QI Boxset: VetSafe Reporting

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

Emma Cathcart, BVMS MRCVS

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 talking to Emma Cathcart. Hi Emma.

Emma Cathcart:

Hi Pam. Thanks for having me.

Pam Mosedale:

Oh, thank you for joining us. Emma is a Veterinary Risk Analyst at VDS. She's a small animal vet and is studying for her master's at Edinburgh University in Human Factors and Patient Safety. So a great person to talk to this about. So Emma, why is it so important that we talk about things that don't go well in practice?

Emma Cathcart:

I think it's important that we talk about those things for two reasons. I think firstly, we need some support. When mistakes happen, it doesn't feel very nice. We've all been there, I know I've been there myself, and it doesn't feel very nice that you feel a lot of self-criticism. You can feel a lot of blame and sort of personal shame, I guess. And so looking for people in your practice that you can trust to talk about it and get some support and reassurance, almost that it's not the only one that it's happened to, you're not alone. So support is one thing, but I think importantly, that learning opportunity, so everything that happens that we don't intend or any mistake that happens is an opportunity to learn something, not just to prevent the same thing from happening again, but perhaps to prevent even other types of mistakes as well.

Pam Mosedale:

Yeah, I think that's so important, isn't it? That we're not just blaming individuals, but we're looking at why these things happen and looking at the systems and doing it in a way that isn't blaming people. And I think it's really good for team morale. If you can take something that's happened that's been fairly negative and turn it into an opportunity to make improvements in the practice, I think that helps with team morale. Do you?

Emma Cathcart:

That's right. I think it shifts that focus away from individuals and perhaps people blaming each other

or people feeling that they're being blamed. It shifts that focus away from the individual and more towards, "Well, what can we all learn to do this better? Or what can we all learn to help each other to not make the same mistake again or not to make other mistakes?"

Pam Mosedale:

And near misses are really important. They really, really good to learn from them as well. When it hasn't actually happened, but that's just by chance that it hasn't happened. But it easily could have done.

Emma Cathcart:

That's right. And near misses often point out the same underlying features of the more serious incidents. So taking time to really look over those near misses and understand why that happened in the first place can again point out things and prevent those more serious incidents from happening.

Pam Mosedale:

So if practices start to do this, they've got to try and do it properly, haven't they? To try and make the situation better. So they presumably need some sort of structure in place to do this.

Emma Cathcart:

I think a structure can help us to shift that focus away from thinking about individual actions and thinking more towards, as you say, the wider system issues of why something happened. Those underlying factors. There's a good quote actually by Sydney Decker who says that human error is a symptom of trouble deeper inside a system. So when things go wrong, we should want to explore and try and understand what else might have been going on. And so having a system or a process, a structured process, to work through to be able to do that, to prompt us to look at what else was going on inside the system, can be a really helpful way to do that and shift that focus away from the individuals.

Pam Mosedale:

Looking for those root causes. Isn't it really? And I think we have some resources at our RCVS Knowledge - free resources around this, and I think you have some at VDS too, don't you?

Emma Cathcart:

That's right. Part of the VetSafe reporting system includes looking at the contributory factors and again, talking about what went wrong can help teams to discover why things went wrong and to be a bit more objective and think about what went wrong in a more objective and bigger picture, holistic way.

Pam Mosedale:

So you mentioned VetSafe, and so that's the way of practices reporting this beyond just their own practice actually trying to get some learning for everybody from it. Is that right?

Emma Cathcart:

Yep. So VetSafe is an incident reporting system. It's available for VDS members and it's a member benefit. It's an online confidential incident reporting system, and it helps practices to better understand their systems, their own local practice systems, how their systems are performing, but also being able to bring data together from the wider profession. We can start to see patterns and trends emerging across the profession and share that learning more widely.

Pam Mosedale:

I think that's really important for all of us, but how will practices actually do this reporting then?

Emma Cathcart:

VetSafe is an online system. If you're a VDS member, you would log into your VetSafe account online. It's a very short, simple reporting form. It's confidential, and it should only take a matter of minutes to complete and it prompts the person entering the report to include details of what happened, but also think about why it happened. So start that process of thinking about why it happened. And then as part of the system, there's a way to view your data and view what's going on in the wider profession within there as well.

Pam Mosedale:

Well, that's great. Because I think it's great and you absolutely must have your local learnings because it could be quite different in individual practices, the causes, but great to report it. So why do you think it's so important for the whole profession to know where the errors mostly happen?

