

Pursuing Professionalism:

Peer Messengers - An Essential
Element to Creating a Safety Culture

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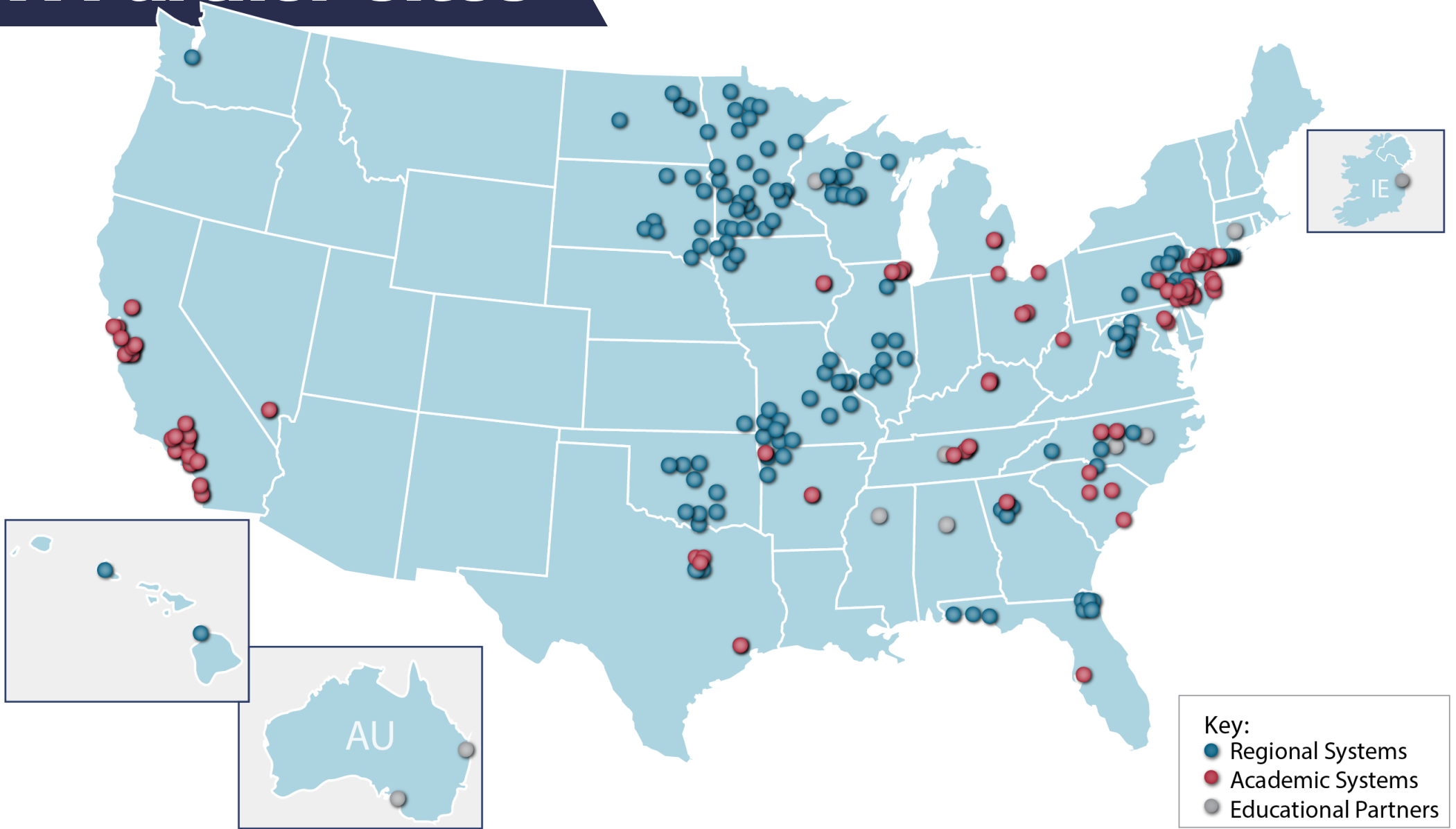


Learning Objectives

- Understand why a culture of peer feedback fosters psychological safety, respect, and patient outcomes.
- Cite reasons why using peers vs leaders creates a culture of support and understanding.

What is your role?

CPPA Partner Sites



PARS and CORS (Effective Tool & Process)

PARS® Patient Advocacy Reporting System

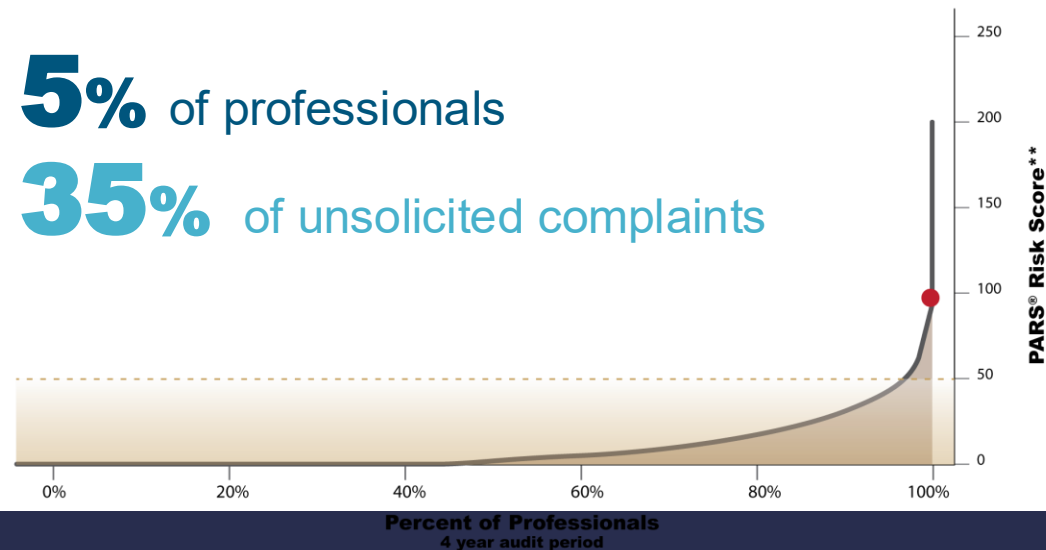
- To identify and intervene with professionals who have greater risk for malpractice claims and suboptimal outcomes of care
- Utilizes unsolicited observations and experiences of patients & families, as reported to an office of patient relations.

CORSSM Co-Worker Observation Reporting System

- To identify and intervene with professionals at risk for suboptimal outcomes of care because of unprofessional behavior towards coworkers
- Utilizes observations and experiences of fellow medical team members (coworkers) from organization's existing incident reporting system(s).

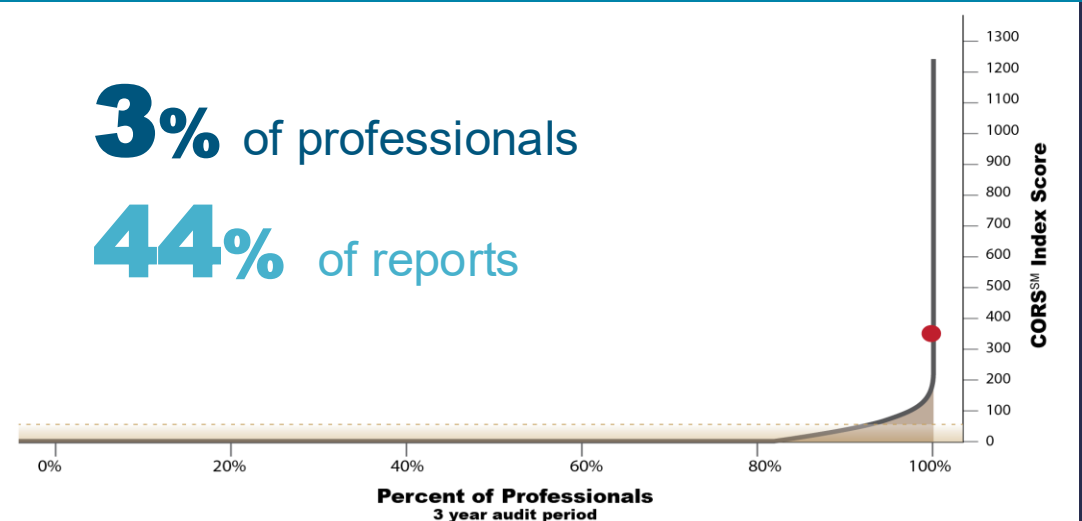
By Patient Complaints

5% of professionals
35% of unsolicited complaints



By Coworker Observations

3% of professionals
44% of reports



High Reliability

Reliability: **failure-free** operation over time

Health care should be safe, effective, efficient, timely, and patient-centered.

