



southpaws

SPECIALTY SURGERY FOR ANIMALS

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Surgical consults are **ALWAYS** free-of-charge at Southpaws

Free surgical consults with Charles in Castlemaine 23rd October. Call 03 5472 5477 to book in.

A MONTHLY NEWSLETTER

1 OCTOBER 2013

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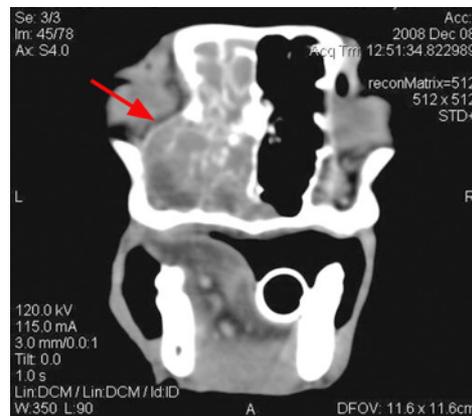


Surgery and Radiation in Dogs with Intranasal Tumours

Intranasal tumours are common in dogs. Treatment options are limited, with survival times of only about two months in untreated dogs and about 12 months with radiation therapy alone.

The Southpaws Experience

We are currently compiling data on dogs with intranasal tumours treated with aggressive marginal surgical excision (to glistening bone) followed by 50 Gy orthovoltage radiation in 17 to 20 fractions. We have treated 18 patients



over 8 years. Our median survival time is **30 months**. Our recurrence free interval (RFI) is **23 months**. We have had 12 recurrences, and 3 metastases. Our median long-term client satisfaction with the whole process and survival

was 10/10 with a range of 5 to 10. The median satisfaction with acute side effects was 8.5/10 ranging from 4 to 10. When asked, all but one owner would repeat the procedure with another dog if in the same situation. We have treated the last six with a carboplatin pump 300 mg/m² for 4-5 days as a radiation sensitizer, but it is too soon to tell if it is making a difference since 5 out of 6 are censored due to lack of recurrence.

These are some of the best outcomes ever published. We surmise these superior results arise from the meticulous nature of the surgery along with close cooperation between surgical radiation services.

A day in the life of a vet nurse at Southpaws

Camille Morris, Head Veterinary Nurse



Working at Southpaws as a nurse is a very rewarding and challenging experience. Our day is certainly never boring. We may assist

with up to 8 surgical cases in one day, including thoracotomies, orthopaedics, soft tissue and neurological cases.

At Southpaws we have the opportunity to follow our cases from admission to discharge. This gives us, as nurses 'ownership' of each case and a feeling of satisfaction once completed. We are able to form a connection with the owner, which helps us have an understanding of their pet and the care required whilst they are with us.

Once we are assigned a patient, we talk through all aspects of the procedure and aftercare with the client. Once admitted to hospital, that nurse looks after the patient until handover at the end of the surgery day. This maintains continuity for the patient and also the nurse.

We are very lucky at Southpaws to have such a high nurse to patient ratio. This means that we are able to dedicate time and a high level of care to our patients. This is probably the most important factor to each nurse that works at Southpaws.

Our day does not always involve surgery cases. We work on a rotating roster, which gives each nurse the opportunity to be ward nurse or surgery nurse. Ward nurse involves looking after patients that have had surgery the previous day and assisting the surgery nurses with their patients on recovery.

During our day we are required to maintain the flow of the surgery cases. This means working closely with each other and having good communication skills. As soon as patients are admitted, there is a hive of activity as charts are made up, iv catheters are placed, bloods are taken (if required) and surgery rooms are made ready. We call it "organised chaos!"

New Arthroscopic Fluid Pump at Southpaws

In the interest of continually providing the best care possible, we frequently invest in new technologies.



We have just purchased a new arthroscopic fluid pump to improve visualisation during minimally invasive joint surgery. This has been shown to reduce operative time significantly.

At Southpaws we almost always perform arthroscopy in conjunction with TPLO surgeries. Arthroscopy has been shown to accelerate recovery when compared with arthrotomy in conjunction with TPLO's

Improvement in Success Requires Diligence

"We always hope for the easy fix: the one simple change that will erase the problem in a stroke. Few things in life work this way. Instead, success requires making a hundred small steps go right - one after the other, no slipups, no goofs, everyone pitching in."

