Transformational Leadership: Visibility, Accessibility and Communication

TL8 The CNO uses various methods to communicate, be visible, and be accessible to nurses throughout the organization.

TL8c: Provide one example, with supporting evidence, of communication between the clinical nurse(s) and the CNO that influenced a change in nursing practice.

Introduction

In 2002, the International Council of Nursing defined Nursing as encompassing “autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.” This is the definition the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® uses to recognize the vast scope and accountability that nurses have in ensuring safe, high quality care for patients.

To truly actualize this definition, clinical nurses must practice in an organization which is committed to promoting an environment for quality and safety, fostering open and honest communication and collaboration among all members of the healthcare team, and providing ongoing educational opportunities. Massachusetts General Hospital (MGH) Nursing & Patient Care Services (N&PCS) promotes open communication, a culture of safety, and professional development through the Professional Practice Model (OOD 8). This structure provides opportunities for nurses to be involved in decision-making that affects their practice as well as involvement in unit, department, and hospital-wide initiatives. A critical aspect of open communication is the feedback clinical nurses give to each other as they work together in caring for patients. This peer review feedback occurs in the moment and as part of their annual performance evaluation.

Peer review is recognized by the American Nurses Association (ANA) (2010) as a component of professional practice that is necessary for self-regulation of a profession. Peer review is defined by the ANA (1998) as, “the process by which practicing registered nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers as measured against professional standards of practice.” Peer review has been found to promote a safe practice environment and quality patient outcomes. Organizations can use peer review as part of a comprehensive performance evaluation process to ensure that registered nurses are competent to practice safely, deliver quality and compassionate care to their patients, and be effective members of the healthcare team.

Despite its benefits to promoting a safe practice environment, peer review has faced many barriers in being fully implemented nationally as well as within N&PCS at MGH.
N&PCS has had peer review as part of its performance evaluation process since 2011. In this process, the clinical nurse would select a peer and ask them to comment on their practice in one of three themes: clinician/patient relationship, clinical knowledge and decision-making, or teamwork and collaboration. Clinical nurses often asked a peer with whom they had a close relationship to complete their peer review which often geared the peer feedback toward recognizing their strengths and away from identification of opportunities for practice development.

Jeanette Ives Erickson, RN, DNP, FAAN, NEA-BC, Senior Vice President for Patient Care and Chief Nurse, recognized that the current peer review process was not as robust as it could be in supporting clinical nurses’ practice in promoting a safe environment. Ives Erickson knew that Kevin Whitney, RN, DNP, NEA-BC, Associate Chief Nurse, Surgical, Orthopaedic, and Neuroscience Nursing Services, was working on his doctoral program capstone project which focused on peer review. She asked him to present on the topic at the Collaborative Governance Staff Nurse Advisory (SNA) meeting on March 1, 2016.

SNA is the monthly one-hour meeting where clinical nurse representatives from each of the inpatient units and some ambulatory settings meet with Ives Erickson and members of her executive leadership group including Associate Chief Nurses, the Executive Director for Nursing and Patient Care Operations, the Director of PCS Informatics, the Executive Director for the Institute for Patient Care, the Director of Patient Care Services Quality and Safety, and the Director of Clinical Support Systems. The SNA meeting allows clinical nurses to participate in open and honest dialogue with Ives Erickson and her executive team on issues affecting nursing practice as well as to respond to presentations on key N&PCS and MGH initiatives and changes in the health care environment. Ives Erickson encourages these open exchanges with the clinical nurses and she and her team are committed to following up on the issues that arise during the discussions. She felt confident that clinical nurses on SNA would identify opportunities to improve the peer review process.

On March 1, 2016, Whitney presented “Advancing Nursing Peer Review at the MGH” to the members of SNA. In his presentation, Whitney reinforced key aspects of peer review including the impact on nursing practice through the promotion of a safe environment. Whitney identified that the current peer review tool focused on strengths in the clinical nurse’s practice, but did not incorporate an opportunity for the peer reviewer to identify an opportunity for practice development.

During the ensuing discussion, a clinical nurse said that she was concerned that peer review would negatively affect working relationships among staff (attachment TL8c.a). Whitney noted in his presentation that a barrier to full implementation of peer review by clinical nurses is often related to that concern and that many nurses lack the skills necessary to give and receive feedback. Ives Erickson also acknowledged that concern, but that in order to ensure a safe practice environment, it was critical to gain comfort in giving and receiving feedback. She noted that the Norman Knight Nursing Center for Clinical & Professional Development (Knight Center) offered courses on peer review.
and how to provide constructive feedback by focusing on the clinical nurses’ practice and not making it personal, as well as role playing to allow clinical nurses to become more comfortable with describing their colleagues’ strengths and opportunities to further develop their practice.

