Conquering the caseload peak

Laura Playforth

RCVS Knowledge:

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Laura Playforth:

So I'd like to start off with a story, and this is hopefully going to lead us into talking about how lots of different Quality Improvement tools and processes can really help teams with a lot of challenges that they're facing at the moment.

So this is Tigger and this is Tigger's story. So Tigger was seen fairly early on in the pandemic when lots of people were working with having clients outside in the car park. And Tigger's owners had noticed that he wasn't feeling very well, seemed to have been straining in his tray a little bit. They thought he was a bit constipated, just generally, not terribly well and not his usual self. So they were a bit concerned, but not really that worried. So they took him down to the vets. They knew from the phone call they were going to have to wait outside so they were expecting a bit of a wait. They handed Tigger off in his box at the door, and then they sat outside in the car and waited. And waited and waited, and then started to get a bit, not really worried, but a little bit irritated, if I'm honest, and thought, What is going on? Tigger's gone in, we want to know what's happening with him.

So they phoned up the reception went 'Tigger's in, what's happening? Is there an update?' And the receptionist said, 'Oh, I'll just check, I'll just look through the records. We haven't got any record of Tigger being in with us.' 'Well he definitely is, because we've just given him off, maybe 45 minutes, an hour ago to one of your members of staff. Do you want to go and have a bit of a look for him?' So the receptionist went off, chatted to lots of different members of the team. 'Have we seen Tigger? This cat came in in his basket.' And nobody seemed to have any recollection of Tigger, unfortunately. So they decided to have a search of the building because they knew Tigger was definitely in there somewhere.

And they found Tigger in his basket, in the cat ward, which was full, and there were cats and baskets all over, and Tigger had been put in a corner. And tragically, by the time they found Tigger he'd passed away in his basket. And as I'm sure we can tell from the history, we can recognise Tigger wasn't actually constipated; he had a blocked bladder. He'd been admitted as a cat that potentially wasn't very sick. And because there wasn't room for him, he'd ended up in the cat basket with all the other cat baskets and paraphernalia from a very busy shift.

So we obviously know the impact of this on Tigger. He not only passed away potentially unnecessarily, but he'd had no triage, no pain relief, no treatment. The owners obviously were not expecting this at all. They thought he was just a bit constipated and would be absolutely fine with a

bit of treatment. And the impact on the team as well. We can only imagine what it's like to go through something like that and know that, not only a patient that was under your care passed away, but also potentially in a really suffering state.

So there's lots of different things we've got to consider. We don't want this to happen again to the next Tigger. We want to be able to help the team deal with this. We want to be able to manage the caseload as well as we can, so that there are no more Tiggers and no more patients waiting. And obviously we've got to speak to the clients and sort that out.

So this is a small animal example, but hopefully lots of the things that we talk about today, you can apply it in your own situation in practice if it's not this type of setting. So just a quick word. I know Sabrina, who was amazing by the way, just chatted a bit about psychological safety. But just to say that I hope that that's something that we can have in the room as well, if people do share stories or ask questions about things that have gone wrong or other significant events, that that's something that we can support each other with and feel free to share without judgment, but with questions at the end. So Tigger's incident would be what we class as a significant event.

And I'm sure many of you will have heard of significant event reviews, where we look at an incident that's happened. It doesn't have to be a negative or tragic incident. It can be anything that's been a little bit exceptional. And we can go through the events and look at what happened, and move onto root cause analysis, which is basically asking questions to unpick all the contributory factors into what happened with Tigger. And there are a number of different methods of doing root cause analysis. I'm not going to go into that in a lot of detail, but if you want to learn more about all those different methods, if you look at the RCVS Knowledge website, which I might mention a few times today, there's lots of resources on there that tell you how to go through it, but a very simple way of doing it can be just to keep asking 'Why?', and digging back in the layers of, well, why did that happen? Well, why was that? And why was that? Until we get to the root cause.

And we can tell in Tigger's case that there was a mismatch between the caseload that was coming in and the staff that they had available. And it could well be that they're struggling with staff that have left, as many people are, staff that are off sick, and also an increase in caseload. And I think it can be tempting to come back to the root cause is, well there weren't enough staff. And obviously that's true, but there can be a limit to what we can do to address that. As we know, we're all trying as hard as we can to address that. So we've got to look at some of the other things we can do as well. So not just going back to the obvious not enough staff, but unpicking all the other contributing factors.