Atul Gawande, *Better: A Surgeon's Notes on Performance*



Gerri - an 11 year old German Shepherd presented with an epulis on her right rostral mandible.

Externally, her mass was small, but a CT

scan was performed as part of our standard protocol for oral tumours. What we found was surprising. The external mass was just the tip of the iceberg. Not catastrophic - but the surgical plan had to be modified.

A partial maxillectomy was performed using the CT scan as a guide. There was virtually no haemorrhage until the last bit of soft tissue was excised - then the

flood gates opened. The blood pressure dropped, and the anaesthetist was directed to administer colloids and crystalloids. Blood loss was closely monitored by weighing bloody gauze sponges as well as the suction bucket. When losses reached 35% of total blood volume, a transfusion was triggered.

Leah, one of our nurses, went home to get her Great Dane, Gracie, as a donor. Our Raelene Wouda, who has done a fellowship in transfusion medicine at the University of Pennsylvania, supervised the blood collection and transfusion as we closed. The diligent surgeon did not rush the closure. She drilled bone tunnels in the hard palate, as we always do with partial maxillectomies in order to prevent complications in the future. It was suggested that the carotid arteries be temporarily ligated, and this was performed. One of our other surgeons scrubbed in to assist the primary surgeon while the other went on to perform surgery on another patient that had already been anaesthetised.

Following surgery, haemorrhage ceased until the following day. The temporary ligatures were released, but left in place in case of further bleeding. At the first feeding, bleeding started again. The ligatures were re-tightened, and Gerri was taken back to surgery for permanent placement of ligatures.

The whole time, the owners were communicated with and the records were updated meticulously. Gerri was kept clean, warm and pain-free. She was cared for by the overnight nurse who continued to expertly monitor and support Gerri through the night.

All the necessary equipment was readily available and in good working order. Consumables were available because of diligent maintenance of stock.

We honestly believe that her care could not have been better anywhere. It truly exemplifies the concept of "whatever it takes." Each development was handled efficiently and expertly with concern only for Gerri's well-being. This is not a case that would be written up in a peer-reviewed journal, but absolutely typifies the best that we have to offer.



“The best interest of the patient is the only interest to be considered...” -W.J. Mayo

I have read some books relating to improvements made in the practice of medicine and compiled a list of principles that have been applied in human hospitals. Some of these may apply to our practices help to improve our outcomes. As clinicians we should be ever striving to improve our results and the well-being of our patients. I found these passages inspiring and we try to apply them whenever we can.

by Charles Kuntz

1. **Evaluate your results.** Don't just assume that things are going well. We tend to forget failures and focus on successes. Measure yourself and be open about how you are doing. Most practice management software packages allow you to search by diagnosis. Compile lists. Followup on cases. We actively perform retrospective and prospective studies on different procedures that we do. When we identify things that are not going as well as we would like, we scour the literature

to see if others are doing better than we are. If they are, we instigate changes to our protocols. Otherwise, we try to devise alternatives ourselves. This is how we have published improvements in survival with osteosarcomas, injection site sarcomas in cats, soft tissue sarcomas in dogs and nasal tumours in dogs.

2. **Be your own harshest critic.** Make a list of your patients with suboptimal outcomes. Investigate them and don't be too quick to blame the patient, the fracture, or the tumour. Get the input of others. At Southpaws, we have a protocol by which any staff member (from specialists to receptionists) can request a case review if they don't understand why a patient of ours has not done well. This triggers an intensive review of the medical record, investigation of the relevant literature and presentation to the rest of the staff by the clinician.

3. **In paediatric critical care,** the risk of mortality is highest during the transport of patients from surgery to ICU. In Formula 1, racing crews can refuel a car

and change all four tires in under 7 seconds. No F1 driver has died at the wheel in a Grand Prix race since 1994. In one hospital, they had a Formula 1 pit crew observe a paediatric critical care unit for 3 weeks. They made recommendations on how they could be more efficient. The results were astonishing.

