Nurses Perceptions of Shared Governance Two Years Post Implementation of a Councilor Shared Governance Model

Kathleen L. Wilson
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NURSES PERCEPTIONS OF SHARED GOVERNANCE
TWO YEARS POST IMPLEMENTATION OF A COUNCILOR SHARED
GOVERNANCE MODEL

A Capstone Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Nursing Practice

By
KATHLEEN L WILSON
M.S.N., University of Phoenix, 2001

2014
Wright State University College of Nursing and Health
University of Toledo College of Nursing
Abstract

Wilson, Kathleen L., DNP, College of Nursing Wright State University, 2014. Nurses Perceptions of Shared Governance Two Years Post Implementation of a Councilor Shared Governance Model.

Participation in shared governance councils can provide nurses with an opportunity for input into organizational policies that influence quality health care outcomes. Nurse leaders are diligently seeking a practice model that has a foundation of engagement of staff in decision making, quality outcomes, competency, evidence-based practice, shared power and job satisfaction. With the Patient Protection and Affordable Care Act (PPACA) of 2010, health care systems can expect an influx of some 30 million more patients (Pfeifer, 2013). In addition, mandated purchase of health care insurance will replace the fee for service model with one that ties payment to outcomes and focuses on care coordination, quality improvement, and cost control. All of these things are impacted by nursing roles as identified by the Institute of Medicine (IOM) 2010 report; *The Future of Nursing: Leading Change, Advancing Health*.

The objective of the project was to determine a particular population-intervention-comparison-outcome-time question (PICO): In (P) nurses, what is the effect of (I) participation in shared governance councils (as (C) compared to nurses not participating in shared governance councils) on (O) perceptions of shared governance. Kanter’s (1977, 1993) Theory of Structural Power provided the framework and the Index of Professional Nursing Governance (IPNG) (Hess, 1994) was the tool used for data
collection. Data were collected from nurses that served on shared governance councils and nurses that did not serve on councils. Data were analyzed by comparative descriptive independent T-tests.

The total sample of forty-four surveys were analyzed with a mean total shared governance score of 174.3. A higher shared governance score of 182.5 was reported by nurses who participated in shared governance councils, while those subjects who did not participate in shared governance councils reported a score of 166.00. Overall, the organization scored within the minimum level for shared governance range with 173.0 being the cut off score for a shared governance environment. There were no observable differences among the groups and no statistically significant differences in the perceptions of governance among the subjects. Nurses participating in shared governance have higher scores for overall governance.
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Introduction

The American Nurses Association (ANA) identified self-regulation as a vital component of professional nursing practice more than 35 years ago (Haag-Heitman & George, 2010). Many nurses are not aware that the ANA Code of Ethics for Nursing encourages and supports nursing participation in professional practice models such as shared governance (Haag-Heitman & George, 2010). Nurses have recognized since 1970 that shared governance, as a professional practice model, provides structure to promote shared-regulation within the practice setting. Nurse participation in shared governance ensures accountability for quality and safety of patient care and the autonomy of the care giver (Haag-Heitman & George, 2010).

The magnitude of working in an environment governed by traditional hierarchies, shared governance, the impact of the Patient Protection and Affordable Care Act of 2010, and the integration of evidence-based practice into the ever changing health care system in a rural hospital will be discussed. The theoretical framework derived from Rosabeth Kanter’s (1977) investigation of organizational structure and its effect on attitudes and behaviors will serve as the basis for this project (see Figure 1). The goals of this quality improvement project are to foster nursing leadership and enhance professional nursing practice through involvement with a shared governance councilor model.

Wilson and Laschinger (1994) studied Rosabeth Kanter’s structural theory of power in an organization (see Figure 1) by examining the relationship of staff nurses’ perceived job empowerment and their commitment to the organization. The results of that
study suggested a strong correlation between the structures of the organization and work environment that allowed greater access to the power, resources, and decision making, which contributed to determinants of employee attitudes and behaviors in the organization.

**Figure 1: Kanter’s Structural Theory of Power in Organizations**


The nursing profession has been associated with labels such as dependence and passivity and nurses have often described themselves as being powerless, with little authority or influence to affect change in their workplace (Buerhaus, Auerbach and Staiger, 2009). According to Buerhaus, Auerbach and Staiger (2009) some believe that this has led to job dissatisfaction, burnout and low commitment, causing increased cost to hospitals. Kanter (1993) suggested that changing structures of the organization would result in increased job empowerment.
Significance and Justification

With the Patient Protection and Affordable Care Act (PPACA) of 2010, health care systems can expect an influx of some 30 million more patients (Pfeifer, 2013). In addition, mandated purchase of health care insurance will replace the fee for service model with one that ties payment to outcomes and focuses on care coordination, quality improvement, and cost control. All of these things are impacted by nursing roles as identified by the Institute of Medicine’s (IOM) report of 2010: The Future of Nursing: Leading Change, Advancing Health. In this report, the IOM (2010) recognizes that organizations must focus on the people, environment and tools to improve workflow and patient safety. If nurses are to take the lead in improving health care as recommended by the IOM, then nurses must have the opportunity to be full partners in all decision-making processes that involve patient care. As health care organizations react to these changes, nurses can anticipate unpredictable pressures, barriers that affect their ability to ensure quality patient care, changes to the workplace environment and engagement in the decision-making processes. Therefore, it becomes essential for nurse leaders to consistently think about developing staff nurses to these roles in order to sustain a committed and engaged workforce.

Health care services cost more than ever and the pressure to control costs are tremendous. The United States spent 17.7% ($2.5 trillion) of its Gross Domestic Product on healthcare in 2012 and that number is estimated to grow to 20% by 2020 (Kumar & Blair, 2013). Healthcare costs are the number one cause of U.S. personal bankruptcies according to a recent Harvard study, which found 62% of bankruptcies listed “medical costs” as the main cause (Kumar & Blair). The health care industry is heavily regulated
and this has created a complex and difficult environment in which health care is delivered (Arnold, 2013). Health care organizations are generally structured as hierarchies that establish a pyramid structure of governance, however, this type of governance is not conducive to shared decision-making processes (Swihart & Hess, 2014). Links between structural empowerment (receiving support, access to resources), job satisfaction and psychological empowerment (autonomy, meaningful work) are evident in shared governance models (Best and Thurston, 2004). These same authors identified other factors important for nurse job satisfaction such as rewards, recognition by supervisors, positive communication with team members, and involvement in decision making for patient care.

Even before the launch of the PPACA, nursing has been the focus of many national initiatives aimed at improving the registered nurse workforce (Buerhaus et al., 2012). These initiatives include the Institute of Medicine’s report, The Future of Nursing: Leading Change and Advancing Health (2010). This report is a call for nurses to be full partners in the delivery of healthcare, to practice to their fullest education and training, and assist with redesigning healthcare in the United States (Buerhaus et al., 2012).

