12-15-2012

Implementation of Shared Governance

Sheryl Glasscock
Bellarmine University, sheryl.glasscock@lpnt.net

Implementation of Shared Governance

Capstone Project

Sheryl Glasscock

Bellarmine University

Dr. Linda Cain

October 8, 2012

Implementation of Shared Governance - Project Proposal

Background and Significance

Recruitment and retention of nurses in the acute care setting has become a strategic initiative for hospitals in an effort to sustain the ability to care for increasingly complex patients in the face of the nursing shortage that looms ahead. The American Association of Colleges of Nursing (AACN) reports that nursing will be the top occupation in terms of projected job growth in the decade between 2008 and 2018, with more than 581,500 new Registered Nurse (RN) jobs during this time frame. In acute care hospitals RN demand will increase by 36% by 2020 (AACN, 2011). The aging of the baby boomer generation is a key ingredient in the projected shortage. Currently over 40% of acute care hospital beds are filled with patients 65 or older. These older patients frequently have chronic, costly-to-treat illnesses, and may require hospital readmissions as often as ten times a year (Kaiser Family Foundation, 2010). The intersection of these two healthcare issues presents an organizational challenge with current hospital vacancy and turnover rates in south central Kentucky tracking higher than state averages (Kentucky Hospital Association, 2010).

In order to recruit and retain a sufficient number of qualified nurses to provide care to this growing population, the Lake Cumberland Regional Hospital (LCRH) nursing organization must evolve to a collaborative structure that meets the professional needs of the bedside caregiver as well as the needs of the patient. Implementation of a shared governance structure is one means of accomplishing this step. Porter-O'Grady and Finnigan (1984) outline an organizational structure that places decision making authority for professional practice in the hands of those professionals. Shared governance has been characterized as "an organizational

innovation that legitimizes health care professionals' decision-making control over their practice, while extending their influence to administrative areas previously controlled by managers" (Hess, 2011, p. 235).

However, implementation of a governance structure is not the desired outcome; rather it is the "means to the end". According to Porter-O'Grady, shared governance "serves as a vehicle for creating and managing change and preparing a desired future" (Porter-O'Grady, 1992, p. ix). The desired outcomes of such an undertaking are increased engagement of the nursing staff, nurse job satisfaction, decreased turnover and vacancy, and improved patient outcomes.

Purpose Statement

The purpose of this project was to implement a shared governance structure in a rural healthcare setting and assess the impact on the nurses' perception of their control over nursing practice. In addition, the effect of this organizational change on operational outcomes such as nurse satisfaction with the work environment, turnover rate and related costs of orientation and agency staffing were measured.

Literature Review

Governance Structures

Several consistent themes surrounding the implementation of shared governance in an organization and its ongoing upkeep were identified in a review of the literature. Hess (2004) described shared governance as a journey rather than a destination. As such it is in a constant process of change. Porter-O'Grady (1987) outlined three professional governance structures that can be employed in practice settings: (a) councilor, utilizes councils to manage processes

and decision-making; (b) congressional, with elected officers and cabinet members overseeing operations; and (c) administrative, with authority divided between clinical staff and administrative functions. Each organization needs to select the model that best fits as the organization transforms itself. Porter-O'Grady (2001) describes the stages of implementing the structure of shared governance as three-fold; making the needed changes in persons and in the system itself, then changing the structure to support the new process of decision-making, and finally reinforcing the new patterns.

Structural elements that have an impact on the successful implementation of shared governance include leadership support, role delineation, decision-making processes, clear vision, communication plans, education, managerial support, time to participate, career ladders, nurse researcher, and the presence of a distinct department of nursing (Ballard, 2010; Havens, 2001; Kramer et al., 2008). Williamson (2005) identified 12 factors that were aids to decision-making for leaders during the implementation of shared governance. These factors were found to be key to the successful performance of the councils. They include clarity and appropriateness of issues presented to the council, having a clear aim/desired outcome, having a lead person allocated with appropriate level of authority, having adequate background information, having a key informant as well as coaching/support, and consistent membership and attendance.

Achievement of the cultural change that occurs with the implementation of this organizational restructuring is important to sustainability (Burnhope & Edmonstone, 2003; Dunbar et al., 2007). Design and implementation of the chosen model is only the first step; the viability of the implementation will be supported by reshaping the culture and maintaining

momentum after implementation (Dunbar et al., 2007). Planning for implementation needs to include an assessment of the supporting structures in order to increase the effectiveness of the shared governance model chosen and the success of the initial councils.

Nurse Outcomes

The implementation of shared governance or the designation as a magnet hospital have been used as independent variables in a number of studies to determine the organizational model's effect on nurse, patient and organizational outcomes. Measured outcomes involving the nurse include burnout rates, job satisfaction, likelihood of leaving the organization, perceived control over practice, autonomy, and perception of their mental health.

A study of 2522 employees in a large healthcare organization was conducted to assess the perception of a participative climate and the employee level outcomes that result (Angermeier, Dunford, Boss, & Boss, 2009). Healthcare employees who perceived their work climate to be participative reported 79% less burnout and demonstrated a 61% lower likelihood of leaving the organization. Similarly, 2045 nurses were surveyed in a comparison of 13 original Magnet hospitals and 7 ANCC magnet facilities. The results showed a lower burnout rate among the ANCC hospitals (Aiken & Havens, 2000).

An evaluation of the impact of shared governance on staff nurse perceptions of elements of the practice environment in a large regional teaching hospital was conducted using survey methodology (Jones, Stasiowski, Simons, Boyd, & Lucas, 1993). Staff nurses were surveyed prior to implementation of shared governance, and again at yearly intervals for the first three years after implementation. The staff nurses reported improvements in management style, organizational and professional job satisfaction. They also indicated that

they were less likely to leave the organization and that they perceived the practice environment more favorably.

In a study involving 279 nurses from 14 Magnet hospitals, a strong relationship was identified between the degree of nurse autonomy and their rankings of job satisfaction and quality of care (Kramer & Schmalenberg, 2003). Similarly, a larger study involving 3016 nurses concluded that higher levels of autonomy, control and collaboration were associated with increased trust in management, along with increased job satisfaction and perceptions of patient care quality (Laschinger, Shamian & Thomson, 2001). In a longitudinal study involving 239 Canadian nurses, a subsample of 75 critical care nurses were surveyed to determine relationships between perceptions of workplace empowerment, magnet hospital traits and nurse mental health (Tigert, 2004). Tigert reported decreased emotional exhaustion and higher levels of mental health of critical care nurses in hospitals that foster empowerment and professional nursing practice.

Hess (2004) reflected on the renewed interest in shared governance as it relates to the nursing shortage, reviewing the models of governance structure, identifying obstacles to implementation and concluding that despite failures at some hospitals, research was beginning to support the model's impact on improving work satisfaction for nurses. Retention of nursing staff in the current environment was the driving force behind implementing an organizational model that fosters improvement in nurses' mental health, burnout rates, job satisfaction, autonomy, empowerment and control over professional practice.

Patient Outcomes

Patient outcomes measured in shared governance literature include perceived quality of care provided, reported incidence of medication errors committed, perception of the patient safety climate, mortality rates and adverse patient events. In a study involving 40 hospitals, a strong relationship was found between structural empowerment and the presence of Magnet characteristics and the perceptions of a patient safety culture (Armstrong & Laschinger, 2006). Access to empowerment structures and a supportive professional practice environment were significantly linked to the patient safety climate in a study with 153 nurse respondents in Magnet hospitals (Armstrong et al., 2009). In a comparison of work environments in a large healthcare organization, employees who perceived their work climate to be participative as opposed to authoritarian provided 14% better customer service and committed 26% fewer medication errors (Angermeier, Dunford, Boss, & Boss, 2009).