Ives Erickson asked Whitney to convene a workgroup comprised of clinical nurses, Nursing Directors (ND), Clinical Nurse Specialists (CNS), Nursing Practice Specialists (NPS) and a Professional Development Specialist from the Knight Center to:

- Use feedback from SNA on the current peer review process to identify opportunities for improvement.
- Revise the current peer review process and forms incorporating SNA feedback
- Develop a curriculum addressing clinical nurses’ needs on how to give and receive constructive feedback.
- Pilot the new process and form.
- Survey NDs and clinical nurses on their experience with the new process and form.
- Evaluate SNA satisfaction with the new process.

Changing Practice through Education

Whitney convened the first meeting of the Peer Review Workgroup (attachment TL8c.b) on June 30, 2016. Whitney reviewed with workgroup members the peer review process and the feedback from clinical nurses obtained at the March 1, 2016 SNA meeting. The workgroup members agreed that the current process was not working and that changes needed to be made. They recognized that while the peer review forms needed to be revised, if clinical nurses did not feel comfortable in giving and receiving feedback, peer review would not be effective in changing nursing practice. Workgroup members stated that for many clinical nurses, the concept of giving “constructive feedback” was assumed to be a negative rather than the opportunity to speak to a peer’s clinical strengths and opportunities for professional growth.

The workgroup identified opportunities to address clinical nurses’ discomfort and concerns on harming workplace relationships through a variety of methods including:

- Creating videos showing examples of giving effective constructive feedback
- Reaching out to expert preceptors and mentors to collect information on how they provided effective feedback
- Creating a Healthstream on-line learning module on the topic.

Sheila Golden Baker, RN, MSN, CRRN, Knight Center Professional Development Specialist, reviewed the curriculum of the current Knight Center educational program entitled, “Peer Review: What it is and What it isn’t”. While the program covered all aspects of peer review, she and members of the workgroup recognized what would assist clinical nurses the most in changing their nursing practice would be incorporating more interactive teaching/learning methods such as role play, case studies, and
debriefing. Golden-Baker agreed to work with her colleagues in the Knight Center to develop an educational plan for the workgroup to evaluate and approve.

On July 27, 2016, Golden-Baker presented the outline for the revised educational program to the workgroup (attachment TL8c.c) and discussed opportunities for improvement. Members of the workgroup recommended that the program be no more than one to two hours and be offered on all shifts as well as weekends in order to improve attendance. The workgroup approved the educational plan.

Golden-Baker and her colleagues re-worked the educational program based on the workgroup’s feedback and constructed a one-hour program consisting of:

- Pre-requisite reading including an overview of peer review and its guiding principles
- Class content:
  - Recap of pre-requisite reading
  - Demonstration of peer review by giving and receiving constructive feedback
  - Participants breaking into pairs to apply learning in three case studies/scenarios
  - Debriefing session

On September 13, 2016, the newly-redesigned “Peer Review: Giving and Receiving Feedback” educational program was presented and positively received by the members of the workgroup. Clinical nurse members especially found that the case studies, scenarios, and role playing were helpful in learning how to give feedback that was constructive and focused on the practice and not the individual. Nurses from the workgroup units were then scheduled to attend the educational program. Nurses whose performance appraisal was scheduled between October 2016 and December 2016 then piloted the new form.

To determine if the educational program influenced a change in nursing practice as evidenced by a change in the peer review process, NDs, CNSs, NPSs and clinical nurses on the pilot units were sent a REDCap (Research Electronic Data Capture) survey, a browser-based, software solution for designing clinical and translational research.

The results showed that, after participating in the new peer review process, clinical nurses were able to identify opportunities for peers to improve in the areas of quality and safety, accountability, and clinical practice. The survey also showed that as clinical nurses engaged in scenarios and role play, their understanding of what peer review is helped them to rethink what it meant to “identify a strength in practice” and the importance of constructive feedback from a peer.

The chart below indicates that the number of clinical nurses who reported giving and receiving both positive and constructive feedback during the peer review process
increased. This demonstrated a change in nursing practice related to peer review as formerly, the majority of clinical nurses only gave and received positive feedback.

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<tr>
<th>Question Role group: Clinical Nurses</th>
<th>Positive &amp; Constructive</th>
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<tbody>
<tr>
<td>During the current/new Nursing Peer Review process I received feedback that was...</td>
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<tr>
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<td>38.3%</td>
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<td>During the current/new Nursing Peer review process, I provided feedback that was...</td>
<td>30.1%</td>
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Creating a Safer Environment through Peer Review

When an opportunity for career advancement caused Whitney to leave MGH in January 2017, Patricia Shanteler, RN, BSN, MPH, Staff Specialist, assumed the lead of this important initiative. Shanteler presented on advancing peer review at the April 4, 2017 SNA meeting (attachment TL8c. d). Shanteler reminded the members that as a result of the discussion at the March 1, 2016 meeting, Ives Erickson had charged Whitney with convening a workgroup made up of clinical nurses and nurse leaders from across N&PCS to make changes to the peer review process. This included the development of a new form and revising educational programming to assist them in becoming comfortable in the process.

