CIVILITY And RESPECT in EVERYTHING

C.A.R.E. Program Plan

Future Hospital Program in partnership with the Cognitive Institute

February 2018 v1.0

Document Approval and Release

This document is authorised for release once all signatures have been obtained.

Author	Hailie Uren	Executive Sponsor	Dr Brian McGowan	Executive Sponsor	Branko Vidakovic
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1. Introduction

In 2009, the Vanderbilt University Medical Centre (VUMC) developed and implemented the initiatives “Patient Advocacy Reporting System” (PARS) and “Co-Worker Observation Reporting System” (CORS) aimed at embedding a sustainable culture of safety and respectful professionalism in the organisation through improved professional accountability. Targeting specific safety and behavioural metrics (such as poor communication skills and hand hygiene compliance), patients/consumers and staff are encouraged to anonymously report incidents of individual staff non-compliance with safety protocol via the respective reporting tool, and graded feedback interventions are given back to the staff member undermining the respectful safety culture, via peer messengers.

Pichert et al evaluated the effect of peer feedback interventions on medical officer risk score of receiving patient complaints (used as the proxy factor for risk of lawsuits). (1) The research found that over the 4 years of the study, the average percentage reduction in complaints received by medical officers was 80%. This indicates that peer feedback is an effective method to reduce unsolicited patient complaints through heightened awareness and reflection of individual behaviour.

Talbot et al completed a three year evaluation of the impact the PARS program had on the reliability of specific safety metrics, which was published in the Society of Hospital Epidemiologists of America Journal in 2013.(2) Prior to the introduction of the PARS initiative, the overall mean hygiene adherence in the organisation was 52%. Three years post implementation; the overall mean hygiene adherence increased significantly to 89%, with adherence over 85% sustained after only 2 years post implementation (p=<0.0001). An inverse correlation was also found to be statistically significant between hand hygiene adherence and monthly number of healthcare associated infections.

Further studies on PARS have determined that the initiative has also resulted in a significantly reduced number of patient/family complaints, and improved self-regulated professionalism.(1,3)

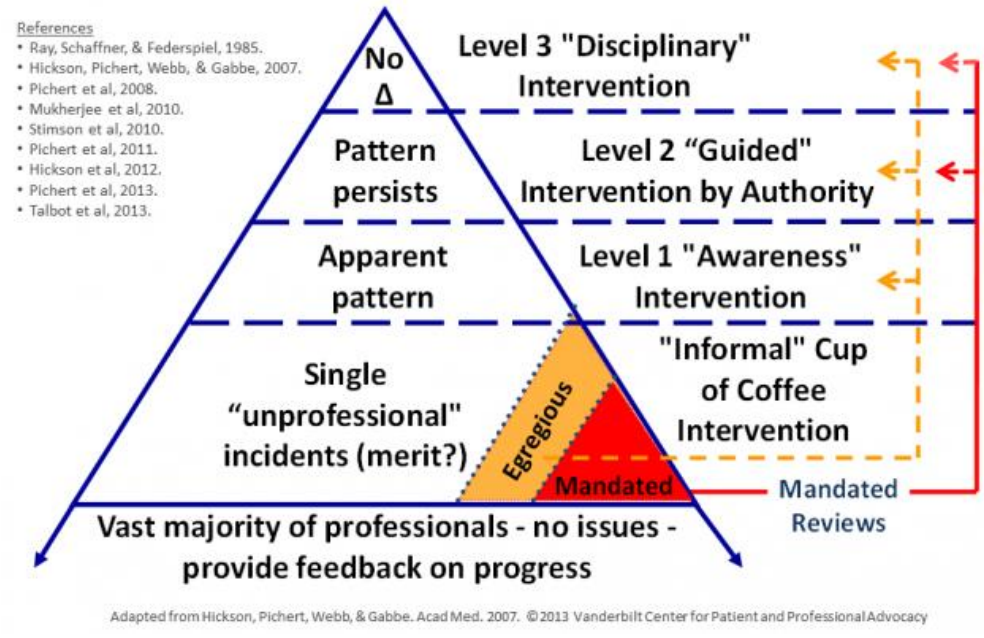


Figure 1. The Vanderbilt Professionalism Pyramid

A review of Vanderbilt’s model of tiered intervention (refer to Figure 1) through the CORS program was completed from January 2012 to December 2014 and published in the “The Joint Commission Journal on Quality and Patient Safety”.(4) The research was conducted in the VUMC, and found that over the 36 month

