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Perception is Everything: Implementation of a Peer Evaluation Program for Nurse Leaders in a Hospital Setting

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This Manuscript Partially Fulfills the Requirements for the

Doctor of Nursing Practice Program and is Approved by:

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March 23, 2022

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Perception is Everything: Implementation of a Peer Evaluation Program for Nurse Leaders in a Hospital Setting

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Abstract

Practice Problem: A hospital in the Sacramento County area seeking the ANCC Pathway to Excellence Program® designation determined upon performing a gap analysis that Element of Performance 2.8, a peer evaluation program, was absent, thus creating a deficiency in the fulfillment of the requirements for the designation.

PICOT: The PICOT question that guided this project was: In nurse leaders (P) how does the development of a formal peer evaluation process (I) compared to no formal process (C), influence the performance outcome score of self-efficacy (O) over 8 weeks (T)?

Evidence: The evidence demonstrated that if a peer evaluation process is implemented among nurse leaders and the outcome is measured using a pre- and post-survey, it can affect self-efficacy scores of those nurse leaders.

Intervention: A formal peer evaluation program for nurse leaders was developed to include a pre- and post-survey tool measuring self-efficacy. Post implmentating the facility policy was amended to include the peer evaluation process at the annual performance review.

Outcome: Nurse leader participants (*n* = 22 pre-survey, *n* = 16 post-survey) completed the new peer evaluation process including self-efficacy scoring. There was a noted increase in the post self-efficacy scores overall after the implementation of the peer evaluation process. Project results were not statistically significant but were clinically significant.

Conclusion: Project results replicated literature findings that implementing a peer evaluation process correlates to an increase in nurse leaders' self-efficacy scores. This program development, implementation, and policy amendment is beneficial to the hospital which will continue to move forward with obtaining the ANCC Pathway to Excellence Program® designation.

Perception is Everything: Implementation of a Peer Evaluation Program for Nurse Leaders in a Hospital Setting

"The Future of Nursing: Leading Change, Advancing Health", a report commissioned by the Institute of Medicine (2011) recognized nursing as an integral piece of the patient safety and quality care puzzle in the United States healthcare system. Strong leadership is the basis of establishing a healthy work environment through peer review and evaluation (Drobny et al., 2019). There is a need for improved nursing leadership by using peer review and evaluation programs to enhance self-perceptions, promote leadership support, and reduce nurse turnover in healthcare facilities (Drobny et al., 2019). Nursing peer review and evaluation should lead to systemic improvements and better outcomes within the work environment (Roux, 2020). Nursing professionals have a duty to utilize peer evaluation but are inconsistent in maintaining peer evaluation programs (Burchett & Spivak, 2014). The American Nurses Association (ANA)'s seminal work on the nursing peer review concept was introduced in 1988, however, recommendations from leading organizations focused on the improvement of safety and culture to implement such programs have not taken hold fully in all hospital-based professional practice areas. Literature as current as 2020 continues to highlight the role of implementation of nursing peer review as a steadfast marker in a culture of safety, yet standardized framework is lacking. ANA's advocacy for peer review more than three decades ago highlighted the continued focus that the nursing profession possessed the ability to self-regulate and to promote the best evidence-based practices

Nursing leaders must consider the nursing profession's complexities when implementing peer review and evaluation programs at the leadership level. The expectations are that nursing management will promote internal and external growth, enhance leadership skills, and reinforce the systemic structure (Drobny et al., 2019). However, it may be difficult for nurse leaders to

demonstrate professional competency because they often have limited interactions with their peers (Spiva et al., 2014). Further, peer review and evaluation for nursing leadership reveals variations and performance inadequacies. Nurse leaders should be able to build their knowledge base to cultivate management decision-making (Sevy Majers & Warshawsky, 2020). For decades, physicians have advanced their peer review and evaluation process, but nursing has been slow to embrace peer review in nursing leadership as imperative for quality of care (Bowen-Brady et al., 2019). Many nursing professionals do not have peer review and evaluation programs at their facilities (Whitney et al., 2016). The purposes of this project were to engage nurse leaders in a peer evaluation program, evaluate the change in self-efficacy of nurse leaders after implementation of a peer evaluation program, encourage leaders to provide support to each other during the process, and explore various opportunities for professional development in the future (Cisic & Frankovic, 2015; Whitney et al., 2016).

Significance of the Practice Problem

The American Nurse Association Code of Ethics indicates that nurses should develop, equip, and preserve the standards of practice using review tools, such as peer review, to enhance quality care for patients, families, and peers (Fowler, 2015). The ANA (1988) stated that peer review is a practice in which nurses evaluate and judge based upon their peers' professional acts with current professional standards. Although this was considered seminal work recent studies provide more specific recommendations on how peer evaluation can be effectively implemented in nursing (Bowen-Brady et al., 2019; Cisic & Frankovic, 2015; Roux, 2020; Whitney et al., 2016).

The literature utilizes the terms peer review and peer evaluation interchangeably, with the tendency of peer review to be more focused on outcomes and peer evaluation to be more focused on general performance standards. Regardless of the terminology, the purpose is to evaluate quality practice, improve professionalism, and identify strengths and weaknesses in practice that may elicit additional training for nurse leaders (Semper et al., 2016). Peer

evaluation enables nurse leaders to gain insight into their performance (Fowler, 2015). Implementing a peer evaluation program can increase self-fulfillment, thereby improving nurse leadership retention (Arthurs et al., 2018). Implementing a peer evaluation process could have a lasting impact on an organization's strategic plan and overall goals. Some facilities spend approximately $300,000 due to turnover per percentage points (Shaffer & Curtin, 2020). Some of the top reasons for increased turnover are lack of leadership skills and lack of confidence to provide mentorship and support to their staff (Bryant et al., 2015). Nurse leaders must receive feedback, so they know whether they are performing well in the work environment. Nurse leaders would use that constructive feedback to determine how much control they have over their work (perceived self-efficacy) and to identify how they can take proactive action to improve skills noted as deficient by their peers (Cisic & Frankovic, 2015).

The organization that served as the setting for this peer evaluation program was seeking the American Nurse Credentialing Center's (ANCC) Pathway to Excellence Program® designation, a program similar to ANCC Magnet Recognition Program®, but different as the focus for the ANCC Pathway to Excellence Program® recognizes the organization's culture of empowering and engaging staff with a sustained commitment for excellence, high staff satisfaction and retention, and quality outcomes. At the time of the gap analysis the organization had committed to the ANCC Pathway to Excellence Program® and the process to gaining this designation had begun.

Further discussion with departmental leaders and review and analysis of program requirements for achieving the ANCC Pathway to Excellence® designation, led to a gap analysis that was performed and led to strategic effort to develop a success plan. The needs assessment revealed that, although the organization had measuring tools in place to evaluate employee work performance, it lacked a way to measure self-efficacy and to evaluate the effectiveness and the efficiency of peer evaluation among the upper level of nursing leadership.

ANCC Pathway to Excellence Program® is a designation that recognizes healthcare organizations that create positive work environments for nurses to excel (2021). For a healthcare facility seeking and considering an application for ANCC Pathway to Excellence® designation (referred to as Pathway® throughout the remainder of the project), the organization must implement a peer evaluation program for nurses at various leadership levels (ANCC, 2021). To achieve Pathway® designation, a peer evaluation process for nursing leaders is a requirement as outlined in the ANCC 2020 Pathway to Excellence Practice Standards and Elements of Performance application manual. Element of performance (EOP) 2.8 a and b state

EOB 2.8

a. Describe how feedback from peers or direct reports staff is incorporated into the performance evaluation of nurses in leadership roles.

   AND

b. Provide documented evidence of a complete performance evaluation for a nurse in a leadership role that clearly identifies where feedback from peer(s) or direct report staff is included. (p. 15).

and at the time of the needs assessment, there was no program implemented at the organization satisfying EOP 2.8 prompting the urgent support towards the objectives of this project to develop and implement an evidence-based system change.