Improved patient outcomes have been reported for facilities that have achieved Magnet Recognition from the American Nurses Credentialing Center (ANCC). Aiken (1994) studied 39 magnet hospitals and 195 control hospitals with regards to Medicare mortality rates as a patient outcome. Risk adjusted analyses described lower inpatient mortality rates in the Magnet hospitals compared with non-magnet facilities (Aiken, Smith, & Lake, 1994). Drenkard (2010), summarizing patient outcomes as a return on investment of achieving Magnet certification, pointed to hospital reports of decreased fall rates and pressure ulcer rates after achieving Magnet status. Medicare patients treated for a fractured hip were less likely to develop a pressure ulcer if treated in a Magnet hospital. Patient fall rates were reported as 10.3% lower in Magnet hospitals compared to non-Magnet facilities.

Organizational Outcomes and Measurement

Organizational outcomes of shared governance include improvements in management style, organizational job satisfaction, perception of practice environment, nurse-physician collaboration, and level of trust in management. The effect of shared governance implementation on nursing leadership has been a topic in the literature. The role of the middle manager transitioned to that of a partner with the staff nurses on the unit, setting the levels of performance expected and allowing the experts at the bedside to implement the appropriate interventions to accomplish the goals. The manager monitored for deviations and alerted the staff of a need for correction (Kerfoot, 2005). Moore and Hutchison recognized facilitative leadership as a strategy to empower frontline staff, and identified seven practices of this leadership style (Moore & Hutchison, 2007, p. 565): sharing an inspiring vision, focusing on results, seeking maximum involvement, designing pathways to action, facilitating agreement, coaching for performance, and celebrating achievement. The authors attributed the development of an empowered work environment to the organization's implementation of a shared governance structure.

Performing an analysis of the costs and benefits of pursuing Magnet recognition, Doloresco and co-investigators (2004) concluded that the benefits demonstrated in nurse turnover reduction and cost-avoidance related to improved rates of nurse-sensitive patient outcomes outweighed the cost of achieving Magnet recognition within four years from onset of the initiative. Jones et al. (1993) found that the significant improvements in the practice environment and other workplace outcomes occurred in the first two years after implementation, indicating the importance of a focus on successful start-up. Blount et al.

(2007) described improved communication and more positive relationships between staff members and leaders as an outcome evident early in the implementation of shared governance in one facility.

Hess (2011) reported on research using the IPNG to determine the distribution of control, influence, power and authority in the organizations in which nurses practice. The total governance score on this instrument is an indicator of which group has dominant control, staff nurses or management/administration. This scoring system has been used by several hospitals to guide the further development of their councils over time. Results reported include positive changes in organizational culture, morale, collegial communication, and productivity, among others (Hess, 2011).

Assessment of Existing Program

Observation of an existing shared governance program was undertaken in the summer of 2010. Baptist East Hospital in Louisville, Kentucky has revised their nursing organizational structure by creating five nursing councils and one Coordinating Council, using the councilor model for shared governance as described by Porter O'Grady (2007). The councils consist of the Practice Council, the Research Council, the Education and Professional Development Council, the Quality Council, and the Leadership Council. In addition to these hospital-wide councils, a unit-based council structure has been created, with representation of all nursing staff members on the unit councils.

Baptist East Hospital chose to implement the overall nursing councils first, adding the unit-based council structure a year later. Based on the reported experience at this facility,

changes in structure and amendments to the bylaws would be made frequently during the first year of implementation of the governance structure. Approximately two years after implementation of shared governance, Baptist East Hospital was awarded Magnet Certification (D. Meredith, personal communication, 2010).

Theoretical Framework

The implementation of major organizational change is an undertaking that requires recognition of the theories behind the change process. Lewin's theory involving the phases of the change process, unfreezing, change, and refreezing, certainly will apply to many of the stakeholders in the organization as they are faced with changes in roles and responsibilities.

Charting the course for the organization requires an understanding of leading change. Kouzes and Posner (2007) offer a model of leadership consisting of five practices common to those leading organizations in accomplishing extraordinary things. The five practices are: (a) model the way, (b) inspire a shared vision, (c) challenge the process, (d) enable others to act, and (e) encourage the heart (Kouzes & Posner, 2007).

Methods and Procedures

Model of Evidence-Based Practice

The project was conducted as quasi-experimental, utilizing a pre and post-test design.

Participants

All registered nurses in the LCRH organization were considered to be participants in the implementation of the shared governance structure. The level of involvement in the organizational change was at the discretion of the individual nurse. Opportunities to actively

participate in the process included involvement in council elections, serving as a council member, involvement in a unit-based council, and serving as a council officer.

Sample

A convenience sample of voluntary participants was used in the pre and post-test surveys. The sample included staff nurses and nurse leaders.

Setting

Lake Cumberland Regional Hospital (LCRH) is a 295-bed acute care facility located in Somerset, a town of with a population of approximately 16,000 in Pulaski County, Kentucky. While the community is relatively small, the facility serves an area which includes seven counties with a total population of approximately 130,000. The counties surrounding Pulaski County (Russell, Wayne, McCreary, Rockcastle, Casey, Adair) have either a small hospital that provides basic medical/surgical services or no hospital at all. Patients requiring tertiary level services are transferred outside those counties, and often are cared for at Lake Cumberland Regional Hospital (LCRH). Specialty services lines available at LCRH include cardiac intervention and surgery, neurosurgery, urology, obstetrics and gynecology, adult and geriatric psychiatry, general surgery, plastic surgery, otolaryngology, nephrology, pulmonology and critical care medicine, bariatric surgery, and rehabilitative medicine. Providing care for patients across these service lines requires a consistent supply of nurses as well as ongoing training and development. Current registered nurse (RN) vacancy and turnover rates in Cumberland Area Development District are higher than state averages (Kentucky Hospital Association, 2010). In order to recruit and retain a sufficient number of qualified staff, the nursing organization

needed to evolve to a collaborative structure that meets the professional needs of the bedside caregiver as well as meeting the needs of the patient.

As part of the facility's strategic planning process, the nursing leadership group has started on the journey toward Magnet recognition. The facility has enrolled in and contributed to the National Database for Nursing Quality Indicators since 2008 in order to establish a baseline in patient and nurse outcomes. In 2007, a Clinical Advancement Program (CAP) to reward bedside nurses for professional development and leadership activities was implemented. Initially the CAP was available to RNs only and was later expanded to include LPNs. Collaborating with the community college, a program for LPN to RN advancement with flexible scheduling to meet the needs of the working nurse was developed. In partnership with Eastern Kentucky University, RN to BSN classes are now being provided locally.

Instruments

Several instruments/measurement tools were utilized to assess the degree to which shared governance has become enculturated within an organization. These tools attempted to measure the staff nurses' control over nursing practice (CNP) or perceived autonomy in practice as a result of the organizational change. The Index of Professional Nursing Governance ([IPNG], Hess, 1994) (Appendix A) was selected for this study. The IPNG as introduced by Hess (2004) as the measure of governance within a nursing organization has been utilized in several studies (Anderson, 2011; Ballard, 2010; Hess, R. G., 2011). Anderson cites the IPNG instrument as the most valid and reliable tool available. This tool consists of demographic information and six subscales: (a) nursing personnel, (b) information, (c) resources supporting practice, (d) participation, (e) practice, and (f) goals. Demographic data include sex, age, educational

preparation, employment status, practice area, years of experience, and specialty certification. Items in the subscales are scored according to the participant's perspective on which group has control over the activity. The five groups to choose from in the survey are nursing management/administration 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 nurses only. The nursing personnel subscale consists of 22 items and deals with issues related to hiring, firing, discipline, benefits, etc., related to traditionally human resources issues. The information subscale has 15 items related to professional and administrative groups' access to information about governance activities. The resources subscale relates to organizational resources that support nursing practice and is comprised of 13 items. The participation subscale includes 12 items in the survey that relate to the level of participation in committee structures. The practice subscale consists of items relating to professional control over practice, direct patient care activities, standards of care, professional development, and staffing levels. The practice subscale includes 16 items. The goals subscale includes 8 items regarding the alignment of organizational and professional goals, negotiating conflict, formulation of goals, and creating a formal grievance procedure. A total score of the six subscales ranging from 86 to172 indicates control by management/administration only; a score from 173 to 344 reflects shared governance by both staff and management; a score from 345 to 430 indicates self-governance by the nursing staff.

