EVERY PATIENT, EVERY TIME

Ensuring accurate documentation for all surgery patients

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Vets4Pets

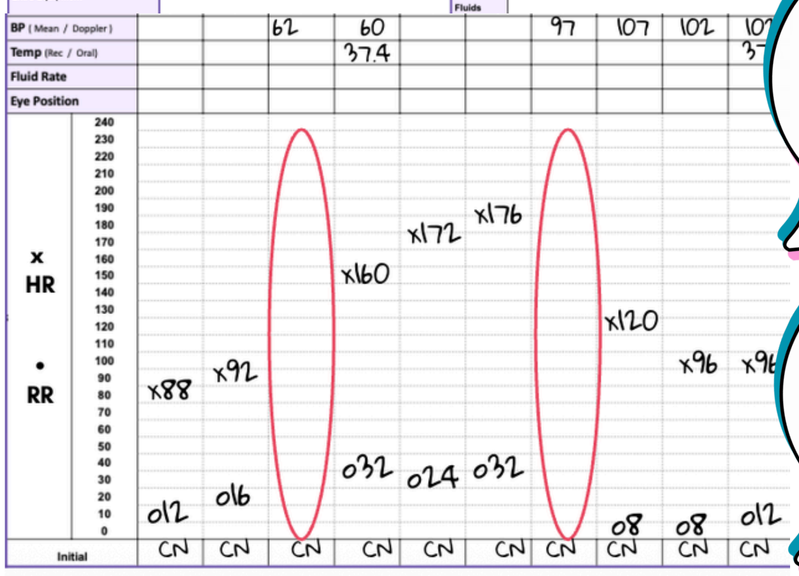
PROBLEM



Patient charts are incomplete

Drug	Dose /kg	Total Volume	Time Given	Route	Initial
Sedator	10ug/kg	0.03ml	09:15	IV	RB
Methadone	0.3mg/kg	0.10ml	09:15	IV	RB
Alfaxan	5mg/kg	1.8ml	09:25	IV	LP
Metacam	0.2mg/kg	0.14ml			
Atipamazole	Half Dose	0.01ml			

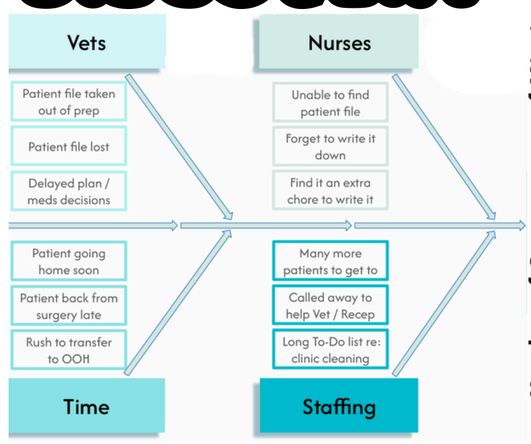
			In	Out
Stage of Surgery	1. Prep Area 2.. Incision	Swabs		
Suture Material	2/0 Monolac 3/0 Monolac 3/0 Ethilon Gluture	Sharps	1 Sharp In	
Extra Equipment		Thorat Pk		
		Warming	Heat Pad / Vet Bed / Blanket / B.Hugger / Other:	
		Fluids		

