



Clinical Governance in Equine Practice: Practical examples of quality improvement

Podcast transcript: Alice Bird, Animal Health Trust, on a significant event audit

Lara Carim: Welcome to Clinical Governance in Equine Practice: Practical examples of quality improvement. The following session was recorded at Ashbrook Equine Hospital during the RCVS Knowledge Equine Roadshow, kindly sponsored by the Horserace Betting Levy Board and accredited by the British Equine Veterinary Association.

Alice Bird of the Animal Health Trust takes us through a postoperative complication that occurred in equine practice. Each step of the significant event audit is discussed to show in detail how a blame culture was avoided, how lessons were learned from the event and what processes were put in place to prevent the incident from recurring.

Alice Bird: Thanks. So I'm going to talk mainly about auditing of significant events and how you can practically do this in your kind of day-to-day working environment. And I'm using an example of a case that Tim [Mair] and I are involved in and how we kind of use the guidelines that RCVS Knowledge have out there that you can take into your practice.

So, the first thing is just really clarifying what we mean by a significant event. So by this we mean basically any event thought by anyone in your team – either the vets, the nurses, the receptionist – to be significant either in the care of your patients or in the conduct of your practice case. It's quite a broad kind of topic, that basically covers anything anyone really thinks can be improved I guess. And within that, it includes what we call critical events.

So, these are like the near misses that Lewis [Smith] was mentioning in the very first lecture today, so any unintended or an unexpected incident which could have, or in those really unfortunate cases, did lead to either the harm for one or more patients. And I'd also add into that (that's kind of the technical definition, that is kind of out there in the literature), but I'd also add to your staff as well, so any harm to your staff or your patients.

And I also, in this kind of umbrella, include any mortalities, because anything that dies, even if we think everything went perfectly, I generally include that as well, just so that we can check, is the assumption true? Or actually could we do better next time? So that's what I would classify as something I would put under the umbrella of any significant event.

So why are we going to audit significance? Why, why bother? So the aim is really to ensure a comprehensive, structured, thoughtful and, curiously, a less accusation investigation of analysis of events. So we want to go beyond the usual identification of what would typically happen, where there's fault and blame, OK, so, where something goes wrong and an individual is kind of the last step in the process and that person is, it's your fault, it went wrong in your hands, OK, so we want to move away from that and really look at what's going on in all those 10, 20 steps before that's led to that final outcome.

So as we sort of already discussed in the previous lectures, individual blame is really unhelpful and it often isn't the whole picture at all. So circumstances leading up to the final event, as I've said, are often multifactorial.

If someone is involved and holds some responsibility, very, very rarely in our profession it's intentional. I think we can all say that we don't go out at the start of our day to cause harm to either one of our colleagues or one of our animals, or kind of cause disruption within our practice. So it's not intentional and blame, therefore it's really unhelpful, and usually that person already has a high level of guilt and self-blame anyway, so they already feel pretty rubbish about themselves and kind of adding blame and the whole practice talking about it doesn't really help at all. It doesn't reduce the recurrence of incidents, because you're not addressing, actually, all those underlying causes that are 99.9% of the problem. And individual blame without actually analysing them properly can be detrimental. It discourages people to kind of admit that things have gone wrong.

It generally makes that person feel even worse than they did at the beginning of the day and it's just detrimental to all. So that's why this blame culture is really unhelpful. The alternative to blame is just going, okay, well you know what, these things happen. Okay. And that's often what people will say when people feel generally bad, something's gone wrong and say "These things happen, don't worry about it." But actually that doesn't help either. Maybe there's occasional circumstances where that's true. You know, we all know that even with our best intentions, we can't cure everything. But are you sure? Or is there a better way that actually we can make sure that these things don't just happen? So that's why auditing events is important.

So by doing a proper audit, you identify all the contributing factors in the case – so the gaps and the inadequacies in the system as a whole and not just in that individual person that was involved at the end. And it identifies the factors, both of the greatest impact and those which actually can be addressed, and those often aren't the same thing. So your greatest impact might be that you've got an absolute idiot of a horse, where you can't really do much about that.

