Peer Review in nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers as measured against professional standards of practice.[1] The key to success in nurse-to-nurse peer review is to give and receive feedback and address problems directly with each other. Nurses must share feedback on a consistent and constructive basis as an integral element of their work to ensure patient safety. The patient's well-being is dependent on numerous crucial acts performed correctly on a daily basis by health care professionals. Patient safety and healing require attentive competent care incorporated into the realm of the nursing process. Inadequate nurse-to-nurse communication is frequently named as one of the most common reasons for errors and adverse outcomes involving patient care.[2]

Peer review as a formal practice of examining sentinel events is well-documented. However, the less formal basis of day-to-day discussions with one's peers in support of the quality of nursing care on the unit is not so well-researched; instead, we see research on bullying and burnout,[3-9] which erode positive communication. The challenge, for nursing leadership, is knowing how effectively nurses are communicating with each other in their daily practice. The quality of this communication may affect patient safety, patient satisfaction, or nurse retention. For bedside nurses, one of the organizational characteristics defining a Magnet hospital is, "Enough time and opportunity to discuss patient care problems with other nurses"(p. 68).[10] Regular, on-going, peer-to-peer review at the work-unit level would be an informative element of how well Registered Nurses (RNs) work together in their daily professional practice. Specifically, we sought to measure peer interactions about the quality of nursing care in the daily work environment.

The purpose of this study was to discover the extent and quality of peer review among nurses within an inpatient or ambulatory care unit. We examined whether or not there were associations with patient-assessed quality of care, employee perception of safety, and nurse retention. Peer review, in this study, was defined as RN-to-RN professional communication about quality of nursing care on their unit.

LITERATURE REVIEW

In 1983, the American Nurses' Association (ANA) *Peer Review in Nursing Practice* defined peer review as "the process by which practicing registered nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers as measured against professional standards of practice."[11] Peer review was seen as an essential element to assure quality professional practice.

The American Nurses Association *Code of Ethics for Nurses* states, "The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care" (ANA Provision 4, 2005; Fowler 2008).[12,13] It further states, "Sound ethical decision-making requires the respectful and open exchange of views between and among all individuals with relevant interests…[and] the nurse has a responsibility to express moral perspectives, even when they differ from those of others, and even when they might not prevail" (ANA, Provision 5.3).[12,13] While this generally refers to communication with physicians and other health care professionals, it is relevant as well to RN communication among nurses themselves.

The Joint Commission's National Patient Safety Goal Two for hospital accreditation is: "Improve the effectiveness of communication among caregivers,"[14] and the Joint Commission

gives the rationale that "Ineffective communication is the most frequently cited root cause for sentinel events. Effective communication that is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved [patient] safety."[14]

Also, the American Nurses Credentialing Center's (ANCC) Magnet framework repeatedly found that nurses value working with other competent nurses. In multiple studies, the top-ranked factor related to quality of nursing care is "working with other nurses who are clinically competent." [10,15-17] Nurses experience psychological or moral distress when they do not feel competent or when colleagues' nursing practice is suboptimal.[18]

The concept of caring interaction and positive communication about the quality of nursing care is supported by the American Nurses Association (ANA) *Code of Ethics*[13] and the American Association of Critical-Care Nurses' (AACN) *Standards for Establishing and Sustaining Healthy Work Environments.*[19] The introduction to the AACN *Standards* opens with a moral imperative from Rev. Martin Luther King, Jr. "Our lives begin to end the day we become silent about things that matter" and lists skilled communication as standard number one; specifically stating, "Nurses must be as proficient in communication skills as they are in clinical skills."[19] While this refers primarily to communication between professions, it is also true among members of the same profession; especially in light of how frequently we hear anecdotally and in the research of lateral violence.

Shift report examines the quality of professional communication in the formal handoff of the patient. Accurate, clear, and comprehensive handoff is crucial to patient safety.[20,21] Shift report accounts for the formalized communication between nurses on different shifts, which covers sequential patient care. Barbara Haag-Heitman suggests that patient handoff, or shift report, is but one opportunity for peer review.[11]

The American Association of Critical Care Nurses (AACN) recognizes "Relationship issues are real obstacles to the development of work environments where patients and their families can receive safe, even excellent, care. Inattention to work relationships creates obstacles that may become the root cause of medical errors, hospital-acquired infections and other complications, patient readmission and nurse turnover" (p. 11).[19] The *AACN Standards for Establishing and Sustaining a Healthy Work Environment* standard two is, "True Collaboration: Nurses must be relentless in pursuing and fostering true collaboration" (p. 20).[19] The AACN Standards also explicitly state the interdependence of all six standards and the importance of a healthy work environment to optimal patient outcomes and clinical excellence (p. 14; fig 1).[19] Effective decision-making in a healthy clinical environment is dependent upon skilled communication and collaboration.