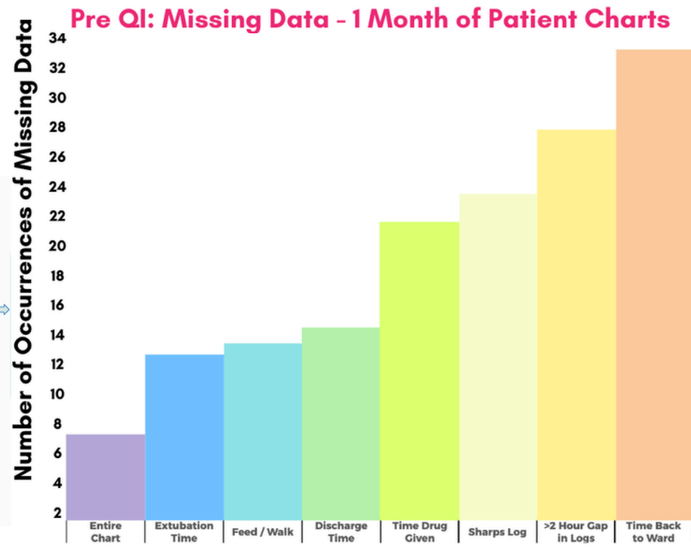


Putting patients at increased RISK

Frustrating the team & duplicating work

DISCOVERY





The Expected

Theatre Nurse records all swabs, sharps, drugs, & patient stats throughout anaesthetic → Theatre Nurse hands over extubated patient to Wards Nurse → Wards Nurse continues recovery, feeds, walks & medicates patients → Wards Nurse hands over to Consult Nurse, who then discharges patient

The Reality

Theatre Nurse must manage anaesthetic, whilst dressing vet, opening kits, & scrubbing patient → Theatre Nurse puts patient into kennel & has to quickly start next anaesthetic → Wards Nurse feeds & walks all patients, but not everything gets written down → Consult Nurse discharges patient using assumed information

Types of Missing Data

AIM

50% drop in missing data by July 2026

Inclusions: All charts from patients receiving sedation/anaesthesia

Exclusions: All charts from patients not receiving sedation/anaesthesia

MEASURES

- Sharps In & Out
- Heart/Respiratory Rate
- Drug Administration Time
- Wards Arrival time
- Time Between Interactions

CHANGE IDEAS

1. **Talking About It** — Raising awareness of the project
2. **Defining Roles** — Who's responsible for what
3. **Staying in Role** — Sticking to those responsibilities
4. **Visual Cues** — Gentle reminders in key places
5. **Vet Support** — State sharps & return charts
6. **Discontinue All** — Can good habits survive?

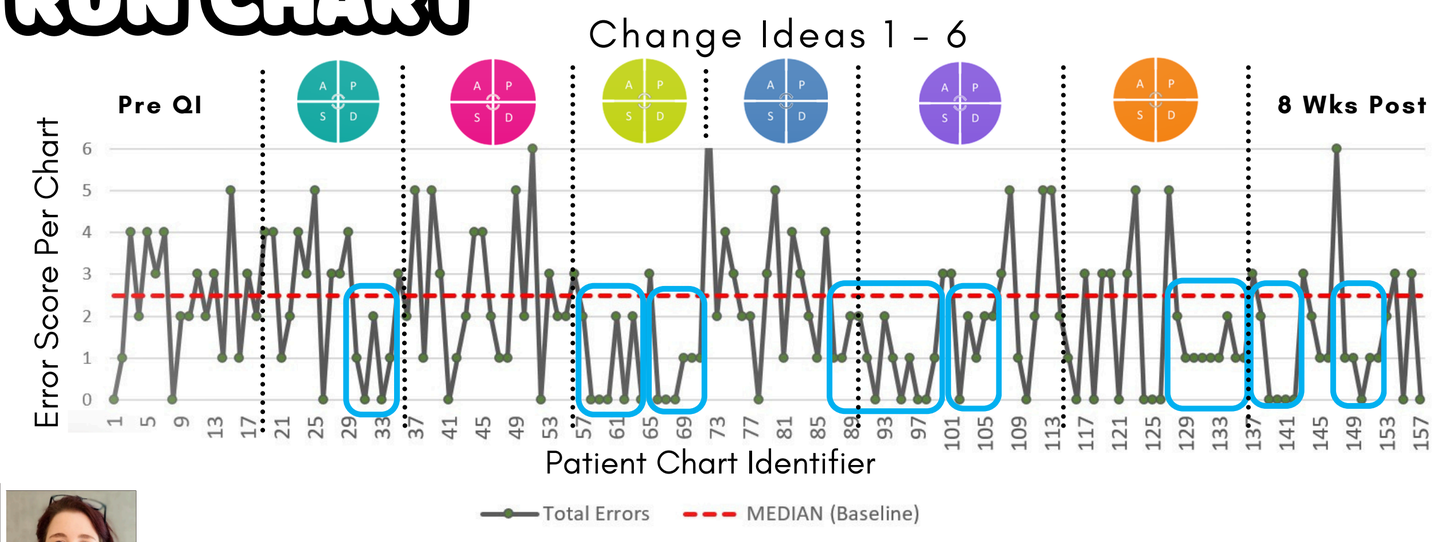
Surgeon Closing? Swabs ✓ Sharps ✓ Every Patient. Every Time.

