


BRIEF REPORT

Implementation and evaluation of a peer review process for advanced practice nurses in a university hospital setting

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Abstract

Background and purpose: Over the past decade, implementation of the peer review process for the development of the advanced practice nurse (APN) has been emphasized. However, little exists in the literature regarding APN peer review. The peer review process is intended to help demonstrate competency of care, enhance quality improvement measures, and foster the professional growth of the APN.

Methods: APNs serving on a professional governance council within a university teaching hospital developed a model of peer review for APNs. Nine months after the tool was implemented, an anonymous follow-up survey was conducted. A follow-up request was sent 4 weeks later to increase the number of respondents. Likert scales were used to elicit subjective data regarding the process.

Conclusions: Of 81 APNs who participated in the survey, more than half (52%) felt that the process would directly improve their professional practice.

Implications for practice: Survey results show that the peer review process affected APN professional practice positively. Additional research might include pathways for remediation and education of staff, evaluation of alternate methods to improve application to clinical practice, and collection of outcome data. The models presented provide a foundation for future refinement to accommodate different APN practice settings.

Background knowledge

The American Nurses Association (ANA, 1988) published its recommendations for peer review in nursing in 1988. Nearly 25 years later, peer review has yet to become formally and universally implemented in registered and advanced nursing practice. Numerous organizational and government reports have enumerated poor patient outcomes and demanded more stringent standards for demonstrating ongoing professional performance and competency (National Research Council, 2011). Implementing a process of peer review has been identified as a quality initiative in the literature (Briggs, Heath, & Kelley, 2005; Scarpa & Connelly, 2011) and at UC Davis Medical Center (UCDMC).

The Institute of Medicine (IOM) report underscores the need to broaden the scope of practice for nurses to ensure that they are practicing to their full potential. This directive is paired with the simultaneous need to create mechanisms that ensure quality (Holzemer, 2010). Development of a peer review process for advanced practice nurses (APNs) provides an avenue to help define practice standards, identify provider remediation needs, and ensure patient safety.

The hallmark of a true profession is the ability to self-regulate (Briggs et al., 2005). Peer review has been defined by the American Association of Critical-Care Nurses (AACN, 2012) as a “process by which professionals with similar knowledge, skills, and abilities judge the processes and/or outcomes of care.” This process has not only

been endorsed by the ANA, but is also a fundamental element for Magnet certification (Haag-Heitman & George, 2011). However, limited literature is available to guide APN providers in developing peer review processes specific to their areas of expertise.

Briggs et al. (2005) published their experience in developing peer review tools for the APN. Their paper highlights the lack of standards for peer review and numerous formats that must be considered when developing a peer review process. It was the opinion of the authors that peer review for the APN is complex and involves both subjective and objective assessment that may be at least partially dependent on the reviewers' expertise and familiarity with the individual's work and role expectations (Briggs et al., 2005). This also raises the inevitable specter of inter-rater reliability in peer review, which was a finding of Sheahan, Simpson, and Rayens (2001) who published their experience of retrospective medical record peer review. The authors examined the degree of medical record review congruence among NPs participating in a peer review process using a tool adapted by another author and revised to fit their needs. They found a low level of inter-rater congruence among NPs (Sheahan et al., 2001).

Because APNs often work in a specialty practice with few or no immediate peers, development of a peer review tool that meets the needs of all providers is problematic. It is not uncommon for an APN to be the sole provider of their type in any given healthcare delivery area. For purposes of peer review, APNs neither belong to the medical nor registered nursing staff. Locating a suitable peer reviewer who understands the complexities of highly specialized nursing care in these isolated settings creates practical challenges. Kenny, Baker, Lanzon, Stevens, and Yancy (2008) described formation of an APN peer review committee to ensure that APNs were involved in the process of reviewing an APN involved in a critical incident, where previously this was performed by the medical staff committee.