Emma Cathcart:

So as you say, I think it's really important that we know what's going on in our own practices and we can gather and bring that data together to see what types of errors are being made. But looking at the bigger profession, we can start to learn from that big data of maybe where things only happen very infrequently in your own practice, but we see patterns of it happening across the whole profession. So for instance, the bag of hypotonic saline that's given to a cat, it's not something that happens frequently in practice, thankfully, but if we start to see that it's happening consistently across the profession, that might indicate that we need to do something about that.

Pam Mosedale:

Absolutely. And that is, as you say, it might only happen once every 10 years in a practice, but it might be happening to lots of practices that year.

Emma Cathcart:

Yeah.

Pam Mosedale:

So what are the riskiest areas do you think, from... You talked then about something to do with medication, is that one of them? What are the riskiest areas?

Emma Cathcart:

Well, we know that in human healthcare as well, medication error are the most common reported type of incident. And that is the same for the data in the VetSafe system. Within that, the wrong drug and wrong quantity happen most frequently. And there are, as you know, lots of different reasons why that might happen. And I suppose this partly highlights the complexity of our practice systems and all the different things that are involved with safe medicines' delivery.

Pam Mosedale:

Absolutely. And so that is something where the profession could act on the data and things like the branding of certain medicines and things... and packaging that look similar and things like this are factors. It's not the fact that that person made a mistake. It was like the mistake was there waiting to happen sometimes, isn't it?

Emma Cathcart:

That's right. It's understanding what was going on underneath that person's actions. So what led them to behave the way they did. People are not going to pick the wrong medication off the shelf on purpose, but looking at, "Well, what else helped to influence their decision that they made on that day in that moment?" And is that the same thing that's happening in local practices and across the profession so that we can start to identify those areas of risk.

Pam Mosedale:

That's great. And at RCVS Knowledge, we've got a medicines management course that we've made with VMD, which is free access and talks about legislation and all the stuff you need for your medicines and inspection. But at the end of that, we've got quite a lot about having systems in the dispensary and how you run the dispensary and trying to avoid errors. So I think everybody can contribute as a whole profession effort to try and improve this.

Emma Cathcart:

Yeah, absolutely. And as we said before, there's wider profession learnings, but also looking at our own local practices and trying to understand why our own practices behaving the way that we are. VetSafe and the other ways of looking at incidents can really help you to do that.

Pam Mosedale:

It's going to be really interesting as time goes on, isn't it? The different errors in different types of practice, whether it be equine practices or small animal practices, or farm practices?

Emma Cathcart:

Yes, absolutely. The majority of reports at the moment relate to dogs and cats. That doesn't mean that there's no mistakes happening more widely. I think we are just seeing more reports from the companion animal side of practice. But yeah, I think as time goes on and we build up a bigger bank of what else is going on in farm animal and equine practice, we'll be able to start sharing those insights again more widely to help inform people where the risks lie.

Pam Mosedale:

And that's what it's about, isn't what quality improvement's about. It's about reducing risk and improving care and outcomes, but also about learning together, isn't it?

Emma Cathcart:

Absolutely. It's those opportunities for learning and the opportunities to make changes to lead to improvement.

Pam Mosedale:

So what would you say to practices then that do have an incident occur where either a serious one or sometimes not such a serious one, what would you recommend they do?

Emma Cathcart:

I think I would always just reiterate that point that every incident, whether it leads to harm or not, is an opportunity to learn something and to really encourage people to be curious about understanding why that thing happened and understand why those people who were involved behaved the way they did because of everything else that was impacting on them. So thinking about the wider systems and trying to refocus the way we think about mistakes, to not just think about individual people, but

thinking about how everything in our workplaces can impact other stuff. And thinking about those relationships between everything in our practice.

Pam Mosedale:

And it's fascinating, isn't it, once you start to think about the systems in practice.

Emma Cathcart:

Absolutely. Once you see it, you can't un-see it, I don't think.

Pam Mosedale:

No. So talk about it and then report it to VetSafe.

Emma Cathcart:

Absolutely. Report it to VetSafe. The more we learn, the more everybody learns. So again, part of the VDS membership is that we share those insights with our members and to help everybody to learn.

Pam Mosedale:

That's brilliant. Thanks Emma. Excellent. I'm sure that our listeners will take something away from this, so thanks very much.

Emma Cathcart:

Thank you, Pam.

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