Talking about what we are doing together: Why and how?

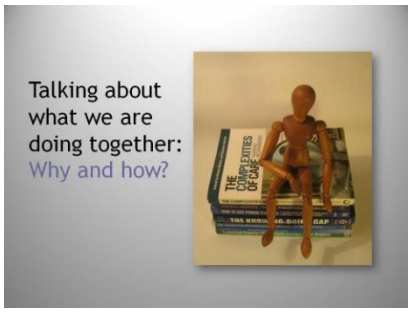
CITATION

JONES Shelley, BOLADERAS Robyn, MANNING Juliet, SHAPLESKI Teresa and SHAW Karen (2011) **Talking about what we are doing together: Why and how?** Presentation at Australasian Nurse Educators Conference 'Innovations in Nurse Education in Practice, Thinking Aloud, Thinking Ahead', Wintec, Hamilton, 23 - 25 November 2011.

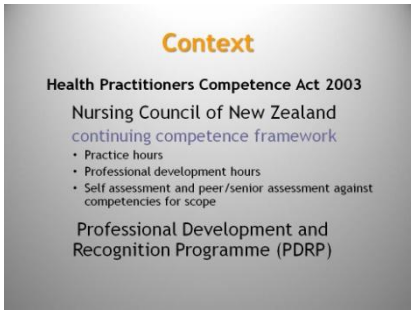
ACKNOWLEDGEMENTS

Thank you to Marian Partington and Maria Baynes who acted as critical readers.

presentation story board

Slide #	ON SCREEN	NARRATION
1		It's often said that nurses are great talkers. This presentation[1] is no exception because we're here to talk about talking! Dialogue is a strength in our collective practice.
2		We're coordinators of professional development and recognition programmes in our respective institutions: • **Teresa Shapleski** from Waitemata District Health Board in the Auckland region • **Juliet Manning** from the Otago end of the Southern District Health Board at the bottom of the South Island • **Shelley Jones** with an independent practice – learn-ability – which includes a role as PNA at Bowen Hospital, a private surgical hospital in Wellington, the capital city. We represent a writing team - which includes our absent colleagues: • **Robyn Boladeras** of Bay of Plenty DHB • **Karen Shaw** of Hutt Valley DHB • **Maria Baynes** at the Southland end of Southern DHB, and • **Marian Partington** of Waikato DHB who is not absent because she is chairing this session. We committed to this presentation as part of a dialogue that began in a conversation at a national meeting of PDRP coordinators in March this year. [Group photo appears] This is our community of practice.

[1] (Note: This image © and used with permission from learn-ability for this presentation)

Slide #	ON SCREEN	NARRATION
3		Because this is an Australasian conference, we're going to briefly review the context of today's conversation by describing our work and the regulatory and legislative context. Starting [from bottom] with nurses' immediate reality – the PDRP. PDRPs are designed to involve and support nurses in things that are good for them professionally, such as • reflecting on practice, keeping a portfolio as a record of practice, and • using that portfolio as a body of evidence of competence, • or to apply for recognition of level of practice. What this means is that a good part of our work is persuading busy clinical nurses that truly, they ***can*** do it, they do ***want*** to do it and besides which, one way or another, they ***have*** to do it. Another part of our work is persuading managers that the nurses do want to do it and can do it, and also the organisation does ***need*** to have the PDRP. Most times, the organization's PDRP has been approved by the Nursing Council of New Zealand and therefore provides a mechanism for nurses to fulfill Council's continuing competence requirements (CCR). Briefly, the requirements are that within the last three years, the nurse has completed 60 days of practice and 60 hours of professional development. And she or he must have completed two of three forms of assessment against the practice competencies defined for her/his scope – the three forms of assessment being self, peer and senior nurse (such as a manager). On renewing their Annual Practising Certificate (APC), nurses sign a declaration that amongst other things, they have completed these requirements. Council audits 5% of nurses to ensure confidence in these declarations. Because Nursing Council approved PDRPs encompass CCR, it is therefore a good thing to participate in your employer's PDRP - you avoid the possibility of audit. The wider context, which gives the legislative imperative for the regulation of health professionals is the HPCA. Broadly speaking, it provides for regulatory bodies and avenues to report and investigate practice that doesn't meet the standard.
4		There were about 30 of us present at this national meeting. We don't meet often as a group, perhaps every two years, and often it seems that we've all rushed to a meeting which is going to be too short to allow us to settle into the kind of dialogue where ideas can develop… but on this day there was a moment when the conversational line on peer review pulled earlier points together in a very productive way. This line of thinking posed an opportunity to think and work collectively on something that exercises all of us – how to help nurses **realise** the benefits of peer assessment or peer review – in both these meanings (coming to understand its value, and getting the return on investment). There is something of a tension – not yet resolved in the conversation we've been having – between peer assessment or feedback in an appreciative sense – and peer evaluation. The point of resolution – common to both – is that peer feedback/assessment/review processes should be developmental. In other words, the process stimulates insight and growth. We are using these terms - peer assessment or peer review - somewhat interchangeably, and by them we mean a structured assessment or review process against given standards, undertaken by one nurse of another, with the two usually having the same positional status (i.e. mostly RNs in Staff Nurse roles), although not necessarily