PICOT Question

After completion of the organization's internal gap analysis, the PICOT question that guided this project was: In nurse leaders (P) how does the development of a formal peer evaluation process (I) compared to no formal process (C), influence the performance outcome score of self-efficacy (O) over 8 weeks (T)?

Population

Nursing leaders perform a significant role in advancing high-quality care for the population they serve. With supportive guidance from Pathway® EOP 2.8 requirements, the

participants include nurse leaders with the designation of manager or higher, regardless of specialization, with an exclusion criteria of leaders in designated nurse leader roles with less than six months of leadership experience in the organization. Additional nurse leader roles excluded included clinical supervisors and charge nurses as their focus is clinical care versus advanced nurse leadership roles (Bryant et al., 2015; Gunawan et al., 2018).

Intervention

The intervention objective is to develop and implement an evidence-based practice peer evaluation program for designated nurse leaders that included scoring related to self-efficacy as a nurse leader.

Comparison

Comparison is two-fold. One, to compare the implementation of a formal nurse leader peer evaluation process including sustainability and acceptance to an informal nurse leader evaluation process; and two, to compare the self-efficacy of the nurse leaders evaluated through utilization of evidence-based practice tools and surveys before and after the implementation of the program. Although there was no set standard for comparing before and after self-efficacy levels, the understanding was to establish a baseline for the population, perform a pre and post-survey using an evidence-based practice tool, compare the data collected and disseminate findings to stakeholders (Bryant et al., 2015).

Outcome

The overarching outcome of this project is to fulfil the EOP 2.8 requirement of nursing leader peer evaluation program, however, for this specific project the desired outcome was measured by taking the average self-efficacy score before the implementation and the average self-efficacy score after and documenting if levels improved or reduced.

Time

Time management can be a challenge for evaluators. The expectation was to complete the project in eight weeks. Peer evaluation makes the process valuable, but change may take time. The average time before a change is noted is usually around 3 to 4 weeks after implementing a peer evaluation project (Pasila et al., 2017). It is reasonable to see a change in this amount of time. It is imperative to start early, use timelines, and focus on deadlines because a well-designed plan mitigates surprises at evaluation time.

Evidence-Based Practice Framework and Change Theory Framework

The framework model chosen for this evidence-based practice initiative was the Johns Hopkins Nursing EBP Model (JHNEBP) (Dang & Dearholt, 2017). The model's three components comprise the practice question, evidence, and translation. These components provided support for practice advancement. This theory was applied to this project in that healthcare organizations typically do not offer processes to support their nurses systematically for designing protocols and policies using scientific evidence. The JHNEBP framework helped to foster professional engagement, empower nurse accountability, and encourage the best nursing leadership practice.

Change occurs as a process, not an event. It considers the stages of change: the current, transition phase, and the future phase. This project was formulated using the Procsi ADKAR® change model. ADKAR is an acronym with five outcomes to achieve sustainable growth. The five components of the ADKAR model are:

A: Awareness for change

D: Desire to support the change

K: Knowledge of how to change

A: Ability to demonstrate skills and behavior

R: Reinforcement of the sustainability of the change (Hiatt, 2006; Wong et al., 2019)

Nurse leaders have a lasting impact on the process of change, but their lack of readiness and, at times, overall refusal to do so will affect their performance. Paying close attention to factors

that affect the five components of the ADKAR model can reveal strengths and weaknesses that affect nurse leaders' participation in implementing lasting change. Nursing leaders' adaptation to consistent change is an essential skill for survival and professional advancement in healthcare. Continuous change may lead to additional stress, but positive change benefits outweigh the risk and increase nursing leaders' productivity.

Evidence Search Strategy

To understand the evidence supporting this practice change, a thorough review of the literature using several electronic databases was completed. Databases utilized were PubMed, CINAHL, and Google Scholar, with a reference time range between 2010 and October 2020, with articles narrowed by English-only text. A broad search strategy was conducted with the general terms "nurse leaders" and "peer evaluation” and “peer review”. The key words utilized were expanded with elements of the PICO question included and Boolean operators were introduced. This resulted in the search string (In nursing leaders) AND [(how does the development of a peer evaluation process AND/OR peer evaluation)] OR compared to no peer evaluation) AND (influence the performance outcome source of self-efficacy) or (In nursing leaders) AND (peer evaluation program OR compared to no program) AND (what is the self-efficacy level of those nurse leaders, pre and post-peer evaluation) OR (performance review) OR (performance appraisal). Articles were limited to included English language, country, setting, and relevance. A comparison search included peer evaluation, absent peer evaluation programs, Magnet® recognition, and Pathway® designated peer evaluation programs. Outcomes examined were Magnet® recognition and Pathway® designation workforce, nurse satisfaction, employee empowerment, nurse leader retention, and nurse-sensitive indicators.

Evidence Search Results

The initial return utilizing the described search methods yielded 154 articles and further restricting using the specific indicator keywords such as peer evaluation, peer evaluation, and performance review, a total of 11 articles met search criteria (see Figure 1). Inclusion criteria

examined nurse satisfaction, achieving Pathway®, or Magnet® recognition items (see Appendix A). Excluded studies were focused on performance appraisal, committee-based, or assessment. The electronic databases provided the most effective method for providing the majority of the citations. Hand searching was the least effective method and yielded none of the sources.

All articles were appraised using the JHNEBP quality grade and level. Studies at Levels I, II, and III were included in the search, and studies at levels IV and V were eliminated for this review (Dang & Dearholt, 2017). This was due to the reviewed EBP-only focused material resulted in narrative reviews and other primary data, such as opinion pieces.

Studies at evidence level III are found to contain well-designed studies on peer evaluation with the majority of reviewed studies focused on Magnet® recognized facilities, Pathway® recognized facilities, or those seeking these designations. Research articles from peer-reviewed journals were in the majority of reviewed content, and the quality was deemed acceptable to use with evidence levels between one and three. Study focus included defining nurse leadership roles with specific leadership versus clinical focus. Further, additional studies examined the nurse's perception of peer evaluation (Burchett & Spivak, 2014; Christina et al., 2016; Kvist et al., 2019). In most cases, nurses accept the peer evaluation process but have reservations about the peer evaluation's performance review portion.

Themes With Practice Recommendations

After analysis and synthesis of the literature, the following three key themes emerged. These themes encompassed (a) peer evaluation information sessions; (b) pre-and post-assessments surveys, synthesis of disadvantages and advantages; and (c) using self-efficacy tools.

Purpose of Peer Evaluation

The purpose of peer evaluation was to evaluate quality practice, improve professionalism, and identify strengths and weaknesses in practice that may elicit additional training for nurse leaders (Bowen-Brady et al., 2019; Semper et al., 2016). Implementing a peer

evaluation process can have a lasting impact on an organization's strategic plan and overall goals. Nurse leaders should be able to build their knowledge base to cultivate management decision-making. Peer evaluation can create a culture that utilizes the best evidence for nurse leaders that deliver positive outcomes that support organizational success towards goals. Additional strategies can be cultivated to sustain nurse leaders' competence and appraise evidence-based practice at leadership levels (Bryant et al., 2015; Burchett & Spivak, 2014; Sevy Majers & Warshawsky, 2020). Further, Bowen-Brady et al. (2019) stated that nurses' obligation to practice meaningful peer evaluation is absent in most practices, supporting the need for greater opportunities for implementation.

Best-practices in Peer Evaluation Process

A pre-assessment survey prior to introducing the peer evaluation process was a recommended intervention for implementing a nurse leaders' peer evaluation process (Semper et al., 2016; Whitney et al., 2016). The pre-assessment is used as a baseline of perceptions, knowledge, and self-evaluations. For example, the pre-assessment self-efficacy tool evaluated the nurse leader's current belief in one's ability to improve skills related to constructive feedback on nurse leaders' perceived ability to do so (Cisic & Frankovic, 2015).

