Organizational Nurse Leaders: A Unique Cohort for Face-to-Face Peer Review

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Introduction

"There is only one corner of the universe you can be certain of improving, and that is your own self."

Aldous Leonard Huxley

The benefits of peer review are well documented. Although widely adopted for clinical nurses and advanced practice nurses, this process is not found to be effectively practiced by nurse leaders. Since 1994, there is only one published article describing a nurse leader peer review process and resultant outcomes.

American Nurses Association's peer review principles include a review that is:
1. performed by someone of the same rank (manager to manager; executive to executive)
2. practice-focused (role-specific competencies)
3. timely, routine, and continuous feedback
4. supportive of a continuous learning culture of best practice
5. not anonymous
6. feedback that incorporates the developmental stage of the nurse

Nursing peer review is often confused with annual and peer evaluations.
An annual evaluation is a managerial function, focusing on goal alignment with the organization. "Peer" evaluations contain peer feedback that is given to the nurse's supervisor. This peer feedback is summarized and delivered anonymously to the nurse during the annual evaluation with the supervisor. The annual evaluation is retrospective and does not allow for real-time practice assessments of the nurse's practice. This peer feedback method violates most of the principles of nursing peer review.

There is a need for all levels of nursing to participate in peer review. At our institution, we identified a deficiency in the organization's nurse leader peer review process during our Magnet® re-designation document writing. There was minimal nurse leader peer feedback, no strengths or opportunities for improvement were indicated, and the organization's process was not based on modern-day peer review principles. This prompted a re-evaluation of our nurse leader peer review process.

Peer review is an essential element that defines all professional disciplines – it is not optional for a practicing professional.

Objectives

1. Create a nurse leader peer review process meeting contemporary peer review principles.
2. Measure the effectiveness of peer review on nurse leader competencies and professional development activities.

Methods

A pilot project was conducted in a 451 bed, non-profit, acute care, Magnet® designated facility. A steering team was created to develop a structure and process to incorporate modern-day peer review principles for the pilot project and select a peer review tool.

The redesign of the structure and process began with a decision to move annual peer feedback to peer review occurring three times per year. The pilot project would have a pre- and a post-time period. There were two distinct groups: Nurse Executives (NE) and Nurse Managers (NM). Due to an insufficient number of Assistant Vice-presidents and Directors, they were combined together as NE based on similar core competencies. The peer review team (self and two peers) met face-to-face at each meeting. The peer review teams were assigned to avoid bias, with each group containing one peer in-division/service line and one peer outside-division/service line. Could peer review begin to develop relationships with individuals outside of their division/service line? Typically, relationships are fostered with peers in their division/service line. A peer could not report to the nurse leader under review, as was possible in the NE group.

The NE tool was adapted from the American Organization of Nurse Executives (AONE) Nurse Executive Competencies.© The tool had five subscales (communication, knowledge, leadership, professionalism, and business skills) equating to 176 core competencies. Feedback from the steering team unequivocally stated the original tool was tool long and unrealistic to complete. The team decided to adapt the tool to a user-friendly, shorter version, while identifying NE core competencies. The tool was reduced to 41 core competencies. All subscales remained in the adapted version. Based on the literature, a four point rating scale ranging from 4 (agree), 3 (slightly agree), 2 (slightly disagree), and 1 (disagree) was chosen for the tool. This eliminated a neutral category, since it was felt nurse leaders should be evaluated for each item.

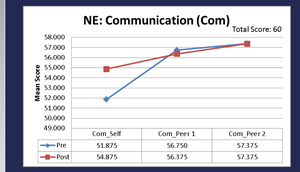
The NM tool was adapted from the AONE/American Association of Critical Care Nurses (AACN) Nurse Manager Skills Inventory.© The tool had three subscales (the science, the art, and the leader within) equating to 65 core competencies. As with the NE tool, the NM tool was shortened to 43 NM core competencies . All subscales remained in the adapted version. The four point rating scale used for the NE tool was used for the NM tool.

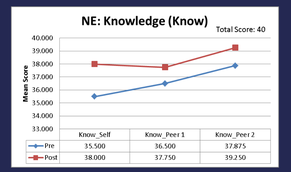
Twenty nurse leaders volunteered (8 NE and 12 NM) to participate in the pilot. A one hour educational session occurred for the volunteers by the project leader. Educational content included: aims of pilot project; review of the pilot peer review process; review of the competency tool and rating system. Dr. Jean Watson's caring theory was incorporated into each educational session. Peer review can invoke feelings of uneasiness. By framing nursing peer review within a caring environment, a foundation was created where nurses felt safe to give and receive feedback.