These issues are compounded by lack of clarity in the definition of peer review and confusion with performance review. Pfeiffer, Wickline, Deetz, and Berry (2012) examined a process for peer review among nurses using a validated questionnaire aimed at elucidating the perceived quality of professional communication and quality of care between nursing peers. Four themes emerged as barriers to peer review that include a lack of understanding of the process, fear of retribution stemming from the peer review process, cultural barriers, and a lack of regard for the peer reviewers' feedback.

George and Haig-Haitman (2011) emphasize that peer review should not be associated with managerial processes and should be transparent. They further recommend avoiding anonymous feedback since this can

be seen as an invitation to "gossip behind a colleagues' back." Branowicki, Driscoll, Hickey, Renaud, and Sporing (2011) cite the need for peer review to be evidence-based, nonpunitive, and confidential.

Rout and Roberts (2008) published a literature review of 91 peer review articles that focused on nursing or mid-wifery. The articles reviewed included an international sample of peer review strategies that ranged in goals from enhancing quality and educating staff, to a means of evaluating performance. Because the articles reviewed were heterogeneous, it is difficult to draw conclusions but some common themes emerged. In the setting of education and improving learning, peer review was viewed as positive with an increase in professionalism and reinforced learning. However, peer review studies that were focused on clinical performance were more likely to promote fear of repercussions. One key insight noted was that nurses often lack the formal training to provide effective feedback to their peers. Several recommendations were made to consider incorporating peer review training as a part of nursing education.

Finally, evaluation of changes in patient outcomes solely attributable to the utilization of peer review is absent in the literature. Given the complexity of factors affecting a provider's performance and competence, peer review, per se, cannot capture all the data necessary to evaluate a provider in this respect. As a tool, however, it is purported to foster a culture of learning, self-improvement, and professional growth (Scarpa & Connelly, 2011).

These studies reinforce the fact that there are challenges that arise in devising, implementing, and evaluating peer review processes. These challenges include a lack of standards both in practice and peer review implementation, location of suitable peers to participate in the process, confusion regarding professional interaction during the process, fear of retribution or data tracking into formal performance reviews, and lack of training on how to effectively review a peer. Despite these obstacles, there seems to be universal sentiment regarding the necessity of peer review. There are presently, however, few examples of its practical application in APN practice.

Local problem

UCDMC is a level one trauma center located in Northern California that services all areas east of San Francisco, west of Salt Lake City, south of Portland, and north of Los Angeles. The medical center and associated hospital-based clinics employ more than 100 APNs. Practice settings vary from family practice and specialty clinics to hospital-based practice. A professional governance council was established to enhance collaboration within the APN community and improve overall quality of care within the

hospital system. Peer review was targeted as a Magnet initiative, a quality improvement measure, and to help establish a mechanism for self-regulation for professional advanced nursing practice.

Intended improvement

Magnet certification is considered the national benchmark of excellence in nursing (Broom & Tilbury, 2007). The Magnet mandate for a nursing peer review process served as a major impetus for this project. As a Magnet facility, UCDCMC's patient care services set goals for the implementation of nursing peer review under the heading "Create a safe environment for patients and staff." As a result, the UCDCMC APN professional governance council was challenged with developing a peer review tool for all of the APNs at the medical center.

The intention of creating a peer review tool was three-fold. First, it would help align the practice of APNs with the goals of their respective professional organizations and those of the medical center. Second, as the implementation of peer review has been associated with quality improvement (QI; Briggs et al., 2005; Scarpa & Connelly, 2011), the process itself is aptly considered a QI measure. Third, it would satisfy a Magnet requirement for universal nursing peer review, which includes the APNs in the applicant facility.

Study questions

In developing the tools and process for peer review, there were three primary questions that became evident during the APN governance council roundtable discussions:

- (1) What are the components of peer review for APNs?
- (2) How can the process be implemented?
- (3) How is the efficacy or utility of peer review determined?

Ethical issues

Peer review implementation demands consideration of inherent ethical stumbling stones. Practical issues ranging from validity and inter-rater reliability are contrasted with the potential for unintended psychological and emotional effects on participants. Patient confidentiality and provider accountability for practice decisions are incidental and vitally important to address.

