nobody wants month to month things to get worse. We only want them to get better. And when some months we do have results which are not as good as the previous months, then it's like, "Well, what's different this month? What have we done differently? Is it us, or is it the environment?"

Or in the summer months for example, I think a pet owner is less likely to rest their dog after they've been castrated, because they just want to get outside in the nice weather and exercise again. But in the winter months, sat on the sofa in front of the fire with your dog that's just been castrated is much more appealing. So we forget that you have to think like a pet owner as well as a veterinary professional, but some of the factors are out of your hands, as you were saying earlier. But that might explain why your statistics this month aren't as good, but yeah.

Amelia Poole:

Yeah. I think a key way to keep the team engaged as well is to try and avoid blame wherever possible. Especially in some of the practices that I worked, it's so easy to just be like, "Oh, that person didn't do that, so that's why the dog's having a bad recovery." When in fact it's probably a little bit of absolutely everything else that's going on, and it's not going to help anyone if you have a blame culture like that. And so keep everyone engaged by explaining why you want to look into postoperative temperatures. It's not because you're trying to kind of ... It's not because you're on a witch hunt. It's not because you want to show up anyone. It's because you want it to be improved for the patient. I think when people realize it's not going to be a bit of a blame game or a witch hunt, they are more likely to kind of get involved and crack on.

Lou Northway:

Yeah, I think that the wording when you talk to your team is really important as well. So it's not I or you, it's we. I think we is really important, like collective, like what we're doing with audits and patient care is a we game. It's not what you're doing or I'm doing. It's what we're all doing, and I think that's the whole point of it really, getting everybody on board.

Amelia Poole:

Sorry, I was just concentrating on some of the questions that have come in. So the first one-

Lou Northway:

That's a good one.

Amelia Poole:

I think is really interesting. So, "I would like to do an audit on lap spays versus bitch spays in terms of whether it is or isn't less painful like it claims to be. I guess I would need to do everything from what they are pre-medicated with, to pain scores on recovery. Any tips?"

Lou Northway:

Yeah, that's a really good one, Kim, actually. Because I have done an audit like this in my practice, many years ago now, comparing buprenorphine pre-meds to methadone pre-meds with ACP or medetomidine. Because there were some papers that came out years ago, I think it was Shah et al. who found that methadone was a superior analgesic to buprenorphine in bitches. So I brought this to my team, and at the time we had vets which were still very much, "Buprenorphine, yes please," and others that were, "Methadone, yes please." So we did two groups, so one set of dogs ... Well, I think it was about 10 bitches that had buprenorphine and ACP or medetomidine pre-meds, and then the other group had methadone, medetomidine or ACP pre-meds.

And then it was how many required rescue analgesia during, and also we pain scored them on recovery. Unsurprisingly, the results of that audit concluded what Shah et al. had found. So therefore we made a protocol change and decided that that was from now on what was going to happen. So I think what you should do is exactly what you've already written in your question. So, do an identical audit but just change your pre-med protocols so you're looking intraoperatively. How many of the dogs needed rescue analgesia, and then pain score them on recovery. And then do a compare and contrast at the end of your set amount of dogs, so I'd probably try and do an equal sample size, so maybe 15 dogs of each or something like that. But I think that would be a really interesting one to look at.

Amelia Poole:

Yeah, that sounds really interesting.

Lou Northway:

Yeah, really good.

Amelia Poole:

And so the next one is, "I'm thinking about doing an audit about using the Glasgow Pain score to monitor postoperative pain. I am thinking about recording pre, peri analgesia use, route administered and dose given. Do you think this is a good idea for an audit?" Yes, I think it's an amazing idea for an audit.

Lou Northway:

Yeah, really good audit, yeah.

Amelia Poole:

"And should I be recording other things?" I don't think you want to get too complicated.

Lou Northway:

Yeah, keep it simple.

Amelia Poole:

I think if you're going to concentrate on pain scoring, then what you're doing with pre, perioperative and post-op pain and analgesia is a really good idea. Maybe once you get a couple of results and you

think you want to look into other things like ... My brain's gone blank. Can't think of other things at the moment, but I think keep it simple. Initially, just audit your pain scoring and go from there, and expand it as you want.

Lou Northway:

Yeah, absolutely. I think that would be a really good one to do. But again, you could look at ... So for example, there's more papers out. There is Ward *et al*, who looked at the analgesics used for cat neutering, so buprenorphine versus butorphanol in cat castrates and cat spays, and again found that buprenorphine was much better than butorphanol. So if you're in a practice that's still using triple combinations of butorphanol, then why don't you speak to your vets about doing triple combinations but with buprenorphine instead, and then just see what their recoveries were like. Were they better? Were they any different, no different? And just look for the evidence yourself, because we have more new evidence out there but sometimes we do have to see it for ourselves as well, I find, to make change in practice.