And veterinary practices are systems. And as W. Edwards Deming said, all systems are perfectly designed to get the results that they get. So it could be that the system, there's something going on in the system that isn't functioning as it should be, that has led to this unfortunate outcome. And there were lots of system factors involved. We've mentioned the staffing levels and that leads to time pressures, the caseload increase, but there can also be other systems factors such as team communication. Did the receptionist know who they were supposed to be speaking to about Tigger? Was it a triage nurse? Was it an in-patient nurse? Was it a vet? Was that system in place or was it all a bit chaotic?

And we'll chat a little bit later about guidelines and checklists and how they can be used to help manage these caseloads. And did we have any in place? Was that system in place to help the staff streamline their workflow? And if it was in place, was it not used? And there can be a number of reasons why these things are not used. People don't know where they are. People don't think

they're very good. People think they're quite cumbersome. So if we have those systems in place, it's good to unpick why people are not using them, or using them in a suboptimal way.

And also equipment and workplace design can play a big factor in our efficient ways of working. And it could be that the clinical team were busy doing something else that actually could have been more efficient. So maybe if they were running blood samples, and they've got to run here for these tubes and run here for the centrifuge, go up and down stairs, it might seem like a small thing and a small gain in time, but actually, when you add that up during the day, you can, maybe if you got 20 minutes, half an hour back, that could have been Trigger's triage, his treatment started, finding somewhere to put him, identifying him.

So the equipment and workplace can make a massive difference. And systems can be very complex. And the one thing we know about veterinary healthcare, like all healthcare settings, is healthcare settings are very complex, but we can sometimes perceive them as being quite straightforward and linear, as you can see with the example of blood testing. You think, well, it's just this step and then that step and then this step. So there's not much we can do in terms of influencing that or making it more streamlined or having checklists. But when we actually look at it properly – this is an analysis from human healthcare of all the interdependent factors involved in taking a blood sample – we realise it's not linear. It's very complex. And we need to think about that when we're doing our root cause analysis and try not to be overly simplistic. And we'll get onto a few of these factors as we go through.

So as well as systems factors, there can be lots of human factors involved. And again, if we've got checklists and guidelines, it can be that people miss out steps in the workflow. And it could be that in Tigger's case, the receptionist maybe knew that they were supposed to go to the triage nurse, but for whatever reason, they skipped that step and told somebody else, or didn't tell somebody, or thought they would do it in a different way. And that, again, can be a reaction to when we're incredibly busy, we want to work efficiently, don't we? And that's the whole big point of Quality Improvement, is to increase efficiency. But the problem with trying to do it on the hoof in the moment, is we skip out steps and don't have the capacity to think about the consequences of skipping that particular step. So it's better to try and protect some time to think about how we can streamline processes strategically and more proactively. So we can think about, if we take this step out, actually, what are the risks of that and what could the potential consequences be? So trying to do it on the hoof, we quite often end up with unintended consequences.

So we've got a lot of other human factors in terms of our own physical, emotional and mental wellbeing. And I know that's been a huge focus over the last few years and continues to be. And I think these are things that we all know, but we don't necessarily do. I think we're very guilty about that in veterinary teams still, of trying to protect ourselves.

So I know some of you will be familiar with this little mnemonic up on the stage. So it's the HALT model. And that's a bit of a physiological check-in: how are you feeling yourself, in terms of, are you hungry, or hangry, as many of us get? I know I'm quite a hangry person. Are you angry for another reason? Are you late? Or the 'L' can also stand for lonely in terms of, have you got other colleagues and peers that you can chat to and unpick things with? And also, are you tired? And some of these things...I can see somebody yawning down there who's looking a bit tired. And these are things that we feel all the time to varying degrees. And some of these things, obviously, we need to be quite proactive in dealing with. And that, again, can make a massive difference if you are working on a very busy shift, which a lot of them are, at the moment.

It's always good to be really pre-prepared in terms of having your water on you, some sort of snack that's not necessarily a Mars bar or a can of Red Bull or what have you; something that's going to give us some longer lasting energy, and making sure the team are prepared. But making sure everyone takes the time to check in with these things themselves, and that will help your cognitive processes hugely. And I think sometimes we tend to power on through, without taking these things into account as much as we should – because we know these things are important.

