INTEGRATING NURSING PEER REVIEW INTO A UNIT SHARED GOVERNANCE MODEL

Submitted by

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In partial fulfillment of the requirements

For the Degree of Doctor of Nursing Practice

Touro University Nevada

Henderson, Nevada

Summer, 2009

TOURO UNIVERSITY NEVADA

November 29, 2009

WE HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER OUR SUPERVISION BY MARY BRANN ENTITILED INTEGRATING NURSING PEER REVIEW INTO A UNIT SHARED GOVERNANCE MODEL BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF DOCTOR OF NURSING PRACTICE

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Abstract of Practice-Based Dissertation

Integrating Nursing Peer Review

Into a Unit Shared Governance Model

Transformational nursing leaders develop environments that empower nurses to achieve nursing excellence. The systems identified by the Magnet Accreditation program, such as shared governance and peer review, help achieve these environments.

During the project, a peer review tool based upon the American Nurses Association (ANA) standards of practice was developed. The tool was revised to assist staff nurses with identification of medical record items that exemplified each standard while they were completing the mandatory medical record audits required by the Joint Commission. Once the medical record audit and peer review tool were completed, the information was tracked for performance improvement (PI) issues and for the nurse's own professional growth. The unit shared governance council (USGC) was responsible for prioritizing tracked PI issues and developing a plan for improvement with the nursing staff. The focus of this process was to return the ownership of improving the quality of nursing care to the nursing staff. This practice-based dissertation addressed the following question: Among staff nurses, how will the implementation of an integrated shared governance-peer review model affect the NDNQI scores on *perceived quality of care delivered?*

The National Database of Nursing Quality Indicators (NDNQI) RN Survey with Practice Environment Scales was utilized to measure the difference in perception of quality of care delivered once peer review had been piloted.

Perceived quality of care over a one year period showed no change (0.00) and some deterioration (-0.13) on the pilot units. A change in the pilot unit's manager, budget cuts, decrease in hours per patient day (HPPD), turnover, and the number of nurses responding to the survey may have influenced the results. The data tracked from the peer reviews was valuable in providing insight into vital processes needing improvement on the units and associated with the quality of care delivered.

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Chapter I

In 2005, a university medical center (UMC) began its journey to Magnet status. The UMC is a 500+ bed acute care hospital with services including a level one trauma center, level two pediatric trauma center, level three neonatal intensive care unit (NICU), regional burn care unit (BCU), general medical-surgical units and intensive care units, and outpatient urgent cares and clinics. The UMC had many components of Magnet, but none were coordinated or recognized by the staff. The Chief Nursing Officer (CNO) wanted to coordinate the components and further elevate the professionalism of the nursing staff. Through the transformational leadership of the Chief Nursing Officer (CNO), the UMC began its Magnet journey three years ago. A Magnet Steering Committee was formed and a shared governance model was developed and implemented. From the gap analysis it was agreed upon that part of the journey would entail developing and implementing peer review for all nurses. Two years after the implementation of the shared governance model, peer review was to be added for all nurses practicing at the UMC in order to further empower the nursing staff and improve quality of nursing care delivered. The purpose of this project was to describe the background and development of an integrated shared governance-peer review model for successful implementation at the UMC and to determine its effects on perceived quality of care delivered as measured by the National Database of Nursing Quality Indicators (NDNQI) RN Survey with Practice Environment Scale.

Background

Nursing Shortage

The Robert Wood Johnson Foundation (RWJF) has produced studies on the aging workforce and the nursing shortage. By the year 2010, it has been estimated that 40% of the workforce in general will be at least 50 years old (RWJF, 2006). The American Association of Retired Persons (AARP, 2005) has stated that there will be shortages in the fields of healthcare, engineering, sales, and leadership. In short, within the very near future, there will not be enough new workers to replace the older workers wanting to retire. Industries will need to forestall labor shortages by retaining the older worker (AARP, 2005).

This problem can be exemplified by nursing. The RWJF (2006) states that the current nursing shortage exists for two main reasons: fewer numbers of people entering and staying in the profession, and the increasing demand for healthcare services. According to the latest published data from the Heath Resources and Services Administration (HRSA, 2004), at the current rate of new nurse education, schools would have to increase the number of graduates by 90% to keep up with the demands projected for 2010. Further, the average age of an RN is increasing (approximately to 47 years of age) as fewer people enter and stay in the profession (HRSA, 2004). The answers to this shortage have been to increase nursing program graduates and to retain RNs in the workforce.

Joseph (2006) stated that most RNs leave nursing for less stressful work. Much research has recently been directed on how to retain nurses in the nursing profession by improving the work environment. Many of the recommendations mirror conditions found

in the work environment of Magnet hospitals. Through transformational leadership Magnet hospitals support a professional environment by fostering autonomy in nursing practice.

Transformational Leadership

The road to Magnet accreditation begins with transformational leaders who can envision the highest levels of nursing practice for all RN staff. The role of the leaders is to share their vision and passion to successfully empower the RN staff and motivate them to achieve the high standards required. Burns (1978) described transformational leadership as a method of leadership that motivates followers by calling on their higher sense of values. This type of leadership occurs when people engage with others in a way that elevates each other to a higher level of motivation and morality. Transformational leadership typically includes the following elements: charisma and inspiration; intellectual stimulation; and individual consideration for all followers (Nahavandi, 2006).

Charisma creates a bond between the leaders and followers which facilitates trust. With trust in the leaders, followers seek to implement the leader's vision (Nahavandi, 2006). This helps to give the staff confidence and empower them within their practice.

Transformational leaders also foster RN empowerment by challenging the staff to solve problems and develop solutions. Questioning existing methods and values is encouraged in the process leading to creative solutions and engagement of the staff. Engagement and empowerment of the staff leads to improved team effectiveness (Nahavandi, 2006). Being involved in the decision making process, the staff will share a vision which ensures change on a long-term basis (Thyer, 2003).

Transformational leaders foster the development of personal relationships with each follower. Each follower is treated as an individual, but equally with all others. Using this approach, each follower feels valued and motivated to perform at a higher level (Nahavandi, 2006).

Peer review, as part of Magnet force nine (Autonomy), was designed to develop and showcase autonomy through increasing staff control over nursing practice. The CNO of UMC shared her vision regarding the hospital and its Magnet journey. She inspired the staff to see the possibilities of nursing practice at UMC and stepped out of their way (after laying the foundation of her vision) to allow the staff to problem solve and develop solutions. With her decade of experience as CNO at UMC and her formal education which included a MSN and MBA, she exhibited awareness of the strengths and weaknesses of each nurse involved in the Magnet journey. She mentored the nurses and provided the resources necessary to develop their strengths and reach their potential. She exemplified the transformational leader in nursing practice.

Shared Governance

The journey for UMC towards Magnet accreditation began with the development and implementation of a shared governance councilor model in 2006. This was based upon findings from the literature related to the nursing shortage and improving the work environment for nurses.

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, and currently named the Joint Commission) convened a panel consisting of health care and nursing leaders to address the nursing shortage. That panel identified and produced a white paper that detailed the scope of the problem. They identified that:

1) there were 126,000 vacant nursing positions in hospitals around the country; 2) the average age of a working registered nurse was 43.3 years; 3) only 12 percent of registered nurses were under 30 years of age; 4) it costs almost an entire nursing salary to fill a vacant nursing position; and 5) that nurses lack empowerment in their own profession (at a staff level) to implement changes to control their environment and deploy resources in many critical situations. The key recommendation from the panel was to implement practices found in many Magnet Hospitals that had been successful in recruiting and retaining nurses (JCAHO, 2001). Magnet hospitals are hospitals that have achieved the highest recognition from the American Nurses Credentialing Center for excellence in delivery of nursing care services. Nurses at these hospitals benefit from three key factors: 1) professional autonomy over practice; 2) nursing control over environment; and 3) effective communication (Batson, 2004). Shared governance and peer review have been identified as means to achieve these goals. The nurse's expertise is showcased in shared governance and has been used as the means to achieve nurse's autonomy in practice. Peer review has been seen as a way to bring about accountability in practice. One of the purposes of peer review is to maintain the standards of care of the profession (ANA, 1988).

Understanding the need for shared governance and peer review requires an appraisal of what it means to be a profession. Further, to understand nursing as a professional group, it is necessary to review nursing's designation as that of an oppressed profession.

Nursing as an Oppressed Profession

Understanding oppressed group behaviors has developed from observations of experiences from previously oppressed groups. African Americans, Jews, and American feminists are but a few groups that have been cited in the literature (Roberts, 2000). Freire (1971) discovered that subordinate groups begin to dislike themselves and their group attributes due to dominance of another group that sets the norms for what is valued within the culture. Nursing, historically, has been groups of women held in a subordinate position to men (physicians). The traditional role of nursing supporting medicine is closely linked to that of typical women's experiences supporting men in everyday life (Witt, 1992; Fletcher, 2006; Roberts, 2003). Matheson (2007) discussed how nursing as an oppressed group may have developed these particular behaviors. In the 1900s, physicians constructed nursing programs to serve physicians in their efforts to cure patients. Matheson (2007) states this was the groundwork for the oppressive relationship between the two professions. Further, the tendency for nurses to readily accept the medical model with its emphasis on tasks and technique versus caring has been seen as an observable outcome of oppressive behavior patterning (Hedin, 1986).

Oppressed groups often adopt the values and attitudes of the dominant group as a method to improve their status and power; this typically does not empower the oppressed, but leads to lowered self esteem. Lowered self esteem leads to passive-aggressive behaviors in the presence of authority and self-hatred and dislike for other nurses which gives way to horizontal violence in the workplace (Matheson, 2007).

Controlling groups, in oppressive relationships, typically have been perceived to have greater prestige, status and power than the oppressed group. This perception of

imbalance of power can be related to position, such as a nurse manager to staff nurse, or to a group with perceived higher status such as nurses with tenure or the medical profession (Olender-Russo, 2009). The controlling group's characteristics are seen as more valuable. This marginalizes the oppressed group and eventually leads to poor self esteem, horizontal violence, and decreased job satisfaction (Fletcher, 2006; Matheson, 2007).

For healthcare organizations, this translates to decreased employee morale, apathy, decreased productivity and loyalty, and poor communication. All of which can lead to increased errors which can compromise patient safety (Olender-Russo, 2009).

> In a survey by the Institute for Safe Medication Practices (ISMP), 7% of a sample of more than 2,000 healthcare professionals and administrators, all of whom admitted to either participating in or observing workplace intimidation, reported being involved in a medication error where intimidation contributed to the event. It is not surprising that the costs of workplace bullying are estimated to be anywhere from $3billion to $36 billion annually (as cited by Beyea and Turney in Olender-Russo, 2009, p. 77).

The outcomes of continuing an oppressed culture within nursing can ultimately lead to poor quality of care with compromised patient safety, unnecessary expense, and health related consequences for the nurse (Olender-Russo, 2009). Roberts (2000) cited past research that has explored the implications of oppressed group behaviors on the nursing profession. The research has shown that powerless groups have difficulty taking control of their destiny due to group internalized beliefs regarding their own inferiority. This in turn leads to a cycle of self hatred and the inability to unite to challenge the inequalities of power that have lead to oppression (Roberts, 2000).

Roberts (2000) proposed, as a solution to oppression, a model for identity development for nursing based upon models of other oppressed groups. One aspect of developing positive identity was advanced through organizational structure that promoted autonomy. Matheson (2007) concluded that empowerment was more important than ever in light of the nursing shortage and that autonomy of the nursing profession can only come from within the profession through introspection, education, and enlightenment. Daiski (2004) solicited suggestions for change from staff nurses. The suggestions included: recognition of nurses' work; awareness of what nurse's say about each other; awareness about workplace issues; education emphasizing mutual support and the nature of oppression; and involvement in decision-making processes. Olender-Russo (2009) speaks of developing a *culture of regard* as an antidote to oppression. The culture of regard consists of three elements: recognition of nursing; empowering nursing; and facilitating goal attainment.

The above recommendations parallel the formation of organizational models that promote nurse empowerment and autonomy within the work environment through shared governance and peer review. These models are typically used within Magnet facilities to promote nurse autonomy over practice resulting in increased job satisfaction, decreased sick time utilized, and retention of nursing staff as the outcomes (Aiken, 2002; Campbell, 2005 ANCC, 2005; May, 2006 Day, 2006; McClure, Poulin, Sovie, & Wandelt, 2001; McClure, Poulin, Sovie, and Wandelt, 2002).

Characteristics of a Profession

Campbell (2005) discussed six characteristics of a profession: 1) a defined body of knowledge; 2) service based orientation; 3) discipline, peer review, and a code of

ethics; 4) autonomy in practice; 5) presence of a professional organization; and 6) a culture that supports the professional activity.

Defined Body of Knowledge

Nursing education through the ages has progressed from apprentice focused training to academia. The guidelines for the essentials of nursing education can be found within accrediting agencies. One such accrediting agency, the American Association of Colleges of Nursing (AACN), describes the essentials for baccalaureate nurse preparation which include: the sciences, basic organizational and systems leadership for quality care and patient safety, scholarship for evidence-based practice, information management and application of patient care technology, healthcare policy, finance, and regulatory environments, interprofessional communication and collaboration, improving patient health outcomes, clinical prevention and population health, professionalism and professional values, and baccalaureate generalist nursing practice. These essentials with their outcomes provide the framework upon which universities develop their curricula for nursing students (AACN, 2009).