Amelia Poole:

And also, I think this is a good one just because we've been talking about multiparameters and capnographs, someone's been asking for a multiparameter or capnograph but no luck, and she wishes she could persuade her work.

Lou Northway:

Just keep trying. It took me years. It really did, and I think it's because they are expensive. They're much cheaper than they used to be, but they are still a lot of money. So I think the best thing you can do is to book someone like ... Am I allowed to say that on here or not? Probably shouldn't.

Amelia Poole:

Probably shouldn't.

Lou Northway:

But find a company which provide anesthesia training in practice. Get them to come to your practice with a monitor, and show your team all that you can learn from your monitor. That is what you need, because then you'll see just how much you don't know and how much you could know, and then hopefully they'll be more obliging to buying you one for Christmas.

Amelia Poole:

I think also perhaps you could do an audit of those patients that you feel would really benefit from a multiparameter or a capnograph, or those times where say it's really busy. You're only one nurse. You're only one person, and you're trying to get temperature or blood pressure. You're trying to monitor the anesthetic, and you're trying to open things for the surgeon at the same time. Actually record how many times you find yourself doing that, and say that it could be a time saver. That in itself is a bit an audit. And while we're talking about general anesthetics and kind of multiparameters and capnographs, I am going to plug the Surgical Safety Checklist here, because I love a checklist.

Lou Northway:

So do I.

Amelia Poole:

So the Surgical Safety Checklist was initially obviously done in human medicine. It's the World Health Organization checklist, so just by using a small, tiny piece of paper before each surgery, they managed to reduce deaths by 47%.

Lou Northway:

Amazing.

Amelia Poole:

They reduced postop complications by 36%, and their general infections fell by 48%. 93% of surgeons said that they would want it used on themselves if they were having surgery. So I think if you can't persuade people to get kind of multiparameters or capnographs, then absolutely get a Surgical Safety Checklist in place. Because in the meantime, that will help you have a look at your anesthetics, have a look at your surgery, and generally just make all of your surgeries safer than before. And it's only a little piece of paper, and that doesn't cost anything, really. It's another great idea to audit, is your Surgical Safety Checklist. Are they working? Are they being filled out and-

Lou Northway:

Yes. Are they being filled out?

Amelia Poole:

Yes.

Lou Northway:

That's a really good one to look at, I can tell you, because that's one that I've looked at as well. That's definitely a work in progress. The problem is I think sometimes when you have clinical forms, you want to record so much information, or I find I do. I put loads of boxes on and then the girls are like, "No, that's so many boxes to fill out." But it's all about planning. You should never be rushed. You should have time to complete applicable forms. And moving on, alongside what Amelia was just saying about the Surgical Safety Checklist, the Association of Veterinary Anesthetists have the anesthesia safety checklists, which are free to download as well, and they're fantastic.

That runs you through all of your equipment checks, your patient checks, that you've got consent, that you've discussed the possible things that might happen during. Also, that you've planned for the recovery period, because that is the most important part of the whole procedure. Statistically, your patients are most likely to die in the recovery period. So I know when the vaporizer goes off you think, "Ah, it's done. It's over. Woo hoo, tea break." But no, now the work really starts, because so the recovery period is when we should really be watching them.

Amelia Poole:

And again, with anesthesia machine checklists, another great audit. My goodness, my words today are awful.

Lou Northway:

That's what happens when you go live.

Amelia Poole:

I know. I can't believe it. I just literally cannot say the right word. What I'm trying to say is, it's a great idea for audit, are all of your anesthetic machines being checked beforehand or are they just being checked once a day, or are they just not being checked at all? Again, that's something really simple.

It's really easy, and something that can improve your patient outcomes and save lives. We've had another really interesting question come in. Sorry while we all stare at the screen for a bit.

Lou Northway:

I'll read it quickly. That's a good one, yeah.

Amelia Poole:

That is a good one, so-

Lou Northway:

Yeah, another good suggestion, yeah.

Amelia Poole:

"I'd like to do a regurgitation audit looking into breeds, if omeprazole was used prior to GA. The hardest aspect is finding out when they last ate to determine if they've been starved for too long/too little. But the vets normally admit as they work in referral, and owners aren't always honest."

