Program Evaluation of Shared Governance Practice and Perception for Registered Nurses in a Community Hospital Setting

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A Scholarly Practice Project presented to the Graduate Faculty
of the University of Virginia in Candidacy for the Degree of
Doctor of Nursing Practice

School of Nursing

University of Virginia
May 2020

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Abstract

Background: The empowerment of registered nurses (RN) with the implementation of shared governance (SG) councils leads to ownership of professional nursing practice issues. The lack of a program evaluation for this combined SG health system council posed a risk for undefined program effectiveness.

Purpose: The purpose of this project was to complete a formal program evaluation of a SG model implemented in two community hospitals within a healthcare system in northern Virginia.

Methods: Methods included a retrospective review of the five combined SG councils' structure and process and the use of the Index of Professional Nursing Governance (IPNG) survey to obtain a baseline measurement of SG and the perception of impact on RN's professional practice. Impact on practice was measured with a Likert scale.

Results: Analysis of completed council SG minutes, agendas, attendance rosters and projects identified inconsistencies from 2018 to 2019. The IPNG survey indicated overall SG score and two out of the six subscales measured in the SG range. The IPNG survey overall score 101.00 (24.44) and two out of the six subscales, influence over resources 25.35 (7.98) and goal setting and conflict resolution 10.59 (4.14) measured in the SG range. The SG program had a 49% moderate to major impact on RNs' professional practice.

Conclusion: A review of SG to obtain a baseline measurement was valuable to both hospitals. These results were shared with key stakeholders to make recommendations to steer the nursing leadership in a direction to create an enduring SG program.

Keywords: shared governance, nursing, and evaluation

Program Evaluation of Shared Governance Practice and Perception for Registered Nurses in a Community Hospital Setting

Introduction

The importance of shared governance (SG) is to place and maintain decision-making about nursing practice in the hands of the clinical staff (Frith & Montgomery, 2006). The environment in which nurses practice impacts their ability to provide high-quality, safe patient care and to maintain fulfillment with their position and profession (Lin, 2007). The term “shared governance” has been used to examine the vertically aligned exercise of power by nurses (Bogue, Joseph & Sieloff, 2009). The term vertical leadership has been traditionally defined as leadership that one person is firmly "in charge," while the rest are simply followers. But research indicates that team members can share leadership roles by rotating the subject matter expert with the abilities for the issues confronting the team at any given time (Pearce, 2004). A more established organizational governance definition by Hess (1998), is that of SG as the processes and structures of authority over decision-making.

Empowerment of SG council members enables them to take the next step to apply evidence-based practice (EBP) interventions and improve patient outcomes (Brody, Barnes, Ruble & Sakowski, 2012). Through the support of governmental and nursing organizations, social and educational changes forced healthcare organizations and their leaders to rethink their strategies of operations and structure. This empowered nurses to influence their work environment (Kanter, 1993).

SG is promoted as a nursing management innovation that legitimizes nurses’ decision-making control over their professional practice while expanding their influence on administrative areas that were controlled by management. These SG programs have changed the balance of

control by professionals and administrators over their respective clinical and administrative areas and also redistributed their influence over more organizational areas regarding information, authority, goals, and conflict (Hess, 1995).

Shared Governance Model

SG is used by nursing leaders to promote and support empowerment and autonomy among Registered Nurses (RN). SG models emphasize nursing ownership of decisions made related to their work as a nurse (Clavelle, Porter, Weston & Verran, 2016). This shared decision-making encompasses the structures and processes through which nurses control their practices and influence the organization (Hess, 2011).

The goals of SG include improved communication, improved relationships, increased professional growth, and satisfaction with decisional involvement in nursing practice (Hess, 2011). There have been reports of changes to collaboration, staff recruitment, staff retention, autonomy, shared values, increased morale, organizational culture, quality patient outcomes, resourcefulness, empowerment, and satisfaction by hospitals that implement SG (Hess, 2011).

The model of SG was first published in 1984 by Tim Porter O'Grady; this model connected a different mental model for relationship and leadership. This framework for the professionalization of nursing provided a broader distribution of decision-making across the profession and allocates decisions based on accountability and role expectation. The key characteristics in SG, according to Porter-O'Grady (1991), include responsibility, accountability, and commitment. Described as a "journey" (Porter-O'Grady, 2019), it is not a one-time implementation process, with a concrete, fixed set of rules, but instead an ongoing process, which requires continual assessment and revaluation to be flexible and adaptive to the environment. According to Porter-O'Grady (1991), hospitals and nursing leadership historically

have been held back from making changes to expand nurses to make decisions that affected the operations of nursing services and influenced hospital operations.

The history of nursing demonstrates recurrent issues that the nursing profession has had to confront over time. Some of the issues have been standards for the profession, autonomy of nurses, and control of nursing practice. The move toward SG provided nurses a chance to control all aspects of professional practice and to fully participate and practice as professionals (Porter – O'Grady & Finnigan, 1994). Porter-O'Grady (2019), describes three fundamental principles to both affirm and validate the existence of SG structures and practices.

- Principle 1: Grounded in practicing, nurse accountability implies an individual obligation that demonstrates a personal connection to the ownership of the principles and practices associated with the nursing profession.
- Principle 2: Structures built around professional accountability and clinical decision-making explain that professionals own their decisions and actions, and are directly accountable for the impact of those actions on the patients.
- Principle 3: Structures reflect distributive decision-making set around the fact that all professions have accountability for practice, quality, competence, and knowledge. In nursing history, traditional structures for nurses did not support decision-making by nursing staff, the work of nursing leaders transformed and continues to transform healthcare for nursing (Porter-O'Grady, 2019).

According to Hess (1998), governance is about power, control, authority, and influence. Nursing SG is a distribution between the leadership and professional clinical staff, whereas traditional nursing governance is a rigid formal hierarchical bureaucracy. Nursing SG is a way of leadership development that creates nurses' control over their practice while extending their

influence into administrative areas previously controlled only by nurse leaders (Hess, 2004). Managers need to exchange their traditional roles from “power over nurses” to “empowerment of the staff nurse” (Erikson, Hamilton, Jones & Ditomassi, 2003). According to Kanter, “empowerment” has two different views: psychological empowerment and structural empowerment. Structural empowerment refers to the application of management in the workplace (Kanter, 1993).

The purpose of this scholarly project was to complete a formal program evaluation of a SG model implemented in two community hospitals within a healthcare system.

Background and Significance

As professionals, nurses should have the accountability and responsibility to direct their professional practice. The SG model is one method to ensure that nurses are empowered to have as much influence over their practice as possible. In the clinical setting, engagement of the RN to develop a structure enabling shared decision-making is sometimes done through SG programs (Porter-O’Grady, 2019). Many hospitals have adopted SG as a vehicle to empower their nurses (Barden, Griffin, Donahue, & Fitzpatrick, 2011). According to the American Nurses Credentialing Center (ANCC), there are 520 Magnet-designated hospitals. Each of these hospitals must have demonstrated evidence of formal empowerment structures and processes that involve nurses in governance and decision-making about their practice (ANCC, 2017).

The SG model was founded on the need for bedside nurses to influence their practice. SG practices provide nurses more input and influence over their practice and how the organization makes decisions that affect them. In this model, every nurse can bring to their clinical expertise, experience, and insight, conveying their voice to nursing practice issues. While many hospitals

and healthcare systems have a SG model in place, this does not necessarily ensure that the fundamental principles of SG are incorporated (Weaver et al., 2018).

When considering the implementation of a SG program in an organization, an evaluation plan is necessary. Successful implementation of SG requires the CNE and senior nurse leaders to dedicate time to program start-up and maintenance and demonstrate an ongoing commitment to the philosophy of SG (Jones, Stasiowoski, Simons, Boyd & Lucas, 1993). A program evaluation assesses and describes the cost, resources, and time required by nurses to complete project requirements and illustrate outcomes. In this way, the organization can decide if resources allocated are providing desired results.

Plan for Program Evaluation: The Centers for Disease Control Six-Step Framework

To conduct a systematic program evaluation of the SG model implemented at the student's practice site, the implementation framework chosen was the Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health (CDC Framework). The CDC Framework is used to demonstrate the impact of a program that has just begun or has been in place for several years (CDC, 2017). The CDC Framework consists of four guiding standards and six steps for conducting program evaluations (CDC, 2017; CDC, 1999). See Figure 1.

The four standards that compose the CDC Framework include utility, feasibility, propriety, and accuracy (CDC, 2017). Utility refers to the program evaluations' relevance to the program, i.e., the results must be usable to the stakeholders. In order to ensure the concept of utility is reached, stakeholders should be involved in the evaluation design. The second standard, feasibility, refers to whether or not the proposed evaluation will be realistic to complete, given the limited time and resources available (CDC, 2017). The third guiding standard of this

framework is propriety. This refers to ethical considerations of conducting the evaluation; procedures need to be in place to protect human subjects and any confidential related data. The last guiding standard is accuracy (CDC, 2017). There needs to be a systematic means of collecting and analyzing data (CDC, 2017). It is essential to have accurate, collected data to be interpreted correctly to make sound recommendations.

The six steps of the CDC Framework are: 1) Engage the Stakeholders; 2) Describe the Program; 3) Focus the Evaluation Design; 4) Gather Credible Evidence; 5) Justify Conclusions; and, 6) Ensure Use and Share Lessons. These steps must be done in order with the guiding standards in mind, to appropriately use the framework as intended.

The CDC Framework was selected as the implementation framework for this scholarly project because it uses elements of shared governance, specifically that it starts with engaging the stakeholders and ends with disseminating the findings to stakeholders.

Purpose Statement

The purpose of this scholarly project was to complete a formal program evaluation of a SG model implemented in two community hospitals within a healthcare system.

After Hospital A implemented a SG model in 2006, there was a merger into a large healthcare system in 2009 and an addition of Hospital B that combined with the SG model that was established in Hospital A in 2017.

CDC Step 1: Engage stakeholders.

The stakeholders – nurse leaders and staff nurses - were engaged through one-on-one meetings and group meetings to review the current state of SG, infrastructure, and processes across the two hospitals. The doctoral student attended multiple meetings over a two-month period, including SG Councils, Coordinating Councils, and Executive meetings. The CDC

worksheet was used to obtain consistent data that was then synthesized into themes and goals for the systematic evaluation. Early engagement with stakeholders in a program evaluation is essential in order to define a common goal for the program (CDC, 2017). During a nurse executive meeting, a review of the strengths, weaknesses, opportunities, and threats (SWOT) analysis was completed to provide information to stakeholders. The key stakeholders for this program included the CNE, eight nurse leaders, three members (two staff nurses and one nurse leader) of the SG Council, and the Magnet Coordinator.

SWOT Analysis

The SWOT analysis is a strategic management process by which organizations can analyze their environment (Hollingsworth, 2011). The SWOT analysis conducted for the combined SG program was essential for strategically planning and identifying areas that would be addressed. The SWOT analysis helped guide the direction of survey execution for the practice site.

Strengths	**Weaknesses**
- Engaged Nursing Leader support - Implementation: 2006/2017 - Hospital System merger 2009 - SG Leader dedicated position - IPNG no cost to the organization - Program already funded	- Lack of implementation SG evaluation - Limited SG Implementation History - Limited RN staff engagement in the process
Opportunities	**Threats**
- Increase SG education - Magnet essential component for structural empowerment; developing staff to achieve better outcomes - Identify areas for improvement - Initial evaluation of organization SG	- CNE Leader changes (Contract CNE) - Communication of practice across Hospital A and Hospital B - Evaluate inconsistent practice across Hospital A and Hospital B

All RN’s are stakeholders and would be impacted by a SG program evaluation, which is intended to measure the perception that nurses regard as shared governance and the feeling of

empowerment and autonomy. Using the CDC (2011) Worksheet 1B, "What Matters to the Stakeholders," questions were asked of individuals (Table 1 through 4). Of the eight individual meetings, the most common concerns were: If the SG meetings are producing results (6 out of 8 respondents); If there is participation and involvement in the SG meetings (5 out of 8 respondents); and If the hospital has achieved shared governance (2 out of the eight respondents). Also, the CNE requested a specific question to be asked of respondents, "Was there an impact from SG on the RN's professional practice?" Campbell, K. (2019, June 19) personal interview. The major themes that emerged from the stakeholders' assessment were:

- Results produced from SG meetings
- Level of participation and involvement in the SG meetings
- Level of achievement of SG
- Impact from SG on the RN's professional practice as requested by the CNE

These themes were the basis of the goals of the program evaluation, which were then aligned with the relevant measure.

Theoretical Framework

Kanter's Structural Theory of Power in Organizations

The theoretical framework for this scholarly project was Kanter's theory of structural empowerment (Kanter, 1993). This theory is particularly suitable as it provides a useful framework to examine factors in the nursing work environment that influences the way nurses respond to the work environment (Laschinger, 1996). According to Kanter, stuck people can be offered challenges, with the powerless granted more discretion over decision-making. This can cause a change in the job relationship (Kanter, 1993). In work empowerment in nursing, Kanter

(1993) described two systemic sources of power that exist in organizations, formal and informal power. (See figure 2).