So what can we do? This is the important bit, isn't it? So we've talked about systems factors. We've talked about human factors. So we can think about how we're going to manage our caseload, and that will differ from practice to practice and situation to situation. And I just want to be clear from the start as well, there's no judgment in this, and there's no ultimate right and wrong for what people decide to do around their caseload, because the times have been incredibly difficult and sometimes people have had to make very difficult decisions because of the situation their teams are in. And that's okay. We need to balance off all the different factors, but there are things we can do around caseload. So the ultimate in the pandemic, we went down to emergency caseload only. That's sort of the ultimate restriction, but in crisis times, sometimes that is the only way that we can function.

We can also look at reducing our caseload in other ways. So I know a lot of people closed their books to new clients at various times during the pandemic. And I know a lot of people have used various different triage tools and also postponed a lot of more elective and proactive procedures. And again, there's nothing wrong in doing that. I think where it can really help as well is to work alongside local practices in making sure that where we can redistribute the caseload, we can try to make sure that as many animals and patients get the ability to be seen somewhere else. And I know that's been a big thing during the pandemic, of people cooperating and working together and collaborating brilliantly, even though they're from different practices that compete. It really helps. But what we don't want to do is everybody closes their books at once. If we can avoid that, we want to try and work with each other. And sometimes that involves coming together for out of hours. Sometimes it involves cooperating about which branches are open and closed where, and there's been some fantastic collaboration. And I think we would all like to really see that continue. So I think that would be a plea from me to everybody for us not to go back to the old ways of being really sort of insular and trying to protect our business needs over everything else. I think we've got to collaborate and work together.

And human factors we're definitely going to talk more about shortly. So this is just going back to the managing the caseload bit. Also triage can be a hugely important part, whatever part of the profession you work in; whatever it is you do, there are lots of things we can do around triage.

So phone triage can be really, really important when we're suffering these caseload peaks and making sure that we've got a really strong process in place. And that's something that we haven't always had. I can definitely speak to our experience when I worked at Vets Now that we were largely a consultation-offering service. And that was what we did. We weren't really set up to be able to prioritise cases. It was a case of, if the client wanted to be seen, unless...we had a process if they really didn't need to be seen, but if they wanted to be seen, then they could come down. So we had to change a lot of the way we worked on telephone triage to make sure that we could, in the caseload real peaks, really prioritise who was coming down and who wasn't. So if that's something that you're not set up to do, then there's something to think about. And also who does that? You know, it doesn't necessarily have to be your team; there are other services that can do that. You can

outsource that, and it can be quite flexible. It doesn't have to be you outsource it all the time. You can really think about how that works.

And again, physical triage. That was something we definitely did a lot of at Vets Now, as you can imagine, but we put a validated triage process into place so that we could effectively score our patients, so that we knew they were either red (super critical), amber or green (could probably wait for a while). And that was a really important thing for us to do. And again, it's not just out of hours; that can be really important in the daytime practice as well. When you've got lots and lots of cases coming in, how are you going to identify which ones of those are really critical? And you don't want to have to be relying on your non-clinical staff. It puts a very unfair burden on them to have to try and identify that. So if you've got a process of getting all the patients seen straight away for triage, and then they can be scored in some way, or you can have some sort of sheet where you can prioritise them, then you can have a much better process for knowing which needs to go to the vet straight away, which can see the nurse, which can go in the kennels.

Laura Playforth:

And again, consultations. So we talked about triage can be done on the phone. There can be some fantastic processes for that, some brilliant checklists as well for certain presentations. But again, we've been very flexible with consultations: some online, some on the phone, some in person. And I think that can and should continue in various different forms. And I think we need to think very carefully about which type of consultations need to be face to face. And again, we'll get onto who does what in the team, but who needs to do what, and which things can be done remotely.