Lou Northway:

Aren't always honest, hmm. I think that's really hard to say if the owners aren't honest. But I think if it's just part of the admission process so, "When did the patient last eat a good meal?" Or well, even a small meal, depending on what the protocol of your practice says. Just putting it on the GA sheet, and you have to work from that. So yes, I know owners can't be honest, but it's not like you can put a lie detector on them and you know they're-

Amelia Poole:

No, but is there a way that you can ask the question? So owners always-

Lou Northway:

Yeah, maybe the wording.

Amelia Poole:

Yeah, owners always want to say what they think you want to hear. So I wonder if there's just another way of wording it like, "When is your dog's normal dinner time?" Or something like that, since-

Lou Northway:

Yeah, "Did he have it at that time last night?"

Amelia Poole:

Yeah, "Did he have any snacks?"

Lou Northway:

Or, "Did he have a bedtime snack?"

Amelia Poole:

And things like that. But I think the actual idea of that audit, seeing if they have omeprazole and they regurg, or if they don't have omeprazole and they don't regurg, or the other way around, is again really interesting and can be used with a bit of research as well, again just to make your patients-

Lou Northway:

Yeah, that would be a really good one, yeah.

Amelia Poole:

A lot happier, and so I think that's a really good one, yeah.

Lou Northway:

A really good one, and also you could write that up. I think a lot of people would be really interested to read the findings of that audit.

Amelia Poole:

And clinical audits, once they are written up, can also be published in Veterinary Evidence, which is the journal at RCVS Knowledge. And so all of these amazing audits, you can get published with Veterinary Evidence as well. So obviously we are saving patient lives, but if that's just a little extra, little tick of something that you feel like you want to do ...

Lou Northway:

And actually, that's a really good comment just came on here by Steve Smith about ways to convince your practice to purchase multiparameter monitoring is as Steve has written, which is correct. If you use a capnograph, you can titrate down your oxygen and often you can use much less than what you calculate. So as long as they're not rebreathing and you're delivering their metabolic oxygen requirement, yeah, you can get away with using a lot less oxygen than what you calculate. So that will save, as Steve has written, he is a mathematician. He's a friend of mine as well, and he's probably right here ... 2,000 to 3,000 pounds a year. At 2,000 to 3,000 pounds, the monitor will pay for itself in a year, just from saving oxygen. So yeah, thanks for that, Steve. That's really helpful.

Amelia Poole:

Again, I think that's a great audit topic as well is-

Lou Northway:

Audit that, yeah. How much money can you save, yeah?

Amelia Poole:

Also, just are your patients going on two and two, or are you-

Lou Northway:

I hope not.

Amelia Poole:

Actually working out your flow rates? And again, it's not a blame game. Some people would have been taught that two and two is absolutely fine for everything. It's just making sure that everyone is working to the same outcomes, which is improving your patient outcomes.

Lou Northway:

Yeah, some really, really good questions. So yeah, I think yeah, as Amelia said, it's not a blame game. It's not, "Oh gosh, two and two. Never changing that." I mean yeah, sometimes obviously even if I'm in a rush I might just ... I will do that occasionally. But you have to make an effort to think, "Oh, actually what am I doing? Am I doing this correctly? Can I do it better? Yes you can, Lou. Let's have a look, shall we?" And yeah, so it's just taking an effort. Keeping patients warm takes effort. Calculating your fresh gas flow rate takes effort. Getting all your wires around the right way for your multiparameter monitor takes effort. But that's what we're doing, isn't it? So really, we have so much responsibility, we should be working hard to do our best.

Amelia Poole:

So we've got a couple of other questions that have come in. Oh, I feel like a game show host. So one of them is really good. So, "How do you implement standards, for example how do you communicate them to the team?"

Lou Northway:

Yes, so standards change often because of suboptimal audit results. That's the way I'm going to put it. So we'll have a look at evidence-based medicine or whatever it is that we're looking at. We'll then have a chat about it. We'll come up with a protocol. We'll implement it. We'll talk about it. Sometimes with the introduction of a new protocol, there is a whole lot of education that needs to come with it. So for example, let's just throw it out there. v-gel's supraglottic airway devices in rabbits; if you haven't used a v-gel before, it's a very different concept to using an endotracheal tube.

Amelia Poole:

Shouldn't use the brand name.