of equal experience[2]. It's our contention that this more formal process happens more comfortably and if it is 'normal' for colleagues to discuss their practice together more informally. We are thinking of a culture of peer dialogue in which ongoing discussion and conversation is the background to more formal processes.

Benefits of peer review are generally expected to be '…shared understanding, a greater sense of ownership, empowerment, responsibility, support within peer groups and better communication'[3]. What, you might ask, is not to like?

However, some provisos accompany such claims – that to work well, peer review processes require:

- that nurses have training in the process and bring to it openness, honesty and the willingness to give and receive feedback
- that managers support the process
- that the organisation provides appropriate timing and time, good tools and a clear distinction between appraisal and peer review.[4]

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There are many good arguments for dialogue between peers about practice, one way or another, and we're going to review three briefly.

Professional self-regulation

Professions have the mandate to restrict practice in exchange for the responsibility to monitor practice. To be a professional is to have internalised codes of ethical conduct and to have integrated guidelines for good clinical practice as personal knowledge, so that checks and balances in practice happen first within the practitioner in a self-reflexive process.

The insightful inner dialogue of self-awareness – including the awareness that one could be unaware or mistaken – is fundamental to practising as a professional, and probably prior to and necessary for peer dialogue. Self-evaluation - which needs to be consciously and purposefully part of everyday work – constitutes the basis for peer evaluation, at the same time that peer evaluation expands and tempers self-criticism[5].

A question that arises here - and which we'll come back to - is this: *If that inner conversation isn't happening, can peer dialogue prompt it?*

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[2] Defined in HPCA Act 2003 1/5/1: ***professional peer***, in relation to a health practitioner, is a person who is registered with the same authority with which the health practitioner is registered http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203321.html

[3] Walker and Joines (2004) cited in ROUT Amelia and ROBERTS Paula (2007) Peer review in nursing and midwifery: a literature review, **Journal of Clinical Nursing 17**: 427-442

[4] *See* HAAG-HEITMAN Barb and GEORGE Vicki (2011) **Peer Review in Nursing: Principles for Successful Practice**. Jones & Bartlett: Sudbury, MA. *Also* GEORGE Vicki and HAAG-HEITMAN Barb. (2011) Nursing peer review: the manager's role **Journal of Nursing Management 19**: 254-259

[5] VUORINEN Riitta, TARKKA Marja-Terttu & MERETOJA Riitta (2000) Peer evaluation in nurses' professional development: a pilot study to investigate the issues. **Journal of Clinical Nursing 9**: 273-281

Positive practice environments

In a community of practice there is care for the thing to be done, care to do it well, and care for those doing it. Work environments that support professional work in these ways are being studied variously as 'attractive and supportive workplaces'[6], 'healthy work environments'[7] and 'positive practice environments'[8].

