QI Boxset: Checklists in Equine Practice.

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RCVS Knowledge:

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

Pam Mosedale:

Hi everyone. Today I'm talking to Debbie Archer, who's a Professor of Equine Surgery, and Deputy Head of the Equine Clinical Department at the University of Liverpool. Hi Debbie.

Debra Archer:

Hi.

Pam Mosedale:

Hi. We're going to talk about checklists today. Do you, in equine practice, do you use checklists much at the university hospital?

Debra Archer:

We do. We've got a few different checklists. I will put my hand up and say I'm a checklist person. I'm a list person as well, but I think the checklist just reinforced for me that if I don't have that, then I can easily forget something. So yeah, we've got various checklists. We've got one on admission, and we've got another one around euthanasia and disposal. And then obviously we've got our surgical site checklist. We've got a hospital rounds checklist as well.

Pam Mosedale:

That's really interesting, I suppose, yeah, the euthanasia one when, you know, emotions can be very high, it can be a high-stress situation. That's a great place to have a checklist, isn't it? Because it's so easy to forget one small detail.

Debra Archer:

Yeah. So, things like, has private cremation or normal cremation been discussed? And then we know, because it's kept on the record system, we know that if we open it up and it says 'client not asked, too upset' we know that we have to double check that. It's very handy actually.

Pam Mosedale:

There's nothing worse, is there, than a client expecting to get the ashes back and that's not happened. It's just something you can't put right, isn't it? So, yeah, checklists are great, aren't they? For just those little steps you might forget.

Debra Archer:

Yeah, anyone who's read the Checklist Manifesto has said that that book for me, it was just a ka-ching moment really. If any persuasion was ever needed, for anyone interested in Quality Improvement and patient safety, that book is just fabulous.

Pam Mosedale:

No, I agree. I'm a huge Atul Gawande fan too. Yeah, and all his books are good, I think, but particularly that one. Once you've read it, that's it, you're hooked aren't you, on checklists. And you said you used them for case handovers and things like that too.

Debra Archer:

Yeah, so for simple things like hospital rounds, actually, we've only literally...I wrote it at the end of last week and we've used it virtually... It must have been the start of last week, but we've used it in a few rounds, partly because I'd led a rounds and I'd completely forgotten and confused a few things. And it is, it's just handy. It gives a structure, and it actually means then you can rattle through things much more quickly. And I think that's what people like, they like to have structure. And when you miss something, it's amazing how much it can have a knock-on effect, just everything takes longer.

Pam Mosedale:

Yeah. And it might take a minute to go through a checklist, but the amount of time you'll then waste if something goes wrong as a result of not using it is disproportionate, isn't it?

Debra Archer:

Yeah. Yeah.

Pam Mosedale:

So talking about the surgical safety checklist then, I'm really interested in their use in equine practice, why did you start deciding to use that one?

Debra Archer:

Well, I must admit it was not long after I'd read the Checklist Manifesto and was thinking about it and I saw that a paper had been published in Veterinary Surgery around it. It was a study that demonstrated very nicely how patient safety...the number of errors, I think it was in the administration of antimicrobials, but various other errors had been reduced. And I thought it was a really nice paper. There's been another paper since then, but yeah, thought 'well, you know, there's no reason why we shouldn't do it'. And actually, our small animal hospital here, they'd just started using a surgical checklist, so we thought we'd implement it in the equine hospital as well.

Pam Mosedale:

Did you find you had to make many tweaks and differences between the one they used for small animals and the one you used for equine?

Debra Archer:

Yeah, and it's quite an iterative process and I think what I discovered in doing this was you really have to get buy-in from your team, you have to get that feedback. And I think checklists, as Atul Gawande explains, you can't have them too long. And I think that's always the... It's a real art, creating a really slick checklist because if they're too long, people just don't want to do them. Or if the questions, people don't feel they're worded properly, people just end up just not using it. So it

did take a lot of iterations. We've got a lot of people in our team, and everyone's thoughts are absolutely valid, there's no one way of doing things, but trying to get a consensus on some of the points was a little bit difficult. So I think you just have to go with something that isn't too long that covers the main things, but that there is buy-in from the team and there's no sort of question or questions that are really contentious because otherwise people just won't use it.

Pam Mosedale:

No, I think you're absolutely right, and there's always a bit of a temptation to make them very long. They almost become a guideline rather than a checklist then, don't they, if they have too much detail? So they've got to be, as you say, short and snappy. So yeah, getting buy-in from the team then. Great that you consulted with them and changed things as it went along, did you find much resistance to getting this going?