Another national campaign, “Raise Your Voice Campaign” an initiative between the Robert Wood Johnson Foundation and the American Association of Retired Persons (AARP) has increased awareness of the profession of nursing by funding research, education, and raised expectations for nurses to lead healthcare reform (Buerhaus et al., 2012). For over a decade the “Johnson & Johnson Campaign for Nursing’s Future” has promoted the profession of nursing and raised awareness of the value and importance of nurses in the media especially in television and print ads (Buerhaus et al., 2012).
Health care is a complex industry with increased pressures for cost reduction. Health care reform coupled with low reimbursement rates has limited the ability of small rural hospitals to maintain their autonomy. In addition to dwindling reimbursement, Molinari and Monserud (2008) stated that the nurse shortage in the United States is expected to intensify from 12% in 2010 to a projected 29% in 2020 creating even more stress on small rural hospitals.

There is little question that personnel are the single greatest cost in health care (Brewer, Kovner, Greene, Tukov-Shuser, and Djukis, 2012). Turnover costs can be as high as three times the annual salary of a registered nurse in the United States or as much as 5% of a hospital’s total budget (Brewer et al., 2012). Brewer et al. (2012) found that 43.4% of newly licensed nurses left their hospital jobs within three years costing the U.S. healthcare system 1.4 to 2.1 billion dollars in turnover costs. Attracting and retaining qualified, engaged nursing staff are essential to maintaining a desired quality of care level. Moreover, high rates of nurse turnover and high nurse vacancy rates have their own costs to be balanced against retention costs (Brewer, et al., 2012).

Nurse leaders are seeking practice models that have a foundation for engagement of staff in evidence-based practice, quality outcomes, competency, learning, shared power and job satisfaction. Curran and Totten (2010) stated that only about 2% of the members on American health care boards are nurses and it is time for nurses to expand their roles from caregiving and care management to care governance. Nurses understand the unique needs of patients and their families but historically physicians have occupied 20% of hospital governing boards. (Curran & Totten, 2010). A recent report (Prybil et al., 2009) on a study of governance in community health systems cited the value of
appointing highly respected and experienced nursing leaders as voting members of hospital boards. Curran and Totten (2010) cited that adding nurse leaders and their perspectives of health care to hospital boards would complement the perspectives of physician members, however, this practice has not been accepted as a benchmark of good governance.

Christman (1976) first introduced the concept of shared governance, he wrote that nurses have a stake in health care but they have not always had parity. Parity or equality is necessary if nurses are to exert influence in decision-making processes within the health care environment. Autonomy, according to Christman (1976), has the basic components of personal accountability, shared power and influence. Shared governance evolved over the next 20 years, becoming one of the top leadership professional practice models. The concept of utilizing shared governance to achieve excellence was emphasized when the American Nurses Credentialing Center (ANCC) announced the Magnet Recognition Program and listed shared governance as one of the core criteria (Swihart & Hess). The Magnet Recognition Program recognizes healthcare organizations for quality patient care, nursing excellence and innovations in nursing practice. Organizations striving for Magnet designation must demonstrate evidence of nurse involvement in governance and decision-making about nursing practice (Hess, 2011).

While the ever-increasing demands and expectations of nurses and nurse leaders in large urban hospitals is recognized, the same is true in the small rural hospitals. These leaders are confronted daily with a competitive market when attracting and retaining talented, motivated nurses that seek empowerment and involvement. History has shown that shared governance is an empowering process designed to achieve organizational
goals by promoting shared decision-making and accountability leading to increased job satisfaction (Johnson, et al. 2012).

**Statement of Purpose**

The purpose of the project was to determine a particular population-intervention-comparison-outcome-time question (PICO): In (P) nurses, what is the effect of (I) participation in shared governance councils (as (C) compared to nurses not participating in shared governance councils) on (O) perceptions of shared governance.

**Guiding Framework**

Several theoretical perspectives have resulted in a variety of definitions of shared governance. Hess (1998) described governance as the structure and process by which organizational participants direct, control, and regulate the goal oriented efforts of other members. Prince (1997) portrayed shared governance as an accountability-based governance system that shared power, control and decision-making with the professional staff. Porter-O’Grady (2001) stated that shared governance was a dynamic way of conceptualizing empowerment and building structures to support it that embodied four principles of partnership, accountability, equity, and ownership. The common characteristics of these definitions are autonomy, independence in practice, accountability, empowerment, participation, and collaboration in decisions that affect individuals, the environment, and group governance.

Hess (1998) described four configurations or different models of shared governance: (1) unit-based systems as to a specific nursing unit, (2) council models as a method to coordinate clinical and administrative activities, (3) administrative models as an executive level of coordination over smaller councils, and (4) congressional model,
where all nursing staff belongs and work is done in cabinets. According to Haag-Heitman and George (2010), organizations must investigate each model and decide on the model that is the best fit for their organization’s culture, resources, and goals.

The council model was implemented approximately two years ago in the rural hospital where this project will be conducted. The model consists of five councils including clinical practice, quality assurance, leadership, research and education, and advocacy. The term council is used to differentiate the work of shared governance teams from the committees and task forces normally seen in hospitals that are formed to address a specified service or function (Swihart & Hess 2014). Each designated council is empowered with accountability and authority for decisions that fall within the framework of that council (Swihart & Hess). This shared governance model consists of five hospital wide councils, Resource Management Council, Quality Council, Inpatient Education and Research Council, Practice and Informatics Council and Nurse/Physician Council, with the Nurse Executive Council overseeing the activities of all councils. Membership to each council is multidisciplinary including nurses, physical therapists, occupational therapists, respiratory therapists, dieticians, information technology staff, pharmacists and physicians. Staff members from other hospital departments including social service, case management and environmental service also participate as council members.

For the purpose of this project, the following definitions will be used to answer the PICOT question:

1. Shared Governance is a model of nursing practice designed to integrate core values and beliefs that professional practice embraces as a means of achieving quality care (Hess, 1995).
2. For the purpose of this project, Kramer and Schmalenberg (2003), described autonomy and control over the context professional practice as “socially granted and legally defined freedom to make practice decisions without technical evaluation from sources outside the profession” (p.539).

3. Empowerment according to Kanter (1977) is the ability to get things done, to mobilize resources, and to get and use whatever it is that a person needs for the goals he or she is attempting to meet. Kanter’s theory espouses the notion that power resembles that of mastery or autonomy over one’s own action.

4. Job satisfaction, according to Hayes, Bonner and Pryor (2010) is not clearly or concisely defined as related to nursing in nursing literature. These authors stated that most of the literature is descriptive of factors that contribute to satisfaction in the workplace and a variety of methods used to measure factors contributing to job satisfaction. Spector (1997) defined job satisfaction as an attitudinal variable that represents the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs.

5. Perception, traditionally, has been regarded as consisting of sensor components, aroused directly by energies that stimulate receptors and non-sensory components supplied by past experiences or a mental impression (Webster, 1997; p.189)

**Evidence-Based Practice Model**

The model chosen to guide this evidence based practiced project is The Model for Change to Evidence-Based Practice developed by Rosswurm and Larrabee (1999). The authors changed the title of the model to The Model for Evidence-Based Practice Change in 2009 (Larrabee, 2009). Permission to use the model was obtained from John Wiley &
The schematic for this model can be found in Figure 1. This six-step model was selected because it is easy to use and nurses within this organization were familiar with the model. This model was used to guide the implementation of a shared governance councilor model in 2012. The model begins by assessing the need for a change in practice, locating the best evidence, critically analyzing the evidence, designing a practice change, implementing and evaluating the change in practice and finally, integrating and maintaining the change in practice.