Kramer and Schmalenberg cite empirical evidence for direct positive links between safe patient care and the quality of work environments for staff nurses. They note that 'only staff nurses can confirm whether strategies designed to improve the health of the work environment are effective'[9].

They argue that 8 'essentials of magnetism'[10] are also essential attributes of a healthy work environment, meaning one in which workers are productive, able to give quality care, able to meet personal needs and which is satisfying (2008:56-57).

How do these factors essential to being able to give quality care relate to peer dialogue? We'd draw links between the factors to argue that peer dialogue can happen when *colleagues who respect each other as competent talk supportively with each other about doing their best for patients.*

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The third argument for peer dialogue about practice is ***patient safety***. Without going into detail, we are going to refer you to two projects reported with these titles:

- **Silence kills: The seven crucial conversations for healthcare**[11],
- **The silent treatment: Why safety tools and checklists aren't enough to save lives**[12].

The first was sponsored by the American Association of Critical Care Nurses and VitalSmarts, an international company offering consulting and training in organisational performance and leadership. AORN (Association of periOperative Registered Nurses) was also a sponsor in the second study, which extended the focus to operating theatres.

The first study found that conversations are crucial to patient safety in seven areas:

1. Broken rules
2. Mistakes

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6 *See* WISKOW Christiane, ALBREHT Tit and DE PIETRO Carlo (2010) **How to create an attractive and supportive working environment for health professionals** *at* http://www.euro.who.int/__data/assets/pdf_file/0018/124416/e94293.pdf Wiskow et al write that 'As a working definition, an attractive and supportive workplace can be described as an environment that attracts individuals into the health professions, encourages them to remain in the health workforce and enables them to perform effectively'.

7 *See* KRAMER Marlene, SCHMALENBERG Claudia (2008) Confirmation of a Healthy Work Environment, **Critical Care Nurse** 28: 56-63. Retrieved from: http://ccn.aacnjournals.org/content/28/2/56.full.pdf+html They write: 'In this article, we consistently use "healthy" as defined in the AACN Standards for Establishing and Sustaining Healthy Work Environments and in our original construction of the Nursing Work Index. Healthy means productive, able to give quality care, satisfying, and able to meet personal needs' (2008:56-57).

8 *See* International Council of Nurse (2007). **Positive practice environments: Quality workplaces = quality patient care.** Information and Action Tool Kit developed by Andrea Baumann for ICN. Geneva, Switzerland: International Council of Nurses *at* http://www.icn.ch/indkit2007.pdf

9 KRAMER Marlene, SCHMALENBERG Claudia (2008) Confirmation of a Healthy Work Environment, **Critical Care Nurse** 28: 56-63. Retrieved from: http://ccn.aacnjournals.org/content/28/2/56.short p 56.

10 *Review the essentials of magnetism at* http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=767074 *You can also access a summary pdf* (KRAMER Marlene, SCHMALENBERG Claudia, MAGUIRE Pat (2008) Essentials of a magnetic work environment) *at that page.*

11 MAXFIELD David, GRENNY Joseph, McMILLAN Ron, PATTERSON Kerry, & SWITZLER Al (2005). **Silence kills: The seven crucial conversations for healthcare.** *Download from* http://www.silenttreatmentstudy.com/silencekills/ *Their summary from page 16:* The problem described in this study is severe. 1) People see others make mistakes, violate rules, or demonstrate dangerous levels of incompetence 2) repeatedly 3) over long periods of time 4) in ways that hurt patient safety and employee morale 5) but they don't speak up and 6) the critical variable that determines whether they break this chain by speaking up is their confidence in their ability to confront.

