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Title: Hello, my name is...: An exploratory case study of interprofessional student experiences in practice.

Keywords: Case study research; compassion; safety; sense of belonging; student experience; uniforms

Abstract:

Background: The 'hello my name is campaign' identifies the importance of compassionate care and places focus on the importance of an introduction. Further research identifies that using names is key for providing individuals with a sense of belonging and can be vital in ensuring patient safety.

Objective: To investigate the student experience of having 'hello my name is...' printed onto student uniforms and implement this campaign in practice.

Design: A case study was used to capture the experiences of 40 multi professional health care students in practice. Participants were asked to complete a reflective diary during their first week in practice and attend a focus group with 4-8 other students.

Setting: A Higher Education Institution in the North East of England with students from adult, child and learning disability nursing, occupational therapy, physiotherapy and midwifery programmes, in a variety of clinical placements throughout the region.

Findings: The implementation of the hello my name is campaign and logo branding on the uniforms of students reported an increase in the amount of times students were addressed by their name in practice. Participants reported that the study helped them to quickly develop a sense of belonging when on placement, aided them in delivering compassionate care and occasions when patient safety was improved were reported.

Conclusion: The use of names is a key feature in human relationships and the delivery of compassionate care, and we advocate the use of the 'hello my name is' campaign for all healthcare professionals.

Introduction

In a health care setting, at the core of each person is the need to seek out interaction with others whether that be through our verbal or non-verbal interactions, it is fundamental to who we are as human beings (Blumer, 1969). From an early age we learn about the importance of introductions to each other, which is seen as the first step in social etiquette enabling the formation of relationship and social interaction, regardless of the culture or the circumstances; personal, professional or social. It produces a sense of commonality. The Nursing Midwifery Council (2018), identifies this behaviour as an element of promoting professionalism and trust and the Health and Care Professions Council (2018a,b) and Royal College Occupational Therapists (2017) emphasise the need to be aware of how this affects the engagement of people in their own health care. Therefore, it must be questioned why so often, at the most traumatic or vulnerable times, health care professionals fail to introduce themselves.

Yet a lack of a basic introduction was experienced during a hospital stay by Kate Granger in 2013 and the momentum which grew when she talked about the issue suggested her experience was far from unique. Granger reflected that during her admission she "lost count of the number of times I have to ask staff members for their names. It feels awkward and wrong. Introducing yourself is the basic first step" (Granger, 2013). As healthcare professionals we pride ourselves on the uniqueness of the therapeutic nature of the patient relationship, yet Kate Granger, passionately articulated that the core foundation of communication was often flawed.

The campaign introduced on social media by Kate and Chris Granger, highlights the importance of prompt and effective communication, treating all patients with respect and dignity and the delivery of compassionate care (NHS England, 2015). Since its launch in 2013, the campaign has gained momentum with healthcare staff wearing badges, scrubs with embroidered names or the #theatre cap challenge in operating environments (Baverstock & Finlay, 2020).

As well as the benefits to compassionate care, links between #hellomynameis, and patient safety have been drawn in previous studies (Kitson *et al.,* 2013; Conroy *et al.,* 2017) with parallels to Maslow's Hierarchy of need (1943) which identifies physical and psychological safety as fundamental to meeting other human needs. Conroy *et al.* (2017, p.6) states that "therapeutic relationships and engaging respectfully with patients enables nurses and other health care professionals to identify patients' unique physical and psycho-social safety needs and address these needs in a person-centred way". There are high profile examples where failing to meet fundamentals of care can link to wider patient safety failures (Francis, 2013) and returning to the words of Kate Granger, a good introduction is "the first rung on the ladder" of compassionate, person-centred care (2013)

It is clear from the literature and the support nationally that the #hellomynameis campaign is much more than a friendly introduction but is an important driver in the delivery of person centred, compassionate and safe care for all patients. However, from the outset of the campaign in 2013 the experiences of those involved in the initiative have not been studied which provided the rationale for this study. This paper will present a research study that explored multi professional health care student experiences of using the #hellomynameis campaign in practice with the logo and their first names printed on their uniform.