However, an institution cannot achieve high reliability and safety on will alone, it requires a plan.



Vision / Goals / Core Values



Leadership / Authority



A **Safety** Culture Includes:

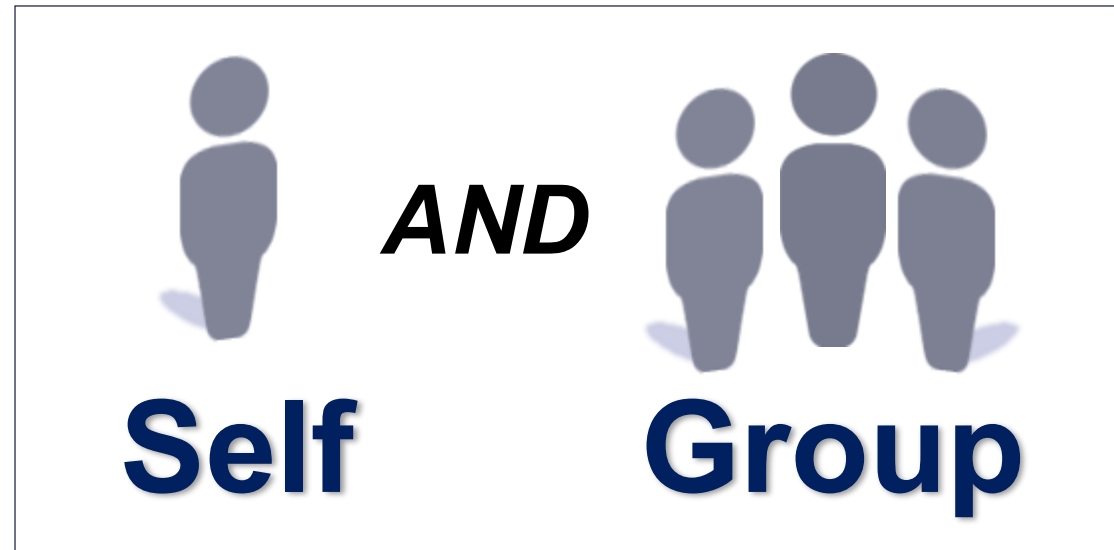
- **Psychological Safety**
- **Trust**

Professionalism and Self-Regulation



Professionalism and Self-Regulation

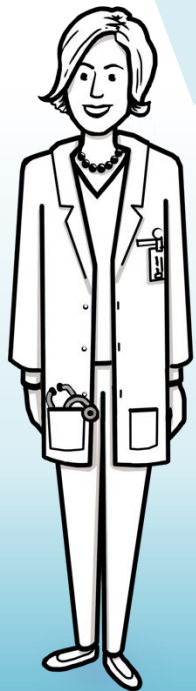
Professionals commit to...



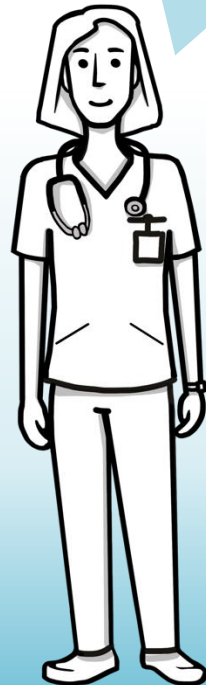
regulation of behavior and performance

Sometimes We are Not the best version of ourselves...

During the case... was pointed out to Dr. XX that they walked between sterile fields... Dr. XX said "concentrate on getting my instruments not me"...

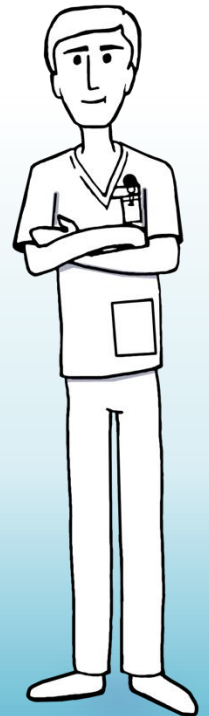
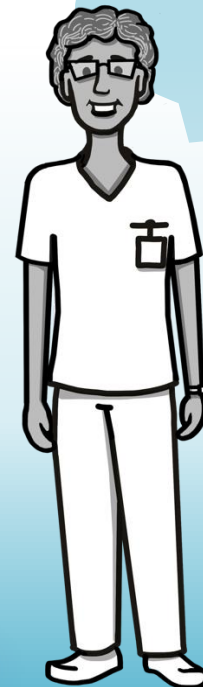


Orienteer asked for clarification about a set-up... Nurse YY smirked... 'nope, the only way to learn is do it yourself and learn from your mistakes'...



...asked Nurse AA to verify the instrument count before I brought the patient back... said, 'You're ridiculous, no one else has to do it before the patient comes back.'

I had my room set up for the craniotomy... Resident ZZ came in... took my headrest without asking...

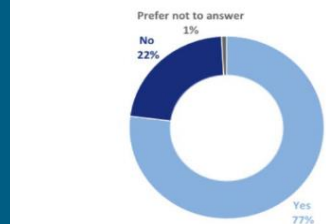


Unprofessionalism Bullying and Incivility

AONL Longitudinal Nursing Leadership Insight Study

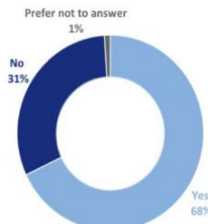
Witnessed or Experienced

In the past year, have you witnessed one or more incidents of **incivility** at work?



Incivility – 77%

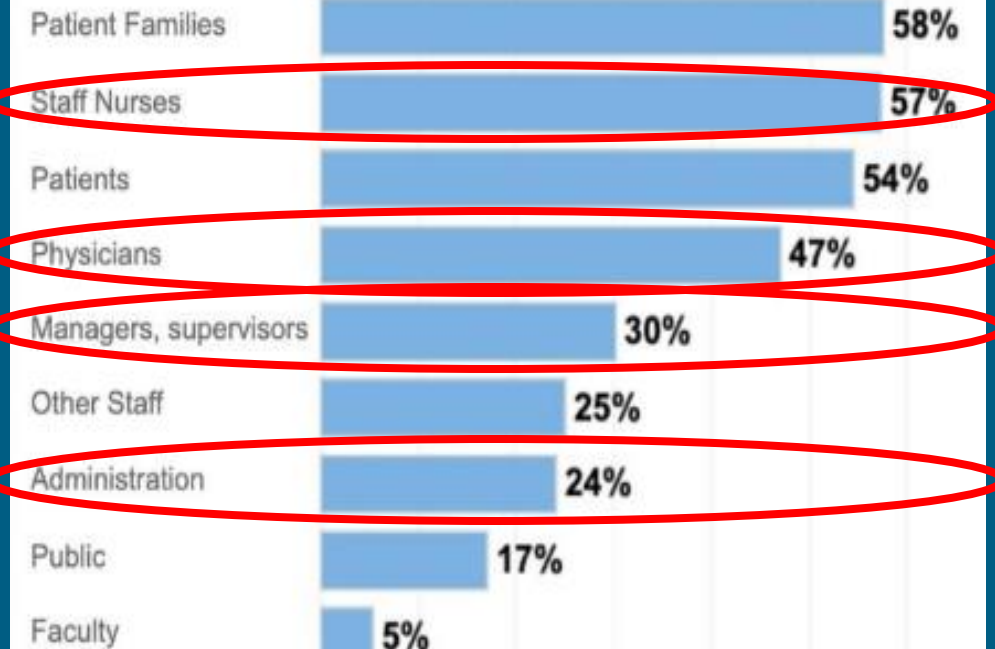
In the past year, have you witnessed one or more incidents of **bullying** at work?



Bullying – 63%

Who From

From whom have the acts of **bullying or incivility** come?
Select all that apply.



Covert unprofessionalism is like a crack in the mortar



What examples of covert unprofessionalism have you seen or experienced?