In the initial development of the IPNG, overall reliability was measured with an alpha coefficient of .97. Reliabilities of IPNG subscales ranged from .87 to .91 in the same research.

Construct validity was established by comparing the scores from the new instrument with those of an established instrument measuring centralization of decision-making, revealing a moderate correlation (.60 using Pearson correlation). Validity was also tested comparing shared governance hospitals with non-shared governance hospitals, resulting in a significantly higher (p=.0005) score for the shared governance hospitals (Hess, 1994).

In addition to the measurement of nurse involvement in decision making, the effects of this initiative on metrics that are normally tracked in the facility were monitored. These included nurse satisfaction and turnover along with the associated costs (orientation and agency costs). Quality measures for improvement such as core measure compliance, hospital-acquired conditions, and patient satisfaction were also compared.

As part of the ongoing appraisal of the Shared Governance program, a survey of staff nurses (Appendix D) was circulated by the Coordinating Council to solicit feedback on the program's effectiveness, current and future level of staff involvement in the activities of the councils, and suggestions for future goals and program direction. Only the first appraisal survey was able to be included in this project, with a projected survey timeframe of August, 2012, one year post-implementation of the governance structure. Basic demographic information and open-ended questions were utilized.

Key Personnel

Key personnel in the implementation of this project were the elected officers of the nursing councils. The officers of each council consist of the council chair, the council co-chair, and the council secretary. The development of the skill sets of these new leaders in the governance

structure was pivotal for establishing the credibility and influence of the new councils. As a part of the budget process for the 2012 fiscal year, a position was approved for a fulltime coordinator to lead the magnet journey and to facilitate the workings of the councils. However, lack of qualified applicants caused the position to remain unfilled during the course of the first year of implementation.

Stakeholders

Stakeholders in the process of implementation of a shared governance model for nursing included staff nurses, nurse managers, ancillary departments, patients, physicians, organizational leaders and the community. Several staff nurses and nurse managers/leaders were directly involved in the start-up processes through participation in the steering committee activities, as well as the ongoing governance councils and decision-making processes. All staff nurses were involved in the selection of council representatives and then many served on the first councils. Ancillary department managers and staff members were indirectly involved in the governance councils, and were asked to participate in practice issues as they pertained to their scope. While not directly or indirectly involved in governance council activities, patients, physicians, organizational leaders and members of the community were impacted by the results. Improvements in patient outcomes, patient care processes, turnover and retention were anticipated results of this project implementation that affected these stakeholders. In Lifepoint Hospitals' organizational structure, the Chief Nursing Officer at the division level (DCNO) helps to facilitate and lead change in nursing operations. This proposal was shared with the appropriate DCNO, and had her full support. This ongoing support will be instrumental in

paving the path for implementation in other Lifepoint hospitals with other leaders such as the Division Presidents and Division Chief Financial Officers.

Potential Barriers to Implementation

An assessment of the strengths and weaknesses of the LCRH nursing organization identified issues that required concerted effort to ensure success. The percentage of registered nurses with bachelor's degree preparation or higher is 22% among bedside caregivers at LCRH. The majority of the entry level nurses were recruited from the local community college in this rural setting, and this trend continues. There are no four-year nursing programs within forty miles of the facility. Strategies to address the lack of BSN nurses were developed in order to sustain the new organizational model; nursing leadership has established alliances with institutions that can produce and supply four-year nurses to the facility. Through subsidy provided by the hospital, a nearby university has established an RN to BSN program in our community.

The RN skill mix on the largest patient care units in the facility was less than 40%, requiring changes in the budgeted skill mix as well as intensified recruitment efforts for the Medical Unit, Surgical Unit, and the Telemetry Care Unit. Additional budget constraints included the lack of nonproductive time for nurses to perform the work of the nursing councils.

There was a lack of experience with Shared Governance and the Magnet certification processes within the organization, both in the ranks of the bedside caregivers as well as nursing leadership. This created a steep learning curve for the implementation process.

As with any implementation of organizational change the lack of participation of frontline nursing staff presented an obstacle that was difficult to overcome. By the end of the first year of the project, a core group of engaged bedside nurses comprised the membership of each council, and they have recruited other nurses to join their efforts.

Data Collection and Analysis

Descriptive analysis of demographic data, nursing experience, educational background and nursing practice area are reported. Pre and post-implementation scoring of the IPNG were compared utilizing t-test of the subscale items. Content analysis of open-ended survey questions was utilized. Turnover rates, nurse satisfaction scores, core measures, orientation costs and agency nurse costs were compared for change from historical trends.

Ethical Considerations

This project as a strategic initiative approved for implementation at LCRH by hospital administration and Lifepoint Hospitals, Inc. leadership. It did not involve patient contact. Participation in the project by completion of the survey instruments was voluntary and the respondents remained anonymous.

Intervention and Implementation Timeline

The implementation of the shared governance organizational structure consisted of a number of steps leading up to and following the first council meetings, and continued throughout the year with regularly scheduled meetings of each council. Because of the extended time frame required to accomplish these steps, initial work done during the summer of 2010 was continued through to the present (Appendix B). The first step in the process was communication with the staff RNs in all departments in the LCRH organization. This consisted

of personal meetings in each work area by the Chief Nursing Officer, educating them about the shared governance structures and outcomes evidence.

The next step was the selection and recruitment of the steering committee that would select the appropriate organization structure, draft the bylaws and organize the initial elections of the council representatives. Steering committee meetings to conduct this work continued from the fall of 2010 to July of 2011, meeting every other week. Dissemination of the selected council structure, solicitation of nominations and the initial election of council representatives took place during the summer of 2011.

All elected council representatives, steering committee members, and nursing leaders took part in a celebration dinner in August of 2011, kicking off the new organizational structure. Initial council meetings were conducted in September 2011 and have been held monthly since that time. At the first council meetings, council officers were elected. The first Coordinating Council meeting was held in October of 2011, with the chairs of each governance council attending. At the present time, the unit based councils have not been created, although the Coordinating Council has drafted the unit-based council bylaws and they have been approved by the governing board. Elections for members of the unit-based councils is targeted for November 2012.

To determine the baseline governance scores for the facility, with the approval of the Institutional Review Board of Lake Cumberland Regional Hospital, the Index of Professional Nursing Governance was distributed to nurse leaders and staff registered nurses prior to creation of the steering committee. Permission to utilize the tool was granted by the author of

the instrument, who provided information about the breakdown of the subscales by item number. Surveys were distributed throughout the facility and were completed on a voluntary basis, anonymously. The baseline respondents included 56 nurse leaders and staff nurses. A limitation of this study is the inability to match pre and post implementation scores. At the request of the author, the data collected have been forwarded to add to the existing database from ongoing studies.

The timeline for implementation of this project continued through the spring and summer of 2012, with further work on development of the council leaders, drafting the bylaws for the unit-based councils, and conducting the first annual appraisal of governance structure effectiveness. In August, the second assessment of the perceptions of nursing governance was conducted using the IPNG tool.

Budget

The implementation of a shared governance model for nursing resulted in costs for supplies and materials, labor costs, media costs, and outside consultants as outlined in Appendix C. With the exception of the costs associated with the work of the steering committee, the costs in the first year of the project are expected to continue in subsequent years with the work of the councils. The budget spreadsheet outlines the costs that were incurred in the implementation of shared governance at the facility. The cost of nursing time for meetings will be an ongoing operating expense for the facility. The total proposed budget of $196,250 for the first year was not utilized, as the coordinator position was unable to be filled, resulting in a revised cost of $106,250. Over time this program will be expected to

produce outcomes that will justify this expense, and correlate with the facility's strategic initiatives of constituency satisfaction, quality outcomes and fiscal responsibility.