Formal power is that which accompanies high visibility jobs and requires a primary focus on independent decision-making. Informal power comes from building relationships and alliances with peers and colleagues (Lanschinger, 1996). The six conditions required for empowerment to take place, according to Kanter, include the opportunity for advancement, access to information, access to support, access to resources, formal power, and informal power. (Wagner, Cummings, Smith, Olsen, Anderson, & Warren, 2010). These six conditions are what many organizational behaviorists have based their scholarship and research on. Kanter's theory can be used to support nursing leaders in creating structures such as SG to increase the accessibility of information and resources, strengthen the importance of workforce empowerment and present a rewarding work environment (Barden, Griffin, Donahue, & Fitzpatrick, 2011).

According to Kanter (1993), when there is a lack of access to resources, information, support, and opportunity, employees experience powerlessness (Kanter, 1993). To empower their patients, it is important the nurses themselves be empowered to accomplish their work in a meaningful way (Laschinger, Gilbert, Smith, & Leslie, 2010). Kanter (1993) maintains that individuals with a high degree of formal and informal power have increased access to structural lines of power and opportunity. The degree of access to these lines influences work attitudes and behaviors and, thus, work effectiveness behaviors.

Definition of Terms

- *Shared Governance (SG)*: "nursing management model that gives clinical nurses control over their practice while extending their influence over the resources that support it" (Hess, 1998).
- *Traditional Governance:* "bureaucratic models, characterized by centralized decision-making, with professional models that are distinguished by an independent authority for decision-making" (Anthony, 2004).
- *Self-Governance:* "workgroups, who are jointly responsible for achieving goals, lead themselves and thus have authority and control over the work and access to information" (Anthony, 2004).
- *Empowerment*: "individuals having the power to accomplish their work in a meaningful way" (Laschinger, Gilbert, Smith & Leslie, 2010).
- *Program Evaluation*: "systematic collection of information about activities, characteristic and outcomes of programs to make judgments about the program, improve the program effectiveness, and/or inform decisions about the future program development" (CDC, 212, p.1.).

Review of Literature

Search Strategies for Review of Literature

The Preferred Method Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guideline was the framework used for this review (Moher, Liberati, Tezlaff, Alman, & PRIMA group, 2009) (Figure 4). A comprehensive electronic review was conducted primarily from three electronic databases: PubMed, CINAHL, and Web of Science. The search strategy was created with the assistance of the UVA research librarian to ensure the broadest and most

comprehensive search. The year of publication was not restricted, and any article with an abstract in English was reviewed. Search terms included “shared governance,” “nursing," and “evaluation." All searches were conducted using the key term as follows "shared governance" AND nurs* AND (measurement OR assessment OR evaluation).

For the gray literature search, a predefined four hours of search using Google Advanced Search for articles and guidelines published by national bodies such as the American Association of Critical-Care Nurses (AACN) was undertaken. The search was set to find literature involving the same key terms.

The database searches revealed 102 total articles from PUBMED, 49 articles from CINAHL, six articles from Web of Science. After excluding duplicate articles, 82 potentially relevant articles remained for shared governance. The remaining articles were screened for an evaluation of the SG model in a community hospital setting, and all large academic settings were removed. Only four articles had the pertinent characteristics for this SG program evaluation in community hospital settings. These were selected for review.

Review of Literature

The following provides the results of four published studies that were appraised for findings related to evaluations of a RN’s perception of shared decision-making perception in a community hospital setting. There are a limited number of studies that provided an evaluation of shared governance in a community hospital setting; much of the evidence was on the implementation of SG, not evaluation. Four studies (one quasi-experimental, pretest/posttest, cross-sectional design; one prospective two-group comparative design; one descriptive comparative design, and one descriptive correlation design) were included.

Barden, Griffin, Donahue, and Fitzpatrick (2011), performed a descriptive correlational design study to examine the relationship between perceptions of SG and empowerment in nurses working in a SG model. The author's response rate out of all clinical RNs, approximately 348, with a total number of participants was 158 nurses. The participants in this study completed two surveys the Index of Professional Nursing Governance (IPNG) using the 2.0 version, 86-item IPNG survey and the Conditions of Work Effectiveness II Questionnaire (CWEQ-II). Descriptive Statistics (Means and Standard Deviation) are presented for total scores & subscores of the IPNG and CWEQ-II survey. The overall score on the IPNG was 157.61, indicative of traditional governance. The total score on the CWEQ-II was indicative of moderate levels of empowerment. A Pearson correlation coefficient on the sum of the IPNG and the CWEQ-II revealed significant relationships among the variables. Results support that when SG increased, so did empowerment (Barden, Griffin, Donahue, & Fitzpatrick, 2011).

Di Fiore, Zito, Berardinelli, Bena, Morrison, Keck, Kennedy, Stibich, and Albert (2018), performed a nonequivalent, two-group comparative design to evaluate the differences in the shared decision-making perceptions of clinical nurses between the initial implementation of a SG model and perceptions three years later in a 500-bed community hospital. A convenience sample of clinical RNs was recruited by placing a paper 86-item IPNG survey in their unit mailboxes. Attached to the IPNG survey was a research information sheet that explained the purpose, risks, and confidentiality and a pre-addressed envelope to return the survey when completed (DiFiore, Zito, Berardinelli, Bena, Morrison, Keck, Kennedy, Stibich, and Albert, 2018).

The author's survey response rate out of all 734 clinical RNs, invited to participate, excluding all nurse leaders were 106 in 2012 and 197 in 2015. The total for both years was 303 returned surveys. The author noted in the demographics that the nursing characteristics differed

from the two groups. In 2015 the participants were younger, had fewer years as a nurse, and at surveyed hospitals were less likely to participate in the hospital unit practice councils, and had differing role specialties. The author wanted to answer two questions to compare 2015 data to 2012; 1) what nurses' perceptions of involvement in the hospital were, and 2) clinical decision-making, and after adjusting for nurse characteristics that differed between each group, is there any difference in decision-making (DiFiore, Zito, Berardinelli, Bena, Morrison, Keck, Kennedy, Stibich, and Albert, 2018).

The authors found the total IPNG scores increased from 2012 to 2015, even with a decrease in unit council participation. The limitation described that an 86-item survey tool is a long tool, leading to not completing the survey, and because a convenience sample was used, those RNs that have a strong SG structure may have been more likely to complete the survey. The authors suggest that shared decision-making should be part of the nursing environment and support that leaders need to emphasize and increase clinical nurse decision involvement (DiFiore, Zito, Berardinelli, Bena, Morrison, Keck, Kennedy, Stibich, & Albert, 2018).

Dechairo-Marino, Collins Raggi, Mendelson, Highfield, and Hess (2018) performed a quasi-experimental, pretest/posttest cross-sectional study to describe the level of SG among all RNs (RN) in a 377-bed Magnet designated, Catholic community medical center. A convenience sample of all part-time and full-time RNs regardless of title and position were sent using the Qualtrics electronic survey platform, the 86-item IPNG survey. The authors had two research questions after a redesign of SG structure and process: 1) will this improve RN reported SG and 2) would personal and work-related nurse characteristics affect RNs report of SG (Dechairo-Marino, Collins Raggi, Mendelson, Highfield, and Hess 2018).

The original 86-item IPNG survey was completed in 2014 and results were used to adjust SG structure and processes (intervention). In 2015 a post-intervention survey was completed using the same instrument. The pre-intervention response rate was 240 out of 740 RNs completed the survey (33%), and the post-intervention response rate was 222 out of 839 RNs completed the survey (29%), but with adjustments, the rate was 26%. The author found that the demographics for both pre- and post-survey were almost identical (Dechairo-Marino, Collins Raggi, Mendelson, Highfield, and Hess, 2018).

The results of the level of SG found by the author before the intervention was a mean score of 169.5, which was within the traditional governance range, as were three out of the six subscales. In the post-intervention, the overall IPNG score was 183.8, and five out of the six subscales were within the SG range indicating success from the restructuring made after the initial IPNG (Dechairo-Marino, Collins Raggi, Mendelson, Highfield, & Hess, 2018).

Weaver, Hess, Williams, Guinta, and Paliwai (2018) performed a descriptive comparative study to evaluate if a new shared decision-making structure was in place for 18 months, what was the extent of perceived shared governance. A hospital system comprised of six hospitals conducted a SG evaluation using the 2.0 version, 86-item IPNG survey in both 2012 and 2015. The author did not indicate the method of survey distribution – paper or electronic or total sample number of participants. A table showed results of the surveys with 469 RNs responses in 2012 and 326 RNs participant responses in 2015. Both surveys indicated overall governance as traditional. A needs assessment was conducted to find areas to focus on to improve shared governance, to explore why the hospitals were still in traditional governance (Weaver, Hess, Williams, Guinta, and Paliwai, 2018).

The author identified what strengths, weaknesses, opportunities, and threats there were to the current SG model. A task force was assembled, and these were the top five found to address; 1) provide additional education on shared governance, 2) improve communication, 3) improve unit-based council meetings, 4) increase night shift involvement, and 5) increase nurse participation. After 18 months, a reevaluation was completed using the 3.0 version, 50-item IPNG survey. The results showed that all six hospitals had moved over into the range of SG with an overall score of 103.84 (101 – 200), with an increase in survey response of 599 RNs (Weaver, Hess, Williams, Guinta, and Paliwai, 2018).

The survey results shown were in a table that indicated SG in four subscales: 1) Clinical staff perceive access to information score was 19.85 (19 - 45); 2) Influence over resources supporting their practice score was 24.74 (19 - 36); 3) Control over their practice score was 15.62 (15 – 28), and 4) Ability to set goals and resolve conflict score was 11.09 (10-20). It was noted from the table that two subscales are measured as traditional governance: 1) Control over personnel 16.55 (25-48) and 2) Participation in committee structures 15.99 (17 – 32). The author stated that a survey would be conducted in 2019, continuing to support the new SG decision-making structure (Weaver, Hess, Williams, Guinta, & Paliwai, 2018).

Gaps in the Literature

The review of the literature revealed a depth of literature on SG implementation but a dearth on SG program evaluations. The literature review illustrated that SG evaluations were in large, academic hospital settings with limited literature found in the community hospital setting.

In 1994, the 86-item IPNG was created, allowing measurement of professional governance, a concept of traditional governance, shared governance, and self-governance (Weaver et al., 2018). The IPNG instrument was used in three of the four studies in this review.

In 2017, the author of the IPNG instrument reduced the number to 50-items while maintaining its validity and reliability (Weaver et al., 2018).

Summary of Literature Review

Four studies that reported evaluation of SG in a community hospital setting were reviewed, including three of the four studies that utilized the IPNG as the primary instrument. The major findings were that studies supported the evaluation of SG programs, and nurse leaders must continue to identify and sustain new ways to empower nurses. This review revealed that systematic program evaluations of SG structures or councils were underutilized or underreported. A limitation of the studies was participation in completing the IPNG survey due to overload from competing surveys in which nurses were expected to participate.

Four studies (one quasi-experimental, pretest/posttest, cross-sectional design, one prospective two-group comparative design, one descriptive comparative design, and one descriptive correlation design) were included.

CDC Step 2. Describe the program.

The SG program evaluated in this program evaluation was initiated in 2006 in one community hospital (hospital A) in northern Virginia and hospital (Hospital B) in 2017. Hospital A has 130 beds and Hospital B has 60 beds with a combined nursing workforce of 464. All RNs included those representing critical care, maternal-child, behavior health emergency department, surgical services, medical/surgical services, float pool, and administration. The nursing staff worked in both facilities, working either eight or twelve-hour shifts.

In order to meet the goal of achieving the ANCC Magnet recognition, a previous Chief Nursing Executive (CNE) in Hospital A, chose to implement a SG program. The implementation of SG began in 2006 for Hospital A in preparation for Magnet designation submission. In 2009, a

merger occurred with a large healthcare system. Hospital B was built and opened in 2014. The senior leadership CNE and RNs were shared between the two hospitals. The CNE decided to combine both SG programs several years later in 2017. The goal of combining the SG councils was to strengthen the program and relationships between RNs in both hospitals

According to this corporate healthcare system SG policy, the aim of SG was to provide a designated structure to empower the voice of nurses. All hospitals within this healthcare system were guided to participate in SG, but not all councils needed to be implemented, and combining councils was acceptable within the health system.

The councils were composed of nurses from all levels, including direct care team members and nurse leaders. The council leadership consisted of a Chair, Co-Chair, and facilitator. The roles and responsibilities of the Chair / Co-chair in the absence of chair were to serve for a minimum of one year, develop agendas, lead meetings, and ensure minutes were documented and approved. Also, council chairs had to attend the monthly coordinating meeting with the CNE. The facilitators' roles and responsibilities were to mentor the council leadership, ensure the work of the council was completed promptly, remove any barriers to work completed, and ensure the council work remained in their scope.

The general guidelines for the SG Councils at the practice site were that members were expected to be active participants and attend a minimum of 75% of meetings. Each council member was responsible for disseminating information from a variety of venues, which may include the organizational nursing home page, newsletters, and department huddles. The expectation for the members was that they report back information to their unit shared governance council.

There are a variety of shared governance models, with the four most popular being congressional, administrative, unit-based, and councilor models. The councilor model is where the councils make practice-related decisions (Yanko, Hardt & Bradstock, 1995), and that model was used in the SG combined councils that were evaluated. The combined SG Council for Hospital A and Hospital B met monthly for two hours. The Coordinating Council met the following day for four hours.

The SG combined councils met in two different conference rooms with access to technology to video conference between the hospitals. During the meeting, the agenda was on the table for members, an attendance roster (hospital A) was passed around, and member names were written in if members were present, on the video conference (hospital B). Minutes from the previous meeting were discussed and current council meeting minutes were written by administrative staff if present. Robert's Rule of Order were followed in the council meetings.