In the day-to-day work setting, strong personal relationships are often developed between coworkers and are apt to influence the review, either positively or negatively. An overly positive review given by colleagues that are friendly

to each other undermines the validity of the review and is of little benefit to either participant. An overly negative review also undermines its validity and creates the potential for emotional distress on the part of the reviewed. Fear of retribution and other consequences as a result of a negative review can be of concern for both participants and inhibit sincere feedback.

This was, in part, demonstrated by Pfeiffer et al. (2012) in a study of RN-to-RN peer review. Respondents' expressed concern over the perceived lack of respect and professionalism from colleagues, as well as difficulty in the offering of "constructive criticism." Sargeant, Mann, and Ferrier (2005) used focus groups to look at responses to performance feedback for the purpose of practice improvement. The study found that feedback by coworkers that was perceived as negative "evoked emotional responses, including anger and discouragement," and participants were not likely to use the feedback to change their practice.

Walker and Joines (2004) in "A Guide to Peer Appraisal," offered guidance for the peer review process and outlined certain skills and attributes they deemed necessary for a successful encounter. They suggested honesty, as well as the ability to give and receive feedback necessary for the process (Walker & Joines, 2004).

Other pitfalls stem from information access and usage during the process. Potential exists for inappropriate data gathering to occur from peer review. These may be misused for staff development, performance evaluation, or become part of a permanent employee record. Through the process of peer review, evaluators may also gain access to medical records or other protected patient information that he or she would not have otherwise. This has the potential to violate patient confidentiality and expose the institution and provider to litigation.

Finally, the issue of provider accountability must also be considered. There exists in peer review the potential for discovery of poor or hazardous practice habits. The identification of a poor outcome attributable to a provider in need of remedial intervention demands further action on the part of the participants. In light of the previous discussion, however, it is clear that this needs to be addressed professionally and discretely.

Setting

The UCDCMC APN professional governance council is composed of six nurse practitioners (NPs) from inpatient and outpatient settings, three clinical nurse specialists (CNSs), and three certified registered nurse anesthetists (CRNAs). The council represents approximately 72 NPs, 11 CNSs, and 24 CRNAs at hospital-wide nursing meetings.

With the exception of the CRNAs, who practice solely in perioperative service areas, there is wide variability in the practice settings of all the UCDCM APNs. These areas span the full spectrum of patient encounters from outpatient clinics, patient education, and critical care in the intensive care units. The council addressed this variability by developing formalized peer review tools to reflect the full range and specificity of APN practice at the medical center. To this end, a separate tool was formulated for each of the three groups by their respective members.

Planning the intervention

From their inception, the peer review processes devised by the council were framed with respect to the ethical concerns outlined earlier. The initial plans for implementation included development of guidelines and goals for the APN peer review process and, primarily, the nonpunitive nature of the process.

This resulted in a packet that accompanied the physical tool the APNs would use for the review. Appendix S1a–demonstrates “Guidelines for Peer Review,” a “Peer Review Confidentiality Agreement,” and a “Completion of Peer Review” form which were created by APN governance council members. The guidelines underscored the confidential, professional, and collegial intent of the encounter. The agreement was to be signed by both participants and cited the importance of appropriate and limited use of patient information. It also specified the absolute confidentiality of the review, with the limited exception of perceived unsafe practice habits, for which a specific avenue is provided as discussed next.

The roles and qualifications of participants and the frequency of peer review were determined based on the ANA (1988) guidelines. These suggested that peer review for APNs should be completed by an APN within a similar specialty and level of experience, thus, physician input would be inappropriate. It was agreed that a peer review completion “at least yearly” for each provider would be needed to maintain momentum of the project.

Once it was determined what types of APNs would review each other, a peer review tool was developed by each subtype (CNS, CRNA, NP). The tools were formed by a synthesis of extant peer review methods employed at outside facilities, the ANA (1988) guidelines for peer review, the APN scope of practice as delineated by their respective professional governing bodies, the APN-specific job description at UCDCM, and input solicited from the APN’s colleagues relative to their specific area of practice.