Service Based Orientation

The delivery of nursing care is the service nursing provides to society. Nursing care is delivered to individuals based upon assessed needs which are then modified according to the nurse's evaluation of the effectiveness of care. Nurse's judgment and knowledge guide their practice and evaluation of care; a set book of instructions cannot substitute for the nurse's judgment in caring for individuals (Campbell, 2005). The privilege and authority to practice as a profession is granted by society. The price for this privilege is in the form of accountability to the public. "Professional nursing can be said

to be owned by society" (ANA, 2003, p.1). The quote continues by adding "society granting nursing (as well as other professions) the authority over its vital functions…self regulation to assure quality in performance is at the heart of this relationship" (ANA, 2003, p1).

Discipline, Peer Review, and a Code of Ethics

The discipline of nursing includes the roles of: provider of care; a designer, manager, and coordinator of care; and a member of a profession (AACN, 2008). Within the discipline of nursing standards of practice are required. The American Nurses Association (ANA), as the national professional organization of nursing, has developed standards of practice which allow society to know what it can expect from every member of the profession (1988). These standards provide the framework for nursing peer review. The ANA published its *Nursing Peer Review Guidelines* in 1988. The guidelines contain information defining peer review and its benefits and relationship to quality assurance.

Nursing has at its core a code of ethics. *The Code of Ethics for Nurses* (The Code) was published by the ANA in 2001. The Code serves as a definitive statement of the ethical obligations and duties for everyone entering the nursing profession.

Autonomy in Practice

Autonomy has been defined as the "freedom to act on what you know in a responsible manner" (Hinshaw, 2002, p.92). It has long been a desire and need of the nursing profession, as staff nurses view themselves as responsible practitioners capable of making practice decisions. The ability to set standards and goals, monitor practice, and measure outcomes are all part of autonomous behavior that give nurses control over practice (McClure, Poulin, Sovie, & Wandelt, 2001). However, several things contribute

to nursing's lack of autonomy. Explanations of nurse oppression range from a history of controlling hierarchies (Campbell, 2005) to relegating women to subservient status (Matheson, 2007). Many nurse leaders feel that it is the nurse's work environment and lack of transformational leadership that prevent nurses from being as autonomous in practice as they could and should be (personal conversation with Joan Trofino, March 16, 2009; Savic, 2008).

Hinshaw (2002) has stated that autonomy "is related to a number of positive outcomes for nurses and patients" (p.93). Research has shown that nursing autonomy is linked to job satisfaction and better patient outcomes. Since autonomy has not been part of the professional roots of nursing, given its history of oppression, it requires that organizational leader's expect and support autonomous nursing decisions to make it a reality. Nursing leadership has been seen by staff nurses as a major factor in influencing the scope of practice. Also, staff nurses tend to act more autonomously when they feel they have a greater responsibility for managing patient care. Lack of house staff in smaller facilities and lack of interns and residents have been shown to increase nurse decision making (McClure, Poulin, Sovie, &Wandelt, 2001). With this in mind, new organizational structures, such as shared governance and peer review, need to be formed under the guidance of visionary, transformational leaders that improve the professionalism and autonomy in individual nursing practice versus the oppressive system in which nurses usually work(Campbell, 2005; Trofino, 2003).

Control over practice results in organizational autonomy for nurses as it allows nurses to take the initiative in shaping policies for patient care and access resources necessary to make those policies a reality. It is an environmental quality that is interactive

with individual nurse autonomy. Control over practice refers to programs that affect patient care and the standards of nursing practice (Hinshaw, 2001). "It requires some type of structure to facilitate nurse decision making about their professional practice at the unit and organizational level" (Hinshaw, 2001, p. 94). Typically, shared governance has been the model used for this purpose (Hinshaw, 2001) as it allows staff nurse input from the unit level to be carried throughout the organization. Integrating peer review into the shared governance model serves as an attempt to further nurse control over standards and their practice.

Presence of Professional Organization

Numerous professional organizations exist for professional nurses. Organizations range from specialty nursing practice to the ANA which represents all nurses in all areas of practice. These organizations make it possible for professional nurses to obtain education, networks, and political clout. For example, the ANA has a political action committee (PAC) to which members can contribute for lobbying efforts on behalf of nursing interests.

Culture Supporting Professional Activity

Traditionally, hospitals have promoted controlling environments using traditional hierarchical and bureaucratic structures. These structures came into being from the belief that management should control decision making and develop a precise system in which the employee simply participated. Intentions were that this type of system would maximize efficiency and effectiveness. However, the unintended consequence was the loss of individual accountability (Campbell, 2005), by not allowing employees to participate with decisions affecting them and the organization. Sumner (2003) has

explained that if those working in the hospital are viewed as a commodity instead of valued professionals, then there is a tendency for the workers to feel helpless, lack autonomy, and perceive themselves as powerless. This in turn leads to victimized behaviors, such as passivity which precedes reduced compassion, caring, energy, knowledge, judgment, and skill (Sumner, 2003). All are not acceptable in nursing.

A growing body of research has shown that employees are more satisfied with their jobs when they "work in climates that have more supportive and empowering leadership and organizational arrangements, along with more positive group environments (often reflecting elements of group support and collaboration)" (Stone et al, 2008, p.62) are in place. "Moreover, although the research base is not as strong, there is emerging evidence that these same organizational attributes impact employee turnover and, most important, patient safety. Improving the organizational climate is likely to improve patient safety and decrease overall health care costs" (Stone et al, 2008, p.62).

The work environments of nurses are well supported within the Forces of Magnetism. Within Magnet facilities, the organizational structure is flat versus hierarchical; unit decision-making prevails. Nursing administration uses a participative management style with feedback from the staff being incorporated at all levels. Nursing leaders are accessible and committed to effective communication with their staff (Bliss-Holtz, 2004). These attributes lead to the positive impacts of Magnet status as defined by many (ANCC, 2009; McClure & Hinshaw, 2001; Stone et al, 2008; ANCC, 2009).

Gaps in Professionalism

Nursing meets all of the criteria for a profession; however, it has a weakness in the area of autonomy. The lack of autonomy has been blamed by many on the history of

nursing as an oppressed profession,the lack of transformational leadership, and the work environment (Campbell, 2005; Daiski, 2004; Olender-Russo, 2008; Trofino, 2009). Autonomy in nursing practice is discussed within the context of freedom of professional nurses to assume and carry out patient care in a responsible manner within their scope of practice without the constraints of another profession or authoritative body. It encompasses the ability to set standards and goals, to monitor practice, and measure outcomes: it is essential to the quality of care (McClure, Poulin, Sovie, & Wandelt, 2002). Aiken (2002) stated that the quality of care in ANCC Magnet hospitals is excellent and that one of the three positive differences between the original Magnet hospitals and the ANCC accredited hospitals was the CNEs reporting "high levels of control over nursing practice and the practice environment" (Aiken, 2002, p. 70-71).

Magnet Accreditation Program

Magnet hospitals are hospitals that have achieved the highest recognition from the American Nurses Credentialing Center for excellence in the delivery of nursing care services. The organizational structure of these special facilities tends to be flattened (versus hierarchical) drawing from the staff nurse's expertise under the guidance of transformational nurse leaders. Nurses at these hospitals benefit from the following key factors evolving from transformational leadership: 1) professional autonomy over practice; 2) nursing control over the environment; and 3) effective communication (Batson, 2004).

Hospitals that have obtained Magnet status have a reputation for high quality nursing care and the ability to attract and retain nursing staff; hence the program name *Magnet.* Facilities choosing to acquire Magnet accreditation must demonstrate the highest

level of nursing practice as documented through evidence found within their organization. The qualities of Magnet facilities that attract and retain nurses and lead to quality care have been outlined in the *forces of magnetism*. In 2005, 14 forces of magnetism were identified: quality of nursing leadership, organizational structure, management style, personnel policies and programs, professional models of care, quality of care, quality improvement, consultation and resources, autonomy, community and the hospital, nurses as teachers, image of nursing, and professional development (ANCC, 2005). Currently, the 14 forces have been distributed into five model components. The changes focus on measuring outcomes and streamlining documentation of evidence. Shared governance and peer review have been major components of Force Nine, *Autonomy*. Currently, Autonomy (Force Nine), is found under *Exemplary Professional Practice* (ANCC, 2009).

The influence of Magnet accreditation on autonomy has been derived through encouraging and requiring documentation of its evidence within the organization (ANCC, 2005). Within the context of autonomy, "nurses are permitted and expected to practice autonomously, consistent with professional standards. Independent judgment is expected to be exercised within the context of a multidisciplinary approach to patient care" (ANCC, 2005, p.54). The components of autonomous practice are: 1) compliance with national professional nursing standards; 2) an established credentialing and privileging process for advanced practice nurses; 3) standards/structures and processes that shape the practice of nursing; 4) access to appropriate resources and databases; and 5) peer review process for all nurses (ANCC, 2005).

Peer Review

Peer review in nursing has been defined by the ANA (1988) 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" (p. 3). The primary focus of peer review is the quality of nursing practice which takes into account the dimensions of quality, quantity, and cost of care. The desired outcome of this process is patient care delivered in a cost effective manner with the appropriate utilization of personnel and supplies.

The ANA believes that the individual nurse bears the responsibility of the quality of care delivered and that each nurse is responsible for maintenance of the standards of nursing practice. Further, the ANA holds that all healthcare agencies providing nursing care need to use peer review as a means to maintain the standards and improve care. Other authors concur stating that "peer review—is considered to be a crucial element of ensuring that quality medical care is provided to patients…That element is just as crucial in the nursing profession" (Harrington & Smith, 2008, p.10). Campbell (2005) stated that new organizational structures needed to be formed that demand accountability in individual nursing practice. "Staff nurses need a structure that allows them to determine the system's standard of care (based on the profession's defined standard) for themselves and their peers" (p.58). According to Campbell (2005), accountability begins with and lives within each nurse and creates a sense of ownership for one's actions and the resulting actions on others. This in turn requires nurses to intervene with clients and to follow up with their practice and improving the quality of care delivered. With accountability between the nurse and client, the nurse becomes empowered

professionally and becomes a valuable asset within the organization. Accountability is at the root of the shared governance-peer review model. It transfers the responsibility of the quality of care delivered back to the staff for them to determine if the care delivered meets the standards and what type of improvements may be needed.

Standards of Care

The ANA (2004) stated that standards of care guide practice and professional performance of nurses. They are an essential part of a profession (Phaneuf & Lang, 1985). The ANA has been actively engaged in developing standards of practice since the 1960's and published the first version in 1973.

> Standards are authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable. Standards reflect the values and priorities of the profession and are based on research and knowledge from nursing and various other sciences and disciplines. Standards provide direction for professional nursing practice and a framework for the evaluation and improvement of practice. These ongoing assessments and evaluations are in keeping with nursing's commitment to lifelong learning, and to providing creative, deliberate, holistic, and up-to-date comprehensive care (ANA, 2004, p.1).

Professional standards evolve from the legal regulation of the scope of nursing practice; however, nursing is responsible for ensuring its members practice within the public's interest (ANA, 2004). It does this by self governing its practice in order to assure the quality of care delivered. Standards have been what the profession and public relies upon to determine the basis of quality for all nursing care (Phaneuf & Lang, 1985). Standards help the profession by maintaining the confidence of the public in the quality of care that will be delivered by professional nurses. The ANA (2004) contended that "a profession

that does not maintain the confidence of the public will soon cease to be a social force" (ANA, 1985, p.2).

Peer review is the mechanism by which the professional nurse reviews practice in relationship to the standards. Standards of care are important regarding peer review in that they identify the important elements of the profession and provide a mechanism against which performance can be measured. When standards are utilized they serve as guidelines for measurement in "licensing, certification, accreditation, quality assurance, peer review and public policy" (Phaneuf & Lang, 1985).

The standards of nursing practice as set forth by the ANA in 2004 are as follows: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The first standard, assessment, is defined as "the registered nurse collects comprehensive data pertinent to the patient's health or situation" (p.21). This standard is measured by reviewing records that demonstrate that: evidence-based data are continuously collected in a systematic manner; that the professional nurse has included the patient, family, and other health care providers as appropriate; the data are prioritized to the patient's condition or situation; the professional nurse uses problem solving tools and models to remedy situations; the professional nurse synthesizes information to identify patterns and variances from baseline; and that the professional nurse documents relevant data in the permanent record (ANA, 2004).

Standard two, diagnosis, is defined as "the registered nurse analyzes the assessment data to determine the diagnoses or issues" (p.22). The measurement of

this standard includes looking for nursing diagnoses based on the assessed data; that the diagnosis is validated by the patient, family and other health care providers as appropriate; and that the diagnoses are documented in such a way that they help determine patient outcomes and the plan of care (ANA, 2004).

Outcomes identification is the third standard of nursing practice and the standard is defined as "the registered nurse identifies expected outcomes for a plan individualized to the patient or the situation" (p. 23). To meet this standard, the registered nurse involves the patient, family and other healthcare providers in developing the expected outcomes; considers cultural influences, risks, benefits, costs, current evidence from science, continuity of care, and clinical experience when developing outcomes; includes a time element of outcome attainment; modifies the outcomes based on patient/situational changes; and documents the outcomes as measurable goals (ANA, 2004).

Standard four, planning, is described as "the registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes" (p. 24). This standard concerns itself with individualization and continuity in planning; collaboration with the patient, family, and others in developing the plan; setting priorities; and the consideration of the financial impact of plan. The plan is then utilized to provide direction to other healthcare providers in the care of the patient (ANA, 2004).

