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TRAINED TO HEAL,

Never Trained to Lead



Why great vets burn out, good staff leave and profits leak, and how to take back your clinic

Oshi Kirk
Vet Edge and Business Consult Group

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"Ineffective management does not show up as a line on your P&L. Finding it takes investigation, because the cost is rarely easy to tie to one manager or a specific reaction to their actions or lack thereof. Your procedures might be profitable, but when your staff retention is poor, can you identify the cost of that?

A lack of sound leadership and management can be very expensive, but sadly it is not always easy to recognise."

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The management models discussed in this book belong to their original authors and are credited where they appear.

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About the Author



Oshi Kirk is the Director of Vet Edge, which works with veterinary clinics across Australia and New Zealand, and the owner of Business Consult Group, an Australian business consulting and coaching firm. Oshi started her first business in 2003, with a complex structure from day one: importing and exporting, currency hedging and trading in multiple currencies, along with cash flow, marketing, building a partner network, hiring, firing and every kind of people problem in between. Oshi ran the business for around twelve years before selling it.

Running that business was rewarding, and it was also a very lonely place to be. In those early years there was no budget for a coach or mentor, and very little practical support for an owner who was great at the work but had never been taught how to lead a team. Business Consult Group was born from that gap.

Since then, Oshi has spent more than twenty years helping startups and established businesses grow, including businesses that arrived stuck, exhausted or close to the edge. Oshi has coached hundreds of owners, managers and team members across many industries, from trades in construction to equipment suppliers, health clinics, hospitality, technology and international startups.

Working alongside clinic owners, practice managers and senior nurses, Oshi kept seeing the same pattern. The clinical work was excellent. The management was improvised. The cost of that gap showed up everywhere: in resignations, in skipped protocols, in tired teams and in clients who quietly went elsewhere.

This book, and the Vet Edge Manager's Toolkit that sits behind it, are the response.

Business Consult Group helps owners and managers build businesses that run well without depending on one exhausted person. Its management program has been delivered as classroom training for years, and has now been rebuilt as a self paced toolkit for veterinary teams.

How to Use This Book

This book has three parts.

Part One, The Cost, looks honestly at what happens to a vet clinic when nobody is really managing it. It covers staff turnover, protocols that drift, clients who leave, and the trap of promoting great clinicians into management without support. If you only read one part, read this one.

Part Two, The Fixes, walks through the core skills every clinic manager needs. Each chapter opens with what goes wrong in a real clinic, explains why it happens, and gives you a practical method you can use this week. Each chapter ends with a short self check and one action to take.

Part Three, Making It Stick, gives you a ninety day plan to put it all into practice.

You do not need to read Part Two in order. Start with the chapter that matches your biggest headache. If your team is leaving, start with Motivation and Feedback. If you are drowning, start with Delegation and Self Management. If you report to an owner who never seems to hear you, start with Managing Up.

If you are a clinic owner who is also a practising vet, start with Chapter 5. It was written with you in mind.

Every chapter matches a module in the Vet Edge Manager's Toolkit, where you will find a fillable worksheet that turns the ideas into a plan for your own clinic.

Introduction: The Clinic That Looked Fine

On paper, Riverbend Veterinary Clinic was doing well. Revenue was up on last year. The waiting room was busy. The reviews online were mostly four and five stars. The owner, a gifted surgeon with twenty years of experience, was proud of what she had built.

Then, over eighteen months, four of her six nurses resigned.

None of them left in anger. Each gave a polite reason. One wanted to be closer to family. One was "looking for a change". One was going to a clinic with better rosters. The last one simply said she was tired.

The owner replaced them, one by one. Each new nurse needed training. Each recruitment round took weeks of advertising, interviews and reference checks. In the gaps, the remaining team covered extra shifts, which made them more tired, which made the next resignation more likely.

At the same time, small things began to slip. Discharge instructions were sometimes rushed. Reminder calls for vaccinations went out late, then not at all for a few weeks. The controlled drug register had gaps that took an afternoon to reconcile. A long time client complained that nobody had called her back about her dog's test results, and then she moved her three pets to the clinic down the road.

Nothing dramatic happened. There was no single crisis. There was just a slow, steady leak of energy, money and goodwill.

When the owner finally sat down to work out what was going wrong, she expected to find a clinical problem, or a pricing problem, or a marketing problem. What she found was a management problem.

Nobody had been managing the clinic. Everybody had been working in it.

A note on privacy: Riverbend Veterinary Clinic is not the clinic's real name. Its name, location, size and other identifying details have been changed to protect the clinic, its owner and its team. The same applies to every clinic and person described in this book.

The problem nobody trains you for

Veterinary professionals are among the most highly trained people in any workplace. A vet spends years learning anatomy, pharmacology, surgery and medicine. A nurse spends years building clinical skill, animal handling and client care. A practice manager often rises from the front desk or the nursing team because they were reliable, organised and good with people.

Almost none of them are taught how to manage.

Management is not the same as being good at your job. It is a separate set of skills: setting priorities, delegating, giving feedback, running a meeting, having a hard conversation, building a team, planning the week, and working well with the owner or

the board above you. These skills can be learned. But in most clinics they are picked up by accident, under pressure, from whoever happened to be in charge before.

In fact, being a vet and being a manager are vastly different in character. A vet is trained to be the best: to top the class, to master the clinical knowledge, to be the person everyone turns to with the hardest case. Success is measured by what you can do yourself.

A manager succeeds in the opposite way. The goal is to make everyone around you better than you, or at least as good. Only then can the clinic run without you in every room, and only then do you have the freedom to work on your business rather than in it.

Human medicine shows the same pattern. Specialist surgeons are trained to be the very best and to operate in the top hospitals in the country. Many are brilliant at what they do, yet they are not always known for empathy or for building strong teams. It is common for such a surgeon to keep one trusted assistant for years, rather than developing a whole team of capable people around them. Their training rewards individual excellence, not leadership. Vets who own clinics often face the same gap, and nobody points it out to them.

The result is that many clinics are run by excellent clinicians who are improvising as managers. They work long hours. They care deeply. And they are often exhausted, because the clinic depends on them for everything.

No one feels this more than the owner vet. Vets are trained to be vets, not leaders or business owners. Yet the moment they buy a practice, they are expected to be both, on top of a full clinical caseload. Many end up working impossible hours, carrying the emotional weight of the whole business, and quietly paying for it with their own mental health.

And a burnt out owner creates a burnt out business. Decisions are rushed or avoided, problems are left to grow, and the financial and technological solutions that could ease the load are never put in place, because nobody has the time or energy to look up from the daily grind. Chapter 5 looks at this in depth. If you are an owner vet, it may be the most important chapter in this book.

Why this book focuses on the cost

Most management books start with the skills. This one starts with the cost.

That is deliberate. Busy people do not change how they work because a book tells them a technique is useful. They change when they see clearly what the current way is costing them.

So Part One of this book asks a blunt question: what actually happens to a vet clinic when it is not well managed? The answer is not abstract. It shows up in staff who leave, in protocols that drift until they are optional, in clients who quietly take their pets elsewhere, and in owners and managers who burn out carrying everything themselves.

Once you see those costs clearly, the skills in Part Two stop looking like extras. They start looking like the cheapest insurance your clinic can buy.

Who this book is for

This book is written for the people who hold vet clinics together:

- **Clinic owners** who have built a good practice and now feel the business running them, rather than the other way round.
- **Practice managers** who are responsible for people, rosters, systems and budgets, often without the authority or the support to match.
- **Senior nurses and head nurses** who lead a clinical team and have been promoted, sometimes over their friends, into a role nobody explained.
- **Associate vets** stepping into clinical director or team lead roles for the first time.

If you are responsible for other people's work in a vet clinic, this book is for you.

What you will not find here

You will not find theory for its own sake. The management models in this book are well established and they are credited properly, but each one earns its place only if it helps you on a busy Tuesday afternoon.

You will not find examples from factories, banks or software companies. Every example is set in a vet clinic, because that is where you work, and because a clinic has its own pressures: emergencies that blow up the schedule, emotional clients, euthanasia, compassion fatigue, a small team where everyone knows everyone, and a culture where the person who is best with animals is not always the person who is best with people.

And you will not find a promise that management is easy. It is not. But it is learnable, and the payoff is real: a team that stays, systems that hold, clients who come back, and a manager who goes home at a reasonable hour.

Let us start by looking at what happens when nobody is managing.



Part One

The Cost

Part One: The Cost

Before you can fix a problem, you have to see it clearly. That is harder than it sounds, because the cost of poor management in a vet clinic rarely arrives as one dramatic event. It arrives slowly: one resignation, one skipped step, one client who quietly does not come back.

Part One brings those hidden costs into the light. Chapter 1 describes drift, the slow slide from managing a clinic to simply surviving it. Chapter 2 counts the real cost of the people who leave. Chapter 3 looks at what happens when protocols become optional. Chapter 4 follows the line from a struggling team to the clients who feel it. Chapter 5 turns to the people who carry the heaviest load: the owner vets and promoted managers who were trained to heal, but never trained to lead.

Some of this may be uncomfortable to read. That is the point. Every cost described here is a cost that good management can reduce, and the rest of this book shows you how.

Chapter 1: The Price of Drift

Vet clinics rarely fail because of poor medicine. They fail, or more often they quietly underperform for years, because of poor management.

The pattern is so common it deserves a name. Call it drift.

Drift is what happens when a clinic runs on habit, goodwill and the energy of a few key people, rather than on clear roles, agreed standards and regular routines. Nobody decides to let things drift. It happens because everyone is busy, the phones are ringing, there is a dog on the table, and management feels like something you will get to later.

Later never comes.

What drift looks like from the inside

If you work in a drifting clinic, you will recognise some of these signs:

- The same problems come up at every team meeting, if there are team meetings at all.
- People say "that's not my job" or, worse, assume someone else has done it.
- The owner or practice manager is the answer to every question, so they can never leave the building.
- New staff learn the job by watching whoever is on shift, so each person learns a slightly different version.
- Protocols exist in a folder somewhere, but nobody can remember when they were last read.
- Feedback happens only when something goes badly wrong, and then it happens all at once.
- Good people leave, and the exit conversation never quite explains why.
- Everyone is busy all the time, but the important projects never move.
- New technology and equipment the clinic has paid for sit unused or half used. Software features are never switched on, and devices end up in a cupboard. Getting real value from any new investment needs leadership: a clear plan, a person to own it, training for the team and follow up until it becomes part of the routine. Without that, the money is spent but the benefit never arrives.

None of these signs is a disaster on its own. Together they describe a clinic that is spending most of its energy just keeping up. Profits go untapped, because most things are not used to their full potential, and the clinic may be missing out on gains it does not even know exist. Drift also creates a workplace that people are not excited to come to each day, and that feeling does not stay behind the scenes. Clients notice it in every visit, even when the owner, who is too close to it every day, may not see it. The result is yet another pressure point for the owner: knowing the bucket is leaking somewhere, but not knowing where the leaks are coming from. One more thing to worry about, on top of everything else.

Reactive versus proactive management

One of the clearest ways to understand drift is to look at how the manager spends their day.

A **reactive** manager responds to whatever lands in front of them. The phone rings, they answer it. A nurse has a question, they answer it. A client is unhappy, they deal with it. A supplier calls, they take the call. By the end of the day they have been busy for ten hours and have done nothing they planned to do.

A **proactive** manager still handles the urgent things. Vet clinics will always have urgent things. But they also protect time for the work that prevents tomorrow's emergencies: training, planning the roster ahead, checking that protocols are being followed, having the conversation with the nurse who has seemed flat for a month, preparing for the meeting with the owner.

Reactive management feels productive. It is exhausting, and it guarantees that the same problems keep coming back. Proactive management feels slower at first. It is the only way the problems actually get smaller.

Most clinic managers know this. The difficulty is that nobody showed them how to make the shift, and the clinic does not slow down long enough for them to work it out.

The four shifts from doing to managing

When someone moves from being a great nurse, receptionist or vet into a management role, four things have to change. When they do not change, drift follows.

From doing the work to getting the work done through others. As a nurse, your value was in your own hands. As a manager, your value is in what the team achieves. A manager who keeps doing all the hands on work becomes a bottleneck and leaves nobody else room to grow. In clinics run by vets, micromanagement is common, and it is completely understandable. Vets are trained to make sure everything is right clinically at all times, so watching over every detail feels like doing the job properly. Teaching others what you do best, then agreeing to manage rather than micromanage, is one of the hardest changes a vet owner can make.

From being liked to being respected. As a team member, you were one of the group. As a manager, you sometimes have to make decisions people do not like. A manager who needs everyone to be happy all the time will avoid the conversations that matter. For many vets this is the toughest pill to swallow. It asks the same winning ego that years of training built, the drive to be the best, to take a back seat so that others can shine.

From short term to longer term thinking. As a team member, you focused on today's appointments. As a manager, you are responsible for next month's roster, next quarter's training and next year's team. If nobody is thinking ahead, the clinic is always reacting. This is especially hard when you spend every day working in the business rather than on it. Buried in today's consults and surgeries, it is difficult to see how much

careful planning and thorough follow through would change the clinic's future, so the planning keeps getting pushed back.

From your own standards to shared standards. As a team member, you did things your way and did them well. As a manager, your job is to make sure everyone does things to an agreed standard, even when they would do it differently. That means writing standards down, teaching them and checking them.

Each of these shifts is uncomfortable. Each is learnable. Chapter 6 comes back to them in detail.

The hidden iceberg

The reason drift goes unnoticed for so long is that most of its cost is hidden.

Above the waterline, you can see a few things: the resignation letter, the angry client, the error that needed an incident report. These feel like isolated events.

Below the waterline sits the real cost:

- Hours spent recruiting and training replacements.
- Overtime and agency fees to cover gaps.
- Lost productivity while new staff get up to speed.
- Revenue from clients who leave without complaining.
- Mistakes and rework from inconsistent processes.
- Medications and consumables wasted or not charged.
- The owner's or manager's time spent firefighting instead of growing the business.
- The slow erosion of morale among the people who stay.

The chapters that follow look at the biggest of these costs one by one. The aim is not to make you feel bad. It is to give you a clear, honest picture of what is at stake, so that the time you invest in management feels like what it is: an investment with a return.

A clinic example: when revenue falls and costs do not

A mixed practice had grown quickly during the pandemic pet boom. When new pet numbers settled, revenue came off its peak. The cost base did not follow. Rosters, locum shifts, software subscriptions and stock levels all stayed where they had been at the busiest time, and within two years a healthy clinic was barely breaking even.

None of this was hidden in the accounts. It was simply that nobody had a routine for looking. There was no monthly review of the numbers, no regular check of fees against costs, no stock ordering tied to actual usage, and no plan for cross training so the clinic could run well with fewer locum shifts. Each of those gaps was a management gap. Once a few simple routines were in place, the owner could finally see where the money was going and make deliberate decisions, rather than hoping next month would be busier.

Self check

Answer honestly. Score each statement from 1 (not at all true) to 5 (very true).

1. I spend most of my day responding to whatever comes up.
2. If I took two weeks off, things would start to go wrong.
3. We discuss the same problems over and over without fixing them.
4. I am not sure every team member follows our key protocols the same way.
5. I have lost a good team member in the past year and I am not completely sure why.

If you scored 15 or more, your clinic is drifting. That is not a judgement. It is the normal state of a clinic where talented people are managing without training or tools. The rest of this book is about changing it.

One action this week: for three working days, jot down every interruption you deal with and who brought it to you. At the end, circle the ones that someone else could have handled with the right information or authority. Keep the list. You will use it in Chapter 7.

Chapter 2: The Revolving Door

Every clinic loses people. Partners move interstate, nurses go back to study, receptionists change careers. Some turnover is healthy and unavoidable.

The problem is the turnover that did not need to happen: the good nurse who left because she felt invisible, the receptionist who left because the roster was always last minute, the young vet who left because nobody had time to mentor him. That turnover is a management cost, and in most clinics it is the single biggest one.

What one resignation really costs

Most owners underestimate the cost of losing a team member because they only count the obvious part: the job advertisement.

The real cost is much larger. The figures below are an illustration only, using round numbers for a vet nurse on a salary of about $65,000. Replace them with your own figures. The point is the shape of the cost, not the exact total.

Cost item	How to estimate it	Example
Advertising and job boards	Actual spend	$800
Manager time recruiting	Hours spent writing ads, screening, interviewing, checking references, times your hourly cost	20 hours, $1,200
Team time in interviews and trial shifts	Hours times hourly cost	8 hours, $350
Covering the vacancy	Overtime, agency or locum costs while the role is empty	6 weeks, $3,000
Onboarding and training	Trainer time plus reduced output while the new person learns	3 months at half output, $8,000
Errors and rework while learning	Missed charges, repeated tasks, stock waste	$1,000
Lost bookings	Appointments not offered because the team was short	$2,000
Total for one resignation		**About $16,000**

In this illustration, one resignation costs roughly a quarter of the person's annual salary. For a vet, the figure is usually far higher, because recruitment takes longer and each unfilled day means lost consults and surgeries.

Now multiply. If a clinic of twelve people loses three people a year who did not need to leave, the cost is close to $50,000 a year, every year. That is money that never shows up on a single line of the profit and loss statement. It hides inside wages, overtime, agency fees and revenue that was never earned.

The costs you cannot put in a spreadsheet

The financial cost is only part of the story.

Knowledge walks out the door. The nurse who leaves knows which clients need extra reassurance, which suppliers are reliable, where the spare oxygen cylinder is kept and how the old anaesthetic machine needs to be coaxed. Much of this was never written down.

The people who stay carry the load. Every vacancy means extra shifts, skipped breaks and more pressure on the remaining team. Tired people make more mistakes and are more likely to leave themselves. This is how one resignation becomes three.

Clients notice. Pet owners build relationships with the people who care for their animals. When the familiar faces keep changing, trust erodes. Some clients will say nothing and simply move clinics.

Culture weakens. A team that is constantly onboarding never quite becomes a team. Shared standards are hard to keep when half the people are new.

Why people really leave vet clinics

When a team member resigns, the stated reason is often pay, hours or a move. Sometimes that is true. But in most cases the decision to leave was made months earlier, and the stated reason is simply the most comfortable one to give.