So yes, who is doing what? And this is something that's been a real theme across the professions recently, in terms of delegation to our nursing colleagues and in terms of nurses delegating to other members of the team as well. And in real caseload peaks, this is absolutely critical to get people doing only the things that they can do. And that's not to say that we're saying, vets never need to walk the dogs or pick the poo up or hoover the floor; 100% not what I'm saying, because in an ordinary situation, we all want to be flexible and help each other out and do everything. But in real caseload peaks, we need to be really, really streamlined on who's doing what. And one of the things that has definitely been mentioned to me a number of times is, also making sure we are delegating appropriately. I mean, we all know that we've got to support our teams and colleagues in being comfortable and being trained up to do the things we're delegating to them, but also particularly making sure that people like our nursing team and our ACAs [animal care attendants] don't get caught in the middle, where they're getting lots of stuff delegated to them, but not having anywhere to get rid of all their other stuff. So that's been a particular pinch point for a number of teams that we really need to consider.

And again, what could, and what should we actually be doing? It's all very well delegating lots of stuff, but if we can automate things, automate what you can do before you delegate it. And that can be things like clients booking online, instead of having to phone up. It can be making consent forms into an app or onto a tablet instead of having to get lots of bits of paper off. Automate whatever you can do before you delegate it. That is the most efficient thing to do. But 100% before you automate something, decide if you ought to be doing it or not in the first place, because there's nothing worse than spending lots of money on tech in automating something and then thinking, actually, do we really need to do that at all? So eliminate what you can do.

And that involves pausing some things, doing some things less frequently, particularly administrative tasks. And sometimes you think, well, we've got to do this absolutely every month or every week or sometimes every day. But I think we really need to challenge ourselves: do we need to do that at that frequency? Is the world going to fall over if we don't do that? Is something catastrophic going to happen? And again, this comes back to our Quality Improvement processes of looking at the risk of adverse consequences. So this is a little plug as well for my colleague's session later on. So Angie Rayner's going to be talking about what matters to you and the adapting the Joy in Work framework for teams. But also to say, if you want to look at what to eliminate, what to do less frequently, who's doing what, what the time thieves are in your practice – so what's taking people valuable time that they could be spending with patients, but also that they could be spending having their lunch and a cup of tea and finishing on time – then ask the team, because they're going to know.

And I think that is something really worth spending some time sitting down together as a team and saying, you know, What matters to you? Where is your time wasted? Where can we do this better? And making sure that everybody has their voice heard, because everybody will know, as we all do in our day-to-day job, what is the thing that you think, ugh, not only is it draining my joy, but it's wasting my time.

And as well as asking the team, which is incredibly valuable and powerful, we can also ask other people to come in from outside. And I think that's really helpful. If you are in a practice with a number of different branches where staff work in a specific branch, get them to move around. If you've got colleagues in neighbouring practices, if you're in a bigger group, get somebody else to come in. And they will look at the way you work, do things and say, 'Oh, that's interesting, we do that really differently. The way you do that is loads better. I'm going to take that away.' Or actually 'What's the reason for doing that, that way? Because that looks like it's taking an awful lot of time that could be done differently.' So a fresh pair of eyes, absolutely worth the time.

And supporting the team. So this is really critical, in terms of our culture and our improvement culture and values in particular. So a really good takeaway that I wanted to share with you today. I think a lot of us have heard about the concept of being a second victim. So the first victim in Tigger's case is Tigger, obviously, who sadly lost his life, and Tigger's owners. In human healthcare, it would be the patient and their family. And the second victims are the team providing the care. And this has clearly been incredibly traumatic for them. And it's quite obvious though, the team would be really impacted by this. There can be other incidents which are less dramatic and actually even sometimes near misses where people can also feel very traumatised by what might have happened. So it doesn't have to be as dramatic as Tigger for people to have a very significant impact on their wellbeing. And there is a brilliant website called secondvictim.co.uk. And I would highly recommend that to everybody. It's free and open access. And it's a brilliant resource if you are impacted by an incident, or if you are trying to support your team through an incident. It gives great resources for managers and it also gives red flags of when somebody's not coping and then you can signpost them to get more professional help.

And I want to mention non-technical skills. I'm not going to say soft skills, Ashley will be pleased to know <laugh>. But I think we do sometimes think of these still as soft skills and not important, but spending time with the team, learning about these different skills is absolutely invaluable. And I think sometimes we focus very much on clinical, clinical, clinical CPD. But in caseload peaks, what's going to help our patients most? Is it going to be learning about a new technique or procedure or how to do something amazing with blocked bladder cats? Would that have helped Tigger? Not so

much. But some of these things: situational awareness, communication, teamwork, leadership – these can be the things that can make a real difference. So I would question what we're spending our CPD time on and the impact that that can have.

