

2015

# Leveraging the Power of Shared Governance

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*Walden University*

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# Walden University

College of Health Sciences

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Cynthia Cohen

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Walden University

2015

Abstract

Leveraging the Power of Shared Governance

by

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MS, University of New Hampshire

BS, University of Wisconsin

Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2015

## Abstract

Shared governance (SG) creates an evidence-based framework to support decision making in healthcare organizations by encouraging nursing staff ownership of nursing practice issues. This project assessed the current state of shared governance at a community hospital through: (a) deployment of Hess's Index of Professional Nursing Governance (IPNG) and the National Database of Nursing Quality Indicators (NDNQI) nursing satisfaction surveys which were open to nurses working in areas included in the SG framework at the project site, and (b) retrospective review of Unit Practice Council (UPC) and Nursing Senate (NS) minutes and agendas. Kotter's theory of change and the logic model informed interventions aimed at creating an effective SG. IPNG data were analyzed using Hess' scoring guidelines to establish total governance and subscale scores. Mean IPNG scores of nurse leaders, clinical nurse managers, and staff nurses were compared using a 1-way ANOVA based on job title, education, employment status, and shift. NDNQI results were analyzed based on benchmarked Magnet objectives and comparison to previous year's surveys. Meeting agendas and minutes were analyzed for attendance and initiation of interventions. Outcomes of this project included successful creation of a UPC on a medical telemetry unit; alignment of meeting times to promote attendance; paid access to remote meeting attendance; standardization of meeting minutes and agendas; and unit-specific, outcomes-data dashboards. Implementation of this model to improve the effectiveness of SG can lead to positive social change through improvement in the decision-making process in the nation's healthcare institutions. Inclusion of all members of the healthcare team in the decisions that impact practice helps ensure comprehensive, evidence-based, and patient-centric care.

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## Dedication

This work is dedicated to Dorothy Davidson. Through our time spent together I came to envision myself as a nurse. I was blessed to be able to care for her as she courageously learned to live with her disability. Dorothy embraced life, regardless of the circumstances. Where it not for our remarkable time together, I would not have been drawn to the profession that I have come to love. Dorothy taught me the value in taking a risk and letting life lead you to your destiny. Our time spent together will remain a cherished memory.

## Acknowledgment

Without the unwavering support of my family this journey would not have been possible. To my husband Mark, thank you for consistently providing the moral support and unconditional acceptance of the time needed to complete this process. To my daughters Sarah and Abbey, your assistance and confirmation of the value of this pursuit helped me immensely.

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## Section 1: Overview of the Evidence

### **Introduction**

The American Nursing Credentialing Center confers the Magnet designation to hospitals that demonstrate exemplary nursing practice and foster an environment that inspires nursing autonomy and control over nursing practice (Burkman, Sellers, & Batcheller, 2012). As demonstrated in nursing research, the shared governance model (SGM) is a useful framework within which to develop this superior nursing practice (Brewton, Eppling, & Hobley, 2012; Burkman et al., 2012; Painter, Reid, & Fuss, 2013; Wessel, 2012). A SGM is an evidence-based approach to empowering staff nurses within an organization to claim ownership of their nursing practice by creating a framework that encourages autonomy and can impact decision making (Brewton, Eppling, & Hobley, 2012; Burkman et al., 2012; Painter, Reid, & Fuss, 2013; Wessel, 2012;). Creating the environment in which shared governance (SG) can take root and flourish requires a seismic shift in how organizations view the nurse's role in decision making. Once created, however, SG has the potential to create a new lens through which nurse's view their professional practice. This paper reports on a DNP project directed at improving the effectiveness of SG within an organization; it provides an overview of the project, a review of the scholarly evidence on shared governance, and outlines how the project was operationalized.

### **Problem Statement**

In the 1970s, Virginia Cleland framed the notion of SG in the context of nurses practicing in a healthcare environment organized by unions (Porter-O'Grady, 2012). Cleland was convinced that collective bargaining was crucial to nursing self-direction, and she envisioned SG

as an avenue to allow unions, organizations, and professionals to achieve balance (Porter-O'Grady, 2012). While collective bargaining did not attain the prominence she had hoped for, SG remained a viable framework.

In the early 1990s, O'Grady and Finnegan formulated a nursing practice model that reimagined traditional hierarchical nursing leadership and created a flattened practice environment that equalized influence between management and staff (Clavelle et al., 2013). Crucial to the success of this model were nursing councils within various hospitals that had both authority over and accountability for nursing practice issues and an ability to come together to support decisions relevant to both nursing and the hospital in which they were created (Clavelle et al., 2013). Multiple studies highlight the improvements seen with successful SGMs, which include enhanced nursing satisfaction, retention of exceptional nursing talent, committed interdisciplinary collaboration, improved patient outcomes and satisfaction, along with a more empowered and engaged staff of nursing professionals (Ballard, 2010; Brody, Barnes, Ruble, & Sakowski, 2012; Clavelle et al., 2013; Porter-O'Grady, 2012).

At the heart of many successful SGMs is the unit practice council (UPC), where the vital connection to the direct care nurse—and much of the important work of nursing—takes place. The unit level is also where SG has its most daunting challenges: engagement of bedside nurses, allocation of time off the floor to attend to UPC business, and a lack of nursing education and support about how to operationalize the UPC in the chaotic atmosphere of the patient care unit (Bogue, Joseph, & Sieloff, 2009). Creating an environment in which UPCs can take root and flourish requires a commitment of resources and the tenacity to address these challenges.

While implementation of this model does not guarantee nursing ownership, autonomy, and control over nursing practice, many hospitals report favorable outcomes when a robust and efficient SGM has been established (Bell, 2000; Brewton, Eppling, & Hobley, 2012; Myers et al., 2013; Overcash, Petty, & Brown, 2012). The evolution of SG requires a shift in organizational culture and changes in deeply rooted behaviors. Critical to achieving this transformation is the development of a supportive structure for SG along with the visible commitment of leadership within the healthcare setting (Bretschneider et al., 2010).

The nursing literature documents difficulties organizations encounter as they attempt to launch SG programs (Bamford-Wade & Moss, 2010; Bell, 2000; Bogue, Joseph, & Sieloff, 2009; Clavelle, O'Grady, & Drenkard, 2013; Drenkard, 2012; Painter et al., 2013). Despite initial investment in the SGM, many organizations have not seen the benefits of SG, as reported in the nursing literature (Bell, 2000; Clavelle, O'Grady, & Drenkard, 2013; Fray, 2011; Overcash, Petty, & Brown, 2012). Given the financial constraints hospitals face in navigating the complex healthcare system, struggling SG structures are being challenged to produce measurable results (Sharkey, Meeks-Sjostrom, & Baird, 2009). This DNP project (a) assessed the barriers experienced by one organization in sustaining the effectiveness and efficiency of its SG structure and (b) proposed and implemented interventions to empower staff nurses to re-imagine the impact SG can have on individual, unit, and organizational nursing practice.

### **Context**

This DNP project was carried out at a 330-bed community hospital in New Hampshire; a SGM had been established in 2011 and the hospital was pursuing Magnet designation. The SG

framework they chose established UPCs in each unit and department. The chairs of the UPCs made up the membership of the nursing senate (NS), which was designed to be the SG lynchpin. The NS was tasked with disseminating best practices and approving nursing policies. Hopes were high that this new approach to nursing leadership and practice ownership would translate to an empowered and satisfied nursing workforce.

Despite the initial investment of resources and energy, the hospital has not seen the results it had anticipated. Numerous UPCs were stalled; the NS struggled with attendance, creating momentum, and establishing relevance for staff nurses. Nursing satisfaction, as measured by the National Database for Nursing Quality Indicators (NDNQI) Nursing Survey, did not show improved scores on questions about autonomy, control over nursing practice, and participation in the decision-making process. A thorough assessment of the current state of SG at the project site was considered critical to the success and sustainability of the framework. The challenges within the current councils were identified; this informed the realignment of SG with the organizational and nursing strategic plans.

### **Purpose Statement and Project Objectives**

The purpose of this DNP project was to assess the current state of the UPCs and the NS at the project site. Following the initial assessment, the DNP student developed and launched multiple interventions, one of which was to embed the DNP student within the unit and organizational SG framework to mentor and teach nurses as they embarked on the development of UPCs and improvements in the NS. The aim of this intervention was to establish high-functioning UPCs throughout the hospital. Early on, the function of the UPCs was measured by



the following: (a) meeting dates were established with minimal cancellations (no cancellation due to high census) (b) member attendance was 80% or greater and (c) agendas and minutes were distributed 2 weeks prior to the monthly meeting, which provided the opportunity for staff to add items, (c) initiatives were implemented using a logic model process. In turn, it was expected that the UPC would provide the impetus for a robust Nursing Senate at the project site and scaffolding on which to build it.

The Index of Professional Nursing Governance (IPNG) was administered prior to the implementation of the DNP project interventions; it will be repeated in approximately 1 year after the completion of the DNP project. Improved scores on the IPNG and the NDNQI Nursing Survey are anticipated outcomes of this project along with staff participation within the SG framework that will be measured.

On units participating in the UPC intervention, expected outcomes included the following: scheduled monthly meetings attended by a minimum of 80% of UPC members, agendas distributed to all unit staff 1-2 weeks before the meetings, published minutes distributed to all unit staff 2 weeks after the meeting, initial goals and timelines for a minimum of two process improvement initiatives identified by staff, along with attendance at 90% of the NS monthly meetings by one or both co-chairs of the UPC. Monthly reporting of current unit-specific outcome data to unit staff and the NS was anticipated.

### **Project Question**

Given the premise of assessment, mentoring, and education by the DNP student, the question to be answered became apparent. The first project question was as follows: *Does a*

*DNP-driven mentoring and education intervention focused on the UPC provide unit staff with the necessary tools to successfully launch and maintain a UPC?* Assuming the success of the intervention at creating functioning UPCs at the project site, an additional question was revealed: *Can firmly embedded UPCs provide adequate impetus and structure to support an effective organizational NS that addresses the practice and decision-making needs of the nurses as knowledge workers at the project site?* Embedding the UPC into the unit and department structure was evaluated in the following manner: Did all units and departments have monthly meetings of the UPC with representation from all shifts along with a standardized processes for meeting structure and performance improvement? The effectiveness of the UPC support for the NS was discerned by (a) the evaluation of attendance of the UPC chairs at the monthly NS meetings, (b) a review of NS minutes to evaluate for performance improvement initiatives that were disseminated across units and departments, and (c) evidence of the alignment of the Nursing Strategic Plan with the goals for the work of the NS and the UPCs.

### **Significance of the Project**

According to Twigg and McCullough (2014), the United States will face imminent nursing shortages, with estimated shortfalls of nearly 285,000 by 2020. In 2009, the Robert Wood Johnson Foundation estimated the cost of replacing a registered nurse ranged from \$22,000 to \$64,000 ("Business case," 2009). This shortage and the high cost of replacement combine to create a need to strategize plans for recruitment and retention of exceptional, engaged nurses. Nursing research has established the positive relationship between nursing staff retention and perceptions of a positive practice environment (Twigg & McCullough, 2014). An extensive

review of the nursing literature on retention found that improving the nursing practice environment had a greater impact on retention than increases in either salary or recruitment efforts. Factors found to contribute to a positive practice environment include control over nursing practice and autonomy in decision-making, both of which are addressed in the SGM. Effective SG contributes to nursing satisfaction, retention, and recruitment (Clavelle et al., 2013). In the nursing literature, a correlation is frequently established between perceptions of both nursing autonomy and control over nursing practice and increased staff satisfaction and improved scores on the NDNQI Nursing Satisfaction survey directed at job satisfaction and intention to remain in one's current position (Clavelle, O'Grady, & Drenkard, 2013; Hess, 2011; Painter et al., 2013).

According to Clavelle et al. (2013), implementation of SG increases nursing empowerment by focusing on four principles: partnership, equity, accountability, and ownership. A nurse's perception of empowerment positively correlates with perceived increases in autonomy, job satisfaction, patient care quality, and work effectiveness. An effective and vital SG has high potential to improve nursing professional practice at the project site. After careful assessment of the current state of SG, and envisioning SG through the lens of an appropriate change theory, it is expected that substantial improvements will increase the effectiveness of, and staff support for, a SGM. These changes may lead to increases in measures of staff support for SG and satisfaction with their professional practice.

### **Implications for Social Change in Practice**

The Institute of Medicine (IOM) has identified six crucial aims for today's healthcare system: to provide each patient safe, effective, patient-centered, timely, efficient, and equitable care (Albanese et al., 2010). SG has the potential to impact an organization's ability to provide the exceptional care the IOM has mandated. Successful SGMs are instrumental in providing structures for translating evidence to the bedside (Bamford-Wade & Moss, 2010; Overcash, Petty, & Brown, 2012). SG actively supports a culture that elevates professional nurses to experts in discovering opportunities to provide the safest possible care for their patients (Painter et al., 2013). With staff nurses consistently scrutinizing care and mindful of best practices, SG has the potential to drive interventions to improve practice at the point of care (Painter et al., 2013). Multiple studies highlight the potential improvements that can be seen with successful SGMs, including enhanced nursing satisfaction, retention of exceptional nursing talent, committed interdisciplinary collaboration, improved patient outcomes and satisfaction, and a more empowered and engaged staff of nursing professionals (Bell, 2000; Bennett et al., 2012; Bretschneider, Eckhardt, Glenn-West, Green-Smolenski, & Richardson, 2010; Clavelle et al., 2013). The profession of nursing has the potential to impact the delivery of care dramatically; leveraging SG can provide a framework to realize this potential.

### **Definitions of Terms**

Due to subtle but important differences, several terms require clarification when discussing SG. For example, *decision-making* and *decisional involvement* both rely on nurse autonomy but have decidedly different meanings (Kowalik & Yoder, 2010). Within nursing

literature, nuanced differences in terms describing SG abound. The following terms are defined for the purpose of this project.

*Knowledge worker.* Nursing professionals are knowledge workers. Distinct from employee workers, the knowledge worker has mastered a necessary quantity of knowledge prior to assuming their role within the organization (Porter-O'Grady, 2012). This knowledge defines their role within the organization, is owned by the individual and is portable (Porter-O'Grady, 2012). This acquired knowledge is central to how the knowledge worker distinguishes themselves and their value as a professional (Porter-O'Grady, 2012). The knowledge worker contributes through the interface between the individual, their acquired knowledge, and the manifestation of their distinct role (Porter-O'Grady, 2012).

*Shared governance.* Shared governance is a structural framework that fully acknowledges the role of the nurse as knowledge worker (Porter-O'Grady, 2012). SG delineates the responsibilities of the organization and professional nursing body (Porter-O'Grady, 2012). This structure facilitates a collaborative partnership between organization, profession, and the individual nurse (Porter-O'Grady, 2012). SG requires nurses to have control over their nursing practice including the professional accountability for quality, competence, and knowledge generation necessary to enable the professional work of nursing (Porter-O'Grady, 2012). Under SG, the healthcare organization is accountable for contextual accountabilities such as the provision of the human, fiscal, material, and supportive needs necessary to enable safe, effective nursing care (Porter-O'Grady, 2012). These separate but interconnected responsibilities align

the healthcare organization with the professional nurse to create an environment that supports partnerships, collaboration, and effective patient care (Porter-O'Grady, 2012).

*Decisional involvement.* In Kowalik and Yoder's concept analysis, decisional involvement is defined as "the pattern of distribution of authority for decisions and activities that govern nursing practice policy, and the practice environment" (Kowalik & Yoder, 2010, p. 260). The attributes that contribute to decisional involvement include distribution of authority, autonomy of practice, empowerment, inter- and intra-disciplinary collaboration, professional responsibility, and personal accountability (Kowalik & Yoder, 2010). Decisional involvement speaks to the nurse's resolution to become involved in the processes of decisional activities that impact nursing practice (Kowalik & Yoder, 2010).

*Decision-making.* Decision-making refers to the act of deciding and in nursing literature is often linked to the ability of the bedside nurse to make autonomous clinical nursing decisions (Kowalik & Yoder, 2010). The ability of the nurse to make decisions is determined by the level of autonomy under which the nurse can practice (Kowalik & Yoder, 2010). SG offers a venue to bring individual issues surrounding decision-making forward allowing them to be addressed at an organizational level (Clavelle et al., 2013).

*Clinical autonomy.* Clinical autonomy refers to the power, liberty, and discretion to deliver clinical nursing decisions in the care of the individual patient (Weston, 2009). Clinical autonomy refers to the anticipated use of nursing knowledge, critical thinking skills, and acquired experience in the care of patients as a member of the healthcare team (Weston, 2009).

Clinical autonomy is seen as a unique attribute and should not be confused or combined with the attribute of work autonomy.

*Work autonomy.* Work autonomy refers to the worker's ability to impact work and break time, and pacing of work related responsibilities (Weston, 2009). In addition, work autonomy encompasses "work methods including influence over procedures and processes; and work criteria including the ability to participate in setting goals and means for evaluating the achievements of goals" (Weston, 2009, p. 88). Work autonomy is seen as a unique attribute and should not be confused or combined with the attribute of clinical autonomy.

*Control over nursing practice.* As described by nurses in Magnet designated organizations, control over nursing practice refers to the ability to provide input, which encompasses access to an ability to exchange information, along with insights into values and judgments, in every important decision-making opportunity (Kramer et al., 2008). These decisional opportunities include any organizational nursing policy, practice standards, equipment, or resource that impacts the profession of nursing, nursing practice, or patient care and outcomes (Kramer et al., 2008). Control over practice by this definition extends the nurse's area of influence into arenas previously predominated by nursing management and administration and is distinct from clinical autonomy (Kramer et al., 2008).

### **Assumptions**

For the purposes of this project, it is assumed that the attributes of control over nursing practice, decisional involvement, decision making, work autonomy, and clinical autonomy are perceived by the clinical nurse as valuable attributes of the professional practice of a knowledge

worker (Hess, 2011). Additionally, it is assumed an effective SG structure furthers advancement of these attributes. However, no assumption is made that the mere existence of a SG structure advances the attributes, as the direct care nurse within an organization perceives them.

### **Limitations**

Limitations of this project involve the role of the DNP student within the project site. Improving the effectiveness of SG has been identified within the project site as a high priority for continuing the Magnet journey. With that focus in mind, nursing leadership has been supportive of the efforts of this DNP project. However, securing resources and garnering support for some aspects of the program are challenging within the role of the DNP student.

The current trends (greater than 6 months) of a consistently high census with increasing acuity has led to critical problems with patient flow in the Southern New Hampshire area acute care hospitals (critical care, telemetry, medical/surgical). Staff nurses have faced challenging conditions that have left little time for the extra effort and commitment needed for SG. These grueling shifts along with consistent pleas from nursing administration for nurses to work extra shifts impacted nurse's ability to participate. For many organizations, this reality erects such a barrier to effective SG that the SG model is never fully realized (Porter-O'Grady, 2012). Strategies for the DNP student focused on creating effective opportunities for direct care nurses to understand the importance of SG in creating an environment in which to practice.

### **Summary**

Use of SG, an evidenced-based practice, is supported in the nursing literature. However, a decision to launch a SGM does not ensure its success nor automatically improve nursing



practice. A SGM requires a dramatic shift in the way nurses approach their practice. Given the current struggles with this model at the project site, and its importance to nursing practice within the organization, this assessment and realignment are a timely and important focus for the DNP project.