The real reasons usually sit in a small number of themes:

- **I do not feel valued.** Good work goes unnoticed. Feedback only comes when something goes wrong.
- **I do not know where I stand.** Expectations are unclear. Performance is never discussed until there is a problem.
- **It is not fair.** Some people seem to get the good shifts, the training or the leniency, and others carry the load. People compare what they give and get with what others give and get, and they notice unfairness quickly.
- **I am not growing.** Nobody has talked about what I want to learn or where my career could go.
- **I am exhausted.** The workload never eases, rosters change at short notice, and compassion fatigue is never discussed.
- **I do not trust my manager.** Promises are not kept, conversations are avoided, decisions seem random.

There is one more reason that deserves its own mention: **the job was not what I was promised.** When we recruit, we sell the clinic. We describe our vision: the training program, the nurse led clinics, the new equipment, the career path, the supportive

culture. Often we mean every word. Then the new team member starts, and reality hits. The training never quite happens, the new clinics never launch, and the vision stays a vision, because nobody had the time to put it into action. The gap between what was promised and what was delivered is rarely discussed, but the new person feels it keenly, and it is often the moment they start looking elsewhere.

Look carefully at that list. Almost every item is about management, not money. A clinic cannot always pay more than the clinic down the road. It can almost always manage better.

A clinic example: the new graduate who was set up to fail

A busy small animal clinic hired a new graduate vet. It was a good decision. The advertisement promised mentoring, a structured first year and support on every shift, and the clinic meant every word.

In practice, the new graduate was on the consult roster from her second week. The senior vet who was meant to mentor her was fully booked. Nobody reviewed her cases or sat in on a difficult consult. After hours shifts started earlier than planned because the roster was short. Within six months she was anxious and exhausted, and she left before the end of her first year.

The next time the clinic hired a graduate, it did things differently. The first month was protected, with longer consult times and a senior vet rostered on the same shifts. A weekly half hour case review gave the new vet a safe place to ask questions and get feedback. After hours work started only when she and her mentor agreed she was ready. The cost of all this was a few hours a week. The difference in confidence, and in retention, was enormous.

The first graduate did not fail because she was the wrong person. She failed because nobody managed her.

The manager is the job

There is a well known saying that people join organisations but leave managers. In a vet clinic, where teams are small and the manager is present every day, this is even more true.

For a nurse, the manager decides the roster, approves leave, assigns cases, notices or ignores good work, handles conflict, and decides whether they get training. In practice, for most team members, the manager is the job.

That is uncomfortable for many managers to hear, especially those who were never trained for the role. But it is also good news. It means the most powerful retention tool in your clinic is not a pay rise. It is you.

Stay conversations, not just exit interviews

Most clinics, if they ask at all, ask why people are leaving after they have already resigned. By then it is too late, and the answer is usually polite rather than honest.

A far more useful habit is the stay conversation. Once or twice a year, sit down one to one with each team member and ask a few simple questions:

1. What do you enjoy most about working here?
2. What frustrates you most in a typical week?
3. What would make you think about leaving?
4. What would you like to learn or do more of in the next year?
5. What could I do differently as your manager?

Then act on at least one thing they tell you, and tell them you have done so. Chapters 8, 10 and 12 give you the tools to make these conversations natural rather than awkward.

Self check

1. How many people left your clinic in the past twelve months? How many of those departures were avoidable?
2. For each person who left, can you name the real reason, not the polite one?
3. When did you last ask each team member what would make them stay?

One action this week: use the table above to estimate the cost of the last resignation in your clinic. Use real numbers. Then decide whether one hour a month spent on each team member would be a better investment.

Try the free cost of resignation example →

Chapter 3: When Protocols Become Suggestions

Every vet clinic has protocols. There is a way to admit a surgical patient, a way to record controlled drugs, a way to discharge a patient, a way to clean the theatre, a way to charge for consumables, a way to follow up on test results.

The question is not whether the protocols exist. It is whether everyone follows them, the same way, every time.

In a drifting clinic, the honest answer is no.

How protocols quietly fall apart

Protocols rarely collapse in one go. They erode, one reasonable shortcut at a time.

It starts on a busy day. A nurse skips one step of the discharge checklist because the client is in a hurry and the step seems minor. Nothing goes wrong. The next busy day, she skips it again. A new nurse watches her and learns that this is how discharges are done. Six months later, nobody does that step, and nobody remembers that it was ever part of the protocol.

This is how a written standard becomes an unwritten habit, and how an unwritten habit becomes "the way we do it here". Each shortcut felt sensible at the time. Nobody decided to lower the standard. It simply drifted, because nobody was checking.

The longer this goes on, the more normal the shortcut feels. When something finally goes wrong, people are genuinely surprised, because they have been doing it that way for months without a problem.

The five reasons protocols are not followed

When a protocol is not being followed, the cause is almost always one of five things:

1. **It was never clearly defined.** The protocol lives in someone's head, or in a document so long that nobody reads it. Ask three nurses how a surgical admission should run and you may get three different answers, each delivered with confidence. When the standard is not written down in a short, clear form that people actually use, everyone fills the gaps with their own version. A protocol that cannot be explained in a page, or shown as a simple checklist, is usually not really a protocol at all.
2. **It was never properly taught.** New staff learned by watching, so they learned whatever version the person on shift happened to use. In a busy clinic, induction is often a quick tour and a week of shadowing, and any shortcuts the experienced person has developed are passed on as if they were the rule. Long serving team members are rarely retrained when a protocol changes, so old habits survive alongside new ones. Teaching takes time, and time is exactly what a stretched clinic feels it does not have.
3. **It is never checked.** Nobody looks at whether it is happening, so there is no signal when it stops. Most clinics only discover a protocol has lapsed when

something goes wrong: a complaint, a missed charge, an audit, an unhappy outcome. By then the shortcut has often been in place for months. Without a light, regular check built into someone's week, the clinic is relying on hope rather than evidence, and the first sign of a problem is usually the expensive one.

4. **Nothing happens either way.** People who follow the protocol carefully get no recognition. People who skip it face no conversation. Over time the team learns that the standard does not really matter, because doing it properly and cutting corners lead to exactly the same result. The conscientious people feel taken for granted, and the shortcut takers feel no reason to change. Often the manager has noticed the problem but avoided raising it, because the conversation felt awkward or the person was a friend (Chapter 11).
5. **It was never made our own.** Many protocols came with the clinic when it was bought, or arrived ready made from a software provider or industry template. They were written once and never revisited or adjusted to fit how this clinic works and what this team is trying to achieve. A protocol nobody has shaped is a protocol nobody feels ownership of. Protocols need regular review and, at times, real change.

Notice that none of these is about the team being careless or lazy. All five are management gaps. A protocol is only as strong as the management routine that sits behind it.

What it costs

When protocols drift in a vet clinic, the costs fall into three groups.

Clinical and safety risk. Missed checks before anaesthesia, incomplete patient records, sterilisation logs that are not kept, medication doses not double checked. Most of the time nothing happens. Occasionally something serious does, and when it does, the gap in the process is usually obvious in hindsight.

Compliance risk. Controlled drug registers, radiation safety records, workplace health and safety requirements and record keeping obligations are not optional. Gaps here can expose the clinic and individual vets to regulatory trouble that is far more expensive than the time it would have taken to keep things in order.

Revenue leakage. This is the cost most clinics never see. Consumables used but not charged. Hospitalisation fees not added. Reminder systems that stopped working, so vaccinations, dental checks and recalls are missed. Estimates not updated when a procedure changes. Each gap is small. Across a year they add up to a significant amount of lost revenue, and in many clinics nobody has ever measured it.

There is a fourth, softer cost. When the conscientious team members see others skipping steps without consequence, they face a choice: keep carrying the extra load and feel resentful, or lower their own standards to match. Either way, the clinic loses.

There is a fifth cost, and it is easy to overlook. When a protocol is introduced or changed without consulting the people who have to carry it out, such as the nurses who run the theatre or the front desk team who handle admissions, they feel

undervalued and unheard. Few will say so openly. Instead, the resentment shows up quietly: the protocol is followed when someone is watching and skipped when nobody is, or followed to the letter but without any care for why it exists. Asking for their input does not mean handing over the decision. Even a short conversation, "here is what we are thinking, what would make this work on a busy day?", tells people their experience matters. Teams follow protocols they helped shape far more faithfully than protocols handed down to them.

A clinic example

A busy clinic noticed that its income from dental procedures was lower than expected, even though the theatre seemed fully booked. A review of a month of records found that dental radiographs, extractions and some medications were often recorded in the clinical notes but not added to the invoice. Different nurses and vets used different methods for charging, and nobody owned the final check before discharge.

The fix was not complicated. The clinic wrote a one page dental charging checklist, assigned the discharge nurse to complete it, and had the practice manager check a sample of invoices every Friday for a month. Charges were consistent within weeks. The protocol had always existed. What was missing was ownership and checking.

The protocol loop

A protocol that holds up under pressure needs five things. Think of them as a loop that never stops turning.

Consult. Start with the people who will deliver the protocol. Ask them what works now, what gets in the way on a busy day and what they would change. Across many years of working with teams in many industries, one pattern holds true: people stand behind a document that carries their name. When team members help build a protocol, and sign off on it, they take pride in it, defend it and keep improving it. Appointing a protocol champion from the team is one of the best ways to make this happen. The champion helps write it, teaches it to others and becomes the first person colleagues turn to with questions.

Define. Write the protocol down in plain language, in two versions. The full version explains each step, why it matters, who is responsible and what to do when something goes wrong. It is the reference document, used for training and reviewed every six months. The short version is a tick box checklist that fits on one page or one screen, used on the floor every time the task is done. The full version keeps the thinking alive; the checklist makes it happen on a busy day.

Teach. Train every relevant team member on it, including the people who have been there for years. Do not assume people know the current version. Show it, explain why it matters, and let them practise.

Check. Build a regular, light check into someone's routine. A weekly sample of five discharge records. A monthly look at the controlled drug register. A quick audit of

surgical checklists. Checking is not about catching people out. It is the only way to know the protocol is alive.

Reinforce. When people follow the protocol well, say so. When they do not, have the conversation early, privately and calmly. Chapter 8 shows you how.

Then go round again. The full version of each protocol should be reviewed every six months, because clinics change, equipment changes and the best version of a process today may not be the best version next year. Wherever possible, bring back the same people who built it. They are best placed to show what needs tweaking, and to be accountable for why steps are being skipped. Go into that meeting with an open ear and one simple question: how can we make sure this is followed every time? That question, asked honestly, goes a long way.

Who owns the protocol?

The single most effective change most clinics can make is to give every key protocol a named owner. Not a committee. One person.

The owner does not have to do every step. Their job is to keep the protocol current, make sure new people are trained on it, and run the regular check. In a small clinic one person may own several protocols. That is fine, as long as everyone knows who owns what.

When everyone owns a process, nobody does.

Self check

List the five protocols in your clinic that matter most for safety, compliance and revenue. For each one, answer:

1. Is it written down in a form people actually use?
2. Was every current team member trained on it?
3. When was it last checked?
4. Who owns it?

Any blank answer is a gap. Any protocol without an owner is drifting.

One action this week: pick the one protocol you are most worried about. Name an owner, agree a simple weekly check, and put the first check in the diary.

Chapter 4: Clients Notice Last, Then Leave

The clients of a vet clinic do not see the roster, the staff room or the team meeting. They see the result.

They see whether the phone is answered warmly. Whether the vet remembers their dog. Whether the nurse explains the discharge instructions clearly. Whether someone calls back with the results when promised. Whether the bill matches the estimate. Whether the faces at the front desk are familiar or new every visit.

Every one of those moments is shaped by management. And when management drifts, clients feel it, even if they cannot name it.

Loud complaints and silent exits

Vet clients are not shy about complaining. They are trusting you with a much loved pet, often at a frightening moment, and the bill can feel high to someone who does not see the work, the medicines and the expertise behind it. When fees are not explained clearly, or care does not go as hoped, some clients will say so loudly: at the front desk, on the phone and in online reviews. Many of those complaints come back to management too: estimates that were not explained or updated, staff who were not trained to talk about costs, and no agreed way to handle an unhappy client. But for every client who complains, there are others who are unhappy and never say a word. They simply book their next appointment somewhere else.

This quiet group is what makes client loss so dangerous. The clinic gets no warning and no chance to fix it. The appointment book looks busy, because new clients keep coming in, so nobody notices that longstanding clients are quietly disappearing.

By the time the owner looks at client retention figures, if anyone ever does, years of goodwill may already have walked out the door.

What a client household is worth

Think about a typical household that brings its pets to your clinic. Over the life of one dog, that household might pay for vaccinations, desexing, dental care, parasite prevention, the occasional injury or illness, senior care and, at the end, euthanasia and cremation. Many households have more than one pet, and get new pets over the years.

As an illustration only: if a household with two pets spends $2,000 a year with you and stays for ten years, it is worth about $20,000 in revenue. If it recommends you to two friends who do the same, the true value is much higher. Please note that these figures are deliberately conservative. Many households spend far more each year, especially those with several pets, older animals, chronic conditions or a major surgery or emergency along the way, so the real value of a loyal client household in your clinic is likely to be considerably higher. Use your own practice data to work out the figure for your clinic.

Now think about what loses that household. It is rarely one dramatic error. It is a missed call back. A rushed discharge where the owner did not understand the medication. A receptionist who seemed impatient. A sense that "they don't really know us there any more". Small things, each of them rooted in how the clinic is managed.

How poor management reaches the client

It helps to trace the line from inside the clinic to the client's experience.

Let me share a personal example. It comes from our family's regular medical clinic, not a vet clinic, but the lesson is exactly the same.

When I call, there is one receptionist, Alice, who is wonderful. Even when there is really nothing she can do to help, she gives me a **"yes" and a "can do"** feeling on the phone. If what I need is difficult to provide, she makes me feel she will go above and beyond to make it happen. She is the reason I have stayed with that clinic at times when I was losing my patience with it.

Most of the other receptionists start the conversation with a **no** and think about it later. More than once, that has made me seriously consider moving our whole family to another clinic.

Clients want a **yes** attitude, and they want warmth in the voice. One person who gets this right can hold on to a family for years. A team that gets it wrong can lose them in a single phone call. Whether your front desk sounds like Alice or like the others is not luck. It comes down to who you hire, how you train them, what you model, and what you recognise and reward.

Turnover becomes unfamiliarity. When staff keep changing, clients lose the relationships that made them loyal. A client who has seen four different nurses in a year has no reason to stay.

Unclear roles become dropped balls. When nobody knows who is responsible for calling clients back with results, the call does not happen. Each person assumes someone else made it.

Inconsistent processes become inconsistent experiences. If each vet explains estimates differently, and each nurse does discharges differently, clients get a different clinic every time they visit.

Tired teams become short tempered teams. People who are stretched, under appreciated and covering extra shifts struggle to stay warm and patient with a worried owner, especially at the end of a long day.

Poor internal communication becomes poor client communication. If the team does not hear about a change to opening hours, pricing or a procedure, they cannot explain it to clients. The client hears three different answers and trusts none of them.

In every case, the client experience is a mirror of the team experience. You cannot reliably deliver excellent client care with a team that is confused, exhausted or undervalued.

Moments that matter

Some client moments carry more weight than others. In a vet clinic, these include:

- The first phone call from a new client.
- Admission on surgery day, when owners are anxious.
- The phone call with results, especially if the news is worrying.
- Discharge, when owners need to understand care at home.
- The estimate and the bill, where trust is either confirmed or broken.
- End of life care, which many owners remember for the rest of their lives.

A well managed clinic knows these moments, has agreed standards for each one, trains the team on them and checks that they happen. A drifting clinic leaves them to whoever happens to be on shift.

A clinic example

A two vet clinic received a complaint from a client whose cat had a blood test before a dental procedure. The client was told she would be called the next day. Nobody called for four days, and when she phoned, the receptionist could not find the results.

When the practice manager looked into it, the cause was simple. The clinic had no agreed process for who checks incoming results, who calls the client and how the call is recorded. Each vet handled it differently, and one of them had been on leave.

The manager introduced a daily results check at 2pm, owned by the senior nurse, with a simple log of calls made and outstanding. Complaints about callbacks stopped. More importantly, the clinic will never know how many clients had left over the same issue without saying a word.

Losing the client is only part of the cost. When results are not communicated, action that should happen straight away may not happen at all. A result that calls for a change in medication, a follow up visit or an urgent recheck can sit unseen for days while the pet's owner assumes no news is good news. The delay can affect the animal's care, and it exposes the clinic to real clinical and reputational risk. A missed phone call is never just a service problem. Sometimes it is a patient care problem.

Listening to the signals

Because clients leave quietly, clinics need to go looking for the signals. Some practical sources:

- Your practice software can usually show how many active clients have not visited in eighteen months. Track the number over time.
- Look at reminder response rates. A falling rate can signal falling loyalty, not just a faulty reminder system.
- Read every review, good and bad, and share them with the team. Then respond to every one. Thank people warmly for good reviews. Reply to bad reviews politely and calmly, acknowledge the client's experience, and offer to talk it through offline. Acknowledgement matters more than most clinics realise: it shows the reviewer, and everyone reading, that someone at the clinic is listening.
- Ask a sample of longstanding clients, once a year, what you could do better.
- Ask the front desk team. They hear the comments, the sighs and the "we used to see Dr Smith" remarks that never reach the manager.

Go one step further and map the client life cycle. Just as you would look at staff retention, look at client retention over time: how many new clients come back for a second visit, a third, a fifth? At what point do they drop away? If you find, for example, that a large share of new clients never return after their first or second visit, that is a signal worth investigating.

When you see a pattern like this, resist the temptation to say "we don't want clients like that anyway". That response is comfortable, and it stops the clinic from learning anything. Instead, find out why those clients never came back. Was it the first phone

call, the wait, the way fees were explained, the vet they saw, or the follow up that never happened? Call a few of them and ask. The answers are often uncomfortable, and they are almost always useful.