12 MAXFIELD David, GRENNY Joseph, LAVANDERO Ramón, and GROAH Linda (2011) **The silent treatment: Why safety tools and checklists aren't enough to save lives.** *Download from* http://www.silenttreatmentstudy.com/index.html *The essence of the findings/argument:* When communication breaks down, it breaks down in two very different ways. Business theorist, Chris Argyris, groups these breakdowns into two categories: honest mistakes and undisscussables. Safety tools such as protocols, checklists and warning systems are designed to address 'honest mistakes' and generally work, except when they are undercut by undiscussables. In Maxfield et al's study nearly 60% of nurses reported being in a situation where a safety tool highlighted a problem but it was either unsafe to speak up or they were unable to get others to listen. [Acknowledgement: Shelley Jones would like to thank her colleague at Bowen Hospital, Pam Kohnke, Theatre Manager, for telling her about these studies]
Other useful and relevant perspectives in WEICK Karl E & ROBERTS Karlene H (1993) Collective Mind in Organizations: Heedful Interrelating on Flight Decks **Administrative Science Quarterly 38**(1993): 357-381

3. Lack of support
4. Incompetence
5. Poor teamwork
6. Disrespect
7. Micromanagement.

The study team said that '*There seven categories of conversations are especially difficult and, at the same time, have been shown to be especially essential for people in healthcare to master because they relate strongly to core competencies such as medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover*'[13].

The bad news from these studies is this: While more than half the health workers surveyed had concerns arising from observing colleagues' behaviour in these seven areas, fewer than one in ten fully discussed their concerns with the coworker. Further, most believed it was neither possible nor even their responsibility to call attention to these issues.

But to report the good news: '*The 10 percent of healthcare workers who confidently raise[d] crucial concerns observe[d] better patient outcomes, work[ed] harder, [were] more satisfied, and [were] more committed to staying in their jobs. If more healthcare workers could behave like the influential 10 percent, the result would be significant reductions in medical errors, increased patient safety, higher productivity, and lower turnover*[14].

And yes, there are things to learn from what the 10% say and do when the stakes are high (high both for patient safety and whether the staff member feels personally un/safe)[15].

This review of arguments ***for*** peer dialogue tells us why PDRP coordinators must continue to make it their business to support peer dialogue as the context for more formal processes of peer assessment and review.

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And that means that we must fully engage with the reasons that nurses give us for not wanting to participate in peer assessment exercises. We quote from our daily practice:

- *I don't have time*
- *It's not my job*
- *I'm too busy being a nurse*
- *I don't like that person so the feedback will be bad*
- *The feedback might be that the person isn't competent – it's the manager's job to tell them that.*
- *I don't have a portfolio*
- *I'm going on holiday*
- *The people who are good at it, get called on all the time*
- *Do you have a sample one to copy?*
- *Some people are saying that they will refuse to do peer feedback.*
- *What's in it for me?*

It all adds up to "NO".

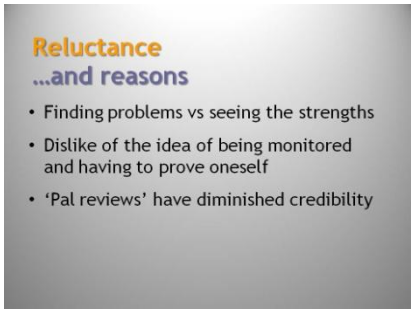
As PDRP coordinators we are not alone in observing that nurses are often reluctant to undertake forms of peer assessment because it is perceived as a difficult and negative experience, or as a process that lacks credibility. How did this come to be? Here are some of the ***reasons*** we've discussed.

[13] http://www.silenttreatmentstudy.com/assessment/

[14] http://www.silenttreatmentstudy.com/silencekills/

[15] Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2002). **Crucial conversations: Tools for talking when the stakes are high**. New York: McGraw-Hill.

6 cont



Finding problems vs seeing the strengths

The dominant mode of enquiry in clinical work is diagnostic - to find the problem. With this goes an imperative not to miss anything that might be a problem or a need.

Dislike of the idea of being monitored and having to prove oneself

Since the assessment is against a standard, there's the potential that there may be a finding that a peer's practice does not meet the standard. What do you do then as the assessor? Or, if you are the person having the assessment, this is not a cheerful thought. What would happen next?

What if we were to look for what you are doing right and well so that we can learn from it?