Nurses must negotiate relationships with patients, doctors, allied health providers, and each other in an environment that is frequently stressful. A good deal of the research literature addresses issues of nurses' communication with doctors[22-24] or with patients,[25-27] but positive communication among nurses themselves is equally important. "Strong positive organizational cultures are built on group cohesiveness in which members insist on high levels of performance and each individual is encouraged to do his or her best"(p. 525).[28] Good communication skills and on-going, regular peer review with nurse colleagues—feedback pertaining to the nursing process and quality of nursing care—is an essential element of excellent clinical care and patient safety. One aspect of transformational leadership focuses on helping each nurse to do his or her best. The AACN Standards state, "It is ethical to request, encourage and deliver feedback on all facets of individual and organizational performance. It is unethical to ignore, discourage or fail to give feedback"(p. 17).[19]

Alspach has called for accountability and respectful, open, honest communication among critical care nurses. He names gossip, withholding information, silent treatment, sarcasm, or belittling gestures as problematic communication in normal exchanges among clinical nurses.[29] Heath, Johanson, and Blake's research identified a healthy work environment as essential to both patient safety and nurse retention. They defined a healthy work environment as having: "(1) effective communication, (2) collaborative relationships, and (3) promoting decision making among nurses" (p. 524).[28] All three are intertwined. As nurse-to-nurse communication improves, collaboration can be both stronger and more embedded in the culture of the unit, and with good communication and strong collaboration comes a more professional work environment with improved and empowered decision-making.

Current research about nurse communication is abundant on formal communication, hierarchical relationships, bullying, problems in physician-nurse communication, and communication skills with patients. Our study focuses on professional communication among *peers* as vitally important to the quality of nursing care. We wanted to determine our nurses' perception of their current professional communication skills as a baseline. The aim of our study was to measure nurse peer-review at the unit level and to explore potential relationships with nurse retention, patient safety, and patient-assessed quality of care.

METHODS

Design

A mixed-methods, cross-sectional, descriptive survey design was used to obtain a baseline of current communication practice on nursing units. Qualitative data was gathered through the inclusion of open-ended questions and optional comment boxes.

Sample

A cluster-sample was created with data from 28 clinical units in an academic medical center in southern California with two hospitals (a total of 492 beds) and several ambulatory care units. Email addresses were obtained for all staff RNs at the medical center. Inclusion criteria were: being a Registered Nurse working on an inpatient unit, emergency department, or a procedural or outpatient clinic. Travelers and per diem nurses were included in the study because their use is not uncommon and their time on the unit is typically extended over months and would presumably be a factor in communication on nursing units. Exclusion criteria were being a nurse leader or being a float nurse on a unit. We excluded nurse leaders[1] because we specifically are interested in peer review or peer communication and did not wish to address, in this research, any hierarchical or management issues. Float nurses were excluded because their time on any one unit is minimal.

The Institutional Review Board approved this study, which qualified for an exempt application. All participants in this research accepted click-through informed consent at the beginning of the survey.

Demographics were collected from participants at the beginning of the electronically formatted instrument and included age group, race or ethnicity, nursing education, years of experience as a nurse, and years of experience on their current nursing unit. Gender was not asked as the low number of male nurses could have potentially identified an individual.

[1] NOTE: At the hospitals where the research was conducted, Nurse Educators and Clinical Nurse Specialists are considered to be part of nursing leadership.

Instrument

Linda Hughes developed the *Peer Group Caring Interaction Scale* (PGCIS)[30] with nursing students (n=873) enrolled in 87 Bachelor's programs. Hughes examined "caring" as a moral value and sought to examine descriptive rather than evaluative interactions among nursing students. Her study also included students employed as externs in a hospital setting. Each of two subscales, the 9-item Caring Behaviors and the 7-item Giving Assistance, showed high reliability ($\alpha = 0.91$) and offer a valid and reliable scale for measuring caring interaction in an academic setting.

In the current study, Hughes' scale was modified for use with clinical nurses at an academic medical center. "Students at this school" was changed to "RNs on my unit" in each question. Three nursing Directors examined the modified questions for content validity. Two staff nurses evaluated the instrument for clarity prior to implementation. Cronbach's alpha test for the data showed high reliability among item-total ($\alpha = 0.998$), while inter-item correlations for subscales showed mean = 0.468, indicating a minimum of redundancy.

Along with the modified Hughes scale, we asked open-ended questions specifically about the nurse's qualitative experience of communication with colleagues on the unit. The evaluative items generally related to generational, gender, and cultural differences, as well as to the value of the information given or received and the nurses' perception of respectfulness in communication between themselves and other RNs. We allowed for optional free-form comments if the nurse wished to further explain or offer additional information that we may not have specifically requested.

Data Collection

The instrument was electronically formatted using SurveyMonkey and distributed via email to 1,406 Registered Nurses. The email was sent from the librarian—a person who does not supervise the staff nurses in any way—in order to eliminate any perceived pressure to participate or hierarchical influence. The electronic document opened with a click-through informed consent that explained the research and explicitly assured confidentiality.