timeframe, 372 incident reports were submitted by staff members which were associated with approximately 15% of the workforce. These staff then underwent an intervention for the behaviours identified.
71% of the recipients who underwent an “informal” cup of coffee intervention were not associated with any further incident reports within a year, and only 3% of the implicated staff members were associated with 3 or more reports.
It was also determined that of the recorded incident reports, 42% of the incident reports were associated with only 3% of the total staff members within the organisation, lending to the credence that it is only a select few members of the workforce who will consistently undermine a culture of professionalism and safety, rather than an even spread amongst the entire organisation.

It is thus expected that implementation of the Professional Accountability Programme in Logan and Beaudesert Hospitals will follow a similar trend of a small percentage of staff associated with a single incident report, and a very small percentage of those staff members requiring further graded intervention.

The Future Hospital Program has recognised that the benefits of implementing and utilising a system such as PARS and CORS directly aligns with the “Safety and Reliability” strategic priority and long term goal of achieving no preventable patient harm and to be recognised as a High Reliability Organisation (HRO).

As an official partner of Vanderbilt University, the Cognitive Institute will be in partnership with the Future Hospital Program, and Logan and Beaudesert Hospital for guidance, education and support in implementing a bespoke “Professional Accountability Programme” initiative for the organisation.

1.1 Purpose

This document describes the Logan and Beaudesert Hospital (LBH) “Promoting Professional Accountability Programme” framework, which will be named the “Civility and Respect in Everything" (C.A.R.E.) Program.

The framework complements evidence based processes developed by the Cognitive Institute in partnership with the Vanderbilt Center for Patient and Professional Advocacy.

This document will provide Logan and Beaudesert Hospital with a sustainable, organisation-wide framework which describes the planning activities, staff training and program workflow and processes of the C.A.R.E. program to achieve alignment and congruence with strategic goals to improve organisational safety and reliability performance.

1.2 Benefits

Expected benefits of implementing the C.A.R.E. program in Logan and Beaudesert Hospital can be extrapolated from the findings of PARS and CORS research.

It is anticipated that the program will result in:

- A reduction in preventable patient harm through increased staff adherence to organisational safety protocols

- Increased reliability of the hospitals in various targeted safety metrics, which will align with the 10 National Standards
- An established and reputable safety culture in the organisation
- Improved self-regulation through vigilance of professionalism and safety
- Reduction in costs relating to penalties, hospital-acquired complications and patient complaints
- **An overall civil and respectful environment for our staff and patients alike.**

2. Program Scope

2.1 Core Components

2.1.1 The C.A.R.E. Program

The C.A.R.E Program is a Logan and Beaudesert Hospital initiative that aims to provide a platform for staff to address individual behaviours that undermine a culture of safety, reliability and professionalism.

The C.A.R.E. Program goes hand in hand with the “Speaking Up For Safety” education seminars that are being rolled out throughout the organisation, which develop staff insights and skills to respectfully raise issues with colleagues when they are concerned about a patient’s safety.

If a staff member identifies or witnesses behaviour that is unprofessional or may compromise patient safety, it is encouraged that the staff member verbally address with the staff member involved using the P.A.C.E (Probe, Alert, Challenge, Emergency) model learnt in Communication and Patient Safety (CaPS) (5) training and “Speaking Up For Safety” (6) presentations.

When a staff member is unable to use effective communication to address patient safety or professionalism concerns, the C.A.R.E. reporting tool can be utilised to send an anonymous report of the incident. The reporting tool is an anonymous electronic notification system which will prompt the user to enter details of the incident (including the name of the person you’d like to report, the category of the incident (see section 3.3.2), and a brief description of the incident). A trained peer messenger will be notified of the online report and then deliver feedback to the staff member who displayed the unprofessional behaviour.