The SG Councils were responsible to consistently communicate and implement approved nursing processes and policies, review data and information to facilitate the use of the best practice, integrate and promote research and evidence-based practice, and facilitate communication between clinical nursing and leadership(Figure 3). The combined SG councils at Hospital A and Hospital B were:

- Nursing Coordinating Council (CC)
- Nursing Research Council (NRC)
- Nursing Professional Practice and Development (PP&D)
- Nursing Safety and Quality (S&Q)
- Nursing Partners (PC)

The CC was made up of facility chairpersons who were the organizing and directing body of SG activities that directly impacted professional practice, professional development, and the work environment of nursing. This council reported to the CNE.

The NRC promoted research and evidence-based activities related to clinical nursing practice. Council members identified and worked collaboratively with others to achieve positive patient outcomes. Decisions were made via a majority vote and forwarded to the CC.

The PP&D Council coordinated processes for defining, implementing, maintaining, and evaluating educational standards. These were completed by promoting professional growth, professional development, and ongoing evaluation on the unit and departmental levels. The council recommendations were made and then brought to the CC.

The S&Q council monitored and evaluated quality indicators to ensure positive patient and organizational outcomes. Decisions were made via a majority vote and forwarded to the CC.

The PC purpose was to recognize excellence in practice, support nursing community outreach, and nursing recruitment: retention and employee engagement. Decisions were made via a majority vote and forwarded to the CC.

The councils each had a distinct purpose, but a common goal was to support the mission, vision, and values of the organization. The council leadership members were elected, volunteered, or appointed into the positions. The long-term effect of this program was to provide a dynamic framework for the empowered voice of nursing. It facilitated collaboration and shared decision-making among the interdisciplinary team to provide a remarkable patient experience within an environment that is safe, caring, and quality focused. The medium-term outcomes were a monthly meeting to address professional practice needs. The short-term outcomes were to increase support and empower nurses on their units on a day to day basis.

CDC Step 3. Focus the evaluation design.

The third step of the CDC Framework used the stakeholders' input and assessment of the program elements to then focus on the evaluation design. The stakeholders' needs, data sources, and feasibility considerations of resources available to perform this evaluation were reviewed. A meeting with stakeholders to clarify the intent and purpose of the data collection was held. Based on the stakeholder assessment, the Doctoral of Nursing Practice (DNP) student investigator identified the following questions that will be answered in this program evaluation:

1. Are the SG meetings generating results?
2. Is there participation and involvement in the SG meetings?
3. Have Hospital A and Hospital B achieved shared governance?
4. What was the impact of SG on nursing professional practice?

Question 1. A retrospective review was conducted for two-months to review all projects completed from all five SG councils for a two-year time period of January 2018 through December 2019. The historical SG archives were obtained from practice site nursing shared drive: SG folder through the assistance from practice site mentor.

Question 2: The same retrospective review of all SG agendas, minutes, attendance rosters was used to address this question.

Question 3: The IPNG, as developed and revised by Hess (1995), was used as the measure of SG perception across both hospitals. The IPNG survey was distributed to all 464 RNs through email with the Qualtrics link provided by the Magnet program manager.

Question 4: As a major stakeholder, the CNE requested a specific question of "What was the impact of SG on nursing professional practice?" This was added to section one of the IPNG survey tool. The use of a 5-point Likert scale of no impact, minor impact, neutral, moderate

impact, and major impact was used to measure the RN response. The response on the continuum of no impact to major impact indicated to what extent the participant perception of impact that SG had on his or her professional practice.

A descriptive design was used to evaluate the response of nurses to the IPNG survey. A Qualtrics link to the Survey was sent to the Magnet Program Manager. The Magnet Program Manager, on behalf of the CNE, sent an email with a survey link to all RNs(Figure 7). This was a baseline assessment of the perception of shared governance for the practice site combined SG program.

Approval of Project

Conversations with the SG Nursing Research Council and Health system nurse researcher were required for approval for the DNP student investigator to conduct the evaluation. (Figure 6) These conversations revealed no barriers to implementation, only the invitation to present to the Nursing Research Council (NRC) after the program evaluation was completed. The author of the IPNG, Robert Hess, approved the use of the survey tool after a phone call to confirm status as a DNP student. (Figure 5).

CDC Step 4. Gather Credible Evidence.

1. Are the SG meetings generating results?
2. Is there participation and involvement in the SG meeting?
3. Has the hospital achieved shared governance?
4. What impact has SG had on nursing professional practice?

The data source for the first and second questions was a retrospective review of SG Council minutes and agendas along with attendance rosters for a two-year period. All minutes were evaluated for the progress of projects, communication, and dissemination methods. A

review of all five SG councils was completed from the period of January 2018 through December 2019.

The IPNG survey was the data source used to answer the third question: “Has the hospital achieved shared governance?”. A link was provided to all 464 RNs employed in the two hospitals. Qualtrics (version 2019; Provo, Utah), an electronic secure survey platform, was used to collect and analyze IPNG data. Prior to the deployment of the survey, the DNP student investigator, the Magnet coordinator, the SG council member, and nurse leader were sent the survey to ensure the link worked, review questions and assess time to complete. Two of the four were able to complete the survey and reported that it functioned properly and took twenty minutes to complete. The nurses were provided time and supported to complete the survey by the administration. During the 2019 annual system-wide nursing skills validation, computers were set up to complete the IPNG survey. The nursing staff were provided the time and computer access to complete the IPNG survey on a volunteer basis.

Quantitative data were obtained using the IPNG survey tool. The 50-item IPNG survey was developed by Robert Hess (2017) and used with his permission. The IPNG was designed to measure an organization’s progress in the implementation of SG by focusing on governance, an essential multidimensional concept that includes the structure and processes by which participants in the organization direct, control, and regulate the many goal-oriented efforts of one another (Hess, 2011). According to Hess (1998), the IPNG measures the governance of RNs and is based on a model of governance that encompasses the following six subscales:

1. Control over personnel
2. Access to information
3. Influence over resources

4. Participation in committee structure
5. Control over practice
6. Goal setting and conflict resolution

The 50-item IPNG survey was used in this study (Figure 8). The survey was developed to assess the degree of professional nursing governance as perceived by nursing personnel on a continuum from traditional, to shared, and self-governance. It included six subscales and 50 items of professional governance including; control over personnel (12 items), access to information (9 items), influence over resources (9 items), participation in committee structures (8 items), control over practice (7 items), and goal setting and conflict resolution (5 items). Scores for the full scale and subscales were computed by summing the responses of each respondent across all 50 items or items comprising each subscale. The IPNG contains six subscales and a composite score that encompasses all subscales. Participants respond to each item on a 5-point Likert scale:

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

The scores for the full scale and subscales are computed by summing the responses of each nurse across all the 50 items or items comprising each subscale. The scoring scheme described indicates that a very low score has a propensity for traditional governance and a very high score indicates a propensity for self-governance (Lamoureux, Judkins-Cohn, Butao, McCue, & Garcia, 2014).

The author gave permission to make changes to only the demographic section of the IPNG survey. The DNP student investigator made these changes to the IPNG:

- Added location Hospital A and Hospital B
- Changed age from a fill in to ranges
- Added per diem to employment status
- Changed types of nursing units
- Added level of participation in SG at the unit or hospital level
- Added the question, "What impact has SG had on nursing professional practice?"

The fourth question was asked exclusively by the CNE, to measure the impact of SG on the RNs' professional practice and was added to section one. To measure impact, a 5-point Likert scale was used with the participants response to the question "what impact has SG had on nursing professional practice," by selecting one of the following:

1 = No Impact

2 = Minor impact

3 = Neutral

4 = Moderate Impact

5 = Major Impact

Protection of Human Subjects

The DNP student investigator met with the healthcare system Nurse Researcher and obtained a letter of authorization to conduct a program evaluation study at both hospitals. Exempt status was received from the practice site Institutional Review Board (IRB). A consent script was required as part of the electronic survey that went to Hospital A and Hospital B RNs. To maintain privacy and confidentiality, participants had no identifying information displayed.

Methods

These methods were used to gather the evidence for this program evaluation. Questions 1: Retrospective review of available minutes were reviewed for project completion for the five SG councils. Data were retrieved from the historical SG archives and were obtained from practice site nursing shared drive: SG folder through the assistance of practice site mentor. Question 2: The same retrospective data review was conducted with a review of available agendas, minutes, and attendance rosters. Review of these minutes provided data on plan for SG, and on communication of projects and dissemination methods.

Question 3: Each item of the survey was scored using a 5-point Likert score. After calculating the total governance score which included all 50-items on the IPNG survey, a subscale key to factor analysis derived subscales provided by Hess was utilized for the six subscales. (Figure 9).

The first subscale was control over personnel and contained 12 questions that focus on who has the responsibility to control personnel. These items addressed hiring, promotion, and evaluation of nursing staff. This subscale also addressed salaries, benefits, unit budgets, and the creation of new positions, along with disciplinary actions and the termination of personnel (Hess, 2017). A benchmark score of 25 - 48 for this subscale marked the achievement of SG but a lower score in the range trended towards traditional governance.

The second subscale, access to information, contained nine questions that assess the nurse's opinion of who has access to the information needed for governance of the organization. This subscale included questions about opinions of providers, staff, managers, and patients; budgets and expenses of the unit/department; goals and objectives that have been established for the unit/department; and organizational strategic plans, financial health and compliance (Hess, 2017). A benchmark score of 19 – 36 for this subscale marked the achievement of SG according

to the IPNG instrument (Hess, 2017), but a lower score begins to fall towards traditional, not shared governance.

The third subscale, influence over resources, measured who within the organization influences resources that support professional practice. This subscale included 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, 2017). A benchmark score in the range of 19 - 36 marked the achievement of SG according to the IPNG instrument (Hess, 2017), with a score in the lower range showing a trend towards traditional governance.

The fourth subscale, participation in committee structures, measured the perception of those who create and participate in committees related to governance. A benchmark score of 17 - 32 for this subscale marked the achievement of SG according to the IPNG instrument (Hess, 2017), but a lower score begins to fall towards traditional, not shared governance.

The fifth subscale, control over practice, encompassed seven items that assess the nurse respondents' opinion about patient care standards, policies and procedures; products used to deliver quality patient care; staffing levels, qualifications, and educational requirements; and the translation of research into practice (Hess, 2017). A benchmark score of 15 - 28 for this subscale marked the achievement of SG according to the IPNG instrument (Hess, 2017), but a lower score trended towards traditional, not shared governance.

The sixth subscale, goal setting and conflict resolution, contained five questions that measured the nurses' view on philosophy, departmental and organizational goals, negotiation and conflict resolution among professionals, hospital personnel and managers, and the existence of a formal grievance procedure (Hess, 2017). A benchmark score of 10 – 20 for this subscale

marked the achievement of SG according to the IPNG instrument (Hess, 2017), but a lower score trended towards traditional governance.

Question 4: The 5-point Likert scale evaluated the final question if SG had an impact on the RNs professional practice that used a scale of no impact to major impact.

Results

SG was implemented in Hospital A in 2006 and then combined SG councils with Hospital B in 2017. Four questions were to be answered at the completion of this SG program evaluation. To answer questions one and two, the combined five SG councils' CC, NRC, PP&D, S&Q and PC minutes were reviewed from January 2018 until December 2019 (Table 4). For question 3 the IPNG survey was analyzed (Table 6), and to answer question 4, an item was inserted in the demographics section of the IPNG survey.

Questions 1: Are the SG meetings generating results?

To determine if the five SG councils were producing any results, a review for a two-month period of all available council meeting minutes for January 2018 until December 2019 was conducted (Table 4). The review of all five SG council minutes for 2018 was examined for presence of completed projects and revealed that a combined ten projects were completed for 2018. The SG council that completed the majority of projects was the PP&E council, with four projects completed. The review of all five SG councils for 2019 was examined for presence of completed projects and revealed that a combined 14 projects were completed. During 2019, the majority of completed projects were generated by the RC, with six projects completed.

Question 2: Is there participation and involvement in the SG meeting?

To determine if the five SG councils had participation and involvement, a review for a two-month period of all available council meeting minutes, agendas, and attendance rosters for

January 2018 until December 2019 was conducted (Table 4). The review of the five councils SG minutes, agendas, and attendance rosters revealed:

For 2018, agendas, meeting minutes, and attendance rosters were filed 98%, 96%, and 46% of the time, respectively. For 2019, SG agendas, meeting minutes, and attendance rosters were filed 62%, 58%, and 40% of the time, respectively.

The overall corporate health system SG charter initial effective date was January 2018, with a review scheduled for January 2021. The general guidelines for councils were that members were expected to be active participants and attend a minimum of 75% of meetings.

This review could not determine if the councils were aligned with organizational and nursing strategic goals. The SG council activities focused mostly on department morale-boosting and community service projects. The SG councils did not identify goals and objectives on an annual basis or review goals to see whether or not they were met.

The project site did not offer a formal on-boarding program for new SG council leaders or members. The SG council members were not given a resource manual.

Each council member was responsible for disseminating information from a variety of venues, which may include the nursing home page, newsletters, and department huddles. The expectation for members was that they report back information to their unit SG committee.

Question 3: Has the hospital achieved SG?