Standard five, implementation, has several components. The standard, itself, is cited as "the registered nurse implements the identified plan" (p.26). Two of the standards are held out for advance practice nurses: consultation (5C) and

prescriptive authority and treatment (5D). In these standards the advanced practice nurse (APN) uses clinical expertise to influence the plan of care and to prescribe evidence-based treatments, therapies, and procedures as dictated by the APN's state scope of practice. The other components 5A and 5B refer to all registered nurses.

The first component, 5A, states that "the registered nurse coordinates care delivery" (p.27). This includes not only the orchestration of the care, but the proper documentation of the coordination. Standard 5B is health teaching and promotion. "The registered nurse employs strategies to promote health and a safe environment" (p.28). Health teaching promotes self care, healthy living strategies and risk reduction at an appropriate developmental level; the nurse seeks feedback as a means of evaluation (ANA, 2004).

Evaluation is the sixth standard. "The registered nurse evaluates progress toward attainment of outcomes" (p. 31). Within this standard the registered nurse is expected to conduct ongoing, systematic evaluations of the care delivered. The standard specifically indicates the effectiveness of the care be evaluated with regard to the patient's response and whether or not the patient is achieving the expected outcomes. Revision and dissemination of the results assists the patient toward the expected outcomes (ANA, 2004).

Beyond the standards of nursing practice are the standards of professional performance. These include standard 7, quality of practice, which seeks to include all nurses in the quality improvement process by identification, data collection, analysis of data and formulation of recommendations (ANA, 2004).

Standard eight, education, concerns itself with the RN attaining "knowledge and competency that reflects current nursing practice" (p.35). The expectation is that nurses will participate in ongoing educational activities, demonstrate a commitment to lifelong learning, remain current with nursing skills, and keep records of such (ANA, 2004).

Professional practice evaluation is standard nine. Within standard nine the RN "evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations" (p.36). The RN is expected to engage in self-evaluation of their practice on a regular basis to determine strengths and areas needing improvement. This includes informal feedback from patient's, peers, and other professionals. Further, the RN is to participate in peer review as appropriate and to take action to achieve goals (ANA, 2004).

Collegiality, standard ten, is defined as the RN "interacts with and contributes to the professional development of peers and colleagues" (p. 37). The RN is supposed to share knowledge and skills with peers and colleagues through patient conferences, presentations, and meetings. They are to provide peers with feedback regarding performance and maintain caring, professional relationships with them. The RN overall is to contribute to a healthy work environment (ANA, 2004).

Standard eleven is collaboration. The RN is to "collaborate with patient, family, and others in the conduct of their nursing practice" (p.38). RNs are charged with communicating with patients, family members, and other healthcare

providers with regard to the patient's care. They partner with others to effect change and lead towards positive patient outcomes (ANA, 2004).

Ethics are the sole purpose of standard twelve. "The registered nurse integrates ethical provisions in all areas of practice" (p.39). The RN is expected to be aware of and use the *Code of Ethics with Interpretive Statements* within their daily practice (ANA, 2001). This includes maintaining confidentiality, delivering care in which the patient is the primary concern, maintaining a nurse-patient relationship within professional boundaries, contributing to resolution of ethical issues of patients, and reporting illegal, incompetent or impaired practices (ANA, 2004).

Finally, standard thirteen covers research. The RN "integrates research findings into practice" (p.40). The participation in research is commensurate with the RNs level of education and position. This could include: identification of research problems, data collection, conducting research, participation on research committees, interpreting research for practice, using research to develop appropriate policies and procedures, and dissemination of information (ANA, 2004).

The scope of the standards of professional nursing and practice are broad and inclusive. They remind professional nurses of their responsibilities to the patient, themselves, and the profession. With the standards as a guide, the peer review tool was developed and eventually implemented. It is through the peer review process that professional nurses maintain the standards of practice and professional performance.

Problem Statement and Purpose

The nursing shortage and concerns for patient safety have given rise to new approaches to retaining nursing staff and developing nursing systems aimed at maintaining and improving the quality of care delivered. Nursing administrators have been challenged to develop systems that meet these demands as well as the financial objectives of their institution. Environments that foster the contributions of nurses and empower them with control over their practice to achieve nursing excellence have been the answer for many transformational nursing leaders. For many progressive institutions, the systems identified by the Magnet Accreditation program, such as shared governance and peer review, help achieve these objectives which translate into quality of care delivered.

The pilot facility already had a peer review process through a central, interdisciplinary committee. The problems addressed by that committee were safety issues that had been reported through the patient safety network consisting of near misses or sentinel events. Root cause analysis would be performed, but the staff nurses were either unaware of the committee's existence or never received consistent feedback. There was no system dedicated to regular, continuous staff nurse participation in professional PI or to monitor quality issues surrounding the nursing process. The purpose of this project was to design an integrated shared governance-peer review model for all staff nurses which would increase the awareness of the nurses about the quality of care delivered and encourage participation in professional and unit performance improvement.

Question

The question being asked was: among staff nurses how will implementation of an integrated shared governance-peer review model affect the NDNQI scores of perceived quality of care delivered?

Chapter II will review the evidence from the literature related to and supporting the project. The literature will allude to the importance of empowering nursing practice based upon the nursing shortage, nursing's history of oppression, and its desires to elevate itself as a profession.

Chapter II

Review of the Literature

Current Nursing Shortage

The United States General Accounting Office (GAO) reported on the emerging nursing shortage in 2001. The shortage of nurses has been discussed in terms of the increased demand for nursing services with dwindling supply. The GAO (2001) pointed to total RN employment per capita decline, decline in the national unemployment rate of RNs, and providers reporting difficulty in recruiting and retaining nurses. Many states have introduced legislation relating to the nursing shortage and numerous task forces and commissions have been established as well. Further, the GAO discussed the obstacles to increasing the supply of nurses; the ageing nursing workforce, other workforce opportunities for women, a decline in candidates passing the NCLEX, and the poor work environment of nurses.

Hart (2005) explored the hospital ethical climate and RN turnover intentions. She found that the "hospital ethical climate could explain 25.4% of the variance in positional turnover and 14.7% of the variance in professional turnover intentions" (p. 173). RN practice environment can be greatly affected by the culture of the organization and the ethical climate is a significant reason that RNs leave their positions or nursing all together.

May (2006) documented hospital strategies to deal with the nursing shortage. Short-term strategies included: the use of temporary staff through per diem and traveling nurses and internal float pools; competitive financial and benefit packages; and flexible scheduling. Long-term strategies that were implemented included: investment in the

nurse's education; improved orientation programs; subsidizing nurse faculty salaries; and changes in the nurse work environment. The changes in the work environment that were utilized were: changes in staffing levels; a change in nurse's roles and responsibilities; decentralizing nursing units; and achieving Magnet status.

Day (2006) conducted a literature review regarding nurse morale. Many nursing workforce issues are linked to poor nurse morale. With greater pressures to improve productivity with a climate of cost containment, morale issues among nurses need to be addressed. Day reviewed staffing issues, organizational issues, leadership issues, and operational issues. The literature review showed that shared leadership and accountability contributed to improved morale. With regard to organizational issues, Magnet hospitals were highlighted as those that fostered nurse fulfillment and self-esteem.

The importance of retaining older nurses in the workforce to abate the nursing shortage was researched by the RWJF (2006). The focus of this study was to discover the best retention strategies to keep older nurses in the workforce. The outcome of the study documented that older nurses are more likely to extend their work life if the following conditions have been met: supportive work environment, social interaction among peers and patients, more control over the work environment, shared decision-making, appropriate recognition, flexible schedules, economic incentives, less physically strenuous jobs, and innovative nursing roles (RWJF, 2006).

The Robert Wood Johnson Foundation (2007) reported on factors affecting RN job satisfaction. The greatest variability in job satisfaction was explained by working conditions; attitude scales accounted for 38% of this variability. Wages were not

associated with satisfaction, but the perception of rewards being tied to performance did significantly relate to job satisfaction.

Transformational Leadership

Transformational leaders are imperative for the growth required for Magnet accreditation. Trofino (2000) discussed the importance of transformational values to achieve the goals of modern healthcare facilities: positive patient outcomes with more challenging budgets. She felt that transformational leaders will be needed to inspire followers to creatively problem solve and share in decision making in order to meet the organization's goals. Through inspiring others to engage in their workplace and make a contribution, the organization will make strides towards being a world-class healthcare organization.

In a separate article, Trofino (2003) discussed the concept of power sharing. She feels that nursing leaders must move towards a model that involves staff nurses in the decision-making process as partners. Empowering the staff helps them improve their own performance and inspires them to meet the organizations goals as well. Nurse middle managers are seen as the primary players in nurse retention and retaining nurses is essential in a quality-driven and cost effective environment. Transformational strategies help build a stable staff through increased job satisfaction and engagement.

Welford (2003) wrote that "transformational leadership is arguably the most favorable leadership theory for clinical nursing in the general medical or surgical ward setting" (p.8). Transformational leaders inspire the staff, encourage professional development and autonomy, work collaboratively with the staff, and trust in the

capabilities of the staff which leads to individual choices of accepting responsibility and maintaining teamwork.

Thyer (2003) described a case study that she felt was all too common in the nursing world; transactional leadership of the status quo with all the power resting with the manager. She described how transformational leadership can ignite its followers with their vision of an autonomous nursing staff. Staff are expected to problem solve during staff meetings and to share in decision making. She felt that under a transformational model, the status quo would become obsolete and a learning environment would prevail.

Kleinman (2004) described the perceptions of leadership behaviors associated with nurse turnover. Two findings of this study were of interest. The first was nurse managers thought they demonstrated many more transformational leadership characteristics than the staff perceived them having. Secondly, active management by exception was statistically significantly and associated with nurse turnover.

Murphy (2005) described the transformational leader as one who can influence the staff within their supervision. She reports that transformational leadership cascades within the organization; being mirrored down the organizational ladder. Transformational leaders are seen as elevating their followers by sharing their vision, using charisma, intellectual stimulation, and individual consideration. When transformational leadership is practiced the staff are seen as having many *positive work attitudes*.

Kerfoot (2009) explains that it takes leaders with vision and passion to get others to move away from the status quo. Further she explains that the status quo, although it may be good, can still be responsible for poor patient outcomes. She sees moving from

good to excellent as an ethical responsibility of nurse leaders. If the nurse leader settles for the status quo (good) and does not strive for excellent then it can be translated as settling for knowingly allowing patient harm.

Shared Governance

Shared governance in nursing has been used as a model to increase staff nurse autonomy through participation in decision-making. Trofino (2003) addressed power sharing and how leadership style could empower staff. She elaborated on understanding power and how to transfer it across organizational levels. This is essential in establishing nursing shared governance. Trofino (2003) holds the middle nurse manager primarily responsible for staff nurse retention through the leadership style that she chooses. She then listed empowering strategies for leaders to consider: 1) serving as a role model or mentor; 2) providing opportunities for staff nurse participation; 3) energizing and lending energy by acting as a consultant to the nursing staff; 4) resisting the ownership of the staff; 5) remaining sensitive to the effect of the managers presence on staff; 6) including staff nurses in interviewing processes; and 7) providing vision of the future.

Anthony (2004) detailed the theory of shared governance; its departure from scientific management; and its development over time into the practice of nursing. The theory of shared governance came from the ideas found in organizational management and sociology. Eventually, these theories combined in the work environment to form work groups that were jointly responsible for achieving goals and governing themselves. This gave the work groups access to information and authority over their work. She continues with the evidence surrounding cost savings and retention of staff as a result of shared governance systems. Moving the decision making from a hierarchical structure to a shared

governance structure has a direct and indirect financial impact. Savings have been reported from various institutions realized by eliminating temporary agency nurses and decreasing recruitment and orientation costs. Other examples of savings were from decreased sick days and increased performance that lead to decreased non-salary costs per patient day.

A similarity between shared governance and work place advocacy was the focus of an article by Green (2004). The three common denominators examined in detail were accountability, empowerment, and conflict resolution. Accountability is the foundation of both systems. Accountability encompasses awareness of workplace issues, how to seek support to solve theses issues, and the authority to make decisions. Empowerment has been defined as the nurse's voice realized in the workplace. For example, nurses can participate in shared governance councils and influence nurse practice decisions.

Collaborative conflict resolution has been seen as another way to enhance nursing empowerment. Green (2004) stated that most nurses have limited skill in this area. Green asserted that effective shared governance systems assist nurses to learn and practice conflict resolution strategies. She continued to explain that both shared governance and work place advocacy use conflict resolution strategies to help move health care from a hierarchical model to a communication model where conflict is resolved at the level at which it occurs.

Hess (2004) documented the history of nursing shared governance, its various structures, and its focus. He defined the three most commonly found structures of shared governance: 1) the councilor model; 2) the administrative model; and 3) the congressional model. The councilor model is the most common and has a coordinating council that integrates decisions made by staff in subcommittees. The administrative model splits the

organizational chart into different tracts with either a management or clinical focus. The congressional model allows nurses to vote on issues as a group. To Hess (2004), the focus of nursing shared governance is control of professional practice. He identified several notable institutions that support this focus on practice and described implementation and insights into the process. The insights included: 1) being mindful that shared governance is a journey; 2) that the journey can be long and difficult; and 3) that not every workplace environment is ready for shared governance.

The Hartford Hospital's experiences were particularly well documented by Caramanica (2004). She stated that shared governance is a philosophy as well as an organizational structure. Implementation included: 1) flattening the nursing hierarchy; 2) establishing clear lines of accountability; and 3) designing a system that supported the staff nurse's authority and responsibility for their own practice. She explained that the nurse manager's role must change to one of facilitator and coordinator. When these changes were realized, the shared governance system evolved into a culture or philosophy change within the institution.