And I was going to mention in particular, it can be great to do these things. It doesn't have to be some expensive CPD course, although there are some great ones out there. It can be something that you do together as a team, a simulation exercise. CPR, particularly in small animal, can be really good for getting the team together and learning about communication and leadership and situational awareness. And you can throw a bit of a curve ball into the team when you're doing a simulation, 'Oh, and now a dyspnoeic cat's turned up, what are you going to do?' Or 'This pet needs a chest drain putting in suddenly, how are you going to get things ready and organised?' And that can really help with these non-technical skills.

Communication failures as well are really, really common. And it can be exacerbated when we've, hopefully, got lots of new team members coming in. That's maybe a bit optimistic, but locum colleagues and people moving around. It's great to spend time introducing ourselves to people and getting to know people. And again, it seems like something we should do anyway, but it doesn't always happen. I've seen some catastrophic incidents because people have assumed somebody was a vet or a nurse, or handed over to the wrong person. Or somebody's not been listened to when they've got a very valid concern, so very important.

And having a safety culture. I know Sabrina talked brilliantly about psychological safety, so I won't speak too much about it now, but a safety culture is really vital for our teams when they're working under pressure. And this is one definition of a safety culture, but I think the definition that I prefer, which is quite practical, is: your team culture is what people do when the boss is not around. And that's what people say, that's what they believe in and how they behave. So that will give you a good measure of the culture. So if you are a leader in the practice, you maybe have to get somebody else to tell you what happens when I'm not around. And that'll give you a good measure, but we can move towards a better culture and a culture of psychological safety. And I think Sabrina made a brilliant point that that can be about us as leaders daring to put our own vulnerabilities forward and talking about 'The time I messed this up, the time I did that wrong.' You know, we've all had our own Tiggers. And if you haven't had your own Tigger of some sort, you maybe haven't been in practice that long or your Tigger is coming. It will happen to all of us at some point. And the more we talk about that, the more our teams feel supported and empowered to identify things.

So I'm really privileged that you are in here listening to me, because you all could be in another one listening to 'Civility saves lives' with Helen from VetLed, who is brilliant. But a quick mention to this because it is really, really important, and I would recommend watching that later on, because the biggest impact – this is assuming that we're all competent at our jobs, and I mean competent, not exceptional – the biggest impact on the outcome of our patients is how we communicate and how we work together as a team. And I think that is something that we don't always consciously recognise. We tend to think, Oh, you know, you've got to be an exceptional vet and have all these letters and a brilliant nurse and all these qualifications and experience, and actually, it's how we communicate with each other, is a much bigger impact.

So we can see the impact of incivility here on the recipient of incivility: 61% reduction in cognitive ability. So sometimes when we're under pressure, our cognitive ability is already pretty narrow. You take that down again by 61% and you can see how things go catastrophically wrong. But it also

impacts on bystanders. If you just witness somebody else being rude or uncivil – patients and relatives, this is human healthcare but our owners and also on our team – and if somebody is rude to you, you're much less likely to help the next person, like 50% less likely. And we don't recognise that about ourselves.

So Quality Improvement is a huge contributor to practice culture, and we need a good improvement culture to be able to drive successful Quality Improvement projects, but also working on the projects themselves can help us to develop that culture. It can be a really strong driver for local teams because we're focused on the care of the patients and the clinical outcome. But alongside that comes all this being open, identifying things, talking to each other, collaborating, not having this awful power hierarchy of 'I'm the vet, you're beneath me and do as I say'. It eliminates a lot of those things because everybody's voice in Quality Improvement is equally important.

And where to start with practice culture? I think it can feel like a very nebulous concept and it can feel quite overwhelming when we're under pressure of how we do that. But my advice, as with any Quality Improvement project, is to start small and do things, the simple things, the basics. Get those right and start with yourself. It doesn't matter what role you've got in the practice. You are an influencer and you can influence that culture with how you behave. And if you start off making small changes to how you are and make those incremental improvements, then it will have an impact eventually. But the more people start to notice, the more other people you get on board, and the more you can make movements.