Furthermore, the introduction of this campaign to students from a variety of pre-registration healthcare programmes may possibly have added impact due to student's frequent movement in and out of healthcare teams. It was highlighted in Chesser-Smyth's study (2005) that when students are made to feel part of a clinical team, this reduced anxiety in clinical placements. Additionally, an

unfriendly atmosphere from clinical staff has been found to be one of the three biggest causes of stress for pre-registration nursing students (Evans and Kelly, 2004), and students report feeling undervalued if clinical staff do not address them by name (Martin, 2019).

Students are generally not supplied with the #hellomynameis badges whilst in practice, unlike permanent staff within some health care organisations and limitations to name badges have been identified. Some of these limitations include interference with electronic devices (from magnets), infection control and lost badges. Therefore, as part of this study funding was secured to permanently print the logo and their first name on the uniforms of each student participant.

Aims and Objectives

Aims

To investigate the experience of having #hellomynameis imprinted on multi professional healthcare students' uniforms.

Objectives

- To select students from a variety of healthcare professions to participate.
- Collect data from reflective diaries from the students' first week in clinical placement with #hellomynameis imprint.
- Conduct focus groups with mixed multi professional groups of health students following their clinical placements.

Methods

Study Design

A case study research design was used, underpinned by a critical realist philosophy. Critical realism supports the notion that there is a reality independent of people's thoughts and actions and in particular, that this reality can be examined at a causal level by exploring the mechanisms which generate events (Bhaskar, 1978). Therefore, the study was designed to examine events experienced by healthcare students related to wearing a name logo, and to reflect on causal mechanisms which led to or influenced these events. Importantly, critical realism also supports pragmatism in the design of methodology and methods, designing research methods which are fit for purpose and can examine multiple layers of reality (Haigh et al, 2019)

Stake (2000) suggests a case is whatever bounded system is of interest to the research. It can be a common or everyday phenomenon, or the case can be an individual, organisation, process or an event (Yin 2012). In this study, the 'case' was the phenomenon of wearing a name logo as experienced by student health professionals on a period of practice placement. Case studies can deal with complexity where there are many variables and support using multiple sources of evidence, and data collection over time, to contribute to a rich portrayal and understanding of the phenomenon to inform education and practice (Simons, 2009; Yin, 2014).

Sampling

All participants were recruited from one Higher Education Institution in the North East of England. Purposive sampling was utilised to identify pre-registration health professional students who would be due to attend a period of practice education within the identified study period. All students had also had at least one prior period of practice placement. Students were from both BSc and MSc pre-registration programmes with all students in their final year of study.

An email was sent to all eligible students detailing the project, with a request for a response within ten days of receipt of the email. Of those who responded to the email, 67 students were approached to take part with 53 students attending a study launch event and giving consent to be involved. The final sample of 53 students represented adult nursing (n23), child nursing (n13), learning disabilities nursing (n3), midwifery (n8), physiotherapy (n4) and occupational therapy (n2). After this initial launch event, 40 students in total submitted diaries and 30 students attended focus groups.

Data collection

Whilst on placement all participants were asked to complete a reflective diary for one week to document their experiences of wearing the uniform including reactions and feedback from staff, other students, patients and families. Reflective diaries are regarded as a valuable tool to record not only rich descriptions of events, but they can also include emotional responses to experiences (Bedwell, McGowan and Lavender, 2012). Reflective diaries were completed by 40 students and sent back to the research team electronically for analysis.

After completion of the placement students were allocated to one of five focus groups (n30) with 4-8 students in each group from different professional groups. Focus groups were facilitated by two members of the research team. Focus groups enabled the researcher to bring students together collectively to interpret and further understand the students' experiences, whilst allowing them to share personal perception of experiences with one another (Krueger & Casey, 2014). Each focus group lasted between 30 and 45 minutes and a guide ensured a standardised approach for all facilitators. Each focus group was audio-recorded, which allowed for later transcription verbatim by an independent person, external to the research team.

Data analysis

Reflective diaries data were either handwritten or electronically submitted by participants and focus group data was transcribed verbatim. Data analysis was completed by the research team using a process of thematic analysis to uncover patterns in the qualitative data (Miles and Huberman, 1994). The research team included eight members of staff, representative of the professional groups involved in the study and all team members were involved in the review of diaries and focus group transcripts.