Finally, try a mystery caller. In other industries, we have long used this simple practice: someone the team does not know calls the business as a brand new customer, and reports back on what the experience was really like. For a vet clinic, it is the best way to hear how your reception sounds to a new client. One clinic that tried it uncovered something nobody expected: a high percentage of calls were going to the third party answering service the clinic paid for, at times when there were enough staff on the desk to answer them. Nobody had noticed, and every one of those calls was a missed chance to welcome a new client. You do not really know until you check for yourself.

Self check

1. Do you know how many active clients your clinic lost in the past year?
2. Where do new clients drop away? What share come back for a second visit, a third, a fifth? Do you know why the others did not return?
3. How are fees and estimates explained to clients, and is every team member confident doing it?
4. Have you used a mystery caller to hear how your front desk sounds to a brand new client? Do they hear a yes and warmth in the voice, or a no first? And are calls actually being answered by your team?
5. For each of the moments that matter listed above, does your clinic have an agreed standard?
6. Who in your team is responsible for making sure every promised callback happens, and that test results lead to action straight away?
7. Does someone respond to every online review, thanking people for the good ones and replying politely to the bad ones?

One action this week: choose one moment that matters and watch it happen three times. Note what the client experiences. Then decide on one change that would make it consistently better, and who will own it. Next, pull a list of new clients from the past year who visited only once or twice, and call three of them to ask, warmly and without defensiveness, what would have brought them back.

Chapter 5: The Promotion Trap and the Burnt Out Owner

In most vet clinics, managers are made, not hired. The best nurse becomes head nurse. The most reliable receptionist becomes practice manager. The vet who bought the practice becomes, overnight, the owner of a small business with payroll, rosters, compliance and a team of people with their own needs and moods.

It makes sense. These people know the clinic, know the work and have earned respect. But it creates a trap that catches almost everyone.

The trap

The trap is this: the skills that got you promoted are not the skills you now need.

A great nurse is fast, precise, calm under pressure and excellent with animals. A great head nurse needs to be good at planning, teaching, delegating, giving feedback and handling conflict. These are different skills. Being brilliant at the first set tells you nothing about whether someone has the second.

So the newly promoted manager does what feels natural. They keep doing the clinical work they are good at, and they squeeze the management work into the gaps. They solve problems themselves rather than teaching others to solve them. They avoid the hard conversations because they never learned how to have them. They work longer and longer hours, and the team becomes more dependent on them, not less.

The clinic loses a great nurse and gains a struggling manager. Neither the person nor the clinic planned it that way.

The owner's version of the trap

Clinic owners face the same trap in a bigger form.

Most vet owners bought or started their practice because they loved veterinary medicine and wanted to do it their way. Running a business was the price of admission, not the reason they came.

The result is an owner who is the clinic's best clinician, its main decision maker, its HR department, its marketing department and its final escalation point, all at once. They are consulting all day and managing at night. Every question comes to them because nobody else has the authority or the information to answer it.

This works, after a fashion, while the clinic is small. As it grows, the owner becomes the bottleneck. Decisions wait. Problems wait. People who want to step up are not given the chance. And the owner, the person the clinic depends on most, is the one most at risk of burning out.

Trained to be a vet, not a leader

Of everyone in the clinic, the owner vet usually pays the highest price for poor management.

Think about how a vet is trained. Years of anatomy, physiology, pharmacology, surgery and medicine. Hundreds of hours learning to examine, treat and care for animals. Almost no time learning to lead a team, read a profit and loss statement, set prices, manage cash flow, negotiate with suppliers, build systems or choose technology.

Then, often in their thirties, the vet buys a practice or a share of one. Overnight they become an employer, a business owner, a manager of people and, in many cases, the person who has personally guaranteed a large loan. Nobody hands them a manual. They are expected to learn it on the job, while still carrying a full clinical caseload.

Most do their best. They are intelligent, hardworking people who care deeply about their patients and their team. But they are trying to do two demanding jobs at once, and they were only ever trained for one of them.

The cost to the owner's mental health

The result, for many owner vets, is a slow slide into exhaustion.

The days are long: consults and surgery all day, then rosters, invoices, emails and staff issues at night. Weekends are interrupted by phone calls. Holidays are short, rare or spent checking messages. Every resignation feels personal, and every complaint lands on their desk.

On top of the workload sits a heavy emotional load. Vets already carry the strain of euthanasia, difficult clients, patients who do not recover and the constant tension between what is best for the animal and what the owner can afford. An owner vet adds to this the weight of the whole business: whether there is enough money for payroll this month, whether the team is happy, whether the loan can be serviced, whether the clinic will survive.

The veterinary profession has spoken openly in recent years about the mental health pressures its people face. Owner vets are often the least likely to ask for help, because they feel responsible for everyone else and believe they should be able to cope.

The warning signs are worth naming:

- Dreading going to work in a clinic you once loved.
- Feeling irritable or short with the team and with clients.
- Being unable to switch off, even at home or on holiday.
- Poor sleep, constant tiredness and relying on caffeine or alcohol to get through.
- Losing the sense of satisfaction that clinical work used to give.
- Feeling trapped: unable to step back, unable to sell, unable to keep going as you are.

If you recognise yourself here, please take it seriously. Talk to your GP, a psychologist or someone you trust. In Australia, Lifeline is available on 13 11 14 at any time. Looking

after your own health is not a luxury or a weakness. Your family, your team and your patients all depend on it.

A burnt out owner creates a burnt out business

Burnout does not stay with the owner. It spreads through the whole clinic.

An exhausted owner makes decisions in a rush, or avoids them altogether. They do not have the energy for the conversations that matter, so problems are left to grow. They hold onto every task because handing over feels like more work. They react to each crisis instead of planning ahead. The team picks up on the stress, the mood in the clinic darkens, and good people start to leave, which adds yet more pressure to the owner.

Over time, the business itself starts to look like its owner: tired, reactive and running on empty. It keeps going, but it stops growing.

Leaving money and technology on the table

One of the least visible costs of a burnt out owner is everything the clinic is not doing, because nobody has the time or headspace to look up from the daily grind.

Financial solutions that go untapped. Many owner vets do not have a clear, regular view of their own numbers. They may not know their true profit per service, their cost of staff turnover, how their fees compare with similar clinics, or how much revenue leaks through missed charges and lapsed reminders (Chapter 3). They may never have reviewed their pricing properly, set a budget, tracked a handful of key measures each month or sat down with an accountant to plan rather than just to lodge tax returns. These are not complicated tasks. But they require time and attention, and a burnt out owner has neither.

Technology that goes unused. Most clinics already pay for practice management software with features nobody has switched on: online booking, automated reminders, client text messaging, reporting dashboards, stock control. Beyond that, there is a growing range of tools that can take load off a stretched team, such as client communication apps, telehealth for follow ups, digital forms, automated clinical notes and new devices that let trained nurses take on more of the routine work. Each of these could save hours or add revenue. But choosing, setting up and training the team on new tools is management work, so in a burned out clinic it never happens.

Equipment that collects dust. The same pattern shows up with equipment. A familiar scenario: the owner visits a veterinary expo, sees an impressive new device and decides it is worth buying. The team was never consulted about whether they need it, how it would fit into their day or who would use it. Sometimes the supplier offers little or no after sales support. The device arrives, a quick demonstration is given, and within months it is sitting in a cupboard. The clinic has paid for it, but it earns nothing and helps no patients.

The lesson is that buying equipment is a management decision, not just a purchasing decision. Before you buy, involve the people who will use it, agree who will champion it, and make sure the supplier will support your team long after the sale.

As a disclosure, Vet Edge, the company I direct, distributes the Vista IQ cancer risk screening device in Australia and New Zealand. Its rollout in clinics has worked well for one main reason: we built the support around exactly this problem. Every clinic receives scanner training in unlimited sessions, for an unlimited number of team members, for as long as they own the machine. As a business consultant, I know that any piece of equipment has to earn its return on investment and deliver the clinical and revenue benefits it promised. Making sure it never collects dust is our top priority, and we owe that to the owners who trusted us with the purchase. Whatever you buy, from whichever supplier, ask for the same commitment.

The irony is painful. The very solutions that could ease the owner's load are the ones the owner is too exhausted to put in place. Breaking that cycle starts with management: freeing up enough of the owner's time and energy to step back, look at the business and make deliberate choices.

The way out

The owner vet does not need to become an accountant, a software expert or a full time manager. They need three things:

1. **Good managers around them,** trained and trusted to run the day to day, so the owner is no longer the answer to every question (Chapters 7 and 15).
2. **A few simple routines,** such as a weekly planning hour and a monthly look at the numbers, that keep the business side on track without taking over their life (Chapters 14 and 18).
3. **Permission to step back,** from the clinical roster, from the inbox and from the belief that they must carry everything alone.

When owners make this shift, the change is often dramatic. They rediscover why they became vets. Their team grows into the space they leave. And the business finally has an owner with the time and clarity to make it stronger.

The rest of this chapter looks at the same trap from the point of view of nurses and staff who are promoted into management.

Three moments that test every new manager

In the classroom version of the program that this book is based on, new managers worked through role plays drawn from real situations. Three come up again and again in vet clinics.

You were promoted over a colleague who also wanted the job. Sarah and Jess were both senior nurses. Sarah got the head nurse role. Jess is polite but cool, does exactly what she is asked and nothing more, and has started making comments in the tea room. What does Sarah do?

The trap is to ignore it and hope it passes, or to overcompensate by giving Jess the best shifts. Neither works. Sarah needs a private, direct conversation that acknowledges the disappointment, values Jess's skill, and is clear about how they will work together from now on.

A friend asks for a favour. Tom has worked alongside Priya for five years and they are good friends outside work. Now Tom manages the roster. Priya asks for a Saturday off at short notice, which would leave the clinic short. Saying yes protects the friendship. Saying no protects fairness for everyone else.

The trap is to make an exception for a friend and hope nobody notices. Somebody always notices. The fair answer is to apply the same rule to Priya that would apply to anyone, and to explain it kindly. The friendship that survives this is a stronger one.

A friend lets the team down. Liam, a receptionist and a close friend of the practice manager, has missed two shifts without proper notice. The rest of the front desk is frustrated and watching to see what happens.

The trap is to let it slide because of the friendship. When that happens, the manager loses the respect of the whole team, not just Liam. The manager needs to have the same conversation they would have with anyone, in private, focused on the behaviour and its impact, with a clear expectation going forward.

Each of these moments is a test of whether the manager can hold the role with warmth and fairness at the same time. Chapters 8 and 11 give you the tools.

Role tensions you need to accept

Part of escaping the trap is accepting that management comes with built in tensions. You will feel pulled between:

- Being close to the team and being responsible for judging their performance.
- Representing the team to the owner and representing the owner to the team.
- Getting today's work done and investing in tomorrow's improvements.
- Doing it yourself because it is faster and delegating because it builds the team.
- Being consistent and being flexible for individual circumstances.

These tensions do not go away. Good managers do not resolve them once and for all. They learn to notice them, make conscious choices and explain those choices to their team.

The cost of leaving managers to sink or swim

When clinics promote people without training or support, three things tend to happen:

1. The new manager struggles quietly, works longer hours and eventually burns out or steps back into a clinical role.
2. The team experiences inconsistent decisions, avoided conversations and unclear expectations, and the best of them leave.

3. The clinic loses its strongest clinician to management and does not gain a strong manager in return.

None of this is the new manager's fault. It is the predictable result of asking someone to do a skilled job without teaching them how.

The good news is that management skills can be learned at any stage. The rest of this book sets out the core skills, one chapter at a time, using vet clinic situations throughout.

Self check

1. How were the managers in your clinic, including you, prepared for their role?
2. Which of the three moments above have you faced? How did you handle it?
3. What percentage of your working week is spent on management, as opposed to clinical or front desk work? Is that the right balance for your role?

One action this week: write down the three management tasks you most often put off. Keep the list handy as you read Part Two.

Put it into practice: explore the Vet Edge Manager's Toolkit

Part Two

The Fixes



Part Two: The Fixes

Part One described what poor management costs a vet clinic. Part Two sets out the skills that prevent those costs. Each chapter follows the same pattern: what goes wrong, why it happens, a practical method, and a self check with one action.

None of these skills require you to become a different person. They require you to add a few practical habits to the strengths you already have. A great clinician already knows how to observe, assess, plan and follow up. Management uses those same muscles, pointed at people and systems instead of patients.

You do not need to read these chapters in order. Start with the one that matches your biggest headache today. If your team is leaving, go to Feedback and Motivation. If you are drowning, go to Delegation and Self Management. If the owner or board never seems to hear you, go to Managing Up.

Each chapter is matched to a module in the Vet Edge Manager's Toolkit, so when you are ready to turn an idea into a plan for your own clinic, the tool is waiting for you.

Chapter 6: Know Yourself as a Manager

Every manager brings a natural style to the job. Some people love getting things done fast. Some love order and detail. Some are full of new ideas. Some care most about how people feel and whether the team is pulling together.

None of these styles is wrong. But every style has blind spots, and in a vet clinic those blind spots turn directly into the costs described in Part One. The first management skill, before any technique, is knowing your own style well enough to see what you naturally miss.

Four management styles

A useful way to think about management style comes from the PAEI model developed by Dr Ichak Adizes. It describes four roles that every organisation needs. Most people are strong in one or two and weaker in the others.

P: Producer. The Producer gets results. They focus on what needs doing today and they do it. In a clinic, this is the head nurse who clears the surgery list, the vet who sees the extra consults, the manager who fixes the broken autoclave before lunch. Their blind spot: they can be so focused on today's tasks that planning, training and people issues get pushed aside. Teams can feel driven rather than led.

A: Administrator. The Administrator builds order. They create systems, protocols, checklists and rosters, and they make sure things are done properly. In a clinic, they keep the controlled drug register perfect and the stock levels right. Their blind spot: they can become rigid, resist change and focus on how things are done rather than whether they are worth doing.

E: Entrepreneur. The Entrepreneur sees possibilities. They spot new services, new ways of working and opportunities others miss. In a clinic, they are the one who suggests a new dental package, a puppy preschool or a nurse led clinic. Their blind spot: they can start more than they finish, change direction often and leave the team feeling unsettled.

I: Integrator. The Integrator builds the team. They notice how people feel, smooth conflict, build trust and help people work together. In a clinic, they are the one who notices the nurse having a hard week after a difficult euthanasia. Their blind spot: they can avoid hard decisions and difficult conversations in order to keep the peace.

What your style costs the clinic

Look back at the costs in Part One and you can see how each style, unchecked, contributes:

Dominant style	What the clinic gets	What it risks
Producer	A lot of work done, fast	Burnout, no training, people feel unheard, high turnover

Dominant style	What the clinic gets	What it risks
Administrator	Consistent systems and compliance	Rigidity, slow change, frustrated innovators
Entrepreneur	New ideas and growth	Unfinished projects, unclear priorities, change fatigue
Integrator	A warm, supportive team	Avoided conversations, unfairness, protocols that drift

The goal is not to change your natural style. It is to know your blind spots, build habits that cover them, and work with people whose strengths complement yours.

A clinic run by two Producers will get a lot done and burn through staff. A clinic run by an Entrepreneur owner and an Integrator manager will feel friendly and full of ideas, but may struggle to finish anything or hold anyone accountable. Knowing this helps owners and managers divide the work sensibly.

Where your authority comes from

New managers often assume their authority comes from their title. In practice, people follow you for several reasons, and the title is the weakest of them. Think about five sources of authority:

1. **Position.** You have been given the role. This gets you compliance, not commitment.
2. **Expertise.** You know the work well. In a clinic this matters a lot, but it can trap you into doing everything yourself.
3. **Relationships.** People trust you and know you care about them.
4. **Example.** You do what you ask others to do. You are on time, you follow the protocols, you keep your word.
5. **Fairness.** You treat everyone by the same rules and explain your decisions.

Managers who rely only on position struggle, because people do the minimum. Managers who build all five find that people follow them willingly, even when the decision is unpopular.

There is a deeper problem with leaning on the title. A manager who relies on their title alone often broadcasts weakness rather than strength. It can look as though the title is masking a lack of confidence or self belief. This is especially common when a manager senses that people around them doubt they deserve the role. The instinct is to become more authoritarian, to insist on the title, rather than to show the substance of leadership. The team sees through it quickly. The title is nothing; the actions are everything.

Your personal SWOT

A simple exercise helps you put this together. Take a page and divide it into four:

- **Strengths:** what you do well as a manager and what people come to you for.
- **Weaknesses:** what you avoid, put off or find draining.
- **Opportunities:** skills you could build, people who could support you, changes in the clinic that would help.
- **Threats:** situations that bring out your worst habits, such as busy days, certain personalities or pressure from above.

Be honest. Then ask one trusted colleague to look at it and tell you what you missed.

The working with me card

One of the most practical tools in this module is a short card that explains to your team how you work best. It might include:

- How I like to receive questions (in person, by message, saved for our weekly catch up).
- What I need from you when something goes wrong.
- What I value most in a team member.
- My blind spots, and how you can help me with them.
- How you can tell when I am under pressure.

Sharing a card like this feels exposing at first. In practice, teams appreciate it enormously. It removes guesswork and shows that the manager is human.

Self check

1. Which of the four styles feels most natural to you? Which feels least natural?
2. Looking at the table above, which risk do you recognise in your own clinic?
3. Which of the five sources of authority do you rely on most? Which could you build?

One action this week: write your own working with me card and share it with one person in your team. Ask them what they would add.

In the Vet Edge Manager's Toolkit, Module 00 Know Yourself as a Manager includes an original twenty question management style questionnaire, a personal SWOT and a working with me card, all completed online.

Get Module 00 and the Manager Profile Tool free →

Chapter 7: Delegation

If there is one skill that separates exhausted clinic managers from effective ones, it is delegation.

Most vet clinic managers know they should delegate more. Most of them do not. They say things like "it's quicker if I do it", "nobody else does it properly" or "they're already too busy". Each of these feels true on the day. Together they create a manager who is the bottleneck for everything, and a team that never grows.

What happens when you do not delegate

The costs of poor delegation show up all over Part One:

- **The manager burns out.** Every task, question and decision flows through one person.
- **The team stays dependent.** People learn to bring problems rather than solve them, because the manager always takes them.
- **Good people leave.** Capable nurses and receptionists who want more responsibility do not get it, so they find it elsewhere.
- **The clinic cannot grow.** There is a ceiling on what one person can do, and the clinic hits it.
- **Nothing important gets done.** The manager is so busy with tasks others could do that the planning, training and improvement work never happens.