This is an individual, informal reminder to staff members of our commitment to safety and reliability and our goal of no preventable patient harm. The idea is that a gentle reminder is all that most health professionals require to self-correct unprofessional or unsafe behaviours. The person receiving the message is informed that they are not to “seek out” The peer-messenger message will follow graded intervention as per the Professionalism Path (Figure 2).

An additional aspect to our C.A.R.E. Program is the ability for staff or patients to report individuals that exemplify and uphold the safety and reliability culture we wish to embed within the Logan Hospital and Beaudesert Hospital. It is essential to not just identify unprofessional or unsafe

behaviours, but to also encourage and celebrate the individuals and teams that are at the forefront of our culture change revolution.

2.1.2 The Professionalism Path

The Professionalism Path follows the concept of escalated interventions as unprofessional behaviour is perceived and repeated. The Professionalism Path as displayed in Figure 2 will be utilised as a guide to assess the level of intervention required for reported incidents, and it is based upon an evidence-based "Professionalism Pyramid" developed by the Vanderbilt Institute (and fully implemented in the Vanderbilt University Medical Center (VUMC) in 2011) displayed in Figure 1.

Due to the high level of professionalism that our staff members uphold and results identified at other sites, it is expected that few individuals would progress past a "single unprofessional incident" brief feedback session. This session is a gentle and private conversation, and this session is all that is normally required for staff to self-reflect on the level of civility, respect and patient safety expected in our organisation.

For the minority of staff with recurrent patterns of unprofessional behaviour, who don't respond to the initial "cup of coffee" feedback session, the behaviour reports may be required to be escalated to higher, or more formal intervention.. This may include a longer assessment of causative factors behind the unprofessional behaviour by the C.A.R.E. Panel, a discussion with team leaders/directors of the corresponding departments or a review by Workforce Services.

Figure 2. The C.A.R.E. Program Professionalism Path

2.1.3 Feedback Messages

Single Unprofessional Incident: Interventions are warranted for first time and a single incident of low severity. The perceived unprofessional or disruptive behaviour is brought to the attention of the individual concerned, it is explained why the observed behaviour is considered unprofessional or disruptive and the format of a response and methods of redress to stop of the behaviour. The person who receives the feedback is informed that they are not to approach the person they believe has submitted the message, as this will be seen as egregious behaviour, and will be escalated to Level 3.

Repeat of behaviour: Interventions are warranted for behaviour that is of moderate severity or where stage one intervention has been ineffective, i.e. repetitive or when a pattern of behaviour has emerged. The line manager of the recipient of the feedback will be contacted, and it is suggested that a meeting is held to discuss the behaviour or actions to work towards an informal solution on how to prevent future unprofessional behaviour.

Pattern persists: Interventions are required for behaviour that has continued despite previous interventions or where there is concern about the quality of care and of Clinical Services. At this level, it is suggested formal performance plans are created and signed by the individual, and their line manager, with or without advice from workforce services.

No change: Intervention is required where there is the sudden appearance of behaviour that is too egregious for a staged approach or where previous responses have failed to correct or stop the unprofessional behaviour. This may be escalated to responses reserved for Level 3 if deemed appropriate by the authority.

Egregious behaviour includes, but is not limited to:

- Persons that have submitted a vexatious, false or misleading report
- Individuals who “seek out” persons who they believe have submitted the feedback message (this includes face-to-face, verbally, or have “asked around” about who submitted the feedback message)
- Persons who have performed illegal acts

2.2 Inclusions

2.2.1 Workforce Inclusions

This framework applies to Logan and Beaudesert Hospital, and is relevant to every staff member of the organisation.

2.3 Exclusions

Nil

2.4 Principles

The C.A.R.E. Program is guided by a set of principles governing the way it is applied and defining how its purpose is achieved. These principles are:

- Patient safety is everyone's business
- A culture of civility and respect in Logan and Beaudesert Hospital is fostered at all levels of the organisation
- The C.A.R.E. program is not intended to be a HR process.
    - For the majority of staff, this is an individual, informal reminder of our commitment to safety and reliability and our goal of no preventable patient harm
- This tool does not replace effective communication.
    - If individuals feel comfortable speaking up when behaviour that may compromise patient safety is witnessed, it is recommended that the individual discusses the incident with the staff member involved using graded assertiveness learnt in CaPS (5) training and in the Speaking Up For Safety (6) presentations.
- There is alignment with legislation, regulations, non-mandatory standards, guidelines, benchmarks, policies and frameworks, and relevant college standards

3. Program Organisation

3.1 Governance

The C.A.R.E. Program will follow the following governance structure seen in Figure 3.