Lou Northway:

Sorry, yeah, yeah. Oops, we're live. Yes, if you haven't used a supraglottic airway device before, they're very different to using an endotracheal tube. So you might want to get some trained professional in to show your team how to use them, rather than just ordering them in and then expecting your team to use them without any training. The same goes for a new breathing system, or let's think of new drugs. "Oh, we're changing our drug protocol, and you're going to be using this now." Well, is anyone going to communicate sort of what's to be expected? What are the positive effects? What are the adverse effects? So training has to come alongside protocol change.

It's not just what we're changing. We have to be explaining to our teams why, and I think that's the key point. And also allowing feedback, so one thing that has been a learning curve for me is I'm an ideas person. I get something in my head and I want to do it. To start with, I used to be like, "Oh, why doesn't everyone else want to do this? It just makes sense to me. Why not?" Well actually, you do have to stop and think that everyone is very different, and some people are more open to change than others, and change does have to happen slowly. So yeah, get everyone involved. Get feedback. Work with them, and yeah.

Amelia Poole:

Yeah, I would pretty much say exactly the same thing. I know nobody likes to hear the hold a meeting phrase, but holding a meeting is actually ideal. It doesn't need to be-

Lou Northway:

Team chat.

Amelia Poole:

Incredibly formal. You can get pizza in.

Lou Northway:

Yeah, that always helps.

Amelia Poole:

It always helps. A bit of bribery always helps. And it doesn't even need to be long. Like if you are deciding that you are let's say changing your pre-med drugs, then you just need to explain why you're doing that. Other people might have more suggestions, and it's important to listen to them. So the people that know best are often the people who are working on the ground floor, so if you are thinking of ways to improve your client waiting times, then speak to your reception team because they see the clients all the time. They've probably got a better idea, so a real group chat is the best way to do it. If people help to come up with the ideas, they're more likely to engage with them and get involved, so it's all about just talking to each other.

Lou Northway:

Yeah, absolutely. That is it. I think taking the formal bit away is really important. I'd much rather have just like a team chat, and almost like a bit of a social sort of, tell everyone or say, "What do you think about this? We might try this for a while, see how we get on. We'll change back if we don't have any positive improvements with doing it this way." And I would say, no change is forever as well. I think that makes things less scary if you think like, "You can always change it back again, but we're just going to see if this is better. It might not be, but ..."

Amelia Poole:

Yeah, and that's the good thing about quality improvement really, is that it's continuous. So you might do an audit. You might make a little change, and the next audit you do shows that it hasn't worked or hasn't helped. That's absolutely fine. You've tried something. It hasn't worked out. Figure out why it hasn't worked out. It could be that you haven't given it enough time. It could be that it was the wrong decision to make anyway, but it's all trial and error. So nobody can get it right absolutely the first time, and even if you do get it right the first time, life goes on. So you've continuously got to audit just to double-check that things are staying the right way. Like you said, you get different post-op complications in winter as you do summer, so everything is going to change. So continually checking up on yourself and admitting that, nobody's perfect. Nothing goes perfectly all the time, and that's just a part of life.

Lou Northway:

I wish it did. Every month I'm hoping I'm going to have 100% no complication rate, but it never happens. I think it never will, because it's life, but-

Amelia Poole:

I think with animals, you can't. You can't ever control what an animal does, and that's why we like them. That's why we got into this job, so that unpredictability is something we're just going to have to work around.

Lou Northway:

It is. But you'll find when you're in practice and you start looking at things you'll be like, "Oh, I could look at that," and, "Oh, I might look at this," and, "Oh, I think I will look at that." And then you'll have like five audits on the go, or yeah.

Amelia Poole:

Yeah. That's another key thing to keep your team engaged, is not to over-complicate things. So, don't start off with five audits all at once, just because some people might be a bit bogged down with it all. Baby steps, absolutely all the time, just to see how things go.

Lou Northway:

I think temperatures, everyone. If that's one thing you take away from tonight, I want you to all start doing postop temperature audit as of tomorrow, and then do it through the winter, and then do it through the summer as well. You'll just see the differences month to month, and yeah, it's so interesting.

Amelia Poole:

Actually for the whole of November, we have a clinical audit challenge going on.

Lou Northway:

Whew.

Amelia Poole:

So we are challenging you. Actually what is much better is the poster of this beautiful little dog. And so you can download this on the RCVS Knowledge website, or you can steal it from Facebook. It doesn't really matter where you get it from. But we are challenging everyone to have a look at our resources, have a sit-down with your team, and just decide on an audit. Decide on a topic. You don't even have to do the audit this month, as long as you sit down with your team and decide it. Get a plan for what you're going to do. So I'm hoping after today, I'm going to see a lot of these with postop temperatures written right there.