The IPNG was distributed to all 464 nurse employees of Hospital A and B. After 15 days, an email reminder with the link was sent to the same group. Flyers were distributed to all nursing units with a flyer and URL code to access the IPNG survey. After 30 days, 149 surveys were returned for an overall response rate of 32%. However, 32 surveys were unable to be used in the analysis due to the absence of consent (3) or incomplete responses (29). Therefore, 117

surveys were available for analysis. All data were analyzed with SPSS (version 26.00 for Windows; SPSS Inc, Chicago, Illinois).

Of the participants who completed the IPNG survey, 105 were female (89.7%), 2.6% of the participants were between 18 – 24 years of age, 19.7% were between 25 and 34 years of age, 23.1% were between 35 and 44 years of age, 29.9% were between 45 and 54 years of age, 23.1% were between 55 and 64 years of age, and only 1.7% were above 65 years of age. The majority of the respondents (59%), had a Baccalaureate of Nursing degree (BSN), while 24.8% had an Associate of Nursing degree (ADN), 8.5% had a Master of Nursing degree (MSN), and 1.7 % had a Doctorate of Nursing degree (DNP). A majority of the respondents (65.8%), worked full time. The mean number of years in practice was 17.65 (*SD* = 12), with a range of 1 to 44 years. The mean number of years employed in the organization was 8.54 years (*SD* = 8.42).

The majority of RNs revealed that they were bedside nurses (77.8%), while 23.2% were non-bedside nurses. The respondents from the ten different types of nursing units were the Emergency Department (18.8%), Medical/Surgical (12.8%), Critical Care (20.5%), Telemetry (11.9%), and Surgical Services (12.8%). There were 35% of the respondents who had a nationally recognized specialty certification. Table 5 shows the results of the IPNG survey demographic data from both Hospital A and Hospital B.

Descriptive Statistics of IPNG Survey

The mean total IPNG score for the sample was 101.0 (*SD* = 26.4). Of the six subscales, influences over organizational resources, had the highest mean score of 25.5 (*SD* = 7.98). The goal setting and conflict resolution subscale had the lowest mean score at 10.59. Table 6 contains the means and standard deviations for the total IPNG full score and the six subscales.

The benchmark for SG in the IPNG survey was 101 – 200. The practice site total score of 101.00 fell within the benchmark. This result denoted a SG overall structure although in the low range (Hess, 2017).

These were the results for SG overall and for the six subscales: 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 for Hospital A and Hospital B SG combined program:

The mean score for the *overall SG perception score* was 101.0 (SD 26.44) for the practice site. A score of 101 – 200 represents the achievement of SG.

The practice site mean score for the *control over personnel* subscale was 16.06 (SD 6.39). A range of 25 - 48 represents the achievement of SG for this subscale, while a score of 16.06 represents the perception of traditional governance (Hess, 2017), not shared governance.

The practice score for *access to information* subscale was 18.06 (SD 6.83). A score of 19 - 45 represents the achievement of SG for this subscale, while a score of 18.06 represents the perception of traditional governance structure.

The practice score for *influence over resources* subscale was 25.35 (SD 7.98). A score of 19 – 36 represents the achievement of SG for this subscale, while the score of 25.35 represents the perception of the achievement of SG structure (Hess, 2017).

The practice site mean score for *the participation* in committee structure subscale, was 16.48 (SD 5.38). A score of 17 – 32 represents the achievement of SG for this subscale, so this survey's score of 16.48 represented a traditional governance structure.

The practice site mean score for *control over practice* was 14.15 (SD 5.58). A score of 15 – 28 represents the achievement of SG for this subscale, while the score 14.15 represented a traditional governance structure.

The project site mean score for the *goal setting, and conflict resolution* subscale was 10.59 (SD 4.14). A score of 10 -20 represented the achievement of the SG overall structure (Hess, 2017).

Question 4: What was the impact of SG on nursing professional practice?

Only 57 of the 116 nurse respondents answered the impact question indicating that SG had a moderate to major impact (49.1%) on their professional practice. The results were: 13 (11.2%) had no impact, 12 (10.3%) minor impact, 34 (29.3%) neutral, 41 (35.3%) moderate impact, and 16 (13.8%) had a major impact.

CDC Step 5. Justify Conclusions.

The analysis of the data collected to answer the four questions synthesized from stakeholder input led to four main conclusions.

For question 1 and question 2, in reviewing meeting minutes, agendas, and attendance rosters for all five SG council meetings, the DNP investigator observed that essential data were not integrated into the issues discussed at council meetings. Administrative support is essential for shared governance to be successful. The role of the nursing manager in shared governance is that of both a mentor and facilitator to council members. This evaluation revealed gaps in communication and several opportunities to improve the structure to support optimal SG.

The general guidelines for councils included the expectation that members be active participants and attend a minimum of 75% of meetings. In this evaluation, the investigator was unable to ascertain intended membership from each of the units. Also, the documentation did not

reveal a clear alignment of the SG Councils with organizational and nursing strategic goals. Council activities focused mostly on department morale-boosting and community service projects. Documentation did not show that the SG Councils identified goals and objectives on an annual basis or reviewed them at the end of the year.

The project site did not offer a formal on-boarding program for new council leaders or members nor were council members given a resource manual. The SG council meetings had a lack of consistency for minutes. The administrative duties required for the SG council meetings for documentation are important. An administrative assistant or proper instruction given on the documentation meeting tools could be a solution.

For question 3, the IPNG shows for Hospital A and Hospital B, there was overall SG in two out of six subscales: influences of resources and goal setting and conflict resolution. In four out of six subscales, SG was found to be in the traditional range: control of personnel, access to information, participation in committee structure, and control of practice. Several organizations using the IPNG instrument found the lowest scoring subscale in the survey was control of personnel (Anderson, 2011; Chavelle et al., 2013; Hess 2011). The results of the IPNG survey tool correlated with these findings. The lowest mean scores for individual items for this practice site were (1.22 - 1.48). The individual items revealed opportunities for target interventions aimed at improving overall scores.

Question 4 about the impact of SG on practice showed that 49.1% reported a moderate to major impact on their professional practice. Almost half of the respondents agreed that SG had a considerable impact on their professional practice.

The nursing leadership has been committed to provide the necessary resources to enhance the effectiveness of SG, as demonstrated by their willingness to provide the needed funds in the

budget to ensure participation in SG meetings and allowed planning for an off-site nursing retreat. Through the completion of this project, the importance of a champion within nursing leadership to speak on behalf of the importance of SG among hospital administrators was revealed. Nursing leaders are accountable for the environment in which RNs practice, and in SG, RNs and nurse leaders are provided the opportunity to exercise control over their professional practice (DeChairo–Marino, et al., 2018).

The CNE played an integral role but had other priorities that limited her mentoring of the newly appointed junior nurse SG chair. The role of the nurse manager in shared governance is that of both a mentor and facilitator to council members. From observations and discussion, there are very few active unit practice councils.

CDC Step 6. Ensure Use and Share Lessons.

The final step of the CDC Framework was to ensure the dissemination of the results to the necessary stakeholders. On March 11th 2020, a presentation to the hospital executive leadership committee was completed by the DNP student. Then a presentation to the SG Research Council with the suggestion for future studies was scheduled for March 26, 2020 but canceled per hospital leadership due to the COVID-19 pandemic mandate. A Zoom presentation will be scheduled in the future. An executive summary with the recommendations will be provided to the practice site. Finally, the practice site IRB exempt study protocol #19 -1419 will be closed (Appendix C).

Discussion

This program evaluation, with the combination of the IPNG survey and retrospective review to evaluate the shared governance current state, proved beneficial in identifying areas for improvement. For both hospitals, the perception of shared governance in Hospital A and

Hospital B was valuable to establish a baseline. This baseline IPNG survey can be used in the future as an outcome measure to implementation of the strategies to address the four subscales that measured below the shared governance range. As a measure of improvement, the IPNG survey has been used primarily as a measure of progress in the journey to reach shared governance and the actual progression of the nurses' perception of governance (Lamoureux et al., 2014). The findings will guide the nursing leadership team to improve this combined SG program for the organization. Shared governance is an evolving process. The responsiveness and support from nurse leaders as issues and challenges evolve, is required.

From the time of SG implementation in 2006, a total of five CNEs who represented the RNs at the executive level in the organizational decision-making, departed the organization. The practice site CNE for both Hospital A and Hospital B, during this program evaluation, was an interim CNE who had remained during the search for a permanent CNE that took two years. When there is a change in leadership, there can be different priorities set. The current SG council is one way that the RNs at this practice can make decisions for their professional practice. With a new organizational CNE, this program evaluation can support revisions needed to the current structure and processes. This program evaluation provides data for the SG leadership and members to review and make decisions to move forward to support the nursing staff and have more involvement in SG. The focus in SG is decisional involvement for the profession of nursing in an attempt to keep nurses satisfied with their job, increase performance, and decrease turnover. This requires continued research (Mangold, Pearson, Schmitz, Scherb, Specht, & Loes, 2006).

To determine if the current SG program was providing Hospital A and Hospital B with the professional practice needs, the program evaluation included the four standards outlined in

the CDC Framework, which are utility, feasibility, propriety, and accuracy. The results were made usable to the stakeholders; for that reason, the utility will be met. The use of the IPNG survey had a short timeline and used minimal resources, so the feasibility standard is met. The data used were de-identified so that propriety was followed. Lastly, descriptive statistics (means and standard deviations) were chosen for data analysis. Using statistical analysis is a systematic method that meets the accuracy standard (CDC, 2017).

In this program evaluation, the level of overall SG by RNs was present in these hospitals' combined SG program. This was evidenced by the overall score and 2 out of 6 subscale scores that were found to be in the SG range. Nursing leaders and clinical nurses have opportunities to be more engaged in improving essential structures that will enhance and maintain shared decision-making over time to enhance IPNG scores and SG.

Strengths and Limitations of the Program Evaluation

There were several strengths of the program evaluation. The use of the only validated SG evaluation survey tool was completed at no cost to the hospitals because a student was conducting the survey. There was support from nursing leadership by allowing each RN a minimum of twenty minutes to complete the IPNG survey as part of their regular duty hours. A resilient and sustained SG model is reliant both on staff nurses' decisional power, and leadership assistance (Gerard, Owens, & Oliver, 2016).

During the annual nursing validation week for both hospitals, the DNP student and mentor were available to encourage nurses to take a survey. A thorough and detailed evaluation of the current state of the SG program was completed. This evaluation provided insight into the areas to focus on improvement. The CNE and nurse leaders shared continued commitment to improve the SG program.

Several limitations related to the survey were noted. The survey was sent out using one link instead of sending it to individual emails. So, the participant had to open the link to access the survey, and if the survey was not completed, the participant had to start over. The results cannot be generalized outside these two hospitals.

Implications for Nursing Practice

As discussed in the first section, the purpose of this program evaluation was to complete a formal program evaluation of a SG model implemented in two community hospitals within a healthcare system. This program evaluation described the current combined SG model process and outcomes. The evaluation showed the current perceptions of SG by nursing staff, and those results potentially will be used to create strategies to improve on the SG structure to better meet the hospital's goals.

Scholarly Product for Dissemination

A comprehensive report will be submitted to the University of Virginia School of Nursing academic repository toward the completion of the Doctor of Nursing Practice Program. The study findings will be presented to the nursing leadership and Nursing Research Council. After the presentation, the SG chair will have access to all the references and data mentioned in the presentation. Findings from this study will guide the nursing leadership team to develop strategies to advance the nursing profession in improving structure and processes to support shared governance. A manuscript will be electronically submitted to the peer-reviewed journal, American Journal of Nursing, for publication according to the journal guidelines. A poster will be created and submitted for presentation at the Doctor of Nursing Practice Conference, Virginia Association of Doctor of Nursing Practice and American Nurses Association of Credentialing Center (ANCC) - National Magnet Conference.

Conclusions

The purpose of this program was to complete a formal program evaluation of a SG model implemented in two community hospitals within a healthcare system. Overall**,** this program evaluation highlighted several important findings. The IPNG survey revealed that the RNs perceived overall SG and two out of six subscales were in the SG range, although low. The RNs perceived the other four of the six subscales as more traditional governance. After an extensive review of SG documents revealed important opportunities to strengthen SG across this health system, strategies include opportunities to align SG councils with organizational goals/mission, provide consistent leadership, complete more structured onboarding provide consistent and stronger communication. Accurate documentation and continuous tracking of SG council projects started and completed can be used to show the value of the SG program to executive leadership and RNs that are unsure about joining the SG council. The impact on professional practice was below 50%, indicating a need to explore this in more in depth to understand why the RNs perception is not higher. Lastly, findings from this study will guide nursing leadership in developing strategies to improve structures and processes to support an enduring SG program. After improvements are made to SG, the IPNG survey can be used to measure scores and re-evaluate SG.

Program evaluations are necessary to determine if a program is meeting the intended outcomes. Once the evaluation data are reviewed, the nursing leader and SG chairs can review and make changes, as necessary. The IPNG survey can be used in future strategies to address the four subscales below the shared governance range. Future evaluations using the IPNG of both hospitals can further examine comparisons between nursing units.