Thompson, et al (2004), described the implementation of shared governance at a facility in the United Kingdom. She described the journey to shared governance from its launch to the problems encountered along the way. One of the problems discussed was avoiding the temptation to resort to former ways of working by having the manager make all decisions. Batson (2004) described a similar accounting at a United States hospital. Batson not only discussed the implementation of shared governance, but the use of a clinical ladder and peer review system.

Porter-O'Grady (as cited in Green, 2004) describes shared governance as "an organizational strategy through which nurses can express and manage their practice with a higher level of professional autonomy" (p.1). Porter-O'Grady (2005) discussed shared governance and its implementation at length. He contends that it is a model of professional maturity due to its demands on the nursing profession of taking pride and control of itself and making a difference in job performance and quality. He believes it is a model that creates transition for both nursing and the healthcare system in that nurses start to see their contributions in relationship to others.

Nursing as an Oppressed Profession

The concept of nursing as an oppressed profession has been documented in the literature for years. It is the key for understanding why transformational leadership, shared governance models and other systems that promote autonomy in nursing are needed.

Witt (1992) looked at post-licensure baccalaureate education and its relationship to the acceptance of oppression. One of the findings, regarding a positive image of nursing was found to be significantly higher in the graduates of the BSN program. Witt (1992) found that all findings, with the exception of self concept (no change), were in the positive direction. This indicated that graduates of the post-licensure BSN program were less likely to accept oppression status for the nursing profession. She stated that nurses will "advance and grow when nurses function autonomously, respect each other and themselves, and feel in charge of their own destiny" (p.155).

Roberts (2000) discussed the process of liberation form oppression. Reviewing the cycle of how oppression affects nursing, she stated that powerless groups have difficulty taking charge of their own destiny which perpetuates beliefs of inferiority and self hatred.

This, in turn, leads to the inability to unite successfully as a group to challenge the oppression. She proposed a model of identity development for nursing based on models from other oppressed groups. The model includes understanding the oppression cycle and actively seeking autonomy. The model has five stages: pre-encounter, encounter, immersion-emersion, internalization, and commitment. In the pre-encounter stage, people are accepting of their oppressed status. In stage two, encounter, the person experiences an event that causes that person to look at their world in a new and different way. Stage three, immersion-emersion is characterized by people beginning to test their new reality. During this time, they typically separate themselves from the oppressing group and gain support from their own group. Stage four, internalization, has to do with the ending the conflict within and between the old and new identity. People gain new confidence and can interact with the oppressor without overt anger. Finally in stage five, commitment, the person translates their new identity to others. The person works within their group to improve the group overall and expand their autonomy (Roberts, 2000).

Farrell (2001) examined interpersonal conflict within nursing. He reviews the history of nursing as an oppressed profession and discusses its relationship to poor interpersonal relationships in the workplace. He cites several behaviors as examples: disenfranchising work practices placing emphasis on task completion, generational and hierarchical abuse, clique formation, low self esteem, aggression, and actor-observer effects (negative behavior arising as a result of things beyond our control). He explained these behaviors as a result of nursing's perpetuation of disempowering work practice; nurses alienated from decision-making and autonomy over practice.

Daiski (2004) explored nursing's disempowered status and its relationship to their inter- and intra-disciplinary relationships. She interviewed staff nurses with open-ended questions to investigate their relationships in the healthcare system. She found that relationships between nurses themselves were frequently hierarchal in nature. Competition among nurses was widespread. These behaviors manifested themselves by talking about one another and lack of support for one another to the point of siding with disciplines outside of nursing (mainly physicians) against each other. These behaviors parallel behaviors described by Roberts (1983) depicting oppressed group behaviors. The nurses in the study felt that education was the most important avenue to overcome disempowering behaviors and status (Daiski, 2004).

Fletcher (2006) discussed the importance of nurses maintaining control over their practice. She described the history of nursing oppression by stronger, controlling groups over a profession that is primarily female. She stated that nursing's self awareness of their history is one step in leading out of oppression. The other necessary component is dialogue. Essential to dialogue is listening and speaking/acting without aggression. She felt strongly that when acting with aggression that we perpetuate it by solidifying the sense of the enemy.

Dialogue and healing relationships are seen as central to nurse empowerment and moving away from oppression according to Olender-Russo (2009). She discusses creating a culture of regard and contends that the unhealthy relationships that nurses have with one another is a primary reason that nurses leave clinical nursing. These relationships go beyond incivility to that of workplace bullying. She defines bullying as "repeated, long-term behaviors targeting an individual (which) include constant criticism, backbiting,

blaming, disparaging, and social exclusion by colleagues or from team activities, either in a group setting or one-on one" (p.76). She looks at the theories regarding oppression of nursing as explanation for the behaviors. Further, she points out that JCAHO issued a sentinel alert (issue 40, July, 2008) in regards to disruptive/bullying behaviors and their expectations of organizations to prevent them in order to protect employees and patients from harm.

Professions

Klass (1961), a physician, gave an overview of what it means to be a profession. He reviewed the various definitions and gave historical background. His first point was that professionals are educated through universities. Secondly, professions have a legal status that has given them the exclusive right to practice/perform in a particular area. He stated that one of the most important essentials of a profession has been its internal governance to include denial of entrance and power of expulsion when warranted. Finally, he concluded with the importance of a profession's dedication to society stating that it is through men's striving for excellence and doing good that a calling can be called a profession.

Hall (1982) discussed professions from the power perspective. He indicated a background for this approach to professions that includes groups seeking to raise themselves in status, providing services that only they can provide, and their achievement of autonomy and influence. He discussed nursing from the standpoint of a group that still sees itself as struggling to become *truly professional*.

Hall also discussed the employed professional and stated that nursing is employed in all three types of organizations that employ professionals: autonomous professional organizations, heteronomous professional organization, and the professional department.

Examples of autonomous professional organizations include law firms, medical clinics, and architectural firms. Heteronomous professional organizations were described as organizations where professionals were at least partially subordinated to an external administrative framework. The professional department was exemplified by research and development departments, legal departments, and engineering departments. Hall continued by articulating how each of these environments can be sources of stress for professional employees due to constraints of organizational rules and problem solving methods. Further, supervisors who are not members of the same profession add to the strain since they are not experts in the same field. The last area of stress documented for professional employees was stated as the conflict a true professional faces to remain at the employing organization. Persons with high degrees of professionalism were perceived to be able to move from location to location while feeling that they owe loyalty to the organization. For nursing, its professional power would lie in dealing not only with the employing organization, but with other dominant occupations and professions.

At last, Hall turned his attention to professional organizations. He felt that the professional association (like ANA) would be the main source for establishing nursing as a profession. The actions of the association are seen as those that can empower nurses through dealing with other powerful organizations.

Styles (1982) stated that nursing can develop documentation of the profession such as standards, code of ethics, etcetera, but it takes power to put them into practice. The power to implement and enforce these documents is essential if they are to have meaning. Without power, the profession is only images. A profession needs clear goals and effective relationships with political influence to be effective.

Styles discussed the professional nurse as predominantly employed in the hospital setting. She developed her discussion by entertaining how nursing came under the organizational power during the Great Depression. The fact that females had little autonomy during that time led to nursing entering into organizational workplaces in a position of powerlessness. She feels that each individual nurse is responsible for reforming nursing into an autonomous profession.

Styles followed her discussion on oppression with methods for nurses to gain autonomy. An interesting point made was that of nurses being at the center of the organization. She differentiated this central, dominant position into that of nurses having communication linkage power and decision-making power. The decision-making power has been lacking and is seen as what needs to be dominant in order for nursing to be a powerful professional group.

Campbell (2005) wrote about redesigning the nursing organization. She identified the components of a profession articulating how nursing meets or can meet the criteria. Although she identified six characteristics of a profession and discussed each, the thread of autonomy permeated the chapter. Autonomy through redesign within the organization is discussed as being the foundation of professional nursing practice models. This assists nurses in being accountable for nursing care delivered with an obligation to meet the needs of the organization. The relationship then becomes one of mutual respect where nurses and the organization are committed to the goals of each other.

Magnet Accreditation Program

The journey to Magnet accreditation provides an institution and its nursing staff with opportunities to showcase their excellence in patient care. It also provides opportunities for considerable professional growth through processes that increase nurse empowerment over their profession.

McClure, Poulin, Sovie, and Wandelt (2002) discussed Magnet hospitals and their ability to attract and retain nurses. They researched Magnet facilities and found that the ones that had the best practices in recruitment and retention had a high level of congruence in the survey answers between staff and the administration. The facilities had the following characteristics in common: participative management; able, qualified nursing leaders who listened and supported the staff; head nurses (unit managers) who were seen as pivotal in the success of the organization; highly educated nursing directors who were viewed as crucial to a positive nursing situation; decentralized nursing departments with directors reporting directly to the Chief Nursing Officer; nurse involvement in committees; adequate staffing; competitive salary and benefits for staff; career ladders with promotion opportunities; and professional practice which emphasized autonomy and quality of care.

Kramer and Schmalenberg (2002) studied staff nurses' opinions on the essential qualities of Magnetism (n=279). They wanted to know what the staff saw in Magnet hospitals that attracted them to that facility. The staff chose eight items that were essential in productivity of care: working with other clinically competent nurses; good nurse-physician relationships; nurse autonomy and accountability; supportive nursing leadership; control over nursing practice and environment; support for education; adequate staffing; and a culture of placing the patient as the primary concern.

Aiken (2002) showcased the superior outcomes for Magnet hospitals. She pointed out the evidence that supports increased nurse satisfaction, retention and safety as well as superior patient outcomes. In Magnet hospitals, "mortality was 7.7% lower (9 fewer deaths per 1,000 Medicare discharges) than in matched non-Magnet hospitals" (p.72). She then described traits that characterize Magnet hospitals as those promoting autonomy and control for nurses with good working relationships between nurses and physicians.

Building Magnetism into organizations is the topic of Hinshaw's (2002) writing. She presented the evidence for developing Magnet characteristics in hospitals and then turned her attention on how to build the characteristics into facilities. She discussed enhancing nurse-patient staffing ratios, autonomy, nurse-physician relationships, education, and developing administrative support.

Urden and Monarch (2002) discussed the processes of Magnet appraiser selection and training and the process of acquiring Magnet status. Magnet appraisers have been chosen as those nurses who demonstrate expertise through experience in their specialty area, multiple practice environments, systems reviews, and professional practice. They must attend mandatory training conducted by the Magnet program and demonstrate their currency in standards criteria. The appraisers must conduct a minimum number of appraisals and site visits each year.

The process of Magnet recognition begins with organizational commitment. Once the facility commits to the pursuit of Magnet status the application process begins. This includes assessment and application, documentation review, site visit, and review with decision.

Usually organizations purchase an application manual that also detail the standards to help them determine their readiness for Magnet status. Some facilities appoint a coordinator to assist with this process and they usually have a steering committee to focus on specifics. Using nurses from all levels of the organization usually ensures success with the process. Once readiness has been determined, the application is submitted.

In phase two, the organization compiles their documents of evidence and submits them to the ANCC Magnet Program. The documents are reviewed by ANCC for completeness and to ensure that the criteria are met for eligibility (Urden & Monarch, 2002). Usually three reviewers score the documents and all must come to a consensus on the score. If the facility achieves a predetermined score set by the Magnet Program, then a site visit will be scheduled (personal conversation with Joan Trofino, November 29, 2009).

The site visit follows with (usually) two appraisers. The number of appraisers and the length of the visit depend upon the size and complexity of the organization. Prior to and during the visit, public notice is posted in the facility. The visit is used to verify the documentation through appraiser interaction with staff, patients, visitors, key hospital administrators and physicians, and other healthcare professionals (Urden & Monarch, 2002).

Following the site visit, the appraisers prepare their report. The report is forwarded to the Commission and they decide whether or not to confer Magnet status. The organization is then notified of the decision. Magnet status, when conferred, is awarded for four years. During that time, ongoing annual quality monitoring occurs. Organizations must go through a re-designation process to maintain Magnet status (Urden & Monarch, 2002).

Stienbinder (2005) identified important items for facilities to consider when applying for Magnet status: innovation, excellence, finance, and engagement. Innovation in facilities is evident through incentive programs for staff excelling and providing leadership in unit activities. Nurses may be asked to be part of recruitment and retention strategies or may be able to design roles for unlicensed personnel to assist them with non-nursing tasks. Staff nurses have the autonomy to develop new ideas and bring them forward to administration.

Excellence is the focus of the Magnet Recognition Program; however, nursing is evaluated within the context of the entire organization. In this area, it is essential for the organization to demonstrate benchmarking regionally and nationally.

Within the finance category, Stienbinder pointed to the importance of using funding to foster education, since learning is an expectation of Magnet accreditation. When nurses are reimbursed for educational programs, it demonstrates that learning is valued by the organization. Further, nurses are recognized for educational milestones in their careers such as completing a nursing degree.

Engagement of staff is a characteristic of Magnet facilities. Unit-based activities are developed by staff who solicit input from colleagues. The feedback is considered an asset that is used in the decision-making process. Evidence of communication and engagement includes: meeting minutes, dissemination of meeting minutes to staff, written receipts of reading minutes; all staff having individual mail boxes, and identified avenues for providing feedback.

Peer Review

The purpose of nursing peer review is to focus on the quality of nursing practice. It demonstrates to the public and other professionals that nursing is fulfilling its obligation as a profession to regulate itself in providing quality care. It meets professional nursing's societal contract in terms of nurse's ethical responsibility to maintain nursing competence (ANA, 1988). The process of peer review meets a profession's responsibility of governing itself along with professional standards and a code of ethics (Campbell, 2005).

