Leveraging Consistent Communication Tools and Organizational Values to Promote Accountability Among Health Care Providers

Cynthia A. Baldwin, MS, RN; Alice M. Krumm, DNP, RN, NEA-BC, CNOR

ABSTRACT

Teamwork and effective communication between all health care staff members are essential to providing safe, high-quality patient care. High-reliability organizations align behavioral expectations with organizational values and prioritize safety over other performance metrics and pressures. Communication breakdowns, such as inadequate or incomplete information shared between caregivers, continues to be an issue that is linked to errors and staff member dissatisfaction. Initiatives to improve health care communication and improve patient outcomes are well documented, yet communication issues in the health care setting continue. An organization's credo defines its values and behavioral expectations. Educating team members on an organization's credo creates accountability among those teams to align their behavior with the organization's values, policies, and professional commitment. A Coworker Observation Reporting System offers a communication method for providing meaningful feedback on behaviors inconsistent with an organization's credo.

Key words: *peer feedback, Coworker Observation Reporting System (CORS), high-reliability organization, credo, peer messenger.*

Providing quality health care takes a team effort and effective communication between and among team members; however, communication issues among health care clinicians are pervasive and continue to result in preventable patient harm.[1] A benchmarking report published in 2016 linked communication failures to 1,744 deaths and $1.7 billion in malpractice lawsuits in US hospitals over five years.[2] Communication breakdowns, such as inadequate or incomplete information-sharing among caregivers, continues to be the leading factor contributing to all sentinel events, including wrong-site surgeries and retained foreign objects.[3] Initiatives to improve health care communication are well-documented and discussed in the literature, yet many organizations continue to struggle with communication breakdowns.

One explanation as to why communication among health care team members remains a challenge is that designing systems and implementing best practices requires professionalism from all team members and for leaders to hold their team members accountable for their behavior.[4,5] According to The Joint Commission, developing trust, transparency, and accountability to support safety culture initiatives is an essential role of leadership.[3,6] Additionally, the Institute for Healthcare Improvement describes leadership commitment and accountability as key elements for establishing system-wide safety strategies.[7]

With an understanding of the criticality of effective communication among health care team members, how should leaders at health care organizations respond to those individuals who choose not to follow the agreed-upon policies

http://doi.org/10.1002/aorn.14204

and best practices to improve patient outcomes and decrease patient harm? One approach found to be effective at *high-reliability organizations* (HROs) is to align behavioral expectations with organizational values and prioritize safety over other performance metrics and pressures.[8] Equally important as ensuring patient safety remains a top priority are a preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise, and commitment to resilience, all of which are tenets of an HRO.[8]

OVERVIEW OF THE PROBLEM

In today's health care environment, patient care continues to increase in complexity. Health care team members are encountering high-acuity patients who require complicated diagnostic tests and are treated with sophisticated technology. These teams are more reliant on decision-making processes that involve diverse personnel from a variety of specialties, often brought together for the first time when caring for that patient.[9] The complexity of patient care is further increased in the perioperative area because of interrelated preoperative activities (eg, completing presurgical checklists, obtaining test results), patients arriving in the middle of the night when resources may be limited, and patients transferring directly to the OR from diagnostic or acute care areas (eg, interventional radiology, emergency department [ED]). This complexity can result in communication that is too late, is incomplete, or is even inaccurate.[10] Because team composition, protocols, charting, and methods of communication vary from unit to unit, interdisciplinary team communication becomes more challenging.[11] These gaps in communication among clinicians—compounded by the high frequency of hand offs in hospital health care—can pose substantial risks to patients, and are why inadequate hand-off communication is recognized as chronic, widespread, and a major contributor to adverse events.[3] In 2022, The Joint Commission once again identified inadequate hand-off communication as contributing to sentinel events such as patient falls, unintended retained foreign objects, wrong-site surgery, and treatment delays.[3]

Recognizing that hand offs are complex and error-prone, The Joint Commission made these a critical focal point by including recommendations related to hand-off communication in their National Patient Safety Goals.[1] These recommendations encouraged organizations to develop systems-level strategies and standardized protocols for hand-off communication, and personally challenged organizational leaders to integrate safety-culture best practices into their norms and expectations.[1]

IMPROVING COMMUNICATION AMONG HEALTH CARE TEAM MEMBERS

There is good evidence to suggest that standardized communication processes improve team communication and consistency of care; perhaps the most compelling example is the World Health Organization (WHO) Surgical Safety Checklist.[12] In a landmark study that was cited as the most comprehensive trial of the WHO Surgical Safety Checklist and took place in eight hospitals across the globe, researchers found that implementing this checklist was associated with a 36% decrease in postoperative complication rates, including surgical site infections and death.[12,13] Since the widespread adoption of the Surgical Safety Checklist, other standardized tools, such as SBAR (Situation, Background, Assessment, Recommendation), have also become well-accepted strategies that provide a contextual framework for effective, clear, and consistent interdisciplinary communication.[1]

There is good evidence to suggest that standardized communication processes improve team communication and consistency of care.