Initial codes using key words and phrases were identified, which are the critical link between data collection and the explanation of meaning (Campbell, 2015). This was followed by the development of themes, which were agreed during face to face meetings, where the research team were able to discuss and compare their generated codes and themes. These meetings aimed to reduce the risk of researcher bias and enhance the trustworthiness of the data (Lincoln and Guba, 1989).

Ethical Considerations

Ethical approval was gained from Northumbria University Ethics Committee (17464). Voluntary consent was gained from the outset and participants were provided with a participant information sheet and consent form. This included their written permission to access and use data from the reflective diaries and the focus groups. Students were aware that they had the choice to withdraw from the study at any time with no impact to their university studies.

Findings

From the qualitative analysis of reflective diary and focus group data, five main themes emerged: care and compassion; a sense of belonging; safety; a positive experience; and challenges and suggestions for improvement. These findings will be supported by verbatim quotes, identifying data sources in brackets (Figure 1).

Figure 1 Key for Data Source
FG = Focus Group and number of Focus Group RD = Reflective Diary P = Participant number

Care and Compassion

Participants shared many examples of how the knowledge of their name, and the ease with which patients and families could see this, impacted on the delivery of compassionate care. Primarily, examples related to how participants perceived the name logo had helped them with relationship building and aided with developing connections on a human and personal level, often within sensitive situations:

> *"I believed it made me more approachable to parents who are potentially stressed who did not have the extra job or remembering my name"* (RD, P6).

> *"It's like, taking that stranger vibe out of the way. Just to create that relationship, I suppose. I think it's quite nice to be in that position"* (FG4, P3)

> *"It just makes you more approachable…people could, erm, feel like they can approach you and you're more personal…they could like maybe feel more comfortable to come and, like, disclose stuff to you"* (FG5, P4)

Some participants suggested that they perceived knowledge of their name aided with minimising differences between healthcare professionals and patients and families, and this in turn could also act as an enabler to therapeutic relationships:

> *"Like, we know a lot about them, names, addresses, we've got everything on them, and they know nothing about us. And I think they've got a name, it kind of balances that out a little bit"* (FG5, P1)

> *"I think it's that human element. 'Cos you can be a nurse and people expect you to give that kind of passion but when you put a name to it, they see that: oh, this is someone else who's just like me only they have a job to do as well and it's just things like that human touch"* (FG1, P3)

And one participant felt that awareness of their name through the logo assisted with the speed in which a relationship could be developed:

> *"so, I think it's speeding up the process of building rapport and trust"* (FG4, P3)

Other examples included how the name logo acted as a conversation starter or took pressure off patients and families to remember names when they were focussed on wider events, or important information being discussed.

Sense of Belonging

Many participants shared examples and reflections about being called directly by their name and often compared this to experiences of being called *'the student'* during previous placement experiences:

> *"Everyone called me by my name, not once was I called 'the student'"* (RD, P4)

> *"I don't think I've been called 'the student' the whole time I've had this on"* (FG5, P1)

> *"The parents as well, so the parents have used my name more than, I think, on any other placement before"* (FG1, P1)

Focus groups participants associated their name logo with starting conversations and integration within their placement team:

> *"Someone commented on the spelling of my name…it's unusual…so I suppose it kind of started the conversation and then people asking sort of about the project and talking a bit about why we were doing it and what we were doing it for."* (FG3, P3)

> *"they've just sort of spoke to me without having to be introduced"* (FG1, P5)

Many participants reflected on being referred to as *'the student'* on placement and how this could feel challenging when attempting to integrate into a clinical team. One participant compared their experiences of wearing and not wearing their name logo and how this affected their integration and sense of value:

> *"I haven't always felt like an integrated part of that team because I'm just in a white uniform; I haven't got blue stripes and people do see you as just the student. But having that on, like, the doctors, like… You've got the F1s working with you who also have like, quick turnover, address you by name every time and I just think, for me personally, that does make you feel as if you're like a valued part of their team because you are… There is that human element; it's not just "oh, can you get the student to…" It's "oh, [name], can you do this?"* (FG1, P1)

This feeling of integration and belonging also presented as extending to how integrated students were within patient and family situations, with a positive association made between the name logo and a sense of belonging with patients, families and carers:

