BOTTOM-UP SAFETY CHANGE IN HEALTHCARE:

OVERCOMING RESISTANCE TO OBVIOUS IMPROVEMENTS

In aviation, as in most industries, we tend to expect that safety improvements will be triggered, designed and implemented from above. Some improvements can, however, be brought to life by the people who do the operational work. Anaesthetist **Rob Hackett** gives two examples from healthcare, which sometimes meet resistance.

KEY POINTS

- **Front line staff have ideas and collective power and can organise to spread small ideas that can make a big difference.**
- **Resistance to change can come from the most senior employees, as well as management. But transparency can help positive change to spread.**
- **Instead of telling front-line staff how to do our jobs properly, there needs to be greater emphasis on making it easier for us to do our jobs well.**
- **Improvement requires much greater collaboration with all interested parties, particularly front-line staff.**

Recently an anaesthetist cancelled an elective operating list because the surgeon repeatedly refused to introduce himself during the team briefing prior to surgery. This was a courageous move given the potential negative consequences to the anaesthetist's reputation in the eyes of that surgeon, but the right one for providing an optimal environment for patient safety. It is important to know the names of team members in surgery. The surgical safety checklist (see Figure 1) includes an item, "confirm all team members have introduced themselves by name and role". Unwillingness to introduce oneself is a sign of deeper issues that could be relevant to safety.

I was interested to see what others would do in a similar situation. So I launched a twitter poll. A large majority of the 515 respondents indicated that they would do the same as the anaesthetist (see Figure 2).

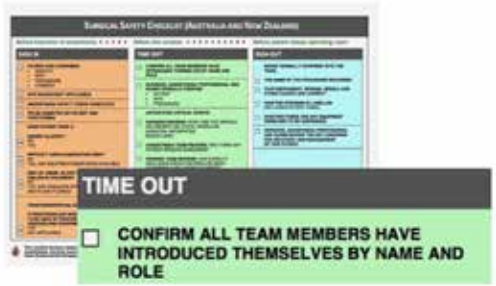

Figure 1: Checklist

Figure 2: Twitter poll

It is can be hard to implement even obvious improvements in a culture that tends to resist change. Within my own career, I've been subjected to intimidation for trying to change things for the better. The worst episode occurred three years ago. It culminated in me being brought into a room with departmental heads and the hospital CEO. I had been trying for some time to introduce another safety intervention. One individual pointed at me and said:

"I don't care who you are or what you do but if you do anything like this again you are out."

Other common responses include "no one else has complained about it" and "show me the evidence". There are also, of course, frequent references to "cost" (ignoring cost to life, and long-term savings) and the use of suffocating inertia. If staff persist with demand for change, then bullying, threats and intimidation can occur. Sometimes, whistleblowing results, at great personal cost.

Name & role hats

After months of deep reflection, mentoring, and learning about change management, I had an idea. Names and roles should be on theatre hats. It's obvious. Humans are very poor at remembering names. After first introduction, even when not distracted, we often forget names. But in healthcare, as in cockpits and as is the trend in ATC units, fixed teams are rare, so people need to remember names that they have just heard.

Alison Brindle, a British medical midwife student, came across the idea and developed the hashtag #TheatreCapChallenge. Alison had been handed equipment accidentally from physicians who mistook her for someone else several times. The initiative began to receive international support.

Four days after the hashtag was released on social media, the initiative was published in The Times newspaper. Two days later it was on the front page of the Sydney Morning Herald. The article received over a million reads two days in a row. It received over 300,000 likes and over 30,000 comments, mainly from patients. Patients thought it was an obvious improvement. A recent survey, as yet unpublished, found that 89% of 228 respondents working in healthcare institutions feel that operating theatre staff should clearly display their name and role at all times. In another survey of over 1000 individuals, 87% of front-line staff supported name & role theatre hats.

Healthcare is emotive, and the different professions and command structures can breed conformity and resistance to change. Some senior theatre staff have fiercely resisted the change. Those working within the industry the longest can be particularly influential and prevent change. While 100% of medical and nursing students supported the initiative, this number fell to 55% for surgeons with over 20 years in healthcare. Even though theatre uniforms look like pyjamas, the addition of a name and role on theatre hats seemed to be a step too far. Within one of my institutions, a senior surgeon prohibited presentations on the #TheatreCapChallenge. Managers have refused to challenge this despite being aware of the issue. The culture of a whole institution can be influenced significantly by one individual. There is also a 'not invented here syndrome' in healthcare, which is infused with innovation. Woodward (2017) noted that *"there can be reluctance to adopt or share new ideas or good practice"* (p. 63).

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Figure 3: Name & Role Theatre Caps and #TheatreCapChallenge Hashtag

Often senior staff will jump from one change-blocking excuse to another. Infection control is a common excuse. Reusable printed cotton hats are perhaps the easiest way for staff to display their identity. Infection control has been used as an excuse to prevent this, even in institutions that already allow reusable hats. But five large studies have demonstrated no difference in infection rates between them and disposable hats. The American College of Surgeons and several others released a joint statement to this effect in February 2018.

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From initial resistance, name & role theatre hats have now been adopted by several trusts in the UK National Health Service, endorsed by the Australian Society of Anaesthetists, and supported by the American Society of Anesthesiologists, the European Society of Anaesthesiology, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. We discovered that it has actually been New South Wales policy since the Garling Inquiry 2008 that we should be displaying our names and roles. We just haven't been doing it.

A 'Name & Role' project group has gathered information to help promote the #TheatreCapChallenge further. The group contains professors of communication, experts in simulation, nurses, midwives, surgeons, operating department practitioners, anaesthetists, and many others.