Lou Northway:

Yes. It will make me really happy. Yeah, send your pictures in, or we want to see the pictures, what you're going to audit written right there, with all of your team sat around it. Send it in. We want to see.

Amelia Poole:

Yeah, we'd love to see it. And this isn't a check-up. We're just genuinely interested as to what people are going to audit, and we just want to get people talking about how to make improvements with patient care.

Lou Northway:

Yeah, absolutely. And those of you that are already auditing as we speak, and you're just being nosy tonight being here, because you know what you're doing already, share with everybody what you're looking at, what you're finding, what your results are, with the consent of your practice as well. Because I think it means a lot more when nurses share to other nurses what they're finding, and it inspires other people, so go for it.

Amelia Poole:

And so one of the last questions we have is, "How can I approach my practice manager about taking a more leading role?"

Lou Northway:

Yes, well, I would really recommend you do what I did. If you find that you are taking sort of more of a leadership role in practice, so I have a head nurse, Mike, he's lovely. He also actually ... Oh, let me just ... Oh, I've just knocked the mic. He owns one of these. He's actually got two of these. These are not his ladies, but I just thought he'd like that.

Amelia Poole:

Yes, we'll push that.

Lou Northway:

Mike, here's your ladies. So I work alongside my head nurse. I'm clinical lead in my practice, and so my job is to look at clinical standards, to the audits, and bits and pieces like that. Anyway, to start with when I started doing all of these things, I didn't really have a title. I thought, "Do you know what? I think I should have one, because I'm doing loads." I went to my practice manager, explained just that, and that was when I was given my title.

I have a role now, and the team know that my job is to be nosy. They know that it is my job to do the surveillance, just have a review all the time, "Why are we doing it that way?" I ask lots of questions, and that is my job role, and it has just helped, yeah, just clarity in the team. They know that I'm not just being a nosy Nora, and it's my job to sort of see what we're all doing. So I would say, go for it. If you find that you're sort of falling into that role, then just put yourself forward. Because sometimes, it depends where you work, unless you ask you don't get, so go and ask.

Amelia Poole:

And it could be that your practice manager is just sitting there thinking, "Oh, I wish. I wish I could delegate this to someone that has got time for it, that is passionate about it." And it seems to be a running theme throughout this evening, is communication and just talking. If it's something that you're passionate about, then your passion will shine through, so go for it.

Lou Northway:

Yeah, absolutely. Go for it.

Amelia Poole:

Right, I'm just having a look at all of our bits and pieces.

Lou Northway:

Does anybody else have any questions that they wanted to fire onto the screen right now whilst we're staring?

Amelia Poole:

I'm actually going to have a sip of tea while we're waiting for that.

Lou Northway:

Oh, I just moved it back. So Shelly O'Brien said, "You did your dissertation on hypothermia. Interesting. I'll be quite interested to know the findings of that if you'd like to share them with me. I love having a read of people's work. I find it so interesting."

Amelia Poole:

If anyone has done any audits in practice that they think are particularly interesting ... I mean they're going to be, because they're audits; always interesting.

Lou Northway:

Always interesting.

Amelia Poole:

Then we do also ... Well, we always want more case examples for our website. The case examples we use to encourage other people to get involved in quality improvement, we share them around and it's great. So if you've got a story, share it with us. It can be anonymous if you like, so you can change names. You can make up a practice and put it in there if you'd rather not have names or anything like that. Just go on to our website and give us an email, and I'm happy to chat it through with anyone who might be interested in submitting a case example to us.

Lou Northway:

And then in a couple of weeks' time, we have Clinical Audit Awareness Week.

Amelia Poole:

It's going to be a good week.

Lou Northway:

So that's starting. It's already starting. We've put in so much preparation for it. So on the 25th, it's Monday the 25th of November that it starts. Over the course of Clinical Audit Awareness Week ... It's quite a mouthful, isn't it?

Amelia Poole:

Yeah.

Lou Northway:

I'm going to be sharing lots of the results of my audits from within my practice, with the consent of my practice. I really want to just show you all of the different things really that I've found with them. So I'm going to share with you some of the complications and you might be, "Gosh, Lou, that's brave." But I've got nothing to hide. We can proudly say that we've improved our clinical outcomes. But I think it will really sort of resonate with some of you, just the types of things that we encounter month to month. So keep your eyes peeled for that, and over the course of the week ... Actually, it's going to be a little bit longer than a week, so I've made loads of posts.