Delegation is not about offloading work you do not want. It is about putting each task with the right person, so that the clinic runs well and people grow.

What to delegate: the A, B, C sort

Take the interruption list from Chapter 1, and add the regular tasks you do each week. Sort every item into one of three groups:

A tasks: only I should do this. These genuinely need your role, authority or expertise. Examples: final decisions on hiring, performance conversations with your direct reports, approving the budget, meeting with the owner.

B tasks: someone else could do this with preparation. These need training, a clear process or some practice before you hand them over. Examples: building the roster, ordering stock, running the weekly team huddle, training new receptionists.

C tasks: someone else should already be doing this. These do not need you at all. Examples: answering routine client questions, restocking consult rooms, chasing supplier deliveries, filing.

Most managers find that a surprising share of their week is C tasks. Those can be handed over almost immediately. B tasks become your development plan for the team.

How to delegate well: prepare, agree, support

Delegation fails when it is done in a rush: "Can you sort out the stock order? Thanks." The person does not know the standard, the budget, the deadline or who to ask, so they either do it badly or keep coming back with questions. The manager concludes that delegation does not work.

Good delegation has three stages.

1. Prepare. Before you hand anything over, be clear in your own mind:

- What exactly is the task, and what does a good result look like?
- Who is the right person, given their skills, workload and interests?
- What authority will they have? Can they decide, or do they recommend and you decide?
- What resources, information or training do they need?

2. Agree. Sit down with the person, not in the corridor, and agree:

- The outcome and the standard.
- The deadline and any checkpoints.
- The level of authority they have.
- How and when they will update you.
- Why you chose them. People take on more willingly when they see it as recognition, not dumping.

Ask them to explain the task back to you in their own words. This takes two minutes and prevents most misunderstandings.

3. Support. Stay available without taking over. Check in at the agreed points. When they bring you a problem, ask "what do you suggest?" before you offer your answer. When it goes well, say so, specifically. When it does not, treat it as learning, not failure.

Levels of authority

One of the most common delegation mistakes is not being clear about how much authority the person has. Try thinking about it as levels:

1. Look into it and report back. I will decide.
2. Recommend what we should do. I will decide.
3. Decide, but check with me before you act.
4. Decide and act, then tell me what you did.
5. Decide and act. You do not need to tell me.

A new task might start at level 2 and move up to level 4 over a few months. Being explicit about the level prevents both overstepping and endless checking back.

A level of authority only works if it comes with a matching level of clarity. Before you walk away, check that you have full feedback from the person that they understand four things:

1. **The task.** What exactly needs to be done, and what a good result looks like. Ask them to explain it back in their own words.
2. **The timeline.** When it is needed by, and any steps that must be done sooner.
3. **The touch points.** When you will check in along the way to make sure it is going well. Do not wait until the end to check, if your door was not open during the work. By then it is too late to help, and the check feels like an inspection rather than support.
4. **The review.** When and how you will look back together at the actions taken and the outcome achieved, so both of you learn from it.

If any of these four is unclear, the delegation is not finished yet.

A clinic example: nurse led lump checks

In many clinics, every lump or bump a client is worried about goes straight into a vet consult. Vets are stretched, appointments are hard to get, and clients sometimes wait weeks with an anxious question.

Some clinics have handed part of this work to trained nurses. With a clear protocol, the right equipment and agreed criteria for referral to a vet, a nurse can run a lump check appointment: taking the history, measuring and recording the lump, and in clinics that use a cancer risk screening device such as Vista IQ, completing a non invasive risk screen. Every result is then run by the vet before any final decision is made. Based on the risk percentage the screen provides, the vet decides on the next step: either the patient comes back to be scanned again in three months, or the vet chooses a further examination.

This is delegation done properly. The task is defined. The nurse is trained. Her authority is clear: she runs the screen and records the result, and the vet reviews every result and makes every clinical decision. The vet's time goes to the cases that need it, the nurse's skills are used and recognised, and the client gets a faster answer. It is a good illustration of how delegation can lift the whole clinic, not just lighten the manager's load.

Why managers resist delegating

If you know all this and still find it hard, you are not alone. The usual reasons are:

- **It is quicker to do it myself.** True today. False over the next six months.
- **They will not do it as well as I do.** Possibly, at first. Your job is to teach until they do, or to accept a different but acceptable standard.
- **I do not want to overload them.** Then take something else off their list. Delegation is about the right work in the right place, not more work.
- **I like doing it.** Honest, and common. But if it is a C task, the clinic is paying a manager's rate for it.
- **If I give it away, what am I for?** Your value as a manager is in the results of your team, not in the tasks you hold onto.

Self check

1. What percentage of your week is spent on C tasks?
2. Which B task, if delegated, would free the most time for you in the next three months?
3. Who in your team is ready for more responsibility and would welcome it?

One action this week: choose one C task and one B task. Hand over the C task immediately. Use prepare, agree, support to start handing over the B task.

Module 01 Delegation in the Vet Edge Manager's Toolkit includes a fillable worksheet that walks you through the A, B, C sort and builds a delegation plan for each task.

Chapter 8: Feedback That Lands

In most vet clinics, feedback happens in two ways. Either it does not happen at all, or it happens all at once, after months of silence, when the manager finally runs out of patience.

Both are expensive. Silence lets small problems become habits and leaves good people feeling invisible. The sudden outburst damages trust, puts people on the defensive and rarely changes behaviour. Chapter 2 showed that "I don't know where I stand" and "I don't feel valued" are among the main reasons people leave. Both are feedback failures.

Two goals at once

Good feedback has to achieve two things at the same time. Think of them as truth and peace.

Truth means the person clearly understands what you saw and why it matters. Vague hints, jokes and sandwiched messages do not achieve this.

Peace means the relationship survives the conversation, and ideally gets stronger. Harsh, public or personal criticism does not achieve this.

Most managers lean naturally towards one. Producers tend to deliver truth without peace. Integrators tend to protect the peace and water down the truth. The skill is holding both.

A simple structure: situation, behaviour, impact

One of the most widely used structures for feedback is the Situation, Behaviour, Impact model developed by the Center for Creative Leadership. It works because it keeps feedback specific and factual.

- **Situation:** when and where did it happen?
- **Behaviour:** what exactly did the person do or say? Describe it as a camera would, without judgement.
- **Impact:** what was the effect on the patient, the client, the team or the clinic?

Then stop and listen.

Compare these two versions:

Vague: "You need to be more careful with discharges."

Specific: "Yesterday afternoon, when you discharged Mrs Patel's cat after the dental, you handed her the medication but did not go through the dosing instructions. She called this morning confused about how often to give it. I am worried about the cat getting the wrong dose, and about her confidence in us."

The second version is longer, but it is far easier to hear. It is about a specific event, not a character flaw. And it makes the next step obvious.

There is a deeper reason the specific version works. The vague version will almost always be heard as emotional rather than factual: it sounds like your opinion or your frustration. And people can always argue with emotions, even if only in their own heads. They may nod politely while quietly disagreeing, and walk away unchanged. The specific version is built on facts: what happened, when, and with what result. Facts are

much harder to argue with, and they are far less likely to be taken personally. The conversation stays on the event, not on how you feel about the person.

The same structure works just as well for positive feedback, which most managers give far too rarely and far too vaguely. "Great job today" is pleasant. "This morning, when the Labrador came in after being hit by a car, you had the oxygen and fluids ready before Dr Lee asked. That saved real time and the whole team noticed" is memorable, and it tells the person exactly what to keep doing. It also builds the person up. Hearing specifically what they did well grows their confidence and their sense of value to the team, and that is how positive reinforcement gets the best out of people.

Lead with what is going right

I first wrote about this idea for a client in another industry with similar pressures, where crews work on site against the clock. The lesson carries straight into a vet clinic, because a busy treatment room is another high pressure environment where leadership style directly affects safety, morale and output.

In many clinics, the default feedback tool is the negative one. Something goes wrong, and the instinct is to correct, criticise or snap. Negative feedback may get immediate compliance, but it rarely builds confidence. Over time it chips away at initiative and self belief, two things no clinic can run well without.

The confidence killer. When a nurse or receptionist only ever hears what is wrong, they stop trusting their own judgement. They wait to be told what to do. They avoid taking initiative. They make fewer decisions, even when time matters, and in a clinic, time often matters a great deal. Eventually they stop engaging beyond the bare minimum. Not because they are lazy, but because they are afraid of getting it wrong. That fear is not a motivator. It is a muzzle.

Positive reinforcement is not softness. It does not mean coddling people or ignoring mistakes. It means noticing what is working and saying so. When a nurse spots a patient deteriorating in recovery and acts before being asked, when a receptionist calms a distressed client and finds a way to fit them in, when someone keeps the surgery list running smoothly on a chaotic day: tell them. Specifically, promptly and out loud. When people know what they are doing right, they do more of it, they trust themselves more, and they feel part of the team rather than bodies filling a roster.

The ripple effect. Recognition spreads. Others notice what gets praised, and it sets the tone. The culture shifts from "don't get it wrong" to "how can I get it right?" In that kind of clinic, new graduates and junior nurses grow faster, mistakes are spotted and raised before they escalate, and the team becomes more accountable, because people feel trusted to act.

Three habits make the difference:

- **Be specific.** "Good job" means little. "Smart move checking that catheter before the anaesthetic started" means a great deal.
- **Be consistent.** Do not only speak up when something goes wrong. Speak up when it goes right.
- **Be real.** Genuine praise goes a long way. Forced or exaggerated praise backfires.

None of this replaces honest correction when it is needed; the rest of this chapter covers how to give it well. But if correction is the only feedback your team ever hears,

you are building hesitant people who wait for instructions, not confident ones who think on their feet. Negative feedback might fix a moment. Positive reinforcement builds a team.

Eight practical rules

1. **Give it soon.** Feedback loses value fast. Within a day or two is ideal.
2. **Give it privately.** Especially when it is corrective. Never in front of clients, and rarely in front of colleagues.
3. **Choose the right platform and the right moment.** This is one of the most important decisions you will make. Should this be face to face, a phone call or an email? Corrective or sensitive feedback almost always belongs face to face, where tone and body language can do their work. A phone call is the next best option when you cannot be together. Email and text are fine for confirming what was agreed, or for a quick note of thanks, but they strip out tone and are easily misread. Timing matters just as much: not in the middle of a busy surgery list, not as someone is walking out the door after a hard shift, and not when either of you is upset.
4. **Be specific.** Describe what you saw, not what you assume.
5. **Talk about behaviour, not personality.** "You did not record the drug in the register" is fixable. "You are careless" is an attack.
6. **Explain the impact.** People change when they understand why it matters.
7. **Ask for their view.** There may be context you do not know. "Talk me through what happened" is a powerful question.
8. **Agree what happens next.** End with a clear, shared next step.

Blind spots: what others see that we do not

The Johari window, developed by psychologists Joseph Luft and Harrington Ingham, is a simple way to understand why feedback matters. It describes four areas of what we know about ourselves:

- **Open:** things I know about myself and others know too.
- **Blind:** things others see in me that I do not see.
- **Hidden:** things I know about myself but keep from others.
- **Unknown:** things nobody has discovered yet.

Feedback is how the blind area gets smaller. Every person in your clinic, including you, has habits others notice that they do not. Without feedback, those habits never change. This applies to managers too: asking your team for feedback on how you manage is one of the fastest ways to improve.

When people push back

Even well delivered feedback can meet resistance. The person might deny it, blame someone else, get upset or go quiet.

Do:

- Stay calm and keep your voice level.
- Acknowledge feelings: "I can see this is frustrating to hear."
- Go back to the facts: what happened and its impact.
- Ask questions to understand their side.

- Give them time if they need it, and agree when you will talk again.

Do not:

- Argue or raise your voice.
- Pile on extra examples to win the point.
- Bring up unrelated past issues.
- Apologise for raising it or withdraw the feedback.
- Threaten consequences in the heat of the moment.

From feedback to coaching

When an issue keeps recurring, a simple coaching structure can help the person find their own solution. The GROW model, developed by Sir John Whitmore, uses four stages:

- **Goal:** what do we want to be true?
- **Reality:** what is happening now?
- **Options:** what could you do differently?
- **Way forward:** what will you do, and by when?

For example, with a receptionist who keeps double booking surgical admissions: the goal is no double bookings; the reality is that admissions are booked from three different screens; the options include a single admissions template or a daily check; the way forward is that she will draft a template by Friday and trial it for two weeks.

People commit far more to solutions they helped create.

Self check

1. When did you last give specific positive feedback? To whom?
2. Is there a piece of corrective feedback you have been putting off? How long has it been waiting?
3. When did you last ask your team for feedback on how you manage?
4. Does your team make confident decisions on a busy day, or do they wait to be told? What does that say about the feedback they usually hear from you?

One action this week: give three pieces of specific positive feedback using situation, behaviour and impact. Then plan the corrective conversation you have been avoiding, and schedule it.

Module 02 Effective Feedback in the Vet Edge Manager's Toolkit includes a Feedback Planner that helps you prepare any feedback conversation, step by step.

Chapter 9: Team Meetings That Earn Their Time

Ask a vet clinic team what they think of their meetings, and you will usually hear one of two answers. "We don't really have them." Or "they're a waste of time."

Both answers point to the same cost. Without good meetings, information travels by rumour, decisions are made in corridors, problems are raised but never resolved, and the team never quite feels like a team. Chapter 4 showed how poor internal communication becomes poor client communication. Meetings are where most of that communication should happen.

Why meet at all?

In a clinic where every hour is booked, a meeting has to earn its place. A good meeting produces two kinds of output.

Task outputs are the practical results: decisions made, problems solved, information shared, actions agreed with owners and dates.

Social outputs are about the team: people feel heard, understand the bigger picture, trust each other a little more and leave feeling part of something.

Poor meetings fail at both. They wander, nothing is decided, the same two people talk, and everyone leaves feeling their time was wasted. Over months, this teaches the team that raising issues is pointless, and the issues go underground.

The right meeting for the job

Most clinics need only a few types of meeting, each with a clear purpose:

Meeting	How often	Length	Purpose
Daily huddle	Every morning	10 minutes	Today's surgeries, special cases, staffing gaps, anything urgent
Team meeting	Monthly	45 to 60 minutes	Updates, problems to solve, protocol changes, recognition
One to one	Monthly with each direct report	30 minutes	Their work, wellbeing, development and feedback both ways
Leadership meeting	Weekly or fortnightly	45 minutes	Owner and managers: priorities, people

Meeting	How often	Length	Purpose
			issues, numbers

The daily huddle alone can transform a clinic. Ten minutes standing up at the start of the day, covering who is in, what is booked, which cases need special care and what might go wrong, prevents a surprising number of problems before they start.

The manager's two jobs in a meeting

When you run a meeting, you are responsible for two things at once.

The content. What is being discussed, in what order, and what needs to be decided. This means preparing an agenda, keeping to time, summarising decisions and making sure every action has an owner and a date.

The dynamics. How people are participating. Who is dominating, who has gone quiet, whether disagreement is being voiced or swallowed, whether the mood is constructive or defensive.

Many managers focus only on content and wonder why the team does not engage. Others focus only on dynamics and wonder why nothing gets decided. Watch both.

Before, during and after

Before the meeting:

- Decide the purpose. If you cannot say it in one sentence, you may not need a meeting.
- Send a short agenda a day or two ahead, with the decisions you need to make.
- Ask the team to add items.
- Invite only the people who need to be there.

During the meeting:

- Start on time, even if people are missing.
- Open with the purpose and the agenda.
- Begin with recognition: a client compliment, a great save, someone who went the extra mile.
- Take each item in turn and close it with a clear outcome.
- Invite quieter people in by name, gently.
- Park topics that need more time and agree when they will be dealt with.
- Finish by reading back the actions: who, what, by when.

After the meeting:

- Send a short summary of decisions and actions within a day.
- Keep a running action log and review it at the start of the next meeting.
- Follow up on actions between meetings.

The action log is where most clinic meetings fall down. If the same items appear meeting after meeting with no progress, the team learns that meetings change nothing.

Useful phrases

Many managers find it hard to steer a meeting without sounding bossy. A few phrases help:

- "Let's make sure we hear from everyone on this. Mia, what's your view?"
- "That's important, but it's a bigger conversation. Can we park it and set a time to talk?"
- "I'm hearing two different views. Let's lay them both out before we decide."
- "So, to summarise, we've agreed that... Is that right?"
- "Who will own that, and when will it be done?"
- "We're running short of time. Which of the remaining items can wait until next month?"

A clinic example

A three vet clinic held a monthly meeting that regularly ran to ninety minutes and was dominated by complaints about the roster. Nurses dreaded it. Nothing changed.

The new practice manager made three changes. She introduced a ten minute daily huddle, which took most of the operational detail out of the monthly meeting. She created a standing agenda with a time for each item, starting with recognition. And she introduced an action log, with every item owned and dated.

Within three months, the monthly meeting was down to fifty minutes. The roster issue was handed to a small working group of two nurses, who designed a fairer system themselves. Attendance and participation went up because people could see their input led somewhere.

Self check

1. Does your clinic have a daily huddle?
2. Do your meetings end with clear actions, owners and dates?
3. Are there items that have appeared at three or more meetings without being resolved?

One action this week: if you do not have a daily huddle, start one. Keep it to ten minutes, standing up, and cover the same four points each day: who is in, what is booked, special cases, and risks.

Module 03 Leading Team Meetings in the Vet Edge Manager's Toolkit includes a Meeting Planner for agendas, actions and follow up.

Chapter 10: Motivation

Almost everyone who works in a vet clinic starts out motivated. People do not become vet nurses for the money. They come because they love animals, want to help, and find meaning in the work.

So when a clinic manager says "my team just isn't motivated", the real question is: what happened to the motivation they arrived with?

Usually, the answer is management. Not one dramatic failure, but a slow accumulation of small things: good work that goes unnoticed, unfair rosters, no growth, constant pressure and a sense that nobody above them really cares. Motivation is rarely lost. It is worn away.

What the research tells us

Several well established ideas help explain what drives people at work. You do not need to memorise them. Each one gives you a practical lens.

