An Inpatient Stroke Unit Quality Improvement Project to Increase Staff Introductions

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Abstract

Background: Staff introductions impact patients' experiences and can reflect the quality of care provided by an organization. After being alerted by a stroke survivor about discomfort and fear associated with staff that failed to introduce themselves upon entry to the patient's room, we aimed to improve staff introductions on a 20-bed stroke unit.

Methods: We conducted staff-blinded observations of staff introductions when they entered patients' rooms to obtain baseline performance data. A Plan-Do-Study-Act approach was then used to develop and implement multiple interventions to improve staff introductions, including visual aids placed outside rooms, enhanced identification badges, and staff education which included patient video testimony describing the perceived importance of staff introductions. The citing of staff names on our Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reports was used as a surrogate measure for staff introductions, with baseline reports compared to post-intervention reports. We also identified a control unit that did not participate in the intervention for comparison, examining their HCAHPS reports for the citing of staff names.

Results: A total of 20 staff-blinded observations were completed prior to intervention implementation, with 55% of staff introducing themselves to patients. Following implementation, staff introductions improved to 73% (n=15). HCAHPS results citing staff by name increased from 57% prior to intervention implementation, to 87% post-intervention. Control unit HCAHPS findings decreased over the same measurement time periods from 62% to 31%.

Conclusions: Patients' perceptions of discomfort and fear tied to staff introductions are important to provision of high quality stroke care. Our introductions intervention has enhanced the stroke patient hospitalization experience.

Keywords: Healthy work environment, acute stroke, nursing.

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Introduction

Receiving medical care can be stressful and frightening for most patients. Staff introductions to patients are a simple, yet inconsistently used form of courtesy that should occur upon entering patients' rooms. Given the many different disciplines and ancillary staff involved in stroke patient care, introductions are key to ensuring patients know the difference between doctors, nurses, therapists and other staff members, including environmental services, food/nutrition support, and engineering personnel.

Our 20-bed stroke unit is supported by a Patient Family Advisory Committee that provides ongoing feedback about the stroke patient experience. We learned from a patient committee member that not all staff who enter the room use their names, titles, and/or explained the purpose of their visit, leaving them fearful and uncomfortable. These findings were similar to those reported by the late Dr. Kate Granger during her treatment for cancer when staff did not introduce themselves while they delivered her care;[1] this led her and her husband to start a social media campaign titled, "Hello, my name is…" to bring awareness among healthcare staff about the importance of introductions.[1] We aimed to initiate a similar program with the goal to make clear to our stroke unit staff the importance of introductions to enhance the human connection and improve patient experiences.

Methods

A quality team was organized and a Plan-Do-Study-Act quality improvement approach was utilized, with the aim of improving staff introductions to patients and families. We initiated our work by obtaining baseline measures of how often staff did or did not introduce themselves to patients. We started this process by using a short questionnaire which asked patients about staff introductions: A) Did staff entering room introduce themselves? B) If so, did they provide name, title, or both? and, C) Was the staff member's name badge easy to read? However, we found that patients were not forthcoming in sharing an honest appraisal of introductions with team leaders; therefore, we quickly abandoned this method of data collection in favor of staff-blinded observational data collection.

Beginning in June 2023, staff-blinded observations were conducted, whereby a project team member observed different hospital staff as they entered patient rooms to note whether an introduction to name, title, and purpose of the visit took place. Once baseline data were collected, the team moved to development of interventions.

The stroke survivor who first made the team aware of the staff introduction problem worked with the project team to create a video testimony of why lack of introductions is unsettling to hospitalized patients and to encourage staff to be mindful of introducing themselves. Video access was disseminated through publication in the hospital's weekly newsletter which was sent via email.

Next, the team identified the small font size on facility-issued ID badges as a significant problem since they were difficult for patients to see. Therefore, procurement of larger font stickers with nursing and support staff first names was arranged for ID badges. Breakaway lanyards were also obtained to ensure name badges were at patient eye level to facilitate easy reading.