Figure 2. Evidence-Based Practice Improvement Model

Summary

Currently, little is known of the impact of the Patient Protection and Affordable Care Act of 2010 on the retention of nurses within small rural acute health care settings. Nurses are the largest group of health care providers in hospitals. Health care administrators must focus on the retention of a qualified nursing staff in order to meet the
demands for reimbursement of the services provided. Therefore, it is essential to enhance the factors that nurses have identified as important to them for continued employment.

Staff nurses’ participation in organizational decision-making is not extensively documented in the nursing literature. Most of the published articles are descriptive in their focus and describe the concepts of shared governance, factors that lead to job satisfaction and encouragement for nurses to be engaged. This goal of this project to better understand nurses perceptions of shared governance are strengthen by participation in shared governance councils. This project explores the concepts of autonomy, empowerment and job satisfaction which are associated with participation in shared governance and may provide direction for nurse leadership to improve quality of care and patient outcomes.
Review of Literature

This chapter will discuss how the evidence was collected, critically appraised, and synthesized. The concepts used for the evidence review included empowerment, shared governance, nursing satisfaction and nursing autonomy. Research studies and other levels of evidence will be described and gaps in evidence will be highlighted. Recommendations for practice will be suggested.

Search Strategies for Review of Literature

The systemic literature review was conducted primarily from four main electronic databases. The databases were the Cumulative Index of Nursing and Allied Health Literature (CINAHL), EBSCO, ProQuest, Ovid Nursing, and JoAnn Briggs Institute. The library search was conducted using online access to The University of Phoenix Library, the medical library at the University of Kentucky, Lexington, Kentucky and the hospital library. Key words used included shared governance, job satisfaction, nurse satisfaction, nursing autonomy, and nursing empowerment.

Melynk and Fineout-Overholt’s (2011) method of rating evidence was used to examine elements of the PICOT question. This rating system contains seven levels of hierarchy of evidence ranging from Level I: meta-analysis, Level II: randomized control trial, Level III: well-designed control trials without randomization, Level IV: case-control and cohort studies, Level V: systematic reviews, Level VI: descriptive or qualitative studies, and Level VII: expert opinion.
More than fifty articles were found that examine shared governance. Ten articles reviewed were Level IV (well-designed, non-experimental studies such as comparative and correlational descriptive and case studies). Twenty-five articles were Level VI (evidence from a single descriptive, quality improvement study) and fifteen articles were Level VII (evidence from the opinion of authorities and/or reports of expert committees). There were no studies available with Level I evidence. See Tables 1 through 10.
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<th>Measurement</th>
<th>Data Analysis</th>
<th>Findings</th>
<th>Appraisal: Worth to Practice</th>
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(Level VI evidence) | None | Design: descriptive correlation and comparative study  
Purpose: to propose the use of a structured instrument, the Index of Professional Nursing governance (IPNG), to measure development of shared governance. | Use of the IPNG in one hospital over time | IPNG tool to measure total governance and 6 dimensions of governance:  
1.) Control over personnel  
2.) access to information  
3.) resources supporting practice  
4.) participation  
5.) control over practice  
6.) goals and conflict resolution | IPNG tool | Comparison of mean scores of total governance and subscales of Index of Professional Nursing governance for 2000, 2002, and 2006. | Scores on the 1999 and 2002 surveys were almost identical with mean total governance score 185.10 in the manager group in 2002 compared to staff nurses in scoring 185.03 in 1999.  
The mean scores for total governance in 2006 increased to 186.79 compared to the 1999 score of 185.03. | Strengths: use of the IPNG showed progression and development of shared governance participation and nurses’ perceptions of governance. Scores can be used to validate perceptions and assist leaders in improving shared governance processes if needed.  
Weakness: the IPNG tool is lengthy. Response rate in 1999 was 32% compared to 19% in 2006. |
### Table 2

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<tr>
<td>Barden, A., Griffin, M., Donahue, M., &amp; Fitzpatrick, J. (2011). Shared governance and empowerment in registered nurses working in a hospital setting. <em>Nursing Administration Quarterly, 35</em>(3), 212-218. (Level III evidence)</td>
<td>Kanter’s Structural Theory of Empowerment</td>
<td>The purpose of this descriptive correlational study was to determine relationships between perceptions of shared governance and empowerment</td>
<td>158 Nurses in acute care hospital setting</td>
<td>Shared governance professional practice model Empowerment</td>
<td>IPNG (Index of Professional Nursing Governance) to measure perceptions of shared governance CWEQ-II (Conditions of Work Effectiveness II Questionnaire)</td>
<td>IPNG scores indicated low perceptions of shared governance total score on the IPNG was 157.61, indicative of traditional governance (must score minimum of 173 for shared governance) CWEQ-II scores a moderate level of empowerment at 19.88 (scores between 14 and 22 are indicative of empowerment at a moderate level)</td>
<td>While nurses’ perceptions of shared governance were low nurses perceived themselves to be moderately empowered. A Pearson correlation coefficient on the sum of the IPNG and the WEQ-II revealed a significant relationship between the variables shared governance and empowerment.</td>
<td>There is a positive relationship between nurses participating in shared governance and empowerment.</td>
</tr>
<tr>
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The 88-Item Index of Professional Nursing Governance was developed to measure professional hospital nursing governance.  
Purpose: define and develop an instrument to measure governance of hospital based nurses. | Psychometric properties were tested with 1162 RNs from 10 hospitals. | Despite studies measuring variables such as job satisfaction, autonomy, etc., no consistent relationships have been established between shared governance models and outcomes.  
Variables:  
-Professional Control (Autonomy)  
-Organizational influence (Empowerment)  
-Organizational recognition  
-Facilitating structures  
-Liaison  
-Alignment | IPNG tool | Content validity was .95, using Popham’s average congruency procedure. Six factors explained 42% of variance with subscale inter-correlations between .43 and .67. Each subscale had high degree of internal consistency (alphas .87 to .91); test-retest reliability was .77. Construct validity testing showed scores between shared governance and traditionally governed hospitals were significantly different. | Results support the validity of the 88- item IPNG as a reliable instrument for measuring the distribution of professional nursing governance in hospitals. | The IPNG should be utilized to measure nurses’ perceptions of shared governance. Leaders can use the results to determine areas of strengths and weaknesses. |
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<tr>
<td>Hess, R. (2004). From bedside to boardroom—Nursing shared governance. <em>The Online Journal of Issues in Nursing</em>, 9(1). (Level VII evidence)</td>
<td>None</td>
<td>The author provides an overview of shared governance, defines its essential elements, and provides suggestions for those who wish to implement the professional model.</td>
<td>N/A</td>
<td>N/A</td>
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The author provides an overview of shared governance models existing in hospitals from the past 25 years. The author gives suggestions and guidance for those professionals wanting to implement shared governance.
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<td>Hess, R. (2011). Slicing and dicing shared governance in and around the numbers. <em>Nursing Administration Quarterly, 35</em>(3), 235-241. (Level IV evidence)</td>
<td>Organizationa l theory and design Governance</td>
<td>N/A</td>
<td>The author provides an overview of different hospital findings using the IPNG.</td>
<td>6 subscales of the IPNG tool: Control over personnel Access to information Influence over resources supporting practice Ability to participate in organizational decisions Control over practice Ability to set goals and resolve</td>
<td>IPNG tool measures the distribution of control, influence, power, and authority within an organization. The author discusses how hospitals use the IPNG to measure baseline scores before implementing shared governance models and to determine subsequent progress.</td>
<td>An organization's overall governance score, which is the sum of the individual items’ scores, is framed within a continuum that encompasses dimensions of traditional governance, shared governance, and self-governance. An essential goal of implementing shared governance is to meet the minimal score of 173.</td>
<td>Some studies using the IPNG LINK governance scores to more nursing empowerment, and higher job satisfaction. Using the IPNG will help nurse leaders assess items that had scores that can be improved on. Improved IPNG indicates stronger governance.</td>
</tr>
<tr>
<td>Citation</td>
<td>Conceptual Framework</td>
<td>Design/Method Setting</td>
<td>Sample Setting</td>
<td>Major Variables Studied and Their Definitions</td>
<td>Measurement</td>
<td>Data Analysis</td>
<td>Findings</td>
</tr>
<tr>
<td>--------------------------------------------</td>
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</tr>
<tr>
<td>Lamoureux, J., Judkins-Cohn, T., Butao, R., McCue, V., &amp; Fatima, G. (2014). Measuring perceptions of shared governance in clinical practice: Psychometric testing of the RN-focused Index of Professional Governance (IPNG). Journal of Research in Nursing, 19(1), 69-87. (Level III evidence)</td>
<td>None</td>
<td>Design: cross sectional descriptive study</td>
<td>Convenience sample of 250 nurses with 79 respondents</td>
<td>6 subscales of the IPNG</td>
<td>Descriptive statistics (means and standard deviation).</td>
<td>High reliability for each one of the 6 subscales (Cronbach alphas of 0.94 and higher)</td>
<td>Concurrent validity was supported by a correlation of the IPNG score</td>
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Table 7