But maybe there's other small factors that you can address, which when you take those out of the equation means that that doesn't quite become a significant event, it becomes a little bit more narrow miss. So those are things that we're aiming to do. And then just to remember, as we've sort of already mentioned, we can't eliminate error completely, OK, we're not superheroes, despite what some orthopaedic surgeons may think (I'm allowed to say that!) maybe in a small animal world, we're not superheroes and we don't know everything, OK. There's forever more that we can learn, but we can act to reduce it and we can act to prevent errors repeating themselves.

So having some kind of formal structured, investigation of events, is already well established, as we've already said in aviation and military and nuclear industry, so there's lots of evidence that it works. There's lots of evidence that it reduces these events occurring. And as we've also alluded to in human medicine, it's kind of taking off. So we're sort of on the last, kind of, a bit behind everybody else. But it's been proven to be a good thing to follow.

So most of this lecture, I'm going to go through an example of using, so the RCVS Knowledge have a significant event audit activity sheet, OK, so it's quite a long title, but it's basically a sheet to help guide you through how to analyse these events properly. So I'm going to use a real-life situation that happened to us and take you through the steps.

It is quite a complicated long case and hopefully, you know, if these happen in practice it won't be quite so in depth, but it's quite a good case to kind of show the full use of the form. So this is

the form and, as I say, you can get it off, I believe off the internet. You can print it out or you can complete it digitally.

So the first part summarises the process to be followed, OK. So it just summarises what the idea of the audit is and then it has these six stages that you work your way through, OK. And if you want to, you can put your practice details at the top of the form, OK? So you can make it a more formal form that you scan in with the patient's history, or if you're keeping a file somewhere, so you can individualise it if you'd like to.

So it's important to note at the top of the sheet it's clearly stated that you need to discuss without blame in an honest and constructive feedback, OK. So we've put that on there in writing just to kind of bang home this message that it needs to be constructive and it needs to be a blame-free environment. So the first two stages are going to be awareness – so actually making your team aware that you need to record significant events and that you are going to audit them, OK? If people don't know about it, nothing's going to get reported. And then you need to gather all your information together, OK? And this is facts, OK, gather facts, not assumptions. And then once you've got all those together, then you are going to arrange your meeting.

So we're going to fully analyse what's going on. So the next step to the form really just takes you through what you're going to do in that meeting. All right. So at the top, at the start of your meeting, you can put in the title, so a description of whatever it is you're auditing, the name of the case and some way of identifying what it is you're doing that day, the date the event happened, the meeting and then people present. And one thing that I would say that it's worth thinking about, who is the appropriate person to lead that meeting? Now typically when you start implementing this in the practices, kind of the practice manager or whoever the most senior vet is, will often be the one that automatically takes that role. But I would actually say maybe they're not the best person to do this.

If you want a non-confrontational meeting where people feel free to, kind of, speak up, it's very hard to kind of say to your boss that, you know, is paying you at the end of the day, and kind of telling you how good you are what you've maybe feel like you've messed up on, even if you haven't messed up. That's kind of how often people feel when they're kind of admitting to these events that happen. So maybe just think about who the most appropriate person would be and maybe that friendly receptionist everyone goes to when they feel a bit tearful – maybe they might be the right person. So it's just something to have at the back of your mind.

So the first step then is going to be to describe what happened, OK, so a brief description or, as brief as you can do, of the event and the outcome. And as I say, we're just going to go with facts. So this is going to be the case example that we've got today. So we've got a 20-year-old 500-kilogram gelding who was admitted for removal of multiple tail and perianal melanomas. It had these before, which had been removed two years previously under epidural anaesthesia.

So at that time we gave a hundred mgs of Xylazine, diluted to 10 mil, and we had no reported complications in the horse's history. So the horse was sedated in the stocks Detomidine and butorphanol and we performed an epidural, so a hundred milligrams of Xylazine, and this time we added a bit of local anaesthetic, so, Mepivacaine. The reason being that, at that time, we believed it provided better anaesthesia coverage and also had a bit of a faster onset time.