Needs come in layers. Abraham Maslow suggested that people's needs build on each other: basic needs such as pay and security first, then safety, belonging, recognition and finally the chance to grow and reach their potential. In a clinic, a nurse who is worried about her hours being cut will not be motivated by a training opportunity. Get the basics right first.

Some things prevent dissatisfaction, others create motivation. Frederick Herzberg distinguished between hygiene factors and motivators. Hygiene factors include pay, conditions, rosters, policies and the relationship with the manager. When they are poor, people become unhappy. But fixing them does not create motivation; it only removes the unhappiness. Motivators include achievement, recognition, responsibility, interesting work and growth. These are what actually lift people. Many clinics spend all their energy on hygiene factors and wonder why nobody is inspired.

People are very sensitive to fairness. J. Stacy Adams showed that people compare what they put in and get out with what others put in and get out. If one nurse always gets weekends off, or one receptionist is never pulled up for lateness, others notice. Perceived unfairness is one of the fastest ways to destroy motivation in a small team.

Effort depends on belief. Victor Vroom's expectancy idea suggests people put in effort when they believe three things: that effort will lead to good performance, that good performance will be noticed and rewarded, and that the reward is something they value. If any link is broken, effort drops. A nurse who believes extra effort will never be noticed will eventually stop making it.

Attention itself motivates. Studies at the Hawthorne factory last century are often cited for a simple finding: people tend to work better when they feel someone is paying attention to them. In a clinic, simply showing interest in someone's work is motivating.

Intrinsic and extrinsic motivation

Extrinsic motivation comes from outside: pay, bonuses, rewards, avoiding criticism. Intrinsic motivation comes from inside: the satisfaction of doing meaningful work well, learning, and being trusted.

Vet teams are full of intrinsic motivation. That is a gift, and a responsibility. The manager's job is to protect it, by removing the things that wear it down and providing the conditions that let it flourish. Pay matters and must be fair, but in most clinics the biggest gains come from the intrinsic side.

What wears motivation down in a clinic

- Recognition that never comes, or comes only in a generic team email.
- Unfair rosters, favourites and inconsistent rules.
- No conversation about career growth or new skills.
- Being given responsibility without authority.
- Constant short staffing, with no end in sight.
- Emotional strain from euthanasia, difficult clients and patient deaths, with no space to talk about it.
- Decisions made without explanation.

Compassion fatigue deserves special mention. Vet teams carry an emotional load that most workplaces do not. A manager who notices it, talks about it openly and makes room for recovery after hard days protects both people and retention.

What builds motivation

- **Specific recognition**, given soon and in person (Chapter 8).
- **Fair systems** for rosters, leave, training and overtime, explained openly.
- **Growth**: new skills, new responsibilities, a path forward (Chapter 12).
- **Autonomy**: trusting people to make decisions within clear limits (Chapter 7).
- **Meaning**: connecting daily work to its impact on animals and their families.
- **Belonging**: a team where people look out for each other (Chapter 13).

Nurse led services are a good example of several of these working together. When a clinic trains nurses to run their own clinics, such as weight management, dental checks, post operative checks or lump checks, nurses gain autonomy, use more of their skills, build client relationships and see the direct impact of their work. Many clinics find this one of the most motivating changes they can make for their nursing team.

A clinic example: the bonus scheme nobody believed in

A clinic had a generous bonus scheme for its nursing and reception team on paper, based on product sales and wellness plan sign ups. In practice, the targets had been set in a record year and never adjusted, and the rules about what counted changed twice in a year. The team had quietly stopped believing they could reach it, and some felt uncomfortable being pushed to sell.

The owner sat down with the team and rebuilt the scheme together: realistic targets based on the current caseload, clear rules written on one page, a focus on recommendations that genuinely help the animal, and a monthly review of progress. The total cost to the clinic barely changed. But because every link in Vroom's chain had been repaired, effort, and results, lifted within a quarter.

The motivation conversation

The most reliable way to understand what motivates someone is to ask them. Most managers never do. A simple conversation, perhaps as part of a monthly one to one, could cover:

1. What part of your work gives you the most satisfaction?
2. What drains your energy most?
3. When did you last feel really proud of something you did here?
4. What would you like more of in your role? Less of?
5. How do you like to be recognised? Publicly, privately, in writing?
6. Where would you like to be in two years?

People are different. One nurse loves public recognition at the team meeting; another would be mortified. One wants to specialise in anaesthesia; another wants to move towards practice management. The only way to know is to ask.

Self check

1. For each person in your team, can you name what motivates them most?
2. Is there anything in your clinic that your team would describe as unfair?
3. When did you last recognise someone specifically for good work?

One action this week: have a motivation conversation with one team member, using the questions above. Write down one thing you will change as a result, and do it.

Module 04 Employee Motivation in the Vet Edge Manager's Toolkit includes a Motivation Planner that helps you map what drives each team member and plan practical changes.

Chapter 11: Difficult Conversations

Every clinic manager has a list of conversations they are avoiding. The nurse who is consistently curt with clients. The two receptionists who no longer speak to each other. The associate vet who keeps running late and leaves the nurses to apologise. The long serving team member who refuses to use the new system.

Each of these conversations feels risky. It might cause upset, damage a relationship, or lead to someone resigning. So the manager waits for a better moment, which never comes.

Meanwhile the cost grows. The rest of the team watches the problem continue and draws conclusions: that standards do not really matter, that some people get special treatment, that the manager will not protect them. Avoided conversations are one of the quietest and most powerful drivers of turnover in any clinic.

Why these conversations feel so hard

Difficult conversations are hard for three reasons, and it helps to separate them.

The people. Emotions run high. We worry about hurting someone, being disliked or facing anger or tears. In a small clinic, where colleagues are often friends, this is especially strong.

The content. The issue itself may be complicated, with facts in dispute and no obvious right answer.

The setting. Clinics are busy and public. There is rarely a quiet room and a free half hour. Conversations end up happening in the corridor, which makes them worse.

When you prepare, think about all three: how people will feel, what the facts are, and where and when you will talk.

The stories we tell ourselves

Before any difficult conversation, most of us have already built a story about the other person. "She doesn't care about the clients." "He thinks he's above the rules." "They're doing this to undermine me."

These stories feel like facts, but they are interpretations. And they shape how we walk into the conversation: defensive, accusing, ready for a fight.

A powerful habit is to separate what you actually saw and heard from the story you have built around it. Ask yourself:

- What are the facts, the things a camera would have recorded?
- What story am I telling myself about why it happened?
- What other explanations could there be?
- What do I not yet know?

You may find your story is right. Often you will find there is more to it. Either way, you will walk into the conversation calmer and more curious.

Positions and interests

In many conflicts, people dig into positions: what they say they want. Underneath sit interests: why they want it.

Two nurses are arguing about the roster. One insists on never working Saturdays. The other says it is unfair that she always has to. Those are positions, and they look incompatible.

When the manager asks about interests, the picture changes. The first nurse has a child with weekend sport and no one else to drive. The second wants a predictable weekend off each month to visit her parents in the country. Now there are options: a rotating schedule with one guaranteed weekend each, or early finishes on some Saturdays. The positions clashed. The interests did not.

Asking "what matters most to you about this?" is one of the most useful questions a manager can learn.

Trust in the room

People can only hear difficult messages if they trust the person giving them. In practice, people judge trust on a few things: whether you are competent, whether you are honest, whether you are reliable, and whether you genuinely care about their interests as well as your own.

If trust is low, start there. Acknowledge past problems, be consistent, and show through your actions that you are on their side as well as the clinic's.

A practical plan for the conversation

1. Prepare. Write down the facts, your story and its alternatives, what you want to achieve, and what you think the other person wants. Choose a private place and a time when neither of you is rushed.

2. Open clearly. State the purpose in a sentence or two, without a long warm up. "I want to talk about how the handovers with the evening team have been going, because there have been some problems and I want us to sort them out together."

3. Share the facts and the impact. Use situation, behaviour and impact from Chapter 8.

4. Listen. Ask for their view and really listen. Reflect back what you hear. "So you feel the evening team never reads the handover notes anyway?" Empathy does not mean agreeing. It means understanding.

5. Explore interests and options. What matters to each of you? What could work?

6. Agree the way forward. Be specific about what will change, who will do what, and when you will check in.

7. Follow up. Check in when you said you would. Acknowledge progress. If nothing changes, the next conversation is firmer and may need to become a formal performance process, following your clinic's policies and employment obligations.

Useful phrases for empathy

- "It sounds like this has been building for a while."
- "Help me understand what it's been like from your side."

- "I can see why that would be frustrating."
- "What would a good outcome look like for you?"
- "I want to get this right for both of us."

Difficult conversations with clients

The same principles apply outside the team. Two situations come up constantly in clinics.

The client who has not paid. A clinic had a growing list of overdue accounts after surgeries and hospital stays. The team hated chasing them and kept putting it off. The fix had two parts. First, clear estimates and payment terms, explained and agreed before treatment started, so expectations were set early. Second, a calm, factual script for the follow up call: what was agreed, what is outstanding, what happens next and by when. Once the team had a structure, the calls stopped feeling personal, and more of the money came in.

The upset client. When a client is angry about a fee, a wait or an outcome, most people either defend the clinic or give in. A better approach is to listen first, acknowledge how the client feels, explain the facts calmly and agree a next step. Many complaints are really worry or grief about a pet. When a client feels heard, they often stay, and some become the clinic's strongest supporters.

When two team members are in conflict

When the conflict is between two people in your team, resist the urge either to ignore it or to decide who is right. Talk to each person separately first, to understand their side. Then, if appropriate, bring them together with a clear purpose: to agree how they will work together from here, not to rehash every past grievance. Focus on interests, agree specific behaviours, and follow up.

Self check

1. Which conversation have you been avoiding the longest?
2. What story are you telling yourself about that person? What else might be true?
3. What is the cost to the team of leaving it another month?

One action this week: prepare for the conversation you have been avoiding using the seven steps above, and book a time to have it.

Module 05 Difficult Conversations in the Vet Edge Manager's Toolkit includes a Conversation Planner that walks you through preparation, facts, stories, interests and the opening line.

Chapter 12: Mentoring and Development

New graduates, both vets and nurses, often say the same thing about their first job. The clinical training at university or college was good. What made or broke their first year was whether anyone at the clinic had time to guide them.

When nobody does, the costs are predictable. Young vets lose confidence, make avoidable mistakes and quietly start looking for a clinic with better support. Junior nurses learn whatever version of the job the busiest person on shift happens to show them. Talented receptionists who want to move into practice management never get the chance, so they leave to find it elsewhere.

Development is not a luxury for when the clinic is less busy. It is how the clinic builds the people it will need next year.

Two ways to get mentoring wrong

Most failed mentoring falls into one of two traps.

Choking. The mentor hovers, corrects every small thing, takes over at the first sign of difficulty and never lets the person own a task. The learner feels watched and never builds confidence. In a clinic, this is the senior vet who takes the scalpel back the moment the graduate hesitates.

Abandoning. The mentor assumes the person will figure it out, gives a quick explanation and disappears. The learner struggles alone, is too embarrassed to ask, and either makes mistakes or develops bad habits. In a clinic, this is the new nurse put on the evening shift alone in her second week because "she'll be fine".

Good mentoring sits between these two. It gives enough support to keep the person safe and enough space to let them grow, and it adjusts as their skill increases.

The mentoring loop

A simple loop works for almost any skill, clinical or non clinical:

1. **Explain.** Describe the task, why it matters and what good looks like.
2. **Show.** Do it while they watch, talking through your thinking.
3. **Try together.** Let them do it with you beside them, ready to help.
4. **Try alone.** Let them do it on their own, with you available.
5. **Review.** Talk through how it went: what worked, what to change.
6. **Repeat** until they are confident and consistent, then step back further.

The review step is the one most often skipped, and the one that does the most good. Five minutes at the end of a procedure, a shift or a difficult client call is enough.

Different kinds of mentoring

Not all development needs a formal program. In a clinic, mentoring can take several forms:

- **Skills mentoring:** teaching a specific clinical or technical skill, such as dentistry, anaesthesia monitoring or using the practice software.
- **Career mentoring:** helping someone think about where they want to go and how to get there.
- **Peer mentoring:** pairing a newer team member with an experienced peer, not their manager, for informal support.
- **Reverse mentoring:** younger team members helping more experienced colleagues with new technology or approaches.
- **Emotional support:** helping someone process the hard parts of vet work, such as euthanasia, difficult clients and loss.

A healthy clinic uses several of these. They do not all have to come from the manager.

The personal development plan

For every team member, a simple development plan turns good intentions into action. It does not need to be long. It should answer:

- **What do you want to gain?** One to three skills, qualifications or experiences for the next twelve months.
- **Why does it matter?** For them, and for the clinic.
- **How will you get there?** Training, mentoring, projects, reading, shadowing.
- **Who will help?** A named mentor or support person.
- **What will you sustain?** The strengths and habits they already have that they need to keep up.
- **How will we know?** What will be different when they have achieved it.
- **When will we review it?** A date, usually every three to six months.

The "sustain" part matters. Development plans often focus only on gaps, which can feel like a list of weaknesses. Naming what someone already does well, and planning to keep it strong, makes the plan feel balanced and fair.

A clinic example

A clinic hired two new graduate vets in the same year. The first was paired with a senior vet who used the mentoring loop: talking through cases each morning, assisting in surgery, then stepping back, and holding a short review at the end of each week. The second was given a quick orientation and a full consult list from day three, with "ask if you need anything".

Twelve months later, the first graduate was confident, well liked by clients and planning to stay. The second had resigned after eight months, citing stress. The clinic then spent several months recruiting a replacement. The difference was not the graduates. It was the mentoring.

Making time for development

The most common objection is time. There is never a quiet week. The answer is to build development into routines rather than waiting for spare time:

- Ten minutes of case discussion after the daily huddle.
- A standing monthly one to one with each direct report that always includes a development question.
- One protected training session a month, rotated around the team.
- Development plans reviewed at fixed dates in the calendar.

Chapter 14 explains how to build routines like these into your week.

Self check

1. Does every team member have a written development plan?
2. When you mentor, do you lean towards choking or abandoning?
3. Who in your clinic is ready to mentor others, and has never been asked?

One action this week: sit down with one team member and draft a one page development plan together, including what they want to gain and what they need to sustain.

Module 06 Mentoring and Development in the Vet Edge Manager's Toolkit includes a Development Planner for exactly this conversation.

Chapter 13: Building Your Team

A group of skilled people working in the same building is not automatically a team. Many vet clinics are really collections of individuals: vets who do their own thing, nurses who stick to their own shifts, a front desk that feels separate from the back. Everyone works hard. But the handovers are clumsy, information gets lost between groups, and small tensions build into silos.

The cost shows up in every chapter of Part One. Turnover is higher where people feel no loyalty to each other. Protocols drift where nobody feels shared ownership. Clients notice when the front desk and the treatment room are not on the same page.

What makes a team a team

A team is a small group of people who share a common goal, depend on each other to achieve it, and hold themselves jointly responsible for the result.

The key word is depend. In a vet clinic, the receptionist depends on the nurse to have the patient ready. The nurse depends on the vet to write clear instructions. The vet depends on the receptionist to book the right length of consult. When these dependencies work, the clinic flows. When they do not, everyone blames everyone else.

Strong teams balance two things: the **mission**, the work they are there to do, and the **relationships**, the trust and goodwill that let them do it together. A team focused only on the mission becomes efficient but cold, and people burn out. A team focused only on relationships becomes friendly but ineffective, and standards slide.

Four building blocks: the GRPI model

The GRPI model, developed by Richard Beckhard, is a simple way to work out what is going wrong in a team. It names four building blocks, in order of importance.

G: Goals. Does everyone know what the team is trying to achieve, and agree on it? In a clinic, this might be excellent patient care, a great client experience, a safe workplace and a sustainable business. If people have different ideas about what matters most, conflict follows.

R: Roles. Does everyone know what they are responsible for, and what others are responsible for? Unclear roles cause dropped balls ("I thought you were calling the client") and turf wars ("that's my job, not yours").

P: Processes. Are there agreed ways of working: how decisions are made, how information is shared, how handovers happen, how problems are raised? Chapter 3 showed the cost when processes drift.

I: Interpersonal relationships. Do people trust each other, communicate openly and handle disagreement well?

The insight in this model is the order. When teams have problems, the symptoms usually look interpersonal: people are irritated, gossiping, not speaking. Managers often respond with team building activities. But the root cause is frequently higher up the list. Two nurses who clash may really be clashing over unclear roles. A front desk that resents the treatment room may really be frustrated by a broken handover process.

Fix goals first, then roles, then processes. Many interpersonal problems ease on their own.

A clinic example

The reception team at a busy clinic complained constantly that the nurses were rude to them. The nurses complained that reception overbooked them and never told them about difficult clients. The manager was preparing for a mediation session.

Using GRPI, she looked at roles and processes first. She found that nobody owned the decision about squeezing in an extra appointment, and there was no way for reception to pass on client concerns to the treatment room. She introduced a rule that reception checks with the lead nurse before overbooking, and a simple flag in the practice software for anxious or difficult clients.

The complaints dropped sharply within a month. The mediation was never needed. It had never really been a personality problem.

Practical ways to build teamwork

- **Share the goals.** Talk regularly about what the clinic is trying to achieve and how each role contributes.
- **Map the roles.** Write down who is responsible for what, especially at the points where work passes between groups.
- **Fix the handovers.** Admission, surgery to recovery, shift change and discharge are where teams most often fail each other.
- **Mix the groups.** Include reception in clinical meetings and nurses in client service discussions, so each side understands the other.
- **Celebrate shared wins.** Recognise team results, not just individual effort.
- **Debrief hard days together.** A difficult euthanasia or a lost patient affects everyone. Talking about it as a team builds trust.
- **Address problems early.** Small tensions handled quickly never become big ones (Chapter 11).

Hiring for the team

Building a team also means choosing who joins it. Clinics under pressure often hire the first available person with the right qualification. It is worth slowing down enough to ask: does this person share our values? How will they fit with the people they will work alongside most closely? A short trial shift with the team, followed by asking the team for their view, is one of the best hiring tools a clinic has.