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<th>Measurement</th>
<th>Data Analysis</th>
<th>Findings</th>
<th>Appraisal: Worth to Practice</th>
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<tr>
<td>Newman, K. (2011). Transforming organizational culture through nursing shared governance. <em>Nursing Clinics of North America, 46</em>, 45-58. (Level IV evidence)</td>
<td>None</td>
<td>Descriptive case study</td>
<td>519 bed acute care hospital</td>
<td>Shared governance structures</td>
<td>The author shares one organization’s journey in shared governance, implementation of a councilor model and achieving outcomes through NDNQI data.</td>
<td>Comparison data showed that as shared governance was strengthened falls, core measures and nursing retention improved.</td>
<td>The author provides an overview of their shared governance structures and correlates outcome data from NDNQI and CMS core measure data.</td>
<td>The article provides an overview of how one hospital implemented shared governance, improved its structures, strengthened the structures and processes in shared governance and assessed clinical outcomes. Shows how shared governance is a journey and not a destination.</td>
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Table 8

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<th>Data Analysis</th>
<th>Findings</th>
<th>Appraisal: Worth to Practice</th>
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<tbody>
<tr>
<td>Porter-O’Grady, T. (2001). Is shared governance still relevant? <em>Journal of Nursing Administration, 31</em>(10), 468-473. (Level VII evidence)</td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>The expert author discusses shared governance and its relevance to the healthcare setting today.</td>
</tr>
<tr>
<td>Citation</td>
<td>Conceptual Framework</td>
<td>Design/Method</td>
<td>Sample Setting</td>
<td>Major Variables Studied and Their Definitions</td>
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<td>Findings</td>
<td>Appraisal: Worth to Practice</td>
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<tr>
<td>Porter-O’Grady, T. (2004). Overview and Summary: Shared Governance: Is it a model for nurses to gain control over their practice? <em>Online Journal of issues in Nursing</em>, 9(1), 92-95. (Level VII evidence)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Expert author discusses the meaning and value of empowerment concepts and structural contexts for nursing practice. The author states that shared governance is a relevant and vital issue in the structuring of professional practice.</td>
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Table 10

<table>
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<tr>
<th>Citation</th>
<th>Conceptual Framework</th>
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<th>Appraisal: Worth to Practice</th>
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<tbody>
<tr>
<td>Porter-O’Grady, T. (2012). Reframing knowledge work: Shared governance in the post-digital age. <em>Creative Nursing, 18</em>(4), 152-159, (Level VII evidence)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5 professional principles shared that are essential to shared governance success: 1. Professions are driven by practice and practitioners 2. It’s about structure 3. Accountability is the centerpiece of professional work 4. Appropriate locus of control for accountability must be designed into the shared governance structure. 5. Management leadership is critical to shared governance effectiveness.</td>
<td>The expert author discusses 25 years of research and development and basic principles that under-grid shared governance. The expert author provides a framework for establishing and maintaining and effective shared governance model.</td>
</tr>
</tbody>
</table>
Critical Appraisal and Evaluation of the Evidence

In the last several years, many articles have been published about what shared governance is (Swihart & Hess, 2014). There is very little published about how to implement or start shared governance or how to measure its effectiveness (Swihart & Hess, 2014). Articles reviewed in this project focused on measuring shared governance.

Research to date indicates that Kanter’s Theory of Organization Empowerment (1993) is supportive of empowerment, autonomy and job satisfaction by sharing of information and resources (Laschinger, Finegan, Shamian, & Casier, 2000; Laschinger, Sabistan, & Kutsczcher, 1997). However, there is a scarcity of literature that links shared governance to nurses’ perception of being empowered or having autonomy over their professional practice. The reality may be that most health care facilities are still structured with power and control at the executive level where all decisions and their impact move in a top-down manner.

From the literature searches, some 50 articles were reviewed concerning the concept of shared governance. Of these, there were only 10 articles from 1991 through 2011 that presented a case for measuring governance in a health care facility, with most of these written by Porter-O’Grady (2004, 2001) or by Hess, (2004, 1998, 1997, 1994). Other nurse researchers have noted the lack of valid tools to measure shared governance as a management model with outcomes (Anderson, 2011; Fray, 2011; Gavin, Wakefield, & Wroe, 1999; Herrin, 2004;). The literature contains limited reports of the use of structured tools to measure shared governance in acute care hospital settings (Anderson, 2011).
Hess (1998) wanted to define and develop the Index of Professional Nursing Governance as a way to measure hospital nurses’ perceptions of shared governance. Psychometric properties were examined in a sample of 162 nurses from 10 hospitals. The content validity after item generation was .95, using Popsham’s average congruency procedure. Six factors explained 42% of the variance with subscale inter-correlations between .43 and .67. All subscales had a higher degree of internal consistency (alpha .87 and .91); test-retest reliability was .77. Construct validity testing showed that scores between shared governance and traditional governed hospitals were significantly different with outcomes of job satisfaction, autonomy, professionalism, turnover, and leadership. The Index of Professional Nursing Governance (Hess, 1998) is an 86-item questionnaire, 5-point Likert scale and is based on a model of governance that encompasses six dimensions extrapolated from the nursing literature that includes: personnel, information, resources participation, and goals.