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Table 1

CDC (2011) Worksheet 1B – What Matters to the Stakeholders I

Stakeholder	**Who is affected by the program, and What activities and/or outcomes of this program matter the most to them?**
Chief Nursing Executive (CNE)	The nursing staff will be affected by the program evaluation of SG - more specific the SG Committee chairs/members. The outcome of the SG program evaluation both survey and review of minutes to see where we can improve.
Nurse Leader #1	Nursing Leader #1 thinks the benefit of SG is knowing the bedside clinical nurses have a voice in their practice - is there shared governance in this hospital?
Nurse Leader #2	Nurse Leader #2 reported that what matters to her the most is patient safety and understands that the Safety and Quality council reviews practice issues.
Nurse Leader #3	Nurse Leader #3 reported what matters most to her is improving patient care. Each SG council has a purpose, but maybe they are not getting anything done - so evaluation of what the outcomes have been.
Registered Nurse #1	RN # 1 reported that what matters to her is the staff involvement.
Registered Nurse #2	RN #2 reported what mattered most to her was the increase in morale with recognition of nursing staff. Enjoyed during nurse's week 2019 that there was something done every day for their nurses like a great massage.
Registered Nurse #3	RN #3 reported what matters the most to her was the follow-up and followed through on information. She noticed that the council representatives bring things to their council, and then nothing is brought back. If there were more follow-up and follow-through, she might be more interested in getting involved.
Registered Nurse #4	What matters most to her was that the nurses have a voice to make a better work environment. So, if the councils are making a difference (being effective) or are just a place to complain. This information would be a marker of if she would invest her time and join the SG Council.

Note. Eight registered nurses selected by the organization leader.

Table 2

CDC (2011) Worksheet 1B – What Matters to the Stakeholders II

Stakeholder	What is important about the SG program to you, and what would you like the SG program to accomplish?
Chief Nursing Executive (CNE)	CNE reported that SG is a way to bring clinical nurses to solve professional issues. An evaluation has not been done since SG implementation, and that may be due to CNE turnover. The most important outcome of the evaluation is to see if shared governance is truly present and has it had an impact on the nursing staff's professional practice.
Nursing Leader #1	Answer the question is there really shared governance in this hospital - is anything being accomplished.
Nursing Leader #2	Concerned about the participation in SG councils. As the leader of several units, she sees that the outcomes of the SG council are to make an impact on nursing practice, SG program should give a voice to nursing staff to make changes.
Nurse Leader #3	She reported some people are only on the SG Council for clinical ladder points. The new Daisy Award - recognizing nurses has been great because recognition is important for nurses. Noted that more information about SG is needed because not all nurses are aware of the program.
Registered Nurse #1	She noted that facilitators (leaders) in SG need to be more engaged.
Registered Nurse #2	During the nurse's week 2019 that there was something done every day for their nurses like a great massage! She felt like someone cared, and it decreased stress on a busy day. I know that the SG councils coordinated the events.
Registered Nurse #3	RN #3 reported what matters the most to her was the follow-up and followed through on information. She noticed that the council representatives bring things to their council, and then nothing is brought back. If there were more follow-up and follow-through, she might be more interested in getting involved.
Registered Nurse #4	This information would be a marker of if she would invest her time and join the SG Council.

Note. Eight registered nurses selected by the organization leader.

Table 3

CDC (2011) Worksheet 1B – What Matters to the Stakeholders III

Stakeholder	**How will you use the results of this evaluation?**
Chief Nursing Executive (CNE)	She is excited about the results of the SG evaluation and will pass on the results to the next CNE.
Nurse Leader #1	Find out are the councils meeting monthly and are the meetings productive- leading to professional practice changes. Are the committee chairs listening to practice concerns?
Nurse Leader #2	She was concerned about the participation in SG councils - So, things can get done.
Nurse Leader #3	Communication to staff
Registered Nurse #1	Some have been "voluntold “to be there and are not fully engaged. (RN#1 selected as SG Chair) more talent management to have the right people on the committees if not voting
Registered Nurse #2	Share with other nurses
Registered Nurse #3	Share with other nurses
Registered Nurse #4	So, if the councils are making a difference (being effective) or are just a place to complain. This information would be a marker of if she would invest her time and join the SG Council.

Note. Eight registered nurses selected by the organization leader.

Table 4

Analysis of SG Agendas, Minutes, Attendance Rosters, and Projects from 2018 until 2019.

2018	**Research Council**	**Coordinating Council**	**Safety & Quality Council**	**Partners Council**	**Professional Practice & Education Council**	Total Present
Council Charter	Present	Present	Present	Present	Present	
2018 Agendas	(11/11)	(10/11)	(10/10)	(11/11)	(11/11)	53/54
	100%	91%	100%	100%	100%	98%
2018 Minutes	(11/11)	(9/11)	(10/10)	(10/10)	(11/11)	51/53
	100%	82%	100%	100%	100%	96%
2018 Attendance in rosters	(0/11)	(7/11)	(6/10)	(10/10)	(0/10)	23/52
	0%	70%	60%	100%	0%	46%
Completed Projects	1	0	2	3	4	10
2019	**Research Council**	**Coordinating Council**	**Safety & Quality Council**	**Partners Council**	**Professional Practice & Education Council**	Total Present
Council Charter	Present	Present	Present	Present	Present	
2019 Agendas	(8/9*)	(4/10*)	(6/10*)	(9/10*)	(9/10*)	36/49
	88%	40%	60%	90%	90%	73%
2019 Minutes	(9/9*)	(2/10)	(6/10*)	(9/10)	(2/10)	51/53
	100%	20%	60%	90%	20%	58%
2019 Attendance rosters	(0/9)	(8/10)	(4/10)	(8/10)	(0/10)	20/49
	0%	80%	40%	80%	0%	40%
Completed Projects	6	0	3	3	2	14

Table 5

Descriptive Information of the IPNG Survey Demographic Characteristics of Registered Nurses

Characteristics	n	%	M (SD)
Location			
Hospital A	96	82.10	
Hospital B	21	17.90	
Gender			
Female	105	89.70	
Male	12	10.30	
Age			
18-24	3	2.60	
25-34	23	19.70	
35-44	27	23.10	
45-54	35	29.90	
55-64	27	23.10	
65+	2	1.70	
Current position			
Beside nurse	91	77.90	
Not bedside nurse	26	22.10	
Years of practicing nursing	117		17.65 (11.72)
Years worked in organization	112		8.54 (8.42)
Years in present position	117		6.68 (7.17)

Note. n=117. M = mean. SD = standard deviation

Table 6

Descriptive statistics for overall IPNG and the six subscales (n total = 117)

Subscale	M	SD	Governance Classification	SG Range	Number of Items
Control Over Personnel	16.06	6.39	Traditional Governance	25 - 48	12
Access to Information	18.06	6.83	Traditional Governance	19 - 36	9
Influence Over Resources	25.35	7.98	**Shared Governance**	19 - 36	9
Participation in Committee Structures	16.48	5.36	Traditional Governance	17 - 32	8
Control Over Practice	14.15	5.58	Traditional Governance	15 - 28	7
Goal Setting and Conflict Resolution	10.59	4.14	**Shared Governance**	10 – 20	5
Overall	101.00	26.44	**Shared Governance**	101 - 200	50

Notes. M = Mean. SD = Standard Deviation. SG = Shared Governance. IPNG = Index of Professional Nursing Governance.

Table 7

Descriptive statistics for SG Impact on Professional Practice by Registered Nurses

SG Impact on Professional Practice	n	%
No Impact	13	11.2%
Minor Impact	12	10.3%
Neutral	34	29.3%
Moderate Impact	41	35.3%
Major Impact	16	13.8%
Total	**116**	

List of Figures

Figure 1. Centers for Disease Control and Prevention Framework for Program Evaluation in Public Health. MMWR 1999;48 (No. RR-11)

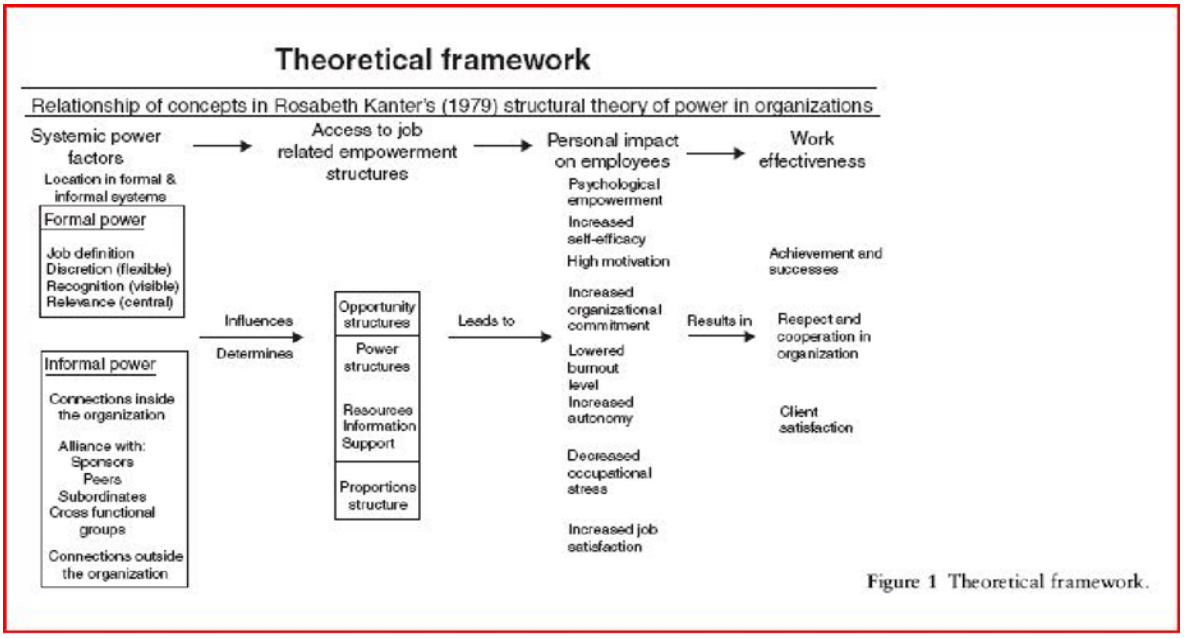

Figure 2. Relationships of Concepts in Kanter's Structural Theory of Power in Organizations