The goal of this project was to enhance nurse satisfaction (as measured by nurse engagement scores) and thus improve patient outcomes by creating a nursing organization that allows the bedside nurse to participate in the decision-making process regarding practice issues. We expected that the implementation of the shared governance model would result in a number of improvements in turnover rate, vacancy rate, orientation expense, and agency cost. The financial savings realized would create the return on investment necessary to recoup the expense incurred during year one of the project, and to sustain the program going forward by avoidance of these costs in future years. As an example of the financial impact of achieving the goals listed above, a decrease in RN turnover of 10% at Lake Cumberland Regional Hospital would be 24 nurses. Utilizing the VHA report of replacement cost (Kosel & Olivo, 2002, p. 7) the range of cost savings would be between $1,104,000 (medical/surgical nurses) and $1,536,000 (critical care nurses). The secondary effect of retention of these nurses is the reduction of agency nursing costs. Using an average hourly rate for an agency Registered Nurse of $50.00 (based on current hospital contract), compared to an average hourly rate plus benefit cost for an employed Registered Nurse of $35.00, there would be a savings to the organization of $31,200 per year for each full time equivalent retained.

Approval of Project

Lake Cumberland Regional Hospital's Institutional Review Board approved the use of the instrument to conduct research in this project. Bellarmine University's Institutional Review Board approved the project under expedited review guidelines.

Evaluation Plan

Utilizing the IPNG baseline and subsequent assessments, the impact of the implementation of shared governance at LCRH was measured. It was anticipated that little measureable impact would be realized within the first year of operation. The open ended question survey used as the appraisal of the governance structure was utilized to provide feedback that will be valuable in the second year of operation. Metrics on turnover, vacancy rate, orientation cost and agency used were evaluated for trends in conjunction with the instruments noted.

Results

Data Analysis

Data were analyzed using SPSS 20.0 for Windows. An analysis for missing data was performed, identifying 10.7% of the cases missing at least one piece of data in the pre-implementation sample, and 25.7% in the post-implementation data. In both cases, respondents chose not to answer individual questions, or in several instances they failed to complete the backside of the data form, omitting multiple data elements. In an effort to include as many of their responses as possible in the data set, frequencies were run using SPSS to identify the mode for each individual question in the governance data, excluding demographics. The pre-implementation modes were inserted in the missing data fields in that

dataset and the post-implementation modes were inserted into the post-implementation data set. The overall governance mean for the pre-data without inserting the mode for missing data was 147.84, and after filling in the missing data the governance mean was 148.86. Likewise the post-implementation governance mean was 152.79 with missing data, and 154.46 with modes inserted. After insertion of missing data, an independent t-test was conducted comparing the pre-implementation sample (control group) and the post-implementation sample (experimental group) with regard to the overall IPNG governance score as well as the six subscale scores.

The Shared Governance Annual Appraisal open-ended questions were analyzed by grouping like responses. Participants who identified themselves as having been actively involved in governance council activities were grouped together in SPSS in order to compare their responses to the IPNG survey questions with those who were not actively involved.

Sample

The registered nurses who participated in the pre-implementation IPNG survey volunteered during July and August of 2010. Seventy-six surveys were distributed with 57 surveys returned (75%). One survey could not be used in the sample because it was completed by an LPN, thus the usable return rate was 73.7% (N=56). Surveys were distributed on the units, and nurse leaders encouraged RNs to complete the surveys and return them. The post-implementation IPNG survey and Shared Governance Annual Appraisal were distributed together during the first two weeks of August, 2012. One hundred seventy packets were distributed on the nursing units and other nursing departments. Seventy survey packets were returned with a 41.2% response rate.

Sociodemographic characteristics of the two sample groups are presented in Table 1. The survey participants for both pre and post-implementation groups were predominantly female (96.4% and 92.9%) and work full-time (98.2% and 94.3%) at the hospital. The age of the participants in the post-implementation group is slightly younger than that of the pre-implementation group with a mean age of 38.08 compared to 44.45 years. For both groups the majority of nurses have an Associate degree as their basic level of nursing education, as well as their highest level of nursing education. The majority of nurses in each group (82.1% and 81.4%) have not yet attained national certification in their area of practice.

Table 1

Sociodemographic Characteristics of the Pre and Post-implementation Sample Groups

	Pre-implementation		Post-implementation	
Characteristic	*n*	%	*n*	%
Gender				
Female	54	96.4	65	92.9
Male	2	3.6	4	5.7
Age				
21-30	6	10.7	19	27.1
31-40	13	23.2	20	28.6
41-50	20	35.7	13	18.6
51-60	12	21.4	6	8.6
>60	2	3.6	2	2.7
Missing	3	5.3	8	11.4
Basic Nursing Education				
Diploma	3	5.4	6	8.6
Associate	39	69.6	48	68.6
BSN	14	25.0	15	21.4
Missing	-	-	1	1.4
Highest Nursing Education				
Diploma	1	1.8	4	5.7
Associate	38	67.9	43	61.4
BSN	12	21.4	17	24.3

MSN	5	8.9	4	5.7
Missing	-	-	2	2.9
Hours Worked				
Full-time	55	98.2	66	94.3
Part-time	1	1.8	4	5.7
Specialty Certification				
Yes	10	17.9	11	15.7
No	46	82.1	57	81.4
Missing	-	-	2	2.9
Years Worked as Nurse				
< 5	8	14.3	15	21.4
5-10	9	16.1	13	18.6
11-20	19	33.9	26	37.1
21-30	7	12.5	8	11.4
> 30	10	17.9	7	10.0
Missing	3	5.4	1	1.4

Both bedside caregivers and nurse leaders participated in the two sample groups and represented a diversity of care/work areas (Table 2). The Shared Governance Annual Appraisal results indicate that 20 of 58 individuals completing this questionnaire (34.5%) were active participants in the implementation or ongoing function of the governance councils.

Table 2

Representation in Sample Groups by Position and Nursing Unit

	Pre-implementation		Post-implementation	
Characteristic	*n*	%	*n*	%
Position				
Staff	35	62.5	56	80.0
Middle Nurse Manager	16	28.6	8	11.4
Executive	1	1.8	-	-
Educator	3	5.4	2	2.9
Support Personnel	1	1.8	3	4.3
Missing	-	-	1	1.4
Nursing Unit				
Medical	1	1.8	5	7.1
Surgical	4	7.1	5	7.1
Critical Care	10	17.9	16	22.9

Operating Room	6	10.7	9	12.9
Recovery Room	1	1.8	1	1.4
Emergency Department	3	5.4	6	8.6
Clinic	1	1.8	3	4.3
Maternity	7	12.5	1	1.4
Pediatrics	2	3.6	-	-
Psychiatry	1	1.8	5	7.1
Education	1	1.8	1	1.4
Quality Management	3	5.4	-	-
Other	16	28.6	18	25.7

Index of Professional Nursing Governance Survey Data

The responses to the 86-item IPNG survey tool were analyzed, comparing the 56 sample control group (pre-implementation) and the 70 sample experimental group (post-implementation). The mean of the overall governance score increased from 148.86 (SD=24.59) to 154.46 (SD=32.05), although the increase is not statistically significant (P = .283) based on the independent samples test. Five of the six subscales (nursing personnel, information, participation, practice, and goals) increased after implementation. Only the participation subscale demonstrated a significant increase, from 19.73 to 23.63 (P = .000). The resources subscale score decreased in the second assessment, dropping from 30.73 to 29.46 (P = .318).