Behaviors That Undermine a Culture of Safety

Disregarding care pathways and established practices (*including conflicts of interest and compliance*)

Threaten safety (*aggressive or violent physical actions*)

Create intimidating, hostile, offensive (*unsafe*) work environment

e.g.

Team jousting

Dismissing work-flows

Rude and disrespectful communication

Delayed responses to pages

Ignoring timeouts and handwashing

ANY behaviors that interfere with the team's ability to achieve intended outcomes

It's About
Safety
and quality

Why is it important to address?

Disrespectful team members create a ripple effect that impacts culture, performance, and retention

INCREASED

- Withdrawal
- Anxiety
- Jousting

DECREASED

- Creativity
- Learning
- Motivation



Patients under the care of disrespectful physicians are



20-30%

more likely to have a surgical site infection...



20-40%

more likely to develop sepsis...



24-30%

more likely to die if trauma care is required

Physicians who model disrespect account for



50-70%

of your organization's malpractice claims experience and cost

Impact of Rudeness on Performance



Residents who Performed
Below Expected Level

8.8% vs. 36.4%

Control Condition

Rudeness Condition

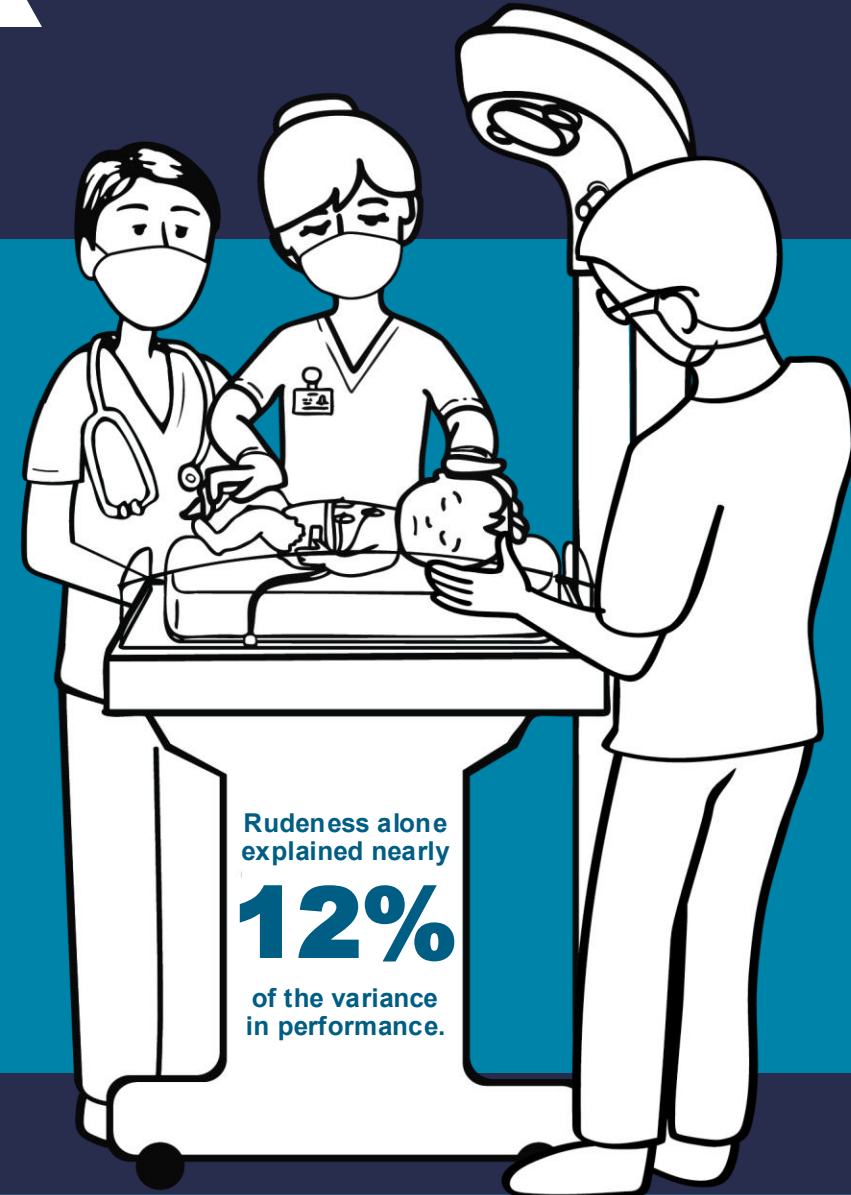
Vigilance – Communication – Teamwork

Individuals exposed to rudeness during an emergency were 4 times more likely to underperform.

Katz, et al., BMJ, 2019 | Weinger, et al., Anesthesiology, 2017

Teams exposed to disrespect don't share information and don't seek help, and as a result the team underperforms.