We requested and received from the Human Resources department an email list of current staff RNs. The list was culled to delete Nurse Managers and Education Department Nurses. 1430 email addresses were on the list; 24 were returned as "system undeliverable" and were deleted from the list (*not* including out-of-office notices) for a final population contact of 1406 staff nurses.

Data collection took place over a two-month period from August to October 2009. The time period was selected to maximize reaching as many nurses as possible with extended time in order to capture nurses out on vacation for part of the period.

Announcement of the survey was published in a weekly newsletter distributed at the hospitals, and flyers were posted in each nursing unit and in public areas. Data collection commenced on August 7, 2009. After initial distribution, two staff nurses and the librarian went to units with a copy of the flyer to raise awareness and encourage participation in the research. Four reminder notices were sent out over the two-month period in emails from the librarian. In the last week of data collection, a paper version was distributed on units via nurse managers for nurses who might be computer-averse; managers were instructed to distribute the paper copy but not to pressure anyone into participating. Three nurses completed the paper version and returned it anonymously via interoffice mail in the provided pre-addressed envelope to the librarian.

Measures of Patient Safety and Satisfaction

We used measures of patient satisfaction and safety from data normally collected, by unit, at the medical center during the same time period—but separate from our study. An analyst from the Continuous Quality Improvement office worked with our statistician to retrieve staff RN data—not including nurse managers or LVNs.

As a measure indicating whether or not the nurses felt their unit provided good patient safety, we used Culture of Safety data, a web-based survey completed by all staff in May/June 2009, and examined the percentage of nurses on each unit who responded positively to the statement "I would feel safe being treated here as a patient."

From our regularly collected and distributed data in the Press-Ganey Patient Satisfaction survey (normally sent to patients after hospitalization), we pulled information for inpatient units from questions about patient satisfaction with their overall nursing care. These patient satisfaction results were an average of monthly scores received in August, September, and October 2009.

The fill rate at our organization was 96% overall during the survey period. For this study, we compared peer communication with nurse retention rates on a unit-basis. While there are many factors associated with nurse retention, this would allow us to see if a correlation existed between units that reported better peer communication and nurse retention rates in that time frame.

RESULTS

Overall response rate was 38.5% (541/1406). Seventy-five percent of respondents (405/541) answered all questions. Units with fewer than four responses were eliminated to ensure confidentiality of individual nurses.

Demographics

Our sample demographics were compared to demographics of the hospitals' population of nurses, which confirmed that our sample was representative in terms of level of education, years as a nurse, age, and ethnicity.

<Insert **Table 1- Sample Demographics** about here>

Sixty-five percent (328/501) of our sample had a BSN or higher educational level. "Years of experience as a nurse" was bimodal with the largest group 34% (169/495) having more than 20 years of experience as a nurse. However, the second largest group, 20% (101/495), had five years or less of experience.

Nurses were asked their age by age-group decades. Age was relatively normally distributed: 2% were below 25 years old; 11% (55/495) were between 25-30 years old, 30% (148/495) were between 31-40 years old, 27% (131/495) were between 41-50, 26% (127/495) were 51-60, and 4% (22/495) were 61-70 years old.

Experience on their current unit showed 49% (244/495) with less than 5 years of experience on their current unit, 25% (122/495) with 6-10 years on the unit, 26% (129/495) with more than 10 years of experience on their current unit.

Fifty-four percent (267/493) of the sample was Caucasian. The next highest ethnicity was Filipino or Asian at 34% (168/493); 5% (24/493) were Latino/a; and 2% (11/493) were African

American. The remaining respondents self-identified as Pacific Islander (7), African (3), or American Indian (1). Twelve people did not answer this question.

Quantitative data analysis

In looking at the quantitative data, nurses reported good communication. Eighty-five percent (366/433) reported that they regularly give peers feedback related to the quality of nursing care on the unit, and 90% (388/433) felt that the quality of the information they received from peers was valuable. There was an overall trend, across all units, of believing they gave more peer review than they received. Nurses also valued the information received at a higher rate than they reported information they gave was valued by peers.

A chi-square test was used to test for significance of whether the survey responses differed from the null ($P<0.05$) across nurses' age, ethnicity, unit type, years of experience on the unit, years of experience in nursing, and highest nursing degree.

Frequency distributions were tabulated from raw data and analyzed as follows: if the survey response was 1, 2, or 3 (varying degrees of disagreement) response was scored as a "0" and if the response was 4, 5, or 6 (varying degrees of agreement), the response was scored as a "1." From this analysis, we determined whether the number of nurses who disagreed vs. agreed with each question was significantly different than the null we would expect, across education, age, experience, and ethnicity. The results showed no significant differences ($P>0.05$) for the nurse's age or number of years experience on the unit for each survey question.