Table 3

Independent Samples Test Results for IPNG Pre and Post-implementation by Subscales

	Pre-implementation (N = 56)		Post-implementation (N = 70)		
IPNG Scale	M	SD	M	SD	Sig. (2-tailed)
Governance	148.86	24.59	154.46	32.05	.283
Personnel	26.91	5.05	27.93	8.35	.424
Information	29.18	7.77	29.97	7.84	.572
Resources	30.73	7.07	29.46	7.09	.318
Participation	19.73	4.66	23.63	5.64	.000
Practice	27.36	6.01	27.80	6.35	.691
Goals	14.95	4.61	15.67	4.34	.366

Using the responses to the Shared Governance Annual Appraisal questions, those participants who have been active in the councils or steering committee were identified and their responses to the IPNG survey were isolated in the post-implementation dataset. A separate t-test was performed with non-members of governance councils in one group and council members in another. Reported means of the subscales of information, resources, participation, practice, and goals were slightly higher for the group of council members compared to non-members. The overall governance mean and the personnel subscale mean were slightly lower for the council members, with a statistically significant t score for personnel (P = .042) (Table 4).

Table 4

Independent Samples Test Results for IPNG Comparing Council Members and Non-Members

	Non-Members (N = 50)		Council Members (N = 20)			
IPNG Scale	M	SD	M	SD	t	Sig. (2-tailed)
Governance	154.70	36.26	153.85	18.41	.129	.921
Personnel	28.80	9.65	25.75	2.40	2.079*	.042
Information	29.70	8.74	30.65	5.05	-.567	.573
Resources	29.36	7.54	29.70	5.98	-.180	.858
Participation	23.48	6.00	24.00	4.71	-.346	.730
Practice	27.78	6.97	27.85	4.60	-.041	.967
Goals	15.58	4.69	15.90	3.37	-.277	.783

* ($p < .05$)

Shared Governance Annual Appraisal

The annual appraisal of shared governance survey was completed by 58 of 70 respondents to the combined survey packet. The appraisal consisted of five open-ended questions regarding their current extent of shared governance participation, communications received from the councils, accomplishments of the councils, recommended goals for the

coming year, and willingness to participate in the councils in the coming year. Of the 58 respondents, 20 (34.4%) were involved in council activities as members, resource persons, officers or steering committee members. With regard to communication received about council activities, 27.3% of the respondents reported no communication was received. Twenty-one respondents (38.1%) reported one method of communication was used to provide them information regarding council activities, 14 reported two methods (25.5%), and 5 could name three methods utilized (9.1%). The forms of communication listed included newsletters, unit meetings, emails, bulletin boards, and council activities on the unit.

Similarly, the appraisal results revealed 42.9% of the respondents could not name any accomplishments of the councils for the first year, while 22.4% could name one accomplishment, 12.2% could name two and 22.4% could list three or more. Accomplishments named in this survey included implementation of the DAISY award, peer monitoring of compliance with safe practices, changes in the clinical ladder program, nursing policy revisions, revision of the preceptor program, and establishing a reference library.

Thirty-five of the respondents to the survey recommended one or more goals for the governance councils for the coming year. Eight of the respondents (19.5%) identified enhanced communication from the councils regarding their activities as a goal. Eighteen others named one goal for the governance councils, other than communication, and another nine listed more than one goal. Goals named in the survey included the formation of unit-based councils, education of staff nurses, national certifications, increased participation in council activities, physician-nurse relations, patient satisfaction and nurse satisfaction.

The final question on the annual appraisal survey was regarding willingness to participate in council activities. Of the 45 nurses that responded to the question, 82.2% reported that they were willing to participate in future council activities or would do so around their work or school schedules.

Operational Metrics

Various operational metrics were tracked during the implementation period to assess for impact that could be related to the change in organizational structure. There was no attempt made to correlate observed changes directly with the intervention, as each is dependent on multiple variables both internal and external to the organization.

Turnover rates for RNs and LPNs from 2010 to 2012 decreased each year to year based on analysis of nursing positions. Turnover percentages were calculated by including all fulltime and part-time nurses who terminated their employment during the year or who converted from fulltime or part-time status to PRN status. The total number of fulltime and part-time nurses at the beginning of each year was used as the baseline. RN turnover decreased from 28.85% in 2010 to 23.48% in 2011, and to 19.75% annualized based on the first three quarters for 2012. LPN turnover decreased from 47.06% in 2010, to 32.61% in 2011 to 20.51% annualized based on the first three quarters for 2012.

Operationally the costs incurred for orientation of new staff and the cost of agency nursing to fill vacancies are both directly related to the turnover of nursing staff in the organization. For 2010, nursing orientation hours totaled 24,491.6 for the months of January through August. During 2012 for the same months, nursing orientation hours totaled

32,099.75, an increase of 31.1%. With regard to agency utilization in 2010, there were 18,211 hours of nursing contract labor utilized from January to August, compared with 10,735 for the same months in 2012, a decrease of 41%.

Nurse satisfaction at LCRH was compared utilizing the mean overall satisfaction score from the data collected each year for Lifepoint Hospitals, Inc. by Healthstream Research. Employee satisfaction scores are reported by department for each hospital. The satisfaction scores for each nursing department were identified for the baseline year 2010 and again for the post-implementation year of 2012 (Table 5). An independent t-test was utilized to compare the mean scores for all nursing departments in the two time periods. The overall mean score increased from 3.0989 in 2010 to 3.2032 in 2012, although the change in means was not statistically significant (t = -.943). Of the 19 nursing departments analyzed, 12 departments experienced an increase in mean overall satisfaction score, while 7 decreased.

Table 5

Mean Overall Satisfaction Scores for Nursing Departments Pre and Post-implementation

	2010		2012			
Department	M	SD	M	SD	t	Sig. (2-tailed)
ASC	3.76		3.43			
ACU	3.59		3.17			
PACU	3.57		2.25			
QRM	3.45		4.00			
Neuro	3.27		3.36			
TCU	3.20		3.19			
BHU	3.17		3.42			
Nurs Other	3.17		2.83			
Rehab/SCU	3.14		3.00			
L&D	3.08		3.40			
OR	3.08		3.03			
CVU	3.08		3.18			
Nursery	3.00		3.50			
SU	2.90		3.19			

Peds	2.83		3.09			
ICU	2.73		3.42			
ER	2.73		3.05			
PP	2.63		3.20			
MU	2.50		3.15			
Overall Mean	3.0989	.33732	3.2032	.34091	-.943	.358

Another operational measure tracked over time as an indicator of the provision of nationally accepted standards of care was compliance with Core Measures. LCRH abstracted data on patients who had diagnoses of acute myocardial infarction, congestive heart failure, community-acquired pneumonia, and stroke, or who had undergone certain surgical procedures. Specific processes of care were measured for each distinct diagnostic or procedural population, and compliance was measured and reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC). Data were compiled and submitted each quarter. Each measure set varied in sample size and thus in the number of possible measures tested for compliance. The hospital's compliance with all measures across all patient populations was reviewed, comparing the fourth quarter of 2010 as the pre-implementation period and the most recent completed quarter, the second quarter of 2012 as the post-implementation period. At the end of 2010, LCRH was compliant with 1958 of 1881 measures (96.76%) compared with 1504 of 1525 measures (98.62%) in the second quarter of 2012.

Limitations

There were several limitations identified in this study. The study would have been optimally performed utilizing a paired t-test methodology in order to capture specific pre and post implementation data. However, the time frame over which implementation occurred

precluded this approach. The sample population was voluntary and this led to variation in the mix of units and nursing roles represented in the two groups. The post-implementation data were collected one year after shared governance councils were initiated, while the literature indicates that little change can be anticipated in perceptions of nursing governance until 3 to 5 years after implementation (Hess, 2011).

Discussion

The purpose of this project was to implement a shared governance structure for nursing and to assess its impact on the nurses' perception of their control over nursing practice. In addition, various operational metrics were to be assessed for change resulting from this implementation. Work done by the selected steering committee during late 2010 and early 2011 led to the election of council members in July of 2011, and the first council meetings were held in September. The work of the councils continued throughout the year and each council identified and was able to successfully complete several objectives.