Using standardized tools is especially critical for teams working in the perioperative setting, where communication errors have been linked to 63% of retained foreign bodies, 68% of wrong-site surgeries, and 56% of operative and postoperative complications.[14] In the perioperative setting, transitions of care can be more challenging because the process involves the physical transport of patients with associated equipment and requires coordination among personnel from multiple disciplines who must communicate in an often chaotic and noisy environment.[15] Acknowledging these complexities, AORN highlights the importance of standardized tools to prevent communication breakdowns in their "Guideline for team communication."[16] The guideline also supports the notion that there may be limited compliance with hand-off and other

standardization strategies unless there is a structure and culture to ensure success.[16]

Alignment With Organizational Values

In addition to using standardized tools and frameworks for communication at an organizational level, core values should be aligned to function as a guide for behavioral expectations. The Agency for Healthcare Research and Quality defines a *safety culture* as a shared set of values, beliefs, and norms that influence health care professionals' behaviors, attitudes, and actions.[17] Many health care organizations design and implement a mission, vision, and set of values that describe to their employees what it means to work at the organization and what patients and families seeking care should expect.

Likewise, creating a strong safety culture and HRO involves integrating an organization's beliefs about a culture of safety into different components of the system that drive everyday behavioral expectations and promote accountability at all levels of the organization.[18] Providing an environment of psychological safety is a key component of a safety culture and is contingent upon an organization's ability to cultivate teamwork, communication, and respect.[18] Values provide the guideposts and direction for all long-term and short-term organizational decisions. In addition, each value needs well-defined behavioral parameters that clearly and specifically describe how the value is (and is not) demonstrated.[19] Keeping organizational values alive and active and ensuring they are adopted and practiced by all staff members requires constant vigilance. These values should be linked to everyday work as well as annual performance reviews and should apply to all staff members, regardless of their role or title. The *credo* of an organization defines its values and behavioral expectations. Vanderbilt University Medical Center's credo is a statement of the values shared by professionals and staff members concerning their commitment to patients, coworkers, and others (eg, volunteers, students, vendors, faculty) (Sidebar 1).[20] All newly hired staff members are made aware of and must acknowledge the credo during orientation; the elements of the credo are then reinforced during annual reviews.

Sidebar 1. Vanderbilt University Medical Center Credo and Behaviors

We provide excellence in health care, research and education. We treat others as we wish to be treated. We continuously evaluate and improve our performance.

- *I make those I serve my highest priority*
- *I respect privacy and confidentiality*
- *I communicate effectively*
- *I conduct myself professionally*
- *I have a sense of ownership*
- *I am committed to my colleagues*[1]

Reference

1. Our credo and our promise. Vanderbilt University Medical Center. Accessed April 26, 2024. *https://www.vumc.org/elevate/our-credo-and-our-promise*

Alignment With Organizational Policies

Just as values provide a foundation for the beliefs to which health care team members should ascribe, policies and procedures should provide guidance for decision making based on laws, regulations, and best practices.[1,3,4] In addition to these policies and procedures, a nurse's commitment and adherence to patient safety principles also includes a commitment to organizational safety culture and the expectations of leaders and colleagues,[6] as well as to communicating with health care staff members and patients.[16] In the perioperative department, teamwork and the use of a structured and formalized method of communication every time there is a transition of care are best practices.[1,11] However, some health care team members will still deviate from their organization's policies or norms. The following scenario illustrates the challenges perioperative team members may encounter when working in complex systems where multiple hand offs occur.

Mr G is a patient in the ED who was involved in a motor vehicle accident and is scheduled for an urgent exploratory laparotomy. Hand offs and bedside reports by phone are an accepted and agreed-upon practice at this organization. The ED RN Sheila calls Mary, the perioperative department's charge RN, to provide a report and initiate the transfer of Mr G. Mary states they are in the middle of a shift change and that Steve, the incoming charge RN, will call Sheila back when he starts his shift. Twenty-five minutes later, Steve calls the ED to receive the report; however, Sheila is now in the middle of a shift change and flatly states, "There is really nothing that I'm going to tell you

that you can't read in the patient's record," and immediately hangs up. Mr G is taken to the perioperative department by a transporter. Because of the lack of communication, the perioperative bay is not ready when he arrives, so he is placed in the hallway. Brady, the perioperative receiving RN, notices that the patient has telemetry orders and is not on a monitor. Brady takes Mr G to a preoperative bay, attaches him to a telemetry monitor, and discovers that he is in atrial fibrillation.