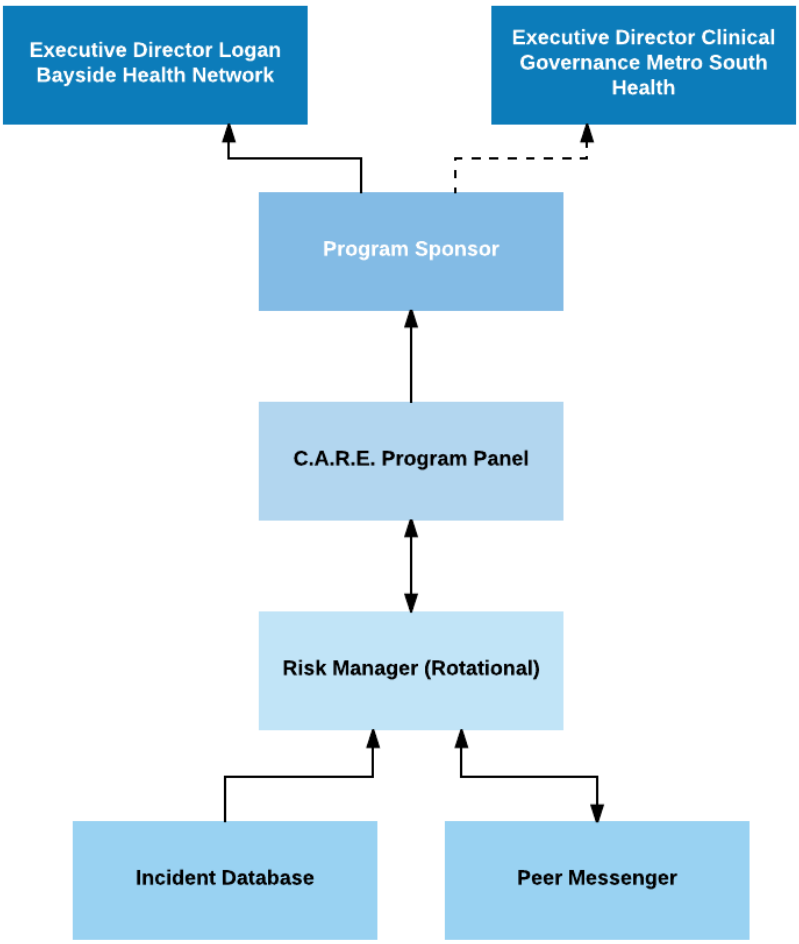


Figure 3. Governance Structure of the Logan and Beaudesert Hospitals C.A.R.E. Program

3.1.1 Program Sponsor

The sponsors for the C.A.R.E. Program are:

- Brian McGowan
    - Clinical Lead, Future Hospital Program
    - Director of Surgery
- Branko Vidakovic
    - Operational Lead, Future Hospital Program
    - Director of Clinical Governance Unit

3.1.2 C.A.R.E. Program Panel

The C.A.R.E. Program Panel is comprised of senior staff members occupying leadership positions. The panel members will be recruited from:

- Division of Women's and Children's Services
- Division of Medical and Emergency Services
- Division of Surgical Services
- Administration/Operational/Environmental
- Allied Health
- Beaudesert Hospital

It is recommended that the C.A.R.E. Program Panel also includes a consumer representative in line with Standard 2 of the National Safety and Quality Health Service (NSQHS) Standards

It is the role of the panel to review incident reports that have been submitted via the C.A.R.E. reporting tool monthly, and assess for trends, inconsistencies and possible training requirements and provide updates to the "Executive Workforce Planning and Performance" meeting. It is the responsibility of the C.A.R.E. Panel to determine appropriate intervention for staff members that are repeatedly undermining the culture of safety and professionalism (3 or more incidents reports associated with the individual). These decisions may be referred or communicated to third parties, such as Workforce Services, divisional directors or managers if individuals are displaying a pattern of unprofessional or unsafe behaviour despite multiple (3+) feedback opportunities.
Please find attached the draft Terms of Reference for the C.A.R.E. Program panel in Appendix 1. The Terms of Reference will be presented for endorsement by the C.A.R.E. Panel in the initial CARE Panel meeting.