The Nursing Practice Council struggled initially to find its focus, and midway through the year the council chair resigned from the council for personal reasons and was replaced by the co-chair. The council's activities during the first year included the implementation of "practice check-ups" on the units to determine the consistency of the performance of basic nursing practices throughout the facility. Practices such as labeling of IV tubing, appropriate allergy banding, and correct placement of EKG leads were assessed by members of the council and unit specific results were posted. Reassessments of the practices were conducted in subsequent months with improvements noted. The Practice Council also assumed the responsibility for

review and revision of nursing policies and procedures. As part of that review, the council identified a need to research best practices on providing nutritional supplements and administration of tube feedings. Another initiative was the development of an acuity system for making patient assignments.

During the first year of operation, the Nursing Quality Council received referrals from the medical staff's Quality Council regarding nursing issues which led to the development of a nursing peer review process and also a focus on nurse-physician communication. In collaboration with the Research Council, the Quality Council investigated current practices in the care of infants born with Neonatal Abstinence Syndrome, and was instrumental in bringing physical, occupational, and speech therapists into the care team.

The Nursing Research Council actively supported the other nursing councils by performing literature reviews on selected topics, and provided the referring councils with annotated bibliographies on the topic in question. The council worked to develop a nursing library including purchase of indexing software to support its use.

The Nursing Image and Community Council focused on building nursing's image both internally and in the community at large. This council implemented the DAISY award program for excellence in nursing at LCRH, and celebrated its first recipient in July of 2012. The council coordinated outreach activities in the school systems in Pulaski and neighboring counties, teaching health related topics and providing information on nursing as a career.

The Nursing Professional Development Council took over the administration of nursing's Clinical Advancement Program (clinical ladder) during its first few months of work. In addition,

the council revised and enhanced the preceptor program, recruiting and training new preceptors in collaboration with the local community college faculty.

The Coordinating Council identified a need to develop skills within the councils' leaders, and provided training on conducting meetings, standardizing minutes, and establishing communication pathways back to the nursing units regarding council activities. This council drafted and approved the bylaws for the creation of the unit-based councils and outlined the process for the election of its members.

While the work of the individual councils was evident during the implementation year, the results of the reassessment using the IPNG instrument demonstrated significant increase in mean score for only one of the subscales (participation). The questions included in this subscale ask the respondent to rate the involvement of nurses in policy and procedure development, unit and hospital committees, and development of unit goals. Based on the work of the Practice Council regarding policy revision and the Coordinating Council in development of unit-based councils, this increase is relevant. One subscale (resources) demonstrated a slight decrease in mean score, although not significant. This subscale consists of seven questions related to making patient care assignments, obtaining supplies for patient care, consulting other disciplines or departments, and regulating the flow of admissions and transfers. With the exception of the work on the acuity system, these topics have not been addressed by any of the councils to date. It is interesting to note that those respondents in the post-implementation survey that were involved as members of the councils rated this subscale higher than the nonmembers.

The remaining four subscale mean scores and the overall governance mean increased slightly from the pre-implementation baseline, though not significantly. This is consistent with reports from other facilities during the early years of implementation (Hess, 2011). An overall governance mean score of 173 is reported as the minimal score indicating accomplishment of the culture change to a shared governance model. LCRH scored 154.46, an increase of 5.6 over the baseline. Hess reported the progress of a community hospital over a four year period from a score of 161.51 to 192.84, eventually achieving Magnet designation shortly afterwards.

The results of the Shared Governance Annual Appraisal yielded information that was useful in evaluating the progress made during the first year, and identifying focuses for the coming year. It is evident from the responses that emphasis must be placed on enhancing communication from the councils back to the nursing departments. The delay in implementation of the nursing website because of the lack of technical expertise was a hindrance to communication throughout the year. Only in the last few months were consistent reports flowing back from the councils in the way of newsletters and emails. This issue will remain on the agenda for the Coordinating Council in the coming year. Future goals identified by the respondents were consistent with the work of the councils. The formation of the unit-based councils is on the horizon with elections slated to occur in November. The continued education of staff nurses and pursuit of national certifications is currently being promoted by the Professional Development Council. The Quality Council continues to work on nurse-physician communication and relationships. Patient and nurse satisfaction metrics will be reported to each unit-based council as it is developed in order to target initiatives at the unit level. The development of the unit-based councils will address another identified goal, that

being increasing participation of staff nurses in shared governance. However, in order to meet this goal, nurse leaders in the organization must acknowledge this participation as an operational imperative for their departments, and be able to remove obstacles to participation. Ballard (2010) discussed nursing leadership's role in preventing breakdown of the shared governance practice environment. Nurse leaders must support attendance at meetings and time to complete council projects in order to be successful. LCRH has experienced varying levels of support from the nurse leaders during the first year, and will need greater consistency in order to accomplish the goal of effective unit-based council development.

Operational metrics gathered during the implementation period provide inconclusive and sometimes contradictory information, until placed in the context of initiatives in progress during the same time frame. Nursing turnover decreased for both RNs and LPNs during the period. Orientation hours remained high and actually increased for the January through August comparisons year over year. The large number of orientation hours for 2011 and 2012 were the result of the high turnover percentages in the preceding year. The total number of nurses lost during 2010 was 114, with 96 leaving in 2011. Year-to-date in 2012 this number has dropped to 58, which would be approximately 77 for the year if the rate is constant in the fourth quarter. During the implementation period the hospital implemented an initiative to encourage LPNs to pursue their RN licensure by alternative clinical schedules and tuition reimbursement enhancements. As the LPNs graduated, their positions were converted from LPN to RN. Additional orientation was provided for the new role on the home unit. Thus, skill mix on the larger units was enhanced while retaining current employees. Orientation hours for RNs increased related to a focus on improving the preceptorship relationship and time frame.

During this same time, agency hours decreased by 41% from 2010 to 2012. This is not only related to the decrease in turnover, but also because during this time focused case management activities drove average length of stay down from 4.6 days to 4.1 days, requiring fewer nursing care hours per admission.

Overall nurse satisfaction for the hospital increased during this period, and also for the majority of the nursing units surveyed. For several of the nursing departments (PACU, Rehab/Skilled Care, Ambulatory Care Unit), nursing leadership changes were required during this time. Effectiveness of the results of the changes made will be assessed in future surveys. These Healthstream Research surveys assess relationships with frontline supervisors and co-workers along with assessments of access to supplies and equipment, unlike the IPNG which focuses on the amount of control the nurse has over each of the categories of the subscales.

In addition to the increase in nurse satisfaction, patient outcomes as measured by Core Measure compliance increased slightly from 2010 to 2012. This operational measure is difficult to assess over time as the number of measures sets changes from quarter to quarter, and the volume of each patient population changes seasonally. The consistency with which care is delivered over time however is certainly impacted by having a workforce that experienced with low turnover, and is less reliant on staffing by temporary agency nurses.

Conclusions

Implementation of shared governance in any facility presents challenges for leadership as well as the nursing staff. In a mid-sized rural facility, resources to support the project may not be readily available, and thus the time frame for implementation may be prolonged. For

this facility, establishing relationships with academic institutions to promote advanced education for the nursing staff and nurse leaders was a key ingredient, leading to an increase in the RN skill mix as well as the number of BSN prepared nurses. The concept of a shared decision-making structure for nursing was foreign to both our leaders and staff nurses, with no hospitals in the region utilizing such a model. Education for the staff was provided prior to formation of the steering committee and continued throughout the implementation process. Participation by staff nurses in meetings and council activities continues to be a challenge, but the formation of the unit-based councils in the next few months is anticipated to increase involvement throughout the organization. As indicated in the annual appraisal that was conducted, communication of council activities will be a key ingredient in the growth and success of this initiative. Positive trends have already been seen in some of the indicators measured. Decreased turnover, decreased agency use, improvements in core measure results, and increased nurse satisfaction scores are positive operational metrics that are already apparent. The increase noted in the IPNG overall governance score is consistent with the literature for early implementation results.

Earlier implementation of unit-based councils would have resulted in broader involvement of the nursing staff in the new structure, with additional gains in metrics. Communication of council activities would have been enhanced by the availability of the nursing website during the first year as had been planned. The lack of a coordinator for the program during this time resulted in more active involvement by nursing leadership, though other job responsibilities for these leaders lessened the amount of time available for this focus.