The tool deemed most appropriate for measuring shared governance and answering the PICO question for project is The Index of Professional Nursing Governance (IPNG) tool, (Hess, 1998). Permission for the use of this instrument has been obtained and a letter of permission can be found with a copy of the tool in Appendix A of this document. The IPNG is an 86-item instrument that measures overall governance and 6 dimensions of (1) control over personnel, (2) access to information, (3) resources to support practice, (4) participation, (5) control over practice/liaison, and (6) goals and conflict resolution/alignment. IPNG examines the balance of control and influence between professional nurses and managers. Shared governance is a professional innovation that encourages staff nurses’ decision-making control over their professional
practice, while allowing them to influence administrative areas previously controlled by nursing management. Attaining an IPNG minimal score of 173 is an essential goal of any hospital implementing shared governance (Hess, 2011).

Anderson (2011) used the Index of Professional Nursing Governance (IPNG) to measure shared governance in two southern acute care hospitals; One hospital was a Magnet hospital with an operational shared governance professional practice model in place for 15 years; the other hospital had a traditional governance structure in place. Anderson (2011) reported significantly higher scores for overall governance, empowerment and job satisfaction by the nurses in the shared governance hospital. Cronbach alpha coefficients for internal consistency for the total scale and the subscales ranged from 0.85 to 0.97. The mean score for total governance was 185.03 (SD=40.08) in 1999 and 186.79 (SD 38.26) in 2006. The author concluded that by using the IPNG, the status of governance at all levels can be assessed. The findings also showed a moderate relationship between governance and job satisfaction and governance and empowerment and high positive relationship between empowerment and job satisfaction.

Using the IPNG tool, Barden, Griffin, Donahue, and Fitzpatrick (2011) found in their study of 158 nurses in an acute care hospital with shared governance in place for almost a year that nurses’ perception of empowerment increased as shared governance participation increased. The score on the IPNG was 157.61, indicative of traditional governance most often seen in early implementation of a shared governance professional practice model. Nurses in this study perceived themselves as moderately empowered (Barden et al., 2011). The authors also used the Conditions of Work Effectiveness II Questionnaire (CWEQ-II) to measure levels of empowerment and found that nurses’
participating in shared governance positively influenced the relationships between nurses’ perceptions of empowerment and access to information, resources and support. The CWEQ-II average score was 19.88 and a score between 14 and 22 is indicative of moderately empowered staff (Barden et al., 2011).

When shared governance is implemented, it is a slow process, sometimes taking years to realize the positive effects. Acknowledging that scores are have not reached desirable ranges and that there is areas for improvement may promote trust and a shared desire to improve the level of nursing governance throughout the organization (Anderson, 2011). Anderson (2012) found in one organization that utilized the IPNG to measure shared governance over many years found that between the first (1999) and second (2002) surveys the findings were nearly identical. The third survey conducted in 2006 showed improvement in some areas of the subscales and disappointment in others. Anderson showed that even though shared governance had been in place for many years, structure alone is not enough to change culture, nor is it enough to implement the philosophy. Changes in leadership and turnover in staff in nursing and at the organizational level were identified as having negative impact on advancement of governance. According to Anderson, had the organization not conducted the surveys and had the status of governance remained unknown, continued deterioration of shared governance would have resulted. By measuring the status of governance, the leadership was able to assess and determine areas in need of improvement over time.

Newman (2011) Chief Nursing Officer for Baptist Health East, a Louisville, Kentucky hospital who has had shared governance in place for many years, wrote that shared governance is not easy and cannot be accomplished overnight. Patience is
essential with developing and implementing a shared governance model and it requires organizational commitment of time, resources, and staff accountability. Newman also stated that shared governance, in her experience, has been an evolutionary process at the organizational level as well as at the individual unit level. Newman shared nursing satisfaction scores for her organization as being consistently high indicating staff members had a strong sense of empowerment as well as satisfaction. Newman utilized the governance councils within her organization to foster autonomous decision-making within the boundaries of shared governance.

Hess (2011) reported in his research of Magnet hospitals over the years, that implementation of shared governance not only assisted hospitals in attaining Magnet status but also lead to improved collaboration, staff recruitment and retention, autonomy, shared values, high morale, improved quality patient outcomes, better collegial communication, increased productivity, stronger feelings of empowerment and higher job satisfaction. Hess reported that small studies have linked higher shared governance scores from the IPNG with more nursing empowerment and higher job satisfaction.

Lamoureux et al. (2014) found that shared governance promotes direct patient care nurses control over practice and improves individual accountability which results in improved quality of care for patients. The authors utilized the IPNG tool and correlated recent nursing satisfaction scores from the National Database of Nursing Quality Indicators (NDNQI) survey. The results of the study demonstrated high reliability of the six subscales of the IPNG tool. The authors concluded that the IPNG is a useful tool for determining nurse’s perceptions of shared governance.
Shared governance is an integral component of hospitals that have attained the American Nursing Credentialing Center Magnet Designation, which is indicative of high levels of achievement in the delivery of nursing care. The creation of work environments within the shared governance model has demonstrated empowerment and greater levels of job satisfaction for nurses to learn and grow.

**Synthesis of the Evidence**

The synthesis of evidence support evaluating shared governance and determining the strength of the shared governance model. The rating of the level of evidence of ten key selected research articles is presented in a summary format in Figure 3.

**Figure 3: Levels and Types of Evidence of Ten Selected Key Research Articles**

<table>
<thead>
<tr>
<th>Level I: Systemic review or meta-analysis</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>7</th>
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<tr>
<td>Level III: Controlled trial without randomization</td>
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<td>Level IV: Case-control or cohort study</td>
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<td>X</td>
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<tr>
<td>Level V: Systemic review of qualitative or descriptive studies</td>
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<tr>
<td>Level VI: Qualitative or descriptive study</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Level VII: Expert opinion or consensus</td>
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<td>X</td>
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<td>X</td>
</tr>
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</table>


**Gaps in Literature**

Although shared governance is growing and many hospitals are implementing the professional practice model as a method of engaging staff nurses, scientific evidence that links the model to improved autonomy, empowerment, increased nurse retention, and job satisfaction is limited (Hess, 2011). Interest in research that could potentially link shared
governance to the concepts of empowerment, higher job satisfaction and autonomy has been outlined by Anderson (2011), Barden et al. (2011), Porter-O’Grady (2012), Hess (2011), and Upenieks, (2000). Hess (2011) has stressed that although research has linked shared governance to positive clinical outcomes, well designed research studies don’t exist.

**Recommendations for Practice Change**

The synthesis of the literature supports the investment in building and implementing shared governance in hospital settings. Nursing organizations within Magnet hospital settings have consistently demonstrated three core features of professional nursing practice (Havens and Aiken, 1999); which are autonomy, control over professional practice environment and a collaborative nurse-physician relationship. Doran (2005) stressed that positive collaboration between nurses and physicians in Magnet designated organizations significantly influence the quality of work environment for nursing staff when compared to non-magnet hospitals. A shared governance professional practice model will provide structure needed to remove the barriers created by the traditional hierarchical management of healthcare organizations.
III. Methods: Project Implementation

This chapter focuses implementation and evaluation of a shared governance model. Using the IPNG tool, nurse perceptions of shared governance were measured two years following the implementation of a councilor model of shared governance.