Debra Archer:

A little bit. I think it's, as we've discussed before, there are some people who are checklist people and some people who aren't. I wouldn't say that it's used universally. It does depend on the individuals in the teams. We use it as guidance that, you know, the checklist is there and we advise that people use it, but there are some situations where it could actually be argued that the checklist is probably at its most important, say, for example, when you get an extremely painful colic, literally throwing itself around, there's a time and a place to do the checklist. And in the melee of getting a horse on the operating table at two o'clock in the morning... You know, I'll hold my hands up and say sometimes I completely forget, but again, it could be argued that actually in those situations, going through the checklist just to make sure that simple things like antimicrobials have been administered. So there's always a really good excuse. But I think, from a patient safety point of view, if anything does go wrong and you sort of feel that it could have been prevented by using that checklist, I think it would make you feel pretty bad.

Pam Mosedale:

Yeah, absolutely. And you're right that in an emergency sometimes it gets forgotten, but as you say, two o'clock in the morning, thinking about people and human factors, it's probably more likely when do get forgotten. So does it actually get read out during the procedure?

Debra Archer:

Yeah, so we've got, and actually, our anaesthetists have a separate sort of checklist that they run through, checking all their equipment, et cetera. So we have a pre, intra, and post-operative part to our checklist. So before we induce anaesthesia in the horse, the anaesthetist and the surgeon, or for example, one of the surgical trainees, one of my residents, might go along to theatre and we'll just run through very quickly, you know, checking that that's the correct horse, that we know what procedure's being done, the duration, that the horse has been vaccinated against tetanus, that we know the plan for antimicrobials and they've been administered, whether the owner's been updated, that we've got owner informed consent, that the anaesthetist has run through their anaesthetic checklist, that the surgeon's happy that we've got all the equipment that we need.

Debra Archer:

That's sometimes the point where I realise I've forgotten to ask the nurses to get the laser or something down. So it just gives us a bit of time before the horse goes onto the operating table. So that's, again, very much led by the anaesthetist. Actually, the whole thing, we try to get our anesthetist to lead it just for some consistency because our nursing team might be busy supervising the students or helping get the horse on the operating table and start prepping it. Once we start we'll call out everyone's name, so we know who's in theatre. We have a lot of visitors. We do have a

system now where people wear different coloured caps, so we knew who are staff and students and visitors, but we've had the odd work experienced student in theatre.

Debra Archer:

And you know...well, I'm so old these days, all the students look young, so some poor work experience students, we do try and make sure that we know who they are so that we don't grill them, expecting them to know a final year student level question, but also to make them feel welcome. So we'll go through, everyone introduces their names because sometimes in our theatre, we can have multiple... Six students, four or five on the anaesthesia team, three on the surgical team, two nurses, a visitor, so it becomes quite a big team. So making sure everyone knows who's who is key. And then we'll ask people if they've got any concerns, and I always say to the students please make sure that you do feel free to say, and that includes during surgery and trying to get that culture of everyone taking responsibility and the fact that there's no one person in that room who can't be told of some concern.

Debra Archer:

It should be a shared concern. And I think that probably comes as a little bit of a shock to the students, but I make it very clear to the students. And actually, a student stopped me a few months ago actually from putting the small colon back in the abdomen, me forgetting I'd put some mosquito forceps on a small vessel, and I would've put it back in the abdomen. But the student felt confident in saying, and that was fabulous. That's exactly what it's there for. And then at the end of the procedure when actually surgeons were as guilty as anyone else of running off rapidly to try and get other jobs done, we do try to have a quick catch-up just to confirm what the post-operative plan is for the horse, but also to see if there have been any problems, particularly with regards to equipment, anything that we need to sort out prior to that piece of equipment being used the next time or some other problem that's come up during surgery.

Pam Mosedale:

That used to be one of my real bugbears in practice that when, you know, you went to get a piece of kit and they said "Oh, it doesn't work. It wasn't working last week". "Have we done anything with it?" "No" So it's, yeah I think that's important.

Debra Archer:

It's not fool proof by any means. No. We still have those scenarios, but it would stop a lot of problems if it was done routinely with every surgical procedure. But I'd say, it's probably done for the majority, certainly, the ones that I'm involved with, maybe they see me coming and know to get the checklist out, but genuinely, our anaesthesia team is really good at driving that.

Pam Mosedale:

Excellent. And really amazing that the students feel that they can speak up. That's great, and have you, apart from that issue with the student that time, have you ever experienced a checklist averting an error, do you think?

Debra Archer:

Yeah, I mean, it's not uncommon that we'll start with a checklist and then we won't know whether the ponies or horse is vaccinated for tetanus, antimicrobials sometimes get missed, and sometimes we've forgotten to update the owner that the horse is going round to theatre. So yeah, there would be a number of occasions, particularly when things are really busy, it's so easy for those things to get forgotten

Pam Mosedale:

And someone might think someone else has done it. That's the trouble, isn't it?

Debra Archer:

Yeah. And particularly in a team like ours where it's not just two or three people involved with a case, it's a whole team of people. So, yeah, it becomes complex.

Pam Mosedale:

And that's interesting that you introduce everybody because I think that's something that people in smaller practices might feel a little bit uncomfortable doing sometimes when they work with everybody the whole time. But for big practices like yours, I think it's really important, isn't it?