## Section 2: Review of Literature and Theoretical Framework

### Introduction

Nursing literature is replete with qualitative, quantitative, and mixed-method studies with a focus on SG and the attributes of nursing autonomy and control over nursing practice (Bamford-Wade & Moss, 2010; Bell, 2000; Bogue, Joseph, & Sieloff, 2009; Clavelle, O'Grady, & Drenkard, 2013; Drenkard, 2012; Painter et al., 2013). Two databases were used in the literature review process, CINAHL and Medline. The following search terms were used: *shared governance, shared decision making, Magnet, Magnet designation, nursing autonomy, control over nursing practice, knowledge worker, clinical autonomy, work autonomy, decisional involvement, Index of Professional Nursing Governance, and National Database of Nursing Quality Indicators.*

Investigation of nursing research pertinent to SG revealed many journal articles that focused on programs designed to engage, involve, and inspire staff nurses to be active participants in an organization's SG structure. In developing a plan for re-engaging nurses at the project site in the SG process, these case studies provided valuable guidance. Several of these papers informed the development of this DNP project.

One validated instrument that is often noted in nursing literature when attempting to measure SG is the Index of Professional Nursing Governance (IPNG) (Anderson, 2011; Clavelle et al., 2013; Hess, 1998; Hess, 2011). Robert Hess' IPNG is an 86-item survey that scores healthcare organizations as either within a shared governance model, a traditional governance

model, or a self-governance model (Hess, 2011). As the instrument chosen for use in this DNP program, research on this tool is highlighted.

## **Specific Literature**

### **Nursing Literature Reviews**

Ballard (2010) compiled the factors associated with both successful and failed implementations of a SG structure. To develop a successful SG culture, it was typically imperative to establish a long-term commitment within the healthcare setting (Ballard, 2010). The most successful organizations were those that understood the need to tailor shared governance structures to meet the needs the organization and allowed these structures to evolve over time. The factors associated with success included leadership support, role delineation, and established processes for decision-making. The factors associated with failed SG models included poor support structure, lack of follow-through, insufficient resources, and ineffective communication. Ballard identified some guidelines to be used when unit-based initiatives were considered for development by councils: (a) concurrency with hospital policy, (b) focus on patient care, (c) issues addressing quality care or the work environment, and (d) projects should be budget neutral or have justified financial expenditures. This literature review highlights the inevitable conclusion that there is no universal template for enabling organizations to implement SG successfully. Rather, each organization must thoughtfully explore the unique framework it needs.

### **Quantitative Studies Using the IPNG Instrument**

Initial work by Hess validating the IPNG was published in 1998 (Hess, 1998). The IPNG was developed and tested by the conduction of four studies; assessment of content validity, assessment of the feasibility of the IPNG tool, tests for reliability, and tests for construct validity (Hess, 1998). In phase one, six nursing administrators evaluated the 78-items Hess proposed. The experts rated the relevance of the items to the dimension to which they had been assigned. These areas included professional control, organizational influence, organizational recognition, facilitating structures, and liaison alignment (Hess, 1998). These dimensions would later become the subscales of the IPNG. Using Popham's Average Concurrency Score (ACS), a level of 0.90 was set as the threshold for content validity (Hess, 1998). Expert participants were also free to suggest elimination or rewording of items and dimensions along with suggestions for additional items. During this phase 13 items were added, 14 items were changed or combined with other items, and two items were placed in different dimensions (Hess, 1998). In phase two the IPNG was tested for feasibility with surgical nurses practicing in a teaching hospital in a large urban setting. Fifty surveys were distributed with 25 returned completed. Participants reported there was no difficulty encountered when completing the survey, and phase two was completed without additional changes to the tool (Hess, 1998).

Two community hospitals provided the setting for the third phase of work on the IPNG tool. To test for reliability, non-convenience samples of nurses were given the IPNG survey including full and part-time direct care nurses and nurse managers (Hess, 1998). A total of 148 surveys were returned from Hospital A (37% response rate) with Hospital B contributing 341 completed surveys producing a 40% response rate (Hess, 1998). Data gleaned from Phase 2 and

3 were both used in this phase, all surveys with missing answers were eliminated (Hess, 1998). Of the 231 surveys examined, a Cronbach alpha for the total scores on the tool was at 0.95, with subscale reliability ranging from 0.85-0.90 (Hess, 1998). Nurses in Hospital A and B were resurveyed one month after the initial survey to perform a Pearson product-moment correlation coefficient on the two data sets producing a test-retest correlation of 0.77 (Hess, 1998). In the fourth phase, construct validity was assessed using factor analysis, correlations between subscales, and contrasting scores among seven hospitals with and without SG structures (Hess, 1998). After completion of these four phases, the IPNG was deemed a valid instrument to measure SG within organizations (Hess, 1998). The IPNG instrument has been used liberally in nursing research and has been further validated by current nursing research (Anderson, 2011; Hess, 1998; Lamoureux, Judkin-Cohn, Butao, McCue, & Garcia, 2014).

The importance of using a validated tool to measure the effectiveness of a SG structure was revealed by Anderson's (2011) study of one hospital's 15-year experience with SG. This study employed Hess' IPNG instrument to follow the maturation of SG over time (Anderson, 2011). Anderson eloquently states the importance of embracing the premise that SG must be much more than simply a structure or model that is facilitated; it must encompass professional accountability at all levels of governance (Anderson, 2011). Without valid measurement, the effectiveness and reported outcomes of SG are often called into question (Anderson, 2011). The IPNG tool was used three times over a 15-year period (Anderson, 2011). The initial survey was completed in 1999 with repeat surveys done in 2002 and 2006. Although the nursing administration believed that SG had matured substantially over the years, the scores on the IPNG

survey remained relatively stagnant (Anderson, 2011). Anderson points out that while the results were disappointing, without the surveys nursing leaders would be unaware of the need to continue to strive for improvement within the SG structure of the organization (Anderson, 2011).

A cross-sectional descriptive study published in 2014 set out to assess the reliability and validity of Hess's IPNG tool by correlating the scores on the IPNG instrument with those of the NDNQI nursing satisfaction survey (Lamoureux, Judkin-Cohn, Butao, McCue, & Garcia, 2014). The NDNQI nursing satisfaction survey is the tool often used by organizations applying for Magnet designation making this correlation an important consideration when determining a tool with which to measure SG. The 76 survey respondents (31.6% response rate) represented seven units within one hospital (Lamoureux et al., 2014). The investigators also sought to add to the construct validity of the IPNG tool as a measurement of SG within an organization by evaluating differences in perceptions of SG between units of the hospital, levels of experience, levels of education, certification, age, and gender (Lamoureux et al., 2014). In order to assess the connection between SG and job satisfaction, one composite score and three individual items were chosen from the NDNQI nursing satisfaction survey. The composite score of the Job Enjoyment Scale (JES) along with individual items regarding Perceived Quality of Care (PQOC), likeliness of nurses to recommend the hospital as a place of employment (REC), and their level of agreement that important things did not get done during their last shift (DONE) were correlated with the IPNG score (Lamoureux et al., 2014). Descriptive statistics, Cronbach alpha, ANOVA, along with Pearson correlation coefficients were used to analyze data (Lamoureux et al., 2014). A Cronbach alpha of 0.94 or higher was found for each of the

subscales (personnel, information, resources, participation, practice and goals) as well as the total score (Lamoureux et al., 2014). With the exception of gender, there was little inconsistency across the variables identified by the researchers, adding to the construct validity of the IPNG's ability to measure SG within an organization (Lamoureux et al., 2014). Concurrent validity of the IPNG tool was examined with the correlation of the IPNG with the NDNQI nursing satisfaction survey. Two of the four identified components and items of the NDNQI survey that were identified by the researchers showed moderate positive correlations with the IPNG tool; the composite JES, and the question regarding recommending the hospital as a place of employment (REC) (Lamoureux et al., 2014). Researchers ponder whether the PQOC and DONE items were not perceived in the minds of participants as being linked to SG (Lamoureux et al., 2014). As with other studies implementing the IPNG, the subscale eliciting perceptions regarding who controls the personnel and related structures showed results most closely aligned with traditional management (Anderson, 2011; Hess, 2011; Lamoureux et al., 2014). This subscale continues to be identified as an aspect of traditional management culture resistant to the changes that SG models bring to organizations. This study, while small in scope further legitimizes the use of the IPNG to discern levels of SG within organizations.

According to Bennett et al. (2012), the IPNG instrument was used in a large Australian hospital to measure perceptions of SG after the introduction of a unit SG structure. Researcher's objectives were to measure the effect of standardized ward meetings and reporting processes on nurses perception of professional nursing governance, measure nurses perceptions of professional nursing governance in individual wards across the organization, and finally to

compare nursing professional governance within the organization to that of both Magnet and Non-Magnet organizations. A descriptive post-test study followed and compared the implementation of ward based SG structures in eight wards alongside eight wards that did not implement the SG structure. The IPNG survey was deployed three months after the implementation of the SG structure to nurses in both the intervention and non-intervention wards. Descriptive analysis and frequencies along with independent samples t-tests were completed comparing the two groups. IPNG database results from 49 hospitals (3-Magnet, 47 Non-Magnet) were provided by Robert Hess to compare the results of the organization and other hospitals who used the IPNG instrument to measure SG. Completed surveys from the eight wards receiving the intervention totaled 106; non-intervention wards completed 119 surveys (response rate 49%). No statistically significant differences were seen across wards or nursing positions. Comparison of the aggregate mean IPNG total and subscale scores between the two groups of wards revealed no statistically significant differences. There was, however, wide variation in scores when comparing the 16 individual units regardless of their placement in the interventional or non-interventional group. Total IPNG scores ranged from 223.38 (SD 66.69) to 140.75 (SD 19.39). The substantial standard deviation speaks to the wide variation in response to questions within each individual ward (Bennett et al., 2012). The study organization ranked tenth when mean IPNG scores were compared with Non-Magnet hospitals (Bennett). Magnet hospitals (n = 3) had statistically significant higher scores on the mean IPNG scores and three of the subscale means scores (access to information, influence over resources, and participation in committee structures) when compared to the study organization. Lack of significant differences



between the two groups studied at this organization suggests that the initial intervention of ward based meetings and standardized reporting structure had not yet influenced perceptions of SG. However, multiple studies speak to the lengthy process needed for enculturation of SG (Anderson, 2011; Barden, Quinn-Griffin, Donahue, & Fitzpatrick, 2011; Clavelle et al., 2013; Porter-O'Grady, 2012). Three months seems a short time to assess for changes in perceptions of SG as unit-based groups may need several months to come together and begin productive work. The wide variation among the wards points out the impact of unit culture and leadership on perceptions of autonomy and decision-making capacity on the unit (Bennett et al., 2012).

A national study of Magnet organizations published in 2013 sought new knowledge involving nursing practice. Researchers set out to discern the qualities of SG in Magnet organizations, describe the characteristics of the nursing practice environment (NPE) in Magnet organizations, and determine the presence of a relationship between SG, the NPE, and outcomes in these organizations (Clavelle et al., 2013). Investigators of this descriptive study reached out to 344 Magnet organizations within the U. S. seeking participation from their Chief Nursing Officer (CNO), and chairperson of the nursing practice council (NPC) operating within each organization (CNO). A total of 95 CNOs (27.6% response rate) completed demographic data and 107 NPC chairs (31.1% response rate) completed the IPNG along with the Nursing Work Index-Revised (NWI-R) survey. Demographic data included total RN Full Time Equivalent (FTE), percentage of nurses with a BSN degree, RN vacancy and turnover rates, along with the age and experience of the CNO. Total scores and subscale scores were evaluated with t-tests and ANOVA in an effort to discover associations with demographic variables. In addition,

associations between overall scores and the subscales associated with the tools were evaluated using Pearson correlations. Examining the results of the IPNG survey of NPCs, 81.9% of the scores placed the organizations within a SG model, but primarily in the management/administration with some staff input grouping. Subscale means for control over practice, access to information, resources supporting practice, participation, and resolution of conflict were consistently within the SG range. However, the subscale inquiring about control over personnel consistently scored within the traditional governance model. Performance of the Pearson correlation revealed highly significant, moderate, and positive correlation between the IPNG and NWI-R total scores. The strongest relationship between these two scales was between the IPNG subscale of control over personnel and the NWI-R subscale of organizational support ( $r = 0.42$ ,  $p < 0.001$ ), and the IPNG subscale of control over practice and resources supporting practice and the NWI-R subscale of autonomy ( $r = 0.367$ ,  $p < 0,001$ ). This study reports that there is a significant positive relationship within these Magnet organizations between SG and the NPE. While the majority of organizations studied scored within the SG model range, it is hoped that organizations will fall more within the category that describes processes that are equally shared by staff nurse and administration than was revealed by this study. These results speak to the challenges of creating a culture of SG to replace the traditional hierarchical models so firmly entrenched in many healthcare systems.

Investigators seeking to determine the relationship between SG and nursing empowerment administered the IPNG tool along with a revised Conditions of Work Effectiveness Questionnaire, the CWEQII (Barden, Quinn-Griffin, Donahue, & Fitzpatrick,

2011). The setting for this study was a tertiary care center located in Queens, New York. Thirteen units participated in the study, all having implemented SG between six and twelve months prior to the study. A total of 158 staff nurses completed the two surveys. Cronbach alpha was used to determine the reliability of the tools with the study population in addition to a Pearson product momentum correlational analysis. Findings of this study show a statistically significant relationship between perceptions of SG and empowerment ( $r = 0.34$ ,  $p < 0.0001$ ), demonstrating that as nurse's perceptions of SG increased, their perceptions of empowerment also increased. Result totals for the IPNG survey were 157.61, showing traditional governance in the beginning stages of changing to a SG model. Similarly, results of the CWEQII revealed that nurses perceived a moderate level of empowerment. A Pearson correlation coefficient on the sum of the two tools administered unveiled a significant relationship among the variables; a moderate positive linear correlation was seen with SG and empowerment. This study adds to the body of evidence that supports SG, showing the positive impact SG can have on the critical perception of empowerment by staff nurses in today's healthcare system.

Overcash, Petty, and Brown (2012) sought to determine if any demographic variables such as nursing education, age, gender, certification, workplace setting, participation in SG activities, nursing work experience, or nursing position were related to or predictive of scores on the IPNG survey. The prospective, cross-sectional study sought input from nurses working in any capacity within a mid-western hospital (inpatient and outpatient). Nurses were invited to participate if they had worked in the hospital for at least one year and were not agency personnel. In order to analyze the relationship of variables to the IPNG scores, analysis of variance models

were constructed for the categorical and ordinal variable. Post hoc Tukey tests were then used to analyze any differences between the IPNG mean groups. Regression models were used for continuous variables. Of those invited to participate, 100 nurses completed the survey; 94 were female with a mean age of 67 and an age range of 39-67, 55% held a BSN, mean number of RN experience was 13.23, with a mean of 6.8 years with the organization. A total IPNG score of 186.5 was obtained, falling in the area of primarily management and administration with some staff input (early SG adoption). Simple linear regression models were used to discover relationships between any continuous demographic variable and total IPNG scores. Statistically significant relationships were not found between total IPNG scores and SG participatory roles, RN experience, or years worked in the organization. There was one relationship found to be significant, that of SG participation and working in the inpatient setting. The investigators posit that perhaps increasing the number of nurses who have a role in SG could increase IPNG scores. This study does not reveal connections between demographic factors such as age, education, and experience and IPNG scores as the investigators had hoped. It does support the belief that participation in SG within an active organizational setting (inpatient vs. ambulatory care) is a factor that may impact the IPNG score.

### **Quantitative Studies**

A rural health care network was the setting for a descriptive correlational study delving into the perceived and preferred degree of decisional involvement of both staff nurses and nurse managers using the Decisional Involvement Scale (DIS) (Scherb, Specht, Loes, & Reed, 2011). The DIS questionnaire measures actual and perceived decisional involvement in nursing issues

using the same Likert Scale that is used in the IPNG tool; nursing management/administrations only, primarily nursing management/administration with some staff nurse input, equally shared by staff nurses and nursing management/administration, primarily staff nurses with some nursing management/administration input, and staff nurse only (Hess, 1998; Scherb et al., 2011). A high score on the DIS questionnaire equates to greater staff involvement, a lower score indicates a low degree of staff involvement, and a mid-range score denotes a shared decisional environment (Scherb et al., 2011). Content validity and reliability for the DIS had been previously documented in nursing research (Havens & Vasey, 2005) The 857 eligible RNs within the study healthcare system were mailed a demographic and DIS questionnaire. A return rate of 39% was achieved with the return of 338 questionnaires (Scherb et al., 2011). After incomplete questionnaires had been eliminated, a final sample of 290 staff nurse and 22 nurse manager completed questionnaires were reviewed. Responses were analyzed to determine the disparity between how nurses described their actual decisional involvement compared to the preferred decisional involvement. Results for staff nurses showed a statistically significant ( $p < 0.001$ ) difference between mean actual decisional involvement rating of 2.10 (SD = 0.58) and the mean preferred level of decisional involvement of 2.79 (SD = 0.52). Likewise with the nurse managers, there was a statistically significant ( $p = 0.001$ ) discrepancy between the mean actual decisional involvement rating of 2.22 (SD = 0.45) and the mean preferred decisional involvement rating of 2.56 (SD = 0.45). In each case, SG represents a mean score of three. Independent sample t-tests revealed that differences between staff nurse and nurse manager's ratings of actual decisional involvement was not statistically significant, however statistically significant differences

between staff nurses and nurse managers were discovered on two DIS subscales. These subscales include unit governance and leadership ( $p = 1.64$ ) and collaboration and liaison activities ( $p = 0.21$ ). Additionally, total scores for preferred decisional involvement between staff nurse and nurse managers were also statistically significant ( $p = 0.46$ ). Both staff nurse and nurse manager's ratings of preferred decisional involvement failed to reach the level of SG (3), highlighting the challenge of engaging nurses in the process of enculturation of SG. Differences between staff nurses' and nurse managers' ratings of preferred decisional involvement bring to light the need to educate managers on the advantages of collaborative decisions and SG.

In an effort to inform hospital efforts to improve the effectiveness of SG, researchers surveyed 425 direct care nurses (DCN) and nurse managers (NM) to discern factors perceived as important for a thriving SG model (Wilson, Speroni, Jones, & Daniel, 2014). Additionally, the researchers hoped to uncover important differences between staff nurse and nurse manager's perceptions surrounding these factors. Researchers provided a 26-item survey asking nurses to self-report their perceptions of activities they had been a part of over the last year along with 16 questions inquiring about the perceived importance of factors associated with SG. The study was conducted until a pre-determined 30% ( $n = 144$ ) response rate of eligible nurses was achieved. Of those who returned surveys, 129 (89.6%) were DCN and 15 (10.4%) were NM. The top four factors identified as "very important" factors to influence the DCN involvement in SG by the combined group of nurses and nurse managers surveyed were, the DCNs feeling supported by unit manager, DCNs on unit working as a team, DCNs having time to participate in SG activities without disrupting patient care, and DCNs feeling they will be paid for activities beyond their

scheduled shift. When examining self-reported participation in activities over the last year, NM reported more activities than DCN in 11 of the 12 activities identified in the survey (all but three of these results were statistically significant). When respondents were asked about their level of engagement 36.4% of DCN reported they were “very engaged” compared with 86.7% for NM. There were two notable differences between the DCN and NM identification of “very important” factors for SG. When responding to the factor of DCN working as a team on the unit, 76% of DCNs identified this factor as “very important” while 100% of NM felt it was “very important”. Additionally, only 62% of DCN identified the ability to make changes at the unit level as “very important” while 93.3% of NM found it to be “very important”. This study helps to shed additional light on the factors important to the DCN in developing engagement in SG. While the sample size of nurse manager is small ( $n = 15$ ) in this study it does expose the challenge of engaging the DCN in the building process needed for SG to take root and provide a voice for the DCN. While input from management and administration is vital, the work of SG must come from DCN (Clavelle et al., 2013; Porter-O’Grady, 2012).