Self check

Rate your team from 1 (weak) to 5 (strong) on each of the four GRPI blocks:

1. Goals: everyone knows and agrees what we are trying to achieve.
2. Roles: everyone knows who does what.
3. Processes: we have clear, agreed ways of working.
4. Interpersonal: we trust each other and handle disagreement well.

Start improving with the lowest score that sits highest in the list.

One action this week: pick the handover in your clinic that causes the most friction. Map exactly who does what at that point, agree it with the people involved, and write it down.

Module 07 Building Your Team in the Vet Edge Manager's Toolkit includes a Team Builder that walks you through the GRPI review for your own clinic.

Chapter 14: Self Management and Management Routines

You cannot manage a clinic well if you cannot manage your own week.

This is where many clinic managers struggle most. They know what good management looks like. They intend to hold one to ones, check protocols, plan rosters ahead and develop their team. But every day is swallowed by the phone, the waiting room, the emergency, the supplier, the broken equipment and the question from the nurse at the door. The important work waits for a quiet week that never comes.

The cost is the reactive management described in Chapter 1. And the biggest casualty is often the manager themselves: long hours, no breaks, work brought home and, eventually, burnout.

Your rock

There is a well known illustration about filling a jar. If you pour in sand and pebbles first, there is no room for the big rocks. If you put the big rocks in first, the pebbles and sand fit around them.

Your big rocks are the few things that matter most in your role, the ones that only you can do and that make the biggest difference to the clinic. For most clinic managers, the list includes things like:

- Developing and supporting the team.
- Keeping key protocols alive.
- Planning rosters and resources ahead.
- Working with the owner on priorities and numbers.
- Improving one thing about how the clinic runs.

The sand is everything else: emails, routine questions, small fixes, the endless stream of interruptions.

The discipline is to put the rocks in the diary first, every week, and protect them. Everything else fits around them.

The 80/20 rule

The Pareto principle, named after the economist Vilfredo Pareto, suggests that a small share of causes often produces most of the results. In a clinic, a small number of your activities probably produce most of your impact. A small number of clients may produce most of your complaints. A small number of protocols probably carry most of your risk.

Ask yourself: which 20 percent of my work produces 80 percent of the value? Then make sure that 20 percent gets your best time, not your leftover time.

The four Ds

When something lands on your desk, decide quickly what to do with it. There are only four options:

- **Do it** if it is important and only you can do it, or it takes less than a few minutes.
- **Delegate it** if someone else can do it (Chapter 7).
- **Delay it** if it matters but not now. Put it in the diary with a specific time, not on a vague list.
- **Delete it** if it does not really need doing at all. More things fall into this group than most managers admit.

The four Ds stop tasks from circulating endlessly in your head and your inbox.

Think in outcomes, not activities

Busy managers measure their day by activity: how many calls, emails and problems they handled. Effective managers measure it by outcome: what is different because of their work.

At the start of each week, write down the three outcomes you want by Friday. Not "work on the roster" but "next month's roster published to the team". Not "look at the dental protocol" but "dental charging checklist agreed and in use". Outcomes are finishable. Activities are not.

Routines as anchors

The single most effective tool for a clinic manager is a set of fixed routines. Routines are the anchors that keep management happening on busy weeks, because they do not depend on remembering or finding time.

A typical set of management routines for a vet clinic might look like this:

How often	Routine	Purpose
Daily	Morning huddle (10 minutes)	Today's plan, risks and special cases
Daily	End of day check (10 minutes)	Results called, tomorrow ready, issues logged
Weekly	Planning hour	Set three outcomes, protect the rocks, review the roster
Weekly	Protocol spot check	Sample a key protocol, such as five discharges or the drug register
Weekly or fortnightly	Meeting with the owner	Priorities, people, numbers, decisions needed

How often	Routine	Purpose
Monthly	One to one with each direct report	Work, wellbeing, development, feedback
Monthly	Team meeting	Updates, problems, recognition, actions
Quarterly	Review of key numbers	Turnover, client retention, revenue leakage, overtime
Quarterly	Development plan reviews	Progress on each person's plan
Every six months	Protocol review with the people who built it	Tweak what is not working, own why steps are skipped, agree how to make it stick
Yearly	Planning day	Review the year, set next year's goals

Do not try to introduce all of these at once. Start with two or three, make them stick, then add more. A routine that happens reliably every week is worth far more than a perfect system that collapses after a month.

What to consider when you design routines

- **Put them in the diary as recurring appointments.** If it is not in the diary, it will not happen.
- **Choose times that suit the clinic.** The morning huddle before the first consult. The planning hour on the quietest morning.
- **Keep them short.** A ten minute routine that happens is better than an hour that gets cancelled.
- **Make them visible.** Tell the team what your routines are and why. They will help protect them.
- **Review them.** Every few months, ask whether each routine is still earning its time.

Looking after yourself

Self management also means managing your own energy. Vet clinics are emotionally demanding, and managers carry the weight of the team as well as their own. Take your breaks. Leave on time at least some days. Talk to someone outside the clinic about the hard parts. A manager running on empty cannot support anyone else, and a burnt out manager is one of the most expensive resignations a clinic can face.

Self check

1. What are your three big rocks? Are they in your diary this week?

2. Which management routines happen reliably in your clinic now?
3. How many hours last week did you spend on tasks you could have delegated or deleted?

One action this week: book a one hour planning session in your diary for the same time every week for the next three months. Use the first one to set your three outcomes for the following week.

Modules 08 Self Management and 10 Management Routines in the Vet Edge Manager's Toolkit include a Week Planner and a Routine Planner to build these habits.

Chapter 15: Managing Up

Most management books focus on managing the people who report to you. But for practice managers, head nurses and clinical leads, one of the most important relationships is with the person above: the clinic owner, the partners, the clinical director or, in a corporate group, the area manager.

When this relationship works, the manager has the backing, the information and the authority to do the job. When it does not, everything in this book becomes harder.

What happens when managing up fails

Picture a practice manager who has carefully designed a new roster system with the nursing team. The owner, who was not consulted, hears a complaint from one vet and scraps it in a corridor conversation. The nurses see that the manager's decisions can be overturned at any time. Next time, they go straight to the owner.

Or picture a head nurse who has known for months that the team is exhausted and two nurses are close to resigning. She has hinted at it to the owner, who is busy and did not pick it up. When the resignations arrive, the owner is shocked and asks why nobody told him.

These situations are common, and they are expensive:

- **Decisions stall** because the manager does not have clear authority or cannot get the owner's attention.
- **The manager's credibility erodes** when decisions are overturned or promises to the team cannot be kept.
- **Problems reach the owner too late**, when they are already crises.
- **The manager burns out**, caught between a team that expects them to fix things and an owner who will not give them the means.
- **Good managers leave**, taking their knowledge and their relationships with them.

Managing up is not about flattering the boss or playing politics. It is about building a working relationship that lets you do your job well, for the benefit of the clinic.

Four principles

1. Understand their style. Your owner has a management style just as you do (Chapter 6). A Producer owner wants short updates, clear recommendations and quick decisions. An Administrator owner wants detail, data and a proper process. An Entrepreneur owner is energised by ideas but may lose interest in the follow through. An Integrator owner will want to know how the team feels. Adapt how you communicate to how they take in information. This is not manipulation; it is good communication.

2. Respect their authority, and clarify yours. The owner has the final say on many things, and it is their business and their risk. At the same time, you need to know what you can decide on your own. Have an explicit conversation about it, using the levels of authority from Chapter 7. Which decisions are yours? Which do you recommend and they decide? Which must always go to them? Write it down and revisit it as trust grows.

3. Show empathy for their position. Clinic owners carry pressures the team rarely sees: cash flow, debt, regulatory responsibility, clinical caseload, their own family, sometimes their own exhaustion. When you understand their worries, you can frame

your requests in terms that matter to them. "Losing another nurse would cost us around $16,000 and a month of overtime" lands differently from "the nurses are unhappy".

4. Bring a positive, constructive attitude. No owner wants a manager who only brings complaints. That does not mean hiding problems. It means bringing problems with options and a recommendation, and acknowledging what is going well as well as what is not.

Practical habits

Supply the goods. Do your job well and reliably. Credibility is the foundation of influence. When you consistently deliver what you said you would, your owner will trust your judgement on bigger things.

No surprises. Tell your owner about problems early, while they are still small, and before they hear about it from someone else. A brief "I want you to know about this before it grows" builds enormous trust.

Come with options. When you raise a problem, bring two or three possible solutions and your recommendation. This turns you from a messenger into a partner.

Use numbers. Owners, especially busy ones, respond to evidence. Turnover cost, overtime hours, client retention, missed charges. Part One of this book gives you ways to put numbers on management problems.

Protect the regular meeting. A fixed weekly or fortnightly meeting with the owner, with a short agenda, is worth more than a dozen corridor conversations. Send the agenda ahead. Keep a list of decisions needed. Confirm decisions in a short message afterwards.

Show loyalty in public, disagree in private. If you disagree with a decision, say so to the owner, clearly and respectfully, in private. Once a decision is made, support it in front of the team, even if you argued against it. Undermining the owner in front of staff destroys trust in both directions.

Ask for feedback. Ask your owner regularly what they need from you and how you could make their job easier. Most owners are rarely asked, and appreciate it.

A simple agenda for the owner meeting

1. Wins since we last met.
2. Key numbers: staffing, overtime, client feedback, anything off track.
3. Decisions I need from you, each with my recommendation.
4. Risks you should know about.
5. What I am working on next.
6. Anything you need from me.

Thirty minutes, every week or fortnight, using this structure, will change the relationship.

When there is more than one boss: partners and directors

Many clinics are owned by two or three partner vets, or by a corporate group with a regional manager above the clinic. This brings its own challenge. Each partner may

have a different view of their role, their clinical hours and their share of the decisions, and nobody has ever written it down.

When roles are unclear, the team feels it. Staff receive different instructions from different partners and do not know whose priorities come first. Who owns the roster? Who signs off on new equipment? What happens if the partners disagree about fees?

If you are in a partnership, three things help enormously:

- **A written agreement on roles and decision rights,** covering who leads which part of the clinic and which decisions need all partners to agree. Your partnership or shareholder agreement should support this; take legal advice to make sure it does.
- **A regular partners meeting** with an agenda, the numbers and a record of decisions, so disagreements are resolved between partners and not in front of the team.
- **One voice to the team.** Once the partners decide, they communicate it together, and staff know whose direction to follow on each area.

When the owner is the problem

Sometimes the hardest part of managing up is that the owner's own habits cause problems: overriding decisions, avoiding conversations, changing priorities weekly, or treating staff in ways that drive them away. This is delicate. The principles above still apply. Choose a private, calm moment. Use facts and impact, not judgement. Focus on the shared goal: a clinic that runs well and keeps good people. Offer a specific suggestion. And accept that change may take time.

If you are an owner reading this, it is worth asking yourself honestly: do my managers feel they can tell me the truth? If not, you are probably the last to hear about your clinic's biggest problems.

Self check

1. Do you have a regular, protected meeting with the person you report to?
2. Have you agreed in writing which decisions are yours to make?
3. Is there a problem your owner should know about that you have not yet raised clearly?

One action this week: request a standing meeting with your owner or manager, and propose the six point agenda above.

Module 09 Managing Up in the Vet Edge Manager's Toolkit includes a Managing Up Planner to map your owner's style, agree your authority and prepare for each meeting.

Chapter 16: Choosing the Right Managers

Sooner or later, every growing clinic reaches the point where the owner cannot manage everyone alone. You need managers around you: a practice manager, a head nurse, a clinical lead, perhaps a client service or reception leader. These people are meant to carry part of the load, so that the clinic no longer depends on you for everything.

Choose well, and the right manager multiplies everything good in the clinic. Choose badly, and the wrong manager multiplies every problem in this book: the team stops trusting the structure, good people leave, protocols drift faster, and the owner ends up doing the manager's job as well as their own, on top of a full consult list.

This chapter is about choosing managers deliberately, and about making it crystal clear what you expect from them before they start.

How most clinic managers get chosen

In most clinics, managers are not chosen. They happen. The three most common routes are:

- **The best clinician.** The most skilled vet becomes clinical lead. The best surgical nurse becomes head nurse. As Chapter 5 showed, being great at the clinical work tells you nothing about whether someone can lead others doing it.
- **The longest serving.** The nurse or receptionist who has been there longest becomes practice manager as a reward for loyalty. Loyalty matters, but it is not a management skill.
- **The trusted friend, partner or family member.** The owner promotes the person they feel most comfortable with. That comfort can make it very hard to hold them to account later.

Each of these can work out. But when they do, it is usually by luck. A deliberate choice is far more reliable.

The attributes that matter

Clinical skill and experience still count. But the attributes that separate good clinic managers from struggling ones are mostly about character and behaviour. Look for someone who:

- **Has integrity.** They do what they say, tell the truth when it is uncomfortable and treat the clinic's money as if it were their own.
- **Takes ownership.** They see a problem and act, rather than waiting to be told or looking for someone to blame.
- **Communicates clearly.** They can explain what they want, listen properly and keep the owner informed without being chased.
- **Is fair.** They apply the same rules to everyone, including friends on the team. Rosters, leave and training are shared out openly.

- **Wants others to succeed.** They get satisfaction from seeing their team do well, not only from doing the clinical work themselves. This is the hardest attribute to find in a high performing clinician, and the most important.
- **Is coachable.** They ask for feedback and act on it.
- **Stays calm under pressure.** On the busiest day, or in the middle of an emergency, the team takes its emotional cue from the manager.
- **Understands the numbers, or is willing to learn.** A manager who does not understand wages as a share of revenue, stock costs and missed charges cannot make good decisions for the clinic.
- **Shares your values.** About patient care, clients and the team. Skills can be taught. Values rarely can.

No candidate will be perfect on every point. Decide in advance which attributes are essential for this role and which can be developed.

Be crystal clear: no hidden messages

The single biggest reason managers fail in clinics is not lack of ability. It is lack of clarity. The owner has a picture in their head of what the manager should do, how they should do it and what success looks like, but that picture was never written down or said out loud. The manager is left to guess. When they guess wrong, the owner is disappointed, and the manager has no idea why.

These hidden messages are everywhere: "I assumed you would handle the client complaints." "I expected you to keep the controlled drug register checked." "I thought you knew you could approve roster changes." "I didn't think I needed to tell you that I want to see the numbers every Monday." Each one is reasonable. None of them was ever said.

Before anyone starts in a management role, whether promoted from within or hired from outside, write down and agree the following:

- **The purpose of the role.** In one or two sentences, why does this role exist? What problem does it solve for the clinic?
- **The outcomes.** What results is this person responsible for? Be specific: a stable nursing team, protocols followed and checked, rosters published on time, missed charges reduced, client complaints resolved.
- **The measures.** How will you both know whether they are succeeding? Agree three to five measures you will review together regularly.
- **Decision rights.** What can they decide alone? What do they recommend and you decide? What must always come to you? Use the levels of authority from Chapter 7, and include spending limits.
- **Who reports to them,** and what they are responsible for in managing those people: one to ones, feedback, development, rosters, leave and performance conversations.
- **How you will work together.** How often you will meet, how they should keep you informed, how you want to hear about problems and how they can reach you when it matters.

- **How much of their week stays clinical, and what they should stop doing.** A head nurse who is still fully rostered in theatre, or a clinical lead with a full consult list, has no time to manage. Without protected time, new managers keep doing their old job and add the new one on top.
- **The non negotiables.** The standards that must never be compromised, such as patient safety, compliance, honesty with clients and how staff are treated.

Put this on two pages, talk it through, and ask the new manager to explain it back in their own words. Then both of you sign it. It may feel formal for a small clinic. It will save you months of frustration and, very often, the manager.

Be honest about the job

Chapter 2 described the gap between the job we sell and the job people actually get. This gap is even more damaging for managers. If you tell a new practice manager they will have full control of the roster, and then keep changing it yourself, you have broken the promise in their first month. Describe the role as it really is today, including the hard parts, and only promise the authority you are genuinely ready to hand over.

A selection process that works

Whether you are promoting from within or hiring from outside, a simple, consistent process gives you far better decisions than a gut feel.

- **Start with the role description, not the candidate.** Decide what you need before you look at who is available.
- **Ask behavioural questions.** Instead of "How would you handle conflict?", ask "Tell me about a time two nurses on your shift were in conflict. What did you do, and what happened?" Past behaviour is the best predictor of future behaviour.
- **Use real scenarios.** Give candidates a situation from your clinic and ask how they would handle it: a long serving nurse who refuses to follow a new protocol, an unhappy client at discharge, a roster gap on a Saturday, a friend on the team who keeps arriving late.
- **Look at how they talk about others.** Do they give credit to their team, or talk only about themselves? Do they blame previous employers for everything?
- **Check references properly.** Ask specific questions about how they managed people, not just whether they were clinically competent.
- **For internal candidates, give a trial responsibility first.** Before a formal promotion, let them own the roster for a month, run the daily huddle or mentor a new graduate. You will learn more in four weeks than in any interview.
- **Ask the team.** Not for a vote, but for their observations. They often know who people trust.

A clinic example: promoting the best surgical nurse

A two vet clinic promoted its most experienced surgical nurse to head nurse. She was brilliant in theatre, and everyone assumed she would make the nursing team brilliant

too. Nobody wrote down what the role involved. She stayed fully rostered in theatre, managed the team only when something went wrong, and kept checking with the owner before changing anything. Within six months two nurses had left, and the owner was quietly managing the nursing roster again.

When the role was filled the second time, the owner did it differently. She wrote a two page role agreement: the purpose of the role, the team outcomes it was responsible for, decision rights over the nursing roster and training, one protected non clinical day a week, and a weekly one to one with the owner. The new head nurse was chosen partly because she had already mentored two new graduates successfully. A year later the nursing team was stable, theatre days ran on time, and the owner had stopped managing the roster altogether.

The first head nurse was not a poor nurse or a bad person. She was set up without clarity or time, and nobody had checked whether she wanted others to succeed as much as she wanted the work done well.