3.1.3 Risk Manager

The Risk Manager is a monthly rotational role held by members of the C.A.R.E. Program Panel. It is the role of the Risk Manager to collate and review the incident reports within 3 days of report submission.

Incident reports will be screened for egregious, illegal or vexatious incidents, and escalated accordingly. Any reports identified to contain information about egregious or illegal behaviour, or are written vexatiously will be immediately escalated to Workforce Services for investigation.

It is also the responsibility of the risk manager to communicate the incident reports with the appropriate peer messenger to deliver intervention. The register of incident reports will be consulted to determine the "level" of intervention required (i.e. how many incident reports have been associated with the individual named in the current incident report submission)

A phone call will be made to the chosen peer messenger to ascertain whether the peer messenger would be agreeable to feedback to the individual identified in the incident report. If the peer messenger accepts, an email will be sent to the peer messenger with details of the incident, and a link to a post-intervention survey.

If the individual named in the current report submission has received over 3 peer messenger feedback interventions, the risk manager may choose to discuss a suitable intervention plan at the next C.A.R.E. Panel meeting.

3.1.4 Peer Messenger

Peer Messengers are comprised of senior staff members occupying leadership positions. 9 Peer Messenger members will initially be recruited from the following departments within the organisation:

- Division of Women's and Children's Services
- Division of Medical and Emergency Services
- Division of Surgical Services
- Administration/Operational/Environmental
- Executive Team
- Allied Health
- Beaudesert Hospital

Additional Peer Messengers may be recruited in the future from divisions not covered within the divisions listed above if the C.A.R.E. Panel identify that appropriate peer feedback cannot be given to certain areas.

The role of the peer messenger is to deliver brief, respectful and non-judgemental face-to-face conversations with peers in which they share concerns reported by their co-workers within 3 days of receiving the report from the Risk Manager. The staff member associated with the incident will be communicated by the Risk Manager, and it is expected that the Peer Messenger provide brief post-intervention feedback via a survey for the C.A.R.E. Program Panel to review at the next meeting.

The Cognitive Institute have suggested several personality traits and professional characteristics that are necessary to succeed in the peer messenger role:

- A high level of emotional intelligence and professionalism
- Good interpersonal and listening skills
- Is identified as a clinician of influence, though preferably not in a formal leadership or management position
- Is respected by their peers and understands the stress and practical challenges of working in a busy health service
- Committed to confidentiality
- Willing to take potentially distressing information to a colleague
- Currently in practice or not too distant from it and can include recently retired, respected clinicians

- Committed to the organisation's values
- Committed to building a culture of safety for patients and staff in which all staff are treated with respect and are happy to come to work
- Has the time and commitment to fulfil the responsibilities of the role. (7)

The Peer Messengers will be asked to sign a confidentiality agreement after the initial training session.

The position description of the Peer Messenger, created by the Cognitive Institute can be viewed in Appendix 2.

3.2 Timeline

The proposed "Go-Live" date for the online reporting tool is Monday 19th February 2018. The stages of implementation can be summarised as follows:

Stage 1: Commitment and Readiness

- Endorsement of the C.A.R.E. Program concept by the LBH executive team and professional unions
- Alignment of the C.A.R.E. Program to organisation policies and procedures

Stage 2: Staff Selection and Training

- Recruit and train staff members for the C.A.R.E. Panel and C.A.R.E. Peer Messenger roles
- Identify leaders who may require additional training in delivering feedback