### **Qualitative Studies**

A qualitative descriptive study that encompassed ten Colorado hospitals explored staff nurse perceptions of involvement in decision-making (Graham-Dickerson et al., 2013). Stratified clustered random sampling determined ten hospitals, which were invited to participate in the study. Focus groups were conducted with staff nurses in each hospital to determine how nurses defined their involvement, how they wished to be involved in decision-making, what existing models of decision-making were currently in place, how participating in decision-making

impacted work environment, organizational function, patient outcomes, and how to more effectively involve nurses in decision-making in their hospitals. Data gathered in the focus groups were analyzed using a constant comparison method throughout the focus group process; as each focus group was completed data were analyzed and immediately compared to previous data. Seven themes emerged from the focus groups, collaboration, increased involvement, problem identification, formal/informal communication, accountability, autonomy in decision-making, and empowerment. SG was identified as a valuable formal model to give nurses a voice in determining practice issues. Additionally, having a voice in the decision-making process was identified as having a positive effect on the work environment. This study adds to the qualitative work that continues to acknowledge the importance of providing a structured framework through which nurses can exercise control over issues that impact their practice.

### **Mixed Method Studies**

Six hospitals in Northern California participated in a study designed to scrutinize the impact of Shared Governance on nurse's perceptions of job satisfaction and leadership development (Brody, Barnes, Ruble, & Sakowski, 2012). The investigators used a three-phase evaluation process, which included an ethnographic evaluation of the SG councils through a three-month observation by the primary investigator, interviews with key stakeholders within the councils, and a web-based survey. Seventy-six nurses participated in the study. Five themes were revealed including empowerment, meaningfulness, leadership growth, exposure to performance improvement, and vision. Like much of the qualitative work investigating SG, participation activities had a positive influence on the perceptions of empowerment and meaningfulness of



nurse's work. The additional themes involving leadership growth, exposure to performance improvement (PI), and vision revealed important considerations in today's data driven healthcare systems. Participants reported that involvement in councils provided a faster paced growth of leadership skills. Of the council members who participated, 21% (n=8) had applied for advancement, of which, 85% (n=7) received the promotion for which they applied. Additionally, 76% (n=29) reported assuming additional responsibilities since their inclusion in SG. Prior to working with SG councils, few participants were familiar with PI initiatives and processes. SG councils also provided participants in the study with opportunities to develop a broader vision of their work as active members of a larger organization beyond their individual units. Although the sample size was relatively small (n=67), the potential for these positive impacts on both individual nurses and the professional nursing culture of an organization are promising.

Although SG is often reported as vehicle to promote control of nursing practice (CNP), nursing literature has shown that merely providing the framework of SG does not ensure increased CNP (Kramer et al., 2008). A 2008 mixed method study explored the connection between a SG structure (doing the right thing), effective SG processes (doing the right thing well), and improved patient outcomes. Researchers used organizational scores on the Essentials of Magnetism (EOM) tool administered to 2,990 nurses to locate a strategic sample. From a sample of 76 hospitals, those with the highest scores in each of four areas of the country were selected for the study group of eight Magnet hospitals. Interviews, observations, and the Conditions of Work Effectiveness Questionnaire II (CWEQII) were employed to study further CNP within these hospitals. Semi-structured recorded expert interviews on high performing units

within the chosen hospitals included two to four staff nurses (n = 244 55%), one to two providers (n = 97 22%), and the nurse manager (n = 105 23%). Main queries for these interviews included: (a) what supports, encourages, or enables you and your peers to exercise CNP and (b) describe three different outcomes achieved by the council this year. Additionally, the CNO, COO, and representatives from multiple departments within the hospital were also interviewed. The CWEQII was administered to staff nurses on each of the high performing units within the eight identified organizations. Primary Investigators also observed 26 unit, department, and organizational meetings. Qualitative data were analyzed using the percentage of responses in lieu of the number of responses. Important structures identified during the study were SG and established clinical ladders. The importance of five attributes was also identified during the study. These include access to power, recognition, participation, evidenced based practice endeavors, and accomplishment. The most frequent responses to the question what enabled nurses to exercise CNP were: “our council structure,” “shared leadership,” and “collaborative governance” (Kramer et al., 2008, p. 549). The CWEQII identifies empowerment as access to lines of power and does not specifically address SG. Nurses completing the CWEQII reported a moderately high degree of empowerment, with those nurses participating in an integrated SG (organizationally based rather than structured around individual departments) showed higher empowerment scores. This study helps to clarify the importance of SG in developing a culture that enables nurses to exercise CNP.

### **Quality Improvement Studies**

The importance of providing up-to-date unit specific data outcomes along with an infrastructure to ensure the data is used to drive practice initiatives was the subject of one case study from the Hospital of the University of Pennsylvania (HUP) healthcare system (Albanese et al., 2010). Leveraging benchmarked data is vital to improving the quality of nursing practice. Despite this knowledge, there has historically been a substantial lack of understanding of benchmarked outcomes data by staff nurses. SG structure provides the necessary scaffolding to allow staff nurses to develop an awareness of the best practices that are uncovered through the sharing of information from other organization's benchmarked data involving nursing sensitive indicators. Nursing sensitive indicators provide a vehicle for staff nurses to lay claim to their professional contribution to patient care. Within the HUP care is exercised to ensure that performance improvement goals are aligned with the strategic plans of the University of the Pennsylvania, the HUP, and nursing strategic plan (Nursing Quality Plan) to leverage resources, system assimilation, and financial support. In setting strategic goals, trended outcomes data from the previous three years were used, and clinical nurses were educated about variables and metrics specific to their patient populations. Through the SG framework, nursing sensitive outcomes data is reported to Senior Leadership on a quarterly basis. Nursing specific data dashboards aligned with strategic goals are utilized to provide near real-time information to clinical staff. Data dictionaries that provide information on numerators and denominators, calculation formulas, criteria for inclusion and exclusion, along with standardization, reliability, and validity are also provided to the clinical staff nurse. Albanese and her colleagues expound on the misconception that collecting and sharing data with clinical nurses will automatically lead to improved quality

without active mentoring, monitoring, and knowledge sharing. This case study provides a compelling connection between the availability of nursing sensitive outcomes data and engaging clinical staff in quality improvement work. SG structure offers a framework to standardize a data delivery process in units and departments as well as linking individual unit/departments to nursing quality outcomes that impact the entire organization.

### **General Literature**

A 2009 literature review of the psychometric properties and validity of available instruments aimed at measuring nurse autonomy and control over nursing practice (CONP) helped to shed additional light on nursing research surrounding these concepts (Weston, 2009). A literature search was conducted to discover current instruments that seek to measure perceptions of these two concepts. Autonomy and control over nursing practice are integral to the SG process necessitating exploration of instruments designed to measure them (Ballard, 2010; Clavelle et al., 2013; Porter-O'Grady, 2012; Weston, 2009). A literature search through CINAHL, Sociological Abstracts, and ABI Inform was completed to identify instruments for analysis. Inclusion criteria for instruments to be studied included (a) use in multiple research studies (b) publication of the psychometric elements of the instrument and (c) inclusion necessitated that the researcher was able to obtain the instrument for study (Weston, 2009). Results of the researcher's analysis revealed several instruments aimed at measuring nursing autonomy actually failed to measure perceptions that fit definitions of either clinical or work autonomy. Often this incongruence involved an instrument that measured the independent performance of the practitioner, while failing to acknowledge the conceptual differences between

autonomy and independent practice (Nurse Autonomy and Patient's Rights Questionnaire). In her review, Weston illuminated the tendency of nurse scientist to measure autonomy with instruments that contain attributes of independence. While all of the instruments reviewed had validity and reliability, construct validity was not stellar in many instances. Weston also delineated the importance of clearly identifying whether insights of clinical or work autonomy are being sought, as the tools must be specific. Instruments found to be valuable in measuring clinical and work autonomy and CONP include the Control Over Nursing Practice Scale, the Participation and Decision Activities Questionnaire, Essentials of Magnetism Scale, and the Nursing Authority and Autonomy Scale (some sub-scales). Instruments to measure the concepts aligned with effective SG are important when evaluating the current state of SG within an organization. This review exposes a need to develop and test new instruments along with continuing the validation of existing instruments to improve the accuracy of research regarding SG.

The Conditions for Work Effectiveness Questionnaire (CWEQ) along with the Organizational Commitment Questionnaire (OCQ) were used in a 2010 quasi-experimental prospective study to quantify changes as one organization developed and implemented a plan for restructuring an established SG model (Moore & Wells, 2010). An early study delving into SG showed correlation between the subscales of the CWEQ and OCQ demonstrating that providing occasions for growth and professional progress were important factors in the participants commitment to their organization (McDermott, Spence Laschinger, & Shamian, 1996; Moore & Wells, 2010). In this study, both the CWEQ and the OCQ were administered to all nurses that

were affiliated with the SG Council structure. This group served as the intervention group while nurses who were not affiliated with SG were surveyed and served as the control group (Moore & Wells, 2010). The surveys were completed pre-intervention to provide a baseline, and approximately one year later to assess for changes in nurse's perceptions of empowerment and organizational commitment after efforts to improve SG had been completed. The investigators hypothesized that nurses who participated in SG would show an increased level of empowerment and commitment post-intervention; results showed no statistically significant improvement in the scores. The author's report that the intervention group did have a significantly higher mean for the CWEQ subscale measuring informal power although these specific results were not reported. The authors posit that perhaps one year is too short a time to show positive results, and additionally surmise that the intervention group may already have a relatively high level of empowerment and commitment. While this study is useful in its consideration of participants of a SG Council compared to those that are not involved, it is important to acknowledge the need for SG to impact the level of empowerment and commitment of all staff nurses regardless of their participation in the SG structure.

The importance of active nurse executive participation and support of SG was highlighted in a paper that tracked nursing satisfaction over time with the development of a Unit-Level Shared Governance (ULSG) model (Brandt, Edwards, Cox-Sullivan, & Zehler, 2012). After participating in a Robert Wood Johnson /American Association of Nurse-Executive (AONE) program to implement Transforming Care at the Bedside (TCAB) on a single unit, Central Arkansas Veterans Healthcare System (CAVHS) implemented ULSG using the TCAB model

throughout their organization. The nurse executive encouraged relational partnerships between nurse managers and staff nurses through planned retreats that fostered this key collaboration. Porter-O'Grady wrote of the importance of cultivating nurse managers that embraced relational partnerships and could see the value of group decision-making in creating a successful SG culture. In addition, implementation and ongoing development of ULSG were incorporated into the Nursing Strategic Plan, prioritizing its development and dissemination throughout the organization. Upon implementation of ULSG, nursing satisfaction as measured by the Veterans Affairs Nursing Outcomes Database (VANOD) Nursing Satisfaction Survey has consistently improved over time placing CAVHS in the top 25% of all VA Medical Centers. This example illuminates the importance of ongoing, visible support from nursing leadership along with the use of a structured framework to plan and implement SG. Continued improvement of nursing satisfaction scores demonstrates the usefulness of SG in recruiting and retaining experienced and engaged nursing professionals.

### **Conclusion**

Many studies have sought to quantify and more fully understand the benefits to nursing practice of a SG framework. Work in nursing research has unveiled multiple tools with which to measure the effectiveness of SG models within organizations. The IPNG has been well validated. Use of instruments such as the IPNG allows organizations to evaluate the effectiveness of the implementation process of SG. Additionally, the IPNG instrument allows organizations to follow the progress of SG by repeating the survey and tracking improvements of SG and its relevance to the direct care nurse. There are important benefits that can be developed with the maturation of

SG councils within an organization. Nursing studies clearly identify the need for a sustained effort with visible Nursing Administration support to effectively incorporate SG into the decision-making process of an organization.

### **Conceptual Model and Theoretical Framework**

Within the project site, a substantial commitment was made to launch SG in 2011. This initiative was undertaken as the hospital began its journey toward achieving Magnet designation. Ongoing financial support has been questioned in light of today's complicated healthcare economic challenges. Missing from the original roll out was a change theory used to inform the original implementation process. Without the underpinnings provided by a theoretical change framework, it is possible that the initial implementation failed to garner the appropriate staff understanding and support. Additionally, steps within change theory directed at sustaining momentum with the change process may have identified important opportunities.

### **Kotter's Contemporary Change Theory**

John Kotter, a storied Professor of Leadership at the Harvard Business School first posited his theory of contemporary change in 1995. Kotter had observed a series of steps that had proven vital to successful change. Perhaps more importantly, he observed that when these steps were eliminated or done in haste the momentum for change was stopped, often never able to regain traction (Kotter, 1995). The most valuable of these steps and perhaps the most difficult to accomplish is creating a sense of urgency (Kotter & Schlesinger, 1979). Kotter's theory acknowledges the trepidation in the hierarchical organization to upset the status quo and established way of doing things (Kotter & Schlesinger, 1979). To create this sense of urgency, it



is vital to understand the four reasons many within an organization will resist change (1) they worry they will lose something they value (2) they do not understand the change or its consequences (3) they do not think the change is good for the organization or (4) they simply do not tolerate the idea of change (Kotter & Schlesinger, 1979). Meticulous attention to overcoming these barriers thereby creating a dynamic sense of urgency is the lynchpin of Kotter's change theory.

Once this sense of urgency is created, seven additional steps, when completed, provide an organization with established and sustained change. These steps include, "forming a powerful coalition, creating a vision, communicating the vision, empowering others to act on the vision, planning for and creating short-term wins, consolidating improvements, and institutionalizing new approaches" (Kotter, 1995, p. 61). This change theory, despite its creation nearly 20 years ago resonates with the challenges faced by today's healthcare organizations.

With that said, challenges to organizations in 2014 are decidedly different than those encountered in the 1990's when this theory was developed. Kotter addressed this concern in an article published in the Harvard Business Review in 2012. Kotter advocated for the development of a second operational system alongside the traditional hierarchical system already in place within the organization (Kotter, 2012). This strategy network, populated by volunteers within the organization is dedicated to identifying ideas and innovations and moving them forward (Kotter, 2012). This strategy network concept, although framed by Kotter in the business world, could be applied to the SGM within a healthcare organization. Kotter describes a model that is centered on a guiding coalition, which has representation from the hierarchy (Kotter, 2012). Surrounding this

coalition are initiative groups made-up of volunteers that report into the guiding coalition. There is certainly similarity with this model to that of a SGM. Before this model can gain support and perform in the way Kotter envisions, the critical first step of building a sense of urgency must be accomplished.

### **The Logic Model for Program Planning**

In discussions with staff members on individual units at the project site, one theme seemed to permeate many of these conversations. There was frustration that in the past when work on the unit was undertaken, there was a lack of sustained change culminating from any successes that were realized. The W. K. Kellogg Foundation found when they examined failed projects that in many, end results of a project undertaken had not been clearly defined and communicated to the key stakeholders in the process (W. K. Kellogg Foundation, 2004). The logic model, explicitly describes not only short-term outputs, and outcomes of the project undertaken, but can also address the long-term (7-10 year) impact of the project (W. K. Kellogg Foundation, 2004). In the case of SG, establishing an understanding of these important long-term changes in how nursing decisions are made within a healthcare organization is vital to obtain buy-in from both staff and leadership. By allowing dreams to become visualized through the logic model, a connection between work being undertaken and future states becomes more tangible and therefore easier to both imagine and articulate (W. K. Kellogg Foundation, 2004). The logic model allows for all involved to have a shared mental model of the work and priorities of the project.

For the staff developing a UPC, use of the logic model allows for a visual connection

between work (inputs and activities), outputs, outcomes, and long-term impact. This visual guides not only members of the UPC, but also the staff that must support the work of the UPC. An important element of the logic model is the creation of “if...then” assumptions that evolve from reading the logic model (W. K. Kellogg Foundation, 2004). When process improvements undertaken by the UPC are displayed within a logic model, it is quickly apparent to all of the staff what work must be accomplished to arrive at the desired output. There are three approaches to the logic model, each one with a different emphasis, a theory approach, an outcomes approach, and an activities approach. The theory approach to the logic model provides focus on the needed change process by identifying and addressing these challenges (W. K. Kellogg Foundation, 2004). Aligning actions undertaken and explained in the logic model that address these barriers can be instrumental in garnering the needed support and understanding for the importance of the UPC to everyone who works on the unit.

Important to the success of SG projects is the early identification of clear, measurable expectations and benchmarks along with expected achievement dates. Use of the logic model allows participants of the program to contribute to the development of these goals thereby attaining a complete understanding of activities, benchmarks, and the timeline. For the staff on the unit, use of the logic model allows for a visual connection between work (inputs and activities) to outputs, outcomes and long-term impact (Burnett, Curran, Loveday, Kiernan, & Tannahill, 2014). Creating a visual model that connects the resources required and expected activities with the anticipated goals the UPC provides an essential roadmap that can be followed. This model guides understanding of UPC members, staff members, along with nursing

leadership. An example of a logic model that envisions the short and long-term impact of creating a UPC on a nursing unit within the project site can be seen Appendix A. Using the logic model allows for the evaluation process to be embedded in each aspect of the program planning, allowing for continuous feedback and the alignment of the current state with envisioned progress during the planning process.

### **Summary**

Cultivating and nurturing an effective UPC or SG requires an approach that emphasizes collaboration and relationship building. Application of a change theory such as Kotter's can impact the approach and structure of the DNP project. Successful use of the logic model in the rebuilding process allows participating staff to identify, articulate, and achieve goals through the use of a visual roadmap depicting inputs, activities, outputs, and outcomes. Implementation of this DNP project allows for clear goal setting and planned evaluation to be woven into each phase of this project.

## Section 3: Methodology

### **Introduction**

A crucial first step in determining changes that may improve the effectiveness of SG at the project site was assessing of the current state of SG with tools validated in nursing research. Essential to completing an assessment of the current state of SG is gathering data to determine baseline understanding of both the UPC and SG within the hospital. Knowledge of nurses' perceptions and beliefs surrounding the SG process inform their identification of existing barriers that impact the successful recruiting of UPC members. Further, staff members identified what elements of the previous UPC were successful and what elements were problematic. Efforts were aimed at opening effective dialog between the DNP student and the clinical nurses on various units through impromptu visits to the unit along with more formal forums.

### **Method**

This quality improvement project used descriptive pre- and post-intervention survey analysis to assess the baseline and post-intervention effectiveness of SG at the project site. Repeated IPNG scores, along with trending NDNQI nursing survey results, will assist in the evaluation of interventions to improve the effectiveness of SG over time. The current state of the SGM at the project site was further evaluated with a retrospective examination of agendas and minutes.

For the purposes of this DNP project, assessment of the project site's current SG structure focused on the UPC and the nursing senate. The assessment included a retrospective and concurrent review (January, 2013–March, 2015) of UPC and nursing senate meeting agendas,

minutes, and attendance sheets. Nursing leadership, unit managers, and staff nurses were invited to complete the IPNG survey in October 2014. Additionally, the project site completed the NDNQI Nursing Satisfaction survey in May of 2014. Both survey instruments will be repeated in the fall of 2015. Data gleaned from past NDNQI surveys was analyzed and utilized in completing the assessment of the current state of SG at the project site.