The NP tool (see Appendix S1d) was developed by NPs and included 10 questions to assess the quality of history taking, consultation, documentation of progress notes, discharge, or transfer summary. CNS peer review was

determined by clinical nurse specialists and involves each CNS reviewing one patient case consultation with another CNS with similar experience utilizing an instrument that measures the CNS’s interventions in three spheres of influence (see Appendix S1e). The CRNA peer review was created by the CRNAs and consists of an anesthesia-specific peer review that was initiated at transfer (or relief) of assignment (see Appendix S1f). This review involves the care of the patient in which both providers have been involved.

The disposition and storage of documents generated from peer review was also considered. The committee determined that the peer review process would not be used as part of an APN performance evaluation or of any documentation for promotion. And so, it would be inappropriate to maintain records of the review. The physical review form was to be handed to the provider reviewed at the end of the encounter. However, a “Completion of Peer Review” form which simply documented participation in an annual peer review would instead be placed in the employment file. This form contained no other information regarding the actual review. This would maintain the confidentiality of the review and yet provide documentation that the employee is actively involved in the process.

If there were cases where the reviewer felt an APN’s practice patterns were unsafe, it was determined by the council that the reviewer would recommend mentoring or further training within the APN specialty subtype and notify both the APN and the APN’s supervisor. APN supervisors at this facility could be another APN or an attending physician on the service in which the APN works. Without specific documentation of a perceived provider deficit, the supervisor could review the records and determine if follow-up was warranted. It was felt that in this way, the APN could receive any remediation required in a manner that was nonpunitive while at the same time improve quality of patient care rendered within the facility.

As a result of this process, the council agreed to work toward an orientation for newly hired APNs. This entails working with nursing education to formalize aspects of the APN orientation process to prepare and educate new hires for participation in peer review. This separate project is currently underway.

Evaluation of the intervention

The peer review tools were a fusion of clinical and professional evaluation items that were honed to address the branch of practice for the APN groups to which they were distributed. A signed confidentiality agreement and a guide underscoring the collegial and nonpunitive intent of the review immediately preceded the encounter. An identifiable colleague of similar training and practice background, and not management, performed the encounter.

The review document that was generated was delivered physically into the hands of the person reviewed and did not become a part of their employment file.

A follow-up survey was designed by the APN council to determine the perceived utility of and gather opinions about the peer review process. The questions were developed in roundtable discussion at the council meetings and were chosen to gather simple subjective data that could be used to help make any improvements in the process. Nine months after peer review implementation, the survey was issued to all UCDCM APNs to solicit their opinion of the Peer Review Process. APN providers received an e-mail request with a link to a nine-question online survey. A follow-up request was sent 4 weeks later to increase the number of respondents. The survey consisted of the following questions:

- (1) Did you participate in peer review in the past 12 months?
- (2) What format was your peer review?
- (3) I am likely to consider changes to my practice as a result of my peer review.
- (4) My participation in peer review was important for the development of my professional practice.
- (5) My participation in peer review was important for the development of my peer.
- (6) I think the format for my peer review was the most helpful in providing feedback about my practice in a useful and constructive manner.
- (7) I felt comfortable providing feedback and giving constructive criticism to my peer.
- (8) I felt confident my reviewer would keep the process confidential and in no way would this be punitive.
- (9) If you think there is another form of peer review, which would be more meaningful.

With the exceptions of questions 1, 2, 8, and 9, all of the questions were answerable using a Likert scale. The Likert scale responses available were as follows: "Strongly agree," "Agree," "Neutral," "Disagree," and "Strongly Disagree." Question 1 had a "Yes or No" answer option. Question 2 had a three choice answer option for "Chart Review," "Case Presentation," or "Hand Off." Question 8 had a "True or False" answer option. Question 9 was only answerable by a free text option. For the data listed, survey data were obtained using the percentage of responses per question; no other statistical data were derived.