After the pre-assessment survey, a peer information session was recommended. The knowledge of the peer-review process and the perceptions about peer evaluation from nurses were adequately assessed. Minimal understanding of the process can have a detrimental impact on implementing a peer evaluation program (Bowen-Brady et al., 2019; Cisic & Frankovic, 2015; Whitney et al., 2016). Providing information sessions was one of the most commented interventions for implementing a peer evaluation program. (Bowen-Brady et al., 2019; Cisic & Frankovic, 2015; Rodriguez-Yu et al., 2020; Spiva et al., 2014; Whitney et al., 2016). During this phase, open dialogue regarding the purpose of peer evaluation, process steps for peer evaluation and participant expectations is key. The literature described the nurse leader participants perception of comfort level in providing and receiving peer feedback.

Perceived self-efficacy toward peer evaluation can negatively affect participants as participants may internalize constructive feedback and feel discouraged about their ability to perform duties. The study conducted by Semper et al. (2016) examined the nurse leader's perception of peer review. Further, that a negative perception of nurse leader peer review could be a barrier to honest surveys. Thus, recommending a peer review information session as an intervention.

The final phase is the post-assessment process, an integral piece supported in the literature. Most studies concluded that there were changes in post-assessments, and those nurse leaders learned about the benefit of constructive criticism. The evidence supports this to evaluate how the organization can assess if there are any changes noted to self-efficacy and has the implementation process worked (Burchett & Spivak, 2014; Cisic & Frankovic, 2015; Drobny et al., 2019; Karas-Irwin & Hoffmann, 2014; Roberts & Cronin, 2016; Rodriguez-Yu et al., 2020; Semper et al., 2016; Spiva et al., 2014; Whitney et al., 2016).

Nurse Leader Perception of Efficacy of Peer Evaluation Program

There are multiple studies that detail and support the implementation of a peer evaluation program for nursing leadership while examining nurse leaders' perceptions (Christina et al., 2016; Burchett & Spivak, 2014; Cisic & Frankovic, 2015; Drobny et al., 2019; Karas-Irwin & Hoffmann, 2014; Roberts & Cronin, 2016; Rodriguez-Yu et al., 2020; Semper et al., 2016; Spiva et al., 2014; Whitney et al., 2016). The most common themes in the literature were centered on professional development, nurse perception, and knowledge on the peer evaluation process and nurse leaders' hesitancy to accept and adopt the implementation of a peer evaluation program. Peer evaluation that promotes the advancement of nurse leaders should be considered. Feedback from peer evaluation should foster professional development and promote growth that empowers nurse leaders (Sikes et al., 2015). Peer evaluation empowers nurse leaders to view their performance more deeply. Frustration and constant dissatisfaction with duties were a common theme among nurse leaders.

The literature reported a positive perception towards peer evaluation for nurse leaders related to the ability to monitor nurse leadership performance and participate in self-evaluations. According to Whitney et al. (2016), 95% of surveyed nurse leaders agreed that their peer evaluation process positively impacted their overall accountability and 93% agreed their ability to move from novice to expert in their field was supported by this process. Proficient nurse leaders' competency and skills image can be established via peer evaluation, and the feedback provided from their peers allows them to make changes in their attitudes and self-efficacy (Whitney et al. 2016).

Difficulty arises when perception of the peer evaluation process exacerbates existing low self-efficacy related to specific skills such as effective communication, they are more likely to be challenged in robust participation in the peer-to-peer evaluation process through effective, honest self-evalution or peer feedback **(**Karas-Irwin, & Hoffmann, 2014). The study found that past unsuccessful peer evaluation participation may hinder a successful peer evaluation process. Fear of retaliation from peers was noted as another disadvantage to nursing leaders' peer evaluation (Roberts & Cronin, 2016; Spiva et al., 2014). However, Rodriguez-Yu et al. (2020) found that it may be more effective if nurses evaluate their peers anonymously. This study found a significantly increased response rate in feedback when leadership peer evaluations were conducted anonymously to eliminate the low response outcome.

Using Self-efficacy Tools

Self-efficacy is the strength of an individual's belief in their personal ability to respond and deal with various situations. For nurse leaders, measuring self-efficacy creates opportunities for increasing leadership capacity that enhances positive behavior and performance and is a determinant in nurse leadership's self-motivation (Cziraki et al., 2018; Hao et al., 2018; Murphy & Johnson, 2016). Self-efficacy tool results can provide additional mastery skills for nurse leadership (Cziraki et al., 2018). The utilization of validated self-efficacy tools proves the nurse leaders with a construct to evaluate their own practice and monitor for growth

over time. The literature suggests positive correlations between implementing a peer evaluation process for nurse leaders, professional development, and increased self-efficacy (Drobny et al.,2019; Rodriguez-Yu et al., 2020; Spiva et al., 2014). Spiva et al. conducted a peer review process where feedback presented common issues amongst nurse leaders who were non-compliant with policy structures and ineffective communication. The nurses gave their concerns for additional training in these areas. Over some time, the nurse leaders began to show confidence and increased their ability to perform on-the-job tasks aligned with communicating with peers and following facility policies. Thompson and George (2016) also used the General Self-Efficacy questionnaire to measure self-efficacy related to the ability to recognize and address bullying in nurses, a concern expressed when peer-evaluations are not annonymous.

Improved self-efficacy and professional development of nurse leaders supports the nurse leaders' experience to move beyond the frustration and dissatisfaction cycle which may exist in their work. Proficient nurse leaders' image can be established via peer evaluation and the feedback provided from their peers affords alternatives in nursing practice. Nurses at various work experience levels provide rich feedback for peer evaluation and are effective at achieving team collaboration, further supporting self-efficacy of the individual members of the team and the team itself. Peer evaluation develops a culture of feedback that advances nurse leadership development if it is a part of their daily work practices. A nurse's continual practice of peer evaluation can influence their performance and warrant positive behavioral change with acceptance and adoption of the purpose of a peer evaluation program (Christina et al., 2016). Interpersonal conflict needs to be mitigated for the successful implementation of a peer evaluation program. Peer evaluation allows for nurse leaders to view feedback as an everyday interaction in their practice environment.

Practice Recommendations

The practice recommendation to develop and implement a nurse leader peer evaluation program is supported by the evidence. This evidence-based peer evaluation program achieves

the organizational need identified in the gap analysis, and promotes growth and development of nurse leaders in practice. Utilizing concepts from the literature the peer evaluation program it measured nurse leader understanding of the program concepts, engagement, and self-efficacy through a validated self-efficacy tool, the General Self-Efficacy Scale.

Setting, Stakeholders, and Systems Change Setting

The project was implemented in a not-for-profit private community hospital located in the northwest United States. The hospital has 342 beds and approximately 2,000 clinical staff. Since its opening in 1925, the facility has added 284 inpatient beds and a 20-bed cardiovascular intensive care unit department, an 18-bed medical-surgical neurosurgical intensive care unit and a 20-bed emergency department.

Organizational Structure

The organization's nursing leadership structure consists of the chief nursing office (CNO), two senior directors, and six operational/clinical directors. Sixteen nurse managers report to the operational/clinical directors. The operational/clinical directors oversee the unit budgets, staff development, nurse manager operations and performance evaluations, organizational goals, and the hospital mission and values. The nurse managers direct the day-to-day operations of the department, the direct care staff for patient care, and provide support for patients and families.

To further understand the organization's current state a SWOT analysis was completed (see Appendix B). This assessment identified operational strengths including willingness to change, high level of experience in nursing leadership, and desire to achieve Pathway® designation. Concerns included the impact of COVID-19 pandemic on organizational resources, lack of experience with structured peer evaluations, and perception of retaliation or lack of trust from prior experiences.