### **Population and Sampling**

For purposes of the IPNG survey, the population under consideration encompassed all registered nurses and Advanced Practice Registered Nurses (APRN) included in the staffing of any unit or department represented within the SG model developed at the project site. This criterion involved all inpatient units and departments along with areas that were considered outpatient departments but were housed at the project site (e.g. endoscopy). Several ambulatory care departments not housed at the project site were not included in the survey because they were not included in the SG system at that time. Two examples are the Pain Clinic and Wound Care Center, which have not developed UPCs and do not have representatives included in the SG structure. Any RN included in the staffing of the units and departments that met inclusion criterion and who could speak, read, and write English were considered a part of the sample population for this survey. No restrictions regarding job title, coded hours, per diem status, education, or length of employment were imposed. A power analysis with a confidence interval of 80% revealed a minimum sample size of 68 returned surveys for the IPNG survey. The NDNQI nursing satisfaction survey included all RNs working within the hospital, regardless of job title or area of practice. Although areas not included in the IPNG survey were included in the

NDNQI survey, the results are unit specific, which allows for comparison of the results with like participant populations.

### **Data Collection**

Retrospective and concurrent review of minutes and agendas for UPC meetings along with sign in sheets were examined. Minutes were also reviewed for identification and progress of initiatives, communication, and dissemination techniques. The DNP student visited each unit and department represented in the Nursing Senate (NS) to ascertain the existence and availability of UPC minutes and agendas.

In addition, NS minutes and agendas reflecting the same time period (January 2013–March 2015) were also reviewed. Monthly NS minutes are recorded and transcribed by an administrative assistant and were available for review. Review of these minutes provided data on attendance of each UPC chair and records current unit objectives and initiatives of the UPC as reported by the chair.

Random samplings of all RNs who meet the inclusion criterion were invited to complete the IPNG survey. Surveys with a letter of introduction and request for participation were randomly distributed via unit/department mailboxes. Envelopes for completed surveys were placed on each unit/department. Directors also had additional copies of the survey/letter packets for any RN that wished to complete the survey. Survey packets were distributed to 200% of the sample size revealed in the power analysis to ensure an adequate sample size of returned surveys. The survey was open for three weeks.

The most recent NDNQI nursing satisfaction survey was completed in April 2014, which provided baseline data prior to the implementation of interventions. Additionally, annual trended data from the 2012 and 2013 NDNQI survey considered in the assessment. October 2015 marks the next time the NDNQI nursing satisfaction survey will be launched at the project site. This survey will provide an opportunity to assess changes in nursing satisfaction and perceptions of autonomy and control over nursing practice after implementation of interventions throughout the DNP project. Because NDNQI provides unit specific data, only surveys submitted by RNs included within units and departments outlined above will be considered.

As the study drew to its conclusion, a short survey monkey was distributed to the members of the Nursing Senate to assist in the evaluation of this DNP project (Appendix D). Survey Monkey was utilized to launch the survey using the distribution list for the Nursing Senate. Because the IPNG and NDNQI nursing satisfaction survey will not be repeated prior to the conclusion of this DNP project, this survey will contribute some data on the short-term perceptions of change resulting from the project.

### **Instruments**

#### **IPNG**

Review of nursing research revealed multiple tools designed to measure the effectiveness and functioning of Shared Governance within an organization (Bogue, Joseph, & Sieloff, 2009; Fray, 2011; Hitchings, Capuano, & Bokovoy, 2010; Hess, 1998; Weston, 2009). Robert Hess' (IPNG) developed in 1997 represents a validated formal measure that is well represented in nursing research (Clavelle, O'Grady, & Drenkard, 2013; Hess, 1998; Hess, 2011). The IPNG



survey consists of 86 questions answered with a 5-point Likert scale (Hess, 2011). An overall score greater than 173 indicates an organization has met the index's standard for achieving functional shared governance (Appendix B).

There are five categories of governance within the IPNG tool: (1) nursing management and administrations only, (2) primarily nursing management and administration with some staff nurse input. (3) equally shared by staff nurses and nursing management and administration, (4) primarily staff nurses with some nursing management and administration input, and (5) staff nurse only (Hess, 1998). The IPNG scores an organization's progress toward enculturation of SG by measuring governance, the concept that permeates all facets of SG allowing participants the control over their practice and autonomy necessary to flourish as knowledge workers (Hess, 2011). Additionally, the IPNG provides data on six subscales allowing investigation around specific areas that may be successful or in need of attention (Hess, 2011). The IPNG subscales include, "control over personnel, access to information, influence over resources supporting practice, ability to participate in organizational decisions, control over practice, and ability to set goals and resolve conflict" (Hess, 2011, p. 237). In the initial work surrounding the IPNG instrument, 231 surveys were examined. The Cronbach's alpha for the total scores on the tool was 0.95, with subscale reliabilities ranging from 0.85-0.90 (Hess, 1998). As of 2011, 150 organizations have deployed the IPNG to assess SG (Hess, 2011). Some organizations deploy the IPNG multiple times to validate and reassess SG progress and maturation over time (Anderson, 2011; Hess, 2011).

### **NDNQI Nursing Satisfaction Survey**

The NDNQI collects unit focused, benchmarked data on a myriad of outcomes that are impacted by nursing care. Examples of this data include hospital acquired pressure ulcers, catheter associated urinary tract infections, and central line associated bloodstream infections to name a few ("JSS-R," 2014). In addition data on nursing hours, staff mix, education, and certification is collected. Organizations can also choose to take part in a nursing satisfaction survey that provides benchmarked data on both the unit and organizational level. There are two nursing satisfaction surveys available from NDNQI, the Job Satisfaction Scales-Revised (JSS-R), and a survey that uses the Practice Environment Scale (PES) (Appendix C). The project site has opted to use the JSS-R and has taken the NDNQI nursing satisfaction survey annually since 2012. The survey administered in 2014 marked the first time the JSS-R instrument was used at the project site. The JSS-R survey shifts the questions from inquiring about the perceptions of the individual completing the survey to the individual's perception of how the question relates to the unit/department in which they work ("JSS-R," 2014). The survey inquires about autonomy, professional development, nursing administration, and nurse-to-nurse interaction. Additionally, the survey delves into work context items that include near future job plans, ratings of last shift worked, lunch and break time, and overtime worked ("JSS-R," 2014). Demographic data collected includes experience, education, and certification. The availability of trended data from the NDNQI nursing survey allows for examination of any changes in nurses' perception of autonomy, professional development, nursing administration, and nurse-to-nurse interaction as interventions designed to bolster the effectiveness of SG are implemented.

### **Protection of Human Subjects**

This DNP Quality Improvement Project received approval from the Walden University IRB (05-07-15-0427814). Exceptional care was taken to ensure the protection of participants in the SG structure of the UPC and NS along with those invited to complete the IPNG survey and the NDNQI Nursing Satisfaction survey. Any activities of the DNP at UPC or NS meetings were introduced with an explanation of the DNP project and a reiteration of the voluntary nature of any activities with the DNP. Further, any individual's comments shared with the DNP student were not communicated in an identifiable manner (written or oral). With that said, honest and forthright discussion along with relationship building activities between the DNP student and UPC members is the lynchpin of this DNP project. The DNP student sought to create new relationships with staff and UPC members on units that were involved in the interventions allowing for a free exchange of ideas.

### **Data Analysis**

After IPNG data was cleaned, SPSS was used to determine means and frequencies of demographic details used to develop an organizational profile (Hess, 2010). Variables were calculated to include governance (all 86 items), and the subscales identified by Hess (Hess, 2011). Mean scores were calculated and compared to benchmarks provided by Hess when permission to use the instrument was granted (Hess, 2010). The mean scores from the governance scales were compared to group scores to evaluate for any differences and ANOVA was used to assess for significant differences (Hess, 2010). The mean scores for each item were also determined to identify low-scoring opportunities for improvement (Hess, 2010).

### **Project Evaluation Plan**

During the early months of the program (1–3 months), work focused on identifying individuals with an interest in participating in the UPC, developing an educational plan, and establishing a mentoring relationship with the DNP student. Goals for this stage were to establish a meeting schedule, identify a chairperson or co-chairs, and work on developing a scheduling protocol to enable members to both attend meetings and complete assigned deliverables for the UPC.

At the end of six months expected outcomes included scheduled monthly meetings attended by a minimum of 80% of UPC members, agendas dispersed 1 week before meeting to all unit staff, published minutes dispersed to all staff, initial goals and timelines for a minimum of two process improvements identified by staff, and attendance at 90% of the Nursing Senate monthly meetings by one or both co-chairs of the UPC.

As the initial year draws to a close and at each annual anniversary, the IPNG and NDNQI Nursing Satisfaction Survey will be repeated. Examination of these trends along with tracking UPC and Nursing Senate meeting participation and initiatives progress will provide ample data to evaluate the effectiveness of the program. Following this data every 12 months will reveal opportunities to put improvement plans in place where needed to ensure the program continues to meet expectations. An IPNG score of 173, demonstrating a functioning SG, is the goal for the end of year one after implementation of the intervention.

### **Summary**

Research has shown that mature and robust SG councils can improve nurses' perception of autonomy and control over nursing practice. The UPC and NS have the potential to provide a

powerful framework for redistributing authority, responsibility, and accountability for nursing practice between staff nurses and nursing administration both within the unit and throughout the hospital. Implementation of SG without diligent nurturing often fails to produce robust SG Councils that are relevant to the direct care nurse. The DNP student was well placed to provide this nurturing through the development of effective relationships; providing mentoring, education, and resources as the council members assumed their leadership roles within the SG structure.

## Section 4: Discussion and Implications

### **Introduction**

The SG framework as developed at the project site was well established. While there was a general feeling by nursing administration, management, and clinical staff that SG could be leveraged more successfully, a definitive assessment of its effectiveness was missing. Without this understanding, interventions to improve SG would lack direction and planning. Once this assessment was completed, opportunities were prioritized to arrive at the optimal areas for intervention within the scope of this project.

This section will discuss the results of the assessment of the SG framework at the project site followed by a review of the interventions undertaken during the project. Additionally, this section will (a) discuss the findings within the context of nursing literature, (b) delineate implications for practice, (c) review the project's strengths and weaknesses, and (d) provide a personal analysis of this project's impact on the student's professional growth as a DNP.

### **Summary and Evaluation of Findings**

The summary and evaluation section will account for the three areas of assessment of SG undertaken at the project site. Assessment objectives included the IPNG survey results, the NDNQI nursing satisfaction survey results, and a review of SG minutes, agendas, and attendance sheets. The intervention summary included work undertaken to develop the Cardiac Medical Unit UPC along with work undertaken through the NS to develop processes to improve the effectiveness of the UPC and NS as the lynchpins of the SG framework at the project site.

## **Index of Professional Nursing Governance Results**

In an effort to ensure the minimum sample size of 68 returned surveys, 150 invitation/IPNG survey packets were placed in RN mailboxes throughout the units and departments of the hospital. Of the 150 surveys distributed, 84 completed surveys were returned for a response rate of 56%. All data were entered into SPSS software for analysis. Of the participants who completed the survey, 80 were female (95.2%), and four were male (4.8%). The average age of the participants was 41 years of age with a minimum age of 23 and maximum age of 63. Of those nurses who completed the survey, 7.1% had a Nursing Diploma, 38.1% held an Associates Degree, 47.6% a Baccalaureate Degree in Nursing, 4.8% a Master's Degree in a discipline other than nursing, and 8.3% held a Master's Degree in Nursing. The mean number of hours worked per week was 25.89 (SD 7.102). Of those responding, 76.2% worked full time. The mean number of years in practice was calculated at 15.3 (SD 12), with a minimum of 6 months and a maximum of 44 years. The mean number of years employed at the project site was 9.38 years (SD 8.72). When queried about their job titles, 75% identified themselves as Clinical RNs, 13.1% as Clinical Nurse Managers, 8.3% as Unit Directors, and 2.4% as Nursing Administrators, and 1.2% as Educators. Those clinical specialties with the highest participation percentage included the Emergency Department (16.7%), Medical/Surgical (16.7%), Critical Care (13.1%), Telemetry (11.9%), and Cardiovascular Surgical Care (10.7%). All units/departments included in the survey completed at least one survey. Of those who returned the survey, 37% held a specialty certification. Participants were also asked to rate their overall

satisfaction with their practice on a five-point Likert scale. The mean overall satisfaction score was 3.26 (SD 1.142).

After calculating the total governance score which included all 86 items on the survey six new variables were created using the subscale key provided by Hess, (a) control over personnel, (b) access to information, (c) influence over resources supporting practice, (4) participation in committee structure, (5) control over professional practice, and (6) goal setting and conflict resolution (Appendix E). Each item included in the survey was placed into one of these six new variables. By creating these additional variables, data gleaned from each subset could be analyzed providing insight into the each variable's contribution to the governance score.

The Total Governance mean score was 151.04 (SD 35.38), short of the 173 score that marks the achievement of a functioning SG using to the IPNG instrument. Rather, the score of 151.04 reflect nurse's perception of traditional governance defined by Hess as relying solely on management and administration for decision-making and control within the hospital as shown in Table 1 (Hess, 2010). There was a significant SD with this score highlighting the wide variation in survey scores among participants.

Table 1

*Governance Distribution for the Index of Professional Nursing Governance Instrument*

Classification	Score on IPNG survey	Dominant group
Traditional Governance	86-72	Management and administration only
Shared Governance	173-257	Primarily management and administration with some staff input
	258	Equally shared by staff and management and



		administration
	259-344	Primarily staff with some management and administration input
Self Governance	345-430	Staff only

The control over personnel variable considers 22 items from the survey, which focus on who within the hospital, is responsible for controlling personnel (Hess, 2010). Included in this variable are questions relating to the hiring, promotion, and evaluating of personnel. Also identified in this variable are the issues surrounding salaries, benefits, unit budgets, creation of new positions, along with disciplinary actions and the termination of personnel (Hess, 2010). The mean score for the control over personnel variable was 29.39 (SD 6.10). A score of 45-88 represents achievement of SG for this variable while a score of 29.39 represents the perception of traditional governance by the participants.

Fifteen questions from the survey are considered in the variable assessing access to information. This variable seeks to tease out perceptions of the participants regarding who has access to the information needed for governance of the organization including (a) opinions of providers, staff, managers, and patients, (b) budgets and expenses of the unit/department, (c) goals and objectives that have been established for the unit/department, and (d) organizational strategic plans, financial health, and compliance (Hess, 2010). The IPNG tool considers a score between 31 and 60 as representative of SG for this variable. The project site score for the access to information variable was 26.37 (SD 7.69), again pointing to the perception by participants of a traditional governance style.

The next variable considers who within the organization and units/departments has influence over the resources that support practice. This variable includes questions that relate to the monitoring and securing of needed supplies, the process for consulting other areas within the organization, creation of daily assignments, along with the management of admissions, discharges, transfers, and referrals (Hess, 2010). A benchmark score of 27-52 for this variable marks the achievement of SG according to the IPNG instrument (Hess, 2010). The score for the project site for this variable was 27.30 (SD 9.28) marking the achievement of SG for this important variable.

The third new variable evaluated respondents' perceived ability to participate in organizational decisions through committee structure. Twelve items from the instrument that address decisional issues that influence clinical practice are a part of this variable. These include, (1) budgeting, scheduling, and unit/department goals and objectives, (2) policies and procedures, and (3) collaboration among multidisciplinary teams (Hess, 2010). The project site score for this variable was 24.30 (SD 7.63), which came very close to achieving the benchmark of 25-48. This score implies that while the SG structure in place at the project site has yet to achieve its goal, it has made significant inroads. Attention to opportunities uncovered within this variable can help to increase its impact on practice to achieve the SG benchmark.

The fourth variable created focused on control over professional practice, an important factor linked to nursing staff satisfaction (Ballard, 2010; Barden, Quinn-Griffin, Donahue, & Fitzpatrick, 2011; Clavelle et al., 2013; Hess, 2011). This variable encompasses 16 items from the survey involving (1) patient care standards, policies and procedures, (2) products used to

deliver quality patient care, (3) staffing levels, qualifications and educational requirements, and (4) the translation of research into practice (Hess, 2010). The benchmark for SG determined by the IPNG instrument is 33-64, with a project site score of 28.78 (SD 8.13). Again for this variable, the score denotes a traditional governance structure (Hess, 2010).

The final variable delved into the nurse's role in determining and achieving unit, department, and organizational goals (Hess, 2010). This variable considered eight items from the survey, which query participants about (a) philosophy, (b) goals and objectives in their department and the organization, (c) negotiation and conflict resolution among professionals, (d) hospital personnel and managers, and (e) the existence of a formal grievance procedure (Hess, 2010). Achievement of SG for this variable is determined by a score of 17-31. The project site score for this variable was 14.73 (SD 5.12) denoting a perception of traditional governance (Hess, 2010).

A one-way ANOVA test was conducted to evaluate the null hypothesis that there was no significant difference in mean scores on the IPNG survey based on job title. The independent variable was comprised of three groups, nursing administration ( $M = 173.1$ ,  $SD = 21.7$ ,  $n = 8$ ), clinical nurse manager ( $M = 179.9$ ,  $SD = 35.3$ ,  $n = 11$ ), and the clinical nurse ( $M = 142.7$ ,  $SD = 33.1$ ,  $n = 59$ ). Leven's Test was used to evaluate the assumption of homogeneity of variances and was found to be tenable,  $F(2, 75) = 1.7$ ,  $p = 0.182$ . The ANOVA did find that there were significant differences in the mean scores of the IPNG survey based on the job title with  $F(2, 75) = 8.15$ ,  $p = 0.001$ . Thus, the null hypothesis stating there is not a statistically significant difference between mean scores on the IPNG survey based on job title was rejected. Although

this difference was statistically significant, based on Cohen's (1988) conventions for interpreting effect size this difference was small (0.18). Post hoc comparisons using the Tukey HSD test was used to evaluate differences among group means. These tests revealed pairwise differences between the mean scores of those in the clinical RN group and both the nursing administration and clinical nurse manager group. Differences between the mean scores of nursing administration and clinical nurse managers were not statistically significant.

One-way ANOVA tests were also conducted comparing scores based on the educational degree held, clinical specialty, and employment status. The one-way ANOVA test comparing the mean scores of the IPNG survey based on the highest educational degree held did not reveal statistically significant differences. Likewise, the one-way ANOVA comparing groups based on clinical specialty and employment status (part-time/full time) revealed differences that were not statistically significant.

The IPNG survey tool provides a very detailed accounting of the strengths and weaknesses of how SG is perceived within the project site. The SG framework set up at the project site is designed to build a model of shared decision making for the items on the IPNG survey. What is clear with these results is that there seems to be both a lack of understanding of the SG framework along with a certain lack of effectiveness visible to those who completed the survey. When evaluating access to resources, the scores on the survey were within the SG range (score 27.30 range for SG 27-52). Many of the aspects of practice addressed in this variable are visible to nurses as they complete their work. Lack of exposure to and understanding of the work undertaken through SG by the nurses at the project site may be an important element in the lower

scores on other variables. In order to develop the effectiveness of SG, communication around its work is essential. As an example, through the SG framework nurses are included in the capital budget process. Each of the four capital budget review teams within the project site has an RN among its members. These interdisciplinary teams review capital requests from all areas of the hospital and provide a score and recommendation to Senior Management at the project site. However, without the effective communication of nurse involvement in this important work, nurses may feel detached from the budget process.

Secondly, SG must become visible and relevant within the hospital. Work at the unit and department level through the UPC is an effective way to ensure this connection to nurses at the practice level (Bretschneider, Eckhardt, Glenn-West, Green-Smolenski, & Richardson, 2010; Duncan, 2011; Fray, 2011). As UPC's work becomes more closely integrated into the NS, and communicated across units/departments, its visibility and impact may elevate the IPNG scores. In addition, projects identified through the creation and communication of a Nursing Strategic Plan can help clinical nurses to become knowledgeable regarding the issues identified as mission critical and plans to address their improvement.