In this scenario, behavior that deviates from the policy (ie, not providing a phone hand off or bedside report) and unsound safety practices stem from several contributing factors. Interruptions such as phone calls during reports, distractions in noisy workspaces, and time and workload pressures (ie, a 25-minute delay for a shift change) are identified in the literature as barriers to hand-off communication.[21,22] These factors also contribute to a drift, or deviation, from sound safety practices that can become normalized in a health care environment (eg, placing the patient in the hallway).[23] The normalization of deviance in the health care environment occurs when factors such as social pressures and the socialization process lead people to adopt values, customs, norms, attitudes, and behaviors that stray from sound safety practices.[23]

Challenges to organizational policy alignment

Does the same commitment to organizational values, policies, and professional standards apply to all nurses in all situations? To assist team members who are working through situations similar to that described in the scenario, leaders need to support speaking up in the moment or the reporting of nonadherence to system processes, policies, and practices to address deviation.[4] An example would be when not all perioperative team members are present during a surgical time out but the surgery is still completed without complications.[24] Another challenge is maintaining safety practices in the OR because of pressure to conform to the culture. Some nurses may experience workplace incivility because they adhere strictly to safety standards, such as requiring direct visualization of sponges during counts or validating sterilization indicators.[24]

The literature discusses many reasons why perioperative nurses do not speak up, including intimidation, fear of retaliation, perceived authority differentials, fatigue, stress, immaturity, and lack of conflict-management skills.[25] These as well as systemic issues, such as increased productivity and time pressures, embedded hierarchy, and poor psychological safety, can all contribute to avoidance of speaking up.[24] Nurses, surgeons, surgical technologists, and other members of the health care team should understand the need to act respectfully and professionally. Failure to exemplify these traits not only threatens trust and teamwork, but may also be noticed by patients and families, leading to them feeling powerless and uncertain that they made the right choice for their health care.[26,27]

To promote a safety culture, organizations need policies, resources, and surveillance tools—such as event-reporting software—to identify both single events and emerging patterns that are inconsistent with the organization's policies, values, and goals.[4,28] The act of reporting unprofessional behavior, near misses, and errors builds trust, increases transparency, and improves the quality of care and patient safety.[4] It is also an acknowledgment that although mistakes happen, accountability is necessary to identify behaviors that inherently expose an organization to risk and to build organizational resistance.[29] Types of unprofessional behavior observed in interactions among health care coworkers can include poor or disrespectful communication, failure to take responsibility, unsafe medical care, and lack of professional integrity.[30] Unprofessional behavior has been linked to increased surgical complications,[26] mortality in trauma patients,[31] and malpractice claims.[32] Additionally, unprofessional behavior can have individual and team performance consequences, such as decreased information seeking, procedural performance, vigilance, and communication.[33,34] It also contributes to increased nursing turnover, which leads to poor nursing outcomes.[35,36]

The act of reporting unprofessional behavior, near misses, and errors builds trust, increases transparency, and improves the quality of care and patient safety.

Alignment With Professional Standards

Professionals are required to govern themselves in the best interests of those they serve as required by standards of knowledge, education, practice, competency, ethics, behavior, discipline, and licensure.[37] Ownership and accountability for professional standards and practices belong to

the members of the profession who are empowered by a shared governance model.[37] Magnet, a nursing excellence recognition program, supports these concepts to align nursing autonomy and improve patient outcomes. As such, peer feedback is part of the Exemplary Professional Practice component of the Magnet Model.[38] At Magnet-designated organizations, nurses at all levels engage in periodic formal performance reviews that include a self-appraisal and peer feedback process for assurance of competence and continuous professional development.[39] Peers are described as those with "the same rank, education, clinical expertise, and level of licensure"[40] and who may perform similar job roles. AORN recommends providing consistent feedback regarding expectations for ideal team behaviors as an essential component of optimal team communication.[16]

PEER FEEDBACK FOR IMPROVED COMMUNICATION

In 2013, the Vanderbilt Center for Patient and Professional Advocacy developed the Coworker Observation Reporting System (CORS) as a tool and process for addressing observations of unprofessional behavior by physicians and advanced practice providers (Figure 1).[41] With the program's success, it was expanded to nursing, including perioperative nursing. The program promotes addressing unprofessional behavior in the moment. When it is not possible to have a conversation in the moment, for whatever reason, coworkers can use electronic reporting systems to document the observation to address nonadherence to organizational values, policies, and professional commitment.[5,42] The use of a peer messenger has been found effective in managing nonadherence to organizational values, evidence-based practices, and professional expectations.[5,43] A *peer messenger* is an individual trained to provide feedback on disrespectful behavior using an electronic reporting system (eg, CORS).[42] The goal of the peer message is to enhance professionalism by sharing the behavior observed to allow for self-reflection and correction. Using a peer messenger model to receive feedback allows for reflection on one's professional behavior to create consistency and self-governance in a nonpunitive manner, recognizing that anybody can have a difficult day. This method also allows leaders to focus on events or situations where observed behaviors require investigation because of laws or policies or are becoming an apparent or persistent pattern necessitating intervention and appropriate follow-up.[5,42,44]