Project Setting and Population

The setting for this project is in a hospital with 139 acute care and 20 behavioral health beds, located in a rural area of northeastern Kentucky. The community population is approximately 7,000 people with a state university located in the center of a rural community. The university population is approximately 10,000 students per semester. The nearest urban area to the north is 65 miles and to the south is 62 miles with connection by an interstate highway. The terrain is mostly at the foothills of the Appalachian Mountains, with the primary industry being lumbering/logging.

The sample is one of convenience and the findings of this project can only be generalized to that population. Inclusion criteria included: registered nurse, in good standing with the state licensure board of Kentucky, full-time employment and having no disciplinary action pending. The sample was then divided into two groups: Group one is the nurses that presently are serving on a hospital wide shared governance council and group two having never served on a shared governance council.

Demographic characteristics such as age, gender, ethnicity, salary, education level, and length of employment of the sample are comparable for both groups. The nursing department secretary compiled a list of nurse membership from shared
governance council meeting minutes. A total of 35 nurses were identified and listed alphabetically as being actively participating in a shared governance council. The first 25 were assigned to group one.

The Department of Human Resources was asked to compile a list of full-time all registered nurses. The nursing department secretary deleted those nurses from the list identified as actively involved in a shared governance council. The nurses remaining on the list were assigned consecutive numbers. In order to assure that each nurse had an equal opportunity to participate, every third name was chosen by the secretary until a total of 25 were reached. These were placed into group two. The goal was to have an equal number of nurses in the two groups.

**Stakeholders and Anticipated Barriers**

Success for organizational change such as the implementation of a shared governance practice model in the nursing department required the identification and involvement of key personnel. The primary stakeholders are the Sisters of Notre Dame, nurses and physicians, and patients and families of the community. Each group of stakeholders will be affected and outcomes may be evaluated by fulfilling the organizational mission, by positive indicators of patient satisfaction and quality outcomes, and by measuring the perception that nurses hold of the shared governance model, their feelings of empowerment and autonomy, as well as the achievement of job satisfaction. The leadership of the Sisters of Notre Dame is interested and has asked for clarification on several concepts of shared governance for possible implementation into the academic or school setting that they govern and oversee.
According to Swihart and Hess (2014), implementing shared governance requires fundamental changes in individual and organizational thinking and culture. Nurse leaders must make a case for changing by: describing why the change is necessary, describing the vision and nature of the change, identifying the benefits of changing, talking with major stakeholders and enlisting feedback, connecting shared governance to what people value, making sure the message is emotionally appealing, including supportive data, and repeating the message often (Swihart & Hess, 2014).

A major barrier to implementation of shared governance at this facility was the lack of baccalaureate prepared nursing staff. Seventy percent of nurses providing direct care at this facility have an associate’s degree. Nurses are encouraged and financially supported by the institution to return to school for their baccalaureate degree. At this time, over 20 nurses are enrolled in baccalaureate nursing programs. As nurses are returning to school for their baccalaureate degree, shared governance is one method of engaging the staff on a higher level of participation in unit activities.

The impetus of leadership is often driven by pay for performance and meeting government regulations such as Medicare and Medicaid and patients expectations of safe and quality care (Studer, 2009). In The Future of Nursing: Leading Change, Advancing Health (2010), the Institute of Medicine has recommended that 80% of all nurses be educationally prepared at the baccalaureate level by the year 2020. While this organization will not realize this goal, the organization supports this goal and readily understands the significance of the goal and what it means to quality patient outcomes.
Ethical Considerations

This project is congruent with the mission, goals and strategic plan of the Nursing Department at this hospital. The hospital is catholic based, not-for–profit. The Nursing Department in 2012, under new leadership, initiated a Shared Governance model grounded in evidence based practice, provided educational programs in Transformational Leadership, established Watson’s Theory of Caring, and implemented the establishment of unit-based and hospital wide structural councils. The unit councils provide the opportunity for the staff nurses or front line care givers to be actively involved in the decision-making processes, management of resources, and measurement of quality indicators of patient satisfaction. The hospital wide councils direct the attainment of goals for each nursing unit, obtaining needed resources and management, identification of research and educational needs of nurses, monitoring quality controls, and nurse/doctor collaboration for the provision of excellent patient care.

The structural councils of the shared governance framework are in alignment with the goals of this capstone project. The Shared Governance Practice Model has been in place for two years at this health care facility, therefore sufficient time has gone by that a measurement of the variables can be obtained. By using the Index Professional Nursing Governance (IPNG) tool developed by Hess, (1997) the nurses’ perception of shared governance will be measured and a high shared governance score will indicate an environment where governance-related decisions are equally shared by staff and management.

Approval to survey the subjects was obtained from the Institutional Review Board (IRB) (Appendix E) of the hospital as well as Wright State University’s IRB (Appendix
D). Participation in this project is voluntary and each subject received a letter (Appendix G) informing them of the purpose, assuring their responses would be kept confidential and instructions for returning the questionnaires. Subjects received information that they had the right to refuse participation or to withdraw at any time without feeling threatened or being jeopardized in their place of employment. The questionnaires were distributed to the participants in organizational or unit based council meetings by the chairs of the councils.

Budget

The monies budgeted by the author for this project include personal costs for production of the data collection tools, the cost paid for the use of the tools, supplies such as paper, mailings, travel expenses, and data analyze. An outline of these projected costs is in Table 11. The monies budgeted by this author personally contains cost of the tools used to gather data, supplies, data analysis and travel expenses for meeting with chair/committee and defense of this proposal.
Table 11: Cost Analysis/Budget

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</tr>
<tr>
<td>Total Cost of project=</td>
<td></td>
<td></td>
<td>$5002.30</td>
</tr>
</tbody>
</table>

Implementation Plan for Shared Governance (developed prior to this project)

Shared governance was implemented two years ago following the framework set forth by the American Nurses Credentialing Center’s (ANCC) *Guidelines for Establishing Shared Governance: A Starter’s Toolkit* (Haag-Heitman & George, 2010).

This guide provided a step-by-step method of designing and implementing a shared governance professional practice model. In addition to ANCC’s guide, the organization followed The Model for Change to Evidence-Based Practice (Rosswurm & Larrabee, 1998).

**Step One-Assess the Need for Change.** As discussed in Chapter 1, the first step of the Model for Change to Evidence-Based Practice is to assess the need for change.

Staff complained they didn’t have a voice in their practice. Brainstorming sessions were held which included nursing leaders as well as staff to discuss various professional
practice models. Nursing turnover and retention rates were discussed and a plan to implement shared governance in one area as a pilot was put into place.

**Step Two – Locate the Best Evidence.** Literature searches were performed to research different shared governance models. Staff and nursing leaders visited several hospitals and investigated their shared governance models. Literature searches were preformed locating numerous articles on shared governance.