< insert **Table 2 – Chi-square Goodness of Fit** about here. >

Level of nursing education

There were significant differences among responses by highest nursing degree for questions on the Peer Group Caring Interaction Scale. Nurses with a bachelor's degree were more likely (40%) than diploma- (30%), Associate's- (28%), or Master's-prepared (20%) nurses to agree that it should be left to the Nurse Manager to work with RNs who need additional help (χ^2_3= 9.4, *P*=.025). Diploma-prepared nurses (70%) were least likely to agree with the statement that "RNs on the unit talk with other RNs about how it feels to care for patients they are uncomfortable with" as compared with Associate's (86%), Bachelor's (91%), or Master's-prepared (90%) nurses (χ^2_3= 9.6, *P*=.022).

Years of experience as a nurse

There was a significant difference in responses by years of experience as a nurse for the Peer Group Caring Interaction question #10. Nurses in the mid-range of experience—either 11-15 years of experience (82%) or 15-20 years of experience (84%)—agreed less with the statement that "RNs on my unit can count on other RNs for help" as compared with nurses with less than 5 years experience (94%), 6-10 years of experience (95%), or nurses with more than 20 years (90%) of experience (χ^2_4= 9.9, *P*=.042).

Ethnicity

There were significant differences in responses by ethnicity for six questions on the Peer Review scale and ten questions on the Peer Group Caring Interaction Scale [see Table 2 – Chi-squared Test for complete list of results]. The most significant differences with P-values less than .01 are delineated here.

More Filipino (95%) or Latino (96%) nurses than Caucasian (86%) nurses agreed with the statement "my peers who are of a different gender speak to me respectfully and communicate well when giving feedback" (χ^2_8= 24.4, *P*=.002).

A significantly higher percentage of Filipino nurses (93%) agreed with the statement that "RNs on my unit are a source of encouragement to each other" than did their Caucasian (84%) or Latino (70%) peers (χ^2_8= 25.7, *P*=.001).

A much higher percentage of Filipino nurses (92%) than Caucasian (77%) or Latino (65%) nurses agreed with the statement that "RNs on my unit help each other by sharing information sources, research articles, or evidence related to our patient care" (χ^2_8= 21.2, *P*=.007).

More Filipino nurses (46%) than Caucasian (25%) or Latino (26%) nurses agreed with the statement that "RNs on my unit will help another RN *only* when it is their own best interest to do so" (χ^2_8= 22.4, *P*=.004).

Qualitative data analysis

Two of the researchers independently reviewed open-ended questions and optional comments for common themes reported by the respondents. Four clear themes emerged as the main barriers to effective peer communication; they were: (1) Lack of clarity around what constitutes peer review; (2) Fear of peer retribution; (3) Concerns with language and cultural barriers; and (4) Concerns regarding lack of mutual respect and professionalism.

Clarity

A common theme in our respondents' comments centered around a lack of clarity or a clear definition of peer review. Despite defining peer review as "professional communication among RNs," many respondents asked for additional educational opportunities on the subject to raise awareness and seemed unclear of the definition themselves. Comments such as, "I am unclear about what peer communication includes" and "I do not perceive a problem with peer communication, but I am not sure what it is" were identified. Clearly, despite the use of the term peer review, our nurses were in fact unsure of exactly how to put peer review into practice.

Peer Retribution

Unless it would cause harm to their patient, nurses reported that it wasn't worth rocking the boat with their peers. Fear of disrupting their perceived smooth workflow with their peers was reason enough to not pursue giving feedback to a peer, unless it compromised patient care. Comments illustrating this include, "Some nurses do not take comments. So unless it's detrimental to the patient, I keep my mouth shut." "Truthfully, I keep quiet if it's not harmful to the patient." "Nurse to nurse criticism isn't well received in general." "We must dispel the concept that peer review is akin to fault-finding about your colleagues." "If it would be more trouble than it is worth to let the person know that it's incorrect, I would hold my tongue."

Language and Culture

Cultural and language concerns were cited frequently as barriers to effective peer communication. Fifty-four percent of our sample identify themselves as Caucasian and 34% identify themselves as Filipino or Asian. Some comments illustrated language as a

communication issue related to ethnicity: “Filipino nurses tend to speak in their dialect in the unit when they don’t want other nurses to know what they’re talking about, which makes me feel that they are talking about me.” “I believe our cultural differences inhibit the way we give and receive feedback from each other.” “We communicate well—we all speak Tagalog.” “We are all Filipinos, so we really don’t have any problem communicating.” “When they speak in their language, it keeps others from communicating with them.”

When nurses offered ideas to improve peer communication, comments such as, “Always speaking English not Tagalog; good grasp of the English language; Everyone speaking fluent English” were identified.

Respect

Another common set of comments centered around the theme of respect and professionalism. For example: “I find that people do not want constructive feedback.” “Our unit does not foster peer review. The nurses would rather talk behind your back than to your face.” “Some nurses are not respectful with their colleagues.” “I find it difficult to give constructive criticism; most do not want it.” “If it is a person who has no desire to hear any suggestions, I may not discuss it at all.” “I tell the RN that on this unit, this is how we do it.” “The problem is that half of the staff that I work with eat their young.”