Amelia Poole:

We've kind of strung it across the back half of November, because-

Lou Northway:

Into Christmas. We just keep going until Christmas, basically. Yeah, lots of different things to think about. I'm going to talk about some of the significant event audits we've done as well, so sadder situations that we've managed better because of the way in which it's being handled. And yeah, lots of food for thought, so I'm really excited on sharing all of that.

Amelia Poole:

So shall we quickly mention significant event audits, for those that might not know what a significant event audit is? So if something happens in practice, obviously a significant event, but it can be ... Not that it can't be something bad, but if something less desirable happens or something great happens. Then it's where a team get together and discuss all the factors that may have led to that particular

event happening, so that you can either put processes in place to prevent it happening again, or you can put processes in place to make sure that the outcome happens again. We've got a good case example on our website about a practice that did CPCR on a patient that crashed off surgery, and although the patient didn't make it, they did a significant event audit.

They looked at everything that happened, and found out that the team did absolutely everything they possibly could, and that they were really proud of the processes that they had in place. Although it wasn't successful this time, it was a great help for the team to actually kind of process what had happened, and get over what happened. So I think significant event audits are really important in practice. I don't know if anyone's seen the latest Vet Times articles, but we are publishing a lot of significant event audit case examples in Vet Times, for people to have a read, to have a look at. It doesn't need to be something bad that happened. It can be a near miss. It can be something great that happens. It's just a way to get you all talking about the processes that made the event happen, and I think they're a really good idea.

Lou Northway:

Yeah, I love them, too. I think they're really, really good. At first when you think ... When you first hear significant event audit it sounds, da, da, da, really dramatic, doesn't it? I always think that, even now. Even now, I know now it's not like that at all, but yeah. I view them more like a debrief, so it's a chat through with your team. To be honest, the only significant event audits I've done in my practice have been for times when things haven't gone to play, or we've had something sad happen. We haven't done any sort of like woo-hoo moments, per se. But they have really helped.

Amelia Poole:

I think that would be an aim for you then is to do more positive-

Lou Northway:

Yeah, to do some woo-hoo significant event audits, yeah, definitely. Yeah, I'm going to share something very briefly. Last year we had a sad case, and the team members at the time when it happened were really upset. It was in the afternoon, to the point where they were just mortified, so upset by what happened. We said to one of the members of staff, "Do you want to go home? Do you want to stay?" And the member of staff turned to her and said, "If I go home now, I don't know if I'll come back." As in, they were so upset by what had just happened that it could have changed whether they wanted to come back to work again.

I thought, "Oh my gosh, this is, well, so significant." So at this point we had a debrief, and afterwards that person said, "Oh, I'm so glad we did this. It made such a difference." Because unless we talk about these events happening at the time, you know what we all do. We go home. We go into self-destruct mode, what I could have done. "I should have done this. Why didn't I do that?" This exercise stops you doing that. It helps you work through the problems together, or sometimes it's nothing that ... You may not have been able to do anything differently, but it helps you all sort of look at the situation. So I'm a big fan, and I think they're really, really good. I would encourage everybody to do it.

Amelia Poole:

Yeah, there are lots of situations when I was still nursing that I look back on and think, "I wish I had done a significant event audit," because it probably would have helped me get over the event a bit better. Especially when you work in kind of emergencies and out-of-hours, I think that's really important just to process. Just to process your thoughts about it really, but also in normal daytime practice, too. So I don't think we have any further questions from anyone. Nothing has come through, so if you do want to ask a question to us, now would be your time.

Lou Northway:

Time, yes.

Amelia Poole:

Because we have been yammering on about all this-

Lou Northway:

55 minutes-

Amelia Poole:

For 55 minutes.

Lou Northway:

And 30 seconds. It goes so fast, doesn't it?

Amelia Poole:

Time flies when you're having fun, yes.

Lou Northway:

Yeah, it goes so fast.

Amelia Poole:

So if you do have any questions, now is your time. I don't know what your takeaways from today are, but I think they should be exactly what Lou said. Go back to your practice.

Lou Northway:

Chat it out, yes.

Amelia Poole:

Have a talk about it, and postoperative temperatures is a great idea. Any idea for clinical audit is a great idea. Even if after this chat you are still a bit like, "Oh, I don't know what to do. I don't understand," then go onto our website. Have a look at free CPD course about clinical audits. We've got case examples. We've got a walk-through. The walk-through is really handy. You can print it off and stick it up on the wall. It's all very pretty, and you can know exactly what you're doing at what point. If you are just really genuinely confused, then get in touch with our RCVS Knowledge, either through social or give us an email, and we can advise you kind of where to go from there.