P.D.S.A CYCLES

Plan . Do . Study . Act

Change 1	Change 2	Change 3	Change 4	Change 5	Change 6
Several discussions had but lacking a notable outcome. **Abandon**	**Talking About the QI Project**	Continue with this idea, and ensure everyone is on board. **Adopt**	**Redefining Nurse Roles**	Continue to lead by example, & encourage others. **Adopt**	**Sticking to Redefined Roles**
Some seemed interested, whilst some did not engage	Discuss the QI project with small groups, individuals, & in work group chats	This brought clarity & the majority liked this. An improvement was seen	Lead discussions regarding what the team felt each role should encompass	Team are solely responsible for their area, & less is duplicated or missed	Lead by example & encourage others to work within role remit
Some improvements over baseline, but not from Change 3. **Abandon.**	**Placing Visual Reminders**	Not done by all, but still a small improvement. **Adapt**	**Vet Reminding Nurses**	Second lowest error rate, after Change 3. **Adapt**	**Remove Previous Change Ideas**
Some signs have fallen down & not been replaced, others have.	Signs placed in relevant areas to act as visual cues	Idea taken on by some vets, but still many occasions where this was not implemented.	Encourage vets to prompt nurses on sharps/ swabs, & other logs.	Improvement still seen, as better practices growing	Remove visual reminders, cease conversations, & stop reminding vets to prompt nurses

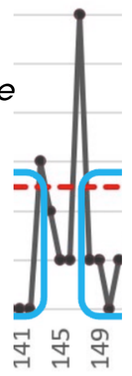
RUN CHART

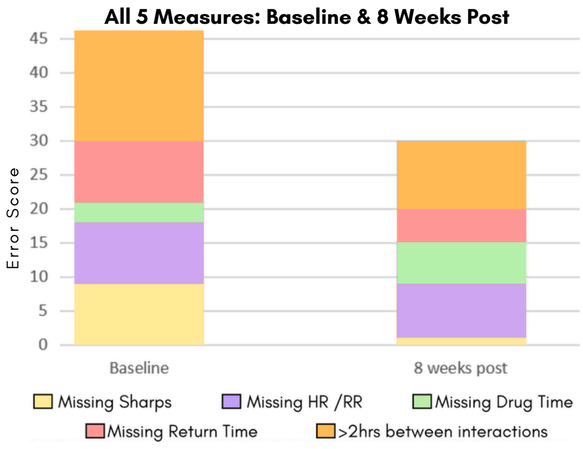


CONCLUSIONS & REFLECTIONS

The run chart shows **eight instances of statistically significant improvements** *(>5 data points below the median baseline)*, with several coinciding with PDSA tests of change. When changes were stopped, improvement was still maintained at 8 weeks, with only one significant lapse. Overall **a 35% reduction in missing data,** and an **increase in entire charts with zero missing data** was achieved. The largest contributor was a **90% drop in missing sharps** data, and **sustained improvements** were also seen in the recording of wards arrival times, and in the gaps between patient interactions. No change in missing heart/respiratory data and an increase in missing drug administration times were noted.

Chart 147 is a 'special cause' *(data point outside the new normal variation)* and further study, for the purposes of learning, would be warranted.





Whilst 5 measures created a vast volume of data, they revealed that **simple changes can have far-reaching impacts**. Softer ideas, such as **'visual cues'**, were insufficient in motivating change, so **ownership-focused** ideas that **empower improvement** should be prioritised. The lack of change in heart/respiratory rate data, alongside the worsening of drug administration time, provides opportunities for further study. Future cycles would also benefit from **consistent sample sizes** to reduce variability and aid comparison.

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