Riskin, et al., Pediatrics, 2015



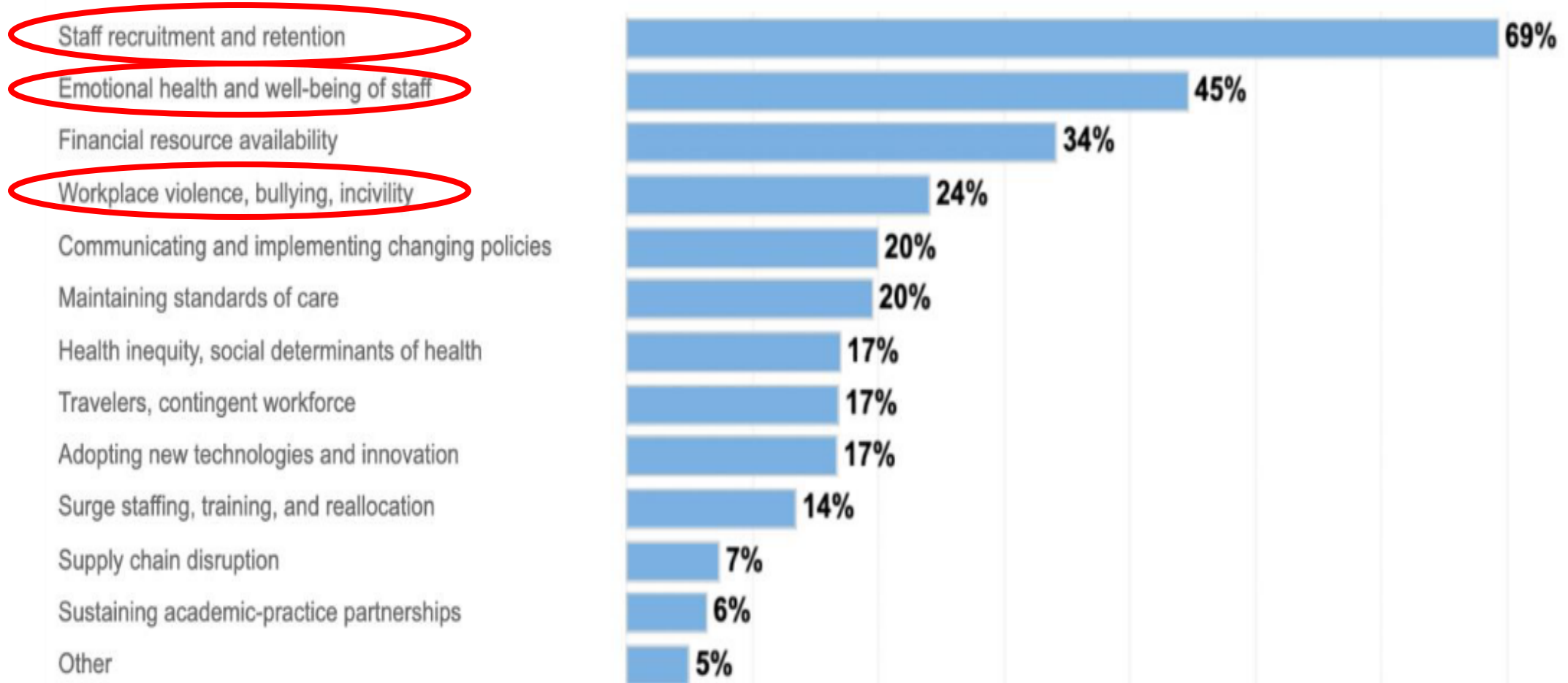
Rudeness alone explained nearly

12%

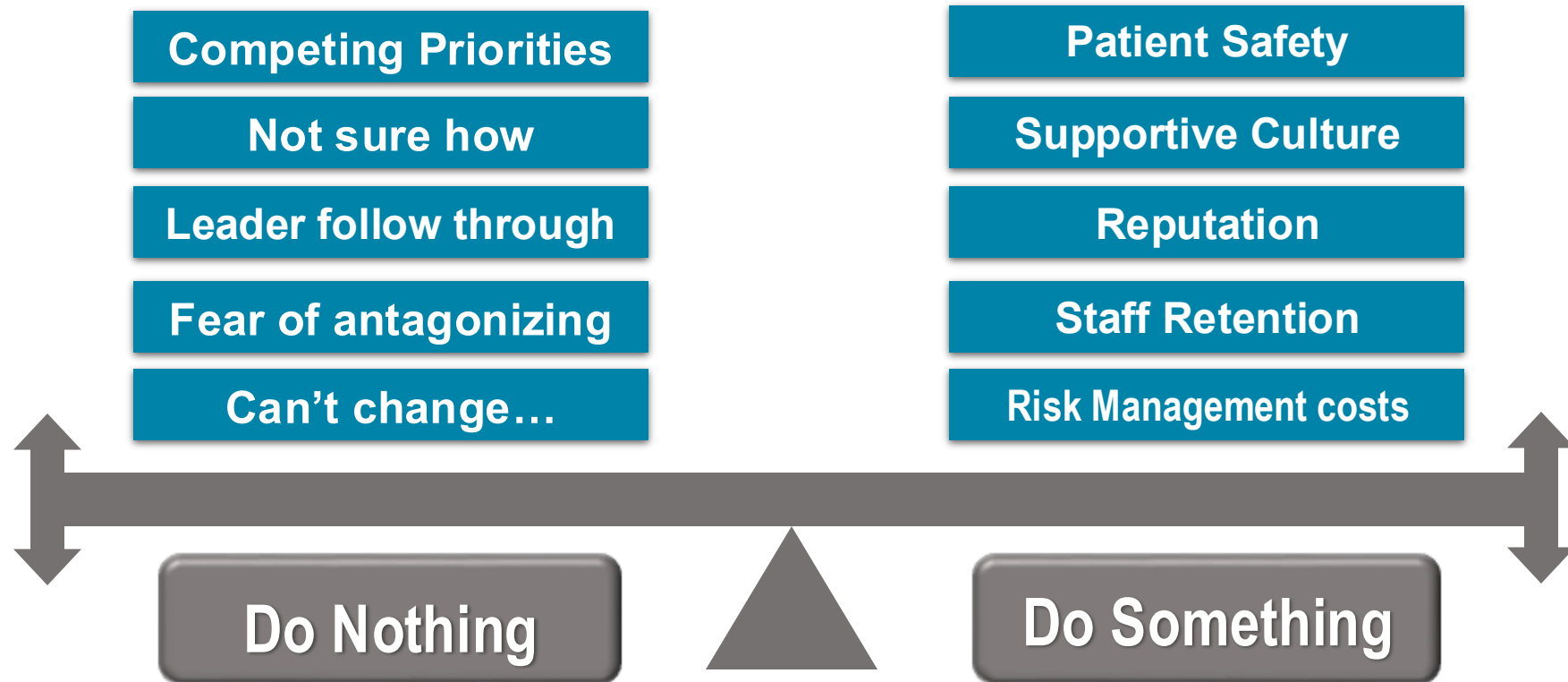
of the variance in performance.

Nurse Leaders are uniquely positioned but equally challenged when trying to address these behaviors...

What are your organization's current top three challenges? *Select top three.*



Deciding whether to address



**What barriers do you face
when trying to address?**

CORSsm : Coworker Observation Reporting System

CORS

Coworker Concerns

Effective tool and process to identify and intervene with professionals at risk for suboptimal outcomes of care because of unprofessional behavior towards coworkers

→ Nurse reports: “I called PACU to give report on the patient. Nurse AA hung up on me.”

→ ST reports: “Asked for clarification on an instrument and RN BB says “How can you not know this by now? Are you even paying attention?”

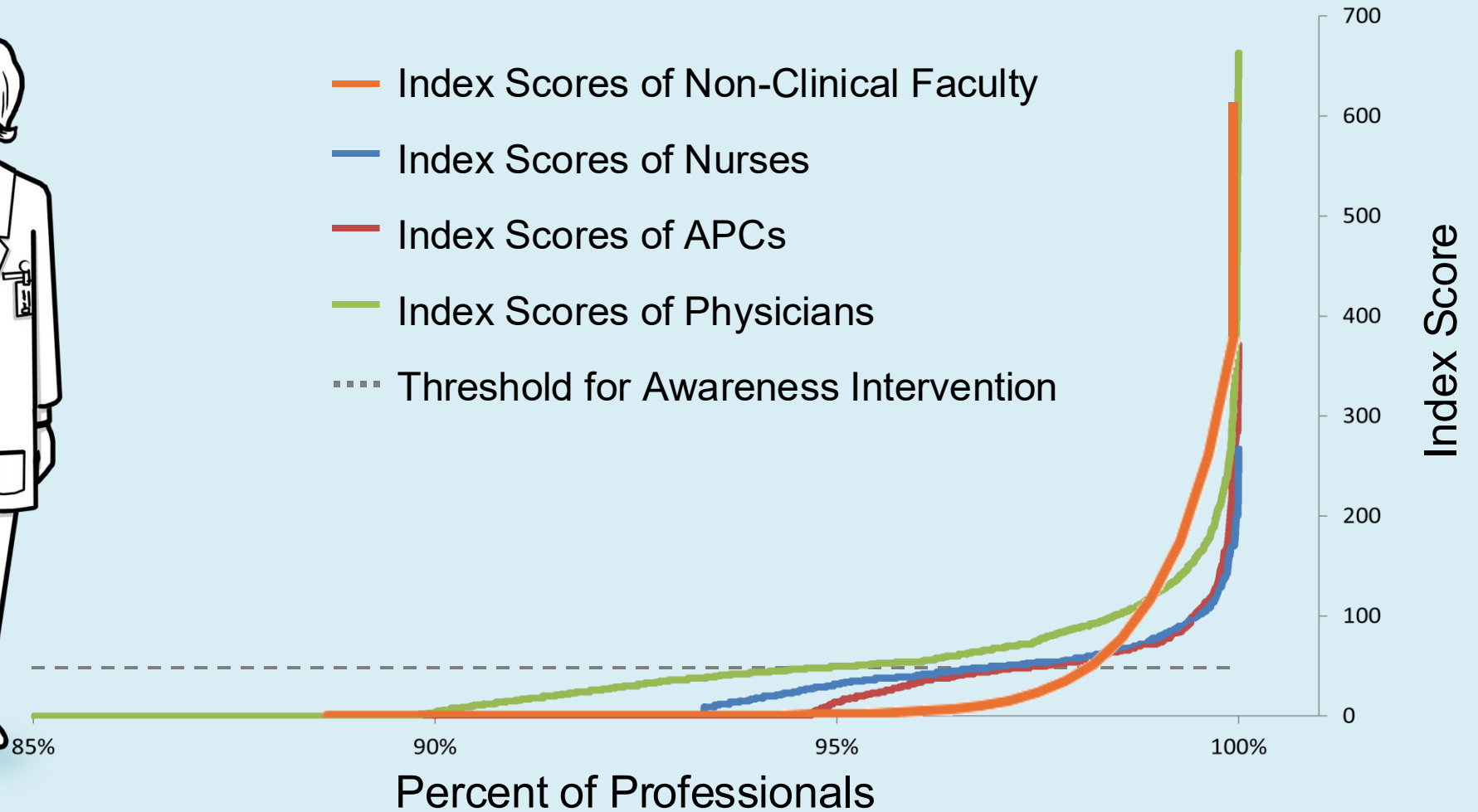
→ FA rolls their eyes and walks when the nurse asks for assistance during turnover.