> *"Yeah. And more familiarity as well, with like patients and families. Like, I've never had that before… Like, the families will come in and address you by your name straight away and it just feels much nicer than it ever has done before, when there's like, not*

really that much engagement I've felt in the past with families…now that's changed because they just address you by your name straight away" (FG1, P5)

Similarly, another focus group participant highlighted that the name logo not only assisted with a sense of belonging to the practice team, but also alluded to a link between the logo and a sense of belonging to the university:

"The uniform belongs to me and I feel like I have an identity because my name is on the uniform, next to [University Name]" (FG4, P3)

This sense of belonging elicited a positive emotional response among many of the participants involved, with words such as *'respect'*, feeling *'empowered'* and feeling *'valued'* discussed by focus group participants and within reflective diaries. This powerful positive emotional response to belonging within a clinical team was summarised by a focus group participant below:

"There was one particular doctor that saw me…and he's identified me by that name, which really gives me goose bumps. You know? For somebody to like, call you by your name, it feels good. It really does…they don't refer also as a student, or 'that lady' or 'that girl over there', so it's really good." (FG1, P4)

Safety

Participants recognised instances from their practice placement experiences where they associated wearing the name logo with a positive impact on patient safety. One participant suggested this could be linked to the time it may take to think about and remember names, suggesting that the name logo negated the need for people to think about this in time-pressured emergency situations:

"If something happens, if you're standing there and your name's there, people can see and shout at you and you can be there and help if needed. Or, they can just shout your name and tell you to go and do something, like without having to think, like: oh, what's her name?" (FG2, P3)

Similarly, one participant suggested that they themselves would respond more quickly to their name if they were in a high-pressure or time-sensitive scenario:

"You respond faster to your name, don't you? So if they refer to you by your name, you're more likely to pay attention to something than if they're like "oy, student"… Kind of that disappears into the background noise a bit, whereas if someone goes "oy, [name]", like, you pay attention to your name" (FG2, P4)

But it was not solely in emergency situations where participants recognised a link between creating safe environments and the clarity about names. One participant reflected on the importance of being clear about their responsibility to carry out routine aspects of patient care:

"I've had people ask you for like drinks and such but like, referring to me as [name] rather than as student…if you don't get them a drink, they're going to get dehydrated" (FG2, P3)

Participants also gave examples where the direct use of their name could increase feelings of responsibility and accountability for aspects of patient care:

"cos they know who they've asked for help. So then if I went off and didn't do it, they could say "oh, well I asked [name] to do that" (FG5, P1)

Some practical elements of wearing the name logo were also associated with improvements to overall safety of patients and staff, with some comments about improving infection risk and risk of tissue damage when comparing to standard issue name badges. Participants also valued only having their first name printed on the uniform and compared this to first and surnames on identification badges which could make them vulnerable in some situations – for example if patients searched for them on social media.

But not all comments were reflective of positive links to patient and staff safety. One participant made a link between the placement of their name on the upper chest area of the uniform and feelings of vulnerability:

> *"It's made us quite vulnerable to the men that are in there, 'cos obviously sexual offences and things like that; I've found that having it here hasn't really been… appropriate"* (FG2, P4)

A Positive Experience

Participants shared some other over-riding reflections about positive aspects of wearing the name logo. Many participants highlighted positive reactions from their wider placement teams:

> *"It was discussed during handover and in the office, where they wanted to know about it, [the team] would be keen to have it on their uniforms"* (RD, P29)

> *"nurses on the team commented on how useful it was and how it helped them"* (RD, P6)

Another interesting positive element was that students reported that the name logo also assisted other people to spell their name, something that they had experienced difficulties with during previous placement experiences:

> *"And they spell it right all the time but like before, never ever"* (FG2, P5)

Pragmatically, participants highlighted that a name logo as an integrated part of the uniform meant that the problems with forgetting, or not wearing a badge were minimised, with the name and information more accessible:

> *"They just don't wear [badges]. Like, in mine, I don't know whether they don't have the badges… I mean, they have… On their uniform, they have 'staff nurse' and 'sister' written on it but they don't have any names. Like, so their badges are all worn round their neck but like, you can't see it 'cos they normally have it flipped over so you can never see what their name is."* (FG1, P1)

Other positive features highlighted by a small number of students was that the logo had potential to help patients and families with hearing impairments. For participants themselves, one more positive element was the fact that they did not have to remember to put on the integrated logo in the same way they would do with a name badge.