Participants and Stakeholders

Participants in the peer-review program are nurse leaders ranked nurse manager or above. Within this population there exists a range of nursing education from associate to doctoral degrees, with a range of experience from five to 20 or more years. Eligible participants number 25 or more based on the organization's leadership structure and program eligibility (greater than six months within current role). This would be consistent with the literature reporting average leadership sample sizes of 14 to 40 eligible participants (Bryant et al., 2015; Christina et al., 2016; Lal, 2020). In addition to the participant stakeholders, indirect stakeholders include all downstream subordinates, and patients and their support persons, who will benefit from the nurse leaders growth and development through the peer evaluation and professional development opportunities. The engagement of the nurse leaders in a continuous professional improvement process fosters work environments that are conducive for learning and positivity, which affects patient satisfaction and nurse retention among frontline staff.

Organizational Need

Improving and advancing peer evaluation in nursing leadership was identified as an organization need through gap analysis in preparation for application for the Pathway® designation. A Pathway® program requirement is nurse leader peer evaluation. With support from the CNO and senior director for nursing, implementation of a formal peer evaluation process was approved. This support provided the sense of urgency required to effectively pursue the change and to support the change through implementation of an evidence-based scholarly change project.

Systems Change

This project was designed to create a systemic change that is sustainable throughout the organization. At the *micro* level, the leaders understood the peer evaluation process and gained additional insight into their perceived performance. The peer evaluation process promotes accountability thus providing a platform for nurse leaders to improve accountability. It encourages greater teamwork based on feedback to yield better operational, professional, and

clinical outcomes. The feedback that the nurse leaders receive from their peers strives to foster a culture for continuous learning and professional development. The non-anonymous feedback format selected for this change further creates a culture conducive to transparency, improved trust, and enhanced collaboration among peers. There is a potential for some leaders to be reluctant to participate in transparent feedback, yet it also provides opportunities for constructive, objective feedback through clear expectations on performance, behavior, and leadership styles.

At the *macro* level, the organization established systemic policies regarding peer evaluation. This structured approach to generating and receiving feedback determines the organization's strengths and weaknesses to facilitate change protocols, improve and empower nurse leaders, and increase professionalism (see Appendix C). This annual peer evaluation is now required for nurse leaders. In conjunction with the peer evaluation program a nursing peer evaluation committee was launched to consistently review, document, and change policies as needed.

Project Overview

In congruence with the organization’s operational vision, this project aimed to improve the inclusion, integrity, excellence, and collaboration of nurse leaders through a formal peer evaluation process. This effort further supported the organization in their desire for the Pathway® designation. The vision of this evidence-based practice peer evaluation program was developed to promote a learning culture focused on empowering and engaging staff with a sustained commitment for excellence, high staff satisfaction and retention, and quality outcomes. This project was developed utilizing a step-wise approach that included creating objectives, organizing and implementing a change plan, communicating progress, and operationalizing the program for sustainability. Ultimately, the final product satisfied the elements identified in Pathway®’s EOP 2.8.

Project Objectives

This evidence-based project analyzed the nurse leader self-efficacy levels implementation of a peer evaluation program for nurse leaders. More specifically, the project sought to address the following:

1.) To evaluate and amend the current evaluation policy for the performance of nursing leaders within the organization by April 2022.
2.) To appraise at least 25% of nurse leaders' self-efficacy levels in distributing constructive feedback before implementing a peer evaluation program by December 2021.
3.) To appraise at least 25% of nurse leaders' self-efficacy levels in providing constructive feedback after implementing a peer evaluation program by February 2022.
4.) To analyze the differences in at least 25% of nurse leaders' self-efficacy levels with the pre-and post-intervention periods with having a peer evaluation program versus not having one by March 2022.

Budget Summary

This project's budget was developed with the understanding of fixed and variable cost categories, such as administrative, project supplies, travel expenses, and nurse leader's salary reimbursement for time spent in information sessions. There are no grant funds warranted for this proposal. The project costs were shared, with the majority of the costs as fixed costs assumed buy the organization, such as administrative and nurse leader salary costs. Variable costs were shared with the project manager incurring minimal expense. Budget development is presented in Table 1.

Project Plan

A 90-day goal was established for the formal development, implementation, and evaluation of the evidence-based nurse leader peer evaluation program. The project plan was informed by the Prosci Adkar methodology’s five steps (Hiatt, 2006; Wong et al., 2019). Prior to

engagement of the nurse leaders, the executive stakeholders and project managers met to develop the peer evaluation policy statement for nurse leaders, which was the guidepost for the program (see Appendix C). The timing of this project was informed by the PICOT question of eight weeks for implementation following the development of the program which occurred in the four-weeks prior to implementation. The intervention for this evidence-based project was scheduled for eight weeks from November 2021 to January 2022 (see Figure 2), following the University of St. Augustine for Health Science Evidence-based Project Review Council validation of excmpt status received October 12, 2021, and facility Evidence-based Practice Project Review Committee approval for implementation received November 2, 2021.

Awareness for Change

The project plan began by identifying eligible participants for the nursing leader peer evaluation project. These participants included nurse leaders with the rank of nurse manager and above, as well as additional nurse educator participants. Following EPRC approval and the facility approval information regarding the purpose, timeline, and expectations were sent to participants. The information session's purpose was to discuss peer evaluation, its importance, and how it was developed. The information session provided a detailed explanation of duties and expectations of the nurse leaders as participants in the peer evaluation process.

Steps in this phase were:

1. Identified eligible participants (including Educators, CNO, Directors, and Managers)
2. Emailed information to the targeted group about a training session

Desire to Support the Change

Following the information session, all eligible leaders had the opportunity to accept or decline to participate in the initial review process. Those that accepted were given a unique identifier, a pre-assessment (self-efficacy) tool, written materials to include the presentation materials for additional review, the post-assessment (self-efficacy) tool, and contact information for additional questions.

Steps in this phase were:

1. Email invitations were sent to all eligible participants to attend one of three information sessions.
    a. Information sessions occurred via a virtual platform with visual aids to support knowledge exchange.
    b. Participation in this project was voluntary.
2. Prior to the presentation the presentation, the participants were asked to complete the General Self-Efficacy Scale (GSE) Pre-Assessment Tool (Appendix D).

Knowledge of How to Change

An organizational policy regarding performance evaluations in existence was amended to include peer-evaluations as a method of performance evaluation (see Appendix C). Reinforcement of the tenants of peer evaluation regarding collaboration, trust, transparancy, integrity, and professional conduct were emphasized as a method of decreasing resistance to change through proactively addressing concerns. Implementing a peer evaluation program of nurse leaders' performance is predicated on the organization's strengths and weaknesses to facilitate change protocols, improve and empower nurse leaders, and increase professionalism.

Steps in this phase were:

1. Reinforcement of the process for peer evaluation, the tools, techniques, and reference documents.
    a. The presentation included the project's purpose, the benefits of peer evaluation, and expectations about participating in peer evaluation.
    b. Participants were provided a copy of the 1988 American Nurses Association Peer- evaluation Guidelines, the Leadership Performance Review Policy, and a Peer-evaluation Assessment Tool (see Appendix E).

Ability to Demonstrate Skills and Behavior

Leadership practices for healthcare entities can have a substantial influence on outcomes for an organization and the population it serves. When information is clearly presented there exists a profound effect on the self-efficacy level in their satisfaction of their leadership skills. The GSE developed a tool to measure self-efficacy and additional tools were developed to meet the context of the facility. The project manager and executive stakeholders recognized a potential significant obstacle to the success of this process was adherence to deadlines for submissions.

Steps in this phase were:

1. Participants were asked to send the Peer Evaluation Tool to at least three peers of the participant's choice within one week of completing the training session.
2. Four weeks after completing the training session, a copy of the General Self-Efficacy Scale Post Assessment Tool (see Appendix D) was sent to all participants via email with a request to complete and return within one week of receipt.

Reinforcement of the Sustainabililty of the Change

Although there was no set standard for comparing before and after self-efficacy levels, the understanding of this initial peer evaluation process was to establish a baseline for the population, perform a pre- and post-survey using an evidence-based practice tool, compare the data collected and disseminate findings to stakeholders (Bryant et al., 2015).

