QIN focus

Case study from East Lancashire Hospitals NHS Trust - An interview with Rob Tomlinson, Junior Charge Nurse, Theatres

The impact of 10,000 Feet in preventing never events and other serious incidents in the operating theatre.

Summary

Following a series of Never Events in operating theatres at East Lancashire NHS Trust (ELHT), Robert Tomlinson, a deputy charge nurse embarked on a crusade to address the problems of concentration and distraction in the operating theatres. He linked up with Pete Smith and John Gibbs from Australia at belowtenthousand.com, the creators of the 10,000 Feet concept.

The Sterile Cockpit Rule originates from the US Feral Aviation Administration in 1981.The regulation requires pilots to refrain from non-essential activities during critical phases of the flight, usually below 10,000 feet. It followed a series of accidents that were caused by flight crews who were distracted from their flying duties by engaging in non–essential conversations and activities during critical parts of the flight.

The results produced two very interesting outcomes from the first set of 10,000 Feet results. Apart from creating a safer environment for both patients and staff -

- 10,000 Feet allows the most junior members of staff to have a voice in the operating theatre with the most junior members having called 10,000 Feet as often as the most senior.
- It has improved quality and is strongly linked to the WHO checklist. When people are not engaging in the checklists as they should be, calling 10,000 Feet has meant every member of staff actively participates in the checklist process.

Rob's work has attracted the interest of the Association of Perioperative Practitioners and will hopefully be adopted nationally in the near future.

What was the problem you were addressing?
The trust was confronted with a recent influx of Never Events. I addressed an issue of concentration and distractions in the operating theatre. Sometimes it can be difficult as human beings to be 100% focussed all the time. '10,000 Feet' encompasses teamwork and delivers 100% focus when needed.

What was the QI project/change brief description?
There was no description or brief. I was involved in a Never Event. Rather than punish us the trust allowed us to be open and honest and express our concerns. This gave way to the birth of '10,000 Feet' in the UK. Without the respect the trust leaders showed us, a service improvement such as this would never have been possible. A 'Just' culture is the foundation needed to improve patient safety when mistakes have been made.

What were your intended outcomes/achievements?
The intention was to deploy the concept of '10,000 Feet' to improve patient safety/patient experiences and help reduce the occurrence of never events in theatres.

Who was involved – leadership, participants, engagement?
Pete and John from belowtenthousand.com are the creators of the '10,000 Feet' concept. Having spoken with these guys in Australia on numerous occasions; their support has been invaluable. Other participants are our medical director and several very senior people at ELHT who share my enthusiasm for the concept. As when anything new is introduced, there is always an element of scepticism but even now, the biggest critics have accepted the concept does work and has benefits to our patients.

What Quality Improvement methodology did you deploy and why?
I am no expert in quality improvement. I am a nurse who works in an operating theatre so please don't expect a profound answer here. The experts have been the Quality Improvement Team at ELHT. They have guided and spent time with me explaining change processes and giving reassurance. They are now analysing the first set of results which are brilliant. Without them 10,000 Feet would not have happened. They are a fabulous, knowledgeable team with whom I have built a great relationship.

My own methodology is taken from Natssips (National Invasive Procedure Guidelines) - standardisation then education creates harmonisation. Education is so crucial in everything we do involving patient safety. When people thoroughly understand their role in patient care, better outcomes are achieved. Understanding 10,000 Feet increases its effectiveness and is enhancing patient safety.

What were the barriers to achieving progress/outcomes and how did you overcome these?
When people resist change, instead of falling at the first hurdle, see this as a good thing! It makes you think about what you are doing from every angle. Calling 10,000 Feet in an operating theatre means everyone has to stop, think and concentrate on patient care and the tasks in hand. People do say they feel a little uncomfortable calling this phrase but also accept when calling it, it DOES achieve a safer environment for the patients.

What was the actual outcome/achievements?
There are two very interesting outcomes from the first set of 10,000 Feet results. Apart from creating a safer environment for both our patients and staff, we can conclude :-

- 10,000 Feet allows the most junior members of staff to have a voice in the operating theatre. The most junior members of staff have called 10,000 Feet as often as the most senior. Jeremy Hunt please get in touch regarding hierarchical issues! The answer is here!
- It has improved quality and is strongly linked to the WHO checklist. When people are not engaging in the checklist process as they should be, calling 10,000 Feet has meant every member of staff actively takes note and participates.

How do you intend to ensure these are sustained over time - is there a plan?
10,000 Feet is now embedded at ELHT. I have taken this concept to the Association of Perioperative Practitioners who would like to work with us as they see this as the 'missing link' for safety in the operating theatres. The next stage is to see the concept used at other trusts. I believe this concept will spread across the NHS due to the current epidemic of Never Events. As time goes by and the occurrence of Never Events decreases, we hope to prove that 10,000 Feet has a strong link to improving patient safety.

How will this be monitored?
At ELHT we expect to see a decrease in patient safety incidents. As other hospital trusts start to use this concept, the evidence will be there for the world to see.

What have you learned-organisation/team/self?
As an organisation how crucial a 'just culture' is when incidents occur. As a team, supporting and respecting each other brings the best out of us. If we can't care for each other, how can we care for our patients? I have learned how incredibly supportive my colleagues are. A group of us got together one Saturday and made an educational video, the fact that they volunteered to do this in their own time was so humbling and something I am so touched by. It also reinforced their belief in 10,000 Feet.

What have I learned personally? Let's just say, six months ago if you told me that I would have introduced a concept called 10,000 Feet at ELHT which is growing in recognition, have made an educational video with my colleagues, had some work published by a journal, been nominated for an award by my colleagues, I would of said "I don't think so, I'm just a nurse in an operating theatre who was unfortunately involved in a Never Event".

What worked/didn't work in this case?
On two occasions 10,000 Feet didn't achieve the desired outcome. Education is vital to its success. On these two occasions I failed by not educating the staff in time, the concept didn't fail.

What would you replicate e.g. in term of methods, approach, measurement, engagement?
I wrote a presentation which I took around the trust which was based around the Never Event. I then started to introduce and talk about 10,000 Feet. Rather than suddenly impose the concept on people I slowly introduced the idea. I used simple marketing techniques by having a quite powerful image which was put on notice boards around theatres. The educational process was gradual but having the concept spoken about was crucial to its awareness. Even people who didn't initially like the concept still spoke about it. The concept's exposure was so vast I'm now known as the '10,000 Feet Man' at ELHT. Artwork, a video and published article, my degree in marketing has proved useful!

What would you do differently next time?
I knew safety in theatres needed improving and we all required a nudge in the right direction. Next time, I won't allow a serious incident to be the starting point. Thankfully, the next project I am involved with (Always Events) is proactive rather than reactive.

Your top tips for others?
If I was to offer anyone any advice, if you can see the benefits for patients in your 'improvement project' and others don't, stick with it. I imagined the patient, I wanted the environment to be safer for my daughter; so the barriers that I have been presented with, I simply walked through them without a thought for the critics.

Contact details
Our gratitude goes to Robert Tomlinson at East Lancashire NHS Trust for sharing his experience.
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