The implementation of shared governance for this organization yielded positive results operationally, and for the development of nursing overall. It will be important to continue to measure the effects of the organizational change as the next phases are implemented. A facility located in a rural setting can successfully implement shared governance utilizing available resources and establishing key relationships.

References

Aiken, L. H., & Havens, D. S. (2000). The magnet nursing services recognition program: A comparison of two groups of magnet hospitals. *American Journal of Nursing*, *100(3*), 26-35.

Aiken, L. H., Smith, H., & Lake, E. (1994). Lower Medicare mortality among a set of hospitals known for good nursing care. *Med Care*, *32*, 771-787.

American Association of Colleges of Nursing. (2011). Nursing fact sheet. Retrieved from http://www.aacn.nche.edu/Media/FactSheets/nursfact.htm

Anderson, E. F. (2011). A case for measuring governance. *Nursing Administration Quarterly*, *35(3)*, 197-203.

Angermeier, I., Dunford, B., Boss, A., & Boss, R. (2009). The impact of participative management perceptions on customer service, medical errors, burnout, and turnover intentions. *Journal of Healthcare Management*, *54(2*), 127-141.

Anthony, M. K. (2004). Shared governance models: The theory, practice, and evidence. *Online Journal of Issues in Nursing*, *9(1)*, 138-153.

Armstrong, K. J., & Laschinger, H. (2006, April-June). Structural empowerment, magnet hospital characteristics, and patient safety culture. *Journal of Nursing Care Quality*, *21(2)*, 124-132.

Armstrong, K., Laschinger, H., & Wong, C. (2009, July/August). Workplace empowerment and magnet hospital characteristics as predictors of patient safety climate. *Journal of Nursing Care Quality*, *24(1)*, 55-62.

Ballard, N. (2010, October). Factors associated with success and breakdown of shared governance. *The Journal of Nursing Administration*, *40(10)*, 411-416.

Blount, K., Krajewski, A., Alminde, C., Swift, S., Green, M., & Sullivan, S. (2007, October). Shared governance: Early payoffs from leadership and staff engagement. *Nurse Leader*, 38-54.

Bogue, R. J., Joseph, M. L., & Sieloff, C. L. (2009). Shared governance as vertical alignment of nursing group power and nurse practice council effectiveness. *Journal of Nursing Management*, *17*, 4-14.

Burnhope, C., & Edmonstone, J. (2003). Feel the fear and do it anyway: the hard business of developing shared governance. *Journal of Nursing Management*, *11*, 147-157.

Doloresco, L. G. (2004, November). *Building a business case for Magnet designation in VHA* (Final Report). Tampa, FL.

Drenkard, K. (2010, June). The business case for magnet. *Journal of Nursing Administration*, *40(6)*, 263-271.

Dunbar, B., Park, B., Berger-Wesley, M., Cameron, T., Lorenz, B. T., Mayes, D., & Ashby, R. (2007). Shared governance: Making the transition in practice and perception. *The Journal of Nursing Administration*, *37(4)*, 177-183.

Edwards, C. (2008, August). Using interdisciplinary shared governance and patient rounds to increase patient safety. *MEDSURG Nursing*, *17(4),* 255-257.

Foster, B. E. (1992). Models of shared governance: Design and implementation. In T. Porter-O'Grady (Ed.), *Implementing shared governance* (pp. 79-110). St. Louis, MO: Mosby Books.

Fray, B. (2011). Evaluating shared governance: Measuring functionality of unit practice councils at the point of care. *Creative Nursing*, *17, Issue 2*, 87-95.

Havens, D. S. (2001, November/December). Comparing nursing infrastructure and outcomes: ANCC magnet and nonmagnet CNEs report. *Nursing Economic*$, *19(6)*, 258-266.

Hess, R. G. (1994). *The measurement of professional nursing governance* (Doctoral dissertation). Available from University Microfilms International. (9427545)

Hess, R. G. (2004). From bedside to boardroom - Nursing shared governance. *Online Journal of Issues in Nursing*, *9(1),* 95-106.

Hess, R. G. (2011). Slicing and dicing shared governance in and around the numbers. *Nursing Administration Quarterly*, *35,(3)*.

Joint Commission on Accreditation of Healthcare Organizations. (n.d.). *Health care at the crossroads: Strategies for addressing the evolving nursing crisis*. Washington, DC: U.S. Government Printing Office.

Jones, C. B., Stasiowski, S., Simons, B. J., Boyd, N. J., & Lucas, M. D. (1993, July-August 1993). Shared governance and the nursing practice environment. *Nursing Economic*$, *11*, 208-214.

Kaiser Family Foundation. (2010). Geriatric population soars while NIH devotes modest resources to aging research. Retrieved from http://www.kaiserhealthnews.org/DailyReports/2010/June/29/Elderly-Issues.aspx?p=1

Kentucky Hospital Association. (2010). *KHA 2010 Workforce Shortage Survey*. Louisville, KY: Kentucky Hospital Association.

Kerfoot, K. (2005, November-December). Establishing guardrails in leadership. *Nursing Economic*$, *23(6),* 334-335.

Kosel, K. C., & Olivo, T. *The business case for work force stability* (White paper). Retrieved from Healthcare leaders media website: www.healthcareleadersmedia.com/content/132674.pdf

Kouzes, J. M., & Posner, B. Z. (2007). *The leadership challenge* (4th ed.). San Francisco, CA: Jossey-Bass.

Kramer, M., & Schmalenberg, C. E. (2003, January/February). Magnet hospital staff nurses describe clinical autonomy. *Nursing Outlook*, *51*, 13-19.

Kramer, M., & Schmalenberg, C. E. (2003, June). Magnet hospital nurses describe control over nursing practice. *Western Journal of Nursing Research*, *25*, 434-452. doi: 10.1177/0193945903025004008

Kramer, M., Schmalenberg, C., Maguire, P., Brewer, B. B., Burke, R., Chmielewski, L., Cox, K., ... Waldo, M. (2008, January 14). . *Western Journal of Nursing Research OnlineFirst*, 1-21. doi: 10.1177/0193945907310559

Kupperschmidt, B. R. (2004, March). Making a case for shared accountability. *The Journal of Nursing Administration*, *34 (3),* 114-116.

Laschinger, H. K., Shamian, J., & Thomson, D. (2001, September-October). Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care, and work satisfaction. *Nursing Economic*$, *19(5)*, 209-219.

Moore, S. C., & Hutchison, S. A. (2007, December). Developing leaders at every level. *The Journal of Nursing Administration*, *37(12),* 564-568.

Porter-O'Grady, T. (1987, November-December). Shared governance and new organizational models. *Nursing Economic*$, *5(6),* 281-286.

Porter-O'Grady, T. (2001, October). Is shared governance still relevant? *The Journal of Nursing Administration*, *31(10)*, 468-473.

Porter-O'Grady, T. (2004). Overview and summary: Shared governance: Is it a model for nurses to gain control over their practice? *Online Journal of Issues in Nursing*, *9(1),* 92-95.

Porter-O'Grady, T. (Ed.). (1992). *Implementing shared governance*. St. Louis, MO: Mosby Books.

Porter-O'Grady, T., & Finnigan, S. (1984). *Shared governance for nursing: A creative approach to professional accountability*. Rockville, MD: Aspen.

Tigert, J. A. (2004, Winter). Critical care nurses' perceptions of workplace empowerment, magnet hospital traits and mental health. *CACCN*, *15(4)*, 19-23.

Williamson, T. (2005). Work-based learning: a leadership development example from an action research study of shared governance implementation. *Journal of Nursing Management*, *13*, 490-499.