Stage 3: Implementation of C.A.R.E. Program

- Marketing of C.A.R.E. Program
- Go-Live of online reporting system

Stage 4: Evaluation of C.A.R.E. Program

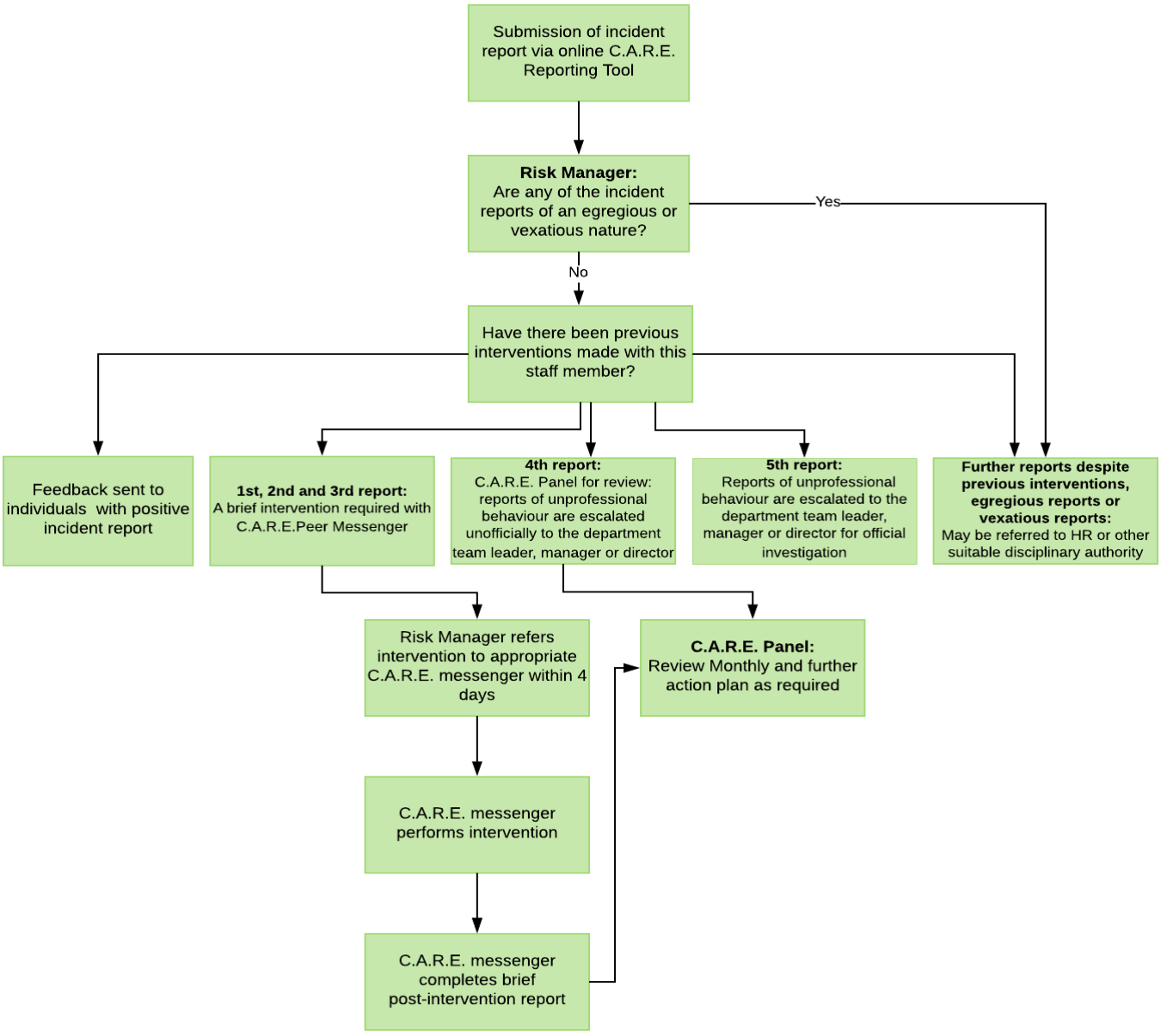
- Continuous review of measurable KPIs associated with the program

Please refer to Appendix 3 for suggested timeline of the C.A.R.E. Program implementation.

3.3 Reporting

3.3.1 The Online Reporting Tool

Figure 4 describes the process of communication in response to incident reports that have been submitted via the online reporting tool. Please refer to Appendix 4 for the online incident reporting tool template.



3.3.2 Reporting Inclusions

All reportable incidents will fall under one or more of the following categories:

1. Professional Behaviour
2. Communication
3. Patient Safety

Tables 1 and 2 provide examples of behaviour that may fall under each of these categories; however this list is subject to change depending on review of submitted incidents or if an intentional change of focus regarding a safety or accountability metric is required.