However, to address unprofessional behaviors, organizations need an infrastructure that supports the process of peer feedback. The infrastructure should include three main categories—people, organizational processes, and systems—and include 10 essential elements (ie, nursing leadership; champions; an implementation team; organizational values; policies; sufficient resources; a tiered intervention model; tools, data, and metrics; report review; and training).[42] The culture should support feedback in the moment or via peer reporting system; effective data management and training for leaders and messengers is required to support a peer feedback program and a culture of safety and respect.

Achieving safe and high-quality medical care requires committed leaders and well-designed systems that closely tie organizational values to safety-behavior expectations.[5] This expectation includes providing a process for professionals to address disrespectful behaviors and a structure that delineates a clear path for an organizational response to patterns of disrespectful behavior. Professionalism embodies the conduct, values, and qualities that characterize members of a profession and guides decision making in ethically challenging, rapidly changing clinical practice environments.[28] Leadership commitment needs to be demonstrated through visible actions, which includes delivering consistent messaging regardless of position or status.

Achieving safe and high-quality medical care requires committed leaders and well-designed systems that closely tie organizational values to safety-behavior expectations.

Application to Perioperative Nursing Practice

In 2019, leaders at the three academic medical centers that were using CORS for physicians and advanced practice clinicians recognized the success of this peer feedback model and decided to expand the program to nursing by adopting the process for delivering peer feedback regarding behavior that was inconsistent with organizational values and expectations (Supplementary Figure 1).[42] When implementing CORS for nursing, it was important to incorporate unique nursing needs and additional considerations to the 10 essential elements.[42] It is important to socialize