### **NDNQI Nursing Satisfaction Survey**

The NDNQI nursing satisfaction survey was open for participant responses for three weeks, April 7<sup>th</sup>-27<sup>th</sup> 2014. Computers equipped to allow nurses to complete the survey were located in each unit/department. Additionally, nurses were instructed on how to complete the survey off-site should they prefer to do so. Upon completion, nurses could print a certificate of completion and receive a gift card for coffee. Reminder emails were sent out after week one and

two. Pizza parties were given to each unit that achieved 100% participation. Nursing leadership was pleased with the 84% participation of the nurses at the project site. The five Magnet indicators considered from the NDNQI nursing survey are autonomy, professional development opportunity, professional development access, nursing administration, and nurse-nurse interaction. Because this was the first year the project site used the Job Satisfaction Scale Revised (JSS-R) instrument, results from past surveys for these five indicators could not be correlated to the results of the 2014 survey. Aggregate results revealed that the project site fell below the NDNQI Mean for non-teaching hospitals. The project site's mean scores were below the 50<sup>th</sup> percentile in all five categories, autonomy was 0.9% below the mean, professional development opportunities 0.38% below, professional development opportunities 0.39% below, nursing administration 0.3% below, and nurse-nurse interaction 0.1% below. While below the mean, these scores reflect a relatively small gap. However, when examining surveys from previous years, it is worth noting that the benchmark has continued to rise each year. Further review of the data revealed that aggregate results for the job enjoyment scale fell 0.81% below the mean. This marks a dramatic decrease from the 2013 score of 5.24%. A decrease from 2013 was also seen in the nurse's perceived quality of care, which fell 0.16%. When considering the nurses assessment of appropriate patient assignments scores have been declining for the last three years and fall below the benchmark. Also problematic for the project site, a threefold increase in the number of nurses planning to leave the project site to work in direct care at another hospital was seen from the 2013 survey results.

Although these results are concerning, they must be viewed within the context of the current state at the project site and similar hospitals in the immediate area. The project site has seen a steady increase in its patient census over the last year. While high census alerts for all units were occasionally observed in previous years, they are now the norm in area hospitals over the last 8 months. As the project site has grappled with reacting to the higher census, staff has been struggling with the constant request to work overtime. Patient days increased at the project site by 3,693 in 2014. This additional patient load is superimposed on an existing structure with little room for increasing its bed capacity. Adding to the dilemma, hiring experienced nurses in the area has become challenging as additional hospitals struggle with the same patient census challenges. While these challenges may have impacted the satisfaction scores for nurses at the project site, they do not release the project site from the need to address and work to improve the nursing satisfaction scores. Work to improve the effectiveness and relevance of the SG framework may help to inform planning for these initiatives. SG can provide a strong forum for nurses to voice their concerns, plan for improvements and be central to the implementation of change initiatives. While this may not change all that is deemed suboptimal within the project site by nurses, it can have a tremendous impact on job satisfaction (Porter-O'Grady, 2012)

### **Review of Unit Practice Council and Nursing Senate Minutes and Agendas**

Nursing Senate (NS) minutes were reviewed from January 2013 through March of 2015. The SG bylaws currently in effect mandate that the UPC chair or co-chair attend at least 80% of the NS monthly meetings and report on activities of their UPC. In assessing unit and department

council meetings and SG committee participation at NS meetings, three criteria were used. For each monthly NS meeting, participation for each UPC or SG Council was given a rating of either, (a) present with report of previous months UPC/Council meeting, (b) present but without report of previous month's meeting (no meeting occurred), or (c) absent. The results of the review of NS can be found in Table 2.

During 2013, one unit (Special Care Nursery), no departments, and two SG Committees (Evidence-based Practice, and Falls Committee) attended at least 80% of the NS meetings and provided a report on their previous month's UPC/Committee meeting. In 2014, two units (Mom's Place, Special Care Nursery), one department (Emergency Department), and one Committee (Falls) attended NS and provided a report. During the first quarter of 2015, three units (Cardiac Medical Unit, Mom's Place, and Special Care Nursery), two departments (Cardiovascular Wellness, Emergency Department), and one Committee (Evidence-based Practice) attended and provided a report to the Nursing Senate. This shows an encouraging trend in attendance.

Table 2

*Nursing Senate Minutes Review January, 2013-March, 2015*

Unit/ Dept./ Committee	Jan-Dec 2013 *			Jan-Dec 2014			Jan-Mar 2015		
	Present Report Given	Present No Report	Absent	Present Report Given	Present No Report	Absent	Present Report Given	Present No Report	Absent
Unit									
CMU	1 (9%)	1	9	3 (25%)	1	8	3 (100%)	0	0
CVSU	3 (27%)	7	1	4 (33%)	2	5	1 (33%)	0	2
E100	2 (18%)	3	6	2 (16%)	3	6	2 (66%)	1	0
E200	2 (18%)	4	5	6 (50%)	4	2	1 (33%)	2	0



HVIU**	3 (33%)	1	5	8 (67%)	2	3	2 (66%)	0	1
ICU	3 (27%)	2	6	6 (50%)	0	6	0	0	3
MOMS	3 (27%)	0	8	11 (92%)	0	1	3 (100%)	0	0
RMU	5 (45%)	2	4	5 (42%)	3	4	1 (33%)	0	2
SCN	9 (82%)	0	2	11 (92%)	1	0	3 (100%)	0	0
Department									
Cath Lab	2 (18%)	0	9	4 (33%)	0	8	0	0	3
CV Well	5 (45%)	2	5	6 (50%)	2	4	3 (100%)	0	0
ED	4 (36%)	0	7	10 (83%)	1	1	3 (100%)	0	0
Endo	6 (55%)	2	3	4 (33%)	5	2	2 (66%)	0	1
EP Lab	0	0	12	4 (33%)	0	8	2 (66%)	0	1
OR	2 (18%)	0	9	2 (16%)	5	5	0	1	2
PACU	3 (27%)	2	6	4 (33%)	2	6			
Committee									
EBP	10 (91%)	0	1	8 (67%)	0	4	3 (100%)	0	0
Ed & Pro	6 (55%)	0	5	8 (67%)	0	4	2 (66%)	0	1
3Rs	4 (36%)	0	7	0	0	12	1 (33%)	0	2
Falls	9 (82%)	1	1	11 (92%)	1	0	1 (33%)	0	2
EPAC	5 (45%)	3	3	9 (75%)	0	3	2 (66%)	0	1
IPC	6 (55%)	0	5	5 (42%)	4	3	0	2	1

\* One NS meeting canceled (11 meetings total)

\*\* New unit opened April 2013 (9 meeting opportunities)

UPC minutes and agendas were examined from January 2013-July 2014 to determine areas for intervention within the scope of this project. Exploration of UPC minutes and agendas uncovered a lack of standardization around recording and dissemination. Five units (Intensive Care Unit, Mom's Place, Special Care Nursery, E-100, E200), four departments (CV Wellness, Emergency Department, OR, and PACU), and all Committees had accessible minutes. Units and Departments had meeting minutes in multiple formats with no clear dissemination process and scant reporting of NS activities back to the UPC members and staff in the unit/department.

Four units had effective UPCs meeting regularly with greater than 70% attendance (Mom's Place, Special Care Nursery, HVIU, and Intensive Care Unit). Four units had established UPCs with identified Chairs/Co-Chairs (E100, E200, Rehabilitation Medical Unit).

On these units, however, there was a lack of staff engagement. Meetings were either canceled, or attendance was minimal. As of July 2014, the Cardiac Medical Unit and the Cardiovascular Surgical Unit did not have established UPCs. Agendas and attendance sheets were not regularly completed or retained.

As of July 2014, five departments had established UPCs (Cardiovascular Wellness, Emergency Department, Operating Room, PACU, and EP Lab). Departments such as the OR, PACU, Cath Lab, and EP Lab were challenged establishing meeting times that members could attend. Staffing numbers in these departments were considerably smaller than on the units that staffed for three shifts. This made it difficult to allow all members to be off the schedule at the time of the meeting. Therefore, meetings were scheduled near the end of the workday and attendance was dependent on how busy the department was at the time of the meeting. These areas showed the highest percentage of last minute cancelation of meetings during the observed months. The Emergency Department along with Cardiovascular Wellness chose to combine their meetings with monthly staff meetings. For the Cardiovascular Wellness Department, (a very small interdisciplinary group) this was an effective tool. For the Emergency Department, this was less ideal as there was little separation of the work of the UPC from that of the management team in the department. Often, time spent on UPC business was relegated to the end of the staff meeting and limited time. During the interventional period of the DNP project, the ED UPC elected to separate the meetings from monthly staff meetings.

SG Committee minutes were well documented and more easily accessible. An administrative assistant who was responsible for taking the minutes and compiling attendance

sheets was part of both the Nursing Senate and Education and Professional Development Committees. The remaining Committees identified members (often the Chair) responsible for minute taking. Minutes and agendas were compiled and disseminated to committee members via email. The SG Committees had the advantage of multiple members who were in salaried non-clinical positions that allowed for a more regular core group of attendees (educators, clinical nurse managers etc.) Committee meetings were scheduled on a yearly basis and cancelations were minimal. Attendance was less fluid than with unit/department UPC meetings comprised solely of staff nurses.

Minutes and agendas of the committees and UPCs were not disseminated beyond the confines of individual membership. There was not a designated place where persons interested in the work of SG at the project site could obtain information about meeting times, agendas and minutes. This lack of transparency hindered the attraction of new members and interest of the staff not currently connected to the UPC or SG Committees. Members vocalized their frustration with the lack of understanding of the work taken on by various groups within the SG framework at the project site.

Review of SG meeting minutes, agendas, and attendance sheet revealed challenges that impact all areas of the SG framework at the project site. Clinical nurses are challenged to find a way to attend both UPC and NS meetings consistently. Rather, the realities of the chaotic nature of the units and departments on any given day impeded their ability to do the work of SG in a timely and effective manner. Given the current demands placed on today's healthcare

organizations to care for more acutely ill patients with fewer resources this proves to be a stubborn barrier to overcome in many organizations (Ballard, 2010).

When examining the minutes and agendas of SG, there was a lack of standardization among the UPCs and committees in the reporting and publishing of these important documents. During the initial rollout of SG, the project site provided templates and set out the expectation of completing this work, however, over time it has failed to take root as members came and went from the UPCs. Additionally, minutes and upcoming agendas of both UPC and SG committee meetings were not readily accessible to anyone interested in viewing them. This lack of transparency may have failed to leverage opportunities to promote the work of SG throughout the project site.

Results of this three-pronged assessment of the current state of SG at the project site reveal significant successes along with challenges for improvement. The SG Committee framework is established and meets with regularity. Participation in SG has the support of nursing leadership and advocates for resources to improve it. The breakdown in the effectiveness of the SG framework seems to lie with its lack of assimilation on the unit level. In order to fully implement SG, connection to the units and departments is critical (Brandt et al., 2012). Understanding these challenges can identify areas on which to focus to bring about positive change for nursing practice through empowerment and self-governance. The current conditions in the area hospitals as well as the patient care challenges throughout the country shine a spotlight on the necessity of these changes.

### **Post Intervention Nursing Senate Survey**

The IPNG and NDNQI surveys provide pre-intervention baseline data regarding SG at the project site. These data were instrumental in determining the focus of the interventions during the DNP project. These instruments are due to be re-launched in the fall of 2015, outside the timeframe for this DNP project. A post-intervention survey of members of the Nursing Senate at the close of the DNP project provided valuable insight into the impact of the interventions to date. The 34 members of the Nursing Senate were sent an email invitation and consent form along with the link to the on-line survey (Appendix D). Members were asked to choose from 5 levels of agreement when presented with statements surrounding the work of SG; strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, and strongly disagree. Twenty-four NS members completed the survey producing a response rate of 71%. Results of the survey can be seen in Figure 1.

The initial question on the survey presented nurses with the following statement, “the Nursing Senate identifies opportunities for improvement at the Unit/Department level and implements hospital-wide solutions. Of those nurses who completed the survey, 46% (n = 11) “strongly agreed” with the statement, while 36% (n = 9) “somewhat agreed”. The second question on the survey queried nurses regarding the impact of unit specific data dashboards. Those who “strongly agreed” that unit data dashboards impacted performance improvement numbered 54% (n =13), while 12.3% (n = 3) “somewhat agreed”. Question three asked nurses to comment on whether UPCs and the NS were supported by Nursing Administration. Fourteen of the NS members who completed the survey “strongly agreed” with the statement while 25% (n= 6) “somewhat agreed”. The fourth question asked nurses to comment on their ability to find the

time to complete and disseminate agendas and meetings. On this question, 67% (n = 16) of those surveyed “strongly agreed” that they had sufficient time to complete minutes and agendas, while 17% (n=4) “somewhat agreed”. The final question on the survey explored whether the subjects agreed that the NS was a part of the decision-making process for nursing practice issues at the project site. On this query, 83% of those who took the survey either “strongly agreed” (n = 16, 67%) or “somewhat agreed” (n = 4, 17%).

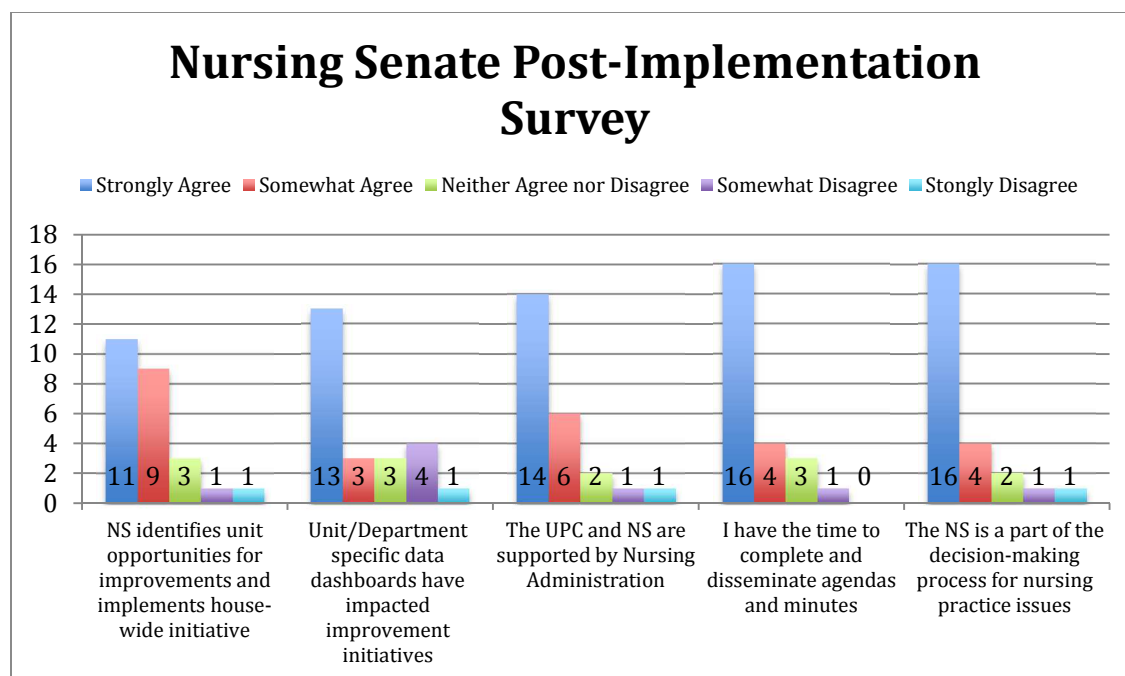


Figure 1. *Post-implementation nursing senate survey.*

Results of the post-implementation survey are encouraging. This survey sought to gather information regarding the success of the implementation strategies of the DNP project. However, for SG to truly be impactful, communication of the work of the SG framework must reach the nurses who are not intimately involved with SG at the project site. Data gleaned from the

repetition of the NDNQI and IPNG surveys will provide a more in-depth assessment of the impact of the DNP project as it relates to the SG framework at the project site.

### **Intervention Summary**

After careful review of the assessment data, two arenas for improvement were identified. The Cardiac Medical Unit was chosen as the interventional unit for development of a UPC with the assistance and mentoring of a DNP student. Work on this unit, it was hoped, could provide a model for growing and nurturing UPCs on other units. In addition, work through the NS on various projects such as the redesign of the Nursing Intranet website, the UPC Summit, and use of remote access to meetings were undertaken to provide support and improve processes for the UPCs and the NS thereby supporting the SG framework at the project site.

### **Cardiac Medical Unit Practice Council**

SG Models in general and UPCs, in particular, require robust support from both nursing leadership and rank and file staff members (Wessel, 2012). The UPC must have their finger on the pulse of the staff and patients on their unit in order to identify nursing practice challenges that warrant discussion and action within the UPC (Bogue, Joseph, & Sieloff, 2009). Similarly, without commitment and visible support from nursing leadership and the greater councils of SG, implementing change can be frustrating and slow to progress (Clavelle, O'Grady, & Drenkard, 2013). To this end, key stakeholders on the CMU were identified and engaged early in the development process. Their input helped to shape the vision of the UPC and drive the discussions to identify goals and objectives.

The UPC interventions began with embedding the DNP student within the unit to establish relationships with staff and begin to create urgency around the development of the UPC (Kotter, 1995). The director of the unit along with the managers from each shift expressed genuine interest and commitment early in the process. They were engaged in re-creating the UPC hoping it would drive improved staff satisfaction. Both planned and impromptu discussions with the DNP student helped to identify the scope of the role of those involved in the beginning stages. Assistance in scheduling staff for administrative time off the unit for meetings and accomplishing the work of the UPC was integral to recruitment of UPC members; many previous members had expressed the frustration in the past of trying to break away from the unit during a shift to attend the UPC meetings. During the initial stages of development, leadership was purposefully asked to refrain from providing recommendations to the DNP student for either inclusion or exclusion from the UPC. Rather, the DNP student worked to create new relationships with the staff on the unit that was unbiased, allowing for a free exchange of ideas.

A series of informal gatherings between the DNP student and each shift allowed staff to self-identify an interest in beginning a new UPC. These gatherings facilitated by the DNP student allowed individuals in all roles on the unit to develop a greater understanding of the successes and challenges the unit faced as they embarked on the advancement of the UPC. Because most staff nurses at the project site worked alternate weekends, these meetings were held on sequential weekends to allow the greatest opportunity for contacting all staff members. Of equal importance, these informal conversations helped to disseminate news of the upcoming creation of the UPC to the staff on the unit.



During these gatherings, a core group of nurses expressed interest in launching the UPC on the CMU. Beginning in August, the first UPC meeting was held with eight members in attendance representing multiple shifts and levels of experience. Initial discussion centered on the creation of a vision for the UPC and the use of the logic model template and Kotter's theory for change (Appendix A). The members collaborated to create the vision: "to create a dynamic UPC that represents the interest of patients and staff of the CMU. Work of the CMU UPC will be dedicated to assisting the unit to provide patient-centric care, translating evidence to the bedside, and ensuring best practice".

Several topics of interest were discussed as initial proposals for improvement projects. Several nurses on CMU had been a part of a national STAR2 (Small Troubles Adaptive Responses) research study early in the year. In this study, nurses were tasked with identifying small troubles during their shift that requiring workarounds. Drawing on this exposure to data collection and hoping to further the impact of the study to CMU nursing practice, the results from the study were re-introduced to the members of the group by the DNP student for further discussion. Results of the STAR2 study revealed that the nurses on CMU who participated identified three categories as contributing causes of these workarounds, equipment/supplies (21.9% of failures), physical unit layout (8.72% of failures), and information/communication (12.1% of failures). A large poster for each category was placed in the conference room, and the UPC members were invited give specific examples of failures in these categories. Subsequently, the UPC developed a plan to encourage staff members, whether or not they participated in the

study to add their thoughts to the posters. Through this exercise, the UPC began to connect their work with the needs of the unit, asking for input to guide the direction of the UPC.