Larson and Herrick (1996) explained peer review within a shared governance model. They stated that the peer review process fosters accountability, increases empowerment, and can show trends in the unit. They described the tool used for peer review, which consisted of questions on guest relations, administration, clinical practice, education, quality and research. Upon review of the tool, the clinical section did mention the nursing process and documenting assessment; however, it was not based upon all of the standards of care. Regardless, the authors described tool implementation and the use of three reviewers; one chosen by the nurse manager, and two chosen by the RN being reviewed. When the peer reviews are completed they are returned to the RN being reviewed. Following, the nurse manager and the reviewed nurse discuss goals for the coming year based upon the review. A survey of the unit nurses found 83% liked the idea of peer review, but 73% thought the process was too subjective. The peer reviews were linked (by a method not mentioned) to several unit-based councils.

Laschinger and Wong (1999) wrote about nurse empowerment stating that "creating work environments that foster professional nursing practice by empowering nurses to act on their expert judgment and that require nurses to be accountable for their practice is an essential strategy for assuring high quality patient care" (p.316). They elaborated by explaining that accountability is closely associated with autonomy. Nurses' work satisfaction and commitment to an organization can be determined by allowing them to practice according to their professional standards and values. In order for nurses to be accountable they need to have the ability to do the job required and the authority to act based upon their knowledge and judgment. Research suggests that having nurses involved in budget planning, self scheduling, peer review, and collaboration allows for fully autonomous professionals.

Austin (2008) discusses the legal implications of using standards of care. By practicing in accordance with the standards, it protects both the nurse and the patient. Basic to this concept is following the nursing process: assessment, nursing diagnosis, planning, implementation, and evaluation. The standards of care as set forth by the ANA (2004) are the same except for the addition of outcomes identification. Austin affirms that most legal actions brought against nurses are in relation to the nurse allegedly breeching a standard of care.

Mantesso, Petrucka, and Bassendowski (2008) present the process of peer feedback in which they state is not the same as peer review, but rather a dialogue among colleagues. They describe the process whereby a nurse chooses someone they work with to provide constructive feedback and that the process is viewed as a learning experience

by both parties. Face-to-face feedback after the review was seen as helpful for allowing both parties to dialogue regarding the review.

Chapter III

Design and Methodology

Nurses at a local 500+ bed university medical center (UMC) have undergone a change in organizational structure on the journey to Magnet accreditation. In 2006, nursing shared governance was initiated. At that time, the nurses were surveyed to obtain their perceptions of shared governance. A year later the nurses were surveyed again regarding their perceptions of shared governance with a few new questions added to the survey. At the beginning of year three, peer review by way of an integrated shared governance-peer review model was introduced. This study describes the process of developing and implementing the integrated model and the nurse's perceptions of the quality of care delivered as measured by the NDNQI after piloting the model.

Study Design

This was a quantitative descriptive pilot study which compared the survey results from the NDNQI RN Survey with Practice Environment Scale used by the hospital before and after implementation of an integrated shared governance-peer review model..

Sample

The study sample for this pilot project was all staff RNs practicing on two medical-surgical nursing units (Unit A and B) at a university medical center. The hospital is a 500+ bed acute care hospital for patient's of all ages that includes a regional level I Trauma Center, a regional Burn Care Unit, full OB/GYN services, neonatal ICU, pediatric ICU, separate adult and pediatric Emergency Departments and several adult care clinics within the community.

Ethical Considerations

The NDNQI was utilized to survey the nurses confidentially. The results were sent anonymously from ANA to the UMC as group statistics versus individual. There was no way for analysts to know how any individual answered. Participants in the NDNQI could choose not to answer any questions if they so desired. The Institutional Review Boards of both the UMC and Touro University Nevada awarded the study exempt status.

Method of Analysis

Descriptive statistics were utilized as well as comparisons between previous years perceptions of quality of care delivered to that after peer review was implemented. Only aggregate data was available from the NDNQI survey; no raw data was made available to any facility (personal conversation with NDNQI office, October 14, 2009). The data was analyzed to determine percentage of difference in a positive or negative direction between the years before and after the implementation of peer review (personal conversation with Dr. Chrissie Grove, September 25, 2009).

Implementation of Peer Review

UMC's patient care delivery model (Figure 1) was developed by the staff nurses based upon Watson's theory for caring. They chose the heart as a symbol of patient centered caring with the acronym "HEARTS" in the foreground. The "H" is for honesty; "E" for excellence; "A" for accountability; "R" for respect; "T" for teamwork; and "S" for safety. All of these represent core values of the UMC nursing staff. With accountability as a core value its importance to the staff in the process of their daily work was documented.

Figure 1: Patient care delivery model

Used with permission (UMC, 2009).

The need for nursing peer review for all RNs was recognized while performing a gap analysis for Force Nine, Autonomy. With no suggestions coming from colleagues, the process of developing a peer review process for all RNs was researched and a rough draft developed. The original tool was developed from the ANA standards of care. The concept of the peer review tool (Appendix A) and the process were presented to the Magnet Steering Committee for discussion. The drafts were approved, but needed to be taken to Human Resources (HR) and the collective bargaining unit (CBU) for approval. The Human Resources department approved the drafts and the CBU agreed to the proposal with a couple of non-negotiable items. The CBU insisted that the process of peer review would not be used for annual performance evaluation by management and that management would only act as a resource to the staff in the peer review process.

Following the first draft approval, the proposal was taken to the Chief Nursing Officer for discussion on process. Originally, the process included the RN choosing one reviewer and the unit manager selecting the other with the unit manager collecting peer review data for trends in practice. The reality of who would determine when the peer review would be performed and tracking the unit's progress became an issue as well. This issue was discussed, and due to the unit managers feeling overwhelmed with their current work load and the CBU's requirements, the idea of empowering the unit shared governance council with peer review emerged.

UMC's shared governance is a counselor model with activity originating within the USGC (Figure 2). Issues having organizational implications are taken to one or more of five councils: nursing research council, collaborative practice council, quality and

patient safety council, recognition council, and the professional development council. These councils are made up of nurses from various nursing departments and other healthcare professionals. These councils send representatives to the Magnet Steering Committee and the Patient Care Advisory Committee. The Patient Care Services Committee is the final destination for organization wide decision-making and dissemination of information. Thus, the unit staff nurse can have input into policy being developed throughout the organization.

Figure 2: Shared governance structure

Used with permission (UMC, 2009).

Once the decision was made to integrate peer review into the USGC, an integrated shared governance-peer review model (Figure 3) was designed with the new process to be taken to the Magnet Steering Committee, HR, and the CBU for review. This concept was exciting from the standpoint that it stood to further empower the shared governance council and allow the staff to own the quality of care delivered within their nursing unit.

Figure 3: Brann Integrated Shared-Governance-Peer Review Model

Used with permission (Brann, 2009).

With the new changes, the model and process were taken back to the Magnet Steering Committee, HR and the CBU for discussion and input. The CBU was the only group having input. They wanted three reviewers for each RN with one being chosen by the RN and two being chosen by the unit shared governance council. They still insisted that management would be present only as a resource and that the process would not be linked to the annual performance evaluation. With these provisions incorporated into the process, the CBU, HR, and the Magnet Steering Committee agreed on the model and process.

The new model was rolled out and presented to the unit manager on the pilot units. An inservice was scheduled to educate the RNs about the new peer review process (Appendices B and C). Following the educational session, the RNs piloted the new process. They had questions and requests almost immediately. The first request was that a category regarding RN professionalism be added. The first questions were: 'where do we start, and how do we begin'?

The category on nurse professionalism was added using concepts from the ANA *Code of Ethics for Nurses* (2001) *and the Standards of Professional Performance* (2004). The nurses responsible for piloting the process also added a few specific items in this category that exemplified the dress code and particular expectations of the institution (Appendix A). After the revisions, the pilot unit nurses reviewed the category and agreed to the content.

The pilot nurses took the initiative to try to create a checklist to help them determine what things to look at in the medical record for each standard of care. They proceeded with the peer review process and made a few changes that they felt were

meaningful. First, they discovered that the process was one that required time to be done correctly. The reviews needed to be done for the entire unit over a year's time. Second, they wanted to go over the reviews, once complete, with the RN being reviewed. The USGC felt a face-to-face review was essential for individual RN professional growth and improved quality of care.

One difficulty the RNs had with the process was that they were unsure of how the items they were reviewing applied to the standards of care. Assistance was given in this area and a checklist was developed with each standard as a heading with various items under the headings that applied to the standard.

The pilot was going well and then the downturn in the economy hit affecting the hospital with decreased Medicaid reimbursement and a mounting deficit. Nurses were laid off, services curtailed, and all expenditures scrutinized for savings. The peer review process was stopped due to the extra time (approximately 24 hours a month) needed for the nurses to participate in the process.

At this point, a cost analysis (Appendix D) was performed to determine the cost of the peer review process. To determine the approximate cost of the process Unit A nursing unit was used as the example. The unit had 23 RNs employed with 5 of them as 1.0 full time equivalent (FTE) and 18 at 0.9 FTE. For those nurses employed at 0.9 FTE, fractional overtime would not be incurred for participating in the peer review process. Those nurses employed as 1.0 FTE would incur fractional overtime for participation. Given this information time estimates were calculated based upon pilot unit staff nurse input. The resulting cost of the original procedure would be $6,552.00 to $9,408.00 annually or $546.00 to $748.00 monthly, depending on the amount of time spent by the

nurses. With this figure used as an average cost per nursing unit, the overall hospital wide cost could run over $150,000.00 annually. Cost neutral or cost effective alternatives had to be developed if the peer review process was to continue. The analysis was sent to the CNO and a meeting was scheduled to discuss alternatives.

Originally, the unit shared governance council had a council member and the reviewers meeting with the reviewed nurse post review. They felt very strongly that the face to face post review was necessary for optimal outcomes. Larson and Herrick (1996) discussed a similar process that had worked well with peer review, so that part of the process was to be salvaged if possible. The original process, as described above, resulted in a great deal of fractional overtime, duplicated work in the form of MR audit, and had the possibility of biasing the reviewers. A revised process based upon tying the standards to the Joint Commission mandatory medical record (MR) audit was developed and implemented. A streamlined post review debriefing was initiated using one shared governance council member and no reviewers. This resulted in substantial savings and reviewer anonymity allowing the project to move forward with decreased possibility of reviewer bias.

Revised Peer Review Process

The final revised process (Figure 4) met the criteria of the pilot nurses, the CBU, HR, CNO, and the Magnet Steering Committee. The Unit Shared Governance Council (USGC) initiates the peer review process by selecting a nurse for review. Once the nurse is selected, the USGC chooses two reviewers and the nurse to be reviewed chooses one reviewer. The three review nurses perform their regulatory MR audit by entering required data into an online database. Simultaneously, when they determine that the nurse

to be peer reviewed was involved in the required MR audit data, they evaluate the nurse under the appropriate standard of care. To assist with the process, the peer review tool was updated to refer to the MR audit questions under the appropriate standard of care. Once the MR audit and peer review are complete, the process continues in two tracts: one reflecting what happens to the MR audit data and one showing what happens with the peer review data. The two tracts eventually merge with feedback to the USGC.

Medical record audit track.

Once the MR audits are completed by the three nurse reviewers, the information is automatically entered in the PI database. PI accumulates the data and summarizes it in a report that is returned to the Unit Manager. The Unit Manager shares the report with the USGC who then determines unit priorities for improvement based upon the data. The USGC collaborates with the unit staff nurses for input and evidence-based research on the topic is conducted as needed. From this process a PI plan is developed and implemented. Through continuous MR audits, improvement can be tracked and alternate plans for improvement developed if needed. Overall, this process puts the staff in charge of improving nursing performance on their own nursing unit. It holds them accountable for the care delivered as evidenced by the data from the MR audits.

Peer review data tract.