So we thought we would try that. It had been used in a number of horses previously, but obviously not in this case in the first situation. Fifteen minutes after the epidural, we got hind limb ataxia, but the horse remained standing. Laser removal was performed uneventfully and on

completion we walked the horse out of the stocks, which is approximately 45 minutes later, and severe hind limb ataxia occurred and the horse fell into a dog sitting position.

So now I want you to just have a think of what your initial reactions are, and these are all reactions that various people in the practice, or people that have been involved in the case analysis afterwards came up with, say, we must've incorrectly performed the epidural, or maybe we didn't inject the right drug doses, so maybe we drew them up incorrectly. Maybe it wasn't actually the reported safest dosage from the literature. This horse is just showing a bit of an odd reaction, maybe it's just sensitive to the drugs, sometimes this happens, or just panic. OK. So these are all responses people had, so maybe have a look at those. Decide which one you agree with or if you've got your own thoughts put that in the back of your mind and we'll see whether that actually is what we come up with at the end of the audit.

OK. So we're going to continue then. So the horse was re-sedated and we anaesthetised it and moved it to the theatre recovery box. We kept the horse anaesthetised for about three hours and then we allowed it to come, allowed it to come around of its own accord with head and tail ropes in place. So the horse tried to stand multiple times unsuccessfully and then finally when it did stand we locked the tail rope into a clutch system to provide support on the tail. And then unfortunately the horse fell again and the clutch system jammed, delaying the release. And then finally it stood about four hours, post-epidural.

Now I'm going to list what happened. So the horse developed facial paralysis and this resolved after about two weeks. These are some x-rays. OK. So we've got multiple rib fractures on the right. We had a pneumothorax. We had thoracic effusion and this thankfully resolved over about five days. And as you can see on the left, we've got quite a significant tail fracture, associated with neurological dysfunction. So we had complete tail paralysis, loss of sensation, loss of skin sensation to the dorsal tail, reduced anal tone, which resulted in a rectal impaction. And then the final outcome was the horse was discharged seven weeks after the epidural with marked muscle atrophy of the tail head and permanent tail paralysis and lack of tail sensation.

So now I'm going to ask you again now, what do you think? So the ropes were used incorrectly? It was an unfortunate incident with a clutch system jamming? The horse woke up too soon? We know that equine recovery from anaesthetic is a known risk? Or just even more panic of what am I going to tell the owner?

All right, so that's kind of the description of the case and now we're going to actually look into it in more detail. So the next stage on the form is why did it happen? And the easiest way to do this is to divide it up into different factors, OK? You want to make sure you cover all of that iceberg and not just kind of go to the immediate obvious thing that's in front of you, all right? So this is a list of an easy way of dividing up the factors. And this is, these are kind of on the form. And you can divide these up further as much as you want, depending on how it's applicable to your practice. All right. So we're going to go through these in turn. So first of all, system factors. So I've listed here, relevant to this case, some system factors that may or may not be involved that we may need to consider at our meeting.

So had the staff been provided with the correct knowledge and skills and experience? Was the intended help – so supervision, nurse assistance, et cetera – available? Were staff distracted at the time, maybe there were too many demands, maybe they were overworked? Were the drugs and equipment checked properly, or maybe the equipment failed? Were checklists or SOPs [*Standard Operating Procedures*] available, or were they available but they just weren't sufficient? Did we have unrealistic expectations and had there been a previous failure to respond to staff concerns? So maybe this had happened before and someone had raised it and

nothing had been done about it. Maybe we didn't plan or prepare properly. Maybe staffing levels contributed or did the culture of the clinic contribute? Was there kind of a culture of 'just get on and do it'? All right. So those are just some examples of things that may come out as system factors.

So if we have a look first at epidural. When we went through all of these, it's the only one really that came up as, as a possible contributing factor with failure of checklist and SOP. So in this it was, is the SOP regarding the volume and the doses used in that practice for epidural injections appropriate, OK? So the volumes that we used were based on somebody's literature search and opinions when that was written, but that was a few years previously. So has the literature changed? Maybe that's now outdated and maybe there's better, better knowledge. But that was the only one really that we could identify. So there was an initial assumption that the intern must've incorrectly injected the wrong drug volumes. But actually we had really good, clear written notes as to how many mls, how many mgs that intern gave and when we looked across it actually was exactly what was necessary, OK, so the intern didn't mess up.