Steps in this phase:

1. Follow-up emails and reminders were sent out at least once a week to encourage the completion of the survey tools.
2. Upon receipt the survey and assessment tool results were entered into a secure computerized software program for data analysis.
3. The results were evaluated and disseminated to internal stakeholders.

Evaluation Plan

Project Participants

Participant inclusion criteria were nurse leaders with rank of nurse manager or higher, with a 0.5 FTE (20 hours per week) or greater commitment, with role experience of greater than six months. Of the eligible participants exclusion from the peer evaluation process related to circumstantial concerns such as extended leave during the project period or declination of participation in the initial peer evaluation process. To determine participation, each eligible team member received an email invitation to the information session. In addition, participants received electronically an informational packet with background information and access to computer based survey tools or paper forms to complete the pre-and post-assessment of self-efficacy levels, peer evaluation tool, and demographic data sheet.

This project offered no risks for violation of the Health Insurance Portability and Accountability Act of 1996 as no protected health information was included. Participant agreement to complete the requested survey tools implied consent to participate. All surveys and assessments were stored electronically on a password-protected device. Personal information from participants was deidentified using their unique identifier on all surveys and assessment tools. The following three questions were used to assign their unique anonymous code:

1. What is the first letter of the high school you graduated from (e.g., Kennedy High = K)?
2. What is the first letter of your middle name (e.g., Dale = D; if you don't have a middle name, use "X")?
3. What is the last number of your home street address (e.g., 852 Main Street = 2)?

Potential Risks

Risks associated with this project are inherent risks to all peer evaluation programs. These risks include increased job-related stressors exhibited as anxiety or tension related to developing or receiving evaluation. Difficulty in clear communication, shared expectations, and perception of critical appraisal may influence ongoing workplace relationships through labeling

or loss of respect for peers, guilt for participating in the process, or loss of self-esteem for self-performance skills. While the literature supports peer evaluations that are well developed as fostering collegiality and teamwork, if poorly constructed mis-communication cues may have the opposite intended effect (Bryant et al., 2015)

Analysis of Data and Data Integrity

Data were entered in a statistical package for analysis by Intellectus Statistics (2021) and comparison by the project manager. In this evidence-based practice project, the pre-intervention mean score was compared to the post-intervention mean score of self-efficacy for each participant. Normality of the distribution of data was performed using the Shapiro-Wilk. Data were analyzed using a two-tailed paired t-test. A comparison was completed for each question area of focus and follow-up.

Clinical Significance

Clinical significance measures the magnitude of a relationship between the outcome (self-efficacy) and independent variables (nurse leaders) (Arthurs et al., 2018). A change in the pre- and post-assessment comparisons of the self-efficacy scores warranted a peer evaluation policy to be added to the current performance evaluation policy.

Post-evaluation indicators of clinical significance for this project include indirect measures of awareness of leadership style and advocacy which may lead to enhanced employee relationships and higher patient satisfaction. Additional latent indicators of clinical significance include nurse retention rates, cost avoidance for onboarding replacement nursing staff, and improved professional development. The essential component of accountability to leadership efficacy is present through self- and peer- promoted accountability. This fosters an environment of continuous improvement. Peer evaluation empowers nurse leaders by linking their performance to the promotion of higher practices and increased positive outcomes from constructive feedback (Lockett et al., 2015).

Results

Evaluation Design and Tools

The project design was a pre- and post-assessment of the participants' self-efficacy through the development and implementation of a peer evaluation program for nurse leaders. The tool for measuring self-efficacy was the General Self-Efficacy Scale (GSE) Pre/Post Assessment Tool. This tool contains 10 questions with a four-point Likert-type scale (see Appendix D). Approval to use the tool was secured from Freie Universität Berlin. The internal validity for the GSE was demonstrated using a Cronbach's alpha between .76 and .83 (Jerusalem & Schwarzer, 1992). The peer evaluation tool consisted of 14 questions with a four-point Likert-type scale, and the demographic data sheet was used for data analysis containing three questions (see Appendices E and F, respectively).

The self-efficacy assessment was administered in a qualitative form and later changed to reflect quantitative data to measure appropriately in the software. For example, answer choices "not at all" were changed to 1, and "moderately" were changed to 3, etc. Tools were administered online and data was downloaded and stored electronically on a password-protected device to limit and protect information. Data were entered in a statistical package for analysis and comparisons were made by the project manager.

After participants received feedback from their peers, each was advised to save their feedback onto their desktops for future reference. In this evidence-based practice project, the pre-intervention mean score was compared to the post-intervention mean score of self-efficacies for participants. The data collection was implemented after 22 (100%) of the nurse leaders were advised to send out the peer evaluation forms to their peers. The implementation period for this project was November 22, 2021 to January 10, 2022. During this period, 22 (100%) of the nurse leaders completed the pre-intervention survey, and 16 (72%) completed the post-intervention survey. Potential factors contributing to the attrition of participants include, but are not limited to, increased clinical requirements due to the COVID-19 pandemic, project schedule, and scheduled or unplanned leave requirements.

To preserve comparison integrity any pre- intervention surveys without paired post-intervention surveys were purged from the data analysis. The paired pre-and post-scores were entered into the Intelletecus Statistics software for analysis.

Project Results

Frequencies and percentages were calculated for demographic data. As shown in Table 2, The most frequently observed category of nursing experience was 11 years or more (*n* = 10, 62.50%), a master's degree in nursing appeared to be the most common level of education (*n* = 8, 50.00%) and peer evaluation competency rating of efficient and capable was most prevalent (*n* = 5, 31.25%). A two-tailed paired samples *t*-test was conducted to examine whether the mean difference of the GSE_Pre_Overall score and GSE_Post_Overall score was significantly different from zero. The result of the two-tailed paired samples *t*-test was not significant based on an alpha value of .05, $t(15) = -1.30$, $p = .214$, indicating the null hypothesis cannot be rejected. This finding suggests the difference in the mean of GSE_Pre_Overall score and the mean of GSE_Post_Overall score was not significantly different from zero. The results are presented in Table 3. A bar plot of the means is presented in Figure 3.

Table 2

Frequency Table for Nominal Variables

Variable	*n*	%
Nursing_Experience		
4-5 years	1	6.25
6-10 years	5	31.25
11 years or more	10	62.50
Missing	0	0.00
Education		
Bachelors Degree in Nursing	6	37.50
Masters degree in Nursing	8	50.00
PhD/DNP in Nursing	1	6.25
Non-Nursing Degree	1	6.25
Missing	0	0.00
Peer_Evaluation_Competency		

Novice(new to or inexperienced)	2	12.50
Advanced beginner (considerable experience)	2	12.50
Competent (efficient and capable)	5	31.25
Proficient (very skilled and experienced at something)	4	25.00
Expert (comprehensive knowledge of or skill in a particular area)	3	18.75
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Table 3

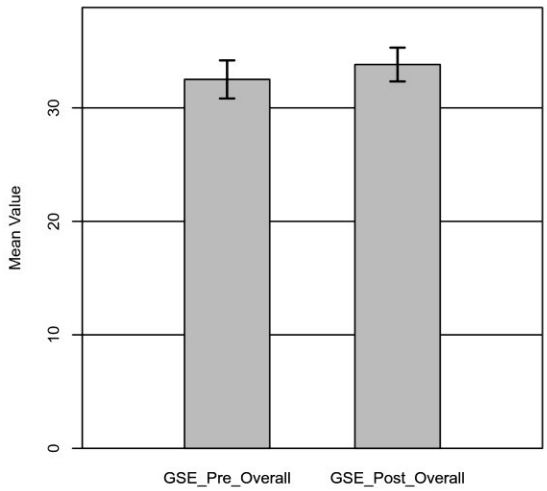
Two-Tailed Paired Samples t-Test for the Difference Between GSE_Pre_Overall and GSE_Post_Overall

GSE_Pre_Overall		GSE_Post_Overall				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
32.50	3.43	33.81	3.04	-1.30	.214	0.32

Note. N = 16. Degrees of Freedom for the *t*-statistic = 15. *d* represents Cohen's *d.*

Figure 3

GSE Pre and Post Assessment Comparison



Note. Mean values of the Pre- and Post- GSE evaluations with 95.00% CI indicator bars.