Problems with vital sign machines surfaced as a source of frustration for staff. Staff complained that there were not enough vital sign machines and that often they were not in working order. Acquisition of additional vital sign machines quickly became a unifying goal for the fledgling UPC. This became an opportunity to address items on the IPNG survey that scored poorly on the survey such as the process for recommending and formulating annual unit budgets for personnel, supplies, major equipment, and education. Additional opportunities included formulating annual unit budgets for personnel, supplies, equipment, and education. With the DNP student guidance, the group began with the creation of a Logic Model Program Development sheet to outline the parameters of their project (Appendix G).

The members of the UPC initiated a time study with the staff on CMU; asking individuals to keep track of the time expended locating vital sign machines to complete tasks on the unit. Additionally, participants tracked their steps during these shifts to provide context to the time study. Word quickly spread throughout the unit and 22 (43%) clinical staff from all three shifts volunteered to participate in the time study. A total of 102 shifts were logged. The mean time spent searching for vitals machines was 13.7 (SD 11.4) minutes per eight-hour shift. The UPC with DNP student guidance used the data to develop a business case for the purchase of vital sign machines (\$3,500 each). The UPC chair met personally with the Executive Director of Nursing to present the case for purchasing additional machines. Funds were approved to purchase an additional three vitals machines for a total expenditure of \$10,500.

With this success under their belt, the Cardiac Medical UPC has continued to gain momentum. Meetings are well attended and productive. Additional initiatives include the utilization of a Licensed Nursing Assistant handoff tool with a detailed implementation plan to ensure the standardized use of the tool. UPC meetings have been held each month since its inaugural meeting. As of this writing, the UPC has met for eight months (July-March) with attendance ranging from 72%-89% of membership (mean 79.2%). The chair and/or co-chair have attended each Nursing Senate meeting since September 2014. A highlight of this work was the CMU UPC chair presentation of the results of the vital sign machine initiative to the members of the NS. This presentation peaked interest and generated robust conversation around nurse's input into the acquisition of equipment and provided an opportunity to link this work back to items on the IPNG survey dealing with budgets and equipment allocation. Nurses were able to observe the impact of SG on their daily practice.

During the initial meetings of the Cardiac Medical UPC, one of the co-chairs expressed trepidation around the use of formal tools such as the Logic model. The DNP student gave purposeful attention to providing assistance in using the template with the UPC members. With this attention, members were able to understand both their ease of completion and importance. Although originally opposed to their use, the co-chair became a driving force behind this initiative and was integral in the writing and presentation of the business case.

Guidance and mentorship with the DNP student provided valuable assistance to the UPC as they began their successful journey. Members were able to come to appreciate the need to formalize their approach through the use of standardized templates for meeting minutes and

agendas and tools used in project planning. The logic model helped keep the group on track between meetings. Agenda planning was facilitated with the assistance of the DNP student during the first several months. Providing direction for connecting with CMU staff, incorporating data, and utilizing standardized processes for agenda building and minute taking helped to give the group confidence and credibility.

Feedback from the Director and Clinical Nurse Managers regarding the effectiveness of utilizing the skill set of a DNP student was also very positive. Barbara Barton, Director of the CMU, reflected on the need to provide mentorship exclusive of the Director and Managers, “In order to truly be an autonomous, members must feel they have resources outside of the traditional hierarchy of the organization. They need to forge their own way, but must have tools and resources to find their way to success” (B. Barton, personal communication, Sept. 2, 2014). With access to the knowledge needed to create successful meetings, communicate their work, and plan and execute an initiative, the group quickly gained much needed skills. The CMU UPC has disseminated both agendas and minutes one to two weeks prior to each monthly meeting. Additionally, they have scheduled their meetings through the hospital’s email and scheduling system for 12 months.

### **Nursing Senate Interventions**

Direct care nurses represented by UPC Chairpersons comprise the voting membership of the NS Council. Additional members include the Chairpersons from SG Nursing Councils (Education and Professional Development, Nursing Leadership Council, Nursing Recruitment Recognition and Retention, EBP Research and Quality, Electronic Practice Advisory

Committee), the Chief Nursing Officer (CNO), the Executive Director of Nursing, a Nursing Director, a Clinical Nurse Manager, a Performance Improvement RN, the Education Council Chair, a Clinical Education Specialists, the Director of EBP and Research, and the Manger of Systems and Support. The Nursing Senate is meant to provide the scaffolding to implement interventions aimed at strengthening the cohesiveness and effectiveness of the UPCs through an organizational lens. It was through the NS that interventions aimed at improving both organizational UPC and SG processes were launched.

Review of the minutes of the NS meetings revealed challenges individuals faced as they attempted to ensure UPC meetings took place and units were represented at NS monthly meetings. Generally, the units relied on obtaining coverage from the unit to allow nurses with patient assignments time off the floor to attend SG meetings. Through discussions with UPC and NS members, it was revealed that this system was untenable. Often, the business of the unit made coverage by a colleague impossible. Frequently nurses would be interrupted during meetings to return to the floor to attend to a patient need or provider phone call. Even more troubling, this meeting plan often dissolved if the census was high or the unit was struggling with admissions and/or discharges.

Through the DNP student, a plan was put in place to attempt to alleviate these pressures. Current NS meetings are held on the second Tuesday of the month from 1530-1700. UPC chairs were encouraged to consider moving their monthly meeting to the same Tuesday from 1330-1530 and to schedule these meetings for a full 12 months. As part of this plan, chairs would take this Tuesday as a full paid administrative day to accomplish the work of the UPC and NS. This

administrative day would replace a day that the chair worked on the floor. Previously, UPC chairs often came in on a day off to run the UPC meetings and complete council work. UPC members working on the day shift (0700-1500) were asked to find an individual working on the evening shift who was not a current member of the UPC to commit to come in two hours early on meeting day each month. Unit directors were asked to agree to this extra time even if it meant overtime pay for the individual coming in early. The goal was to work with clinical nurse managers to arrange the schedule in such a way that these individuals were always paired on the second Tuesday of each month. UPC members that worked the day shift would complete handoff report before the start of the meeting thereby ensuring an uninterrupted meeting. UPC members working the evening shift were asked to come in early for the meeting and paid overtime if necessary.

Engaging nurses from the night shift had its own set of challenges. To encourage participation, a request was made to Nursing Administration to subscribe to GoToMeeting. This program allowed members to attend the meeting remotely while still getting paid for their time. Approval for the subscription to GoToMeeting provided a needed addition to the toolbox for SG and has been met with great enthusiasm. It has been frequently used by those on the night shift currently involved in SG and has directly led to the recruitment of one night shift UPC member on a medical/surgical floor. Previous to these changes, many nurses sacrificed sufficient sleep to come into the hospital to attend SG meetings. Three of seven units have successfully adopted this change. UPC meetings on Mom's Place and Special Care Nursery were previously held on the same days the NS meetings. Improvements in attendance can be seen in Figure 1.

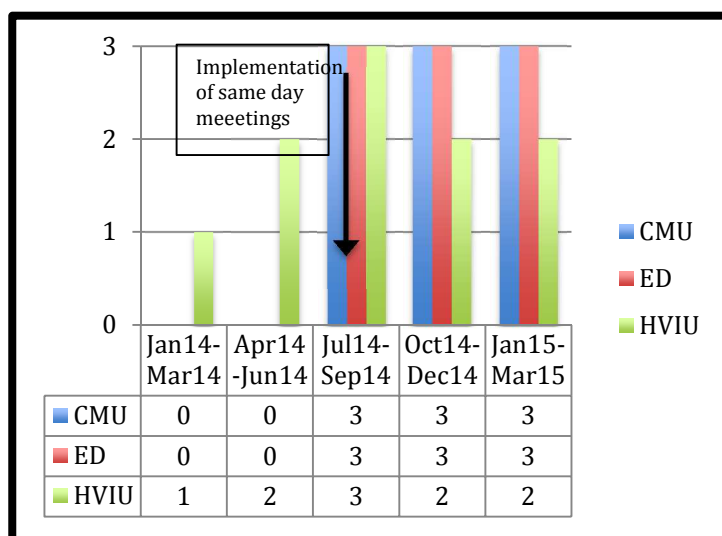


Figure 2: *Units with UPC and NS meetings held the same day.*

In an effort to standardize SG procedures at the unit/department level, a UPC Summit was held for all UPC chairs and co-chairs. The Summit provided an opportunity for the introduction of tools and templates to assist the UPC in identifying goals, standardize processes, discuss unit quality data, and introduce the Plan Do Study Act process along with Kotter's change theory and the logic model. During this summit the group discussed the creation of goals and planning objectives with a focus on strengthening structure and the connection of unit outcomes data to the clinical nurse via the Nursing Data Dashboard (further detail below). The focus of the UPC Summit helped solidify the understanding with UPC chairs that they were a part of the nursing leadership team at the project site. Catered dinner and time to interact with colleagues provided an opportunity to build important relationships between units and departments.

Attendees of the UPC Summit received a resource binder that included information needed to begin the process of meeting planning, agenda setting and dissemination of the work

of the UPC to the unit/department staff and beyond. Included in the binder were step-by-step instructions on setting up a distribution lists and scheduling recurring meeting invitations through the project site's email platform. Additionally, standardized meeting agenda templates were created and placed on a thumb drive for each participant. Clear expectations were set out during the summit that each UPC was expected to use these templates thereby creating a standard format throughout all UPCs.

Though attendance at the monthly NS meetings, the DNP student fostered discussion of Organizational and Nursing Strategic goals. Opportunities to align the Organizational and Nursing Strategic Plans with that of the SG would help to ensure all worked with a shared vision. Nursing strategic plans assist in identifying strengths, opportunities, and gaps that must be overcome to achieve these common goals (Drenkard, 2012). This alignment helps to channel resources and energy to assist in the spread of innovation throughout the organization (Drenkard, 2012). An offsite Nursing Retreat occurred in May 2015 to develop a Nursing Strategic Plan that aligns with the goals of the organization. Participants in the retreat included the CNO, the Executive Director of Nursing, nursing directors, clinical nurse managers, nursing educators, chairs of UPCs and SG Councils.

To establish Kotter's change theory and the logic model template throughout nursing at the project site, a presentation was made at the Magnet Steering Committee monthly meeting. Approval was given for the incorporation of Kotter's theory and the logic model throughout nursing at the project site. A long-term goal for these tools will be their incorporation into the fabric of each plan for innovation and change throughout the project site.



### **Nursing website re-design**

Delivering quality patient outcomes has become the driving force for many health care system boardrooms and the executive level of many hospitals (Albanese et al., 2010). For those holding positions in Hospital and Nursing Administration, understanding and utilizing benchmarked outcomes data has become an integral requirement of their work. For many bedside nurses there is still a considerable disconnect between individual practice, unit practice and nursing sensitive outcomes data (Albanese et al., 2010). To this end, the DNP student embarked on the creation of a transparent and data rich Nursing Website on the hospital's intranet site. The new website created individual pages for each unit/department along with the SG Councils. Tabs on each page were created for the monthly posting of UPC minutes and agendas. Through the use of this tool, schedules, agendas, and minutes are easily accessible to both members and non-members of SG UPCs and Councils.

An additional webpage was created for each unit/department displaying a unit specific data dashboard. Nationally benchmarked unit data gleaned from NDNQI, Press Ganey, and Core Measures abstractions were used to develop the dashboard (Appendix H). Additionally, the dashboard provided information to be used to drive practice changes at the bedside. As an example when displaying data on Catheter Associated Urinary Tract Infections (CAUTI), both the rate per 1000 patient days (Magnet data reported to NDNQI) and Unit Catheter Days was graphed and displayed. To reduce CAUTIs, reinforcing the connection between trended catheter

days on the unit and preventing CAUTI is critical. However, it is also vital that nurses become adept at understanding and articulating outcomes as they are reported to groups such as the Center for Medicaid and Medicare Services (CMS) and NDNQI. Providing unit level data to nurses that is current, specific, and relevant to practice and easily interpreted is key to driving innovation from that data (Frith, Anderson, & Sewell, 2010). The data dashboard is now used at UPC Council and NS meetings to increase understanding of quality data and develop plans for quality improvement initiatives.

The visual representation of data via the dashboard was integral to a performance improvement initiative carried out on the CMU. The unit experienced a sharp increase in patient falls over the span of few months late in 2014. The unit implemented a three-pronged approach to address this unsettling trend, pre-shift huddles, post fall huddles, and a pilot study of new chair alarms. Use of the data dashboard helped to guide and document the improved outcomes realized with these innovations. Additionally, the chair of the UPC brought this project forward to the NS, and the process of pre-shift huddles and post-fall huddles has now been disseminated to two additional units. This exemplifies the strategic use of standardized processes as a tool to improve the effectiveness of SG within the project site.

### **Discussion of Findings in the Context of Literature and Frameworks**

Interventions initiated at the project site during this DNP program focused on developing a model for the initiation of a UPC and focused improvements in NS processes. Integral to the development of the UPC in this project was the direction and assistance of a mentor with the skill set to connect effectively with staff and guide them through the process of establishing a

meeting schedule, developing performance and practice improvement opportunities, and disseminating the results of their work to both the unit and project site. Work with the NS focused on the development of tools such as data dashboards and the logic model to inform the work of the NS as a vehicle for practice change at the project site.

In Ballard's review of nursing literature regarding SG, she highlights the importance of taking a long view of the growth of SG within an organization. Several factors were linked with the breakdown of the SG structure in organizations including poor support structure, lack of follow-through, insufficient resources, and lack of effective communication (Ballard, 2010). Through completion of a detailed assessment of the current state of SG, opportunities to improve the support structure were revealed along with a lack of transparent communication. Interventions implemented during the project have improved these deficiencies. Nursing leadership has been committed to providing the necessary resources to improve the effectiveness of SG as demonstrated by their willingness to allow for overtime to enable participation in SG meetings, purchase of the GoToMeeting subscription, and planning for off-site nursing retreat. Through the completion of this project, the vital importance of identifying a champion within nursing leadership to speak on behalf of the importance of SG among hospital administrators was revealed. In this project, the Executive Director of Nursing played an integral role paving the way for many of the project objectives to be realized.

Many of the studies utilizing the IPNG tool also reinforce the view that SG is an ever-evolving entity that requires vigilant scrutiny and assessment. In Anderson's work, the importance of completing multiple assessments to track the progress of SG within an

organization is revealed (Anderson, 2011). Use of the IPNG instrument as a tool for the assessment of the current state of SG at the project site revealed areas that require focused intervention. Future use of the IPNG assessment survey will assist in the evaluation of efforts to mature the SG structure. The next IPNG survey is due to be repeated in December 2015.

Several organizations deploying the IPNG instrument find the lowest scoring subscale in the survey is Control Over Personnel (Anderson, 2011; Clavelle et al., 2013; Hess, 2011). Results of the IPNG tool at the project site correlates with these findings. Mean scores for individual items on the survey were evaluated to identify those items with the lowest scores (between 1-1.5). Identifying these items reveal opportunities for targeted interventions aimed at improving these scores to have a maximum impact. These survey items along with the subscale variables in which they are included are listed in Table 3. A quick glance at this table easily reveals the preponderance of low scoring items that fall within the control over personnel variable. Of the 18 lowest scoring items all but two are a part of this variable. Hess has documented in his writing that queries related to the control over personnel are generally among the lowest scoring and are the issues that organizations struggle with the most to improve (Hess, 2011). Never the less, these IPNG items reveal great opportunities for improvement at the project site.

Table 3

Index of Professional Nursing Governance Survey Items with Mean Scores Below 1.5

<i>Item</i>	<i>Item Query</i>	<i>Mean (SD)</i>	<i>Subscale Inclusion</i>
3	Establishing level of qualifications for nursing practices	1.49 (.734)	Control Over Professional Practice

6	Conducting disciplinary action of nursing personnel	1.38 (.810)	Control Over Personnel
9	Promoting RNs and other personnel	1.41 (.612)	Control Over Personnel
10	Appointing nursing personnel to management and leadership positions	1.33 (.638)	Control Over Personnel
19	Formulating annual unit budgets for personnel, supplies, equipment, and education	1.29 (.647)	Control Over Personnel
20	Recommending nursing salaries, raises, and benefits	1.22 (.617)	Control Over Personnel
26	Creating new clinical positions	1.24 (.628)	Control Over Personnel
27	Creating new administrative or support positions	1.23 (.682)	Control Over Personnel
30	Mandatory RN credentialing levels (licensure, education, certification) for hiring, continued employment, promotion, and raises	1.19 (.428)	Control Over Personnel
32	Organizational charts that show job titles and who reports to whom	1.27 (.574)	Control Over Personnel
33	Written guidelines for disciplining nursing personnel	1.17 (.408)	Control Over Personnel
34	Annual requirements for continuing education and inservices	1.33 (.596)	Control Over Professional Practice
35	Procedures for hiring and transferring nursing personnel	1.15 (.363)	Control Over Personnel
36	Policies regulating promotion of nursing personnel to management and leadership positions	1.21 (.406)	Control Over Personnel
43	Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education	1.35 (.641)	Control Over Personnel
44	Procedures for adjusting nursing salaries, raises, and benefits	1.12 (.360)	Control Over Personnel
59	Forming new administration committees for the organization	1.35 (.599)	Control Over Personnel
72	Physicians opinion of the quality of bedside nursing practice	1.46 (.678)	Access to Information

When considering the items contained in the Control Over Personnel variable, their strong dependence on organizational change for improvement is unmistakable. Strong and effective SG structure can have formidable success in improving many aspects of nursing practice within an organization. However, results in many of the items contained within this variable will remain unchanged without a strong alliance with other departments such as Human Resources and organization's senior leadership. Within the project site, there is opportunity to improve the understanding and appreciation of SG throughout the hospital. Every opportunity to expose areas outside of nursing to the work and successes of SG should be maximized.

The results of Wilson and colleague's survey of over 425 nurses align with the struggles revealed in the assessment of SG within the project site. Both direct care nurses and nurse managers identified four important factors supporting a strong SG, (1) feeling supported by unit managers, (2) working together as team, (3) having time to participate in SG activities without disrupting patient care, and (4) feeling they will be paid for activities beyond their scheduled shift (Wilson et al., 2014). Efforts to improve these identified factors were considered over the course of the DNP project. When considering the importance of teamwork, the Cardiac Medical UPC's attention to connecting the work around vital sign machine acquisition with staff when completing the time study developed a sense of teamwork on the unit. When considering the other factors identified, support from unit managers, time for SG activities, and being compensated for time spent on SG activities much of the work of the DNP project reinforced these perceptions. Unit managers not only approved extra time but also authorized overtime pay to facilitate appropriate scheduling for UPC members to attend meetings without impacting

patient care. Nursing leadership approved the use of GoToMeeting to facilitate remote attendance for SG meetings. UPC chairs were given the opportunity to request an administrative day each month to allow for uninterrupted time to complete the work of the UPC and attend the NS meeting. This change allowed nurses to participate without relinquishing one of their days off to attend meeting at the hospital. Nursing studies aimed at identifying perceptions of direct care nurses informed the efforts of this DNP project. Use of this data has been an effective source of guidance as these changes were met with approval and the successful development of a UPC on CMU.

Discussion of the findings of the DNP project in the context of frameworks reveals the importance of such frameworks as Kotter's change theory and the logic model. Not only did these frameworks drive the implementation of this project, they were also introduced into the SG structure of the organization as important elements for leading change initiatives. Details of the application of Kotter's theory in the DNP project setting are shown in Table 4. Purposeful use of both Kotter's theory and the logic model framework were integral components of the project and positively impacted its success.