The first ninety days as a manager

The first three months shape how a new manager is seen by the team and how they see the role. Plan them:

- **Week one:** introduce the manager to the team yourself, explain their role and authority, and say clearly that you will back them.
- **First month:** weekly one to ones with the owner, focused on questions, early decisions and relationships with the team.
- **First ninety days:** agree two or three early wins the manager can deliver, a short training plan for any management skills they are missing, and a review at the end of the period against the role agreement.

Self check

1. How were the current managers in your clinic chosen: deliberately, or because they were the best clinician, the longest serving or the most trusted?
2. Does each of your managers have a written role agreement covering outcomes, measures, decision rights and protected management time?
3. What are you expecting from your managers that you have never actually told them?
4. Which of the attributes above is weakest across your management team?

One action this week: for each of your managers, write down the three outcomes you expect from them and the decisions they are allowed to make on their own. Then sit down with each of them and compare it with what they believe. The gaps will tell you where the hidden messages are.

Module 18 Choosing the Right Managers in the Vet Edge Manager's Toolkit includes a Manager Selection Scorecard to write the role agreement, score candidates on evidence and plan their first ninety days.

Chapter 17: Managing Your Managers

You have a good practice manager and a good head nurse. So why is everyone still coming to you?

Choosing the right managers is only half the job. The other half is managing them so they work well for you, and for the clinic. This is a different skill from managing a team of nurses and receptionists. When you manage the people doing the work, you are mostly managing tasks and standards. When you manage managers, you are managing judgement, authority and leadership. Your job is no longer to make sure the work gets done. It is to make sure your managers can get the work done through their people, without you stepping in.

Many practice owners find this the hardest shift of all, because it means letting go of the very thing that built the clinic: their personal control over the work.

How owners accidentally undermine their managers

Most owners would never deliberately undermine a manager they appointed. But in busy clinics it happens every day, usually with the best intentions:

- **Going around them.** A nurse asks the owner directly about leave or a shift swap, and the owner answers it, instead of sending them back to the practice manager. The team quickly learns that the real decisions are made by the owner, and the manager becomes a messenger.
- **Overriding decisions in front of the team.** The manager says no to a request, and the owner says yes at the front desk. Even if the owner is right, the manager has lost authority in a single moment.
- **Giving responsibility without authority.** The manager is accountable for the roster or stock, but every change still needs the owner's approval. They carry the blame without the power.
- **Rescuing.** As soon as something goes wrong, the owner jumps in between consults and fixes it personally. The manager never learns, and never gets the chance to show they can handle it.
- **Changing the goalposts.** Priorities shift every week depending on the owner's latest worry. The manager cannot build momentum on anything.
- **Silence.** The owner is unhappy with the manager's performance but says nothing, until it boils over (Chapter 11).

Every one of these sends the same message to the team: the manager does not really run things. And once the team believes that, the manager cannot lead them.

The owner's rules for managing managers

1. **Back them in public, challenge them in private.** If you disagree with a manager's decision, talk to them privately. In front of the team, support them. If a decision must be reversed, let the manager communicate the change wherever possible.

2. **Send questions back down the line.** When a team member comes to you about something their manager owns, redirect them: "That's one for Sarah. Have you spoken to her?" Then tell Sarah it happened. It feels slower at first. Within a few weeks, the team stops going around their manager.
3. **Give real authority, in writing.** Use the role agreement from Chapter 16. Spell out what each manager can decide, including spending limits, rosters, leave, stock ordering and client refunds. Then honour it, even when you would have decided differently.
4. **Manage outcomes, not methods.** Agree what result you need and by when. Let the manager decide how. If you dictate every step, you have not delegated management; you have hired an expensive assistant.
5. **Be consistent.** Agree priorities for the quarter and stick to them. When something genuinely must change, explain why, and agree together what drops off the list.
6. **Let them make mistakes, within limits.** Agree in advance where the safety net is: what risks are too big to take, especially where patient safety or compliance is involved, and what mistakes are an acceptable price of learning. Then let them learn.

The manager one to one

The most important routine in managing managers is a regular one to one: weekly for a new manager, fortnightly or monthly for an experienced one. Thirty to forty five minutes is enough, booked outside consult and surgery time. Protect it like a surgery booking.

A simple agenda keeps it focused:

- **Results.** How are we tracking against the outcomes and measures in the role agreement?
- **People.** How is the team? Anyone struggling, anyone ready for more?
- **Decisions.** What decisions do you need from me? What decisions have you made that I should know about?
- **Obstacles.** What is getting in your way, and how can I help?
- **Development.** What are you working on as a manager? What skill would make the biggest difference?
- **Feedback both ways.** One thing that is going well, one thing to improve, and one thing I could do differently to support you.

The last item matters. Asking your managers how you can support them better is one of the most powerful things an owner can do. It shows you see the relationship as a partnership, and it surfaces problems you would otherwise never hear about.

Build a management team, not a set of individuals

Once you have more than one manager, bring them together. A short weekly or fortnightly management meeting, with the owner, the practice manager, the head nurse and the clinical lead, turns separate roles into a team. Use it to:

- Review the key numbers together, so every manager understands the whole clinic, not just their part.
- Sort out the handovers between areas, such as reception to the nursing team, or the vets to the discharge nurse (Chapter 13).
- Agree priorities and resolve conflicts between areas before they reach the wider team.
- Make decisions that affect more than one area, with each manager's input.

The goal is a group of managers who support each other and hold each other to account, so that problems are solved at the management table rather than escalated to the owner one by one.

Develop them as leaders

Most clinic managers were promoted because they were good at the clinical or front desk work, exactly like the owner. They need help to develop as leaders, and it is the owner's job to make sure they get it. That help can include:

- Working through this book together, one chapter a month, and discussing how it applies to your clinic.
- External training or coaching on specific skills, such as feedback, difficult conversations or understanding the clinic's financials.
- Mentoring from the owner, using the mentoring loop in Chapter 12.
- Gradually widening their decision rights as their judgement proves itself.
- Including them in planning and budgeting, so they think like owners, not just supervisors.

An owner who develops strong managers is building the thing that gives a clinic real value: a team that can run it without the owner in the building every day, and an owner who can finally take a holiday.

When a manager is struggling

Sometimes, despite good choices and good intentions, a manager struggles. Before you conclude they are the wrong person, check three things in this order:

- **Clarity.** Do they genuinely know what is expected of them? Revisit the role agreement together. Many "performance problems" turn out to be clarity problems.
- **Authority and support.** Have they been given the authority, information, time and training to succeed? Have you been undermining them without realising?
- **Capability and fit.** If clarity and support are in place and things still are not improving, have an honest, private conversation using the approach in Chapter 11. Agree specific changes and a clear timeframe.

If it still does not work, it may be kinder to everyone, including the manager, to agree a different role. Many people who struggle as managers are excellent senior nurses or clinicians, and are relieved to return to that work. Handle this with care and respect, and take advice on your employment obligations.

A clinic example: the practice manager who could not manage

A clinic owner appointed a capable practice manager. Three months later the owner was frustrated that nothing had changed. Nurses and receptionists still came to her with every roster question, the same problems came up at every meeting, and the practice manager seemed more like an assistant than a manager.

When we looked closely, the cause was the owner. She was still approving every shift swap, still changing the roster herself and still answering front desk questions between consults without speaking to the practice manager first. The practice manager had the title but none of the authority.

The owner agreed three changes: every roster and leave question would be redirected to the practice manager, roster changes would go through the practice manager, and the owner would meet the practice manager for thirty minutes every Monday before consults started. Within two months the team had stopped coming to the owner, and the practice manager had grown visibly in confidence. She had been capable all along. She just needed her owner to step back.

Self check

1. In the past month, how many times have you answered a question or made a decision that belonged to one of your managers?
2. Do you have a regular, protected one to one with each manager?
3. Have you ever asked your managers how you could support them better?
4. Do your managers meet together as a team, or only with you individually?
5. What are you doing to develop each manager as a leader?

One action this week: tell your team, in front of their managers, that from now on questions about rosters, leave and day to day work go to their manager first. Then, for the next two weeks, redirect every question that should have gone to a manager, and tell the manager each time it happens.

Module 19 Managing Your Managers in the Vet Edge Manager's Toolkit includes a Manager One to One Planner to check your own habits, set up a regular one to one, agree who decides what and plan how you will grow each manager as a leader.

Chapter 18: Action Plans and Decision Making

Every clinic has a list of things that "we really need to do". Update the website. Introduce a puppy preschool. Fix the reminder system. Review the pricing. Get the new team member trained on dentistry. The list is discussed at meetings, nodded at, and carried forward month after month.

At the same time, decisions pile up. Should we hire another nurse or pay more overtime? Should we extend opening hours? Should we replace the old anaesthetic machine now or next year? Without a clear way to decide, these questions either drag on or get settled on impulse.

Both problems have the same cost: a clinic that stands still while its people work harder and harder.

Why good intentions do not become action

Ideas stall for predictable reasons:

- Nobody owns them.
- They are too big to start, so nobody does.
- There is no deadline, so they are always next month.
- Nobody checks progress, so nobody notices they have stopped.
- They compete with daily work and always lose.

An action plan solves all five.

Building an action plan

A useful action plan moves from the big picture down to the specific. It answers seven questions:

1. **The rock.** What is the big priority this plan supports? For example: a stable, well trained nursing team.
2. **The goal.** What specific result do we want, and by when? For example: every nurse confident in dental procedures within six months.
3. **The activities.** What steps will get us there? Break the goal into tasks small enough to start this week.
4. **The dates.** When will each step be done?
5. **The partners.** Who owns each step, and who needs to help?
6. **The routines.** Which regular routine will we use to check progress? For example: the monthly team meeting or the weekly owner meeting.
7. **The measures.** How will we know it is working? For example: number of nurses signed off, dental procedures completed, client feedback.

Here is what that might look like for a reminder system that has stopped working:

Step	Owner	Due	Check
Pull a report of	Practice manager	Week 1	Report saved

Step	Owner	Due	Check
reminders sent in the past three months			
Identify which reminder types failed and why	Senior receptionist	Week 2	Findings at team meeting
Fix templates and settings in the practice software	Senior receptionist with software support	Week 4	Test reminders received
Train front desk on checking the daily reminder list	Practice manager	Week 5	All front desk trained
Add reminder check to the weekly protocol spot check	Practice manager	Week 6	In the routine
Review response rate	Practice manager	Month 3	Rate compared with before

One page. Clear owners. Real dates. A routine to check it. Most clinic projects need nothing more complicated than this.

Fewer plans, finished

The most common mistake is having too many plans at once. A small clinic can realistically run two or three improvement projects at a time alongside daily work. More than that, and none of them finish.

Choose the projects that matter most, finish them, then start the next. Finished projects build momentum and confidence. A long list of half started projects builds cynicism.

Do the homework first: feasibility before commitment

One root cause appears again and again when clinics get into financial difficulty: a big decision made without a proper feasibility study. A second site, a new service such as rehabilitation or advanced dentistry, an expensive piece of equipment or a major refit, committed to on enthusiasm rather than evidence.

A feasibility check does not have to be a large report. It needs to answer a few honest questions:

- **Is there real demand?** Which clients will use it, how often, and at what fee?
- **Who else is already there?** What do nearby clinics and specialist centres offer, at what fee, and how will we be different?

- **What will it really cost?** Including equipment, consumables, training, marketing, extra staff and the vets' time.
- **When will it pay back?** And what happens to cash flow in the meantime?
- **Who will own it?** Who in the team will lead it, and what will they stop doing to make room?
- **What is our exit point?** At what result, by what date, will we stop or change course?

When one clinic was considering a large equipment purchase, the first step was to estimate how many patients a week would genuinely benefit, what fee clients would accept, and who would be trained to run it. That one piece of work changed the decision. The clinic chose a smaller investment, trained two nurses properly and built a service around it. Equipment that sits unused is one of the most common hidden costs in a clinic (Chapter 5).

Making better decisions

Vet professionals make clinical decisions all day, using a structured process: history, examination, tests, options, plan. Management decisions deserve the same discipline, but they rarely get it. They are made in a rush, in a corridor, based on whoever spoke last.

A simple seven step approach helps:

1. **Name the decision.** What exactly are we deciding? Who should decide? By when?
2. **Get the facts.** What do we know? What do we need to find out? Who should we ask?
3. **List the options.** Always more than one. Include doing nothing.
4. **Weigh the options.** For each, consider the benefits, the risks, the likely consequences for patients, clients, team and finances, and whether it is practical with the people, time and money we have.
5. **Choose.** Make the call. Waiting for perfect information is itself a decision, and usually a poor one.
6. **Communicate.** Tell the people affected what was decided, why, and what happens next.
7. **Review.** Set a date to check whether it worked, and adjust if needed.

Who decides?

Many clinic decisions stall because nobody is sure who should make them. The owner assumes the manager will. The manager assumes the owner wants to. Meanwhile, nothing happens.

It helps to agree, in advance, who makes which kinds of decisions. Routine operational decisions, such as roster swaps, stock reorders and small purchases within a budget, should sit with the manager. Larger or riskier decisions go to the owner, ideally with a recommendation from the manager. Chapter 15 shows how to agree this.

Involving the team

People support decisions they helped shape. When a decision affects the team, such as a new roster system or a new procedure, involve them in steps 2 to 4. Ask for facts, options and concerns. You do not have to reach a consensus, and the final call may still be yours. But a team that was consulted accepts a decision far more readily than one that was surprised by it.

Self check

1. How many improvement projects is your clinic running right now? How many have an owner and a deadline?
2. Which decision has been waiting longest? Why?
3. Are decision rights clear between you and the people above and below you?

One action this week: take the most important stalled project in your clinic and write a one page action plan for it, using the seven questions above.

Modules 11 Action Plans and 12 Decision Making in the Vet Edge Manager's Toolkit include an Action Planner and a Decision Planner to work through both.

Chapter 19: Clear Communication

Almost every problem described in this book has a communication failure somewhere inside it. The protocol that drifted because the change was never explained. The nurse who left because nobody told her she was doing well. The client who left because the callback never came. The owner who overturned a decision because nobody briefed him.

In a vet clinic, communication is constant: handover notes, rosters, group messages, emails, noticeboards, conversations in the corridor and the treatment room. Yet very few managers have ever thought carefully about how to communicate well. They say it once, in passing, and assume it landed.

Every conversation creates waste or value

Think about how much of your week is spent in conversations: consults, handovers, phone calls, emails, group chats and quick words in the treatment room. Every one of them either creates value or creates waste. A conversation that ends with shared understanding and a clear next step creates value. One that ends in confusion, a bruised relationship or the same discussion again next week creates waste: of time, energy and goodwill.

Most clinics make this harder than it needs to be. Messages arrive through half a dozen channels at once, everyone is interrupted, and few people read to the end. In that environment, getting a message through and turning it into action takes deliberate effort.

Why conversations fail

We form opinions very quickly, often within seconds, and we stop listening the moment we think we understand. Yet it usually takes far longer for the other person to explain what they really want and what worries them. That gap, between how fast we judge and how slowly we understand, is where most conversations go wrong.

Once we have an opinion, we start asking the worst question in any conversation: what proves I am right? We defend our side, look for agreement and treat our own beliefs as if they were facts. We assume there is only one truth, and that it happens to be ours. Or we avoid the conflict altogether and say nothing useful.

If the conversation does not change, behaviour will not change either. Two things usually stand in the way: we do not really listen, and we tell far more than we ask. The next two sections deal with each.

Listening comes first

Good communication starts with listening, and most of us listen far less well than we think. It helps to imagine listening as a ladder with several rungs:

1. **Ignoring:** not really listening at all, while doing something else.

2. **Pretending:** nodding and saying "mm" while thinking about your reply.
3. **Selective listening:** hearing only the parts that interest you or confirm what you already think.
4. **Attentive listening:** paying full attention to the words.
5. **Empathic listening:** paying attention to the words, the feelings behind them and what the person really needs.

In a busy clinic, managers spend a lot of time on the lower rungs. A nurse raises a concern while you are checking the schedule, and you hear half of it. A receptionist explains a problem with a client, and you jump to the solution before she has finished.

Climbing the ladder takes discipline. Stop what you are doing. Look at the person. Let them finish. Reflect back what you heard before you respond. These habits take seconds, and they change how people feel about raising things with you.

Where viewpoints meet

Every message passes between two people who see the world differently. The vet sees a treatment plan. The client sees a bill and a frightened pet. The owner sees a cash flow problem. The nurse sees another late finish.

Effective communication starts where your viewpoint and theirs overlap. Before an important message, ask yourself: what does this look like from their side? What do they already know? What are they worried about? What do they care about? Then build your message from that shared ground.

Three questions before you communicate

Before any important message, whether a team announcement, a change to a protocol or a difficult email, answer three questions:

1. **What do I want them to know?** The essential facts, in as few words as possible.
2. **What do I want them to feel?** Reassured, motivated, valued, clear about the urgency.
3. **What do I want them to do?** The specific action, and by when.

If you cannot answer the third question, your message may not need sending yet.

The four tests of a good message

A good message passes four tests:

- **Clear:** one main point, in plain words, with no jargon the reader may not share.
- **Relevant:** it matters to this reader, and it is obvious why.
- **Impactful:** it is memorable, and the important part stands out.
- **Reliable:** it is accurate, consistent with what others are saying, and backed by action.

A clinic example: the email nobody read

A practice manager sent this to the whole team:

"Hi all, just a reminder about a few things. Please make sure the theatre is cleaned properly at the end of the day as there have been some issues lately. Also the new drug register process starts soon, more info to come. And can everyone please be on time for shifts. Also, staff party is on the 14th, let me know if you're coming. Thanks!"

The theatre cleaning did not improve. Nobody knew when the drug register process started. The people who were late did not think it applied to them. Most people replied only about the party.

The problem was not the team. It was the message. Four topics of very different importance were mixed together, nothing was specific, and the most important item, a compliance change, was vague.

A better approach would split it up. The drug register change gets its own message, explained at the team meeting and followed up in writing with the start date, what changes and who to ask. The theatre cleaning gets a specific standard, a named owner and a checklist. Lateness is handled one to one with the people concerned. The party gets a cheerful separate note.