**Step Three – Critically Analyze the Evidence.** Staff and nursing leaders took their time in assessing the positives and negatives of different models of shared governance. These models included the councilor model, congressional model, administrative model and the unit or practice-level model (Swihart & Hess, 2014). Turnover and retention rates of hospitals having shared governance models in place were methodically evaluated. Nurse satisfaction surveys from these hospitals were also reviewed if permitted.

**Step Four – Design Practice Change.** In this phase staff and nursing leaders utilized the American Nurses Credentialing Center’s *Guidelines for Establishing Shared Governance: A Starter’s Toolkit* (Haag-Heitman & George, 2010) to define the proposed practice change, identify the needed resources, and design the pilot.

**Step Five – Implement and Evaluate Change in Practice.** In this phase staff and nursing leaders implemented shared governance in one area, the Emergency Department. The trial lasted three months and during that time staff and leaders assessed time commitments, needed resources, costs, and developed recommendations and conclusions. Staff and nursing leader’s recommendations and comments were overwhelmingly positive.
Step Six – Integrate and Maintain change in Practice. The councilor model was fully implemented within all nursing departments two years ago. Staff and nursing leaders have consistently supported shared governance since its implementation. As a logical progression of shared governance this project was implemented to evaluate nursing staff perceptions of shared governance.
IV. PROJECT EVALUATION

This chapter will examine the data collection and analysis used to evaluate nurses’ perceptions of shared governance. All data was collected by the shared governance council chairpersons and co-chairs.

Data Collection Instrument and Procedures

A printed list of potential subjects meeting the inclusion and exclusion criteria was obtained from the hospital’s human resource department. That list was compared to attendance lists of shared governance council meetings throughout the hospital for potential inclusion into the project. The nursing department’s secretary placed a number on the data collection survey (Index of Professional Nursing Governance tool) so that each survey could be directly linked to one of the participant groups.

Each participant was full time, employed by the hospital, and was a registered nurse. There were two distinct groups, one was those nurses that held membership on one of the hospital wide structured councils or a unit based council, which is referred to as group one and the other group contained an equal number of nurses that did not participate in any shared governance council, which is referred to as group two. Each participant was given a letter explaining the purpose of the project (Appendix G) along with the survey material (Appendix B). The anonymity of the participants was protected and no personal identification or responses were shared with the organization. The data was reported in aggregate only. The tool used for data collection the IPNG (Hess, 1998) is located in Appendix B and the letter granting permission to use the tool can be found in
Appendix A. The Index of Professional Nursing Governance (IPNG) measures the perceptions of governance of healthcare personnel (Hess, 1998). The defining aspects of professional governance are represented by six (6) subscales. The subscales are (a) personnel-who controls personnel and related structures; (b) information-who has access to information relevant to governance activities, (c) resources-who influences resources that support professional practice, (d) participation-who creates and participates in committee structures related to governance activities, (e) practice- who controls professional practice, and (f) goals-who sets goals and negotiates the resolution of conflict at various organizational levels. Reliability coefficients for each subscale are displayed in Table 12.

**Table 12: Reliability Coefficients**

<table>
<thead>
<tr>
<th>Factor Subscales</th>
<th>Items</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personnel</td>
<td>22</td>
<td>.96</td>
</tr>
<tr>
<td>2. Access to Information</td>
<td>15</td>
<td>.90</td>
</tr>
<tr>
<td>3. Resources Supporting Practice</td>
<td>13</td>
<td>.89</td>
</tr>
<tr>
<td>4. Participation</td>
<td>12</td>
<td>.89</td>
</tr>
<tr>
<td>5. Control Over Practice</td>
<td>16</td>
<td>.93</td>
</tr>
<tr>
<td>6. Goals and Conflict</td>
<td>8</td>
<td>.89</td>
</tr>
<tr>
<td>Total Instrument</td>
<td>86</td>
<td>.98</td>
</tr>
</tbody>
</table>

There are eleven (11) single item questions on the Index of Professional Nursing Governance tool that address age, gender, education, employment status, years as a nurse, current position, type of unit of work, and certifications. This data was used to describe the characteristics of the two groups that completed the survey tools.
Data Analysis

Forty-five subjects returned questionnaires, however one subject was eliminated from data analysis due to incomplete data. Surveys from 44 participants were analyzed with SPSS 15.00 for Windows. Included in the data analysis were 22 nurses (50%) who had participated in the shared governance councils, while 22 nurses (50%) had not. Descriptive statistics were used to summarize demographic data. Descriptive analysis was performed for each dimension of the subscales. The mean total IPNG score for the combined group was ($M = 174.30 \pm 43.90$). A description of IPNG shared governance scoring is found in Table 13.

Table 13: IPNG Shared Governance Scoring Description

<table>
<thead>
<tr>
<th>Shared Governance Score</th>
<th>Description of Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>173-257</td>
<td>Primarily management/administration with some staff input</td>
</tr>
<tr>
<td>258</td>
<td>Equally shared by staff and management/administration</td>
</tr>
<tr>
<td>259-344</td>
<td>Primarily staff with some management/administration</td>
</tr>
</tbody>
</table>

The significance of findings highlights the need for continued support and education among the nursing staff as well as nursing leaders. According to Hess (2011) nursing leaders often believe that staff have more control and influence over their practice than staff members perceive they do. This score ($M = 174.30 \pm 43.90$) indicated that the nursing groups overall perceptions of governance fell within the range of a shared governance environment, but decision-making is still controlled primarily by management/administration with some staff input. A higher shared governance score of
(M = 182.59 ± 42.90) was reported by the nurses in group one, while a traditional score of (M = 166.00 ± 44.3) was reported by nurses in group two. A traditional score of 166.00 was reported by nurses who did not participate in shared governance councils. This score reflects an environment where decisions are made by management/administration. The independent sample, T tests were used to evaluate the difference between the mean total governance scores for the two groups (shared governance participation vs. no shared governance participation). There was no statistically significant differences in mean governance scores by practice area, position, or highest nursing education.

The reporting sample included 38 (84%) women and 6 (14%) men (See Demographic Table 14). The educational preparation of the sample was 22 (50%) held an associate degree, 14 (32%) were baccalaureate prepared, five (11%) held a master’s degree in nursing and the remainder three (7%) held a diploma.

**Table 14: - Demographic Data**

<table>
<thead>
<tr>
<th>Characteristics of Total Sample</th>
<th>44</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>22-63</td>
<td>100%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Female</td>
<td>38</td>
<td>84%</td>
</tr>
<tr>
<td>- Male</td>
<td>6</td>
<td>14%</td>
</tr>
<tr>
<td>Highest Nursing Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Associate</td>
<td>22</td>
<td>50%</td>
</tr>
<tr>
<td>- Baccalaureate</td>
<td>14</td>
<td>32%</td>
</tr>
<tr>
<td>- Masters</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>- Diploma</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>Practice Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Emergency Department</td>
<td>11</td>
<td>25%</td>
</tr>
<tr>
<td>- Medical/Surgical</td>
<td>10</td>
<td>23%</td>
</tr>
<tr>
<td>- Critical Care</td>
<td>8</td>
<td>18%</td>
</tr>
<tr>
<td>- Maternity</td>
<td>7</td>
<td>16%</td>
</tr>
<tr>
<td>- Behavioral Health</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>- Other</td>
<td>5</td>
<td>11%</td>
</tr>
</tbody>
</table>
Twenty-five percent of those completing the surveys came from the emergency department, 23% from the medical-surgical areas, 18% from critical care, and 16% from maternity. The average age of the nurse was 36 years ranging from 22 years of age to 63 years of age with fairly equal distribution across the ages except for spikes in frequency around 23, 25, and 33 years of age (See Table 15 Age Distribution).