DISCUSSION

In general across all units, nurses believed they gave more peer review than they received, and they rated their own communication behavior higher than they rated that of their peers. They also valued information from peers more than they felt feedback they gave was

valued by peers. It was interesting to note that there were no significant differences in responses, to either questionnaire, based on age or years of experience on the unit, two areas—generation gap and "nurses eat their young"—that frequently appear in the literature (despite the occasional comment reflecting that belief). Significant differences based on ethnicity did occur for many questions. This may reflect cross-cultural differences, as the demographics of this nursing workforce is 54% Caucasian and 34% Filipino or Asian. Filipino nurses overall scored higher than other ethnic groups on items related to positive peer interactions and caring factors. The Filipino culture, which stresses group orientation[31] rather than individual focus, may be an influencing factor.

Qualitative information gathered from open-ended questions and optional comments was occasionally at odds with the overall stated agreement that they receive feedback that they value. To some, communication or feedback was apparently not perceived as peer review even though peer review was defined as such in the instrument. Some comments reflected "peer review" as having a negative connotation.

Although nurses generally agreed that they give and receive peer feedback related to the quality of nursing care on their units, some commented on areas that need attention. One of the key areas—understanding the meaning of peer review—indicates a need to better define this term for nurses. The term has too frequently been used for annual performance reviews or hierarchical feedback. Peer feedback should not be confrontational, yet we received a number of responses to an open-ended question indicating that nurses would "confront" a peer if they encountered a practice issue needing to be addressed. Barbara Haag-Heitman[11] emphasizes that peer review is *not* the same as annual performance review; it is not a managerial process—managers should only support the process and remove organizational barriers to peer review.

Peer review should never be anonymous because "anonymous staff input has tarnished the notion of peer review for many" (p.7) and effectively represents an invitation to talk behind a colleague's back. Nurses need to have peer review defined for them as, literally, professional, direct, caring communication between RNs working at the same level.

In order to protect the dignity and autonomy of nurses in the workplace, the ANA's *Bill of Rights for Registered Nurses* clearly states that "nurses have the right to freely and openly advocate for themselves and their patients, without fear of retribution." Translation of this concept to the bedside, however, is challenging at best. In this study, it was apparent that cultural and language barriers led to perceptions of retribution, whether or not they were based in fact.

Effective teamwork begins with effective communication. Communication can be influenced by departmental culture and affected by variation in years of experience as a nurse or level of education. Communication is a foundational skill in peer review. Basic effective communication skills provide the cornerstone of peer-to-peer exchange. This study raised the question: Is lack of effective communication a fundamentally missing skill and subsequently a deal breaker to peer review?

In order to have effective peer review on the unit, nurses need to speak the same language because communication is affected by language preference and cultural expectations within the workplace. Speaking a language other than English while in the break room or cafeteria is normal and acceptable, but in a hospital work environment it is essential that other nurses, other co-workers, and the patients, be able to understand what is being spoken. The intent behind communication ties back to the *respect* theme evidenced from comments received. Development of collegial bonds would allow the *intent* to come across, even when the style differs or actual

communication is less than perfect. Nurses who effectively bracket their personal issues can provide their professional colleagues with effective peer review.

The Peer Group Caring Interaction Scale (PGCIS) scores in comparison to patient satisfaction and patient safety data did not appear to have any direct association. A high PGCIS score did not necessarily follow the same trend as the patient satisfaction or patient safety score for the individual units.

< insert **Figure 1. Patient satisfaction, safety & caring score** about here>

PGCIS scores across the units were generally (64%) lower than the patient satisfaction and patient safety perception scores. It appears that although we "would feel safe being treated here as a patient," we perceive ourselves as less caring toward each other. In the seven units that scored at 90% or higher on patients' satisfaction with overall nursing care, the PGCIS score remained significantly lower. These findings support evidence of an independent practice model versus a collaborative team model. Collaborative team models are essential to ensure a professional work environment, foster peer review, and lead to improved decision-making and higher quality outcomes.

The nursing fill rate during August through October 2009 was homogeneous across units. We were unable to establish a relationship between nursing unit fill rate and peer communication results.

LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

Because this was a non-probability sample at one institution, data cannot be generalized. However, the methods may be useful to other senior nursing leadership in identifying their own unit-based nurse peer communication. The cross-sectional nature of this research offers an exploration of some nurses' beliefs about peer review related to the quality of nursing care.

Only 75% of those who began the survey completed it. Dropout may have been due to survey length in a busy clinical environment or due to nurses not wishing to answer certain questions. Larger studies across multiple institutions with randomized samples are needed for generalizability.

In all survey-based research there is the risk of bias in self-selected samples (in terms of responders vs. non-responders), and in self-report (which in this case might include a lack of awareness about one's own communication skills or a lack of recognition of others' skills). It is possible that units with poor communication were also those that did not have enough responses to evaluate. Observers on the unit would be needed to determine whether or not communication is happening as reported.