Table 4

#### Application of Kotter's Change Theory

Kotter's Steps for Change	DNP Intervention
Create a sense of urgency	Informal meetings on Cardiac Medical Unit to discuss UPC development
Form a coalition	Gather individuals interested in UPC to initial meetings held on unit and open to new participants
Create a vision	To create a dynamic UPC that represents the interest of patients and staff of the CMU. Work of the CMU UPC will be dedicated to assisting the unit to provide patient centric care, translating evidence

	to the bedside, and ensuring best practice
Communicate the vision	Completion of Logic model template displayed on unit and articulated by UPC members to CMU staff (Appendix A)
Plan for short-term wins	Vital sign machine time study and business plan creation
Consolidate improvements and create more change	Present business plan to Executive Director of Nursing and secure funding to additional machines
Institutionalize new approaches	Report vital sign time study activity to members of the Nursing Senate Incorporate the use of Kotter's Change Theory and Logic model template throughout SG and Nursing Leadership

### **Implications for Practice**

As previously discussed, shortages of nearly 300,000 nurses loom on the horizon (Twigg & McCullough, 2014). For many organizations, including the project site, this shortage has arrived. The cost of training new graduate nurses is steep, estimated between \$22,000 and \$64,000 ("Business case," 2009). New graduates are now filling positions formerly held by experienced nurses (Twigg & McCullough, 2014). These circumstances existed at the project site where many units had five to ten new graduates needing orientation by qualified preceptors. Because an effective SG framework addresses many factors linked to retention such as autonomy and control over practice it must be considered when discussing tactics to increase nursing satisfaction within their work environment. For many of the nurses involved in this DNP project, merely exposing them to the possibility of impacting practice on their units has resulted in a new level of engagement with their colleagues. Exposure to the templates and tools chosen for the project kindled an interest almost immediately. This exposure also created an engagement in the



process with the DNP student that brought about a quick win on the unit helping to build a commitment to SG.

The ability to access and use current, benchmarked, unit specific outcomes data to drive nursing care can have great impact on patient outcomes. Understanding and articulating outcomes data is a necessary component of nursing care in today's healthcare environment. It is incumbent on organizations to compile and disseminate this information not only to the hospital leadership, but also to the units and departments that can impact these outcomes. Use of the nursing website as a resource allows units and department to observe and react to trends seen with these outcomes data. Understanding and using this data has potential to improve not only patient outcomes, but also the level of understanding and ease with which care team members throughout the organization use and understand data.

Strategies utilized in this DNP project were geared toward the development of a mentoring relationship between the DNP student and nurses involved in the SG framework at the project site. The success of these interventions was made possible through this genuine connection and collegial relationship. Use of a nursing leader skilled in transformational leadership, program management, and leading teams through change may be an effective way to mature and grow SG. As organizations consider developing or re-inventing SG within their nursing ranks this model for improvement may have merit. The DNP is perfectly poised to bridge understanding between leadership and staff and align efforts to improve current processes within SG. This connection, when linked with the Magnet journey toward excellence in nursing can help increase understanding about Magnet's impact on nursing practice.

The focused interventions deployed during this DNP project relied on the purposeful use of both a change theory and a program evaluation tool. Not only did these frameworks guide the planning, completion, and evaluation of the project, they also became valuable tools for use within the project site. Resolute use of these tools did not come easily for the nurses involved in SG. The value of these tools lies in the standardization of their use across the organization (W. K. Kellogg Foundation, 2004). Within the project site, this will require a substantial change in their approach to the change process. With use, however, the value of these frameworks can be seen as the successful implementation of innovations and sustained change in practice.

#### **Project strengths and limitations (strengths, limitations, recommendations)**

This project offered an opportunity to examine the impact of using a doctoral student to mentor the development of clinical nurses as they developed and exploited skills needed to become nurse leaders at the project site. Where the interaction with the DNP student was most prominent, the greatest changes in SG were seen. Development of a functioning and effective UPC on the Cardiac Medical Unit was a successful outcome of this project. Also of note, several nurses involved with this process have taken on leadership roles within their units. Although time intensive, the work completed to successfully launch this UPC can pay hefty dividends in the future. This relationship building model provides the project with both its greatest strength and a significant limitation. Delegation of the manpower required by an individual with the skill sets needed to successfully mentor groups to success with SG would be challenging in many

healthcare environments. Successfully tying the work into the Magnet journey may be advantageous in securing the support needed obtain the necessary resources.

A thorough and detailed assessment of the current state of SG proved to be an invaluable learning experience for all involved at the project site. This assessment provided insight into areas that require consistent attention and accountability. Attendance at NS meetings is now tracked and trended monthly at the project site. Convening of monthly UPC meetings and attendance at the NS meetings is now a part of the Director's evaluation sheet used to set goals for the unit during monthly meetings with the Executive Director of Nursing and CNO. Further, reassessment with the IPNG and NDNQI will reveal comparative data to track improvement to the SG processes.

Work accomplished within the NS framework while encouraging, will require more time to become truly integrated into the SG structure. Standardization of the meeting minutes and agenda templates along with posting on the nursing website has been a successful transition toward transparency. Easy access to information regarding initiatives of SG, meeting times and agendas is now complete. Use of the logic model template to document initiatives is not consistently completed. Areas expected to use this process may need more individual education and assistance in the use of the evaluation tool. As the NS begins to launch programs as a group throughout the project site, opportunities to use the logic model together may help individual units become more familiar with its use and advantages.

Ideally, SG frameworks support the translation of evidence-based practice to the bedside (Brandt et al., 2012). To effectively accomplish this requires that involved nurses be given the

opportunity to provide uninterrupted efforts to SG. Despite the best intentions of nursing leadership and SG members, the realities of chaotic, busy units and departments seem to stand in the way of consistent meeting attendance. These barriers certainly existed at the project site. While attempts to impact this problem were implemented, the difficulties in departments such as the OR remain intractable. Current issues within these departments at the project site hindered a focus on SG in lieu of issues of more pressing importance for the project site.

Nursing leadership along with the Magnet Steering Committee were willing to establish a meeting day and implement set UPC meeting times on the day of the NS meetings. However when this plan was presented to the NS some members met it with resistance. Several units with established meeting times were reticent to disrupt these meeting times and implement the proposed scheduling tactics despite poor attendance at both the UPC and NS meetings. Rather than push vehemently for this change across the SG framework, nursing leadership along with the DNP student opted to facilitate the change for those UPCs interested but not force the change for those who felt it would negatively impact their councils. With time, it is hoped this transition will be viewed as a valuable change and more units will opt to change their meeting times.

Results of the IPNG survey revealed substantially lower scores for the variable assessing control over personnel. Although low scores on these items have proven intractable problems in many organizations that deploy the IPNG survey, interventions implemented in this DNP project have minimal impact on these issues within the project site. Implementing change that address these deficiencies in SG requires was not substantially addressed within the scope of this DNP project. The importance of this work, however, is essential to achieving dramatic changes in the

IPNG scores. Collaborative work between Human Resources along with Nursing and Hospital Administration is needed to address the issues surrounding items in the control over personnel variable.

### **Analysis of self (as Scholar, as Practitioner, as Project Developer, as Professional)**

Reflection on self-growth throughout this DNP project revealed valuable opportunities to begin to define myself as a leader in the nursing profession. The most prominent and revealing transformations have resulted from those experiences that have helped me imagine the type of leader I wished to become. Early in the project process it became clear that my greatest impact resulted from the relationships developed on the units interacting on a personal level with clinical staff. I recall an experience that illustrates the importance of these interactions. As I endeavored to reach out to individual nurses on the CMU early on in the project, I had set myself up in the conference room on the unit. A nurse was in the conference room completing patient charting and asked me a few questions about what I was doing on the unit. From this encounter, an active member of the UPC was recruited. A per diem nurse, she admits to having had no idea her input could make a difference to the nursing practice on the unit. For her, this was a chance encounter. For me, this was the plan. As leaders in nursing, we must be diligent to leave nothing to chance. Rather, we must be unyielding in our commitment to provide regular opportunities to connect with those whose experiences must inform the direction of our work. As the time to nurture these connections becomes harder to schedule, I am reminded of their importance and my commitment to their completion.

Today's healthcare organizations are faced with great challenges necessitating the implementation of change. As teams grapple with these challenges, the DNP is well placed to step up to this challenge. Armed with the skill set I have developed throughout this program I feel well equipped to take on this exciting and nuanced role as a member of a leadership team. Donning the many hats required of the DNP, successfully managing each role as it is called upon. As a scholar, this role will require the assiduous commitment to ensuring practice remains evidenced based and aligned with best practices. The DNP stands out within the organization as a conduit between academia, nursing research, and current practices. Additionally, I view myself in this new role as a steward of the vital connection between the realities of organizational leadership (fiscal responsibility, long-range planning, value-based purchasing) and the impact these organizational decisions have on patient care (NDNQI, HCAHPS, Core Measures) and staff job satisfaction (high census, acuity-based assignments, overtime). As a project manager, my commitment to the use of frameworks to provide direction and cohesiveness to projects that span multiple departments and occur over multiple fiscal years assists in the measured implementation process that marks successful integration of change into the culture of an organization.

### **Summary and Conclusions**

SG has the potential to be a powerful framework for redistributing authority, responsibility, and accountability for nursing practice between staff nurses and administration within an organization. This collaborative management structure requires not only empowering nurses with the tools to impact decision making within the organization, but also actively

engaging them in this rewarding work. Once implemented, continued attention and resources are necessary to bring forth the benefits of SG for the organization. Without a strong commitment to this ongoing support, SG is at risk of becoming a structure without the relevance and impact anticipated by nursing leadership.

The insights offered by an in-depth, detailed baseline assessment of SG provide vital details on how best to launch initiatives to improve its effectiveness. Use of instruments validated in nursing research such as the IPNG survey are effective in the gathering of baseline data and provide the opportunity to evaluate the emergence of SG over time. Along with the insights gleaned from the NDNQI nursing survey data and review of SG minutes and agendas, a picture of both successes and challenges is revealed. Nursing research aligns with the need to complete this assessment in order to properly tailor an action plan to support the leveraging of a SG model. Additionally, the data compiled can then be used in conjunction with future use of these assessment instruments to track and document the success of programs implemented.

This DNP project highlights the necessity of providing participants in SG with both the tools and the guidance to successfully participate in the SG process. Without nursing leadership's commitment to effectively using the structure of SG, the risk becomes the creation of a SG that exists merely as a platform without a dynamic structure to support. Embedding the DNP student within the SG of the hospital illustrate the effectiveness of providing transformational mentorship through meaningful relationship building, supporting nurses, as they become competent leaders within the SG framework and the organization.

The realities of the nurses working at the project site illustrate the complexity of developing a feasible plan to allow nurses to easily engage in SG activities. Across the country the demands levied on the nurse are ever increasing, the environment of care has become ever more complex and chaotic. These conditions place an additional burden on the SG framework while simultaneously elevating the critical importance of having a strong structure in place. Effective SG addresses issues within the organization that ensure autonomy, best practice, and control over nursing practice. These are critical components of the practice of the professional nurse in today's healthcare system.



## Section 5: Scholarly Product for Dissemination

When considering a vehicle for the dissemination of this work, accessibility by those who took part in it was of great importance. Formal presentation of these results to Hospital and nursing leadership along with the members of the NS is a valuable technique. My hope, however, was to allow for any and all individuals within the project site to have access to data, information, and conclusions revealed throughout the project. The same transparency we strived to achieve with SG throughout the project should also inform the choice of format for the scholarly product. To that end, a password protected website was created to allow those interested in reviewing this DNP project the opportunity to do so ([www.cohendnp.com](http://www.cohendnp.com)). Further, use of the website will serve as a platform for both formal and informal presentation to groups within the organization from the boardroom to the unit staff meeting.

There are several advantages of the website format for dissemination. One is the ability to provide links to detailed documents embedded within the website. These links provide easy access to products such as this project paper, the IPNG survey tool, and the NDNQI website to those who wish a more detailed review. The website allows for individuals to easily obtain a high-level understanding, or conversely a very detailed accounting of the work undertaken. Rather than a pre-planned presentation of the results, the website format allows for easily navigating from one topic to another should questions arise from the group during the presentation. After the presentation, members of the audience have easy access to all references mentioned in the presentation.

Use of the website as the format for product dissemination connects the work undertaken during this project to those with whom I worked closely during the implementation period. It becomes a shared document, a celebration of the relationships forged and hard work expended by nurses throughout the project site. This DNP project is a product of their efforts to engage and commit to the SG framework. The results of this cooperative work should belong to each one of us.

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Appendix A:

Logic Model

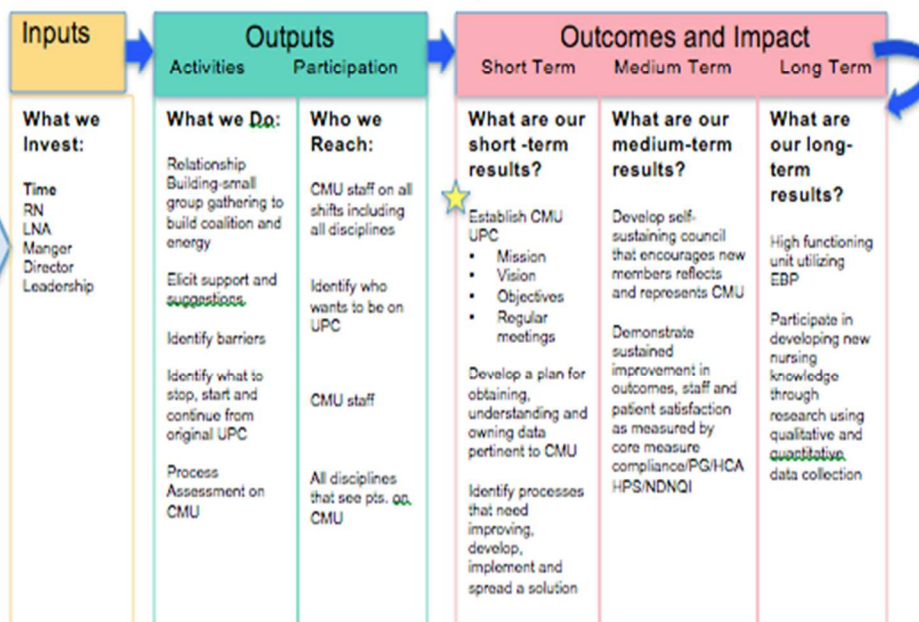
Planning → Implementation → Evaluation

**Theory of Change Logic Model**

**Steps to Change:**

- Create a sense of urgency
- Form a coalition
- Create a vision
- Communicate the vision
- Empower others to act on the vision
- Plan for short-term wins
- Consolidate improvements and create more change
- Institutionalize new approaches

**Our Vision:** To create a dynamic UPC that represents the interest of patients and staff of the CMU. Work of the CMU UPC will be dedicated to assisting the unit to provide patient centric care, translating evidence to the bedside, and ensuring best practice.



## Appendix B:

## IPNG Survey Instrument

**PROFESSIONAL GOVERNANCE**

***Please provide the following information. The information you provide is IMPORTANT. Please be sure to complete ALL questions. Remember confidentiality will be maintained at all times.***

Today's Date \_\_\_\_\_

1. Sex:  Male  Female                      2. Age: \_\_\_\_\_
3. Please indicate BASIC nursing education preparation:
 

<input type="checkbox"/> Nursing Diploma	<input type="checkbox"/> Associate Degree in Nursing
<input type="checkbox"/> Baccalaureate Degree in Nursing	
4. Please indicate the HIGHEST educational degree you have attained:
 

<input type="checkbox"/> Associate Degree in Nursing	<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Baccalaureate Degree in Nursing	<input type="checkbox"/> Doctorate, Nursing
<input type="checkbox"/> Master's Degree in Nursing, Specialty	<input type="checkbox"/> Doctorate, Non-nursing
5. Employment Status:
 

<input type="checkbox"/> Full-time, 36-40 hours per week	<input type="checkbox"/> Part-time, less than 36 hours per week (specify number of hours/week): _____
--	---
6. Please specify the number of years that you have been practicing \_\_\_\_\_
7. Please indicate the title of your present position \_\_\_\_\_
8. Please indicate your clinical specialty:
 

<input type="checkbox"/> Case Management	<input type="checkbox"/> Maternity	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Clinic	<input type="checkbox"/> Medical/Surgical	<input type="checkbox"/> Quality Management
<input type="checkbox"/> Critical Care	<input type="checkbox"/> Operating Room	<input type="checkbox"/> Recovery Room
<input type="checkbox"/> Education	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Other (specify): _____	
9. Please specify the number of years you have worked in this organization \_\_\_\_\_
10. Please specify the number of years you have been in your present position \_\_\_\_\_
11. Have you received any specialty certifications from professional organizations?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

 Type of certification and year received: \_\_\_\_\_

- 12 Please rate your overall satisfaction with your professional practice within the organization (1 = lowest, 5 = highest): 1 2 3 4 5

***In your organization, please circle the group that CONTROLS the following areas:***

- 1 = Nursing management/administration only  
 2 = Primarily nursing management/administration with some staff nurse input  
 3 = Equally shared by staff nurses and nursing management/administration  
 4 = Primarily staff nurses with some nursing management/administration input  
 5 = Staff nurses only

***PART I***

- |   |           |
|---|-----------|
| 1. Determining what nurses can do at the bedside  | 1 2 3 4 5 |
| 2. Developing and evaluating policies, procedures and protocols related to patient care         | 1 2 3 4 5 |
| 3. Establishing levels of qualifications for nursing positions.                                 | 1 2 3 4 5 |
| 4. Evaluating nursing personnel (performance appraisals and peer review)                        | 1 2 3 4 5 |
| 5. Determining activities of ancillary nursing personnel (assistants, technicians, secretaries) | 1 2 3 4 5 |
| 6. Conducting disciplinary action of nursing personnel  | 1 2 3 4 5 |
| 7. Assessing and providing for the professional/educational development of the nursing staff    | 1 2 3 4 5 |
| 8. Making hiring decisions about RNs and other nursing personnel                                | 1 2 3 4 5 |
| 9. Promoting RNs and other nursing personnel  | 1 2 3 4 5 |
| 10. Appointing nursing personnel to management and leadership positions                         | 1 2 3 4 5 |
| 11. Selecting products used in nursing care   | 1 2 3 4 5 |
| 12. Incorporating evidence-based practice into nursing care                                     | 1 2 3 4 5 |
| 13. Determining models of nursing care delivery (e.g. primary, team)                            | 1 2 3 4 5 |

***In your organization, please circle the group that INFLUENCES the following activities:***

- 1 = Nursing management/administration only  
 2 = Primarily nursing management/administration with some staff nurse input  
 3 = Equally shared by staff nurses and nursing management/administration  
 4 = Primarily staff nurses with some nursing management/administration input  
 5 = Staff nurses only

***PART II***

- |  |           |
|--|-----------|
| 14. Determining how many and what level of nursing staff is needed for routine patient care  | 1 2 3 4 5 |
| 15. Adjusting staffing levels to meet fluctuations patient census and acuity   | 1 2 3 4 5 |
| 16. Making daily patient care assignments for nursing personnel  | 1 2 3 4 5 |
| 17. Monitoring and procuring supplies for nursing care and support functions   | 1 2 3 4 5 |
| 18. Regulating the flow of patient admissions, transfers, and discharges   | 1 2 3 4 5 |
| 19. Formulating annual unit budgets for personnel, supplies, equipment and education   | 1 2 3 4 5 |
| 20. Recommending nursing salaries, raises and benefits   | 1 2 3 4 5 |
| 21. Consulting and enlisting the support of nursing services outside of the unit (e.g. clinical experts such as psychiatric or wound care specialists, diabetic educators)                             | 1 2 3 4 5 |
| 22. Consulting and enlisting the support of services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance)   | 1 2 3 4 5 |
| 23. Making recommendations concerning other departments' resources   | 1 2 3 4 5 |
| 24. Determining cost-effective measures such as patient placement and referrals or supply management (e.g. placement of ventilator-dependent patients, early discharge of patients to home healthcare) | 1 2 3 4 5 |
| 25. Recommending new services or specialties (e.g. gerontology, mental health, birthing centers)   | 1 2 3 4 5 |
| 26. Creating new clinical positions  | 1 2 3 4 5 |
| 27. Creating new administrative or support positions   | 1 2 3 4 5 |