Report Distribution is Similar for All Professionals (*National CORssm Database*)

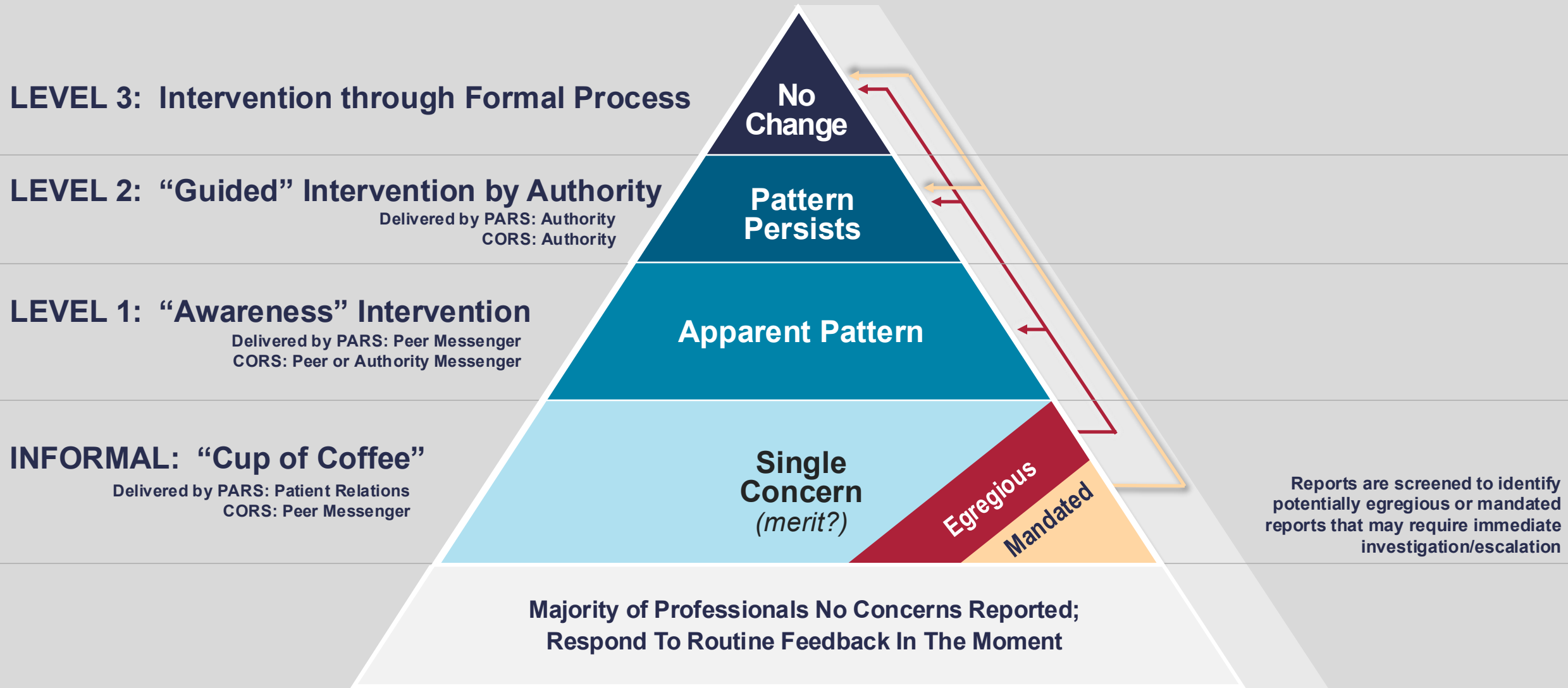


- Index Scores of Non-Clinical Faculty
- Index Scores of Nurses
- Index Scores of APCs
- Index Scores of Physicians
- ⋯ Threshold for Awareness Intervention



CPPA's Approach: Promoting Professionalism Pyramid

We utilize a tiered intervention model to provide the right-level of conversation / action at the right time.



Data-Driven Tools

Transforming Subjective Observations to Impactful Results



Patients and families observe...

Unsolicited Patient Complaints

- I heard Dr. Y yell at staff before procedure... always like that?
- Dr. X gloved... picked up their phone - texting, sneezing and rubbing their hair... did not reglove...
- Dad told Dr. W it was difficult to breathe... checked him out briefly, said a URI... next day in hospital with pneumonia
- I asked a question. NP Z rolled their eyes and said, "Great another patient who uses ChatGPT to second guess me."

Measurable Data

PARS Coding

- 6 Major Categories
- 34 subcategories

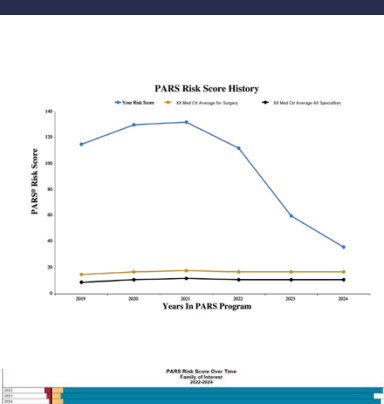
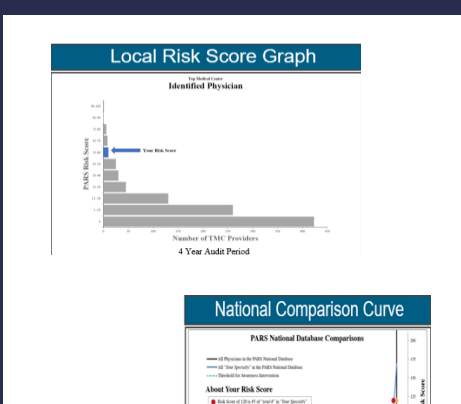
- Care & Treatment
- Communication
- Concern for patients
- Access
- Billing related to care
- Safety of environment

DUKE LAW | Law and Contemporary Problems | Wilcock et al., Law and Contemporary Problems, 1997.

Patterns & Insights

PARS

Clinician	Risk Score	Field Rank	# Rpts 12 mos
A	46	128	0
B	57	12	2
C	71	6	4
D	108	3	3
E	168	1	6



Fellow team members see things too...

Coworker Reports

- Attempted to give report to RN AA 3x. RN AA refused to come to the bedside for report.
- Had a question about patient called Dr. BB. Dr. BB replied, "Why do you need me to hold your hand? Can't you handle this on your own?"
- Overheard NP CC tell the patient that the ICU team didn't know what they were doing.
- During time out, I (circulator) stated, "2 gm of Ancef given...". Dr. DD stated loudly, "Ancef? She's allergic." I replied, "No, she isn't..." Dr. DD replied, "Just joking... hahaha."

Measurable Data

CORS Coding

- 4 Major Categories
- 13 subcategories

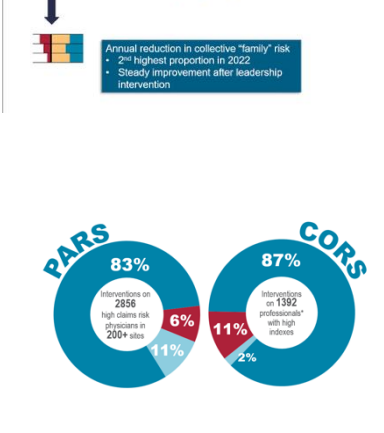
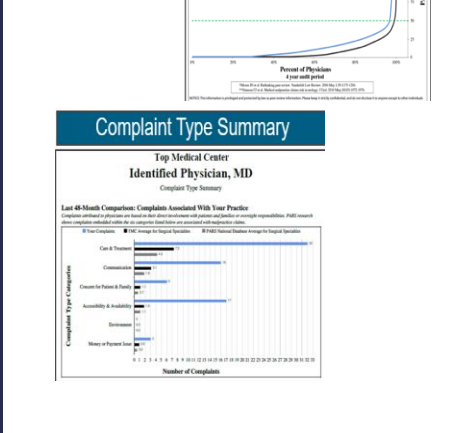
- Competent Care
- Clear and Respectful Communication
- Responsibility
- Integrity