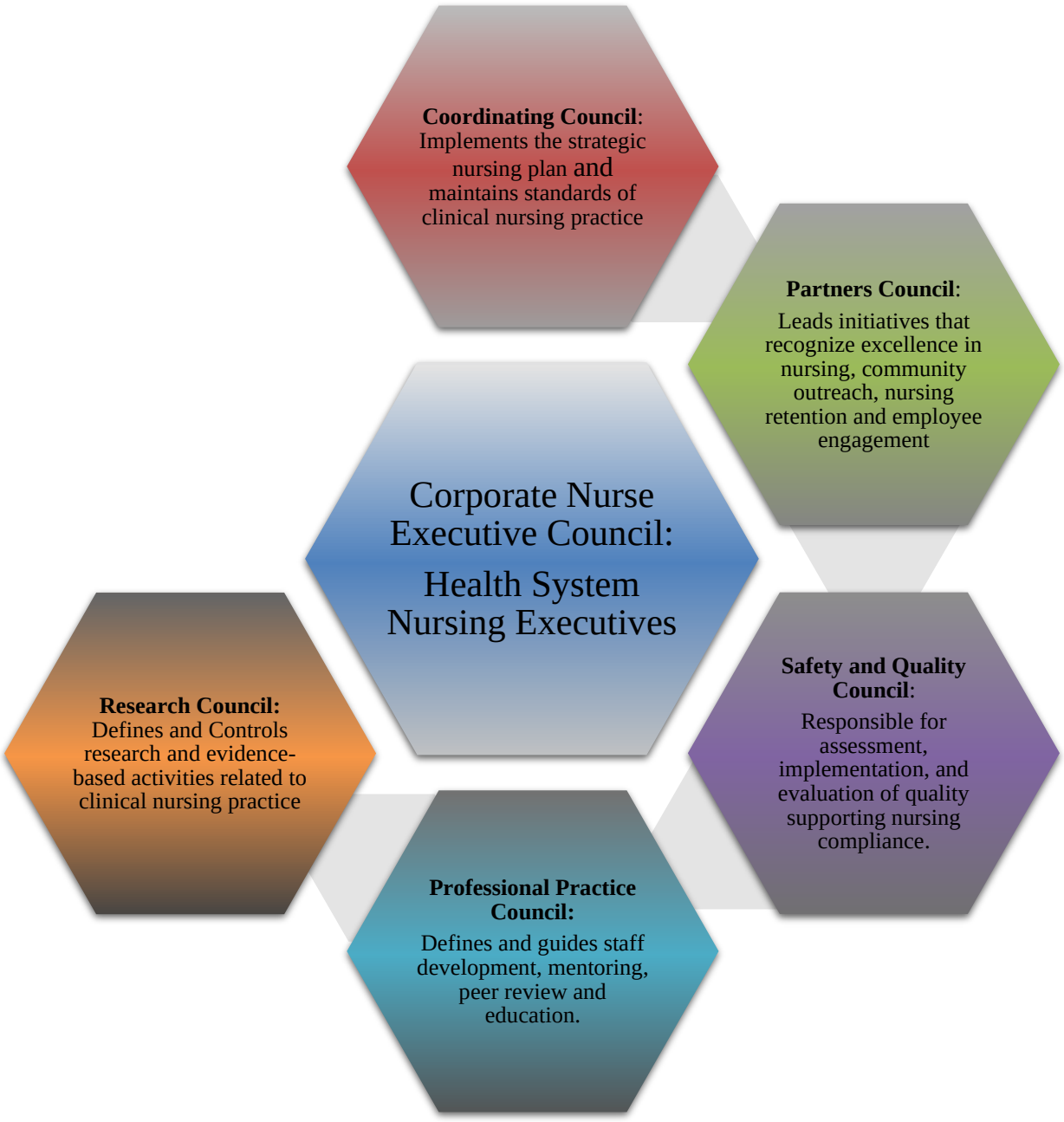

Figure 3. Practice Site Shared Governance Model

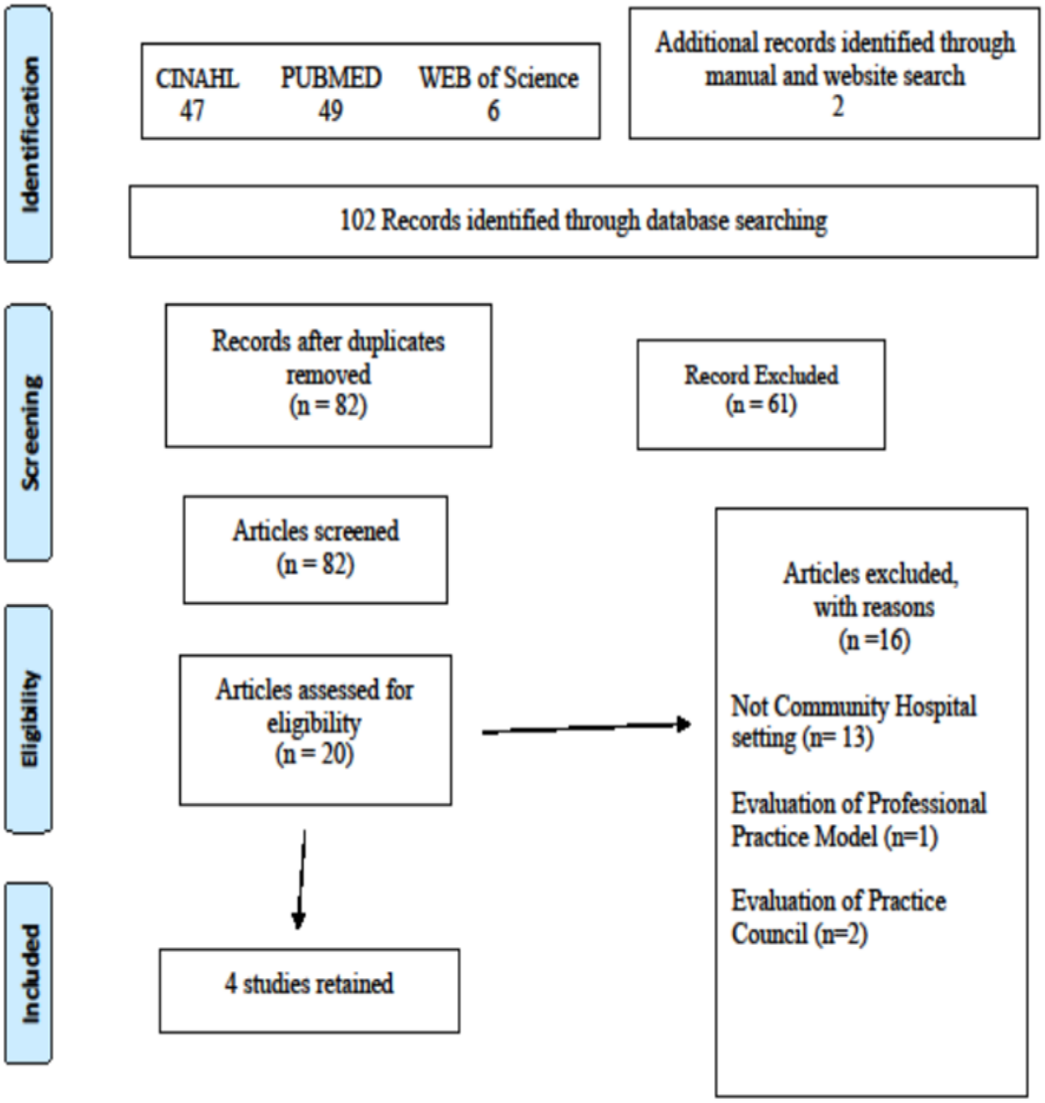

Figure 4. Literature Review Prisma Flow Diagram

FORUM FOR Shared Governance LLC
P.O. Box 8132
Hobe Sound, FL 33475
info@sharedgovernance.org
www.sharedgovernance.org

Robin L. Smith
UVA DNP student

June 17, 2019

Dear Robin:

You have permission to use my instruments, the Index of Professional Governance (IPNG), 2.0 or 3.0, the Index of Professional Governance (IPG), 2.0 or 3.0, for your DNP Study with University of Virginia at UVA Novant Prince William Medical Center (Manassas VA) and UVA Novant Haymarket Medical Center (Haymarket VA). In return, I require that you, upon request:

- Report summary findings to me from the use of the IPNG/IPG, including a 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.

I will email Word documents of the current versions of the IPNG/IPG, along with Scoring Guidelines. Because of your student status, I will waive all charges to register use of the instruments and scoring guidelines. You might want to revise the demographic section to reflect the organization and/or units you're surveying. You do not have permission to alter the individual items in any way, which would invalid the measurement of governance.

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 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, PhD, RN, FAAN
Founder & CEO, Forum for Shared Governance

Figure 5. Permission Letter for the Use of Survey Instrument from Author

University of Virginia
Claude Moore Nursing Education Building
225 Jeanette Lancaster Way
PO Box 800826
Charlottesville, VA 22908

Subject: Site Approval Letter

Dear Robin Smith,

This letter acknowledges that I have received and reviewed a request by Robin Smith, MSN, RN to conduct a research project entitled "*Perception of Shared Governance"* at Novant Health, and I support this research to be conducted in our organization.

When Robin receives approval for her research project from the Novant Health IRB, I agree to provide support for the approved research project. If we have any concerns or need additional information, we will contact Dr. Regina DeGennaro at the University of Virginia.

Sincerely,

Gloria A walters

Gloria Walters PhD, RN, RN-BC, CCRN-K
Nurse Scientist
Clinical Education
Novant Health
3333 Silas Creek Parkway
Winston Salem, NC 27103
Office 336-718-6033
Cell 910-730-3368
gawalters@novanthealth.org

*Figure 6***.** Letter of Authorization to Conduct Program Evaluation

Dear Nurse Participant,

In the fall, we have a UVA Doctor Nursing Student implementing a program evaluation on the perceptions of shared governance for Registered Nurses at both Hospital A and Hospital B. The project is projected to be open from 1 – 30 November 2019.
The Program evaluation consists of a 50-question survey and will take approximately 20 minutes. Participation is voluntary but is strongly encouraged. To participate in the program evaluation, click on the following link or copy & paste this link into your web browser. Qualtrics link Insert link here

The unit who has maximum participation completing the survey will receive a gift card to have a pizza celebration get-together after final results have been presented.

The findings based on this project's results will identify strengths and bring the recommendation to strengthen our shared governance structure.

Questions about the program evaluation can be directed to DNP student rls2bb@virginia.edu and/or Magnet Program Manager klgarrison@novanthealth.org

Thank you for your consideration in participating in this program evaluation,

CNE
Magnet Program Manager

Figure 7. Sample of letter sent to Registered Nurses

INPG Survey Instrument

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.

1. ***Which is your primary work location?*** Hospital A / Hospital B
2. ***What is your gender:*** Male / Female
3. ***Please select your age group:***
   18 – 24, 25 – 34, 35 – 44, 45 – 54, 55 – 64, 65+
4. ***Please indicate BASIC nursing education preparation:***
   Nursing Diploma
   Associates Degree in Nursing
   Baccalaureate Degree in Nursing
5. ***Please indicate the HIGHEST educational degree you have attained:***
   Associates Degree in Nursing
   Baccalaureate Degree in Nursing
   Master's Degree in Nursing
   Master's Degree in Nursing, Specialty
   Doctorate, Nursing
   Doctorate, Non-Nursing
6. ***Employment Status****?*
   Full Time, 36 – 40 hours per week
   Part Time, less than 36 hours per week
   PRN/Per Diem
7. ***Please specify the total number of years that you have been practicing nursing****:*
8. ***Please indicate you present nursing position:***
9. Bedside Nurse, Unit Leader, Supervisor, Director, or Other
10. ***Please indicate the type of nursing unit that you work on:***
    Critical Care, Maternal Child, Behavioral Health, Safety & Quality, Float Pool, Cath Lab and IR, Emergency Department (Includes CDU), Surgical Services, Nursing Administration, Medical/Surgical (ORTHO/ONC & OPI)
11. ***Please specify the number of years you have worked for the organization.***
12. ***Please specify the number of years you have been in your present position.***
13. ***Please specify any specialty certification from a professional organization (i.e. CCRN, CEN, etc.)*** CCRN, CEN, other fill in, None
14. Have you led or participated in a shared governance council? Yes / No
15. ***Please indicate to what extent shared governance has impacted YOUR professional practice:*** Rate Overall Impact. 1-No Impact, 2-Minor Impact, 3-Neutral, 4-Moderate Impact, 5-Major Impact
16. ***Please rate your overall satisfaction with YOUR professional practice within the organization*****:** Rate Overall Satisfaction. 1-Not at all Satisfied, 2-Slightly Satisfied, 3-Moderately Satisfied, 4-Very Satisfied, 5-Completely Satisfied

In your organization, please select 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 beside. 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 qualification for nursing positions. 1 2 3 4 5
4. Determining activities of ancillary nursing personnel
5. (assistants, technicians, secretaries). 1 2 3 4 5
   Conducting disciplinary actions of nursing personnel 1 2 3 4 5
6. Assessing and providing for the professional/educational development of the nursing staff. 1 2 3 4 5
7. Selecting products used in nursing care. 1 2 3 4 5
8. Determining models of nursing care delivery (e.g., primary, team). 1 2 3 4 5

In your organization, please select the group that INFLUENCES 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 II

9. Making daily patient assignments for nursing personnel 1 2 3 4 5
10. Regulating the flow of patient admissions, transfers, and discharges 1 2 3 4 5
11. Formulating annual budgets for personnel, supplies, equipment, and education 1 2 3 4 5
12. Recommending nursing salaries, raises and benefits 1 2 3 4 5
13. Consulting and enlisting the support of nursing services outside the unit (e.g., clinical experts, such as psychiatric or wound specialist, diabetic educators) 1 2 3 4 5
14. Consulting and enlisting the support of services outside of nursing (e.g., dietary, social services, pharmacy, human resources, finance) 1 2 3 4 5
15. Creating new clinical positions 1 2 3 4 5
16. Creating new administrative or support positions 1 2 3 4 5

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

17. Mandatory RN credentialing levels (licensure, education, certification) for hiring, continued employment, promotions and raises. 1 2 3 4 5
18. Organizational charts that show job titles and who reports to whom. 1 2 3 4 5
19. Written guidelines for disciplining nursing personnel. 1 2 3 4 5
20. Procedures hiring and transferring nursing personnel. 1 2 3 4 5
21. Policies regulating promotion of nursing personnel to management leadership positions. 1 2 3 4 5
22. Procedures for determining daily patient care assignments. 1 2 3 4 5
23. Daily methods for monitoring and obtaining supplies for nursing care and support functions 1 2 3 4 5
24. Procedures for controlling the flow of patient admissions, transfers and discharges. 1 2 3 4 5
25. Process for recommending and formulating annual unit budget for personnel, supplies, major equipment, and education. 1 2 3 4 5
26. Procedures for adjusting nursing salaries, raises, and benefits. 1 2 3 4 5
27. Formal mechanism for consulting and enlisting the support of nursing services outside the unit (e.g., clinical experts, such as psychiatric or wound specialist, diabetic educators). 1 2 3 4 5
28. Formal mechanism for consulting and enlisting the support of services outside of nursing. (e.g., dietary, social service, pharmacy, human resources, finance). 1 2 3 4 5

In your organization, please select the group that PARTICIPATES 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 IV

29. Participation in unit committees for administrative matters, such as staffing, scheduling, and budgeting. 1 2 3 4 5
30. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting. 1 2 3 4 5
31. Participation in interprofessional committees (physicians, other healthcare professions and departments) for collaborative practice. 1 2 3 4 5
32. Participation in hospital administration committee for matters such as employee benefits and strategic planning. 1 2 3 4 5
33. Forming new unit committees. 1 2 3 4 5

34. Forming new nursing departmental committees. 1 2 3 4 5
35. Forming new interprofessional committees. 1 2 3 4 5
36. Forming new administrative committees for the organization. 1 2 3 4 5

In your organization, please select the group that has Access to Information about 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 V

37. Compliance of nursing practice with requirements of surveying agencies (The Joint Commission, state and federal government, professional groups). 1 2 3 4 5
38. Unit and nursing departmental goals and objectives for this year. 1 2 3 4 5
39. Organization's strategic plans for the next few years. 1 2 3 4 5
40. Results of patient satisfaction surveys. 1 2 3 4 5
41. Physician/nurse satisfaction with their collaborative practice. 1 2 3 4 5
42. Current status of nurse turnover and vacancies in the organization. 1 2 3 4 5
43. Nurses satisfaction with their general practice. 1 2 3 4 5
44. Nurses' satisfaction with their salaries and benefits. 1 2 3 4 5
45. Management's opinion of the quality of bedside nursing practice. 1 2 3 4 5

In your hospital, please select 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

46. Negotiate solutions to conflicts among professional nurses. 1 2 3 4 5
47. Negotiate solutions to conflicts between professional nurses and physicians. 1 2 3 4 5
48. Negotiate solutions to conflicts between professional nurses and other healthcare Services (respiratory, dietary, etc.) 1 2 3 4 5
49. Negotiate solutions to conflicts between professional nurses and nursing Management. 1 2 3 4 5
50. Negotiate solutions to conflicts between professional nurses and organization's administration. 1 2 3 4 5

Figure 8. INPG Survey Instrument

Subscale #1, Personnel (12 items) - 5,11,12,15,16,17,18,19,20,21,25,26

Subscale #2, Information (9 items) - 37,38,39,40,41,42,43,44,45

Subscale #3, Resources (9 items) - 9,10,13,14,22,23,24,27,28

Subscale #4, Participation (8 items) - 29,30,31,32,33,34,35,36

Subscale #5, Practice (7 items) - 1,2,3,4,6,7,8

Subscale #6, Goals (5 items) - 46,47,48,49,50

Figure 9**.** Item Key to Factor Analysis-Derived Subscales (IPNG) 3.0 Short Form

Appendix A

Submission Criteria for American Journal of Nursing (AJN)

Writing for the American Journal of Nursing: Author Guidelines and Submission Checklist

Authors should carefully review these author guidelines.

