TITLE: You Can Have Both Quality & Efficiency

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When Quality & Efficiency Fail

Have you ever experienced one of those days – the day when a mistake is made? Perhaps you got busy and forgot about a client waiting out front, maybe a test sample was thrown away before the results were recorded, or maybe you forgot to pass along an important client message to the doctor. Worse case scenarios may involve dispensing the wrong medications, or perhaps an error in a surgical procedure. Any of these scenarios hit you hard in the gut, take your breath away, and immediately cause you to shift into reactive overdrive to save the patient and save the client relationship.

When you have a failure in quality and/or efficiency, it affects what is known as the Law of Memorable Events (Lee). It takes only one brief experience on only one day - a comment, a forgotten client, or a call to come back in to repeat a test – to cause a client to question the quality of medical care their pet is receiving at your practice. Moreover, we all know about those catastrophic failures and the effects on relationships. Quality and efficiency isn't just about business and revenue, it is about the trust between you and the client, it is about successful treatment of a pet, and it is about your team's satisfaction with their personal performance.

Do you have a strategic plan to monitor and improve the level of quality and efficiency (Q&E) in your practice? Do you know where you are experiencing failures in your Q&E? The first step is to identify areas where Q&E are at risk, then take action to mitigate the risk and make improvements.

Common Points of Q&E Failure

Q&E failure can occur in 3 different areas of patient care – No Care, Poor Care and Unknown Care.

Examples of "No care" are having a patient not able to be seen because your scheduling procedures prevented scheduling an appointment, or delays in getting a scheduled time to come in due to your scheduling protocols. It can also be missed opportunities to manage a chronic condition or offer preventive care (such as not recommending care or long-term management of medicines). "No care" failures can also occur when there are fragmented treatments as what can occur between the primary doctor and specialty/referral doctors or even two associate doctors in the same building (such as lack of information regarding follow up or continued care). Lastly, care can be derailed with poor client communication resulting in the client not seeking care or being compliant with recommended care.

"Poor care" can be the result of your team, your procedures and protocols, or your physical plant and equipment. Dispensing wrong prescriptions, performing wrong procedures and other errors due to a lack of training will result in poor care. Poorly trained team members are not only inefficient in how they perform their tasks; they also put patients at risk of receiving poor quality medical care. Outdated SOPs or overly bureaucratic SOPs can open the door to risking adverse effects of treatment, performing inappropriate diagnostic procedures and poor communications about continuity of care. Work space, workflow, accuracy of testing equipment, safety and sanitation may be part of your physical plant but can contribute to inefficient movement through job tasks (taking too much time, having to repeat tests or procedures due to poor equipment), and placing patients at risk for acquiring infections due to poor care of the physical plant.

"Unknown" care is really about a lack of information, not following up with clients, or communicating with clients once a pet goes home resulting in your team not knowing if the treatment improved the pet's well-being or even if the client followed the recommended treatment. Failures in this area affect future performance of the team – if the team has no idea if a treatment is successful or not how can they make changes in the current SOP? Quality suffers when there is a lack of follow up communications. If a client fails to carry out a treatment who really suffers? The pet suffers. The team has also suffered – especially when they do not know that their

instructions were too vague, or the plan too confusing for the client. The team has suffered a loss of quality and efficiency in delivering medical care to a patient when they are unaware of the success or failure of the treatments they recommended for a patient.

Your Q&E can face multiple challenges at multiple levels of contact (or lack of contact) with a patient. Some of these you will never hear about. Sometimes, the error is 'swept under the rug' and quietly covered up or resolved without involving management. Other times, the dam breaks and chaos floods the practice as an error results in a catastrophic event. Do you know when there is a breakdown in Q&E at your practice? Do you look for potential points of risk to your Q&E? Do you have a psychologically safe environment to discuss Q&E errors with your team?

Psychologically safe means that you and your team can openly discuss concerns, troubleshoot root causes and formulate solutions without the risk of being embarrassed, criticized or 'thrown under the bus'. In a recent study of human healthcare organizations, some staff knew of problems leading to wrong site surgery procedures and other errors, but they did not speak up because the environment was not safe for them to intervene (Sherman). Could your practice be suffering from a Q&E problem in patient care because those who see it cannot speak up about it? Is your practice work environment and culture actually causing you to suffer from Q&E problems because it will not permit individuals who see a problem to discuss it (e.g. do you kill the messenger)?

