

CORRESPONDENCE

Mad as a hatter? Evaluating doctors' recall of names in theatres and attitudes towards adopting #theatrechallenge

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Editor—The use of people's names leads to better exchange of information which results in more effective teams and improved patient safety.^{1,2} Team communication is a central component of managing and averting errors.³ Crucially, omissions, misinterpretations, and conflict arising from poor communication can result in adverse patient outcomes.³ Knowing and recognising team members by name has been quantitatively and qualitatively associated with increased trust, work engagement, and clinical outcomes.^{1–3} Introduction by name and role is thus an integral part of the WHO team brief. However, humans only recall 30% of names after first introduction,⁴ and personal names are known to be particularly difficult to retrieve.⁵

Methods of physical staff identification within theatres include lanyards, pin badges, scrubs with embroidered names used in emergency departments, and velcro name badges attached to military uniforms. These methods all have significant drawbacks. Badges are often covered up by theatre gowns, lanyards are tucked away, and both often have too small a font to discern from a distance. Specialised uniforms attract additional costs and present laundering challenges. Whiteboards with staff names and roles may not always be in view of all staff, are often incomplete, and are not updated as staff change during the day. Memorial Sloan Kettering's Josie Robertson Surgery Center in New York City has overcome this problem by installing an innovative real-time locating system with 39 electronic whiteboards which automatically display names and roles of staff members as they enter or exit a room. However, such systems are likely to be prohibitively expensive for most hospitals.

Recognising the importance of using first names, especially in crisis scenarios, one of us (R.H.) advocates having names and roles easily visible on theatre hats. Names and roles may be written directly onto disposable hats, printed onto stickers,

ironed-on, or embroidered onto fabric hats. This simple low-cost initiative has gathered global momentum through social media platforms in the form of #theatrechallenge.

At Queen Alexandra Hospital in Portsmouth, UK, we aimed to locally evaluate recall of theatre staff names and to assess attitudes towards adopting this simple patient safety initiative, identifying potential barriers to implementation. This project was registered locally as a quality improvement initiative. In January 2018, anaesthetists and surgeons of all grades across theatres in our trust were asked how many theatre staff names they could recall after the WHO team brief. Theatre location, specialty, and grade of clinician were recorded. Data were presented at a local clinical governance meeting along with the background behind #theatrechallenge. Anaesthetists and allied theatre staff were then asked to complete a short survey asking whether they would support the adoption of names and roles on theatre hats.

Name recall was assessed amongst 52 anaesthetists and 26 surgeons ($n=78$) in 26 theatres. Overall, 51% were consultants and the remainder trainees (CT1–ST7). Mean recall across all grades was 71%; this improved with seniority from 52% (CT1–2's) to 77% (consultants). Total staff numbers present were highest in emergency and orthopaedic theatres (>9 people). Ninety-four percent ($n=46/49$) of anaesthetists and scrub staff supported widespread adoption of names and roles on theatre hats. Barriers related to cost and 'looking silly' or unprofessional. Only one respondent felt it would not improve patient safety.

There was room for improvement in knowing names of theatre staff. Recall was poorest in emergency theatres where staff density was highest, and amongst less experienced doctors. This group were unable to identify almost half of theatre staff by first name. Junior trainees represent a vulnerable cohort, already subject to higher cognitive load in crisis

situations. Recall by consultants was better, probably because of longer service in the trust and regular operating lists within similar teams.

The poor recall of names shown in our study is not in isolation. Another UK study showed 14% of anaesthetists did not know the name of their operating department practitioners, 30% of surgeons did not know their anaesthetist's name, and 25% of surgeons did not know the name of their scrub nurse.⁶ Importantly, recall was not improved by presence at the WHO team brief or wearing an identification badge. A further study of 150 theatre staff in the USA⁷ showed that 98% were able to name the consultant surgeon correctly. However, consultant surgeons were only able to name 44% of other theatre staff. Only 62% of the theatre staff could correctly name the anaesthetist.

In our study, cost, aesthetics, and maintaining professionalism were key to respondents' appetite for embracing the theatre hat initiative. Multidisciplinary team buy-in was present from anaesthetists, surgeons, obstetricians, paediatricians, and scrub and recovery staff. There was also unanimous support from the trust's lay patient collaborative committee. In further support from a patient perspective, a recent national Twitter poll conducted by an anaesthetic trainee curating the @NHS account for a 1 week period surveyed 206 patients, 88% of whom stated they would like to see the name and role of team members looking after them.

As a result of our study, funding has been secured to support the voluntary introduction of professional personalised name and role hats in our hospital. All theatre staff have been offered hats with a choice of iron-on or embroidered name and role labels. Widespread adoption of this simple low-cost initiative could improve communication in crisis scenarios and help break down hierarchical barriers on a daily basis, resulting in improved patient safety.

Declaration of interest

The authors declare that they have no conflicts of interest.

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