AJN is a peer-reviewed journal that follows publishing standards set by the International Committee of Medical Journal Editors (ICMJE; **www.icmje.org**), the World Association of Medical Editors (WAME; **www.wame.org**), and the Committee on Publication Ethics (COPE; **www.publicationethics.org.uk**). *AJN* reaches more nurses than any other nursing journal through our robust print, digital and social media channels. It's the leading nursing journal viewed on Ovid and #5 overall.

AJN's mission is to promote excellence in nursing and health care through the dissemination of evidence-based, peer-reviewed clinical information and original research, discussion of relevant and controversial professional issues, adherence to the standards of journalistic integrity and excellence, and promotion of nursing perspectives to the health care community and the public.

AJN's readers are experienced clinicians, just over half are hospital-based; we also have a large readership among faculty and those in community health. Most (¾) have a BSN or higher degree; over 1/3 have masters or higher and over 40% are certified in their specialty.

AJN welcomes submissions of evidence-based clinical application and review papers, descriptions of best clinical practices, original research reports, case studies, quality improvement reports, narratives, commentaries, and other manuscripts on a variety of topics. The journal also welcomes submissions for its various departments and columns, including artwork and poetry that is relevant to nursing or health care. Guidelines on writing for specific departments—*Art of Nursing*, *Viewpoint* and *Reflections*—are available below. Authors who wish to submit photo essays should send a query letter to the editor-in-chief before submission.

All accepted papers undergo editing that includes fact-checking, reference checking, determinations of balance and accuracy, and line editing to enhance the readability and accessibility of the paper. Submission of a manuscript implies the authors' agreement to work on the manuscript with the editorial staff—on a continuing basis—during production. Poems and artwork are not edited. For more information on *AJN*'s editing process, go to **https://edmgr.ovid.com/ajn/accounts/Expect_from_editing.doc.**

QUERY LETTERS

We encourage authors to familiarize themselves with the journal in print or online at **www.AJNonline.com**. Query letters should include a paragraph describing the proposed manuscript, its projected length, an abstract and/or outline, and a short biographical sketch that includes the author's qualifications for writing on the topic. Do NOT send the manuscript. Query

letters should be sent to **diane.szulecki@wolterskluwer.com**. We do consider completed manuscripts without a prior query.

Authors may send query letters to an unlimited number of journals simultaneously. However, **it is not appropriate for authors to submit a manuscript to more than one journal at a time. We do not consider manuscripts that are being reviewed by another publication or previously published manuscripts. Authors who violate this standard of biomedical publishing will not be welcome to submit other manuscripts to the journal.**

SUBMISSION
The journal will only review manuscripts formatted according to the style of the American Psychological Association (APA; **www.apastyle.org**).

We do not accept submissions via email. **Authors must submit all manuscripts online at www.editorialmanager.com/ajn**. Log on to register and submit a manuscript. This is a secure site; *AJN* editors control access to all submissions. For questions about submitting a manuscript, contact Diane Szulecki, editor, at **diane.szulecki@wolterskluwer.com**.

To accommodate blinded peer review, authors enter their names and the names of their institutions directly into the website, as instructed, and that information will remain linked to their manuscripts but will not be visible to peer reviewers. **Do not** include names and affiliations anywhere on the manuscript itself (except for the cover letter).

The cover letter. Authors should submit a cover letter with each manuscript. The cover letter should include the following:

- a description of any other submissions or previous publications that might be considered redundant or that duplicates any part of the submitted manuscript. In this case, please include a link to an online version of the article.
- a statement about whether permission has been obtained for reprinting or adapting any tables, charts, illustrations, or other parts of the manuscript that have been previously published.

Conflicts of interest and authorship. *AJN* adheres to journalistic standards that require transparency and disclosure of real and potential conflicts of interests that authors, peer reviewers, and editors may have. All individuals listed as authors will be required to fill out the *AJN Author Agreement*. The corresponding author fills it out in the "Additional Information" step of the Editorial Manager submission process; co-authors fill it out via an email link that will be sent to them upon submission of the manuscript.

Photographs and art. Authors who submit original artwork or photographs should post clear images with the manuscript. If the paper is accepted for publication, high-resolution images will be required (see *Tables, Figures, Illustrations, and Photos* below for the specifications required). Authors must make sure that their artwork and photos will meet these requirements before submitting low-resolution images with the manuscript. Authors may also contact editor Diane Szulecki if they have questions or need assistance with the online submission of such materials.

REVIEW PROCESS

AJN uses double-blind peer review in the consideration of most manuscripts, including many columns. Some columns will receive internal peer reviews in which the authors' identities are known. The peer-review process provides authors and the journal editors with critiques and recommendations based upon expert knowledge. It doesn't ensure that manuscripts are accurate, free of plagiarism, readable, or balanced. As noted above, the journal edits accepted papers to ensure the quality and readability of the paper.

Initial reviews usually take three to four weeks from the date of submission, although expedited reviews can be provided for manuscripts with time-sensitive data. Authors who believe their manuscripts are time sensitive should contact editor-in-chief Shawn Kennedy, MA, RN, FAAN, at **shawn.kennedy@wolterskluwer.com** before submitting.

After editors evaluate the peer review responses, the author will receive notification of a decision by e-mail. Most of the manuscripts published in *AJN* require some revision before acceptance. Please note that a decision of "accept with revision" is not a commitment to accept the paper if the author fails to make the recommended changes.

A rejection may be appealed by e-mailing Diane Szulecki to request that she "initiate a rebuttal" so a revised paper can be posted. A cover letter to the revised manuscript should explain why the author is requesting review of another revision of the paper.

Authors can log on to www.editorialmanager.com/ajn at any time to check the status of their submissions. Authors who do not receive notice of a decision within eight weeks of submission may contact the editorial offices for an update on the manuscript's status.

Plagiarism. All direct quotes—including those from government sources, online publications, and publications that are in the public domain—must be presented as such, with quotation marks and appropriate citations. **Treating direct quotes otherwise will be considered plagiarism.**

All manuscripts undergo review via a plagiarism-detecting software program prior to acceptance. Manuscripts that contain plagiarism or have extensive poor paraphrasing will be rejected, even after acceptance. The journal highly recommends that authors review the journal's plagiarism policy at **www.editorialmanager.com/ajn** under "Author Guidelines" (or **http://edmgr.ovid.com/ajn/accounts/PlagiarismPolicy.doc**).

PREPARATION OF THE MANUSCRIPT

*********AJN* only considers manuscripts prepared in the format specified by the American Psychological Association (APA; www.apastyle.org), so, (author, year) in parentheses in text and alphabetical listing of references. **Do NOT use any reference formatting software (e.g. EndNote) in your submission.**

General Guidelines. Detailed descriptions of styles for various types of manuscripts are included below. Authors are encouraged to write in active voice, and first and second person are permitted as appropriate. Write for the experienced clinician. These are the nurses other nurses turn to for answers.

Presentation. Margins should be 1½" on all sides, left justified only. Type must be a minimum of 12-point font size. Double-space throughout and arrange the text in the following sequence: acknowledgments page; abstract with key words for indexing; main text; references; and figures, tables, and illustrations when appropriate. **Number the pages consecutively, in the upper right-hand corner. Number the lines continuously beginning with the main text.** Include a short title in the header of each page, just above the page number.

We encourage authors to use headings and subheadings throughout the manuscript. We also encourage the use of diagrams, tables, charts, illustrations, and photos; however, authors should **include these as attachments**, as opposed to placing them in the body of the text. Use generic drug names instead of proprietary names whenever possible. If it's necessary to use trade names, they should be capitalized and inserted within parentheses after the generic name on first mention. Thereafter, the generic name should be used, if possible. Product names should be treated likewise, with the manufacturer's full name and the city in which the product is manufactured in parentheses

Length. CE features, research, and QI papers generally run 5,000 words. Papers over 7,000 words are discouraged. Do not reduce font size to get the manuscript to under that amount. We prefer to advise authors on reducing length after their papers are peer reviewed. Columns are shorter, more tightly focused and generally run 2,000 – 3,000 words. *Viewpoint* and *Reflections* articles are 800 words.

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****Be judicious in citing references – it is often not necessary to cite multiple references for one fact; use one or two recent primary sources. On average, a 4,000 word paper should have no more than 30 references.**

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Clinical papers on health problems should include a discussion of the relevant epidemiology; assessments and diagnostics; medical treatments (including pharmacologic therapies) and their advantages, disadvantages, and nursing implications; the physical, psychosocial, and educational issues confronted by patients, families, and nurses caring for them; and sufficient detail on nursing interventions. Essentially, the reader will ask, "What can I take away from this piece that will improve the care I provide or my patients' lives?" Provide examples and specific details.

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Original research manuscripts should follow reporting guidelines endorsed by the ICMJE; the CONSORT Group (**www.CONSORT-statement.org**) for randomized clinical trials, including the checklist for authors (which can be found at**www.CONSORT-statement.org**); and the TREND Group's statement on Transparent Reporting of Evaluations of Nonrandomized Designs (**www.TREND-statement.org**) for studies with nonrandomized.

Reports on quantitative studies should include the following sections:

- A structured abstract that includes a statement of the problem and its significance, the study design, the sampling method, the variables examined, the most important finding(s), and most important conclusion(s)
- Introduction stating the problem and its significance
- Background or literature review
- Statement of the study aims, research questions, and/or hypotheses
- Methods, including study design; a statement showing institutional review board approval and procedures for obtaining informed consent from or for subjects; details of the sampling plan and instruments; and protocols or procedures (please include as an attachment a copy of the protocol if the research is an interventional study)
- Findings or Results, including flow of participants throughout the study using the CONSORT Group guidelines (the flow diagram of the CONSORT Group is available at **www.CONSORT-statement.org**); descriptive statistics with absolute numbers as well as summary statistics (for example, mean, SD, and percentages, as appropriate);and inferential statistics (for example, t test = 3.41; df = 10; P = 0.002) for all relationships tested.
- Discussion, including examination of the findings within the context of other research; limitations of the study; and recommendations for practice, policy, and future research.
- All data display charts must include actual data points; for example, bar graphs must include the actual end point datum for the bar. (See "Tables, Figures, Illustrations, and Photos" above.)

Reports on qualitative studies should follow the same format as above but with appropriate detail on and referencing of study approach, including design, sampling determinations, methods of data analysis, findings that include sample demographic data and qualitative data, and discussion of the findings within the context of prior research and theory.

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When you are ready to submit, please refer to the following checklist to ensure that you have all of the elements in place. Detailed information about all of these elements is provided earlier in this document.

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- Main text
  - Use APA format.
  - Number all lines using the Line Numbers feature in Word.
  - **Do not** use any reference formatting software such as EndNote.
  - **Do not** include author names or affiliations in the body of the manuscript, (except for in the cover letter).
  - Stay within word count limit for your article type.
  - Be sure to follow SQUIRE guidelines if submitting a quality improvement manuscript.
- Figures, tables, and photos (optional)

Appendix B

CITI Training Certificate

CITI PROGRAM

Completion Date 26-Sep-2019
Expiration Date 25-Sep-2022
Record ID 33236052

This is to certify that:

Robin Smith

Has completed the following CITI Program course:

Course in the Protection of Human Subjects Research (Curriculum Group)
Group 3: Nursing Researchers (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Novant Health

CITI
Collaborative Institutional Training Initiative

Appendix C

Letter of Authorization from IRB

Presbyterian Medical Center
200 Hawthorne Lane
Charlotte, NC 28204

DATE:	November 04, 2019
TO:	ROBIN SMITH, DNP, Nursing and Patient Care Kathleen Garrison, MSN, Nursing and Patient Care
FROM:	Vickie Zimmer, Director, Presbyterian Healthcare IRB
PROTOCOL TITLE:	Program Evaluation of the Current Status of Nursing Shared Governance in two community hospitals
PROTOCOL NUMBER:	19-1419 Approval Date: November 04, 2019

The Presbyterian Healthcare IRB, operated by Novant Health, has reviewed the protocol entitled: Program Evaluation of the Current Status of Nursing Shared Governance in two community hospitals. The IRB has determined that this project meets one or more criteria contained within 45 CFR 46.101(b) exempting the project from the requirements of continued review. You are free to conduct your study without further reporting to the IRB. In the event that you revise your study significantly, this revision must be submitted for review to ensure that the study continues to meet the federal guidelines for exemption from review.