Challenges and suggestions for improvement

It is important to note that not all participants shared positive experiences of wearing the name logo with some participants reflecting that they did not notice differences between practice experiences when wearing, and not wearing, the name logo.

"No one mentioned my name or the uniform" (RD, P24)

"None of the staff really paid attention or asked about the uniform, service users did not either." (RD, P65)

Some participant reflections indicated that this may be associated with the client group or the placement environment:

"It was sort of redundant almost. I've been working with older people with severe dementia, so even if it was helpful that they can't remember your name audibly, nobody was looking and even if they did, it was unlikely to be recalled." (FG5, P6)

Whilst other participants reflected that name logo should not directly alter the fundamental principles of verbal introductions or of providing high quality care:

"Important to note even with this project before any patient contact, I introduce myself by name, then say I am the student" (RD, P60)

The main suggestion for improvement linked to identifying a more appropriate place for the logo, rather than the chest area of the tunic:

"I think for me, the only negativity is where it is. I've had a few staff saying "oh, what's your name, sorry" and I'm like [gestures] "[name]" and they're like "oh, sorry, I just didn't want to look". It's just where it is" (FG2, P3)

"all health care professionals noted the change in uniform and suggested it should be located higher up the tunic." (RD, P61)

Discussion

The primary aim of the original #hellomynameis campaign was to promote compassionate care; it is significant that this emerged as a key theme from the findings. Participant quotes of how the name logo helped build relationships with vulnerable people and helped them to make personal connections, emphasised this link to compassion. This is particularly noteworthy as much of the literature discussing the link between the campaign and compassionate care is opinion-based and therefore it is important to support this with qualitative research of the student experience. The ability to develop improved compassionate relationships when healthcare professionals form meaningful individual connections with patients is identified in healthcare literature (Conroy *et al.*, 2017; Christiansen et al, 2015; Jones *et al.,* 2015).

It is important to reflect that it is perhaps the clear verbal introduction, rather than the printed logo, which improves compassionate and person-centred care and the importance of this verbal introduction is not disputed. However, the fact that students noticed differences in their relationships with patients and families when wearing the logo suggests that it acted as an important enabler to overcome some of the inherent challenges to remembering names or to making personal connections. Furthermore, such an initiative is a valuable contribution to overcoming the widely acknowledged barriers to delivering compassionate care that are often identified (Christiansen *et al.*, 2015; Jones *et al.*, 2016), and the challenges of compassion fatigue and the tendency for healthcare professionals to distance themselves from emotional connections with patients and families (Austin, 2009).

The findings of this research study demonstrate that the act of being addressed by their name is a powerful catalyst for belonging and team integration for students – with a perceived link between the sense of involvement and an increased sense of responsibility among students. Participants reflected that they have had the experience of being called *'the student'* on other placements and this issue of being called *'doctor', 'nurse',* or *'student'* is very much a part of the culture within healthcare. For participants, the experience of being called *'the student'* rather than their name can contribute to feeling undervalued (Martin, 2019). The lived experience of the participants in this study linked the use of personal names to feelings of value, esteem and belonging. Arguably, helping the student to make meaningful emotional connections in learning within the affective domain leading to transformational learning (Mezirow, 2000).

Furthermore, critics suggest labels such as *'the doctor'* or *'the nurse'* risk people feeling more a function of care and challenges the personal involvement in care acting (Eckardt & Lindfelt, 2019). Participant quotes suggested a sense of identity in practice corresponded with a sense of value as a member of the team and supports the notion that being known by name helps to facilitate a more personal and embodied care-giving experience (Martin, 2019). Whilst it is widely acknowledged that one can read a name badge or ask a person's name to achieve the same result, any change to facilitate the personalisation should be welcomed.

The NHS Improvement's Patient Safety Team (Safety Initiative Group, 2018) highlight that specific, spoken words and introductions such as names can be critical in clinical practice. Consequently, inadequacies related to information exchanges, such as those which may occur if information is not received by the person for whom it was intended, can result in misunderstandings or delays in care (Safety Initiative Group, 2018). Sarcevic, Palen and Burd (2011) highlight the importance of role identification in emergency situations and areas such as Accident and Emergency where individuals may not be familiar with one another but need to work efficiently and effectively together to manage critical care settings. Hindmarsh and Pilnick (2002) identify that this lack of familiarity can occur in operating departments when unfamiliar colleagues meet for a period, to work as a team. Sarcevic, Palen and Burd (2011) argue that when assigning tasks in critical situations, leaders are often forced to direct their instructions to the team at large rather than being able to instruct an individual with their name which can lead to delays in the task being accomplished.