Table 1. Suggested unprofessional behaviour to report utilising the C.A.R.E. online tool

Professional Behaviour	Communication	Patient Safety
• Blaming of colleagues • Intimidating staff, patients and colleagues • Publicly degrading team members • Frequently late • Derogatory comments about other staff members	• Inappropriate or hostile response when concerns about patient safety are raised • Consistently failing to return calls or pages	• Individuals with inconsistent or absent hand hygiene routine • Operators of workstations-on-wheels (WoWs) or other technology that neglect to clean or sterilise the apparatus in between each patient contact • Individuals with inconsistent or absent use of appropriate personal protective equipment

Table 2. Suggested positive behaviour to report utilising C.A.R.E. online tool

Professional Behaviour	Communication	Patient Safety
• Individuals promoting a non-hierarchical environment • Staff members who are honest and transparent in their planning (particularly to patients) • Individuals who noticeably treat others with equity, civility and respect	• Consistent clear, thorough and timely handover • Consistently timely in returning calls or pages • Consistently introducing themselves to other multidisciplinary team members and to patients • Effective use of the PACE model which resulted in preventing harm to a patient	• Individuals who actively seek and/or participate in offered training in safety and reliability Individuals encouraging staff members to actively Speak Up For (patient) Safety and the positive outcomes • Individuals who proactively raise potential patient safety concerns • Staff who consistently and accurately assess patients for incident prevention E.g. Consistently completing Falls risk forms and Waterlow scores)

4. Stakeholder Engagement and Communication

4.1 Stakeholder Analysis

Table 3 describes the stakeholder consultations required throughout the various stages of program implementation and the corresponding impact on the program.

It is a requirement of the National Safety and Quality Health Service (NSQHS) Standards, *Standard 2: Partnering with consumers* that consumers are involved in:

- Health service planning and design
- Service delivery
- Service monitoring and evaluation

As a result, it is important for C.A.R.E. program to consult with consumers or a consumer representative in the design of this initiative and include consumers on the C.A.R.E. program panel. It is also essential to communicate the results of the program with consumers

Table 3. Stakeholder Analysis

Level of Influence ↑		
	Maintain Confidence (High Influence - Low Impact)	**Collaborate (High Influence- High Impact)**
	• Professional Unions	• Divisional Directors • Team leaders and Managers • LBH Executive Team • Consumer Liaison Services
	Monitor and Respond (Low Influence- Low Impact)	**Keep Informed (High Impact- Low Influence)**
	• Frontline Staff • Consumers	• Executive Director of Clinical Governance MSH • Executive Director of LBHN • The Cognitive Institute • Workforce Services • Standard committees
	Level of Impact →	

4.2 Engagement Plan

The stakeholders identified in the 4.1 require independent level and forms of engagement and communication in regards to the development, implementation and monitoring of the C.A.R.E. Program. Table 4 provides an overview of the corresponding levels of engagement for stakeholders, and method of communication required.

Table 4 Stakeholder communication outline

Project stage	Stakeholder / Interested Party	Level of engagement Required i.e. inform, involve, consult, collaborate, empower	Method(s) of engagement
Stage 1 - Commitment and readiness	Executive Team	Consult and endorsement	Submission of project plan into agenda for exec meeting
	Workforce Services	Involve and consult	Meeting to align current policies and procedures with C.A.R.E. framework
	Professional Unions	Inform	Meeting to discuss intentions of C.A.R.E.
	Consumers	Collaborate	Meeting to discuss intentions of C.A.R.E.
Stage 2 – Staff Selection and Training	Divisional Directors	Collaborate	Meeting to discuss suitable C.A.R.E. messenger applicants and panel
Stage 3 – Implementation of C.A.R.E.	Digital Manager	Collaborate	Meeting to finalise C.A.R.E. online reporting tool
	C.A.R.E. Messengers	Involve, Empower, Collaborate	Meeting verbally and via email to support C.A.R.E. Messengers to deliver program intentions
	C.A.R.E. Panel	Involve, Empower, Collaborate	Meeting verbally and via email to support C.A.R.E. Messengers to deliver program intentions
	All Logan and Beaudesert Hospital Staff	Inform and Empower	Agenda items, meetings, presentations, media and displays on C.A.R.E. Program

5. Evaluation

Evaluation of success of the C.A.R.E. Program will be determined quantitatively and qualitatively as suggested in Table 5. “Expected Benefits” to be evaluated are also found in section 1.2.