'Pal reviews' have diminished credibility of peer feedback processes

Because it is perceived as a potentially negative and fraught experience, nurses are anxious that giving feedback will harm or upset work relationships and sometimes feel it is not worth the risk. Sometimes nurses have arranged for the certainty and comfort of unchallenging mutual 'pal' reviews. If I do a nice review for you and you do a nice one for me and then we've both completed PDRP paperwork… Unfortunately, the intent of an unbiased dialogue to assist a colleague to better articulate their practice and reflect on that practice, is lost. Peer review loses credibility as a valid and useful tool in reflecting on and subsequently improving nursing practice.

7

If we are to support nurses in a collective professional accountability through peer assessment processes, how do we start afresh without this baggage? We signalled that we thought a shift from 'why you should do it' to 'how you can do it' was in order. We've shared our experiences with each other and each reviewed a couple of articles from a small literature search on terms from our abstract[16]. Here's what we have found to work well, along with some new insights.

Clarify, re-frame, re-focus (from Karen Shaw)

When those who were reluctant to engage with peer review were shown a different approach, a different and more professional meaning and different outcomes for peer review. It has become less about the arduous task of 'finding someone to do the paperwork' and more about finding a colleague(s) to help me through the process and help me reflect on my practice in a positive manner/help me see what I cannot.

Renaming it as competence assessment – even though it is done through a peer review process - means that the stigma of cronyism has also been removed. Changing peer review's image from one of punitive assessment to one of enabling and self reflection also changes the focus of the process. When the focus is 'how can I help you better articulate your practice, reflect on it and thus improve it', changes the power dynamic of the process and puts the power back in the hands of the person seeking the review and removes it from the reviewer.

Senior nurses (those in nurse educator, CNS and CNM positions) appear to find it difficult to see how they can complete competence assessment requirements for NCNZ until peer review is offered as an option. They are frequently turning to other senior nursing colleagues to provide competence assessment, and recognising the value of dialogue with colleagues even though they do not work in the same clinical area.

[16] Thank you to Robyn Boladeras for organising this with the librarian for BOPDHB.

Multiple and particular perspectives (from Robyn Boladeras)

A previous expectation was that one nurse could provide a comprehensive peer review – with an attendant burden of responsibility and work. A helpful shift is to request a small review of practice (attestation) or to select a range of peers to provide feedback against different competencies.

This involves consideration of how to make the request and what the requester will prepare - they need to provide a small selection of examples of practice and be clear about the competencies they are requesting evidence for (as well as the level of practice descriptors). It is also important to coach the nurse who'll complete the feedback on what to expect. How can they contribute to the professional development of their peer? This is the primary question that is lost in a flurry to provide examples for constructed templates and competencies.

Shift focus from person to practice/portfolio (Shelley Jones)

There's a model in Jenny Grainger's beautiful account of 'clinical conversations' as an appraisal process in her master's thesis[17]. The focus is primarily on pieces of practice evidence in the nurse's portfolio. We often remind ourselves that practice is the thing, not the portfolio (the portfolio simply documents or reflects the practice), and it's possible that the account of practice on paper helps the pairs focus on the practice rather than the person and thus avoid the perils associated with having to say something 'personal' about the person.

This also builds on the idea that it seems an OK thing to say to a peer about their practice 'That would be good for your portfolio'. It's an elliptical way to compliment someone about their practice, but as PDRP coordinators, we have no problems with nurses helping each other build their portfolios!

Making time in a workshop for learning activities in which new approaches can be tried out and supported, recognises that it's 'all new' for a certain generation of nurses, who might not actively seek feedback – whether that's to do with professional socialisation or personality[18].

8

Learn from what the 10% say and do (from Teresa Shapleski)

In ***The Silent Treatment*** report[19], proof is found that it is possible to discuss serious concerns in almost any environment and succeed: 10% of nurses were confident about their ability to speak up. Insight into this group reveal they are similar to their peers in most ways; background, work environment, access to resources.

A review of their handling of 'crucial' conversations identified patterns in their approach. What struck me about the seven patterns identified could be summarized as 'good intent' - a genuine caring approach for their colleague and positive patient outcomes. These are core nursing attributes. The key skills they employed were to

- begin by exploring their positive intent
- use facts and data as much as possible
- make it safe for the other person
- avoid negative stories and accusations, and
- deflect anger and emotion.