Further evaluation and assessment is needed in the area of identifying barriers to peer review and prioritizing a collaborative practice model.

IMPLICATIONS FOR PRACTICE

Communication is a complicated process with seemingly unlimited factors, but good communication skills are teachable for most people. We may not solve all communication problems because communication inevitably involves the personalities of two individuals; however, it is the ethical and right thing to raise awareness about the importance of professional peer communication on the unit and to redefine it as a caring interaction among colleagues as opposed to the confrontational or judgmental connotation it apparently currently carries.

We found that nurses with the least years of experience (<5 years) and those with the most (>20 years) agreed that they could count on each other for help. Perhaps more attention needs to be focused on those nurses in the middle range of experience. The least experienced have special

programs designed for them while the most senior receive recognition for their longevity. Everyone needs to be recognized to foster collaboration which comes partly from valuing each other.

With Filipino nurses scoring significantly higher than other groups on items related to positive peer interactions and caring factors, nurses from this cultural background may be able to inspire other nurses by sharing their cultural beliefs in this area. Integrating diverse views enhances each nurse's ability to relate and communicate more effectively.

As diversity increases in our nursing population, this study indicates the need to ensure English fluency. Are nurses from diverse backgrounds able to communicate their expertise in English as well as in their native language? How can nurse leaders assess this factor and develop methods to improve fluency if needed?

From this study, we found that nurses had difficulty communicating with the perceived un-receptive nurse. A common method used to manage this situation was avoidance. Methods of communicating information regarding a patient's condition need to be freely given regardless of the recipient's response. Role modeling, coaching, and mentoring more adaptive coping skills may reduce the nurse's reluctance to provide peer review in these situations.

Evaluating communication in the daily work environment of nurses, along with its relationship to levels of patient safety, will provide staff nurses with information about the importance of good communication and can facilitate training in professional communication skills. This may, eventually, enhance the ethos of each unit to a true culture of safety. Nurses are expected to treat their colleagues with respect and communicate in a professional manner. Education, engagement and participation of nurses at the unit level are critical to moving forward with acceptance and practice of informal peer review. Nurses' outcome measures are reaching

new levels of excellence, which demonstrate to other health professionals and consumers the value nursing provides. Increasing their skills and abilities to communicate with their nursing peers will assist nurses themselves to own the valuable contributions nursing makes every day.

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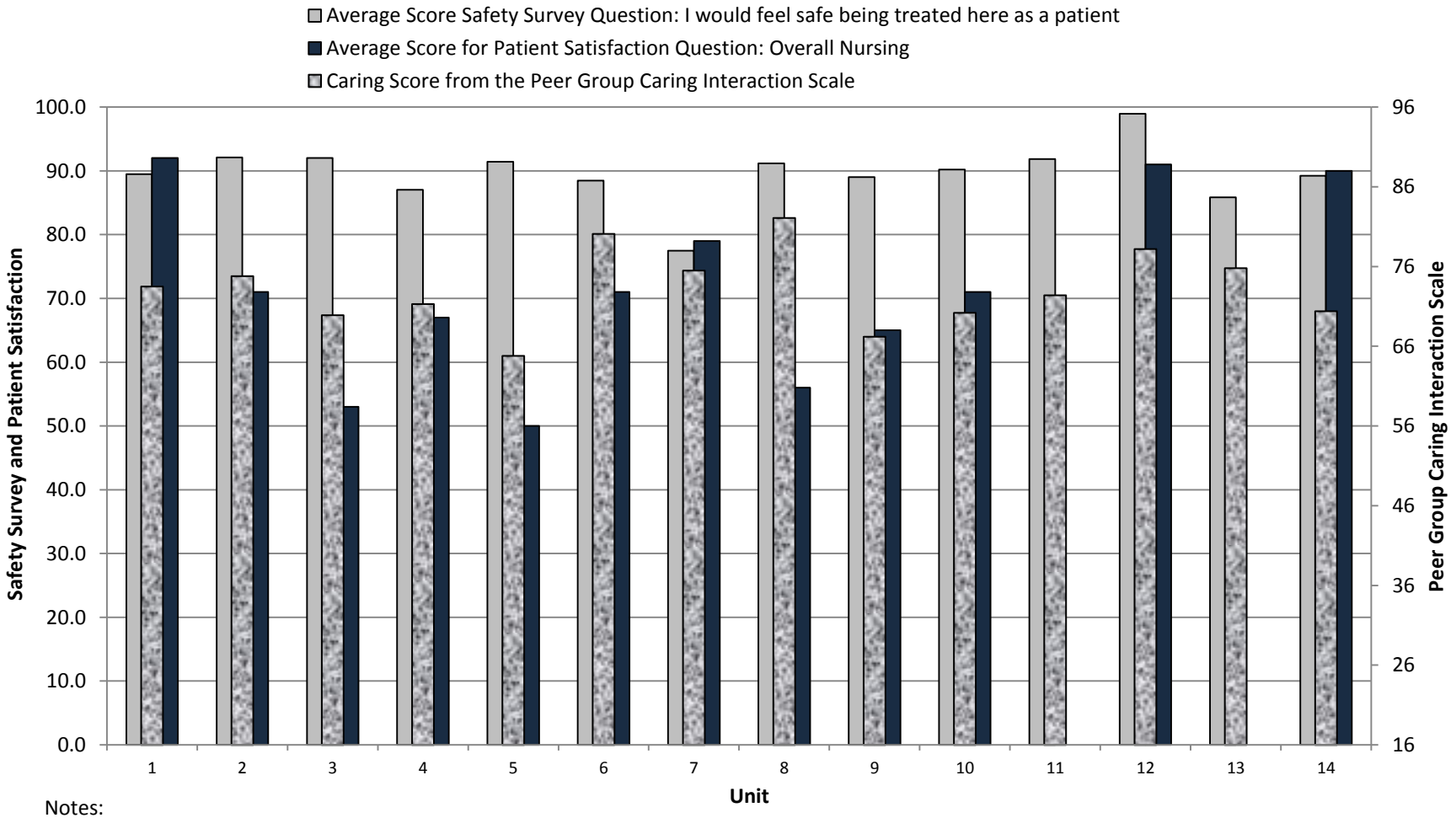
Table 1. SAMPLE DEMOGRAPHICS