Attachments

Professional Nursing Governance Evaluation Survey Tool 3.0

Survey Tool Approval Letter from Author (Dr. Robert Hess)

PowerPoint Presentation: Program Evaluation of Shared Governance

Participant Letter

This exempt determination will be documented in the minutes of the November 21, 2019 IRB meeting. A copy of the protocol is maintained by the IRB office. All minutes and proceedings pertinent to this protocol are maintained by the IRB office. The Novant Health IRBs are registered with the Office of Human Research Protections (OHRP) and in compliance with the requirements of federal regulations 45 CFR 46, 21 CFR 50, 21 CFR 56 and internal policies as revised to date. If you have any questions or need additional information, please contact the IRB office at (336)718-9670 or irb@novanthealth.org.

Sincerely,

Mark Clemens, PhD

Presbyterian Healthcare IRB Chair

Note: The study specific rationale provided by the investigator is sufficient to justify the waiver of HIPAA authorization [45CFR164.512(i)2(ii)].
Exempt Category 4iii

Appendix D

Draft Manuscript

Program Evaluation of Shared Governance Practice and Perception for Registered Nurses in a Community Hospital Setting in Northern Virginia

Robin Louise Smith, Reginia DeGennaro

Abstract

Background: The empowerment of registered nurses (RN) with the implementation of shared governance (SG) councils leads to ownership of professional nursing practice issues. The lack of a program evaluation for this combined SG health system council posed a risk for undefined program effectiveness.

Purpose: The purpose of this project was to complete a formal program evaluation of a SG model implemented in two community hospitals within a healthcare system in northern Virginia.

Methods: Methods included a retrospective review of the five combined SG councils' structure and process and the use of the Index of Professional Nursing Governance (IPNG) survey to obtain a baseline measurement of SG and the perception of impact on RN's professional practice. Impact on practice was measured with a Likert scale.

Results: Analysis of completed council SG minutes, agendas, attendance rosters and projects identified inconsistencies from 2018 to 2019. The IPNG survey indicated overall SG score and two out of the six subscales measured in the SG range. The IPNG survey overall score 101.00 (24.44) and two out of the six subscales, influence over resources 25.35 (7.98) and goal setting and conflict resolution 10.59 (4.14) measured in the SG range. The SG program had a 49% moderate to major impact on RNs' professional practice.

Conclusion: A review of SG to obtain a baseline measurement was valuable to both hospitals. These results were shared with key stakeholders to make recommendations to steer the nursing leadership in a direction to create an enduring SG program.

Keywords: shared governance, nursing, and evaluation

Introduction

Shared governance (SG) is used by nursing leaders to promote and support empowerment and autonomy among Registered Nurses (RN). SG models emphasize nursing ownership of decisions made related to their work as a nurse (Clavelle, Porter, Weston & Verran, 2016). When considering the implementation of a SG program in an organization, an evaluation plan is necessary. Successful implementation of SG requires the chief nurse executive (CNE) and senior nurse leaders to dedicate time to program start-up and maintenance and demonstrate an ongoing commitment to the philosophy of SG (Jones, Stasiowoski, Simons, Boyd & Lucas, 1993). A program evaluation assesses and describes the cost, resources, and time required by nurses to complete project requirements and illustrate outcomes. In this way, the organization can decide if resources allocated are providing desired results.

Background

The review of the literature revealed a depth of literature on SG implementation but a dearth on SG program evaluations. The literature review illustrated that SG evaluations were in large, academic hospital settings with limited literature found regarding the community hospital setting. Four studies were found, (Di Fiore, Zito et al., 2013; Weaver et al., 2018; Barden et al., 2011; Dechairo-Marino et al., 2018) that reported evaluation of SG in a community hospital setting. These were reviewed, including three of the four studies that utilized the Index of Professional Nursing Governance (IPNG) as the primary instrument. The major findings were that studies supported the evaluation of shared governance programs, and nurse leaders must continue to identify and sustain new ways to empower nurses. This review revealed that systematic program evaluations of shared governance structures or councils were underutilized or underreported. A limitation of the studies included participation in completing the IPNG survey due to overload

from competing surveys in which nurses were expected to participate. In the literature, the only validated and reliable measurement tool to measure perception of shared governance was the IPNG survey. The 50-item IPNG survey was developed by Robert Hess (2017) and used with his permission for this program evaluation. The IPNG was designed to measure an organization's progress in the implementation of shared governance (Hess, 2011). The theoretical framework of this program evaluation is based on Kanter's theory of structural empowerment (Kanter, 1993). It is a useful framework to examine factors in the nursing work environment that influence the way nurses respond to the work environment (Laschinger, 1996). According to Kanter (1993), when there is a lack of access to resources, information, support, and opportunity, employees experience powerlessness (Kanter, 1993). Nursing SG is a way of leadership development that creates nurses' control over their practice while extending their influence into administrative areas previously controlled only by nurse leaders (Hess, 2004).

Purpose

The purpose of this study was to complete a formal program evaluation of a shared governance (SG) model implemented in two community hospitals within a healthcare system in Northern Virginia.

Methods

Two community hospitals in a health system located in Northern Virginia with a combined 190-beds created a partnership to expand council engagement. This gave the combined 464 registered nurses a place to solve common nursing practice related issues. Approval from the healthcare systems' institutional review board (IRB) was obtained. The implementation framework utilized was the Center for Disease Control Six-Step Framework (CDC Framework) to evaluate the current status of SG in the organization The six steps of the CDC Framework are: 1) Engage the

Stakeholders; 2) Describe the Program; 3) Focus the Evaluation Design; 4) Gather Credible Evidence; 5) Justify Conclusions; and 6) Ensure Use and Share Lessons. These steps must be done in order with the guiding standards in mind, to appropriately use the framework as intended. To engage the stakeholders, interviews were conducted with eight RNs with the following four questions formulated; is there participation and involvement in the SG meeting; has the hospital achieved shared governance and what impact has shared governance had on nursing professional practice.THESE ARE THREE QUESTIONS. Using the CDC Framework, a descriptive and retrospective design was used to address the stakeholder four questions.

Questions 1: Are the SG meetings generating results? (ADD THIS ONE TO SENTENCE ABOVE

Retrospective review of available minutes was performed for project completion for the five SG councils. Data were retrieved from the historical SG archives and were obtained from practice site nursing shared drive: SG folder through the assistance of practice site mentor.

Question 2: Is there participation and involvement in the SG meeting?

The same retrospective data review was conducted with a review of available agendas, minutes, and attendance rosters. Review of these minutes provided data on plan for SG andminutes provided data on communication of projects and dissemination methods.

Question 3: Has the hospital achieved shared governance?

A 50-item IPNG survey tool was used to measure the perception of SG of RNs. The IPNG survey is composed of six subscales: 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. The IPNG measures SG along a spectrum from traditional (administrative/management) to shared (shared decision

making) to self-governance (staff primarily make decisions). For each subscale, the RN has the choice of the following decision-making authority using a 5-point Likert scale:

1. Administration/Management only
2. Primarily administration/management with some staff nurses' input
3. Equally shared by administration/management with some staff nurses
4. Primarily staff nurses with some administration/management
5. Staff nurses only

Question 4: What impact of SG had on nursing professional practice?

The 5-point Likert scale evaluated the final question asked in the demographic section of survey, measured with a range of no impact to major impact.

Results

The results of the retrospective review of the five SG councils' minutes, agendas, and attendance revealed that in 2018, the overall presence of council agendas was 98%, council minutes were 96% and attendance rosters were 46%. The partners council and professional practice council had consistent documentation of agenda, minutes, attendance and completed more projects. For 2019, the overall presence of council agendas was 73%, council minutes were 58% and attendance rosters were 40%. The research council conducted twice as many projects but never kept attendance rosters. The SG completed projects included 10 projects in 2018, and 14 projects in 2019 (Table 1).

After data cleaning there were 117 valid surveys from nine clinical units and several nurse administrators. Most (66%) were full-time nurses, greater than 80% of participants worked in hospital A, and most were women between the ages of 45-55 years of age (Table 2). Scores on the survey indicated that RNs in both hospitals perceived an overall governance and two

subscales (influence over resources and goal setting and conflict resolution) within a SG range. Traditional governance was perceived for the remaining four subscales (Table 3).

Lastly, 49.1% of the RNs indicated that SG had a moderate to major impact on their professional practice (Table 4).

Discussion

Both hospitals began with established SG councils and then combined to better allocate resources. An extensive review of SG documents revealed important opportunities to strengthen SG across this health system. Strategies are to align SG councils with goals/mission, provide consistent leadership, complete more structured onboarding, and develop consistent communication. Accurate documentation and continuous tracking of SG council projects can be used to show the value of the SG program to executive leadership and RNs that are unsure about joining the SG council. The impact on professional practice measured below 50%, indicating a need to explore this in more in depth to understand why the RNs perception is not higher. Lastly, findings from this study will guide nursing leadership in developing strategies to improve structures and processes to support an enduring SG program. After improvements are made to SG, the IPNG survey can be used to measure and re-evaluate SG. The limitations of the study related to the survey were noted. The survey was sent out using one link instead of sending it to individual emails. Participants had to open the link to access the survey, and if the survey was not completed, the participant had to start over. The results cannot be generalized outside these two hospitals.

Conclusion

For these hospitals, an extensive program evaluation of shared governance was a valuable tool to establish a SG baseline. In order to improve the SG council program for both hospitals,

leaders at both hospitals have to recognize the benefits and need for nursing empowerment and SG infrastructure. The evaluation measured the current perceptions of SG by nursing staff, and those results can be used to create strategies to improve on the SG structure to better meet the hospital's goals better. An extensive program evaluation of SG programs is necessary to determine if a program is meeting the intended outcomes. Once the evaluation data are reviewed, the nursing leader and SG chairs can review and make changes, as necessary. The IPNG survey can be used in future strategies to address the subscales below the shared governance range. The chief nurse executive (CNE), took advantage of this program evaluation to evaluate the impact of SG on RNs professional practice that validated the SG program. Future evaluations repeating this program evaluation and focusing the IPNG of both hospitals can further examine comparisons between nursing units.

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Table 1

Analysis of SG Agendas, Minutes, Attendance Rosters, and Projects from 2018 until 2019.

2018	**Research Council**	**Coordinating Council**	**Safety & Quality Council**	**Partners Council**	**Professional Practice & Education Council**	Total Present
Council Charter	Present	Present	Present	Present	Present	
2018 Agendas	(11/11)	(10/11)	(10/10)	(11/11)	(11/11)	53/54
	100%	91%	100%	100%	100%	98%
2018 Minutes	(11/11)	(9/11)	(10/10)	(10/10)	(11/11)	51/53
	100%	82%	100%	100%	100%	96%
2018 Attendance in rosters	(0/11)	(7/11)	(6/10)	(10/10)	(0/10)	23/52
	0%	70%	60%	100%	0%	46%
Completed Projects	1	0	2	3	4	10
2019	**Research Council**	**Coordinating Council**	**Safety & Quality Council**	**Partners Council**	**Professional Practice & Education Council**	Total Present
Council Charter	Present	Present	Present	Present	Present	
2019 Agendas	(8/9*)	(4/10*)	(6/10*)	(9/10*)	(9/10*)	36/49
	88%	40%	60%	90%	90%	73%
2019 Minutes	(9/9*)	(2/10)	(6/10*)	(9/10)	(2/10)	51/53
	100%	20%	60%	90%	20%	58%
2019 Attendance rosters	(0/9)	(8/10)	(4/10)	(8/10)	(0/10)	20/49
	0%	80%	40%	80%	0%	40%
Completed Projects	6	0	3	3	2	14

Table 2

Descriptive Information of the IPNG Survey Demographic Characteristics of Registered Nurses

Characteristics	n	%	M (SD)
Location			
Hospital A	96	82.10	
Hospital B	21	17.90	
Gender			
Female	105	89.70	
Male	12	10.30	
Age			
18-24	3	2.60	
25-34	23	19.70	
35-44	27	23.10	
45-54	35	29.90	
55-64	27	23.10	
65+	2	1.70	
Current position			
Beside nurse	91	77.90	
Not bedside nurse	26	22.10	
Years of practicing nursing	117		17.65 (11.72)
Years worked in organization	112		8.54 (8.42)
Years in present position	117		6.68 (7.17)

Note. n=117. M = mean. SD = standard deviation.

Table 3

Descriptive statistics for overall IPNG and the six subscales (n total = 117)

Subscale	M	SD	Governance Classification	SG Range	Number of Items
Control Over Personnel	16.06	6.39	Traditional Governance	25 - 48	12
Access to Information	18.06	6.83	Traditional Governance	19 - 36	9
Influence Over Resources	25.35	7.98	**Shared Governance**	19 - 36	9
Participation in Committee Structures	16.48	5.36	Traditional Governance	17 - 32	8
Control Over Practice	14.15	5.58	Traditional Governance	15 - 28	7
Goal Setting and Conflict Resolution	10.59	4.14	**Shared Governance**	10 – 20	5
Overall	101.00	26.44	**Shared Governance**	101 - 200	50

Notes. M = Mean. SD = Standard Deviation. SG = Shared Governance. IPNG = Index of Professional Nursing Governance.

Table 4

Descriptive statistics for SG Impact on Professional Practice by Registered Nurses

SG Impact on Professional Practice	n	%
No Impact	13	11.2%
Minor Impact	12	10.3%
Neutral	34	29.3%
Moderate Impact	41	35.3%
Major Impact	16	13.8%
Total	**116**	