There was also another thought that maybe they'd placed the epidural in the wrong place. So you can see the clip patch on the horse on the left is actually, for any of you familiar with epidurals, quite high, and usually a clip just above where the tail hairs start. So there was a suggestion that the intern obviously put it one place too, too far forward. But if you look at the x-ray, you can see the gas bubbles, which are not uncommon following an epidural placement and actually they are in the right place. So I think they just had quite an angled needle placement. So that also was an issue assumption, which was proved incorrect.

So now let's look at the recovery then. So in this case we've got a few more factors that are probably contributing. So all of us agreed that probably there was low experience in the team regarding the rate recovery, so training was undertaken. We would send our interns and nurses away to places that regularly did rate recovery and training, you know, it was done on a yearly basis, but unfortunately had quite a high turnover of interns. So there was actually limited experience present on the day and rate recovery isn't something that at that time was done as a routine at the practice. It wasn't possible for various reasons, so it was only really undertaken when things went wrong. And actually we felt that in hindsight, maybe it was unfair to kind of expect that team to be able to do that. There's obviously a clear, a clear equipment failure, the clutch system jammed.

So that didn't do its job properly. And then the checklist and SOPs, certainly, we decided that in hindsight, again, locking the tail rope with the clutch system, which actually is performed in various clinics that I've worked in seems to be quite standard. In this case we decided it was one of the contributing factors. So, you know, maybe that needed to be altered. And then secondly there wasn't an SOP in place for what do we do if a horse goes down after Xylazine. How long do we keep it asleep for? We didn't know, we guessed three hours. But was that appropriate? And that's something that actually we needed to look into.

So now let's look at human factors. So did the staff make a mistake? OK. We're not going to remove that completely. It's still part of the analysis. Did they feel they could ask for help? And then on the other hand, did they ask for help when they should have done? Were staff tired, stressed, distracted? Was support and supervision appropriate and were there issues maybe within the team (collaboration, kind of attitude between staff members that contributed), maybe they weren't communicating well that day. And then, if the SOPs were in place, were they actually followed? So if you look at the epidural, actually it was done perfectly. The intern did a brilliant job and there was no fault at all that we could find in that. If we look at the recovery

maybe as we've already alluded to and maybe support and supervision of that team maybe could have been improved.

So next let's look at patient factors. So was there something about the horse that predisposed to what happened? So presenting condition, temperament breed. And if we look at the epidural, there was a question raised as to whether it may be the presenting condition. So these melanomas maybe had some impact on how the horse responded to the injection. We don't know. It was something that was raised as a possibility, so something for us to look further into.

And then temperament. Undoubtedly the temperament of this horse on its recovery certainly played a factor. It wasn't the most sensible of horses: it just continued to keep trying to get up even though it couldn't, whereas perhaps some of, some other more sensible breeds might have just sat there for a little while until it felt fully, fully awake. So temperament certainly played a role, which unfortunately we can't do much about.

So owner factors: did owner attitude, did their finances affect the decision on how we manage that case throughout? And actually we didn't really feel that it had any impact in this situation. And then communication. So this is the final one we're going to look at. So again we're looking at team communication and changes in team members, kind of misinterpretation of instructions or misunderstanding instructions between individuals. So again, with the epidural, we didn't find issues at all. And with the recovery, again changing the team members definitely had an impact.

So we've now looked at all the contributing factors and what we're now going to do is list what's been learned, and also look at what changes we want to implement. So firstly, what did we learn from the epidural? So the epidural actually was performed as per instructed without any apparent mistake. The staff actually during the meeting reported that they do remember some previous cases with similar ataxia and maybe this has happened before. So we need to go back and have a look back at our records.

There was also further investigation needed as to whether the technique and the doses we used actually is, is what the current literature recommended. Also it's an investigation of whether the horse's complaints, so the melanomas, might've contributed. And generally there was a feeling that the staff all felt better after the meeting with proper assessment. And the initial assumption that the intern has some blame was no longer present. So the intern certainly felt a hell of a lot better after this.