JOURNAL OF PATIENT SAFETY | Martinec et al., Journal of Patient Safety, 2018

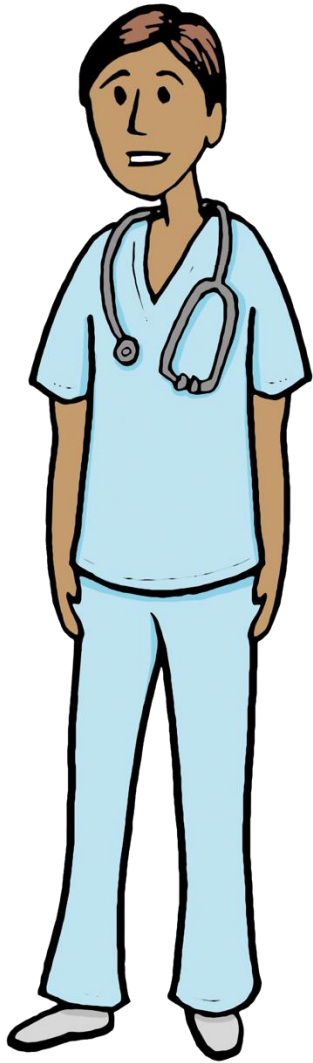
Patterns & Insights

CORS

Clinician	Index Score	Field Rank	# Rpts 12 mos
F	61	94	2
G	92	23	4
H	138	3	1
I	194	2	6
J	239	1	8



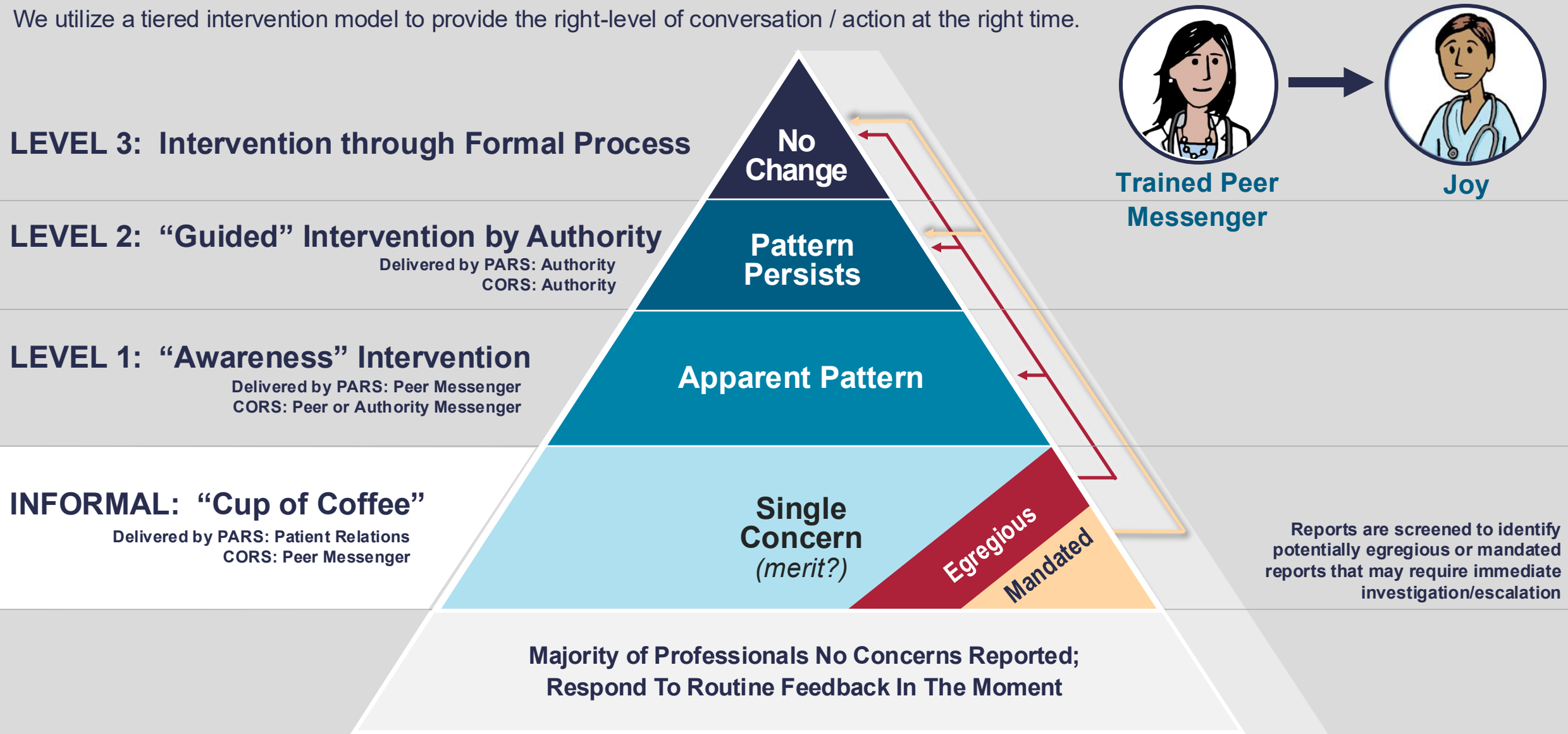
Let's look at a case...



“I saw Joy skip parts of the surgical safety checklist. I spoke up, and she said, ‘I’ve been working with this team all day.’”

CPPA's Approach: Promoting Professionalism Pyramid

We utilize a tiered intervention model to provide the right-level of conversation / action at the right time.