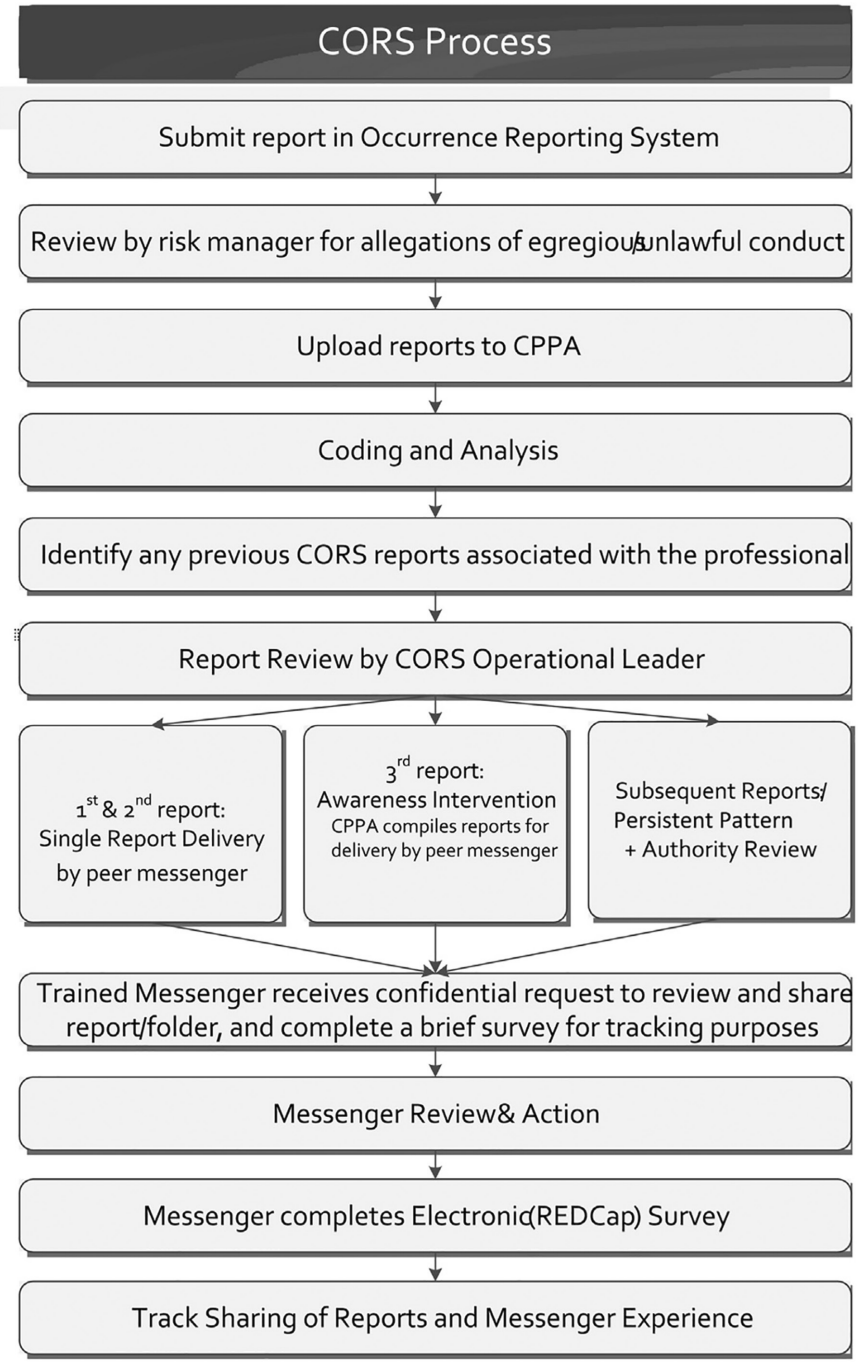

Figure 1. Diagram of the Coworker Observation Reporting System procedure. CORS = Coworker Observation Reporting System; CPPA = Center for Patient and Professional Advocacy; REDCap = Research Electronic Data Capture. *Reprinted from Baldwin CA, Hanrahan K, Edmonds SW, et al. Implementation of peer messengers to deliver feedback: an observational study to promote professionalism in nursing*. Jt Comm J Qual Patient Saf. *2022;49(1):14-25,* https://doi.org/10.1016/j.jcjq.2022.10.001*, with permission from Elsevier, Amsterdam, the Netherlands*.

the concept with nursing leaders and their shared governance committees to connect the use of CORS to organizational values, policies, and professional commitment.

One of the first steps to socializing the concept and enrolling nurse managers includes collaborating to align behavioral expectations with organizational values and

Key Takeaways

- Communication breakdowns, such as inadequate or incomplete information sharing, continue to be a leading factor contributing to sentinel events. In addition to using standardized tools and frameworks for communication at an organizational level, staff members' core values should also be aligned as a guide for behavioral expectations.
- Many health care organizations design and implement a mission, vision, and set of values or a credo that describes to their employees what it means to work at the organization and what patients and families seeking care should expect. To promote a safety culture, organizations may need surveillance tools—such as event-reporting software—to identify both single events and emerging patterns that are inconsistent with the organization's policies, values, and goals.
- At Vanderbilt Health, the Coworker Observation Reporting System was developed to provide a tool for designated peer messengers to report behavior that is inconsistent with the organization's credo or values. Peer messengers should have excellent communication skills, be established as informal leaders, and receive training in empathetic messaging.
- A reporting system provides a communication method for nurses and leaders to provide meaningful feedback on behaviors inconsistent with organizational values, policies, and professional commitment. Organizational leaders aiming for high reliability, a safety culture, and self-governance should consider a peer feedback model to address issues of behavior or practice among staff members.

Magnet foundational principles. This alignment is a critical step to creating buy-in for all nurses and organizational leaders.[42] On the front line, nurse managers play a crucial role in aligning nurses with the values and policies of an organization to promote patient safety by encouraging the use of communication channels and fostering collaboration among health care professionals.[45] To that end, nurse managers should be encouraged to attend peer messenger training. Engaging the human resources (HR) department is also essential to support the process of peer feedback as a precursor to instituting organizational policies involving progressive discipline. The act of delivering a message allows peers to provide feedback in a safe, private environment without fear of "getting in trouble."

The essence of CORS is to take each peer report at face value—meaning the peer who reports the observed behavior that was inconsistent with the organization's credo, policies, or practices submits a report and a peer messenger will follow up with the person named in the report—no leader investigation occurs.[5] In the scenario described earlier, a peer messenger would be assigned to provide feedback to the ED nurse (Sheila), who did not provide a bedside report. Routing of the peer reports allows for notifying the leader who the report is about for awareness only; the expectation is the leader does not follow up, but instead allows time for the peer messenger to follow up. An important element of this peer feedback process is that leaders and HR personnel only become involved if a pattern of unprofessional behavior develops or the report describes behavior that requires investigation based on laws or policies (eg, physical altercations, chemical or cognitive impairment, inappropriate touching).