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[17] *See* GRAINGER Jenny (2007) **Mind Shift: Creating Change Through Narrative Learning Cycles. A qualitative interpretive study of clinical conversation as an appraisal process for sexual and reproductive health nurses.** A thesis submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree of Master of Health Science.

[18] *See* MANTESSO Jaime, PETRUCKA Pammla & BASSENDOWSKI Sandra (2008) Continuing professional competence: Peer Feedback success from determination of nurse locus of control **The Journal of Continuing Education in Nursing 39** (5):200-205. *And also consider having a look at this discussion of low self-esteem in relation to PDRPs:* JONES Shelley (2001) Theorising expectations of 'over and above': Organisational citizenship behaviour, social exchange and disposition. Paper presented at: The Path to Portability Fourth NZNO National Forum for Clinical Career Pathways

[19] MAXFIELD *et al* (2011) *op cit*

The researchers concluded: *'If every caregiver has these skills, it will go a long way toward resolving the problem of organisational silence'.*

Sue Hayward, in her welcoming address this morning, talked about the role of the nurse educator in 'breaking down barriers'. Creating an everyday culture of peer dialogue, getting used to talking and developing these key skills would mean when the time came for those 'critical' conversations, it would not be such a big deal.

Provide a range of models and tools for both appreciative and constructive feedback (from Robyn Boladeras and Shelley Jones)

While expecting nurses to seek and give feedback, offering some options on how it happens might enable individuals to choose tools and approaches that have a good fit with their personal style and particular purpose.

For example, some may find it helpful to understand that feedback can be given at three levels (task, motivational, self), and which levels are encompassed in the peer feedback exercise (i.e. feedback on the personal aspect of self is not included)[20].

We can help people emphasize what is good in our practice through simply looking for what worked well and why. Appreciative enquiry is a positive alternative to traditional problem seeking and problem solving[21]; perhaps using a space within handover or the team meeting to give feedback and thus positioning appreciative enquiry within a key task of daily practice. A technique worth looking at is the feedback ceremony[22]. Another idea is the game of problem free talk, supporting peer conversations to appreciate practice diversity or triumphs.

It is one of the unsolved mysteries of nursing practice that nurses can be skilled communicators with patients, with other members of other disciplines… but somehow fall to pieces when something needs to be said to a colleague? Formats such as this will be useful if they need to make a suggestion:

- **Describe** the specific behaviour
- **Acknowledge** how the behaviour affects you/team/organisation
- **Specify** the parameters of a replacement behaviour
- **Reaffirm** the value of the team member and their contribution[23].

It would be useful to look at peer coaching[24] and peer learning partnership[25] models - the dialogue that peers might have would likely include the questions you'd be addressing in professional supervision.

Talk about self-awareness using the Johari window (from Robyn Boladeras and Shelley Jones)

At our PDRP coordinators' meeting in March, Pam Doole, Professional Standards Manager at Nursing Council had made the comment (in

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[20] *From* MOSS Sherry and SANCHEZ Juan (2004) Are your employees avoiding you? Managerial strategies for closing the feedback gap **Academy of Management Excutive18** (1) 32-44, p 41

[21] HAMMOND (1998) The Thin Book of Appreciative Inquiry. Thin Book Publishing Company, 1998, pages 6-7: The traditional approach to change is to look for the problem, do a diagnosis, and find a solution. The primary focus is on what is wrong or broken; since we look for problems, we find them. By paying attention to problems, we emphasize and amplify them. …**Appreciative Inquiry** suggests that we look for what works in an organization. The tangible result of the inquiry process is a series of statements that describe where the organization wants to be, based on the high moments of where they have been. Because the statements are grounded in real experience and history, people know how to repeat their success'.

[22] Sharry J, (2006). **Solution-Focused Group Work**. London: Sage

[23] Ibid p41.