Lastly, the team and unit leadership promoted the new initiative at department huddles of all

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disciplines. They educated everyone on the importance of introductions and the goals of the "Hi, my name is…" initiative. Signs were also created that were placed outside patient rooms as a visual reminder to all who enter a room to say, "Hi, my name is…" (Photo).

Photo: Example of the "Hi, my name is…" sign placed outside patient rooms on the stroke unit.

To measure the impact of the quality study, HCAHPS surveys were evaluated 8 months prior to and 6 months following intervention implementation. Because HCAHPS surveys do not utilize items about staff introductions, the team examined survey results for the number of times that staff members were identified by name in free text fields as a surrogate for introductions. Staff courtesy and teamwork items were also evaluated as indicators of staff introductions within HCAHPS. A similar-sized 20 bed medical/surgical unit in the hospital that did not participate in the initiative was used as a control unit for HCAHPS results, and post-implementation staff observations on the stroke unit were completed.

Results

Table 1 presents our quality study results. A total of 20 baseline observations took place during the month of June 2023, before implementation of the project in July 1, 2023, and post-implementation observations (n=15) occurred between November 1, 2023 to December 31, 2023. Staff introduced themselves 55% of the time prior to implementation of the intervention, and this improved to 73% following implementation. No differences were noted in staff roles or disciplines among those that did or did not introduce themselves to staff.

HCAHPS results were run on for the 8 month period from October 1, 2022 to June 30, 2023 prior to project implementation. A total of 30 surveys had written comments and 17 (57%) of these included staff names. Post-implementation HCAHPS data were evaluated from July 1, 2023 to December 31, 2023; 39 surveys had written comments and of these, 34 (87.7%) cited staff names (Table). HCAHPS results from the 20-bed comparison unit showed use of staff names in 62% during the pre-implementation period, and a decrease to 31% in the post-implementation period (Table). Additional HCAHPS items showed score increases for, "Nurses treated you with courtesy and respect," and "Staff worked well together to care for you." The item, "Nurses treated you with courtesy and respect" showed steady improvement prior to and during project implementation (Figure 1). The HCAHPS item, "Staff worked well together to care for you" increased throughout the implementation period (Figure 2).

Discussion

Our quality project showed improved staff introductions following implementation of our intervention. Nurse theorist Hildegard Peplau posited that the nurse-patient relationship was the foundation for nursing practice. Her theory of interpersonal relations assumes that interactions between people are noticed, studied, explained, and understood,[3]

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identifying the need for partnership in the therapeutic relationship to promote health.[4] Peplau's theory applies not only to nursing, but to all staff who interact with a patient. The "Hi, my name is…" intervention improved the therapeutic relationship existing between

Table 1: Quality Study Results

Quality Indicator	Baseline/Pre-Intervention		Post-Implementation	
Did hospital staff introduce themselves when entering the room?	No 45% (n=9)	Yes 55% (n=11)	No 27% (n=4)	Yes 73% (n=11)
Stroke Unit: Number of staff identified by name on HCAHPS	57% (n=17 out of 30)		87% (n=34 out of 39)	
Control Unit: Number of staff identified by name on HCAHPS	62% (n=21 out of 34)		31% (n=11 out of 35)	