Links between introductions and a culture of patient safety is identified by the World Health Organisation Surgical Safety Checklist (WHO, 2009); the first factor to be established before skin incision is the introduction to the person. But even with verbal introductions, some studies suggest that retention of names can be poor, and that the introduction may be a procedural task rather than something that staff attend to and remember (Birnbach *et al*, 2017).

The study findings demonstrate participant acknowledgement of increased recognition and retention of personal names which was often attributed to the use of the name logo. As such situations where direct use of name was encountered, this was highlighted by the participants as having resulted in more prompt action or enabled a team member to give clearer instruction in an emergency, echoing the literature (Sarcevic, Palen and Burd, 2011). Although beyond the scope of this study to make direct causal claims between the name logo and improvements to patient safety, participant perceptions do suggest an important link which could be evaluated by further research. Furthermore, any initiative which improves communication within teams, whilst facilitating direct responsibility or ownership of actions, is likely to have a positive impact on safe and effective patient care.

It was undoubtedly a pleasing element of the study that student participants discussed the value they placed on the initiative and there was reference made to the value noted by their student and practice colleagues. Some data extracts did suggest participants had not noted any difference although this was mainly gathered from reflective diary extracts, which were collected after week one. Interestingly, this perception seemed to have changed by the time of the focus groups, with most participants reporting positive reflections and experiences. Although, it is important to recognise that those who attended the focus groups may have been those who had positive experiences of the project and were more invested overall in the research study. The main suggestion for improvement was the positioning of the logo on the uniform. There was recognition that for MH, LD and OT students working in secure areas that patients could make inappropriate comments, and this may impact on the healthcare student-patient relationship (Conroy *et al*, 2017). This is an important point to note from both a patient and staff safety perspective and will help to inform future decisions about how to implement the initiative on a wider scale.

A strength of the case study design was the multiple approaches to data collection which meant the issues could be examined at different time points and through methods which encouraged individual reflection and group discussion. The recruitment of participants from different professional programmes was also a strength of the study. However, it is acknowledged that numbers from some disciplines were low. Therefore, in order to protect the anonymity of the participants from those professional programmes, we have not attributed quotes to different groups. Although, developing an understanding of whether the themes above are experienced by different groups in different ways presents opportunities for further research. Research using real-time immersive methods to further understand the links to improved communication, or the link to patient safety would also offer important developments to knowledge. Finally, and returning to the primary aim of the #hellomynameis initiative, research to understand the patient and family perspective of the impact on person-centred compassionate care would provide additional insight on this important theme.

Conclusion

Findings from this study suggest that a clear and visible name logo has perceived links to providing compassionate personalised care and patient safety. Findings also suggest that it assists with team-working and integration and was an initiative which, in the main, was positively received by those students wearing the logo and their wider teams. Moreover, this may be a catalyst for encouraging all individuals, irrespective of grade to feel involved and be accountable and can help students to feel valued members of healthcare teams. Therefore, we are working towards this initiative becoming an established part of the uniform for healthcare professional students within our institution and for this to act as a visible reminder for students to be advocates and champions for the overall campaign. Beyond this, we then look forward to sharing this initiative with wider organisations and practice-partners to involve the wider healthcare and multi-professional workforce. We will also utilise feedback from students about the placement of the logo to improve the design and emphasis how the printed logo should be an adjunct to, not a substitute for, clear verbal introductions in all practice settings.

We return to the fundamental principle that the use of names is a key feature in human relationships and the delivery of compassionate care, and we advocate the use of the #hellomynameis campaign – more specifically a printed name logo on uniforms - for all healthcare professionals and students. Whilst there will be cost and pragmatic considerations to resolve, we believe this simple, yet powerful,

initiative can make a meaningful difference to compassionate, collaborative and safe care and can empower and enable both staff and patients.

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Declaration of interest statement

No conflicts or interests to declare

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