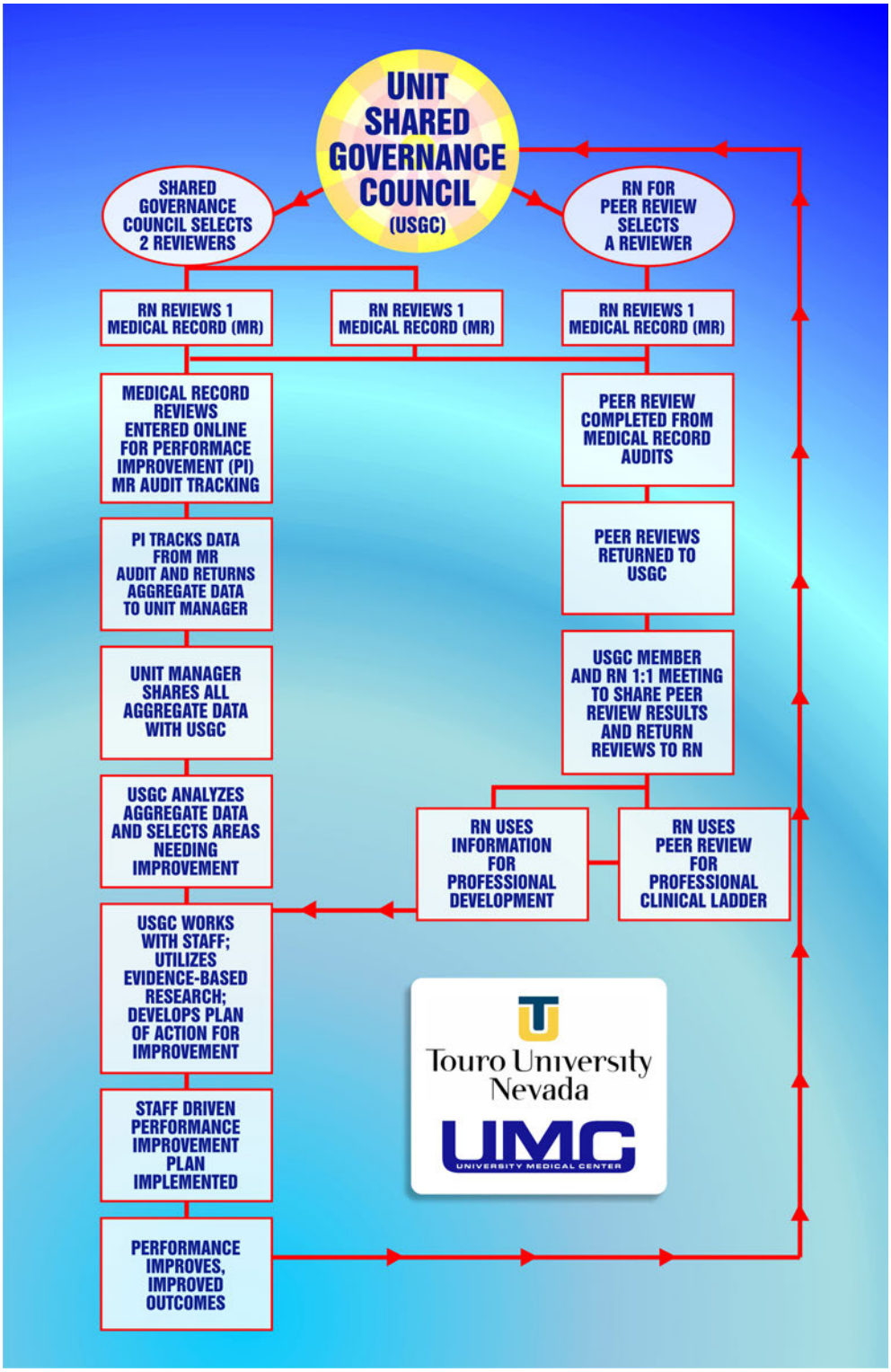
Once the three nurse reviewers complete the peer review based on the MR audit, the reviews are returned to the USGC. The USGC selects a member to meet with the staff nurse being reviewed and a meeting time is arranged. At the face to face meeting, the peer reviews are discussed as a means to assist the staff nurse in improving professional performance. The reviews are then given to the staff nurse; no copies are

made or kept on file by the USGC or management. The reviewed nurse can use the reviews for the facility's clinical ladder which requires two peer reviews as part of the criteria of completion and for individual professional growth.

Uniting the tracks.

The Peer Review Tract joins the MR Audit Track when the reviewed nurse's input is given to the USGC regarding unit PI planning. This process allows the individual staff nurse to actively participate in the quality improvement process by understanding the unit's performance challenges and by having input into maintaining and improving the standards of practice. Once the process is complete by implementing the PI plan, the data are monitored through future MR audits, thus allowing the USGC to analyze the unit's performance and continued needs for improvement.

Figure 4: Brann Peer Review Process Algorithm



Used with permission (Brann, 2009).

Staff Re-education

With the process revised, a new challenge surfaced after discussion of the revisions with the staff. The staff nurses did not know how to perform the MR audits. There was one nurse on the pilot units that routinely performed all MR audits using the online reporting system. The staff had abdicated their responsibility to one nurse who gladly performed the MR audits as part of her duties. This practice not only unfairly burdened the one staff RN, but was unacceptable from the standpoint that it circumvented a professional responsibility of all RNs being involved in the quality process (ANA, 1988) and did not result in enough MR audits being performed. To answer the challenge the staff nurses were educated in the process and a tracking system was put into place to monitor nurse participation. Once the nurses felt comfortable performing MR audits, the peer review process was added to be completed concurrently with the MR audit.

Data Collection

The National Database of Nursing Quality Indicators (NDNQI) was utilized to measure the perception of quality of care delivered once peer review had been piloted. The data collected was then taken from the annual NDNQI RN Survey with Practice Environment Scale.

NDNQI is a repository for nurse sensitive indicators and it is the only repository with nursing data collected at a nursing unit level (ANA, 2009). The nurse sensitive indicators "reflect the structure, process, and outcomes of nursing care" (ANA, 2009). Montalvo (2007) stated that the annual RN Survey data could be used to evaluate the work environment of nurses and to improve patient outcomes. The database enables researchers to identify elements that can influence patient outcomes. "Structures and

processes and observed nursing outcomes can help facilities improve patient outcomes" by identifying correlations among the elements (p.10).

The NDNQI was established in 1998 by ANA and is managed at the University of Kansas Medical Center (KUMC) School Of Nursing under contract with ANA. Indicators are developed by evaluating the evidence that an indicator is indeed nurse sensitive. There is ongoing monitoring and testing for validity and reliability (Montlavo, 2007).

The nurses were surveyed using the NDNQI RN Survey with Practice Environment Scale online via the hospital intranet. The data were collected by KUMC on behalf of the ANA and added to the national data base. The data, once analyzed, was sent back to the UMC in a final report. Data on the pilot units and other nursing units at the UMC could be gleaned from the report. The last two years, the survey had an 80%+ response rate from the UMC staff nurses. On Units A and B, prior to the pilot, the response rate had been 100%.

Chapter IV

Results

The demographics of the UMC nurses, in table one, were taken from the NDNQI 2009 report. The NDNQI report stated, for anonymity purposes, the demographics represented a composite of all RNs taking the survey at the UMC, not just the pilot units. Comparison data from other participating hospitals, although included in the NDNQI report, were not allowed to be published, so data from the latest published 2004 National RN Survey (HRSA, 2004) were used as a comparison for interest. Eligible RNs were either "full or part-time, regardless of title, who spend at least 50% of their time in direct patient care and have been employed a minimum of three months on their unit. Unit based PRN or per-diem nurses employed by the hospital were eligible; agency or contract nurses were not" (NDNQI, 2009a).

Table 1

NDNQI Demographic Characteristics Compared to National RN Survey

Demographic	**UMC (N=969)**	**2004Nationa RN Survey (N= 35,724)**
Gender		
Male %	90%	96%
Female %	10%	4%
Race		
White %	40%	84.9%
Asian %	45%	1.7%
African American %	3%	3.2%
Hispanic %	5%	1.2%
Average Age	46	46.8
Basic RN Education in USA %	60%	97%
Highest Level of Nursing Education %		
Diploma	8%	17.5%
ADN	31%	67.8%
BS	58%	34 %
MS/doctorate	3%	12.9%
Years in Practice %		
≤ 1 year	2%	*
>1 year	2%	*
>2years, ≤5 years	8%	*
>10 years	75%	*

NDNQI data used with permission (UMC, 2008 and 2009)
*No information available in HRSA 2004 National RN Survey

The data from NDNQI survey regarding the nurse's perception of quality of care were delivered electronically to the UMC as aggregate data. The use of aggregate data without the raw data necessitated the use of descriptive statistics in the form of percentage of improvement or lack of improvement (personal communication with Dr. Chrissie Grove, September 22 and 25, 2009). The aggregate data were broken down by unit, so that unit data could be used to compare to the previous year. Table two shows the change on the pilot units between 2008 and 2009 regarding perceived quality of care delivered.

Nurses rated questions concerning perceived quality of care on a Likert scale of one to four. One equaled a "poor" perception; two equaled a "fair" perception; three equaled a "good" perception; and four equaled an "excellent" perception; the higher the score, the more positive the rating (NDNQI, 2009a). The following questions were evaluated in this category:

1) "How would you describe the quality of nursing care for your unit on the last shift that you worked?" (NDNQI, 2009a).

2) "In general, how would you describe the quality of nursing care delivered to patients on your unit?" (NDNQI, 2009a).

The third question, "Overall, over the past year what has happened with the quality of patient care on your unit?" (NDNQI, 2009a) had options of "improved, remained the same, or deteriorated" (NDNQI, 2009a). A score of -1 equaled 'deteriorated; 0 equaled 'no change'; and +1 equaled 'improved'. A higher mean score indicates a more positive rating. The unit level data represents the mean score of all participating RNs on the unit (NDNQI, 2009a). The mean score for the questions along

with the mean change over the year was calculated by NDNQI (2008, 2009) and has been depicted in table two.

Table 2

NDNQI Perceived Quality of Care Delivered for 2008 and 2009

Unit	2008 mean questions 1&2	2009 mean questions 1&2	Mean Change in care over the year
Unit A	2.83	2.74	0.00
Unit B	2.77	3.0	-0.13

NDNQI data used with permission (UMC, 2008 and 2009)

The data suggests that perceived quality of care over the year after piloting the peer review process showed no change (0.00) on Unit A and some deterioration (-0.13) on Unit B. Unit A showed a 0.97% decrease (from a mean 2.83 to a mean of 2.74) in the response to the first two questions. Unit B showed an improvement in the response to the first two questions by 1.08% (from a mean of 2.77 to a mean of 3.0)

The implications of the results will be discussed in Chapter V. Many confounding variables could have influenced the results from the survey.

Chapter V

Discussion and Recommendations

Many factors may have influenced the outcome of this pilot study: the response rate of the nurses to the NDNQI survey was less than the previous year; not all nurses had the opportunity to participate in the peer review process; the pilot units' manager retired; the facility's financial problems; and discrepancies in the hours per patient day (HPPD). Further, the data as provided from the NDNQI has limitations regarding specific analysis.

Survey Response Rate

During 2008, 100% of the RNs on the pilot units responded to the NDNQI survey (NDNQI, 2008). In 2009, the response rate for Unit A was 86% and the response rate for Unit B was 89% (NDNQI, 2009b). Although the response rate is considered good for a survey, the difference in the response rate could have affected the unit's aggregate mean response to the questions in either a positive or negative manner.

Nurse Participation in the Peer Review Process

The pilot peer review process was in place for a couple of months and not all RNs had the opportunity to participate. The USGC discovered that the process was so involved that only two to four nurses could complete the process per month per unit. Therefore, the peer review process would be an ongoing process over the entire year. This had advantages since the process would be continuous and would become part of the unit culture. However, since all RNs had not had the opportunity to participate in the process prior to the NDNQI, the results may have been affected.

Change in Unit Manager

The unit manager who retired during the pilot was a well seasoned nurse manager with years of experience. She knew her staff well and was transformational in her leadership style. She was enthusiastic about the peer review pilot and encouraged the staff with the process. When she retired, she was replaced with a novice nurse manager. Due to her lack of previous leadership experience, the new manager was busy learning her duties and could not turn her attention to the pilot project. Despite the situation, the staff nurses persevered with the process until they were told to stop due to financial concerns. Unfortunately, the timing of the cessation of the project came approximately two months prior to the NDNQI survey and likely influenced the results.

Financial Constraints

During the same period, the facility was under financial stress from cuts to Medicaid and the increasing numbers of uninsured patients. In response to the financial situation, hospital services were cut, fractional overtime was curtailed, employees felt their jobs were in jeopardy, and HPPD were scrutinized. This resulted in the HPPD being decreased on the pilot units with resulting decreases in staffing by one RN on the day shift.

The combination and timing of the above factors may have had the effect of decreasing nurse satisfaction within the work environment. This could have lead to poor work attitudes with resulting less than optimal perceptions about being able to deliver the needed or desired quality of care. Other factors that could have affected the nurses' perceptions which were reflected on the NDNQI are documented in the table three below.

Other Nurse Satisfaction Factors

Table 3 gives rise to factors taken from the 2008 and 2009 NDNQI surveys that may have affected the outcomes of the perceived quality of care delivered with overall job enjoyment falling below the facility mean of 56.45. Increased hours worked, decreasing influence over their work schedule, and a high percentage of Unit B nurses floating outside of their competency were seen from 2008 to 2009. Could these be the reasons that 11% of nurses on Unit A and 19% of nurses on Unit B want to work on a different units in the same hospital (NDNQI, 2009)? These events have the potential of affecting the staff morale and their perception of the quality of care delivered.

Table 3

NDNQI Nurse Satisfaction Factors 2008 and 2009

	2008		2009	
	Unit A	**Unit B**	**Unit A**	**Unit B**
% Floating Outside Competency	not reported		0%	50%
% RNs Working Extra Hours - Short Staffed	26%	9%	37%	31%
Mean Rating of Influence Over Schedule 1=very little→5=very much	2.87	3.29	2.84	2.75
Overall Job Enjoyment Scale 40-60= moderate satisfaction	54.16	49.06	46.09	50.43

NDNQI data used with permission (UMC, 2008 and 2009)

Limitations to Interpretation of Findings

Two of the three questions indicating perceived quality of care delivered were scored based on a Likert scale ranging from one to four. Without the raw data to determine percentages indicated in each scaled item, the information as published may not reflect the true changes. Also, incremental differences (even if statistically significant) between the years' results may represent changes in nursing staff during the year as a result of retirement, resignation, transfer, new employment or to the change in response rate (personal communication with Dr. Richard Tandy, September 8, 2009; personal communication with Dr. Chrissie Grove, September 22, 2009). This makes the results very difficult to interpret as to whether a change is truly the result of adding the peer review process.

Plans for Facility Wide Roll Out

Although the NDNQI results were not improved, other results from the peer review process were identified as important enough to justify facility wide roll out. A plan for peer review roll out was drafted. Since the implementation of the pilot peer review process, the nursing staff have had input into the process to make improvements. This has led to *ownership* of the process with resulting *buy in*. The peer review process will be rolled out to all nursing units of the facility which will include: systematic implementation, facility wide intranet education; marketing the process; mentoring; and continuing evaluation.