So safety checklists I wanted to mention, because this is something that definitely could have helped in Tigger's case. And this is clearly a very important Quality Improvement tool. So what we want from a safety checklist, again, there's walkthroughs of how to build some of these on the RCVS Knowledge website, but essentially they need to be really precise, short. They want to just look at the safety-critical steps of the process, and they need to be adapted to your way of working: your practice, your clinic, your team.

So we can look at areas where a checklist could have been useful, particularly in Tigger's case. So this is an example of an anaesthetic safety checklist, because it was the nicest looking one I could find, but triage in particular we could have, we don't need to have a really complicated scoring system. We can just have a very specific checklist of who the patient is going to, how they're identified, what we're checking when we triage them, where do they go next. So that can be the clinical triage, but also the flow of the triage process.

Specific presentations and specific cases can be good. Would this have helped in Tigger's case? Could have, so if we have a checklist for a cat with a blocked bladder, would it have helped in Tigger's case? Not unless we made some other changes. If we have a checklist for a cat that presents straining, which is what the front-desk people are going to hear and what the clients are going to be communicating, then yes, that might have helped, because that could have indicated to them this needs to go to the triage nurse straight away, I need to flag this to somebody.

And case handover. I know in Tigger's case, Tigger may not have been handed over to anybody. It could well have ended up in the cat kennels waiting for somebody else to get alerted, which didn't happen. But if we are handing over a case at any point in the patient's journey, it is good to have some sort of checklist summary. And I know we all do that generally in little bits of paper and we scribble something down. But it's good if we've got a bit of a structure around that and that just really speeds things up. You've got the really critical details on there.

And we can move things through lots of other areas of practice, obviously, which are really great for doing checklists and lots of real-life examples on the RCVS Knowledge resources too. And checklists can really just help to focus on the really critical things. And as you're building them, you might have a long list of, like the complex blood sampling task, a long list of things that you need to do and you can start off with that and then you go, Well, we know to do that. That's not critical, actually. We don't need to do that. We can make that more efficient. And you end up with a really short list, which can really speed things along in terms of efficiency.

And this is an example of a case handover framework. It doesn't have to be this one; other frameworks are available. And this one wouldn't have been perfect for Tigger's initial handoff, but something like this, again, it just puts a structure around what we're doing. It reduces risk for our patients. It makes things simple for the team. They don't have to look at a different piece of paper from every single different member of staff that looks different and is in different handwriting and takes time to process, and things get missed and you forget things. This just makes things really structured. And again, you would adapt that to the way that your team work, the kind of patients you have, but these kind of frameworks can be really helpful. I'm just going to see how we're doing for time. I think we're doing all right for time, which is very good.

So just going back to Tigger and the resolution of Tigger's case. So we've talked a lot about the situational factors, system factors, how we can change things. In that sense, we've talked a lot about the team and how we can protect them and how we can make sure that they're okay. And a big part of protecting the team as well, is looking at how we can prevent this from happening in the future. Not just for Tigger. I mean, this is an extreme example of things that can go wrong, but for all those other patients that are going to get delayed, their triage is delayed. Their pain relief is delayed. Their surgery is delayed. It's going to help all of those patients, and putting those things in place really helps the team to move past an incident. Number one, because they should be a big part of looking at how we improve things. But also it gives them that reassurance of, We've really changed something, we've really done something about this. So next time something happens, we're going to be in a much better place. And the risk of it happening again is much lower.

But also we need to think about the clients in this situation as well. So this has been a very traumatic experience for them. And in this particular case, somebody found the client, well, brought the clients from the car park, had a face-to-face conversation with them, and just told them what had happened and explained it to them with, you know, the compassion and the care that we always give to our clients. But were just totally open and honest about it and the failings that had happened. And although they didn't know all the details of what had happened, that is an important part of letting the clients know, 'Look, this has happened, this is what we know now. And this is what we're going to look at for later because we don't have all the answers right now.' But then we come back to the clients and let them know what the next steps are. And as the investigation goes along and as we make changes, we can keep them updated with that.

And I think certainly my experience of being involved in quite a number of very escalated complaints over the years is the majority of clients...Yes, some of them do want money, but the majority of them just don't want it to happen again. So using these processes, we can say, We've put this checklist in place. We've got a clinical guideline now. We've got a different process here, or we've managed to cut this time down by so much. So the chances of this happening to somebody else's patients are hugely reduced. And that can be very helpful for clients. And actually the clients in this case were incredibly understanding, despite the traumatic incident that they'd been through.