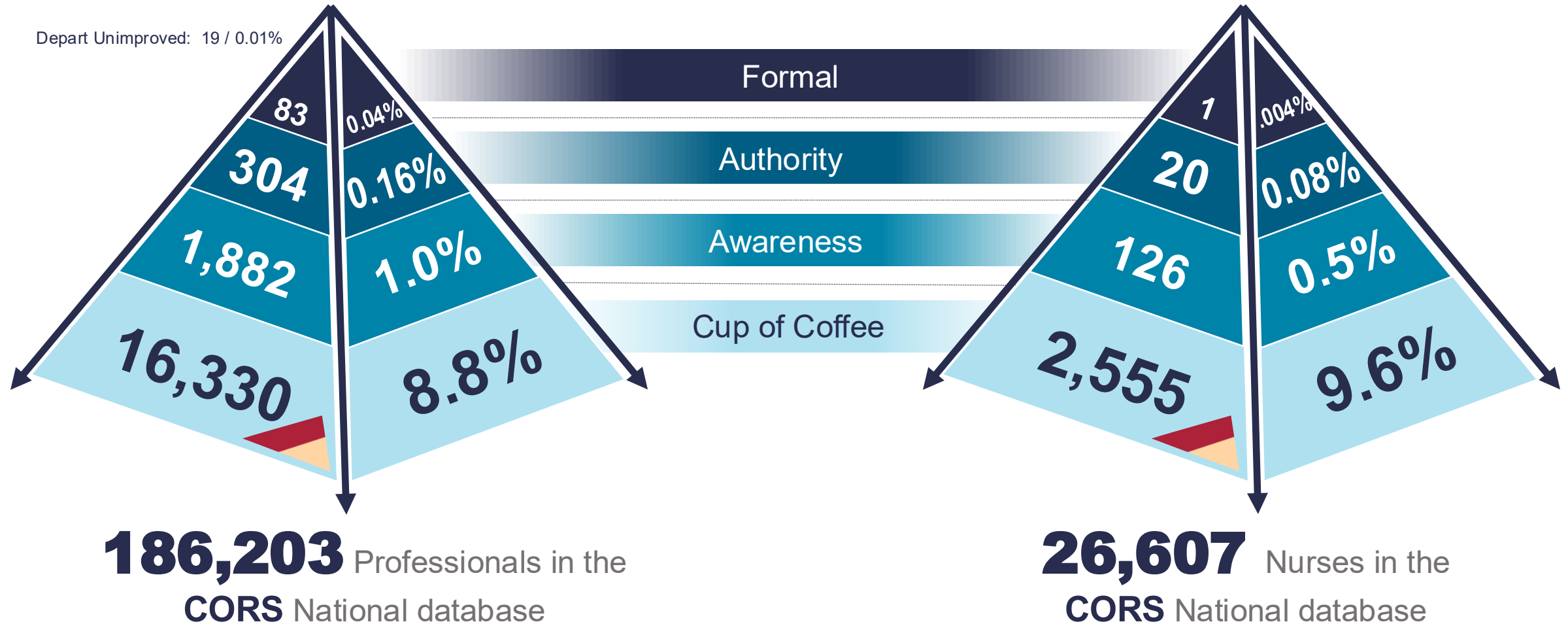
Elements of “Informal” Conversations

Elements of a Cup of Coffee



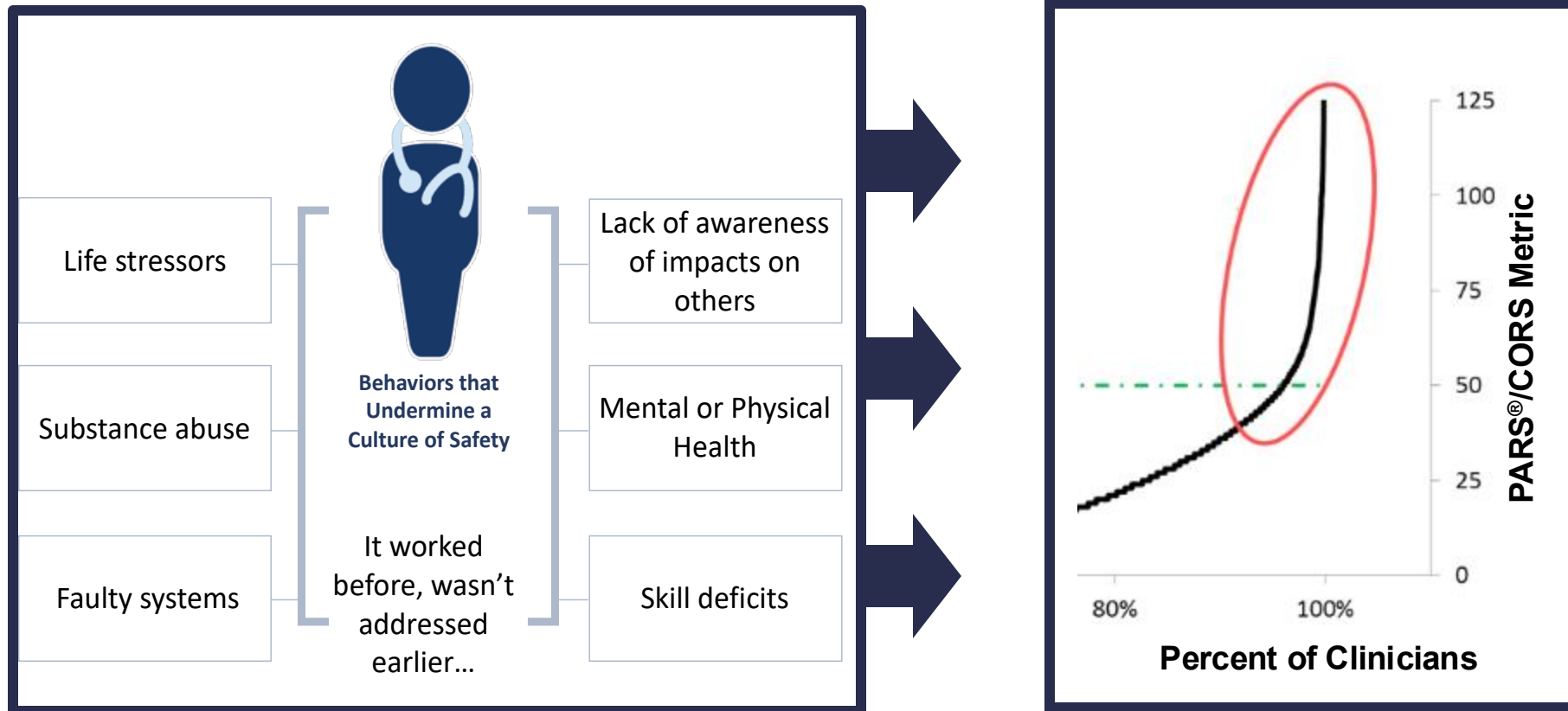
- I am here as _____ (peer, professionalism committee, etc.)
- You are an important team member...
- I observed/received a report...wanted you to know
- We are committed to sharing...
- We don't investigate... two sides to every story
- Inconsistent with our core values...
- ...could this have gone differently

Our Findings: Most Professionals Respond...



The High-Risk Clinician

High Risk Clinicians can be affected by a number of influences...





Joy's Reports Continue

Nurse Reports: "... Nurse Joy didn't call to report before bringing their patient to PACU. I didn't have a vent set up or anything..."

Resident Reports: "Nurse Joy told me to stand in the corner until the patient was draped... I was humiliated."

CPPA's Approach: Promoting Professionalism Pyramid

LEVEL 3: Intervention through Formal Process

No Change

LEVEL 2: "Guided" Intervention by Authority

Delivered by PARS: Authority
CORS: Authority

Pattern Persists

LEVEL 1: "Awareness" Intervention

Delivered by PARS: Peer Messenger
CORS: Peer or Authority Messenger

Apparent Pattern

INFORMAL: "Cup of Coffee"

Delivered by PARS: Patient Relations
CORS: Peer Messenger

**Single Concern
(merit?)**

**Egregious
Mandated**

**Majority of Professionals No Concerns Reported;
Respond To Routine Feedback In The Moment**



Trained Peer Messenger



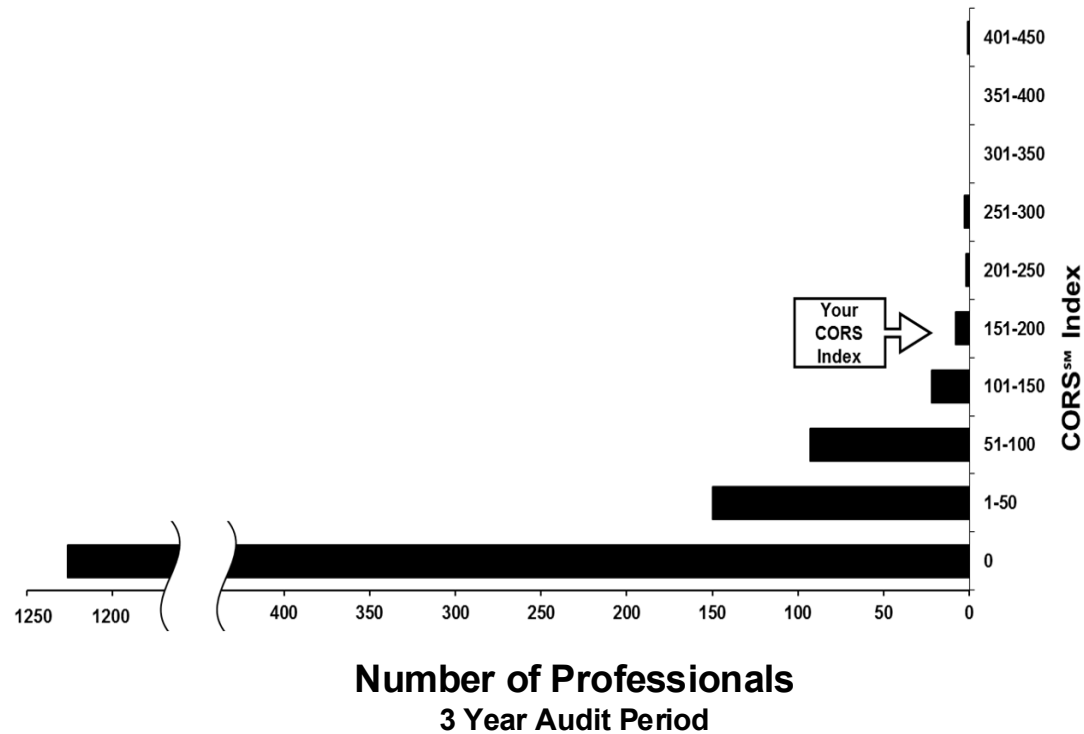
Joy

Reports are screened to identify potentially egregious or mandated reports that may require immediate investigation/escalation