Rolling out a new process to multiple nursing units (over 25) needs to be accomplished systematically. Since the process began as a pilot on two medical-surgical units, facility wide roll out could be started on the remaining medical-surgical units. This

would give the USGC of the piloted units the ability to answer questions arising from implementation on the new units. Once the medical surgical units are on board, the critical care units and specialty care units can be added. It is anticipated that the facility wide implementation of the process would be able to be accomplished within a six month period. Troubleshooting can be accomplished through using the USGC of the piloted units, clinical instructors, and nursing leaders as resources.

The education of thousands of RNs facility wide, while on a tight budget, would be best accomplished through the hospital's intranet. Each RN has a webpage that is password protected where they complete annual competencies. The peer review general education can be uploaded to the site for the RNs to complete. New RNs to the facility can complete the education during their hospital and nursing orientation program. Once the RNs have their basic education, the facilities RN clinical instructors and USGC members can be resources and mentors for the process. The instructors and USGC members will be given detailed education about the process prior to roll out.

Marketing the process will be accomplished through the facilities intranet homepage and Magnet site as well as professional posters aimed at peaking interest. RNs can be linked to their intranet page to complete the education. The clinical instructors, nursing leaders, and USGC members can all assist in marketing by dialoging about the new process and encouraging the staff.

During the facility wide roll out, concurrent evaluation and troubleshooting will need to take place. This requires nursing leadership to be available as resources and to be involved with the staff as they transition to a more empowered role. Clinical instructors and other nurse leaders can determine if the roll out has been successful by the numbers

of reviews done per month and by reviewing the unit performance improvement data. Staff suggestions to improve the process can be handled through the shared governance councils. Changes are limited to keeping the process in congruence with the standards of practice.

The new process, once implemented, will take most nursing units a year to complete all of the RN peer reviews. Evaluation of the units' progress can be appraised quarterly by reviewing the unit's PI and peer review trends. Annually, the NDNQI results for improvement in the perceived quality of care category can be evaluated for changes. As nurse empowerment and accountability for practice grow, it is foreseeable that perceived quality of care will progress and that nurse job enjoyment and retention will improve as well.

Nurse Feedback

The peer review process was started on the pilot units with some positive changes noted almost immediately. Some of the nurses volunteered commentary that they discovered ways to improve their performance in emergent situations. This could mean immediate returns in the area of patient rescue. The nurse who had been involved in medical record audits for years noted that there was increased compliance in documentation required by regulatory agencies (e.g. restraints). The USGC members became aware of trends in the unit's performance. They discovered areas that could improve the quality of care through increased patient safety and streamlining care. Their results are documented in table four (personal communication with Ben Gaither, September 25, 2009).

Table 4

USGC Documentation of Peer Review Trends

Standard	Findings
All standards	Legibility key needs increased compliance.
All standards	Medication reconciliation delayed on night shift.
Assessment	Admission nursing assessment delayed on weekends until Monday morning.
Assessment	Social services input lacking on weekends.
Diagnosis	Lack of continuity between RNs on nursing diagnoses.
Diagnosis	Diagnosis delayed if consults from other healthcare providers needed.
Expected Outcomes	Delay in documentation of expected outcomes with patients experiencing financial, homeless, or undocumented situations.
Planning	Interdisciplinary team approach lacking in care documentation.
Implementation	Difficulty obtaining family support of plan.
Evaluation	Evaluation notes lacking by other healthcare disciplines.
Professionalism	Maintaining HIPAA compliance.

Used with permission (UMC, 2009)

It is interesting to note the significant findings of the USGC over a couple of month's time. All of the findings have significance for nursing. Many of the findings could lend themselves to evidence-based research to determine problem significance and solutions. Some of the findings indicate interdisciplinary issues which can be addressed at larger multidisciplinary councils. This has the possibility of improving communication and collaboration among healthcare professionals by allowing others to see the significant contributions from each discipline and the interconnectedness of their processes.

From the list, the USGC can begin to prioritize and address the issues through staff nurse input. In this way, the ongoing peer review process allows for continuing evaluation of the quality of care delivered with staff nurse accountability for practice. With increased accountability and input, the staff should become further empowered and autonomous; nurse perceived quality of care delivered should improve over time.

Future Research and Recommendations

The peer review tool was developed from the ANA standards of nursing practice. The tool was revised by adding MR audit items as indicators for standard compliance. The use of the MR audit items as indicators for meeting the standards needs to be tested for validity and reliability.

The peer review process needs more time to be established on the pilot units so that all RNs have had the opportunity to participate and complete the quality cycle with the USGC. It is anticipated that as the RNs become involved in the peer review/quality process and as they are empowered with the resources to improve their unit's performance, their perception of the quality of care delivered will improve.

Aside from the perception of quality of care, immediate insights into the care delivered can be gleaned on an ongoing basis from the MR audits and peer reviews. This allows the USGC and the staff to determine priorities on their unit and develop an action plan to improve deficiencies.

The study should be repeated once the peer review process has been in place long enough for all nurses to have had a chance to participate and the quality cycle has been actualized. Once the process has been established, the NDNQI perceived quality of care delivered data can be tracked for improvement. Other methods of tracking improvements could be obtained from internal PI data. Further research is needed to determine how the nurses view peer review specifically and if they believe the process has improved quality of care.

The process may reach further than nursing and may need to be considered by other allied health departments. The same process could be applied to other providers using their standards of practice.

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APPENDICES

Appendix A: Peer Review Tool

Standard of Care	Met	Not Met	Specific Comments
Assessment The RN collects comprehensive data pertinent to the patient's health or the situation. **Refers to**: Chart Audit - Initial Assessment - #s 2-24. Chart Audit - Invasive Procedure - #s 56-72. Refers to discharge plan - individualized with medical, social, cultural considerations; core measures if appropriate.) ***APNs** - Initiates and interprets diagnostic tests and procedures relevant to the patient's current status.			
Diagnosis The RN analyzes the assessment data to determine the diagnosis or issues. **Refers to**: Chart Audit - Initial Assessment - #s 2-24. Chart Audit - Care Plan - #s 25-35. Chart Audit - Invasive Procedure #s 68-72. Discharge plan - individualized with medical, social, cultural considerations; core measures if appropriate.)) ***APNs** - Systematically compares and contrasts clinical findings with normal and abnormal variations; utilizes complex data and information obtained during interview, physical exam and diagnostic procedures; assists staff in the development and competency in the diagnostic process.			

Standard of Care	Met	Not Met	Specific Comments
Planning The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes. **Refers to**: Chart Audit - Care Plan - #s 25-35. Chart Audit - Invasive Procedure #s 68-72. Discharge plan - individualized with medical, social, cultural considerations; core measures if appropriate.) ***APNs** - Identifies assessment, diagnostic strategies, ant therapeutic interventions that reflect the current evidence; selects or designs strategies to meet the needs of complex patients; includes synthesis of patient's values and beliefs regarding nursing/medicine within the plan.			
Implementation The RN implements the identified plan. A) Coordination of Care - the RN coordinates care delivery B) Health Teaching and Promotion - the RN employs strategies to promote health and a safe environment **Refers to**: Chart Audit - Initial Assessment - #s 2-24. Chart Audit - Care Plan - #s 25-55. Chart Audit - Invasive Procedure #s 56-72. Discharge plan - individualized with medical, social, cultural considerations; core measures if appropriate.)			

Standard of Care	Met	Not Met	Specific Comments
Evaluation The RN evaluates progress toward attainment of outcomes. **Refers to** : Chart Audit - Care Plan - #s 25-51. Chart Audit - Invasive Procedure #s 62,66, 68-70. Discharge plan - individualized with medical, social, cultural considerations; core measures if appropriate.) ***APNs** - Evaluates the accuracy of the diagnosis and effectiveness of the interventions; synthesizes the results of the evaluation to determine impact of the plan; and, uses the results of the evaluation analyses to make or recommend process or structural change.			
Professionalism The RN practices with compassion and respect for others (includes patients, families, and coworkers). **Practices with the patient as their primary concern.** **Presents themselves with professional appearance and responsible behavior.** This includes: participating in quality improvement; maintaining clinical competency; evaluation of own practice; contributing to the professional development of peers and colleagues; practicing according to the professional code of ethics; collaborating with others; consideration of utilization of resources; providing leadership with practice; integrating research into practice; advocacy; confidentiality; and identifying any conflicts of interest that may affect their practice (ANA, 2004). Further, this includes cleanliness and orderly appearance; timeliness; and being responsible for their behavior and professional practice (UMC Nursing Staff, 2009).			

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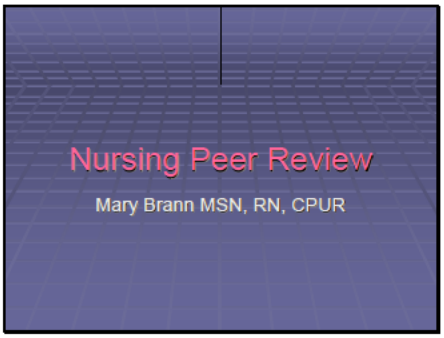
Appendix B: Peer Review Presentation

Slide 1



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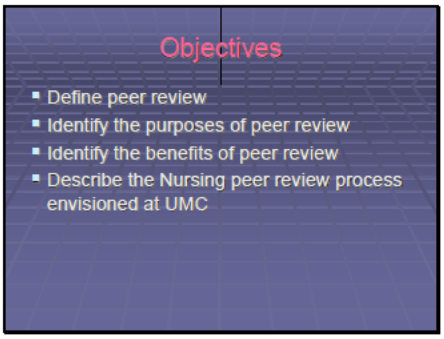

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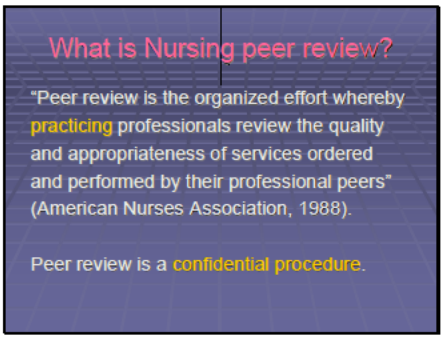


Slide 4

What is the purpose?

The primary focus of nursing peer review is the quality of nursing care.

Another purpose is to determine opportunities for improvement of nursing care.

Slide 5

The Quality Cycle

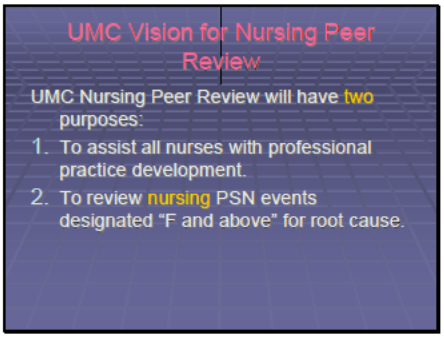
The following slide is a diagram of how nursing peer review can identify areas for improvement in nursing care. The needed improvements lead to research and education of best practices. This ultimately results in improved quality of care. The cycle repeats itself in our efforts to maintain high standards of practice at UMC.

Slide 6

Opportunity for Improvement

Slide 7

Slide 8



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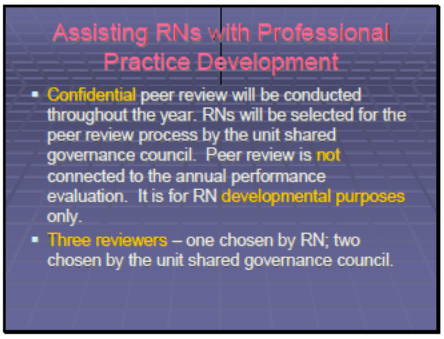

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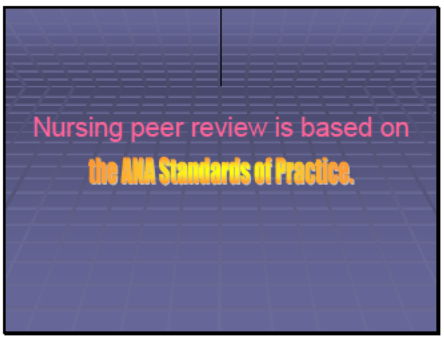

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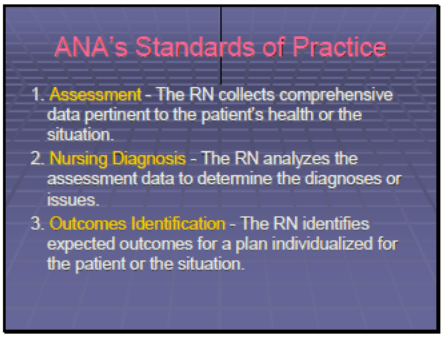

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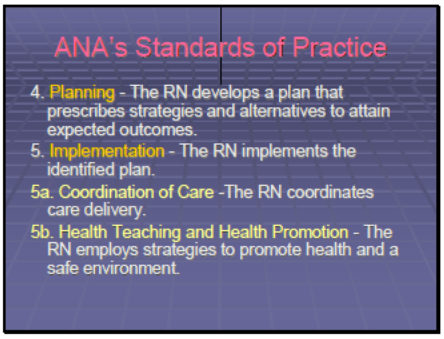

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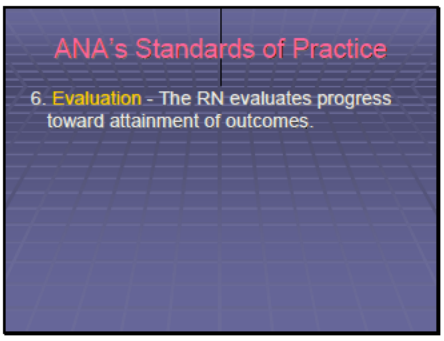