So this is a quote from Don Berwick, the President of the Institute for Healthcare Improvement. And this is the potential that we can get from Quality Improvement. So no needless deaths, no needless pain or suffering, no helplessness in those served or serving, so that's our owners and also our teams. No unwanted waiting, no waste and no one left out. So although we can't do all those things perfectly all the time, using Quality Improvement tools – like guidelines, like checklists, like significant events, like auditing, are we using the checklist? Are we not using the checklist? – can have a massive impact on the care that we provide and can help us to eliminate risk, and make things more efficient, more streamlined, which means we can give better care to all the patients, but also, like I said, make sure people get their breaks. That's a critical part of being more efficient.

So this might be an odd place to end where we started off with a tragic death, but I think it's really vital that we share and collaborate when incidents like this happen, but also about what we did and what changes we made, and we share that with each other. Because, you know, it's fine for me to stand up here and talk about Quality Improvement and how it can help, but the most powerful stories are the ones that you tell each other about what you did and how it helped. And it will be different from your practice to your practice. You know, you might work in large animal, you might work with exotics, but there will be some things that can be changed and modified and applied into your setting. And the more we share these stories, the better we will all be, and the more we can help each other, particularly when it comes to efficient ways of working.

And like I said, that second pair of eyes that you don't necessarily see it yourself, but somebody else will have seen it. And then you can read about what they've done and go, Oh, light bulb, we could do that differently. And I've definitely worked in lots of practices and done things a certain way for years and years and just never questioned it, and somebody else has come in and gone, 'Wow, okay.' And then you realise that there are big efficiencies to be gained in sharing these stories.

So this is about celebrating the successes as well, not just sharing the stories, but when your team have had a traumatic incident, it is worth celebrating the fact that you've put different processes in place. You've made a checklist, people use it, you've audited it, you know that that's working. So celebrate that with the team. Maybe you don't want champagne right after Tigger has died, but we definitely want to speak to this team and go, 'This happened, it was awful, but look what we've done, look what we've achieved.' And I think when we've got teams that are struggling so much, we really need to take the time to do that and make sure they know how amazing they are, to have not only come through this last few years, but to have done something like this.

And I'm one of the people fortunate enough to judge the RCVS Knowledge awards, and being able to look at some of these things that have been done during the pandemic. You will have seen the award winners got announced recently. Some of these incredible projects that they've managed to achieve during this time have been absolutely exceptional, and it has helped them in dealing with this caseload peak and the various peaks that you will suffer each month, each week, each day, each shift, each night for some people. It will really help. So don't forget about the RCVS Knowledge awards. We would love to see you sharing your team's stories on the website, but also submitting them for the awards so that we can share that knowledge more widely. The idea of the awards, it's to make the team feel great and happy, but it's to really promote the sharing of these stories so that we can all learn from each other.

So it just remains for me to say thank you to RCVS Knowledge for asking me to speak about this today, and a plug for the website. If you want to know more about how to do a significant event review, root cause analysis, checklists, guidelines, audits, it's all on there. And it's got a step-by-step

walkthrough guide for all of these things and lots of real-life examples. And we would love to have more real-life examples to be able to share, particularly large animal and equine actually. So I think we can take some questions. <applause>

Audience member 1:

I just wondered if you had any tips for when we are trying to discuss significant events or things that have gone wrong, I mean we tried to do it in a completely blame-free culture, but to stop people feeling defensive and to be able to talk about it freely, especially if certain people are involved.

Laura Playforth:

Yeah, yeah, definitely. And I think my top tip would be, don't start with Tigger; do something that's less traumatic for the team. You can maybe start with something like a near miss. That's much less challenging for people emotionally, that, 'Oh, this almost happened, but actually, well done. We caught it in time. Nobody got hurt. That's brilliant.' And that starts the conversation and the culture going, and normalises the fact that this is something we are going to talk about.

And I think, again, leaders sharing their own stories of when things have gone horrendously wrong, again, helps to normalise it and make people feel comfortable in talking about it together. And I think it's really powerful for the team members that are involved in something like that to tell their own stories. I think it can be very challenging if somebody else tries to tell the story, because that does make people feel defensive. And you won't tell it in the way that it happened, because you won't tell it in the way that they thought about it or what was going on for them at the time. So I think that would be my tips.