[24] See WADDELL Donna & DUNN Nancy (2005) Peer Coaching: The Next Step in Staff Development. **The Journal of Continuing Education in Nursing 36**(2): 84-89

[25] *See* EISEN Mary-Jane (2001) Peer-based professional development viewed through the lens of transformative learning. **Holistic Nursing Practice 16**(1):30-42. *Definition page 32:* 'Peer learning partnerships are voluntary, reciprocal helping relationships between individuals of comparable status, who share a common or closely related learning/development objective'.

relation to a recently published review of the continuing competence framework) that the competencies currently defined for the RN scope work effectively for Nursing Council's purpose in competence reviews. Except, Pam said, perhaps sometimes in professional practice aspects where a nurse 'lacks insight'[26].

The Johari window is one tool that could be used objectively to prompt understanding that there are things we do not know about ourselves, but others do. More positively for our situation supporting competent nurses in peer feedback, the Johari window[27] could be used to help reveal positive things of which one is unaware and that would be very affirming and confidence building to hear about.

Johari window: feedback and disclosure

	known to self	unknown to self
known to others	PUBLIC/OPEN	BLIND
unknown to others	PRIVATE/HIDDEN	UNKNOWN

9

As PDRP coordinators, we must model what we wish to support – here we are talking about our practice, and inviting your comment.

Resources

But before we do that, we're going to highlight that we've not yet dealt with the real challenge for nurses - ***time and resource*** to do this. We've been conscious of what is required in doing something 'extra' in the reality of our own email discussion in preparing this presentation.

Here we are talking about our part in changing professional and organisational culture. We should do all these things and more, yet as PDRP coordinators we don't have the levers of line management.

Juliet cited what happened recently when changes to the scope of Enrolled Nurse practice required that large numbers of RNs had to be involved in assessing the competence of their EN colleagues, so that they could transition to the new scope of practice. Without going into the detail of changes to the scope and requirements for transition, we should note two factors in that process which were probably critical to it gaining considerable organisational resource (and we can look at how to bring these factors forward):

- The outcomes of assessment were understood to be really important by all involved, as was the imperative to do it properly
- Clear guidelines for assessment requirements were available.

Relationship

In addition to the ideas we've discussed for improving our practice as PDRP coordinators – helping nurses with the 'how' of peer assessment – we need to also work at unit and organisational level on the 'how' of peer dialogue. Karen identified that senior nurses are key allies - their lived understanding of the value of peer review is helping support uptake.

Reasons

We also need to match our expectations that nurses will more readily embrace formal processes of peer feedback and assessment by ensuring that their employers value these processes and allocate resource to them – and we come back to 'why'.

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[26] *See also* LOCKYER Jocelyn, VIOLATO Claudio, FIDLER Herta (2007) What Multisource Feedback Factors Influence Physician Self-Assessments? A Five-Year Longitudinal Study. **Academic Medicine 82** (10) S77-80

[27] *See* http://www.businessballs.com/johariwindowmodel.htm http://www.mindtools.com/CommSkll/JohariWindow.htm

As PDRP coordinators we are already part of the resource allocated – what further value can we add to what we are doing? Our advocacy should include evidence for the relationship between all forms of constructive peer dialogue and patient safety and positive/healthy work environments[28].

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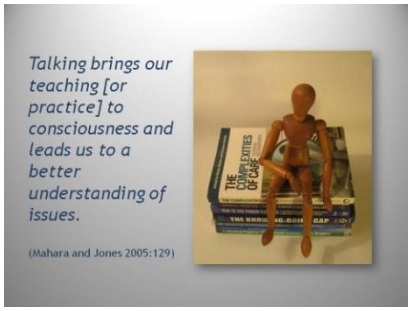

'…the nature of learning requires participation in the doing, ***the sharing of perspectives*** about the doing itself, and the mutual development of both the individual and the collective's capabilities in the process' (Liedtka 1999), and that's been our experience in preparing this presentation.

Thank you.

[28] An example cited by Karen was of community-based nurses who have formed peer review groups to help each other through difficult experiences, the outcome being the successful support of colleagues, rather than assessment. She notes that the desired outcome strongly influences the behaviours of those taking part.