Shanteler outlined the changes to the peer review process:

- Peer review will include two aspects of an individual’s practice: recognizing practice strength and identifying a practice development opportunity to assist a peer in developing goals to enhance or advance an aspect of nursing practice.
- A new form will guide the clinical nurse in giving peer review feedback.

The roll-out plan included educating nurses through an on-line course delivered through Healthstream, the MGH learning management system. The course was assigned on April 11, 2017 so that clinical nurses can become familiar with the changes to the process. Clinical nurses will begin utilizing the new process for their performance appraisal this year.

SNA members reviewed and endorsed the new process and form. Several SNA members, who were part of the educational pilot, stated that the classes were very helpful in improving their comfort in delivering constructive feedback to a peer. Another clinical nurse shared that it is much easier to offer constructive feedback when there are praises and accolades offered during the process. Ives Erickson suggested that Shanteler return to a future SNA meeting as well as present on this important opportunity to change nursing practice in other forums. Shanteler agreed and shared that she would be presenting on peer review at the Collaborative Governance Quality and Safety committee meeting on April 25, 2017.
Nursing Practice Change: Example of Clinical Nurse Peer Review

Shelby Horn, RN, BSN, is a clinical nurse on Thoracic Surgery & General Medicine Unit (Ellison 19) who was due for her performance evaluation in November 2016. She chose her clinical nurse colleague, Erica Ouellette, RN, BSN, to be her peer reviewer. Ellison 19 was a member of the workgroup and therefore had agreed to pilot the new peer review process and so both clinical nurses were aware of the new expectations on the new process. On November 30, 2016, Horn and Ouellette met to review the peer review (attachment TL8c.e).

For an area of strength, Ouellette chose to write on the theme of Collaboration/Teamwork. Ouellette described Horn's care of a patient with a Cystic Fibrosis (CF) flare up 4 days post-partum. Ouellette noted that Horn was able to collaborate with her colleagues to care for the patient which was particularly important when the patient developed mastitis. Ouellette wrote “Horn got the patient a breast pump and a surgical bra. She called the OB floor and asked one of the nurses to come up and educate the new mom on breast feeding and treating mastitis.” Ouellette’s comments commend Horn for recognizing the unique needs of a patient not usually cared for on the unit, by identifying and accessing the resources needed to safely care for the patient.

For a practice development opportunity, Ouellette chose to focus on the category of Clinical Knowledge and Decision-Making. Ouellette reflected back on Horn’s care of the patient 4 days post-partum with a CF flare and noted that, while Horn went above and beyond in her care of that patient her care, it also showed an opportunity to improve on her delegation skills. Ouellette gave Horn a specific example and how she could improve her delegation skills: “She took care of her new admission while trying to do required documentation and finish up tasks with her other two patients. To improve, she could have asked an Operations Association (OA) to work on obtaining a breast pump and ask the resource nurse to arrange for a nurse educator to come up from the Obstetrics unit.” Ouellette’s constructive feedback identifies both Horn’s strength in her compassionate care of the patient as well as opportunities for her to appropriately delegate care to licensed as well as unlicensed staff.

This feedback allows Horn an opportunity to reflect on when she can safely delegate aspects of care so that she is available to her other patients to ensure their safe care. Ouellette had noted that Horn stayed late to complete all aspects of her patient’s care and, while at times this may occur, to consistently stay late after a twelve-hour-shift can lead to stress and exhaustion. Ouellette’s guidance in appropriately delegating to others will be helpful to Horn throughout her career.

In their discussion as they reviewed the document, Horn was able to ask Ouellette for further guidance on when and how to delegate and to form a partnership with her as she develops her practice in delegation. Horn agreed with the peer review and she and Ouellette signed it on November 30, 2017. Ouellette’s written comments illustrate concepts presented in the educational program including providing feedback that is specific, descriptive, factual, and behavior-focused. In addition, the feedback supports
effective clinical behaviors and provides suggestions for improvement in a kind, supportive manner.

**CNO Communication**

The CNO’s ongoing communication with clinical nurses on the SNA regarding the peer review process and her charge to Whitney to incorporate SNA feedback into the redesign led to a change in nursing practice at MGH which strengthens clinical nurses’ ability to provide a safe environment for patients. Changing the way clinical nurses work and communicate with each other can improve not only the quality and safety of patient care, but also contributes to open communication and improved teamwork.

**References**