If the organization has a collective bargaining contract, the stewards, labor relations, and collective bargaining business leaders should be invited to discuss the peer reporting process and learn when and if the progressive disciplinary policy would be enacted. Because the process for CORS is outlined and taught to all nursing professionals and HR leaders, the program provides consistency in addressing unprofessional behaviors and helps eliminate subjectivity. Collective bargaining business leaders and stewards appreciate the process of addressing unprofessional behavior in a consistent manner.[42]

Another critical element of the CORS peer feedback process includes the role of the peer messenger. Peer messengers are uniquely positioned and respected among their colleagues and are perceived as trustworthy, which is essential to promoting psychological safety when delivering

messages.[5] Messengers should be nominated by their unit leadership team based on their consistent, high-level demonstration of the values or credo of the organization. An ideal peer messenger should also represent the nursing community, as reflected through tenure, practice area (eg, inpatient, ambulatory, perioperative), nursing specialty, race, gender, and types of shifts worked.

Just as important as identifying the right people to be peer messengers, assigning the right messengers to deliver the message is also an essential element of the CORS model because nurses perform in multiple roles and work in various environments with different schedules. Peer messengers should have excellent communication skills and be established as informal leaders. Additionally, tenure and practice locations are important, as well as including service lines in the perioperative setting, to ensure mutual understanding of the workflow and environment. Because many nurses work around the clock and in many different roles, assistance with scheduling and coordinating is essential to delivering a message. In the OR, coordination also includes the nurse's assignment, so as to provide time for messaging without disrupting a surgical procedure.

Organizationally, to prepare peer messengers, training consists of a 90-minute session that includes case scenarios, such as the one outlined previously, and simulated practice of skills and training to address predictable pushback from the receiver.[5,42] Peer messengers should also be trained in empathetic messaging, considering stressors and biases that may affect the delivery of the message. This training includes concepts of nonpunitive language, encouraging the person to self-reflect and respond differently in a similar situation. The training helps peer messengers to feel supported after providing feedback, as evidenced by comments on a brief survey that was completed by the peer messengers after delivering feedback to recipients. Two sample survey responses included the following.

- *RN remembered the situation and talked openly to me about it. She acknowledged that communication between the two could have been better and the stress of lack of bed availability for the patient needing ICU care played a role. She was very appreciative of my role in the delivery of this report.*
- *RN was incredibly receptive to this information sharing. She stated that yes, she remembered the event and she indeed was frustrated, but she also expressed that she probably could've handled it differently. She also thanked me, and we left the conversation on a positive note.*

Finally, at a minimum, leaders at each facility participating in such a program should meet annually with all peer messengers to discuss the elements of the program, how to navigate recipient pushback, and to solicit peer messenger feedback.

In the scenario described earlier regarding transferring a patient from the ED, the perioperative charge RN (Steve) would ideally speak up in the moment when the patient was transferred to the perioperative bay and remind Sheila about the organizational expectation of a consistent method of hand-off communication for the best outcome for the patient and to align with the credo or values of the organization. However, if that does not happen, a report would be submitted and the CORS process would supply a communication method for nurses and leaders to provide meaningful feedback on behaviors inconsistent with organizational values, policies, and professional commitment.

CONCLUSION

Effective communication is essential for a successful hand off and safe patient care. All health care team members should be held accountable to their organization's credo—a clearly defined outline of the behavior and communication expectations that are aligned with the organization's values, processes, and professional standards. Likewise, leaders' commitment to provide an environment that is psychologically safe is a key component of cultivating teamwork and open communication. A uniform method for communication, whether about hand-off communications, direct patient care, or unprofessional behavior in the work environment, is crucial for an HRO. Organizational leaders aiming for HRO status, a safety culture, and self-governance should consider a peer feedback model to address issues of behavior or practice among staff members, as they appear to support the elemental structures of these concepts.

SUPPORTING INFORMATION

Additional information may be found online in the supporting information tab for this article.