Debra Archer:

And I think even in a small practice, I would hope and imagine they've got students seeing practice and it makes them feel very welcome. You know, makes them feel part of the team. And they may not know the name of the nurse, you know, who's anaesthetising that cat. I think it just has so many benefits, not just from a safety point of view, but also making everyone feel part of a coherent team.

Pam Mosedale:

And there is evidence, isn't there, there are papers that say if you have spoken up, either read out the checklist or just introduced yourself, that you're more likely to speak up. So maybe that's what happened with your student.

Debra Archer:

Hopefully, I always make it very clear I've got the potential to make mistakes as much as anyone else, and if they see something, to say, there should be no fear around that.

Pam Mosedale:

No, that's great that they're learning that so early on in their careers, really. And you say that you use it most of the time, but have you actually audited how much of the time you do use it?

Debra Archer:

No, that's on the never-ending to-do list. It does need to be done. And it's amazing... Until you have figures in front of you... So for example, we did an audit on our financial consent. You know, we are very good at making sure we get consent for the procedures, but as our hospital management team will attest to, we are sometimes not so good at making sure that we've got all the i's dotted, and t's crossed with the financial consent. When you audit it, you can't defend it, with people saying, 'of course we do that' when you've got the figures in front of you, that's the evidence and that's all you need.

Debra Archer:

So we do need to do it. And I think people never like to be seen to be lower on a list of people doing things, so it probably is a good way to do things. But, we haven't done it yet, but we will be doing it at some stage. I suspect that will be one of our students' audit projects. Our students in the third year do research projects or they can do a clinical audit, and it's always lovely having those projects. Not all students are absolutely thrilled about the idea of doing research, but everyone should know what a clinical audit is and be able to run a basic clinical audit. So I tell our students that if they can

do an audit on day one when they get into practice, I'm sure a lot of practices would think that that's a fabulous skill to have.

Pam Mosedale:

They will, they'd be welcomed hopefully in practice, especially now it's in the Practice Standards Scheme at general practice level to be doing that. But I think you're right, I think it'd be a brilliant project for a student to do. And then once that's measured, it gives you a real opening to discussing the barriers with everybody, doesn't it?

Debra Archer:

Yeah. I think that there are some people who, and I suppose I'd maybe put myself in that camp before I'd done a bit of reading that I just didn't realise how useful checklists were. And I think once you see the evidence from, you know, like the airline industry, the construction industry, then there's no excuse for not doing it.

Pam Mosedale:

No, and the Atul Gawande pilot project when...I mean it reduced deaths and infections massively, but one that really resonated with me was that 93% of the people who were involved in it said if they were having an op, they would want a checklist used. So I think it's brilliant that you are, that the students are seeing it as well.

Debra Archer:

Yeah, it's one of those things, I think, once you become a big proponent of it, it's very difficult to sort of un-see it, I guess. And I just think it's really important that students are exposed to all of this at an early stage, whether they choose to use it or not, and whether my powers of persuasion are enough. But I think it's really important that at least it's not something completely alien to them, and they've seen it being used in a real-world situation, not in a lecture, but being actually used in real life. And, certainly, as a student when I was seeing practice, I would love to have felt sort of included in a team that at least knew what my name was and that I was a student. And it's the same with our students. I forget the names usually fairly quickly. I'm hopeless with names, but you know, I know that they're a student and I know that they're being made to feel a welcomed part of the team and as I said, encouraged to speak up if they see something that concerns them.

Pam Mosedale:

And it is a really useful tool for teamwork, isn't it? So you are in a big equine teaching hospital, do you think this would be relevant for a smaller equine practice that doesn't do so much surgery, but maybe does some procedures?

Debra Archer:

Yeah, I mean, for most surgical procedures there would be, at least, a veterinary surgeon and a veterinary nurse involved in that procedure. But again, just simple things that are easy to forget...I know that I've certainly been about to do a procedure in practice, and I completely forgot to give the antimicrobials because I was about to do it when somebody asked a question, and it disrupted my normal flow of doing things. So absolutely, you can just apply checklists to anything that you do, anything where there is room for something to be forgotten, then a checklist goes.

Pam Mosedale:

So, our message then is for the equine practice's out there to give it a go.

Debra Archer:

Yeah, absolutely. And I suppose with my vet school hat on, with having vet students around, I think it's a really, really nice thing to do. And, you know, it gives you an extra pair of eyes as well from a safety point of view.

Pam Mosedale:

That's a really good point, a really good advantage for having students on EMS, isn't it? Yeah.

Debra Archer:

Yeah.

Pam Mosedale:

Brilliant. Well, thank you so much, Debbie. I think that's...hopefully, people will think that it's a good idea if they're not using checklists already but thank you for your time. That's been brilliant.

Debra Archer:

No problem. Thank you, Pam.

Pam Mosedale:

Thanks

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