So what's going to be changed? So we need to wait for a review meeting because these are all questions that we couldn't get the answers to. So we need to go away and have a look both at our records and at literature.

If we now look at the recovery and then the subsequent complications after that. So there was a risk in the rate recovery set up, identified in the clutch system. So the SOP was actually followed, but as we discussed earlier, we decided it was inadequate. Training was carried out on use of rate recovery, but the high turnover of staff definitely contributed to the complications and what we decided was training needed repeating and refreshing.

So I think it's very easy in practice that you implement training and you then pass over to that individual when you've been trained, you should now know what you do. Certainly where I work now I have a very good health and safety department, who send me endless PowerPoints to look at where I have to learn for every aspect of the practice, which is great. But I can guarantee you a week after I've done a half hour PowerPoint, I can remember the topic and maybe three points, but I don't know what was on page 15.

OK. So if you've got something that you're doing on an infrequent basis such as rate recovery in this practice and you've trained someone a year ago, it's completely kind of unfair to expect that staff member to remember everything exactly. At best you can remember that you shouldn't expect them to remember that there is an SOP or there's some information somewhere in place. OK. And so this was where maybe the management let the team down. The horse's temperament definitely played a role. And as I said, we can't really do much about that. And then we decided we need to look into the literature as to whether we kept the horse asleep for long enough.

So what are we going to change? So the clutch system was changed and SOP was updated. So we in the practice now never lock the tail rope. And we also updated the SOP. So there's always a trained member of staff, either advising or in charge of the rope recovery. So if the team were there and they realised that no one actually really felt confident that they knew what they were doing, they would ring or call someone else to come and help. So we had that as kind of a, just a thought point that everyone in the team just said, "Hang on, is there someone here that's happy to lead this?" We implemented regular refresher training on the use of the ropes. And then, then we needed to wait for the review meeting on how long we needed to keep the horse asleep if this happened again.

So if we go back to our six-point plan, the next stage is going to be to agree and implement those changes and importantly to monitor those changes. And then the fifth point is to write it up. So either write it up, so there's a record in your practice, but also what you can do or what we would encourage is if you've got something that you feel others can benefit from, is write it up and let the rest of the veterinary profession know about it. So you're going to arrange a follow-up. So the date of the review is at the end of your form, so that it's just a reminder for everyone that we're going to come back and look at this case.

So an additional audit was performed during the time after the discussion of the case and the follow-up meeting. And we looked at our cases. So over the previous seven years, we'd performed 30 epidural injections on 25 horses, so a number of those had had an epidural on two occasions. Three out of the 30 developed ataxia, 2 out of the 30 became recumbent and all of them presented with melanoma removal, which is probably not unsurprising. It's one of the most common procedures that I can certainly think of that you'd need an epidural for. Eight out of the 30 received local anaesthetic as part of their injection. And the other 22 would only receive Xylazine and all three of those with ataxia had received local anaesthetic.

So we did literature search. So there is a suggestion in the literature that inclusion of local anaesthetic provided better anaesthesia with faster onset than Xylazine alone. But we found that in our cases, Xylazine alone was sufficient in all of those 22 horses to perform the procedure. The doses we used were actually less than the recommendation from pretty much every literature source that I could find.

And spinal melanomas were reported in the literature, so perhaps a small epidural space might have caused more cranial spread of the injection in this case. But to be honest, we don't know. It was a possible assumption. None of the horses had neurological deficits. None of them showed signs that they had spinal melanomas, but it is a possibility, maybe the condition added to the complication and that's why the literature doses were different to the ones we'd used.

And then looking at the reports and literature of the duration of motor nerve action of Xylazine and the mepivacaine combinations for the epidural administration was basically lacking, OK. So there's good evidence or, or there's certainly some evidence, maybe not good, but there's some evidence of how long Xylazine actually lasts. But there wasn't evidence for the combination and

what we do know very clearly is if you mix multiple drugs together and give them the epidural route, the onset of action, duration of action is actually nothing related to the individual drugs alone, OK, they seem to have synergistic and differing effects. So we don't know how long the combination lasts, was the conclusion. Maybe we didn't wait long enough.