Evaluative methods are subject to change depending on the evolution of the Program focus.

Table 5 Key Measurable metrics of the C.A.R.E. Program

Expected Benefits	Evaluation Method
An overall civil and respectful environment for our staff and patients alike.	This will be measured quantitatively through results of the BPA Staff Survey. Baseline data on staff perception will be obtained from the 2017 BPA survey questions: • Do employees think they are treated with respect, honesty, fairness & equality? • Does the organisation provide a workplace that is free from bullying, harassment, discrimination and favouritism? • Do you believe that high quality standards of behaviour, work and service are practiced in your workplace? • Are you confident that if you report any bullying or harassment, then it will be acted upon? • Does the organisation provide a workplace that is free from Bullying or Harassment? • Has there has been significant improvement in the last 12 months in how well the organisation identifies and addresses bullying and harassment? Follow-up data will be obtained from the BPA survey in 2019 for these questions.

	A segment on C.A.R.E. will be included within the BPA survey from 2019 onwards to obtain specific data relating to the program. These questions will relate to professionalism and communication, civility and respect amongst colleagues. The volume of incident reports under the category of "professionalism" or "communication" will be monitored for trends (by staff member, department and division)	
Improved self-regulation through vigilance of professionalism and safety	This data will be determined through the number of incident reports (and corresponding incident category) submitted associated with each individual. As found through the VUMC research (see section 1.0), 71% of staff with a single incident report had received no further incident reports within a year after the initial "coffee cup" intervention. 3% of staff were associated with over 3 incident reports, upgrading the level of feedback to "Level 1" Awareness Intervention (1)	
An established and reputable safety culture in the organisation	This will be measured quantitatively through results of the Best Practice Australia (BPA) Staff Survey. Baseline data on staff perception of a safety culture will be obtained from the 2017 BPA survey (see questions relating to safety within the organisation) and then follow-up data will be obtained from the BPA survey in 2019.	
Increased reliability of the hospitals in various targeted "leading indicators" of safety, which will align with	This data is audited bi-annually by the Metro South Clinical Services Excellence Team (CSET). It is recommended that "change in focused safety metric" aligns with the bi-annual audit cycles audit results. Initially safety metrics aligning	

the 10 National Standards	with Standard 3 “Preventing and Controlling Healthcare Associated Infections” will be “suggested behaviours to report”. These safety metrics will show an inverse correlation with the “lagging indicators” listed below	
A reduction in “lagging indicators of poor safety” preventable patient harm through increased staff adherence to organisational safety protocols	The evaluation method will correspond to safety metric being measured. The initial “preventable patient harm” metric chosen is healthcare-associated infections, specifically Blood Stream Infections (BSI). This metric is measured monthly, and is correlated with hand hygiene compliance and Personal Protective Equipment reports (See 2nd expected benefit).	
Reduction in “lagging indicators of poor safety” costs relating to penalties, hospital-acquired complications and patient complaints, staff sick leave, staff turnover rate	As of November 2017, there are three penalty-acquiring purchasing initiatives; Hospital-acquired blood stream infections; Hospital-acquired stage 3, 4 and unstageable pressure injuries and never events. This data will be utilised to determine whether focused safety metrics (such as hand hygiene or completion of waterlow scoring) has resulted in a reduction in penalty liability. Department of Health are intending to incorporate a “hospital acquired complication (HAC) funding approach” as developed by the Independent Hospital Pricing Authority (IHPA) as part of the potential 2018-19 Pricing Framework. The introduction of this may result in reduced payments for consumers who experience a hospital-acquired complication during admission. It is recommended that once this approach is finalised and confirmed, that selected HACs are utilised as “focused safety metrics” and then measured through decision support reporting Patient complaints can be measured qualitatively through	•

	the reports generated by consumer liaison services. Staff sick leave and turnover rate are measured through workforce services.

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