***According to the following indicators in your organization, please circle which group has OFFICIAL AUTHORITY (i.e., authority granted and recognized by the organization) over the following areas that control practice and influence the resources that support it:***

- 1 = Nursing management/administration only  
 2 = Primarily nursing management/administration with some staff nurse input  
 3 = Equally shared by staff nurses and nursing management/administration  
 4 = Primarily staff nurses with some nursing management/administration input  
 5 = Staff nurses only

### ***PART III***

- |  |           |
|--|-----------|
| 28. Written policies and procedures that state what nurses can do related to direct patient care | 1 2 3 4 5 |
|--|-----------|

- |  |           |
|--|-----------|
| 29. Written patient care standard/protocols and quality assurance/<br>improvement processes  | 1 2 3 4 5 |
| 30. Mandatory RN credentialing levels (licensure, education, certifications)<br>for hiring, continued employment, promotions and raises  | 1 2 3 4 5 |
| 31. Written process for evaluating nursing personnel<br>(performance appraisal and peer review)  | 1 2 3 4 5 |
| 32. Organizational charts that show job titles and who reports to whom   | 1 2 3 4 5 |
| 33. Written guidelines for disciplining nursing personnel  | 1 2 3 4 5 |
| 34. Annual requirements for continuing education and in-services   | 1 2 3 4 5 |
| 35. Procedures for hiring and transferring nursing personnel   | 1 2 3 4 5 |
| 36. Policies regulating promotion of nursing personnel to management<br>and leadership positions   | 1 2 3 4 5 |
| 37. Procedures for generating schedules for RNs and other nursing staff  | 1 2 3 4 5 |
| 38. Acuity and/or patient classification systems for determining how many<br>and what level of nursing staff is needed for routine patient care  | 1 2 3 4 5 |
| 39. Mechanisms for determining staffing levels when there are fluctuations<br>in patient census and acuity   | 1 2 3 4 5 |
| 40. Procedures for determining daily patient care assignments  | 1 2 3 4 5 |
| 41. Daily methods for monitoring and obtaining supplies for nursing care<br>and support functions  | 1 2 3 4 5 |
| 42. Procedures for controlling the flow of patient admissions, transfers<br>and discharges   | 1 2 3 4 5 |
| 43. Process for recommending and formulating annual unit budgets<br>for personnel, supplies, major equipment and education   | 1 2 3 4 5 |
| 44. Procedures for adjusting nursing salaries, raises and benefits   | 1 2 3 4 5 |
| 45. Formal mechanisms for consulting and enlisting the support of nursing<br>services outside of the unit (e.g. clinical experts such as psychiatric<br>or wound care specialists, diabetic educators) | 1 2 3 4 5 |
| 46. Formal mechanisms for consulting and enlisting the support of services<br>outside of nursing. (e.g. dietary, social service, pharmacy,<br>human resources, finance)                                | 1 2 3 4 5 |
| 47. Procedure for restricting or limiting patient care (e.g. closing hospital<br>beds, going on ER bypass)   | 1 2 3 4 5 |
| 48. Location, design and access to office space, staff lounges<br>and charting areas   | 1 2 3 4 5 |

49. Access to office equipment (e.g. smart phones, computers and copy machines) and the Internet 1 2 3 4 5

***In your organization, please circle the group that PARTICIPATES in the following activities:***

- 1 = Nursing management/administration only  
 2 = Primarily nursing management/administration with some staff nurse input  
 3 = Equally shared by staff nurses and nursing management/administration  
 4 = Primarily staff nurses with some nursing management/administration input  
 5 = Staff nurses only

***PART IV***

50. Participation in unit committees for clinical practice 1 2 3 4 5  
 51. Participation in unit committees for administrative matters, such as staffing, scheduling and budgeting 1 2 3 4 5  
 52. Participation in nursing departmental committees for clinical practice 1 2 3 4 5  
 53. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting 1 2 3 4 5  
 54. Participation in interprofessional committees (physicians, other healthcare professions and departments) for collaborative practice 1 2 3 4 5  
 55. Participation in hospital administration committees for matters such as employee benefits and strategic planning 1 2 3 4 5  
 56. Forming new unit committees 1 2 3 4 5  
 57. Forming new nursing departmental committees 1 2 3 4 5  
 58. Forming new interprofessional committees 1 2 3 4 5  
 59. Forming new administration committees for the organization 1 2 3 4 5

***In your organization, please circle the group that has ACCESS TO INFORMATION about the following activities:***

- 1 = Nursing management/administration only  
 2 = Primarily nursing management/administration with some staff nurse input  
 3 = Equally shared by staff nurses and nursing management/administration  
 4 = Primarily staff nurses with some nursing management/administration input  
 5 = Staff nurses only

***PART V***

60. The quality of nursing practice in the organization 1 2 3 4 5



61. Compliance of nursing practice with requirements of surveying agencies  
(The Joint Commission, state and federal government, professional groups) 1 2 3 4 5
62. Unit's projected budget and actual expenses 1 2 3 4 5
63. Organization's financial status 1 2 3 4 5
64. Unit and nursing departmental goals and objectives for this year 1 2 3 4 5
65. Organization's strategic plans for the next few years 1 2 3 4 5
66. Results of patient satisfaction surveys 1 2 3 4 5
67. Physician/nurse satisfaction with their collaborative practice 1 2 3 4 5
68. Current status of nurse turnover and vacancies in the organization 1 2 3 4 5
69. Nurses' satisfaction with their general practice 1 2 3 4 5
70. Nurses' satisfaction with their salaries and benefits 1 2 3 4 5
71. Management's opinion of the quality of bedside nursing practice 1 2 3 4 5
72. Physicians' opinion of the quality of bedside nursing practice 1 2 3 4 5
73. Nursing peers' opinion of the quality of bedside nursing practice 1 2 3 4 5
74. Access to resources supporting professional practice and development  
(e.g. online resources, CE activities, journals and books, library) 1 2 3 4 5 *In your  
organization, please circle the group that has the ABILITY to:*

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

## ***PART VI***

75. Negotiate solutions to conflicts among professional nurses 1 2 3 4 5
76. Negotiate solutions to conflicts between professional nurses  
and physicians 1 2 3 4 5
77. Negotiate solutions to conflicts between professional nurses and  
other healthcare services (respiratory, dietary, etc) 1 2 3 4 5
78. Negotiate solutions to conflicts between professional nurses and  
nursing management 1 2 3 4 5
79. Negotiate solutions to conflicts between professional nurses and  
the organization's administration. 1 2 3 4 5
80. Create a formal grievance procedure or a process for resolving  
internal disputes 1 2 3 4 5

- |   |           |
|---|-----------|
| 81. Write the goals and objectives of a nursing unit                              | 1 2 3 4 5 |
| 82. Write the philosophy, goals and objectives of your department.                | 1 2 3 4 5 |
| 83. Formulate the mission, philosophy, goals, and objectives of the organization. | 1 2 3 4 5 |
| 84. Write policies and procedures   | 1 2 3 4 5 |
| 85. Determine departmental policies and procedures                                | 1 2 3 4 5 |
| 86. Determine organization-wide policies and procedures                           | 1 2 3 4 5 |

Appendix C:  
NDNQI Job Satisfaction Scale-Revised

**NDNQI Job Satisfaction Scales-R**

*Stem: Based on your experience, please indicate your agreement or disagreement with the following statements about your unit and the RNs with whom you work.*

*Response options: strongly agree, agree, tend to agree, tend to disagree, disagree, strongly disagree.*

**Task**

1. RNs are satisfied with the nursing care we provide on our unit.
2. RNs on our unit have sufficient time for direct patient care.
3. RNs have plenty of opportunity to discuss patient care problems with each other on our unit.

**Nurse-Nurse Interaction**

1. RNs I work with count on each other to pitch in and help when things get busy.
2. There is a good deal of teamwork among RNs I work with.
3. RNs I work with support each other.

**Nurse-Physician Interaction**

1. In general, physicians cooperate with RNs on our unit.
2. There is a lot of teamwork between RNs and physicians on our unit.
3. Physicians at this hospital generally appreciate what RNs do.

**Decision-Making**

1. As RNs, we feel we have ample opportunity to participate in administrative decision-making.
2. As RNs, we have all the voice we want in planning policies and procedures for our unit.
3. Nursing administrators generally consult RNs on our unit about daily problems.

**Autonomy**

1. As RNs, we have sufficient input into the program of care for each of our patients.
2. RNs on our unit have a good deal of control over our own work.
3. As RNs, we are free to adjust our daily practice to fit patient needs.

**Professional Status**

1. RNs are satisfied with the status of nursing on our unit.
2. RNs recommend our unit as a good place to work.
3. Work contributes to a sense of personal achievement for RNs on our unit.

**Pay**

1. Our present salary is satisfactory to myself and RNs I work with.
2. Our pay is reasonable considering what is expected of RNs at this hospital.

3. Pay here is fair, compared to what we hear about RNs at other hospitals.

**Professional Development Opportunity**

1. RNs have career development opportunities on our unit.
2. RNs on our unit have support for pursuing nursing degrees.
3. RNs on our unit have opportunities for career advancement.

**Professional Development Access**

1. RNs on our unit have access to regional and national conferences.
2. On our unit, RNs have access to regular in-service programs.
3. RNs on our unit have access to continuing education.

**Supportive Nursing Management**

1. Our nurse manager is a good leader for our unit.
2. Our nurse manager is supportive of RNs on our unit.
3. Our nurse manager backs us in decision-making even in conflicts with physicians.

**Nursing Administration**

1. RNs on our unit are satisfied with the hospital chief nurse executive.
2. RNs on our unit view the hospital chief nursing executive as equal in authority to other top-level hospital executives.
3. Our hospital chief nurse executive is visible to myself and RNs I work with.

Appendix D:  
Shared Governance Survey

### Survey Questions

1. The Nursing Senate identifies opportunities for improvement at the Unit/Department level and implements hospital wide solutions.
  1. Strongly agree
  2. Somewhat agree
  3. Neither agree nor disagree
  4. Somewhat disagree
  5. Strongly disagree
  
2. Unit/Department specific data dashboards on the Nursing website have impacted improvement initiatives.
  1. Strongly agree
  2. Somewhat agree
  3. Neither agree nor disagree
  4. Somewhat disagree
  5. Strongly disagree
  
3. The Unit/Department Practice Councils and the Nursing Senate are supported by Nursing Administration.
  1. Strongly agree
  2. Somewhat agree
  3. Neither agree nor disagree
  4. Somewhat disagree
  5. Strongly disagree
  
4. I have the time to complete and disseminate agendas and minutes for Unit/Department Practice or Hospital-wide Councils.
  1. Strongly agree
  2. Somewhat agree
  3. Neither agree nor disagree
  4. Somewhat disagree
  5. Strongly disagree
  6. Not applicable
  
5. The Nursing Senate is a part of the decision-making process for nursing practice issues.

1. Strongly agree
2. Somewhat agree
3. Neither agree nor disagree
4. Somewhat disagree
5. Strongly disagree

## Appendix E:

## Item Key To Factor Analysis-Derived Subscales (IPG/IPNG)

**Subscale #1, Personnel** (22 items) -

4, 6, 8, 9, 10, 19, 20, 25, 26, 27, 30, 31, 32, 33, 35,  
36, 43, 44, 47, 48, 55, 59

**Subscale #2, Information** (15 items) -

60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74

**Subscale #3, Resources** (13 items) -

16, 17, 18, 21, 22, 23, 24, 40, 41, 42, 45, 46, 49

**Subscale #4, Participation** (12 items) -

50, 51, 52, 53, 54, 56, 57, 58, 81, 84, 85, 86

**Subscale #5, Practice** (16 items) -

1, 2, 3, 5, 7, 11, 12, 13, 14, 15, 28, 29, 34, 37, 38, 39

**Subscale #6, Goals** (8 items) -

75, 76, 77, 78, 79, 80, 82, 83

## Appendix F

## Permissions

Cynthia Cohen, MSN, CNL  
49 Haverhill Rd.  
Windham, NH 03087  
June 17, 2014

Dear Cynthia:


You have permission to use my instruments, the Index of Professional Governance (IPNG), or the Index of Professional Governance (IPG) at [REDACTED] for your DNP program with Walden University. In return, I require that you:

- Report summary findings to me from the use of the IPNG/IPG, including reliability analysis, for tracking use and evaluating and establishing the validity and reliability of the IPNG, and for possible research publication without identification of the institutions.
- Credit the use and my authorship of the IPNG/IPG in any publication of the research involving the IPNG.

A pdf of the IPNG/IPG can be downloaded for the Forum for Shared Governance's website at [www.sharedgovernance.org](http://www.sharedgovernance.org). I will email the factor analysis-derived subscales, which are different than the subscales apparent in the instrument itself, along with text that can be used to construct the six governance subscales and the overall governance score in SPSS. I can forward the SPSS codebook for data entry. You might want to revise the demographic section to reflect the organization and/or units you're surveying, which I can have done for you.


Please don't hesitate to call upon me to discuss your process or if you need help managing the data. If you need me to perform data entry and analysis and to generate a formal report with benchmarking, there is a consultant fee. I am also available for onsite speaking or consultation. Thanks for thinking of the IPNG and the Forum for Shared Governance. Good luck with your survey.

Sincerely,



Robert Hess, RN, PhD, FAAN  
Founder, Forum for Shared Governance





January 21, 2013

Dear Cynthia Cohen,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Leveraging the Power of Shared Governance within [REDACTED]. As part of this study, I authorize you to access and utilize survey results from the Index of Professional Nursing Governance (IPNG) survey, the National Database of Nursing Quality Indicators (NDNQI) Nursing Satisfaction Survey and NDNQI outcomes data. Additionally, I give my permission for you to access and utilize agendas, minutes, and attendance sheets for Committees and Councils within the Shared Governance Framework at [REDACTED] (January 2013-May 2015) and attend and participate in any Shared Governance meetings. Permission is also granted to utilize [REDACTED]'s Survey Monkey account to complete a post-project survey to members of the Nursing Senate. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include providing access to data previously mentioned along with access to Shared Governance council meetings. In addition we will supply hospital email distribution lists for Nursing Senate members. We reserve the right to withdraw from the study at any time if our circumstances change.

The student will be responsible for complying with our site's research policies and requirements, including maintaining the anonymity of participants of the survey.

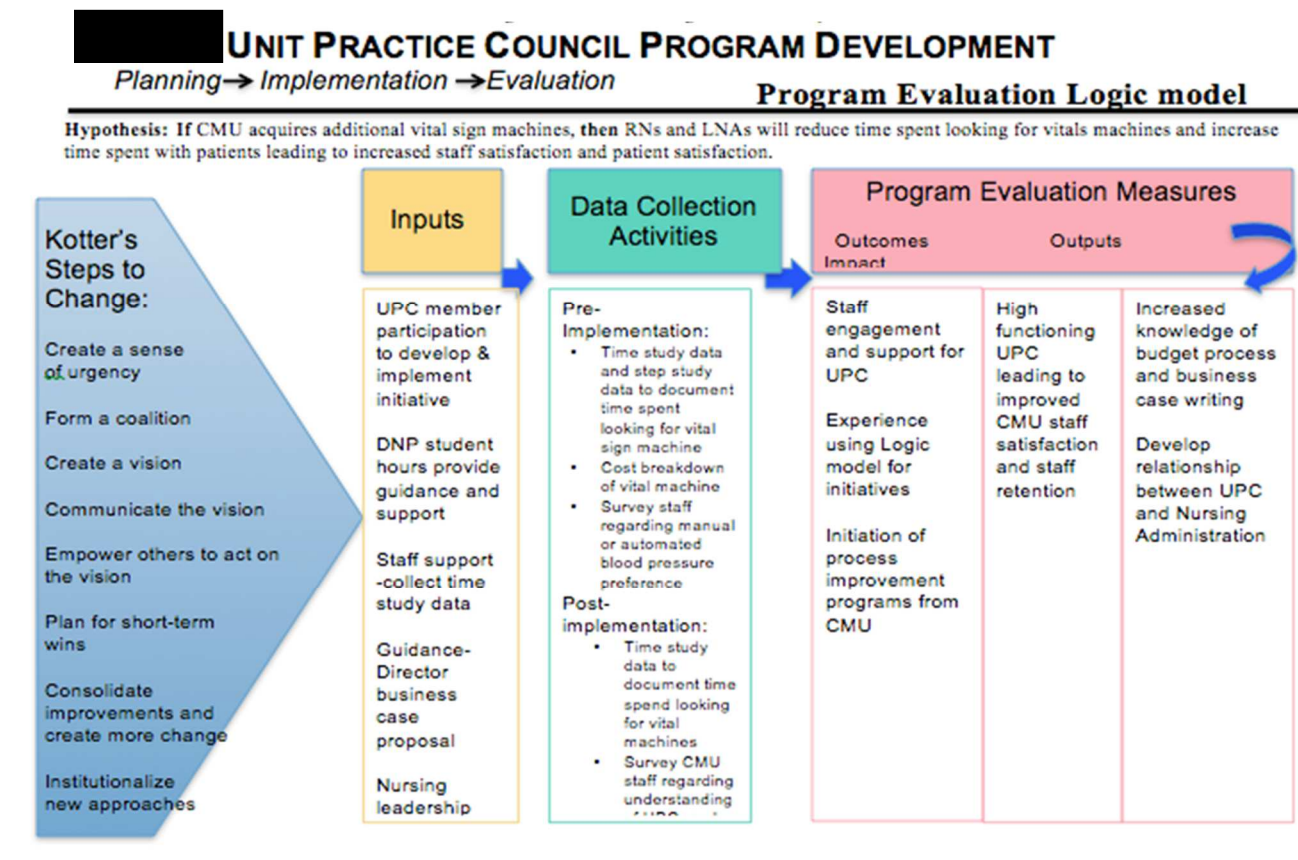
I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,



Appendix G:  
CMU Logic model for Vital Sign Machine Acquisition



# Appendix H

## Unit Specific Data Dashboard

Welcome to our website!

### CMU Data Dashboard

- Home
- Nursing Unit
- Department of Education
- Magnet Journey
- Nursing Annual Report
- Nursing Online Journal Club
- Nursing News
- Nursing Policy
- Nursing Practice Manuals
- Peer Review
- Shared Governance

### CMU Patient Falls

March 2015

2

Jan-15	Feb-15
4	2

Month	Falls
APR	2
MAY	6
JUN	3
JUL	2
AUG	2
SEP	5
OCT	8
NOV	9
Dec	5
JAN	4
FEB	2
MAR	2

Date	Age/Gender	Fall Risk Status	Detail	Injury
3/23	70/Male	13- High Risk	Moving from commode to bed /Assisted to floor/Hoyer lift needed	None
3/20	85/Male	16 -At Risk	Walker stuck on bed/assisted/lowered to chair	None
2/6	83/Male	21-High Risk	Bed alarm on/failed/attempt to stand/assisted to knees	None

All Falls Assisted Nice!