So additional changes which we implemented. We now perform epidural surgery alone and only using Xylazine. So we no longer implement them, sorry, use local anaesthetic. The cases that we had, there wasn't enough of them to actually be able to say definitively that local anaesthetic caused the problem. Okay. It might just have been coincidence. But we personally felt that Xylazine alone was sufficient in all the other cases. So we felt happier using it and also because we knew or there was more evidence for how long Xylazine lasted for if it did happen again, we felt more confident in how long we had to keep that horse anaesthetised. So we made that practice decision that that was what we would do.

So if we go back and look at the sheet again and the final step stage six, which I alluded to earlier, so we've written it out for our practice to report, share and review. So we did that and we actually wrote it up in EVE [*Equine Veterinary Education*] as a report of a series of cases and the complications that we'd had.

So just to summarise then, analysing significant events allows a full assessment of all the contributing factors and removes that sole individual blame where often it's not actually the case. It improves team morale, it improves willingness to discuss error and kind of implements an improvement culture within your practice. It's important that the discussion is done as a non-accusation, supportive environment, and that kind of blame culture kind of is removed, as it generally results in people not wanting to report stuff, and also just general despondency amongst staff if you don't actually act on it when they've kind of come up and been brave enough to admit that these things have happened. Just remember: we can't eliminate error, but we can learn from our mistakes. And where no mistakes were made, we can question whether we are actually following best practice.

So just the final couple of slides I've just put in just a practical application of this significant event auditing a case, so basically just what I do personally. So where I work, we implemented a book to record significant events as and when they happen, OK. And the important thing is, it needs to be easy to spot. It needs to be visible in a non-threatening location, OK. And I would personally say, don't call it the significant event book, OK. If you come back and you've had a rubbish day and something's gone wrong, the last thing you want to do is go up to your boss's desk, ask for the big threatening black book that says, I fucked up today, OK?

So what we have is a bright pink book. It sits in our pharmacy next to the computer where you log all the drugs in and out, and it's referred to as the pink book, OK. And it's much easier to say to someone, Oh, where's the pink book than where's that big black scary book, all right? And I've implemented or tried to implement it now and where I work currently, and I stupidly let the residents decide what they wanted and they have a bright pink book with a unicorn on that they call the unicorn of improvement. So I mean you can call it what you like, but I mean they, they now love it and they're forever asking for the unicorn of improvement. And if that means they write stuff down, that's fine by me.

So inside the front cover of the book, I have a definition of what a significant event is, just as a reminder, and also then a list of the contributing factors that they can go back to refer to, OK. If you're tired at the end of the day, you don't want to have to sit there thinking all the things. If you could have a list on the side that you can run through and go system factors, you know, was

reception involved? Was I involved? Was it management? It's much easier and much quicker to go through. So I have a list already printed out there that they can kind of refer to.

And then how to fill in. So you just put a number and whatever the next number is following on from the input kind of previously, describe briefly what happened, list any of the possible contributing factors and any ideas for improvement after the event. And the key is to try and put this in when it's fresh in your mind, OK, so not two weeks later, three weeks later, kind of in the evening or the morning after.

If there's a large incident, such as the one that we've discussed today, that kind of needs a full sit-down analysis on it, then we have a way to indicate this. So we use kind of just an asterisk. All right, so this is an example then. So number one, so notice that we're not putting individual blame, we're just stating the facts. So an individual nearly drew up Medetomidine instead of Methadone. So I work in equine and small animal practice, so for those of you who aren't familiar, Medetomidine, this is for a Labrador, you would maybe give it 0.1 or 0.2 mls. Methadone, you'd probably give it a mil.