Eighty-one APNs in total participated in the survey. Some questions were skipped by individuals. The number of respondents and the respective percentages for each of the questions below was reported as follows.

The APN respondent type (i.e., NP, CRNA, or CNS) was inferred from the format of peer review performed, which was specific to the APN role. Sixty-seven respondents

indicated their peer review format. This represented 37 NPs for a 55% response rate; 9 CNSs for a 13% response rate; and 21 CRNAs for a 31% response rate to this question.

Sixty-two of the total APN respondents reported that they had completed the peer review process within the present year. This represents 76% of the total respondent pool.

Seventy-two APNs responded to the question addressing peer review utility. Thirty-seven or 52% felt that the process was important for the development of their professional practice.

Seventy-one APNs responded to the question regarding peer review utility for their colleagues. Thirty-three or 47% felt that the peer review process would be beneficial to their peer, 24 or 33% were neutral, and 14 or less than 20% felt there would not be a benefit.

Seventy-two APNs responded to the question regarding their comfort level for participating in peer review. Fifty-three or 73% felt comfortable providing constructive feedback to a colleague, 15 or 21% were neutral, and only 4% or 5% felt uncomfortable providing feedback.

Seventy-two APNs responded to the question regarding confidentiality and punitive concerns. Sixty-seven of the respondents or 93% reported that they found the process to be nonpunitive and felt that their practice information would be kept confidential.

Responses to question 9 varied from case presentation to hand-off type review. There were also a few responses that indicated peer review was not meaningful to the individual because of difficulty in finding a reviewer. One commented on not using the word "criticism" as this takes on a negative connotation and peer review should be viewed as more positive. There were no instances identified during this peer review period in which a reviewer felt an APN's practice was unsafe or that mentoring or further training was necessary. However, at the end of the peer review process, the APN council determined that a process would need to be put in place for future mentoring or training of APNs' practice patterns that were deemed unsafe.

Conclusion

The survey results seem to suggest that our staff felt comfortable providing direct feedback to their colleagues and that they felt that the peer review process was important to the development of their professional practice.

These major components of our peer review process were largely derived from the literature cited in this article. The authors of these studies seem to emphasize that when these ethical and pragmatic considerations were either addressed or lacking from peer review, the process

was, respectively, received as positively or negatively. The former apparently supported the results of our survey.

The problem of locating a suitable peer reviewer was unresolved for a few individuals practicing in remote areas of the medical center. The council is working on a manner in which using information technology can help facilitate an interaction with other providers for peer review. Other APN councils in large facilities such as UCDCMC will likely encounter this same problem for some of their colleagues. Ensuring that APNs of similar background and practice can connect for this process is important in order to uphold the standards and spirit of the ANA (1988) guidelines. The problem of how to provide additional mentoring and education to APNs with unsafe practice was identified and has become a future goal of the APN council.

This project and subsequent evaluation were undertaken as a quality improvement measure. It was only recognized after the conclusion of the survey as having merit suitable for publication. For these reasons, our project did not include formal testing of the survey materials for reliability. Internal validity was confirmed by the multidisciplinary panel of the APNs serving on the council who devised and reviewed the survey questions both together and with their colleagues. The survey was designed to gather necessarily qualitative and subjective data with the intent for review by the council in order to enhance the peer review process for the APNs within the facility.

Outcomes measurement is perhaps an inappropriate endpoint for evaluating peer review as it seems impossible to isolate it as a single variable. But if developing professionalism and continued learning among APNs is a desirable and worthy goal, there is already sufficient data to suggest its value.

As a result of the wide variation of peer review experiences cited in this article, including our own, as well as the different APN practice environments and backgrounds, it would be useful for APNs to share peer review best practices in a more formal setting on a regular basis, such as at regional or national APN conferences and meetings.

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Supporting Information

Additional supporting information may be found in the online version of this article at the publisher's web-site:

- Appendix S1a**
- Appendix S1b**
- Appendix S1c**
- Appendix S1d**
- Appendix S1e**
- Appendix S1f**