Improving Q&E

The emphasis on improving Q&E is not without merit. The purpose of any Quality & Efficiency program is to prevent errors, establish consistency in service and procedures, and consistently meet and exceed patient, client and business needs. Q&E is all about consistency – every patient, every client, every time.

The benefit of improved Quality & Efficiency can be seen in improved client satisfaction, patient care, employee engagement, and business reputation in the community. It can also improve the business's bottom line by lowering costs of inventory, wages, and service 'fixes' such as offering free services or repeating services.

Begin by assessing the status of your Q&E performance. Examine key areas such as collaborative care with in-house associate doctors and outside referral doctors, ease of accessibility to your doctors and to appointments, quality of medicine practiced by your team, accuracy and safety of equipment, level of patient-centered and client-centered focus, communication and the efficiency of operations (Moore).

Once you have identified key areas needing attention, review the way you are doing things in the practice. Update policies, manuals, and standard operating procedures to reflect changes for improved Q&E. Then train the team on these new SOPs. Use technology to declutter a process and take advantage of your internal strengths to overcome weaknesses. The technique of appreciative inquiry can help you recognize strengths in your team and how to apply those strengths to other areas in need of improvement.

Monitor your culture – this is particularly important in regards to a psychologically safe environment. You need every single individual on your team to be the eyes and ears for patient care and client satisfaction (Lee). People often do not complain to an authority figure but will readily unload on another person (how many times will a client not complain to a doctor but once they exit the exam room they are unloading on the receptionist). Can your team members speak up when their eyes and ears have seen something of concern? The following behaviors must be established in your culture to permit everyone to speak up (Sherman):

- Show civility when a concern is presented for discussion
- Argue with respect, be tolerant of other viewpoints, it is OK to respectfully disagree
- Be supportive, share information and ideas, and work toward a solution

How would this process look in a practice?

For instance, your team has been experiencing problems with missing lab results.

The assessment shows that clients drop off samples or different technicians draw samples and run tests throughout the day. Test results pile up waiting for a doctor to review the results. Inefficiency abounds with single tests being run multiple times throughout the time eating up time and control samples. Clients call

the clinic asking for results. Some days the lab work is done while the client waits, other times the client is told they will be called – no day is ever the same. No one is in charge of lab equipment, machines are not calibrated, and everyone has their own way of doing things from obtaining sample – to running tests – to charging the client.

The battle cry goes out to hire more people but is that really the answer to inefficiency? Instead, the practice sets up a troubleshooting meeting. The team walks through the process and finds out that a lab sample can easily pass through 3 or more different people. They notice the number of times people "handle" a case – from the initial arrival of the patient, to obtaining the sample, to handling repeated calls from the client for results, to searching for results to give to the doctor…. The team notices that "Who did this" is a common question. All of these show the opportunity for a breakdown in quality and efficiency. Their goal: to prevent errors and improve consistency in lab performance and client service.

In the end, it is decided to change the operations. Lab equipment is centralized in one area instead of spread out around the clinic. A 'lab tech' position is created and the job description identifies this person as responsible for obtaining/drawing samples, running tests and batching some tests, forwarding reports to the correct doctor, performing follow-up phone calls with the clients, conducting lab maintenance and quality assurance runs on lab equipment, and overseeing inventory levels. A few individuals are identified for the position and undergo additional training in regards to equipment maintenance and consistency in obtaining samples and performing tests. The change is monitored for the next 6 months regarding testing completions, client satisfaction, and level of busy-ness for the new position.

Successful Q&E

Ask your team this question – "What do you see as barriers to delivering excellent, exceptional service?" "What do you see as barriers to performing our jobs without errors?" Do not wait for a client complaint to take action to improve your Q&E (Lee). After all, why risk a poor "memorable moment" for a client (one that they will post on social media) when your team already knows about a Q&E problem and could have prevented it from reaching the client experience level!

References

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