OK. So if you're suddenly going to give five times a dose of Medetomidine, that's quite a lot of Alpha-2 to a dog, all right? So that was the significant event that happened. So they listed their factors as the individual performing the anaesthetic didn't check properly. I mean, they did try and draw up the wrong drug so you have to put that in as a factor, you know, take some responsibility. But actually what we also had was we had a new Methadone supply and their bottles looked almost identical, so they were white labelled 10 ml bottles with blue writing on. That individual had also been on call overnight, had had a very busy shift in ICU and was rushing to get the first case of the day started.

All right. So that is all they needed to write in there. And underneath they've just put suggested improvements. So the night duty vet was not to be allocated the first case of the day, maybe someone else that had a good night's sleep should be. And then just to go back and say, 'Do we really need to have methadone that looks identical to Medetomidine or maybe we could go back to the previous supply where it looked quite different?' so that that was all they needed to put in.

Then number two. So let's pretend now we had our complication with the epidural horse. This is obviously going to take up about 10 pages of our book. So instead we just put complication following epidural, developed ataxia and complications with recovery requires individual analysis, details recorded in full elsewhere, OK. So we just put it in our book as a reminder and somewhere else that whoever that occurred to, would scribble on a bit of paper, everything they remembered and we'd book a time for that at another date.

So what we do is we meet once per month and we go through each item through that book for that month, and discuss those cases between us. And then what we do on the first clear page of the book, we write down any actions to be taken from that month's discussion, OK, including who will implement them. So if those were the only two cases in that month, we'd put 'Look into Methadone change back to old one. Implement that the vet that had been on night duty didn't do first case of the day', OK.

So we just bullet point those, then we draw a line underneath when we're finished and then we're ready to start next month numbering from afresh, and at the start of every month we briefly go back to the points that we've made from the previous month. Just run through them and check how they were getting on: had they been implemented, had it been improved,

anyone have any comments before we start that month? And then at the same time we'd schedule a date for any kind of asterisked kind of larger events that we wanted to look at.

So that's how I kind of practically apply it where I work. Generally what I found is when you start this off, initially you have very few kind of inputs into your book. So people are a little bit hesitant. They don't quite know how it's going to go. They didn't want to admit to things. Then generally as people realise the meeting's actually quite positive – you know, no one's going to kind of get blamed or kind of shot down – all of a sudden you get a flurry of all of those things that have been bugging people for the last four years that they kind of feel like no one's done anything about, and maybe now's the time something might happen, OK.

So you get inundated with things. And then it kind of settles down to somewhere in between, OK. So that's kind of the pattern that I found whenever I've done this that seems to be followed. And whereas we kind of say you have a non-accusation, or kind of a non-blame situation, so we don't generally name people. What I tend to find is that once people feel comfortable with it, usually you'll start off by saying, 'Oh, someone's put here an individual, you know, mixed up Methadone'. Someone will go, 'Oh, that was me. Yeah, this happened', OK. So you'll find that people become more willing to discuss and open up. And I kind of do that. But what we will do is kind of not make it compulsory that we need to name people or shame people. That's kind of not the aim of it.

And even if things seem kind of one-offs or kind of not related to each other, what certainly I found, we had a situation where I used to work where we had a nice steady kind of same number of things every month. Then all of a sudden we got a flurry of lots of really silly errors, just sort of mistakes that people were making forgetting to turn oxygen on at the beginning of the day, forgetting to check their ET tubes, all sorts of little things like that, which maybe all seem separate.

But then running through all of it, we found that everybody was tired. Everybody was rushing around, everybody felt overworked. And actually what we realised was that we'd had an anaesthetist leave and management still hadn't got around to getting an anaesthetist six months later, although everyone said it was fine and they were coping. Actually everyone was exhausted, everyone was just doing their best and no one had quite realised that it was having an impact, and we were all making these mistakes.

And when I presented this to management initially, they all got very upset saying that they couldn't be blamed for what we were doing on a day-to-day basis. And then when I said that we were writing it down and it was getting recorded, they suddenly got an anaesthetist in very quickly [laughter]. So things come out of it that you don't necessarily expect. All right.

So just my final thought is from is Rear Admiral Grace Murray Hopper: the most dangerous phrase in the language is: 'We've always done it that way'. And if that's what you take away today from this, hopefully I've achieved something. Thank you.

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