A Shapiro-Wilk test was conducted to determine whether the differences in GSE_Pre_Overall score and GSE_Post_Overall score could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were not significant based on an alpha value of .05, $W = 0.90$, $p = .084$. This result suggests the possibility that the differences in GSE_Pre_Overall score and GSE_Post_Overall score were produced by a normal distribution. The GSE scores indicated participants had average to high self-efficacy scores. There was a noted difference in pre- and post-survey results confirming the anticipated outcome of the development of a formal peer evaluation process influence the performance outcome score of self-efficacy for nurse leaders. Levene's test was conducted to assess whether the variances of GSE_Pre_Overall score and GSE_Post_Overall score were significantly different. The result of Levene's test was not significant based on an alpha value of .05, $F(1, 30) = 0.01$, $p = .925$. This result suggests it is possible that GSE_Pre_Overall score and GSE_Post_Overall score were produced by distributions with equal variances, indicating the assumption of homogeneity of variance was met.

Impact

This project aimed to develop and implement a peer evaluation process and instrument to evaluate the self-efficacy of nurse leaders for an organization seeking the Pathway® designation. After evaluating the before and after survey results, the implementation of a peer evaluation process was deemed successful towards increasing the self-efficacy scores of the nurse leaders. This is a vital finding for an organization seeking The Pathway® designation, as implementing a successful peer evaluation program is a requirement for this designation (ANCC, 2021).

The self-efficacy surveys should be administered annually around the nurse leaders' yearly performance evaluation. This is to be measured against pre-survey score benchmarks to investigate the sustainability and viability of the peer evaluation process. It would also be beneficial for Human Resources to include the peer evaluation process for onboarding new employees and hold nurse leaders responsible for the process. Leadership agrees to continue improving this process and offering additional educational and training opportunities to increase confidence levels.

A nurse leader’s continuous practice of peer evaluation can influence their performance and warrant positive behavioral change with the acceptance and adoption of a peer evaluation program (Christina et al., 2016). Further discussions with some nurse leaders found that their perceived ability to perform essential tasks was also judged comparably through the lenses of their counterparts. There were nurse leaders who agreed with their feedback, while others disagreed completely and felt there needed to be a more personal meeting with their peers to discuss the results.

Themes or trends from the self-efficacy surveys should be taken into consideration for leadership development opportunities. For example, there were a few nurses who scored low on coping skills at work. Professional development in mental health can be explored as a learning opportunity for nurse leaders. Nurse pods could be formed to share in-person feedback and

added to the peer evaluation process annually. Having an open and honest discussion about feedback will improve overall scores and increase comfortability with transparency amongst nurse leaders (Semper et al., 2016). In turn, the hospital can use this peer review process to hire skilled staff, retain current workers, and improve the work environment.

Limitations

There were two identified limitations of this project which could be addressed in future studies. First, the project had a fixed time constraints which may have lead to difficulty with coordination, communication, and engagement of participants. Due to the nature of the time constraints the project was initiated during a surge in SARS-CoV-2 infections and during the winter holiday leave cycle. This was a contributor to participant attrition. Second, due to the limitations of information exchange, the ability to adequately prepare for and create a organizational culture change without bias related to peer evaluations was lacking. Despite efforts participants had concerns with sending feedback as agreed to (missed deadlines) or receiving constructive feedback (desire for personal confrontation for “more information”). As this was the first iteration of this process, there was no comparison to prior peer evaluation processes.

To combat these limitations in the future an information campaign to include professional development could be constructed and delivered in the future. Additionally, completion of the peer evaluation will be made mandatory in the future. During internal dissemination barriers such as limited skills in providing honest feedback to peers and fear of retaliation was identified as a major barrier, and this is consistent with the literature (Karas-Irwin, & Hoffmann, 2014; Roberts & Cronin, 2016; Rodriguez-Yu et al., 2020; Spiva et al., 2014).

Dissemination

Internal organization dissemination of project findings to stakeholders occurred with the CNO, nurse leaders including participants, and nurse educators. The presentation and question and answer period with the project manager occurred virtually with a recorded session for

invitees who were unable to attend. During the presentation the opportunities for sustainability through professional development and policy requirements for participation were reinforced.

Additional dissemination occurred at the facility's Virtual Nursing Excellent Showcase highlighting employees' and students' evidence-based projects. The showcase audience consisted of a variety of nurse leaders, managers, supervisors, and other nursing specialty leaders within the organization's Northwestern region including leaders external to the facility.

The project manuscript will be archived in the Scholarship and Open Access Repository at the University of St. Augustine for Health Sciences (SOAR@USA). Scholarly dissemination will occur through an oral poster presentation at the DNP Scholarly Project Symposium sponsored by the Alpha Alpha Alpha Chapter of Sigma Theta Tau International Honor Society of Nursing.

Conclusion

In a healthcare organization, nursing leadership is vital and requires competency, knowledge, and continuous improvements through professional development to evoke workforce change. The development and implementation of an evidence-based nurse leader peer evaluation program supports the development of the nurse leader's self-efficacy in leadership competencies. Futher, the program closes the gap identified by the organization through development of a program that meets the requirements of the element of performance 2.8 in the the Pathway to Excellence Program®.

Through the structure of a nurse leader peer evaluation program, the leader experiences support to increase self- efficacy and fulfillment, thereby improving nurse leadership retention (Arthurs et al., 2018). Fostering a culture of feedback that is transparent offering insight to issues not otherwise relayed, built on trust, advances nurse leadership in daily practice. The program is designed to encourage change through empowering peers to accountable practice. This project met the overarching objective of designing a peer evaluation program or process

that encouraged open and pure dialogue exchange at a leadership level, and improved self-efficacy of the nurse leader.