Lou Northway:

Yeah, and RCVS Knowledge are really, really helpful. So since I've been doing it, I message Amelia all the time. I'm like a bad smell. I just don't go away now. They've helped me so much with lots of things, so I'm going to be sharing some work that Amelia has helped me with, during Clinical Audit Awareness Week. Hopefully, that will give you even more inspiration as to what you can do in practice. But the practice really is your oyster when it comes to audits. There we go. There's a new tagline.

Amelia Poole:

The practice is your oyster.

Lou Northway:

The practice is your oyster-

Amelia Poole:

Absolutely.

Lou Northway:

When it comes to audits, so yes. And perhaps, maybe following the thread tonight, you can write down below your two take-homes.

Amelia Poole:

Oooh that would be good

Lou Northway:

And then if you do some reflective comments, you could claim this whole hour as CPD on your PDR record. How awesome is that?

Amelia Poole:

Absolutely, so some take-home messages and reflective comments, and you guys have got an hour's CPD on clinical governance in practice.

Lou Northway:

Yay.

Amelia Poole:

Also, so just keep an eye on RCVS Knowledge over the next coming weeks. We are celebrating Clinical Audit Awareness Week for the whole month of November, so we're going to be sharing a load of useful tips for you, interesting case examples, a load of information about the Knowledge Awards. I hope a lot of you do think about applying, because it sounds like what your ideas are and what you are doing in practice are really interesting.

Lou Northway:

Really good, yeah.

Amelia Poole:

And I think a lot of you have got great ideas. You just don't have the confidence to know that they're great ideas, so I want you all to know, they're amazing ideas and I would love to read about every single one of them.

Lou Northway:

Yeah, and just find your way. If you don't end up using any of the templates that are available, but you sort of find your own way, that's all cool, too. So to start with, I did have the vet audit access but there's been some others that I've just sort of meandered my way through to get the results that I was looking for. Or sorry, that's not worded right, but looking for results. There are other ways of doing it as well, so just like don't be scared of looking for what you're looking for. Just go looking.

Amelia Poole:

Yeah, that's it. That's it, really. Oh, we have-

Lou Northway:

Well, my mug's empty now.

Amelia Poole:

Oh, my goodness. Okay, we've got a really good comment. "Significant event audits don't have to be just about clinical things. Anything that affects the practice; lab samples that don't get sent away."

Lou Northway:

Oh, that's a good one. Oh yeah, that's a really good one, yes.

Amelia Poole:

That is a really good one, and absolutely one that I think brings a lot of inadvertent blame. Everyone's just like, "Oh, they didn't do it," or, "They didn't do it," or, "They didn't tell me to do that." Well, why don't you have a look? Because if a lab sample didn't get sent away, it might be because it was really busy. And why was it really busy? Maybe someone called in sick. It could just be a whole different factor that you haven't thought about, and so thank you, Pam, for that reminder.

Lou Northway:

Yeah, that's a really good suggestion, yeah.

Amelia Poole:

It doesn't have to be about the clinical things. And actually to get involved in audit and significant event audits, you don't have to be a nurse or a vet. You can be upstairs in the offices. You can be on the front desk. Anything that you think you can look at to see if you can improve your practice, you can get involved in. You don't have to be an RVN or a veterinary surgeon to get involved, not at all.

Lou Northway:

Everybody should be getting involved, everybody. It doesn't matter your job role. Audits are for everybody. If we work in a practice collectively as a team, the team should be doing this collectively. So yeah, for example I do share the results of our audits with our client care team. So they find it all very interesting as well, and so they should. They sometimes have suggestions too. "Oh well actually, Lou, some of these dogs haven't been going home with Buster collars." So they can see why things may not be going that great as well, so everyone's input is welcome.

Amelia Poole:

Yeah, absolutely. So, now that we've given you your full hour's of

Lou Northway:

Yes, claim an hour of CPD.

Amelia Poole:

One claimable hour. Sorry, I'm just reading this last comment that's come in.

Lou Northway:

"We would like to do one on nurse consults, actually make clients more aware of what nurses can do front of house." So yeah, I mean I guess you could do almost like a questionnaire type audit, couldn't you, for awareness on there from the client perspective? Or, "I'd like to do one on nurse consults, actually."

Amelia Poole:

You could audit what you do in nurse consults, to get kind of percentages of ... Sorry, the explanation's gone out of my head. But for example, then you can say to clients, "Actually, 50% of nurse consults are blood pressure monitoring consults and 72% are blood tests and things like that." So that they are aware of what happens when a nurse comes out, and actually that they're worth their time.