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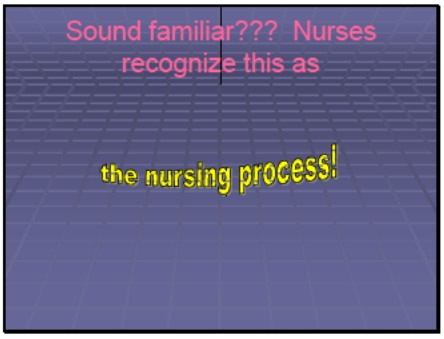

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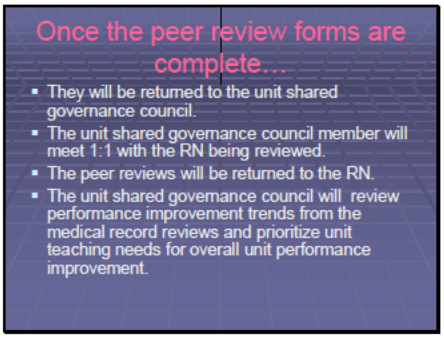

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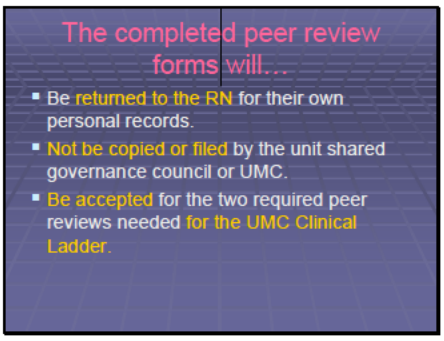

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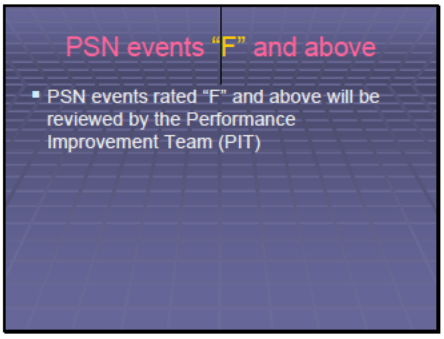

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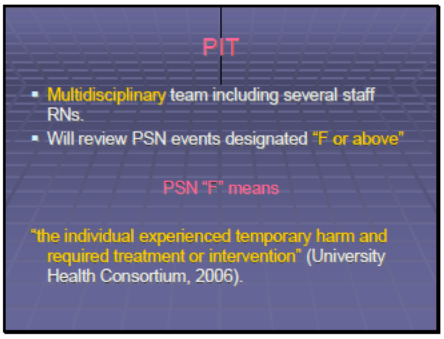

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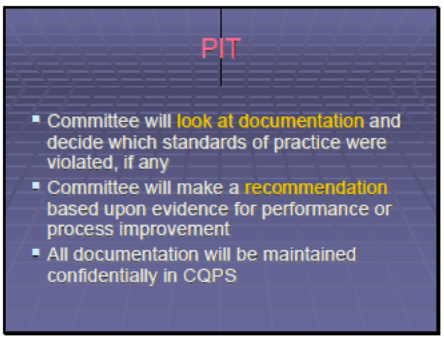

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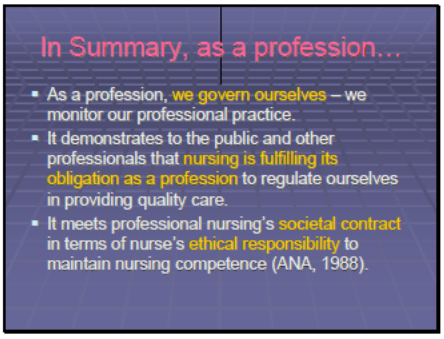

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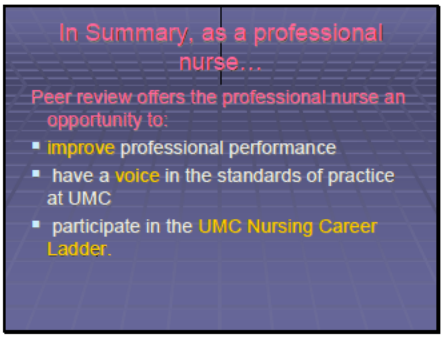

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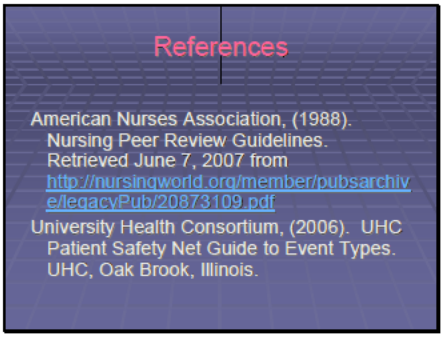
References
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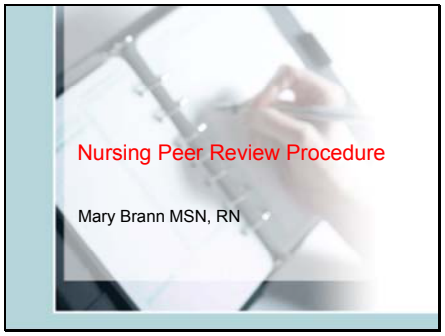
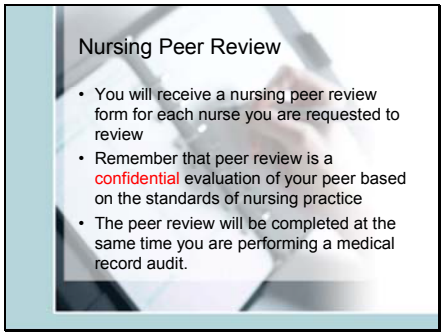
Appendix C: Peer Review Procedure Presentation





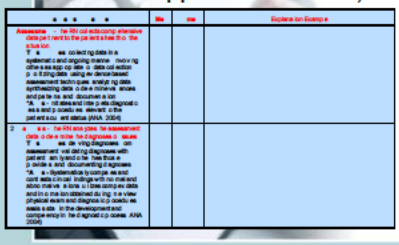
Nursing Peer Review

- When you are completing your medical record audit, check to see if the nurse you are reviewing was involved in the process being reviewed. If so, complete the appropriate standard on the peer review form.
- For each standard of practice, you will decide if the nurse you are reviewing meets the standard at least 90% of the time.

Nursing Peer Review

- If the standard is met, place a check mark in the “Met” square next to the standard.
- If the standard is not met, place a check mark in the “Unmet” square next to the standard. If you mark “Unmet” you must give a brief explanation under the “Explanation/Example” section.

Nursing Peer Review Form (note - all standards appear on the form)



Nursing Peer Review

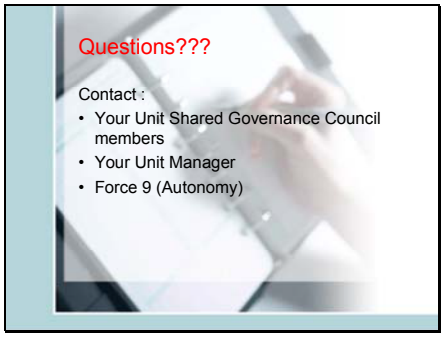
- Remember that all commentary should reflect how the nurse could improve practice to meet the standard. Give specific examples.
- Continue with this process of "Met/Unmet" until all standards are addressed.

Nursing Peer Review

- Return your completed peer reviews to your Unit Shared Governance Council representative.
- The areas for improvement will be tracked. No names will be attached to the items tracked.
- If trends are noted within the Unit, the Unit Shared Governance Council can develop process improvement.

Nursing Peer Review

- The forms will be returned to the nurse being reviewed. The nurse will keep the originals of the reviews for his/her own professional development. No copies will be made. Peer review is for the RN's professional development only.
- The peer reviews can be used by the nurse to meet requirements for the UMC Clinical Ladder.


Questions???
Contact :
• Your Unit Shared Governance Council members
• Your Unit Manager
• Force 9 (Autonomy)

Appendix D: Peer Review Cost Analysis

Peer review is an essential part of professions (Campbell, 2005). It is the way professionals maintain high standards of care and govern themselves. Further, in pursuit of Magnet accreditation, it is an essential process to assure autonomous practice which is found in the five model components of Magnet accreditation; without peer review for all nurses, accreditation is not possible (ANCC, 2005).

The peer review process as planned at UMC can be streamlined to contain the cost of implementation. Piloting of the project has been in progress for several months on Unit A and Unit B. As the nurses piloted the project, they developed the process to maximize its effectiveness and to assure professional growth of the RN staff.

Active Review Phase

When an RN is to be peer reviewed, the RN chooses one RN and the Shared Governance Council chooses the other two RNs to be reviewers; per the SEIU's request. That means that a total of three RNs will review each RN on the unit. With approximately 24 RNs on the unit, each RN would perform review approximately 8 times. The feedback from many RNs indicates that it is difficult for the reviewers to review a medical record and the RN during active work hours. The RN reviewers need approximately 30 minutes to 1 hour to do a thorough review. At this rate, the total cost would be $2,856.00 to $5,712.00 annually or $238.00 to $476.00 monthly. Please see the chart below.

Cost of RNs to Review RN for Peer Review

Unit A	Number of RNs (23 total)	Time allotted	FTE	Average salary/hr	Total per year
RN reviewing (5* doing 8 reviews each)	5x8=40	30 min. to 1 hr.	1.0	$42/hr (overtime)	$840 to $1,680
RN reviewing (18* doing 8 reviews each)	18x8=144	30 min. to 1 hr	0.9	$28/hr (regular pay)	$2,016 to $4,032
Total					**$2,856 to $5,712**

*Per the SEIU request, 3 RNs will review each RN being reviewed. One will be selected by the RN being reviewed and the other 2 will be assigned by the SG Council

Post Review Phase – Current Practice

With Unit A/B RN's development of the peer review process, all nurse reviewers (3), the nurse being reviewed, and one or two of the Unit Shared Governance council was meeting for approximately 15 – 30 minutes to review the peer reviews performed on the nurse being reviewed. The nurses respect the procedure and feel that it is essential to have this human connection in the process. Under this system, using 4North as an example, the cost can be estimated at $3,696.00 annually or $308.00 monthly. Added to the $2,856.00 to $5,712.00 annually or $238.00 to $476.00 monthly, the total cost using the current practice system would be $6,552.00 to $9,408.00 or $546.00 to $784.00 monthly. Please see the table below for the additional breakdown of costs.

Cost of RNs for Post-Peer Review Process – Current Practice

Unit A	Number of RNs (23 total)	Time allotted	FTE	Average salary/hr	Total per year
RN being reviewed	5	30 min.	1.0	$42/hr (overtime)	$105
RN being reviewed	18	30 min.	0.9	$28/hr (regular pay)	$252
RN reviewers needed (3/RN**)	5x8=40	30 min.	1.0	$42/hr (overtime)	$840
RN reviewers needed (3/RN**)	18x8=144	30 min.	0.9	$28/hr (regular pay)	$2,016
SG Council member***	1	30 min.	Figured at 1.0	$42/hr (overtime)	$483
Total					**$3,696**

**With 23 RNs on the unit needing to be reviewed, each RN would be involved in reviewing approximately 8 RNs.
***SG council members will be figured as overtime, since they may review more than one nurse at a time and it gives the worst case scenario.

Post Review Phase – Recommended Practice

The alternative that is being proposed requires a 1:1 meeting between the RN being reviewed and the Unit Shared Governance council representative. This would allow for the important face to face connection, keep the reviewers anonymous to prevent bias in reporting, and allow for discussion regarding professional development and improvement. This would cost $840.00 annually or $70.00 monthly. Added to the $2,856.00 to $5,712.00 annually or $238.00 to $476.00 monthly, the total cost using the recommended practice system would be $3,696.00 to $6,552.00 annually or $308.00 to $546.00 monthly. Using the recommended practice would save $2,856.00 annually or $238.00 monthly. Please see the table below for the additional breakdown of costs.

Cost of RNs for Post-Peer Review Process – Recommended Practice

Unit A	Number of RNs (23 total)	Time allotted	FTE	Average salary/hr	Total per year
RN being reviewed	5	30 min.	1.0	$42/hr (overtime)	$105
RN being reviewed	18	30 min.	0.9	$28/hr (regular pay)	$252
RN reviewers needed (3/RN**)	5x8=40	30 min.	1.0	$42/hr (overtime)	$0
RN reviewers needed (3/RN**)	18x8=144	30 min.	0.9	$28/hr (regular pay)	$0
SG Council member***	1	30 min.		$42/hr **(overtime)	$483
Total					**$840**

**With 23 RNs on the unit needing to be reviewed, each RN would be involved in reviewing approximately 8 RNs. ***SG council members will be figured as overtime, since they may review more than one nurse at a time and it gives the worst case scenario.

Conclusion

The cost of transforming a nursing staff into an autonomous, highly functioning group of professionals requires vision, a new way of looking at expenditures, and the

courage to move forward in new directions. Nursing peer review holds the promise of empowering the staff to monitor their own practice, uphold the standards of the profession, and improve the quality of care. The improved outcomes that should follow, although hard to document and assign a cost savings in dollars, should: improve nurse satisfaction, improve nurse perception of quality of care delivered; improve patient satisfaction and outcomes; and decrease length of stay and possible litigation. It is the recommendation that nursing peer review be implemented as planned and evaluated over the coming years as to its relevance and importance to the Department of Nursing.