EDUCATION		
Diploma	6.6%	
Associate's	31.0%	
Bachelor's	59.2%	
Master's	6.2%	
AGE		
Mean Age	**43.4**	
< 25	2.4%	
25-30		10.9%
31-40		30.0%
41-50		26.5%
51-60		25.7%
61-70		4.5%
RACE/ETHNICITY		
Caucasian	54.2%	
Filipino/Asian	34.1%	
Latino	4.9%	
African American	2.2%	
others	4.6%	
YRS AS NURSE		
Mean Years	**18.6**	
less than 5	20.2%	
6-10 years		15.4%
11-15 years		13.2%
16-20 years		17.0%
> 20 years		34.2%
YRS ON UNIT		
Mean Years	**8.1**	
less than 5	49.2%	
6-10 years		24.7%
11-15 years		9.9%
16-20 years		5.7%
> 20 years		10.5%

Factor /Questions with statistically significant difference	*df*	*n*	X^2	*p-value*
Highest Degree				
PGCIS Q6: RNs on my unit think it should be left up to the Nurse Manager(s) to work with RNs who need extra help related to patient care.	3	430	9.36	.025
PGCIS Q15: RNs on my unit talk with fellow RNs (on the same unit) about how it feels to care for patients who they are uncomfortable with.	3	430	9.61	.022
Years of Experience as a Nurse				
PGCIS Q10: RNs on my unit can count on other RNs on the unit for help.	4	430	9.92	.042
Ethnicity				
PR Q2: My peers regularly give me feedback related to the quality of nursing care I deliver on our unit.	8	430	16.04	.042
PR Q3: The quality of the information I receive from my peers (related to MY delivery of nursing care) is valuable.	8	430	15.63	.048
PR Q4: The quality of the information I give to my peers (related to the nursing care THEY deliver) appears to be valuable to them.	8	430	16.17	.040
PR Q6: I deliver feedback to my peers in a way that they appear to be comfortable receiving (listening to with an open mind).	8	430	17.43	.026
PR Q7: My peers who are of a different gender speak to me respectfully and communicate well when giving feedback.	8	430	24.42	.002
PR Q9: My peers who are of a different ethnicity or race are respectful and communicate well when giving feedback.	8	430	17.61	.024
PGCIS Q2: RNs on my unit talk with each other about their problems & concerns related to nursing practice on the unit.	8	430	15.79	.046
PGCIS Q4: RNs on my unit talk with each other about things they wish they had done better while caring for a particular patient.	8	430	16.92	.031
PGCIS Q5: RNs on my unit will help another RN ONLY WHEN it is in their own best interest to do so.	8	430	22.39	.004
PGCIS Q6: RNs on my unit think it should be left up to the Nurse Manager(s) to work with RNs who need extra help related to patient care.	8	430	16.37	.037
PGCIS Q7: There is a lot of positive personal interaction among the RNs on my unit.	8	430	20.77	.008
PGCIS Q9: RNs on my unit get advice and suggestions from other RNs on the unit related to patient care.	8	430	16.37	.037
PGCIS Q10: RNs on my unit can count on other RNs on the unit for help.	8	430	15.91	.044
PGCIS Q12: RNs on my unit are a source of encouragement to each other.	8	430	25.66	.001
PGCIS Q13: RNs on my unit help each other by sharing information sources, research articles, or evidence related to our patient care.	8	430	21.20	.007
PGCIS Q15: RNs on my unit talk with fellow RNs (on the same unit) about how it feels to care for patients who they are uncomfortable with.	8	430	16.56	.035