REFERENCES

1. The Joint Commission. Inadequate hand-off communication. *Sentinel Event Alert*. September 12, 2017;(58). Accessed April 25, 2024. https://www.jointcommission.org/-/media/tjc/newsletters/sea-58-hand-off-comm-9-6-17-final2.pdf
2. Hoffman J, Siegal D, Bergquist K. *Malpractice Risks in Communication Failures: 2015 Annual Benchmarking Report*. Boston, MA: CRICO Strategies; 2015. Accessed July 18, 2024. https://www.candello.com/Insights/Candello-Reports/Communications-Report [registration required]
3. The Joint Commission. *Sentinel Event Data 2022 Annual Review*. 2023. Accessed April 25, 2024. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/03162023_sentinel-event-_annual-review_final-(002).pdf
4. Hickson GB, Moore IN, Pichert JW, Benegas M Jr. Balancing systems and individual accountability in a safety culture. In: Berman S, ed. *From the Front Office to the Front Line: Essential Issues for Healthcare Leaders*. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources, Inc; 2012:1-36.
5. Webb LE, Dmochowski RR, Moore IN, et al. Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. *Jt Comm J Qual Patient Saf*. 2016;42(4):149-161, AP1-AP3. https://doi.org/10.1016/s1553-7250(16)42019-2
6. The Joint Commission. The essential role of leadership in developing a safety culture. *Sentinel Event Alert*. March 1, 2017;(57). Revised June 18, 2021. Accessed May 9, 2024. https://www.jointcommission.org/-/media/tjc/newsletters/sea-57-safety-culture-and-leadership-final3.pdf
7. National Action Plan to Advance Patient Safety. Institute for Healthcare Improvement. Accessed April 25, 2024. https://www.ihi.org/initiatives/national-steering-committee-patient-safety/national-action-plan-advance-patient-safety
8. High reliability. Agency for Healthcare Research and Quality. September 7, 2019. Accessed April 25, 2024. https://psnet.ahrq.gov/primer/high-reliability
9. Diaz CM, Egide A, Berry A, et al. Defining conditions for effective interdisciplinary care team communication in an open surgical intensive care unit: a qualitative study. *BMJ Open*. 2023;13(12):e075470. https://doi.org/10.1136/bmjopen-2023-075470
10. Lingard L, Espin S, Whyte S, et al. Communication failures in the operating room: an observational classification of recurrent types and effects. *Qual Saf Health Care*. 2004;13(5):330-334. https://doi.org/10.1136/qhc.13.5.330
11. Appelbaum R, Martin S, Tinkoff G, Pascual JL, Gandhi RR. Eastern association for the surgery of trauma – quality, patient safety, and outcomes committee - transitions of care: healthcare handoffs in trauma. *Am J Surg*. 2021;222(3):521-528. https://doi.org/10.1016/j.amjsurg.2021.01.034
12. WHO Surgical Safety Checklist. World Health Organization. Accessed April 30, 2024. https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources
13. Haynes AB, Weiser TG, Berry WR, et al; Safe Surgery Saves Lives Study Group. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med*. 2009;360(5):491-9. https://doi.org/10.1056/nejmsa0810119
14. Kirschbaum K, McAuliffe MS, Swanson M. Team communication in the operating room: a measure of latent factors from a national sample of nurse anesthetists. *AANA J*. 2018;86(1):11-18.
15. Barbeito A, Agarwala AV, Lorinc A. Handovers in perioperative care. *Anesthesiol Clin*. 2018;36(1):87-98. https://doi.org/10.1016/j.anclin.2017.10.007
16. Guideline for team communication. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2024:1085-1120.
17. What is patient safety culture? Agency for Healthcare Research and Quality. Reviewed March 2022. Accessed April 30, 2024. https://www.ahrq.gov/sops/about/patient-safety-culture.html
18. Kaplan GS, Stokes CD. *Leading a Culture of Safety: A Blueprint for Success*. American College of Healthcare Executives. https://www.osha.gov/sites/default/files/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf
19. Marcus J, Loeper E. Keeping our organizational values front and center. *AHNA Beginnings*. February 2019:4-6.
20. Our credo and our promise. Vanderbilt University Medical Center. Accessed April 30, 2024. https://www.vumc.org/elevate/our-credo-and-our-promise
21. Powell M, Brown D, Davis C, et al. Handover practices of nurses transferring trauma patients from intensive care units to the ward: a multimethod observational study. *Aust Crit Care*. 2020;33(6):538-545. https://doi.org/10.1016/j.aucc.2020.03.004
22. Vaismoradi M, Tella S, Logan PA, Khakurel J, Vizcaya-Moreno F. Nurses' adherence to patient safety principles: a systematic review. *Int J Environ Res Public Health*. 2020;17(6):2028. https://doi.org/10.3390/ijerph17062028
23. Wright I. Normalization of deviance is contrary to the principles of high reliability. *AORN J*. 2023;117(4):231-238. https://doi.org/10.1002/aorn.13894
24. Wright MI, Polivka B, Clark P. Exploring normalization of deviance among perioperative registered nurses in the operating room. *West J Nurs Res*. 2022;44(2):116-124. https://doi.org/10.1177/0193945921999677