CORSsm Awareness Intervention Tools

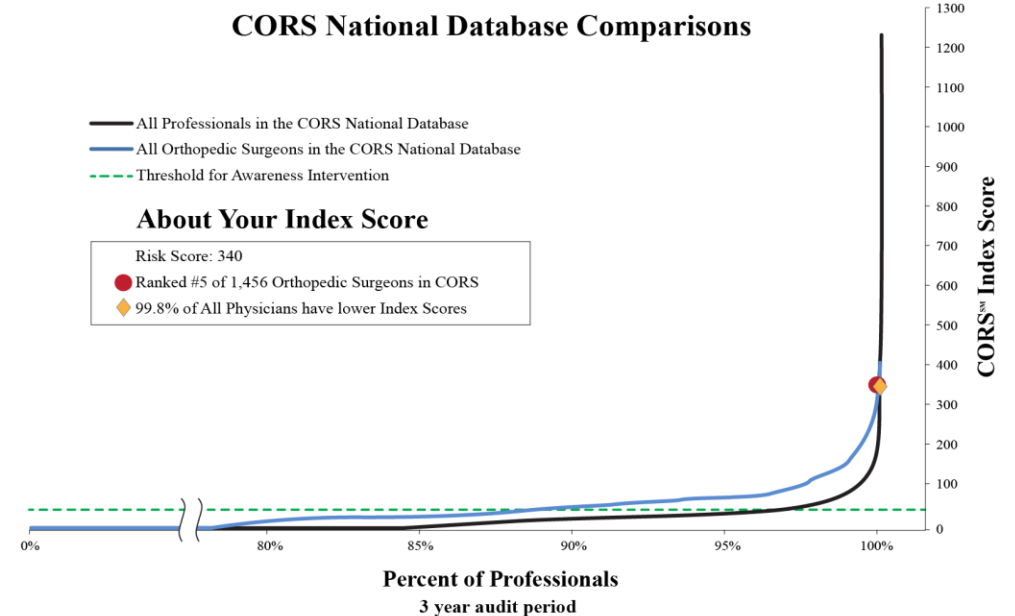
Local Comparison

CORS Index Score Comparison at Your Institution



National Comparison

CORS National Database Comparisons



Webb, et al., The Joint Commission Journal on Quality and Patient Safety, 2016 | Martinez, et al., Journal of Patient Safety, 2018
Cooper, et al., JAMA Surgery, 2019 | Baldwin, et al., The Joint Commission Journal on Quality and Patient Safety, 2022

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What if a change of culture could...



...Support Nurse Retention?

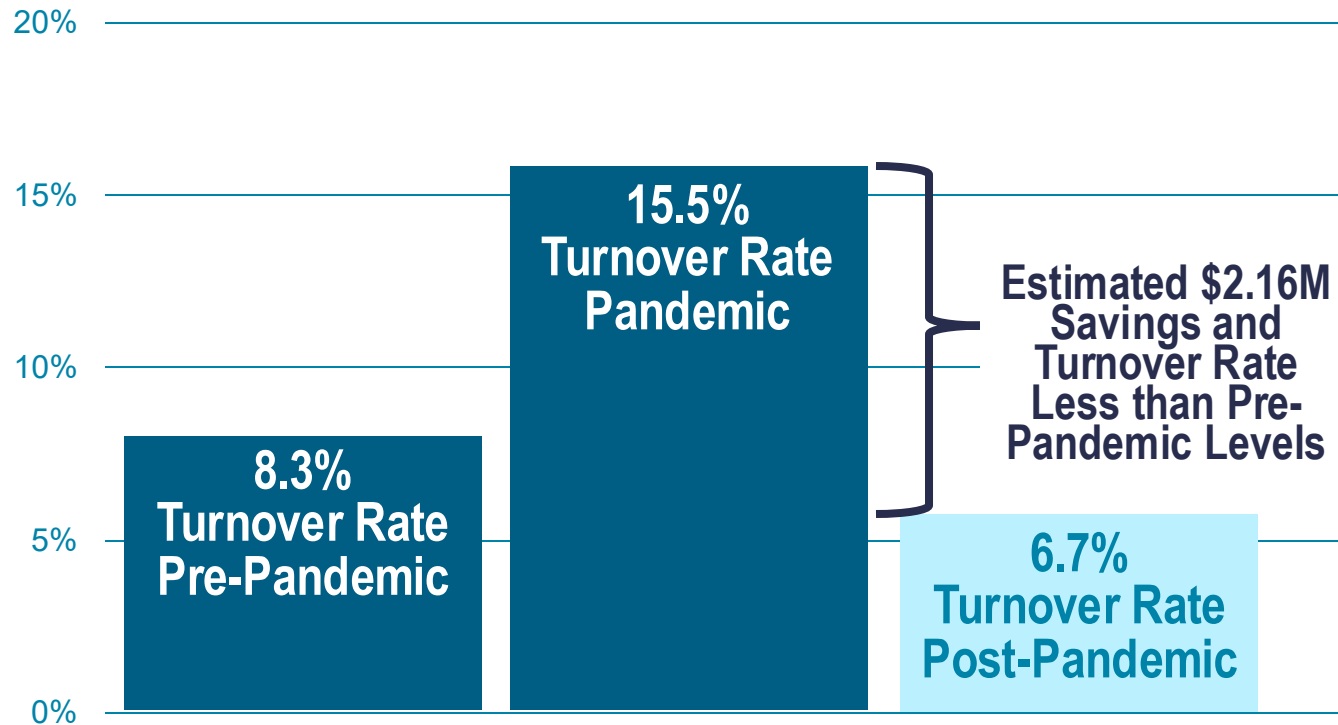
What other benefits might you see?

- Quality Outcomes
- Safety Culture
- Staff engagement and satisfaction
- Travel nursing costs
- Continuity of care
- High Reliability



Value of Culture & Team Engagement: MD Anderson Reduction in Staff Turnover

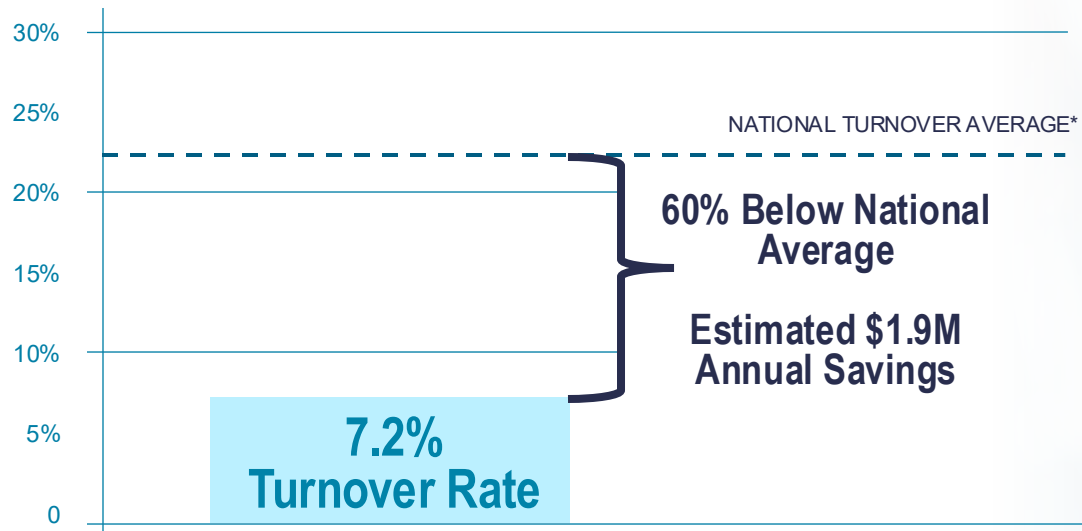
MD Anderson: Impact of Professional Accountability Model on Turnover Rates in Perioperative Setting



“ We recommend hospital organizations consider implementing appropriate organizational approaches to ensure lapses in professionalism are addressed early in order to enhance workplace culture, employee well-being and patient safety. ”

Culture & Team Engagement

Keck Medicine of University of Southern California: Nurse Attrition



VUMC Professional Accountability Model

WHAT OUR MODEL HAS TARGETED

DOES IT WORK?

THE RESULTS



Improve and sustain hand hygiene practice



From 50% to > 95% compliance ¹



Reduce malpractice claims expenses



By >70% ^{3, 4}



Improve unprofessional behavior towards patients and coworkers



Approximately 85% of professionals improved (PARS/CORS) ^{2, 4}



Improve and sustain vaccination compliance



From 80% to 97% ⁵



Adhere to surgical bundles to reduce infections



Improvement ⁵

¹ Talbot, et al., Infect Control Hosp Epidemiol, 2013

² Schaffner, et al., JAMA, 1983 | Ray, et al., JAMA, 1985 & 1986

³ Catron, et al., Am J Med Qual, 2016 | Webb, et al., Joint Commission, 2016

⁴ Hickson, et al., JAMA, 2002 | Hickson, South Med J, 2007 | Pichert, AHRQ, 2008 | Hickson, Jones & Bartlett Publishers, 2012 | Pichert, Jt Comm Jnl, 2013 | Webb, et al., Joint Commission, 2016

⁵ Talbot, et al., Infect Control Hosp Epidemiol, 2021

Thank you



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