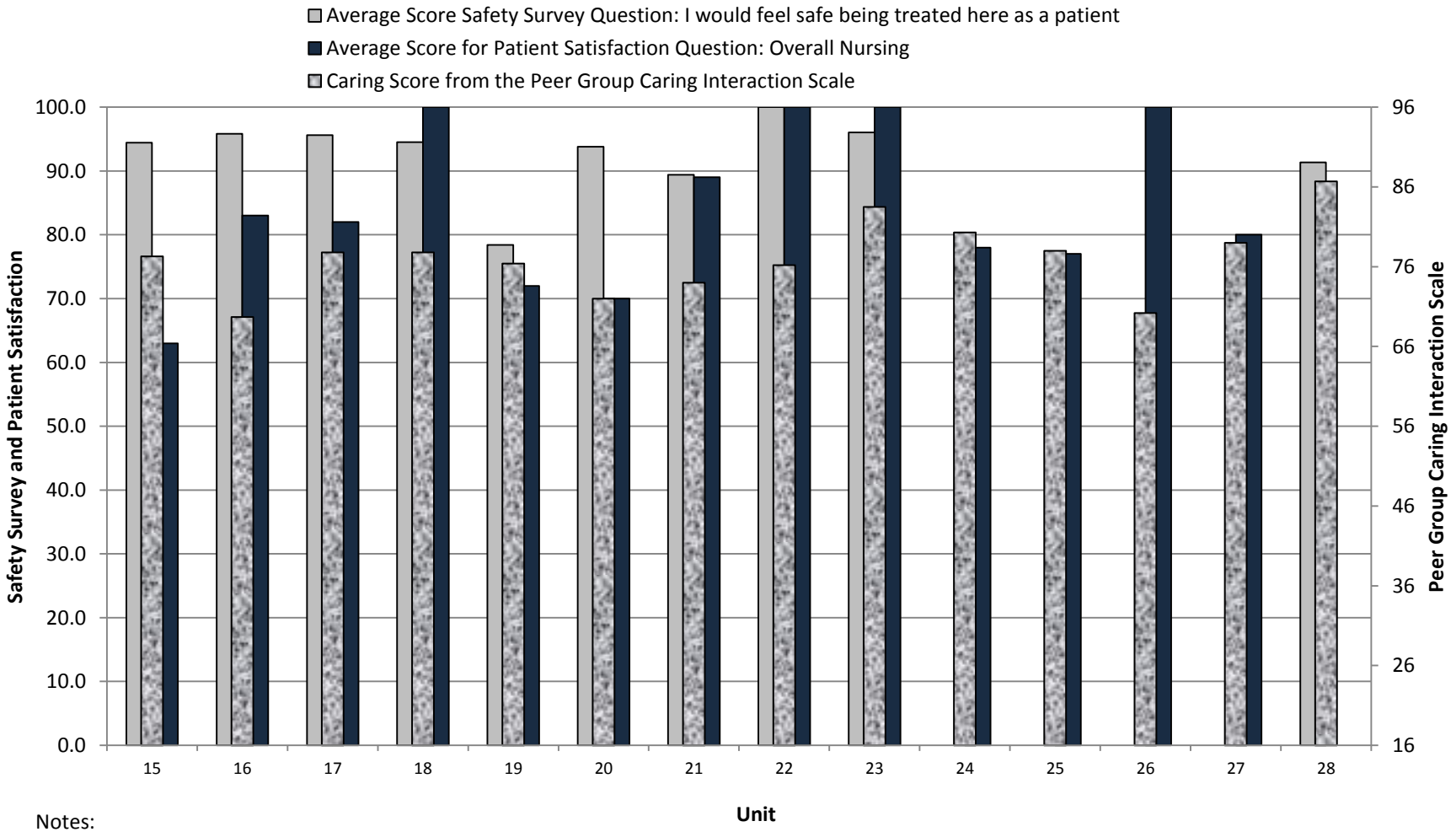
Average Scores for Patient Satisfaction, Safety Survey, and Caring Score
August - October 2009, by Unit



Notes:

1) The Press Ganey Patient Satisfaction question displayed in the graph is for "Overall Nursing."
2) The Safety Survey question displayed in the graph is "I would feel safe being treated here as a patient."
3) The Caring Score is the summative score of the Peer Group Caring Interaction Scale.
4) Safety Survey data is not available for unit #11 and #13.

Average Scores for Patient Satisfaction, Safety Survey, and Caring Score August - October 2009, by Unit



Notes:

1) The Press Ganey Patient Satisfaction question displayed in the graph is for "Overall Nursing."
2) The Safety Survey question displayed in the graph is "I would feel safe being treated here as a patient."
3) The Caring Score is the summative score of the Peer Group Caring Interaction Scale.
4) Safety Survey data is not available for units #24-27 and Patient Satisfaction data is not available for unit #28.