25. Maxfield D, Grenny J, Lavandero R, Groah L. *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*. VitalSmarts, AORN, AACN. Accessed July 18, 2024. https://faculty.medicine.umich.edu/sites/default/files/resources/silent_treatment.pdf
26. Cooper WO, Guillamondegui O, Hines OJ, et al. Use of unsolicited patient observations to identify surgeons with increased risk for postoperative complications. *JAMA Surg*. 2017;152(6):522-529. https://doi.org/10.1001/jamasurg.2016.5703
27. McDaniel SH, Morse DS, Reis S, et al. Physicians criticizing physicians to patients. *J Gen Intern Med*. 2013;28(11):1405-1409. https://doi.org/10.1007/s11606-013-2499-9
28. Hickson GB, Cooper WO. Pursuing professionalism (but not without an infrastructure). In: Byyny RL, Papadakis MA, Paauw DS, eds. *Medical Professionalism: Best Practices*. Menlo Park, CA: Alpha Omega Alpha Honor Medical Society; 2015:81-98.
29. Bashaw ES, Lounsbury K. Forging a new culture: blending Magnet principles with just culture. *Nurs Manage*. 2012;43(10):49-53. https://doi.org/10.1097/01.numa.0000419492.49675.25
30. Martinez W, Pichert JW, Hickson GB, et al. Qualitative content analysis of coworkers' safety reports of unprofessional behavior by physicians and advanced practice professionals. *J Patient Saf*. 2021;17(8):e883-e889. https://doi.org/10.1097/pts.0000000000000481
31. Cooper WO, Hickson GB, Guillamondegui OD, et al. Professionalism of admitting and consulting services and trauma patient outcomes. *Ann Surgery*. 2022;275(5):883-890. https://doi.org/10.1097/sla.0000000000005416
32. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. *JAMA*. 2002;287(22):2951-2957. https://doi.org/10.1001/jama.287.22.2951
33. Riskin A, Erez A, Foulk TA, et al. The impact of rudeness on medical team performance: a randomized trial. *Pediatrics*. 2015;136(3):487-495. https://doi.org/10.1542/peds.2015-1385
34. Katz D, Blasius K, Isaak R, et al. Exposure to incivility hinders clinical performance in a simulated operative crisis. *BMJ Qual Saf*. 2019;28(9):750-757. https://doi.org/10.1136/bmjqs-2019-009598
35. Sauer PA, McCoy TP. Nurse bullying and intent to leave. *Nurs Econ*. 2018;36(5):219-245.
36. Arnetz JE, Neufcourt L, Sudan S, Arnetz BB, Maiti T, Viens R. Nurse-reported bullying and documented adverse patient events. *J Nurs Care Qual*. 2019;35(3):206-212. https://doi.org/10.1097/ncq.0000000000000442
37. Porter-O'Grady T. Principals for sustaining shared/professional governance in nursing. *Nurs Manage*. 2019;50(1):36-41. https://doi.org/10.1097/01.numa.0000550448.17375.28
38. Magnet model - creating a Magnet culture. American Nurses Credentialing Center. Accessed June 7, 2024. https://www.nursingworld.org/organizational-programs/magnet/magnet-model
39. Lal MM. Peer feedback: a tool for growth. *J Nurs Adm*. 2020;50(1):3-4. https://doi.org/10.1097/nna.0000000000000829
40. Foster RR. Peer review tip: distinguishing the difference between peer review, peer evaluation, and peer feedback. American Nurses Association. April 2015. Accessed June 7, 2024. https://www.nursingworld.org/organizational-programs/ana-consultation-services/tips-articles-and-videos/distinguishing-the-difference-between-peer-review-peer-evaluation-and-peer-feedback/
41. The Coworker Observation Reporting System (CORS) Program. Vanderbilt Center for Patient and Professional Advocacy. Accessed April 30, 2024. https://www.vumc.org/patient-professional-advocacy/cors-program
42. Baldwin CA, Hanrahan K, Edmonds SW, et al. Implementation of peer messengers to deliver feedback: an observational study to promote professionalism in nursing. *Jt Comm J Qual Patient Saf*. 2022;49(1):14-25. https://doi.org/10.1016/j.jcjq.2022.10.001
43. Schaffner W, Ray WA, Federspiel CF, Miller WO. Improving antibiotic prescribing in office practice. A controlled trial of three educational methods. *JAMA*. 1983;250(13):1728-1732. https://doi.org/10.1001/jama.1983.03340130046031
44. Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. *Acad Med*. 2007;82(11):1040-1048. https://doi.org/10.1097/acm.0b013e31815761ee
45. Lee W, Jang I. Effect of nurses' professionalism, work environment, and communication with health professionals on patient safety culture (AHRQ 2.0.): a cross-sectional multicenter study. *J Nurs Manag*. 2023;2023:1591128. https://doi.org/10.1155/2023/1591128

Cynthia A. Baldwin, MS, RN, is a senior associate in the Department of Pediatrics and School of Nursing at Vanderbilt University Medical Center, Nashville, TN. *Ms Baldwin has no declared affiliation that could be perceived*

as posing a potential conflict of interest in the publication of this article.

Correspondence: *cynthia.a.baldwin@vumc.org*.

Alice M. Krumm, DNP, RN, NEA-BC, CNOR, is the director of Patient Engagement at Vanderbilt Health Center for Patient and Professional Advocacy and an adjunct faculty member at the Vanderbilt University School of Nursing, Nashville, TN. *Dr Krumm has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.*