We've since heard of problems from staff misidentification. In one case, an Anaesthetist believed that a staff member was a nurse qualified in checking blood, and allowed it to be given. However, the person was a theatre porter. The blood hadn't been checked. The patient died from an incompatible transfusion. Based on previous research, we believe that name & role theatre hats will improve name recall and increase theatre efficiency and improve communication during simulations, and increase the performance of name and role introductions. The hats create an environment where name & role introductions become less forgettable and more likely to be performed properly.

The visual nature of name & role theatre hats provides a visual and symbolic indication of a culture supportive of change and improvement.

We aim for the surgical safety checklist to be updated to something like: "ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES AND HAVE THEIR NAME AND ROLE CLEARLY DISPLAYED ON THEIR PERSON."

Hospital Emergency Numbers

The #TheatreCapChallenge is only one of numerous initiatives we're driving through The PatientSafe Network. We've helped deliver several other human factors design improvements.

One of these is hospital emergency numbers.

We identified 51 different numbers within Australia (data obtained through crowd sourcing on social media). This is relevant to safety because staff move between hospitals. As discussed by Suzette Woodward (2017) in the context of different prescriptions sheets and different colours allergy bands and labelling, there are too many local variations in designs, which makes it hard to standardise. This situation has developed over many years.

A project group was formed to standardise the Hospital Emergency Number in Australia. NSW Health recently agreed to standardise internal hospital emergency numbers across the state to 2222. Dr David Whittaker has helped to extend the UK standardised number 2222 to Europe and elsewhere, internationally.

Making change transparent

The UK NHS already produces a subjective league table based on the feedback of front-line staff, focussed on how well they believe their opinions are listened to. This transparency can help positive change to spread. Within Australia the hospital emergency numbers (HEN) have been displayed on a map, indicating visually which institutions have upgraded to the standardised 2222 number. Displaying information in this way is helpful in encouraging standardisation and in helping to raise awareness. We are looking to encourage the same internationally in the future.

Transparency could be extended to other aspects of patient care. For instance, which hospitals use:

- the standard hospital emergency number?
- name and role identification?
- safer oxygen cylinders?
- vivid antiseptic solutions?

- standard labelled drug ampoules?
- resuscitators that supply sufficient oxygen?

Front-line staff driving improvement

We can all lend our support to a culture of safety by considering how the design of work, tools, artefacts and environments helps or hinders our work, whether as an anaesthetist, surgeon or nurse, or as an air traffic controller, pilot or engineer. Staff can work together to improve the system, one 'small' change at a time.

There also needs to be a shift in thinking amongst managers and senior staff. Instead of focussing on telling front-line staff how to do their jobs there needs to be greater emphasis on making it easier for them to do their jobs well. To me, this is what human factors design is all about: providing an environment which makes it easier for us to do our jobs well. This requires much greater collaboration with all interested parties, particularly front-line staff. This is how the PatientSafe Network operates. The PatientSafe Network is a non-for-profit charity focussed on collaborative implementation of effective safety interventions. The PatientSafe Network brings together different sources of expertise to improve patient safety.

We can now work in ways not available to us in the past. Through social media, networked international teams can help to improve patient safety and the effectiveness of services. Social networks like Twitter, Facebook, LinkedIn and others allow us to collaborate efficiently, sharing information. Other software platforms (we're using BaseCamp) allow us to utilise this information within focussed project groups of passionate individuals. It's amazing to see this in action, and to be part of it through the PatientSafe Network.

Perhaps you and your colleagues could do something similar.

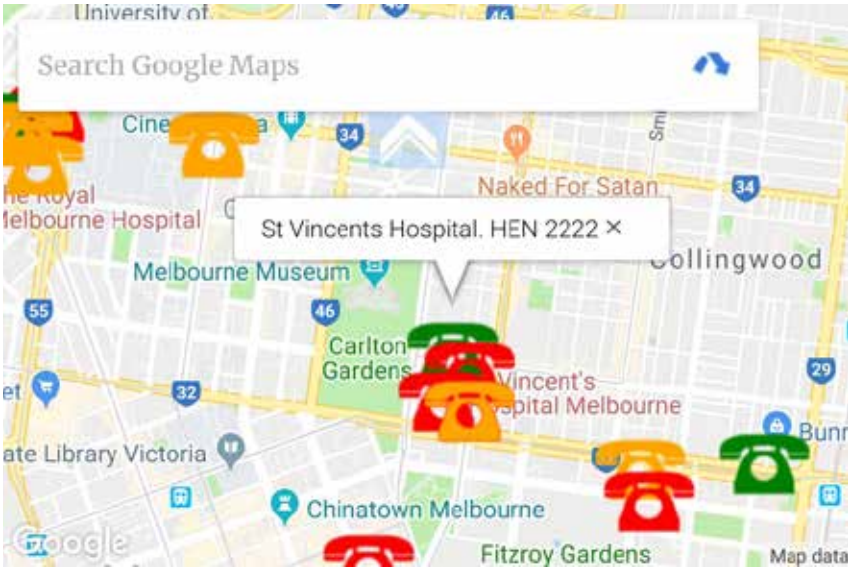

Figure 4: Standardised Hospital Emergency Number in Australia

References

Woodward, S. (2017). The problem of many imaginations. HindSight, Issue 25 – Work-as-Imagined and Work-as-Done. Brussels: EUROCONTROL.

Dr Rob Hackett is a senior consultant anaesthetist who works at several distinguished hospitals throughout Sydney Australia. He has an interest in human factors and is passionate about improving front line work environments for patient safety. He hosts the PatientSafe Network, www.psnetwork.org/about/. **patientsafe@icloud.com**