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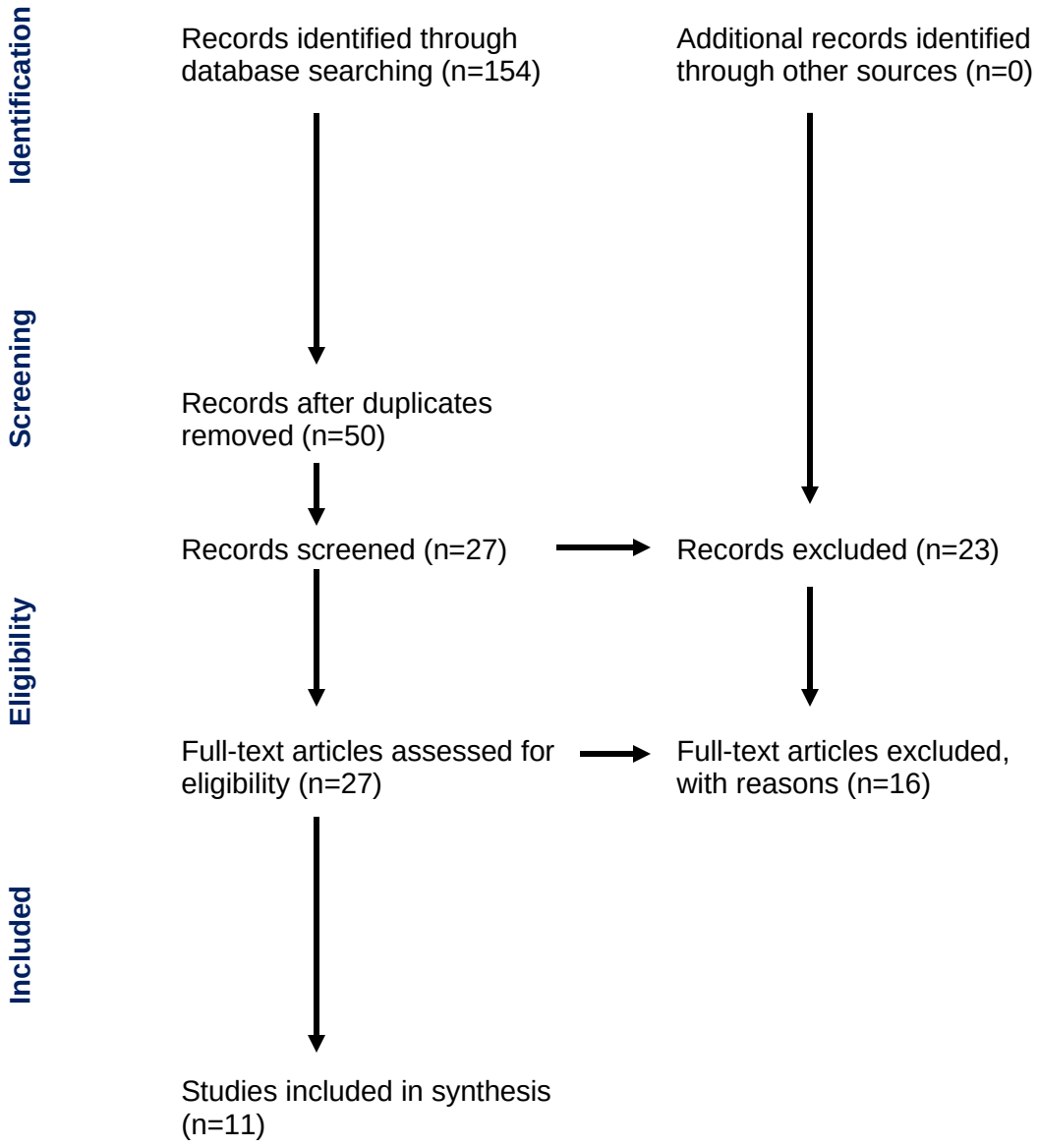
Table 1

Budget and Resources

Category	Expenses	Potential Cost
Project Manager (DNP student)	Gasoline at the government reimbursement rate of $0.59 cents per mile per day Time, which the DNP student will donate and which is estimated to be approximately 100 hours for monitoring during implementation, paper and electronic survey management, evaluation of the project, and dissemination of the project findings at the conclusion.	$150.00
Training Materials		$0.00
Salary and Benefits	Participants will be reimbursed $75.00 per hour, which will be paid for by the facility. Each participant will be reimbursed for two hours, and 20 to 25 participants will be included in the project.	$3,750.00
Project Supplies	Paper for the copy machine Notebooks to hold the packet of project information Pens/pencils PowerPoint Electronic survey tool	$100.00
Hospitality	Rooms will be used for peer evaluation information session, pre- and post-intervention survey, dissemination of information and as needed for follow up.	$0.00
Statistician	Average cost in the US at the 25th percentile is $54.00 per hour, and the project will require approximately three total hours of statistician time.	$162.00
Total Costs		$4,162.00

Figure 1

PRISMA Flowchart



Note. Prisma flow chart diagram from "Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement," by D. Moher, A. Liberati, J. Tetzlaff, & D.G. Altman, 2009, Annals of Internal Medicine, 151(4), p.267 (http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00135). Copyright 2009 by The American College of Physicians.

Figure 2

Gantt Chart Project Timeline

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022 and beyond
Submit to EPRC for approval/ submit to IRB (facility)								
Information session on peer evaluation/gain stakeholders								
Solidify participants/review packet information								
Implement project								
Evaluate/gather findings								
Disseminate findings to participants/stakeholders/ interested parties								
Sustain and spread								

Note. This figure demonstrates the cadence of the project from approval to sustainment.

Appendix A

Summary of Primary Research Evidence

Citation	Design, Level, Quality Grade	Sample, Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Arthurs, et al., 2018.	Level I Grade B	*N* = 43	Surv & int	JHEBP	Nur sat - The hos engaged employee opinion surveys; the transformation leaders helped raised the desire for change by rounding with their N Ldr.	• Initiated RN satisfaction surveys and conducted them annually • Supported ongoing support for a Nur Preceptor program • Implemented Peer fbk at all levels for nurs • Engaged nurs at all levels in patient satisfaction to improve hos experience
Burchett & Spivak, 2014.	Level II Grade B	*N* = 618	Surv & int	NIT	Increased staff knowledge about a peer evaluation program and its application into practice. Strategies were incorporated to build communication and peer accountability.	• Per staff fbk received from evaluation provided additional benefits of knowledge and helped with teamwork
Cisic & Frankovic, 2015.	Level 11 Grade C	A small number of participants	Peer Evaluation Tool	NIT	Implemented peer evaluation and self-evaluation. And compared to previous facility scores for their N Ldr	• Primary results differed with implementing PR process of the N Ldrs

Cziraki et al., 2018.	Level II Grade B	*N* = 727	Cross-sectional survey	NIT	Shows that nurs' ldr self-efficacy affects job performance	• Nurs' ldr self-efficacy influenced motivation to lead and affected ldr career
Christina et al., 2016.	Level III Grade A	*N* = 14	Semi structured int	NIT	Perceptions of staff. What were the primary perception of the nursing staff on fbk,. Personality, Timing, and relevance.	• Increased relevance of perception findings to staff, Acknowledge success
Bryant, et al., 2015.	Level IV Grade B	*N* = 31	Short questionnaires	Watson's theoretical model	Perspectives regarding peer as a concept. Building trust with openness and willingness to receive and give fbk	• Peers found that fbk or communication with peers was invaluable • And helped create meaningful relationships
Bowen-Brady et al., 2019.	Level 2 Grade A	*N* = 11	Focus group int	NIT	PR is a meaningful tool for professional growth. N Ldr reported fbk as a part of the annual goal	• Results validated the PR process at an organization level. • There were essential components of the PR process and ldr support for N Ldr
Drobny et al, 2015.	Level I Grade C	*N* = 21	Surv	EBP	To achieve honest fbk from their N Ldr and perceptions that are objective without bias. Problem due to a small rural area and close relationships may be challenging to achieve.	• Barriers included a limited number of N Ldr peers for the review process • Bias due to personal relationships between N Ldr, peers, and others

Kvist et al., 2019.	Level II Grade B	*N* = 17	Cross-sectional surv	Kohonen's self-organizing map	Does background of the RNs affect whether they would give positive or negative fbk during the process	• RNs evaluated their peer's qualities • Various backgrounds and characteristics affected evaluation amongst leaders
Whitney et al., 2016.	Level 3 Grade C	*N* = 85	Web-based surv	Conceptual Model for Staff Nurse Accountability and Autonomy	PR promotes the growth of prof for N Ldr	• Gaps in knowledge regarding N Ldr PR is noted • Fbk was an issue

Legend: emp = employee; fbk = feedback; hos = hospital; int = interview(s); JHEBP = Johns Hopkins Nursing Evidence-Based Practice; ldr = leadership; NIT = no identified theory; N Ldr = nurse leader(s); nur = nurse(s); Nur sat = nurse satisfaction; PDP = professional development program; PR = peer evaluation; prof = professionalism; RN= registered nurse(s); surv = survey

Appendix B

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
1. Staff is committed to participation 2. A similar program has been used in the past 3. Minimal time and resources needed to implement project 4. Experienced nurse leaders; no new graduates	1. Requires a level of commitment to timing and scheduling 2. Presence of COVID may delay results with altered employee schedules 3. Leadership participates on various boards 4. Participants don't understand benefits of peer evaluation	1. Improvement in nurse leader professionalism 2. Ultimately improve overall patient care and safety 3. Increase nurse retention 4. Advance onboarding process for new nurse leaders and recruitment strategy 5. Potential community awards for findings	1. Feedback may cause distrust amongst peers 2. Constructive feedback may not be received well 3. Fear of retaliation from peers 4. Possibility of creating a hostile environment 5. Unable to obtain pathways to excellence designation

Appendix C

Sample Performance Management Policy

SUBJECT: **Nursing Leadership Performance Review**

ASSOCIATED DOCUMENTS: HR policies: Performance Management Policy, Performance Management Procedure

DEPARTMENTS: Nursing

POLICY: [**Facility Name**] Nursing Department is committed to creating a foundation of collaboration among staff and supports a shared governance environment. As leadership champions within the organization, the Chief Nursing Officer, Directors, Managers and Educators are accessible and support direct care nurses. Nurse leaders are provided a role-specific orientation and leaders continuously strive to increase their core knowledge and role competency through leadership development activities along with feedback from their supervisor, peers, and nursing staff. These leadership strategies are intended to create a positive practice environment.