Writing to clients

The same principles apply to everything your clinic writes to clients: estimates, discharge instructions, reminders, newsletters and social media posts. The most common problem is a message that is all about the clinic and its services, and says little about the client and their pet. The fix is usually the same: shorter, specific to the reader, one clear reason for writing, and one simple next step. Run every client message through know, feel, do before you send it.

Review an important email before you send it

A useful exercise, on your own or with your managers, is to take a real email that carried an important message and pull it apart. Read the whole email, then ask:

- What is the main message?
- How urgent is it, and how would the reader prioritise it?
- Which parts would the reader relate to, and which would they skip?
- Is there a hidden agenda or an unspoken message?

Then count the sentences, the negative words and phrases, the positive words and phrases, the actual requests or questions, and the people on copy. The numbers are often revealing: long, negative, crowded with recipients and light on clear requests.

Finally, rewrite the email so it achieves what the sender really wanted, using the four tests. Doing this a few times with your managers builds a shared standard for how the clinic writes.

Choosing the right channel

Message	Best channel
Praise for an individual	In person, soon, then in writing if it is significant
Corrective feedback	In person, privately
A change to a protocol	Team meeting, then written summary, then training
Urgent operational update	Daily huddle or group message
Roster and leave	One reliable written place everyone checks
Sensitive news about the clinic	In person to the whole team at once, before rumours start

The rule of thumb: the more emotional or important the message, the more it needs to be said face to face. Written messages are good for confirming, not for persuading or comforting.

Say it more than once

Managers often feel they have communicated something because they said it once. For the team, hearing it once in a busy week is rarely enough. Important messages need repeating, in different forms: at the huddle, in the team meeting, in writing, on the noticeboard. By the time you are sick of saying it, most of the team has probably just heard it.

Self check

1. Where on the listening ladder do you spend most of your day?
2. Think of the last important message you sent. Did it pass all four tests?
3. Does your team have one reliable place to find rosters, protocols and updates?

One action this week: before your next important message, write down your answers to the three questions: know, feel, do. Then check it against the four tests before you send it.

Module 13 Clear Communication in the Vet Edge Manager's Toolkit includes a Message Planner for any important message.

Put it into practice: explore the Vet Edge Manager's Toolkit



Part Three

Making It Stick

Part Three: Making It Stick

Knowing what to do is the easy part. Doing it consistently, on busy weeks as well as quiet ones, is where most good intentions fall away.

Part Three is about turning everything in this book into habits that last. It gives you a simple ninety day plan, built in three stages: see clearly, fix the foundations, then build. It also shows you which numbers to watch, so you can tell whether your clinic is really moving from drift to direction.

You will not get it all right at once, and you do not need to. Start small, stay consistent, and let your team see that this time the changes are here to stay.

Chapter 20: Your First 90 Days

Reading about management changes nothing on its own. What changes a clinic is a manager who does a few things differently, consistently, for long enough that they become habits and the team notices.

This chapter turns the book into a ninety day plan. It is deliberately modest. Trying to fix everything at once is how good intentions collapse. The plan builds in three stages: see clearly, fix the foundations, then build.

Days 1 to 30: See clearly

The first month is about understanding where your clinic really stands, and starting two simple routines.

- **Know your style.** Work through Chapter 6. Identify your natural management style, your blind spots and your sources of authority. Write your working with me card.
- **Track your time.** For one week, log your interruptions and tasks (Chapter 1). Sort them into A, B and C (Chapter 7).
- **Count the cost.** Estimate the real cost of the last two resignations (Chapter 2). List your five most important protocols and check who owns each one (Chapter 3).
- **Start the daily huddle.** Ten minutes, every morning, same four points (Chapter 9).
- **Start the owner meeting.** Book a standing weekly or fortnightly meeting with the person you report to, using the six point agenda (Chapter 15).

By day 30, you should have a clear, honest picture of your clinic's biggest management gaps, and two routines running.

Days 31 to 60: Fix the foundations

The second month is about the habits that stop the biggest leaks.

- **Delegate.** Hand over all your C tasks. Begin handing over one or two B tasks using prepare, agree, support (Chapter 7).
- **Name protocol owners.** Give every key protocol a named owner and a simple weekly check (Chapter 3).
- **Start one to ones.** Thirty minutes each month with each person who reports to you. Include a motivation question and a development question (Chapters 10 and 12).
- **Give feedback.** At least three pieces of specific positive feedback each week. Have the difficult conversation you have been avoiding (Chapters 8 and 11).
- **Protect your rocks.** Book a weekly planning hour and set three outcomes for each week (Chapter 14).
- **Clarify your managers' roles.** If you have managers, write a role agreement with each one covering outcomes, measures, decision rights and protected

management time (Chapter 16). Start a regular one to one with each manager, and send every question that belongs to a manager back to them (Chapter 17).

By day 60, you should feel the first signs of change: fewer interruptions, a few protocols back on track, and team members who notice that they are being listened to.

Days 61 to 90: Build

The third month is about investing in the future of the team.

- **Development plans.** Draft a one page plan with each direct report (Chapter 12).
- **Team review.** Rate your team on goals, roles, processes and relationships, and fix the weakest handover (Chapter 13).
- **One action plan.** Choose the most important stalled project and write a one page action plan with owners and dates (Chapter 18).
- **Check your clients.** Run a mystery call and phone three clients who have not been back (Chapter 4).
- **Communicate the changes.** Tell the team what you have been working on and why, using know, feel, do (Chapter 19).
- **Review the numbers.** Look again at overtime, resignations, protocol checks and client feedback. Share what you find with the owner.

What to expect

Change will not be smooth. Some routines will slip in a busy week. Some team members will be sceptical at first, especially if previous initiatives faded away. Keep going. Consistency is what builds trust. The team is watching to see whether this lasts.

Most managers who follow a plan like this notice three things within three months. They feel less overwhelmed, because work is better distributed. The team brings fewer problems and more solutions, because people have clearer roles and more authority. And the relationship with the owner improves, because there is a regular place for honest conversation.

The bigger gains, such as lower turnover, steadier protocols and stronger client loyalty, take longer to show in the numbers. They are built on exactly these habits.

Measuring progress

To know whether your management is improving, track a small number of measures every quarter:

Measure	Why it matters
Resignations in the past twelve months	The clearest signal of team health
Overtime and agency hours	A sign of gaps and pressure
Protocol checks completed and passed	Whether standards are holding
Active clients and reminder response rate	Whether clients are staying

Measure	Why it matters
One to ones held as planned	Whether management routines are happening
Your own hours and leave taken	Whether the manager is sustainable

Share these with the owner. Over a year, they tell the story of a clinic moving from drift to direction.

Self check

1. Which stage of the plan will be hardest for you? Why?
2. Who could support you through the ninety days: a colleague, a mentor, the owner?
3. What will you do in the first week?

One action today: put the first three items from days 1 to 30 in your diary, with dates.

Put it into practice: explore the Vet Edge Manager's Toolkit

Conclusion: From Drift to Direction

Remember Riverbend Veterinary Clinic from the introduction: the busy, successful clinic that lost four of six nurses in eighteen months, watched its protocols slip and quietly lost longstanding clients.

The owner did not fix it overnight. She started small. She began a daily huddle and a fortnightly meeting with her practice manager. She handed the roster, stock ordering and the reminder system to people who were capable of running them. She gave each key protocol an owner. She started monthly one to ones with her senior nurses and asked each of them what would make them stay. She had two conversations she had been avoiding for a year.

A year later, the clinic had not lost a single nurse. Overtime was down. The reminder system was working again and recalls were up. The owner was leaving at a reasonable hour most evenings, and for the first time in years she took a full two weeks off without being called.

None of what she did was complicated. All of it was management.

Knowing it is working

This book began with the cost of poor management. It never shows up as a line item on your P&L, yet it is one of the largest costs your clinic carries. So it is fitting to finish with the opposite question: how do you know that sound management is paying off?

Good management will not deliver massive profits overnight. It builds habits, and good habits build an ecosystem: clear roles, protocols people can follow, managers who develop and mentor their teams, and a regular rhythm of meetings and reviews. The gains show up in the numbers, if you know where to look: revenue from your main services, time given back, leaks closed and good people who stay. They do not come from rushing people. They come from people who are supported to do their best work.

When a number does not move, it usually points to the part of the system that is missing: steps that are not being followed, strong people with no protocols to support them, protocols nobody was taught, or recruitment that brings in the wrong people.

That is why the Vet Edge Manager's Toolkit finishes with a Conclusion module, Evaluate the Results of Sound Management, and an online Bottom Line Improvement Calculator. Use them every quarter to see what your efforts are yielding and where to adjust.

The real lesson

The central message of this book is simple. In a vet clinic, poor management is not a minor inefficiency. It is one of the largest costs the business carries. It drives good people away, lets standards drift, loses clients and burns out the very people the clinic depends on most. It also leaves profit on the table: revenue that leaks through missed charges and lapsed reminders, equipment and technology that were paid for but never

fully used, and services the clinic could offer but never gets around to launching. These unrealised profits rarely show up in the accounts, because they are money the clinic never earned rather than money it spent. That makes them easy to overlook, and often larger than anyone expects.

Poor management can also leave the clinic legally exposed. A performance problem that was never raised, documented or handled fairly can turn into an unfair dismissal or general protections claim. Unclear rosters, missed award entitlements and poor records can lead to underpayment claims and back pay. Bullying that is left unchecked, unsafe work practices and fatigue are work health and safety risks, and the clinic, and sometimes its owners and directors, can be held responsible. Gaps in protocols, such as a controlled drug register that does not reconcile or incomplete clinical records, can also draw the attention of regulators. Clear roles, written protocols, documented one to ones and regular check ins are not just good management. They are the clinic's best protection.

And it takes a heavy personal toll on the head vet. When every decision, problem and worry flows to one person, management becomes a very lonely place to be. The head vet carries the clinical load, the team's frustrations and the financial pressure, often without anyone to share them with. They cannot always confide in the team, and the people at home may not fully understand the strain. Over time, that isolation wears down even the most capable and committed vet.

And unlike many of the pressures facing vet clinics, such as workforce shortages, rising costs and changing client expectations, management is something you can change, starting this week, with no capital outlay at all.

If you are an owner vet, this message matters most of all for you. You were trained to care for animals, not to run a business, and nobody should expect you to carry both jobs alone. Building good managers, simple routines and a clear view of your numbers is not about doing more. It is how you get your health, your time and your love of veterinary work back, and how your clinic finally makes full use of the financial and technological tools that are already within reach.

You do not have to be a natural manager. Very few people are. You need a clear picture of what matters, a handful of practical tools, and the discipline to use them consistently. This book has given you the first two. The third is up to you.

About the Vet Edge Manager's Toolkit

This book is the companion to the **Vet Edge Manager's Toolkit, developed with Business Consult Group.**

The Toolkit turns the ideas in this book into practical, self paced modules built specifically for vet clinics. Each module opens with a short video and has two parts:

- **An introduction** that explains why the skill matters, why managers struggle with it, the common traps, and a quick self check.
- **A fillable tool** that you complete on screen, building a real plan for your own clinic. Save it, print it or share it with your owner or team. It is yours to keep.

The Toolkit includes twenty one modules and a Conclusion:

Module	Tool
00 Know Yourself as a Manager	Manager Profile
01 Delegation	Delegation Tool
02 Effective Feedback	Feedback Planner
03 Leading Team Meetings	Meeting Planner
04 Employee Motivation	Motivation Planner
05 Difficult Conversations	Conversation Planner
06 Mentoring and Development	Development Planner
07 Building Your Team	Team Builder
08 Self Management	Week Planner
09 Managing Up	Managing Up Planner
10 Management Routines	Routine Planner
11 Action Plans	Action Planner
12 Decision Making	Decision Planner
13 Clear Communication	Message Planner
14 Counting the Cost	Cost of Drift Calculator
15 Keeping Good People	Stay Conversation Planner
16 Processes That Stick	Process Owner Plan
17 Clients Notice	Moments That Matter Map
18 Choosing the Right Managers	Manager Selection Scorecard
19 Managing Your Managers	Manager One to One Planner

Module	Tool
20 Your First 90 Days	90-Day Plan
Conclusion: Evaluate the Results of Sound Management	Bottom Line Improvement Calculator (online)

It is designed for clinic owners, practice managers, head nurses and clinical leads, and every example is set in a vet clinic.

Module 14 also links to an online Cost of Drift Calculator that adds up the figures for you, and Modules 18 and 19 support Chapters 16 and 17 of this book.

The Conclusion module closes the program. Its online Bottom Line Improvement Calculator turns the changes you have made into dollars, so you can see what sound management is yielding for your clinic and where to adjust.

Explore the Vet Edge Manager's Toolkit

Working with Vet Edge

Vet Edge helps clinic owners and managers build clinics that run well without depending on one exhausted vet.

We do not offer cookie cutter coaching. Every engagement starts by learning the DNA of your clinic: your people, your numbers, your clients and your protocols. From there, we work with you on the areas in this book that matter most to you, with practical tools your team will actually use.

Our work includes:

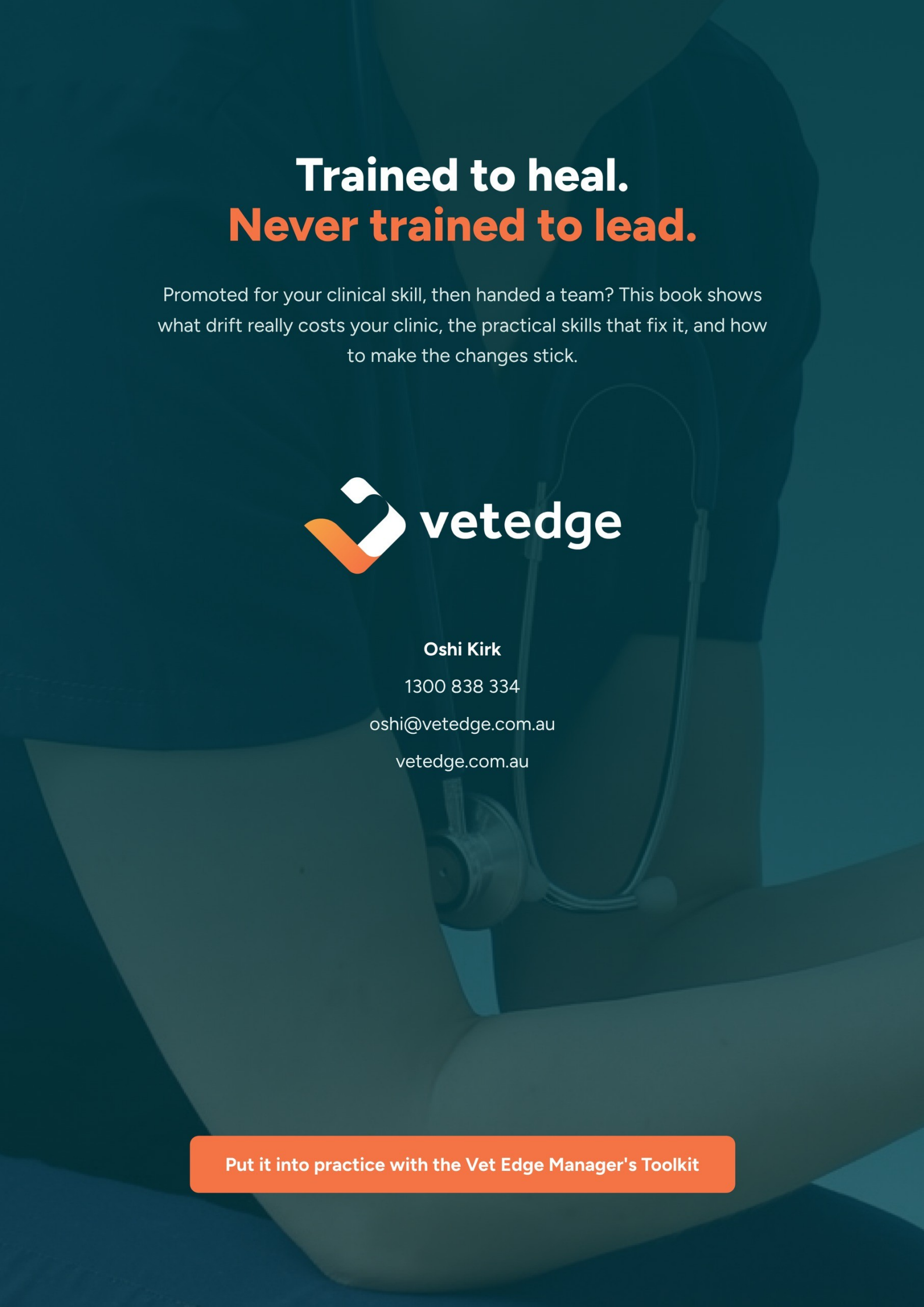
- Management and leadership development for clinic owners, practice managers, head nurses and clinical leads, delivered four ways: a three month one to one program that alternates a theory session with a practical session on your real day to day situations; a group classroom program for up to eight people, run as one six hour day a week for three weeks, with a printed workbook and handouts to keep; the self paced online program built on the Vet Edge Manager's Toolkit; and, by request, remote business consulting.
- Sales and client communication coaching for front desk, nursing and business development teams, including recommendations, follow up and rebooking.
- Business reviews covering finance, overheads, fees, marketing and operations, with clear recommendations.
- Feasibility and growth planning for new services, locations, equipment and investments.
- Process and systems design, from estimates and charging to onboarding and hiring.

To find out how Vet Edge could help your clinic, contact Oshi Kirk at oshi@vetedge.com.au or call 1300 838 334.

Acknowledgements

This book draws on many years of management training delivered by Business Consult Group, and on conversations with clinic owners, practice managers, vets, nurses and receptionists who were generous with their time and honest about their challenges.

A note of disclosure: Vista IQ is distributed in Australia and New Zealand by Vet Edge, the company I direct. It is mentioned in Chapter 5, in relation to equipment training and support, and in Chapter 7 as an example of a cancer risk screening device used in nurse led clinics.



Trained to heal.
Never trained to lead.

Promoted for your clinical skill, then handed a team? This book shows what drift really costs your clinic, the practical skills that fix it, and how to make the changes stick.

vetedge

Oshi Kirk

1300 838 334

oshi@vetedge.com.au

vetedge.com.au

Put it into practice with the Vet Edge Manager's Toolkit