- ✓ Mean number of technical errors dropped from 5.42 to 3.15.
- ✓ Mean number of omissions of critical information dropped from 2.09 to 1.07.
- ✓ Total number of patients suffering errors dropped from 39% to 11.5%.

This crazy idea was thought up by two doctors watching Gran Prix one afternoon. The improvements were attributed to well-defined leadership, task sequencing, checklists, training and repetition.

4. **Make checklists.** Airlines do it. Make a science of performance rather than waiting for new discoveries. Nurses should be allowed to stop doctors if



checklists are not followed. Nurses have the backup of the administration if steps are not followed by doctors. This process dropped catheter line infections from 11% to 0% at Johns Hopkins University, saving hundreds of lives per year. Checklists provide a kind of cognitive net. They catch mental flaws inherent in all of us; flaws of memory, attention and thoroughness.

5. **Diligence** - This is the constant and earnest effort to accomplish that which is undertaken. There is a simplistic relentlessness to it. It sets a high, seemingly impossible, expectation for performance and human behaviour. In the US, the average lifespan with cystic fibrosis is 30 years. One clinic, however has an average lifespan of 47 years. They have not had a single death in the last 10 years in a patient under 10 years of age. This is not through advances in technology. It is through consistent application of established knowledge of the treatment of these patients.

6. **Do right** - Medicine is a fundamentally human profession. It is fraught with human failings like avarice, arrogance, insecurity, misunderstanding. Integrity is paramount.

7. **Always fight.** Always look for what more you can do. Avoid giving up on a patient you could have helped. As long as the patients are unwilling to give up, there should be a relentless search for things that we can do to save them - to increase quality and quantity of life.

8. **Ask your staff** for advice on what they would suggest to make things better in your hospital. Give them a voice.

9. **More mistakes are made by not looking than not knowing.**

10. **Be an early adopter.** Look for opportunity to change. Centres that are

willing to change will improve the fastest.

11. **The Bell-shaped Curve.** It is distressing for doctors to have to acknowledge the bell curve of success. It belies the promise that we make to patients who become seriously ill: that they can count on the medical system to give them their very best chance at life. It also contradicts the belief nearly all of us have that we are doing our job as well as it can be done. But evidence of the bell curve is starting to trickle out, to doctors and patients alike, and we are only beginning to find out what happens when it does. It drives hospitals to try to improve their outcomes.

12. **The Mayo Clinic** is a huge hospital network in the US which was started over 140 years ago in Rochester Minnesota by Dr. William Mayo and his sons William and Charles Mayo. It currently has campuses in Minnesota, Arizona and Florida. There are 42,000 employees, students and volunteers. 300 surgeries are performed on a typical weekday. By noon, up to 13,500 patients will have received medical services. During a 24 hour period, 4600 radiological procedures will have been performed. 2,500 Mayo clinicians will conduct more than 9,000 consultations. Revenue totaled 7.3 Billion dollars in 2007. It is a non-profit organisation. It is the only medical school not associated with a University in the United States. At any one time, there are more than 7,000 approved research projects underway.

Early on, Dr. William Mayo established conditions that he considered essential to the future success of the clinic. They included:

The continuing pursuit of the ideal of service and not profit.

The primary and sincere concern for the care and welfare of each individual patient.

The continuing interest by every member of the staff in the professional progress of every other member.

A willingness to change in response to the changing needs of society.

Continuing effort toward excellence in everything that is done.

Continuing conduct of all affairs with absolute integrity.

The needs of the patient ALWAYS COME FIRST. This guides every decision from the reception desk to the boardroom. It encompasses all medical, ethical and service decisions in patient care. It sustains the organisation by creating a rock-solid basis from which to operate.

Dr. Mayo articulated these values in a commencement address in 1910: "The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, union of forces is necessary. It has become necessary to develop medicine as a cooperative science."

These are some of the books that I used as resources. All are available on Kindle

1. *Better: A Surgeon's Notes on Performance* by Atul Gawande 2010
2. *Management Lessons from the Mayo Clinic* by Leonard Berry and Kent Seltman 2008
3. *The Checklist Manifesto* by Atul Gawande 2010
4. *Complications* by Atul Gawande 2010
5. *Safe Patients Smart Hospitals* by Peter Pronovost 2010