PROFESSIONAL NURSING 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 your BASIC nursing educational preparation:
   ____Nursing Diploma ____Associate Degree in Nursing
   ____Baccalaureate Degree in Nursing
4. Please indicate the HIGHEST educational degree that you have attained at this point in time:
   ____Nursing Diploma ____Master's Degree, Non-nursing
   ____Associate Degree in Nursing ____Doctorate, Nursing
   ____Baccalaureate Degree in Nursing ____Doctorate, Non-nursing
   ____Master's Degree in Nursing, Specialty
5. Employment Status:
   ____Full-time, 36-40 hours per week
   ____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 nursing_____
7. Please indicate the title of your present position_____
8. Please indicate the type of nursing unit that you work on:
   ____Medical ____Maternity
   ____Surgical ____Pediatrics
   ____Critical Care ____Psychiatry
   ____Operating Room ____Education
   ____Recovery Room ____Quality Management
   ____Emergency Room ____Outside Nursing
   ____Clinic ____Other (please specify):_____
9. Please specify the number of years you have worked in this institution_____
10. Please specify the number of years you have been in this present position_____
11. Have you received any specialty certifications from professional organizations?
    ____Yes ____No
    If YES, please specify the type of certification and year received_____

In your hospital, 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 activities nurses can do at the bedside.	1	2	3	4	5
2. Developing and evaluating patient care standards and quality assurance/improvement activities.	1	2	3	4	5
3. Setting levels of qualifications for nursing positions.	1	2	3	4	5
4. Evaluating (performance appraisals) nursing personnel.	1	2	3	4	5
5. Determining activities of ancillary nursing personnel (aides, unit clerks, etc.).	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 their nursing staff.	1	2	3	4	5
9. Promoting RNs and other nursing staff.	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 research ideas into nursing care.	1	2	3	4	5
13. Determining methods of nursing care delivery (e.g. primary, team, case management).	1	2	3	4	5

PROFESSIONAL NURSING GOVERNANCE

In your hospital, 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 in 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 nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	1	2	3	4	5
22. Consulting hospital 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 (e.g. placement of ventilator-dependent patients, early discharge of patients to home health care).	1	2	3	4	5
25. Recommending new hospital 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 hospital, please circle which group has OFFICIAL AUTHORITY (i.e. authority granted and recognized by the hospital) to 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 in direct patient care.	1	2	3	4	5
29. Written patient care standards and quality assurance/improvement programs.	1	2	3	4	5
30. Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises.	1	2	3	4	5
31. Written process for evaluating nursing personnel (performance appraisal).	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 inservices.	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 and leadership positions.	1	2	3	4	5
37. Procedures for generating schedules for RNs and other nursing staff.	1	2	3	4	5

PROFESSIONAL NURSING GOVERNANCE

38. Acuity and patient classification systems for determining how many 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 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 and support functions.	1	2	3	4	5
42. Procedures for controlling the flow of patient admissions, transfers and discharges.	1	2	3	4	5
43. Process for recommending and formulating annual unit budgets 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 services outside of the unit (e.g. administration, psychiatric, medical-surgical).	1	2	3	4	5
46. Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy).	1	2	3	4	5
47. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass).	1	2	3	4	5
48. Location of and access to office space.	1	2	3	4	5
49. Access to office equipment (e.g. phones, personal computers, copy machines).	1	2	3	4	5

In your hospital, 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 multidisciplinary professional committees (physicians, other hospital 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 multidisciplinary professional committees.	1	2	3	4	5
59. Forming new hospital administration committees.	1	2	3	4	5

PROFESSIONAL NURSING GOVERNANCE

In your hospital, 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 hospital nursing practice.	1	2	3	4	5
61. Compliance of hospital nursing practice with requirements of surveying agencies (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. Hospital'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. Hospital'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 hospital status of nurse turnover and vacancies.	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 bedside nursing practice.	1	2	3	4	5
72. Physicians' opinion of bedside nursing practice.	1	2	3	4	5
73. Nursing peers' opinion of bedside nursing practice.	1	2	3	4	5
74. Access to resources concerning recent advances in nursing practice (e.g.journals and books, library).	1	2	3	4	5

In your hospital, 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 hospital 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 hospital administration.	1	2	3	4	5
80. Create a formal grievance procedure.	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 the nursing department.	1	2	3	4	5
83. Formulate the mission, philosophy, goals and objectives of the hospital.	1	2	3	4	5
84. Write unit policies and procedures.	1	2	3	4	5
85. Determine nursing departmental policies and procedures.	1	2	3	4	5
86. Determine hospital-wide policies and procedures.	1	2	3	4	5

Appendix B

Item #	Process Steps	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	August-12
1	**Clinical Project Questions:**																											
1.1	1. Does the implementation of a shared governance model positively impact the engagement scores of RNs?																											
1.2	2. Does the implementation of a shared governance model positively impact nurse retention?																											
1.3	3. Does the implementation of a shared governance model positively impact quality and satisfaction measures?																											
2	Education on Shared Governance																											
2.1	Literature Review																											
2.2	Staff meetings - education on Shared Governance																											
2.3	Visit other facilities to observe Shared Governance meetings																											
2.4	Nursing Leadership engagement meeting																											
2.5	Sharing of literature with Steering Committee																											
2.6	KY Virtual Library License																											
3	Communication of Shared Governance Initiative																											
3.1	Creation of Nursing Website																											
3.2	Create website pages for governance councils																											
3.3	Update web pages																											
4	Data Collection																											
4.1	IRB approval of IPNG tool																											
4.2	Conduct presurvey of staff RNs with IPNG tool																											
4.3	Research baseline metrics for comparison																											
4.4	Reassess identified metrics																											
4.5	Resurvey RNs using IPNG tool																											
4.6	Analyze data for effects of program implementation																											
5	Implementation of Shared Governance Structure																											
5.1	Recruitment of members of steering committee																											
5.2	Steering committee meetings																											
5.3	Development of bylaws																											
5.4	Dissemination and revision of bylaws																											
5.5	Submission of bylaws to Board of Trustees for approval																											
5.6	Organize and conduct council elections																											
5.7	Implement council meetings; conduct monthly meetings																											
5.8	Conduct effectiveness survey of council members at yearly intervals																											
5.9	Development of unit councils																											

Appendix C-Budget

Expense Analysis	Item	Unit	Unit Cost	Extended (Actual) Cost	Annualized Cost
Office Expenses/Supplies					
	Copies for Educational Materials	300	$0.25	$75	$900
	Nursing Leadership Meeting books	18	$15	$270	$3,240
	Steering Committee books	20	$15	$300	$3,600
	Subtotal				**$7,740**
Manhours					
	Directors/Managers salaries			$0	$0
	Shared Gov/Magnet Coord	2080	$43.27	$90,000	$90,000
	Steering Committee meeting manhours	12	$28	$336	$4,032
	Governance Councils meeting manhours	Monthly			
	Quality Council	54	$28	$1,512	$18,144
	Research Council	30	$28	$840	$10,080
	Practice Council	54	$28	$1,512	$18,144
	Professional Development	20	$28	$560	$6,720
	Nursing Image and Community	20	$28	$560	$6,720
	Leadership Council	40	$40	$1,600	$19,200
	Coordinating Council	24	$40	$960	$11,520
	Subtotal				**$94,560**
Website					
	License for website	Annually	$1,000	$1,000	$1,000
	Consultant for website development	30	$25	$750	$750
	KY Virtual Library License	Annually	$1,000	$1,000	$1,000
	Subtotal				**$2,750**
Data/Survey Instrument					
	Robert Hess' IPNG Instrument	No cost	$0	$0	$0
	Subtotal				**$0**
Honoraria					
	Outside Researcher	Monthly	$100	100	$1,200
	Subtotal				**1,200**
	Total				**$196,250**

Appendix D

Shared Governance Annual Appraisal

Unit/Department _____

Shift _____

1. **To what extent have you participated in the nursing governance councils during 2011-2012?**

2. **What communication have you received during the year from the councils regarding their activities?**

3. **What accomplishments have been achieved by the governance councils during this year?**

4. **What goals would you recommend for the governance councils for the upcoming year?**

5. **To what extent are you willing/able to participate in the activities of the governance councils in the upcoming year?**