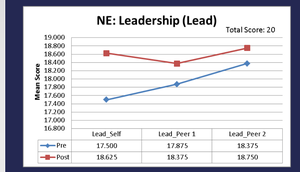
The pilot project occurred over four months. Each nurse leader was evaluated twice (pre/post). Prior to each meeting, the nurse leader under review completed the competency tool (self-appraisal) and emailed the completed tool to his/her assigned peers. A one hour face-to-face peer review meeting occurred (pre and post) to review the nurse leader's competency tool. At the meeting, there was discussion and dialogue regarding nurse leader achievement and rating of the core competencies. In addition, the nurse leader was to set achievable professional development goal(s) at the pre-meeting and discuss the achievement of the professional development goal(s) at the post meeting. The nurse leader then discussed the peer review feedback with their supervisor during their annual performance evaluation.

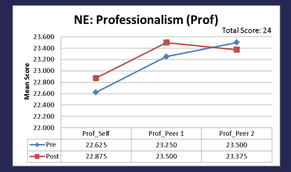
Postulates:
The nurse leader competency scores would improve from pre- to post-pilot.
The nurse leaders would achieve their professional development goals by the post-pilot meeting.

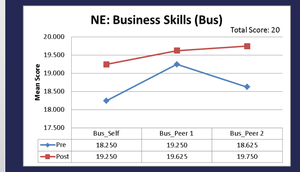
Results: Nurse Executives (NE)





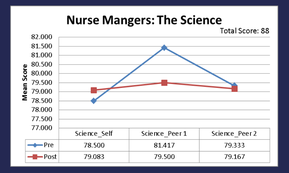


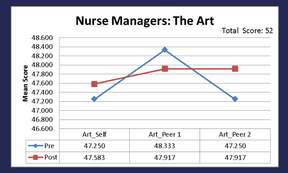


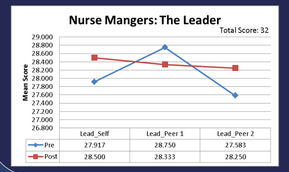


100% of Nurse Executives achieved their set professional goals by the end of 4 months.

Results: Nurse Managers







52% of Nurse Managers achieved their set professional goals by the end of 4 months.

Conclusions

Nurse leaders were evaluated by specialty-specific, core competency tools developed by national specialty organizations. The majority of NE and NM competencies improved from the pre- to post-session. There was more variability in the NM pre- to post-session scores. All of the NE achieved their selected professional goals and the majority of the NM achieved their selected professional goals from the pre- to post-session. Anecdotally, all nurse leaders verbalized that face-to-face peer review was superior to blinded peer review. The NM were particularly vocal to continue to assign peers in-division/service line and outside-division/service line.

Implications for Nurse Leaders

- Revise the organizations' nurse leader peer review process to incorporate modern-day peer review principles. Include the CNO in the NE group since the role-specific core competencies align with the NE core competencies.
- Assign peer review teams and ensure in-division/service line and outside-division/service line peers.
- The peer review teams are recommended to stay together for two years to develop relationships between peers.
- Continue with face-to-face meetings for the peer review teams.
- Create education for nurse leaders to increase comfort level to rate a peer with a lower than "agree or slightly agree" rating.
- Create opportunities to improve low-rated, individual core competencies and set professional goals for formal presentations, publications, and research.
- Develop succession planning for future peer review teams as nurse leaders are promoted, change roles, or leave the organization. Incorporate nurse leader developmental stages into the peer review process.

Current State

- A face-to-face peer review process has been expanded to all leaders who oversee areas where nursing is practiced.
- A face-to-face peer review process was expanded to nurses in advanced nursing roles (Advanced Practice Nurses, Clinical Practice Specialists, Clinical Resource Coordinators, Diabetic Educator, and Nurse Educators).
- Face-to-face meetings were continued for the peer review teams.
- The peer review team meetings were moved from three times to twice a year.
- Peer review teams continue to be assigned ensuring in-division/service line and outside-division/service line peers.

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