Lou Northway:

Or you could maybe audit, like if you had a campaign coming up, say dental awareness month, how many pets did you see? How was that month different to previous months? You can just ... Yeah, gosh, my brain's going off. It's like fireworks are going off up here.

Amelia Poole:

It's like, "Oh, I can't read them." And someone else has also said, "I would do a checklist completion audit," yay.

Lou Northway:

Woot.

Amelia Poole:

"And an audit to see how often TPRs are done on hospitalized inpatients."

Lou Northway:

Mm-hmm (affirmative), that's a really good one.

Amelia Poole:

Oh, I'm a medical girl myself. Yes, love that one. That would also be really interesting.

Lou Northway:

Oh, another one; just thought of another one.

Amelia Poole:

Yeah?

Lou Northway:

How about phlebitis scoring?

Amelia Poole:

Yes.

Lou Northway:

So when we undress and re-dress IV catheters every day. So back in the December 2018 article in the VN, Vet Nurse Journal, there was a brilliant article written by an RVN about phlebitis scoring. She-

Lou Northway:

Actually, that's on the website on as well, isn't it?

Amelia Poole:

Yes, so-

Lou Northway:

Yes, that's lovely, and that's a good read.

Amelia Poole:

The lovely nurse that did that, and that came up with the Ward phlebitis score, actually helped us with our IV checklist. I guess it was about two months ago it was published now, so we have an IV checklist and phlebitis score. So introducing that into your practice, and then you're auditing about whether it's improved things, is another great one and great for patient care as well. Because there's nothing worse than a fat foot or a sore IV leg, and I know as a nurse it used to make me feel awful if I came in and saw an animal with a fat foot. So anything that I could have done to prevent that was always good, and that would be a really interesting topic. Actually, I hope the next year's Knowledge Awards, once you've all done these audits, you're going to submit them, because I really want to know what they're all about.

Lou Northway:

Yeah, it's going to be great.

Amelia Poole:

Yeah, absolutely. So oh, we're getting more.

Lou Northway:

Bandage scoring too, yeah, that's a really good-

Amelia Poole:

Oh yeah, yes. Sorry.

Lou Northway:

Yeah, brilliant. Really good. The screen's going so fast, it's hard to keep up. Yeah, bandage scoring is a really good one. So yeah, whether your bandages are staying on, yeah.

Amelia Poole:

Yeah, so-

Lou Northway:

I'm going blank.

Amelia Poole:

This is one going for ... "Definitely going to look at the post-op temperatures to start off with. They've put lots of changes and protocols in place, so it would be good to look into how things are hopefully changed for the better." Yes, absolutely. That's what audit is all about, is changing for the better. And you have a really good line that you use, that you probably can't think of now because I've just mentioned it.

Lou Northway:

And what sense?

Amelia Poole:

In what sense? Something like, you can always ... You can always do better.

Lou Northway:

Yeah. Even if you're doing good, make it better. Make it even better. Aim for even better. That's it. There you go, there.

Amelia Poole:

Sorry. You can tell our tea is running dry now.

Lou Northway:

Yeah. Even if you're doing good, you can make it even better. That is true all the time.

Amelia Poole:

Absolutely. So I think we are going to sign off now. Thank you everyone for tuning in to listen to a full hour on clinical audit. Hopefully we have inspired you to get started.

Lou Northway:

I hope so, yeah.

Amelia Poole:

Remember to get in touch with your audit topics. Have a look at our website and download all of the things. And thank you to Lou for taking over for a Tuesday Teatime Takeover.

Lou Northway:

Taking over for an hour, and I didn't swear or say anything inappropriate, I don't think. Woo, thank God. I was so worried. But yeah, great. Yeah, thanks everyone for tuning in. Yeah, I do hope you were really inspired, and look forward to reading what you're all going to be auditing. Hopefully lots; well, maybe not. One thing at a time; lots, lots.

Amelia Poole:

Yeah, start steady, start slow, then build up to lots. You don't want to overwhelm people, and you don't want to overwhelm yourself, either.

Lou Northway:

No, you don't.

Amelia Poole:

Right. Oh, thank you, Paul. Thank you for your comment. Lots of brilliant tips.

Lou Northway:

Good, yay.

Amelia Poole:

Thank you for tuning in, and hope you have a lovely firework night. But you guys are probably all sitting at home with your animals, with the Feliway and other pheromone things plugged in. Bye.

Lou Northway:

Bye, everyone.

Amelia Poole:

Bye.

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