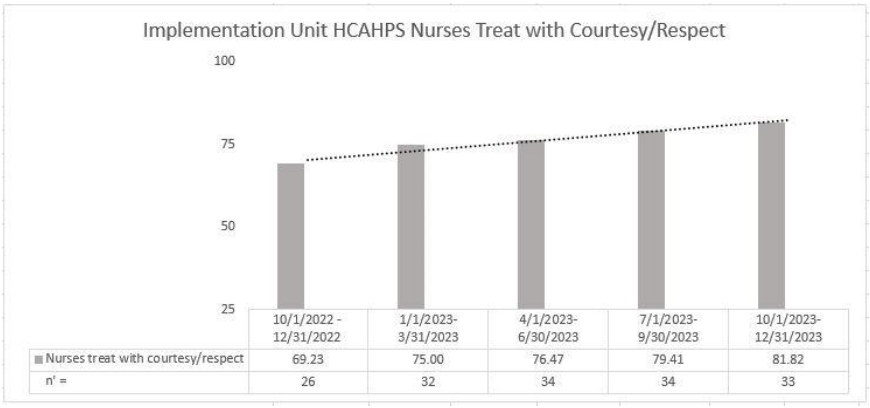

Figure 1: HCAHPS scores over time for the indicator, "Nurses treat you with courtesy and respect."

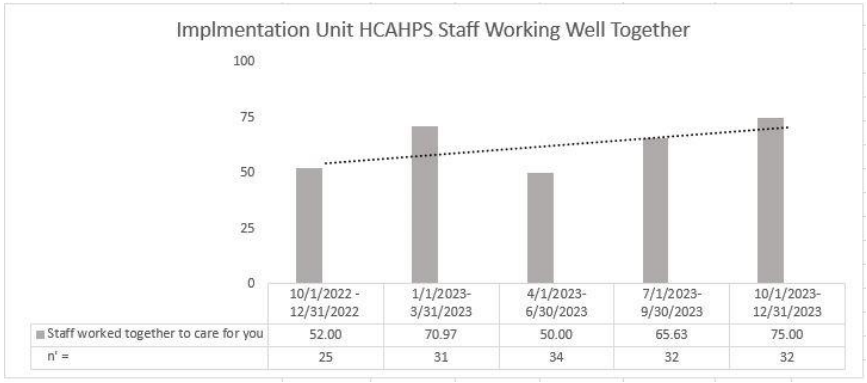

Figure 2: HCAHPS scores over time for the indicator, "Staff worked well together to care for you."

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patients and staff. Our intervention made clear how important the first introduction can be to patients, regardless of the type of staff member role, as it promotes patient courtesy and respect.

We found that our methods offered a unique way to examine the impact of improved staff introductions on the patient experience, by using the citing of staff names in HCAHPS surveys as surrogate indicators for introductions. Gallan and colleagues identified that by utilizing patient narratives and comments, measurable improvements can be achieved and facilitate quality improvement.[5] Our quality initiative started with patient feedback, and we were able to use HCAHPS comments as measures of improved introductions, since results often cannot be fully captured by standardized survey questions.[5]

Our improvements included educating staff about the need to introduce themselves, adding door signs, and increasing the font on their name badges. Our interventions were inspired by Dr. Granger's "Hello, my name is…" campaign.[6] Dr. Granger's campaign continues to influence healthcare providers, and is utilized by over 80 National Health Service organizations in the United Kingdom[6] and by more than 400 primary health staff in northwest Tasmania, Australia.[7]

Our project has limitations. First, our study sample size was quite small. However, despite this we were able to obtain results that were meaningful as a quality project. Second, our team members that conducted staff-blinded observations noted that it was often difficult to properly hear staff introductions due to the hallway noise, closed doors, and multiple people entering the room at the same time; this complicated observations and may have impacted our results. Third, we utilized surrogate measures for staff introductions, and these may have been imprecise and led to lower introduction level counts than actually occurred. Nonetheless, our overall HCAHPS scores steadily increased during the study period, and this may have been due to more than introductions, but also attention to the fact that discomfort and fear among hospitalized patients requires staff to be more fully present in their patient interactions.

Conclusions

Every person entering a patient's room has the ability to influence and positively impact the hospital experience for both patients and their family members. Listening to a patient's feedback was the key driver for our initiation of "Hi, my name is…" By utilizing simple, easily implemented interventions, we were able to produce sustainable results. Our team has now set the stage for the continued success of this initiative, ensuring improved therapeutic connections with our patients.

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