Audience member 2:

Hi. We've instigated systems in human factors over the last couple of years and it's working very well. Have you got any tips in the early days about how to make it work efficiently? So it's a different way of working, it's a different mindset, but what happens in a busy environment, we found, is it slowed things down a bit. There was a bit of death by checklist. There was a bit of paralysis by assessment and then frustration built in. So there's this sort of efficiency balance that eventually you get there and it becomes much more efficient, happier team, but there's a challenge within instigating it. Have you got any tips in those early days, because for us, it was trial and error, and it was a little bit tense. It was surgeons, you know, not blaming, but 'Can we just get on with this?' Nurses kicking back, you know, that sort of thing.

Laura Playforth:

Yeah. That's a very familiar story. I think having the whole team on board in the first place obviously is really key. It's very difficult if part of the team is on board and thinks it's amazing, and the other part, normally the vets, are much less keen and want to just keep going and don't really see the value in it. So I think if all the team's involved from the start and they really agree that this is something valuable, looking at the evidence – particularly as scientists, we like to see the evidence – I think that can be really powerful for people. There was a lot of papers on it in human healthcare and human surgeons. The vast majority of them were sceptical to start with, and some of them were downright resistant and ‘This is a waste of time’. But you asked them if they were having a surgery

themselves, did they want it doing on them? And it was 93% said yes. So I think that's a very interesting difference.

But it can slow things down when you start using any new process. And I think that's when it's really key for a checklist to be really concise, like really short. So 90 seconds is probably about the best at each pause point. So with a surgical one, for example, you might have one before you start, you might have one at the end, you might have one at anaesthetic recovery and what have you. But at each point you want it to be super short, and you think 90 seconds, it's hard to argue that 90 seconds is going to be a big loss in your efficiency. And I think starting off small. So with one checklist, because like you say, death by checklist is very easy, to get overexcited and you want a checklist for everything. And you soon realise that some of them are not very practical. I mean, it'd be great to have checklists for what fluid we're going to administer to make sure we don't give the wrong one, but you try putting that in any practice. No, didn't work. So I think there comes a point where, like you say, you've got to get over that hump, but sometimes you've also got to recognise what's not going to work. Was there any checklist in particular?

Audience member 2:

No, I think it was just, there's so much resource out there and there was so much enthusiasm. It was interesting. We're half referral, half first opinion. So there was this cultural thing that we don't do it in first opinion, we'll do it in referral and it'll filter through. And actually that a mistake: we should have just all started off, but I think it was just the volume of resource. So there were so many pauses in the day that we didn't get as much done, but the work was still there. So then people were getting stressed at the end of the day. The work was still there and owners were, you know, so it's just that efficiency thing was really interesting.

Laura Playforth:

Yeah. It'd be great to learn from your experience, I think that would be a great thing to write up. Some of the things you've learned, like, you know, starting with one team and not the other team. And that might work for some people, but I think you can see where there would start to be some friction in that as well. I think that's really interesting. So it would be good to write something about it that we could share about what you've learned, because, like you said, a lot of it is trial and error, but it's good to see somebody else's trial and error.

Audience member 3:

Hello. Could I just say that as a practice that does a lot of QI and clinical audit, what really has helped to embed it over the years – and it is something that we built from a very small start and just introduced more and more improvements – is when people see the results. And you need somebody flagging that up every month to say, 'Look how well we're doing, look how we are compared with the industry benchmarks. Look how well we're doing with how we did previously because we've made this change.' And that really gets everybody on side.

Laura Playforth:

Yeah. 100%.

Audience member 3:

I think it's just making sure that you keep analysing, keep reviewing and keep letting everybody know the difference it's making.

Laura Playforth:

Yeah. That's a brilliant point. And I think it's great to look at the research before you start and all the evidence, but like you said, nothing is more powerful than seeing this is what we did as a team. This is our patients. This is how we've made things better. Nothing is more powerful than that. That's us. Thank you very much.

RCVS Knowledge:

You can find more information about Quality Improvement and free resources to help you embed Quality Improvement techniques in your practice at rcvsknowledge.org/quality-improvement