PROCEDURE:

A. Job performance is evaluated based on the following:
   - Established competencies
   - Established responsibilities/job duties and
   - Established goals as determined by the organization, manager and employee.
B. Annual performance is measured using the following evaluation scale:
   - *Significantly Exceeds Expectations*: Job performance is exceptional. Contributions are substantially higher than peers and advance the department or function. Applies initiative and delivers results. Always exceeds expected behaviors.
   - *Exceeds Expectations:* Job performance and initiative results are beyond expected level of achievement. Consistently performs above the norm and higher than peers. Frequently exceeds expected behaviors.
   - *Meets Expectations* (strong performance): Performance fully meets expectations and requirements. On occasion, may perform above expectations. Consistently demonstrates expected behaviors.
   - *Needs Improvement:* Performance meets some expectations and requirements and improvement is needed.
   - *Does Not Meet Minimum Expectations:* Performance is consistently below what is expected. Rarely demonstrates expected behaviors.
C. Leader (employee) responsibilities:
   - Abide by performance management policies, processes, and tools.
   - Seek clarification of uncertainties in duties and performance expectations.
   - Timely completion of required performance self-evaluation.
   - Timely request of required peer evaluation from 1-3 peers and submission of results to manager to incorporate into the annual performance review.
   - Acknowledge by written or electronic signature receipt of performance evaluation.
D. Manager responsibilities:
   - Ensure performance planning is in place for new or transitioning employees.

- Set clear performance expectations.
- Solicit employee performance feedback from peers or direct reports.
- Provide ongoing coaching as needed.
- Provide ongoing constructive performance feedback throughout the performance evaluation period.

References:

1. 2020 Pathway to Excellence Practice Standards and Elements of Performance. American Nurses Credentialing Center.
2. Haag-Heitman, B. & George, V. (2011). Peer review in nursing: Principles for successful practice. Sudbury, MA: Jones & Bartlett Publishers.

ORIGINATED: [DATE]

APPROVERS: [Suggested Committees]

Policy and Procedure Committee

Pharmacy & Therapeutics Committee

Medical Executive Committee

BOARD APPROVAL DATE:

Appendix D

Sample Image of the General Self-Efficacy Scale (GSE) Pre/Post Assessment Tool

Administration of The General Self-Efficacy Scale (GSE)

Participant ID _____ Date_____

The scale is self-administered, and consists of 10 items.
Time: It requires 4 minutes on average to complete.
Instructions: please circle the one best response based how you feel about **each** of the following10 statements.

I can always manage to solve difficult problems if I try hard enough.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

If someone opposes me, I can find the means and ways to get what I want.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

It is easy for me to stick to my aims and accomplish my goals.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

I am confident that I could deal efficiently with unexpected events.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

Thanks to my resourcefulness, I know how to handle unforeseen situations.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

I can solve most problems if I invest the necessary effort.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

I can remain calm when facing difficulties because I can rely on my coping abilities.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

When I am confronted with a problem, I can usually find several solutions.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

If I am in trouble, I can usually think of a solution.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

I can usually handle whatever comes my way.
1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

Note: Sample questions from the GSE Pre/Post Assessment tool. From “Generalized Self-Efficacy scale” by M. Jerusalem and R. Schwarzer, In J. Weinman, S. Wright, and M. Johnston, *Measures in Health Psychology: A User's Portfolio. Causal and Control Beliefs*, pp. 35-37. Copyright 1995 by Freie Universität Berlin. Used with permission.

Appendix E

Sample Peer Evaluation Assessment Tool

Evaluator: _____ Name of person being evaluated: _____ Key: 1=Does not meet expectations 2=Meets Expectations 3=Exceeds Expectations 4=Significantly Exceeds Expectations		
Building Partnerships & Teamwork		
1)	Identifying opportunities and taking action to build strategic relationships between one's area, teams, departments, units, or organizations to help achieve business goals. Resolves issues and problems, and makes significant contribution to team efforts	Score
Building Trust		
2)	Interacting with others in a way that gives them confidence in one's intentions and those of the organizations.	Score
Conflict Management		
3)	Understanding of how to anticipate, recognize and deal effectively with existing or potential conflicts at the individual, group, or situation level; ability to apply this understanding appropriately to diverse situations.	Score
Empowerment and Delegation		
4)	Sharing authority and responsibility with others to move decision making and accountability downward through the organization enabling individuals to stretch their capacities and accomplish the business unit's strategic priorities.	Score
Leading Through Mission, Vision & Values		
5)	Keeps the organization's mission, vision & values at the forefront of the associate decision making and action.	Score
Managing People, Projects and/or tasks		

6)	Manages collaboratively and coaches' others to achieve optimal performance, delegates effectively, praises/rewards contributions, defines clear roles and responsibilities, sets goals, and leads initiatives and adjust plans as necessary	Score
Patient/Customers Focus		
7)	Ensuring that the patients/customers perspective is a driving force behind our actions and business decision; crafting and implementing service practices that meet patients'/customers and own organization's needs (Focus' also includes internal and external customers.)	Score
Technical Competence		
8)	Demonstrates breadth and/or depth of professional/technical skills and capabilities required for position; shares knowledge; sets or contributes to the company's direction within area of expertise.	Score
Clinical performance improvement		
9)	Knowledge of the factors contributing to quality patient care, and the ability to influence these factors in a positive way	Score
Clinical policies and standards		
10)	Knowledge of all clinical standards and policies set for a healthcare environment; ability to use industry standards, policies, and procedures in the processes of clinical practice.	Score
Decision making and critical thinking		
11)	Knowledge of the decision-making process and associated tools and techniques; ability to accurately analyze situations and productive decisions based on informed judgement	Score
Healthcare business acumen		

12)	Knowledge, insight and understanding of business concepts, tools and processes that are needed for making sound decisions in the context of the company's business; ability to apply this knowledge appropriately in both clinical and non-clinical situations.	Score
Health policy and ethics compliance		
13)	Knowledge of healthcare policies for all clinical practices and applicable laws and regulations governing proper clinical practice; ability to demonstrate ethical behavior in diverse situations.	Score
Workforce diversity management		
14)	Understanding of the business value of diverse perspective and opinions and ability to understand, appreciate and employ the unique contributions of associations of varied cultures, nationalities, ethnic backgrounds, genders, ages, points of view, etc	Score

Appendix F

Demographic Data

Unique ID_____

Please select the following response that best describes you.

1). What is your highest level of Nursing Education?

- Licensed Vocational Nurse
- Associates/Diploma in Nursing
- Bachelors in Nursing
- Masters in Nursing
- PhD/DNP in nursing
- Non nursing degree _____

2). How many months/years of Nursing Experience would you say that you have?

- 6mo - 1 year
- 1 - 3 years
- 4-5 yrs
- 6-10 yrs
- 11 + yrs
- Other _____

3). As it relates to peer evaluation, what would you rate your experience level?

- Novice (new to or inexperienced)
- Advanced beginner (considerable experience)
- Competent (efficient and capable)
- Proficient (very skilled and experienced at something)
- Expert (comprehensive knowledge of or skill in a particular area)