The average years worked as a nurse was nine years ranging from one to thirty-five with 45% working four years or less (See Table 16 Years Worked as a Nurse). Average years worked at the institution was eight years with a range of one to thirty-two years with more than 50% working three years or less. Average years worked in the hospital was four years and a range of one to 30 years, with more than 58% working two years or less. These results support the higher number of newly licensed graduate nurses within the institution.

Table 15: Age Distribution and Histogram

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Histogram for council: Participates in a council" /></td>
<td><img src="image2" alt="Histogram for council: Does not participate in a council" /></td>
</tr>
</tbody>
</table>
Table 16: Years Worked as a Nurse

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histogram &lt;br&gt;for council Participates in a council &lt;br&gt;Mean = 9.82 &lt;br&gt;S.D. Dev. = 2.755 &lt;br&gt;N = 21</td>
<td>Histogram &lt;br&gt;for council Does not participate in a council &lt;br&gt;Mean = 8.82 &lt;br&gt;S.D. Dev. = 10 &lt;br&gt;N = 22</td>
</tr>
</tbody>
</table>

Returned surveys indicated that nurses participating in shared governance councils perceived that control and influence over practice and other governance decisions are controlled primarily by management/administration. Successful implementation of a shared governance model shifts staff and managers’ perceptions closer to an environment where governance related activities are equally shared by staff and management/administration.

Summary

Data were collected from 44 participants which were divided into two groups; group one had participated in shared governance councils and group two had not participated in shared governance. While there were differences between the two groups in the IPNG total governance and subscales scores, these differences were not statistically significant. The results will be examined further in Chapter V.
V. PROJECT FINDINGS

Discussion of Results

Shared governance was implemented two years ago in the facility where the project was conducted. There are five hospital wide councils, Resource Management Council, Quality Council, Inpatient Education and Research Council, Practice and Informatics Council, and the Nurse /Physician Council, with the Nurse Executive Council coordinating and overseeing the activities of all councils. The mean total IPNG score for the combined group (those participating in shared governance councils and those not participating) was 174.30 (range = 173-257). This score indicates that the nursing group’s perceptions of governance fell within the lower range of a shared governance environment where decision-making is controlled primarily by management/administration with some staff input. Looking at each group individually, the IPNG score for those nurses participating in councils (group one) was higher at 182.59 (range = 173-257), well within the shared governance range. Those not participating (group two) in shared governance scored 166.00 (range = 173-257). Table 16 contains a comparison of total governance and subscales of IPNG. Figure 4 shows the Group Statistics and Figure 5 shows Independent Samples Test.

Figure 4: Group Statistics

<table>
<thead>
<tr>
<th>Council</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participates in a council</td>
<td>22</td>
<td>182.5909</td>
<td>42.87486</td>
<td>9.14095</td>
</tr>
<tr>
<td>Does not participate in a council</td>
<td>22</td>
<td>166.00</td>
<td>44.34175</td>
<td>9.45369</td>
</tr>
</tbody>
</table>
Figure 5: Independent Samples Test

<table>
<thead>
<tr>
<th>Govern</th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.134</td>
<td>.716</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>1.262</td>
<td>41.953</td>
</tr>
</tbody>
</table>

Table 17: Comparison of Total Governance and Subscales of IPNG

<table>
<thead>
<tr>
<th>Variables</th>
<th>Group One (N= 22)</th>
<th>Group Two (N= 22)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td>Range</td>
</tr>
<tr>
<td>Total Governance</td>
<td>182.6 ± 42.87</td>
<td>173-257</td>
</tr>
<tr>
<td>IPNG Subscales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Control Over Personnel</td>
<td>34.54 ± 15.51</td>
<td>44-88</td>
</tr>
<tr>
<td>- Access to Information</td>
<td>34.59 ± 7.18</td>
<td>31-61</td>
</tr>
<tr>
<td>- Influence Over Resources</td>
<td>33.00 ± 9.84</td>
<td>27-52</td>
</tr>
<tr>
<td>- Professional Practice</td>
<td>36.13 ± 10.74</td>
<td>33-64</td>
</tr>
<tr>
<td>- Goal Setting &amp; Conflict Resolution</td>
<td>17.36 ± 5.02</td>
<td>17-32</td>
</tr>
</tbody>
</table>

Analyzing the combined scores of both groups, the hospital achieved minimal scores within the range for shared governance in three out of six subscales; (a) information, 33 (shared governance: 31-60), (b) resources, 31 (shared governance: 27-52), (c) practice, 34 (shared governance: 33-64). Traditional scores less than a single
point from the shared governance thresholds were achieved for two out of the remaining subscales; (e) participation, 24 (shared governance: 25-48), and (f) goals, 16 (shared governance: 17-32). Scores indicative of traditional governance were found on the subscale for personnel, 33 (shared governance: 45-88). According to Hess (1998) many organizations score low in the category of personnel, represented by items related to hiring, promotions, evaluation process, adjusting salaries and benefits, conducting disciplinary actions and terminations. These items are traditionally overseen by administrative management personnel. Because the scores were low for both group and two, a test for statistical significance between the groups was not indicated.

Remembering that the IPNG range is 173 to 257, mean governance scores on the IPNG by highest nursing education showed that the 14 baccalaureate degree participants scored 182.68 well within the shared governance range, compared to the 22 associate degree participants score of 168.09, indicating a traditional governance score. The one diploma participant scored in the traditional governance range with a score of 138.00. Not surprising, there were five master’s prepared nurses completing the IPNG with a governance mean score of 195.00 indicating a shared governance score. However, the difference was not statistically significant ($p<.05$).

Mean governance scores by units on IPNG showed the specialty areas of critical care (186.62), maternity (204.85) and psychiatry (182.33) all scoring in the shared governance range (range = 173-257) with medical (151.60) and emergency departments (161.09) scoring within the traditional governance score (range = 173-257). Table 18 shows data comparison between groups.
Table 18: Data Comparison*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group One (N=22)</th>
<th></th>
<th>Group Two (N=22)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td>Range</td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>Total Governance</td>
<td>182.59 ± 42.87</td>
<td>174.00</td>
<td>118.00</td>
<td>292.00</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Female</td>
<td>191.11 ± 44.33</td>
<td>160.00</td>
<td>132.00</td>
<td>292.00</td>
</tr>
<tr>
<td>- Male</td>
<td>153.60 ± 20.74</td>
<td>52.00</td>
<td>118.00</td>
<td>170.00</td>
</tr>
<tr>
<td>Highest Nursing Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Associate</td>
<td>169.44 ± 26.13</td>
<td>90.00</td>
<td>118.00</td>
<td>208.00</td>
</tr>
<tr>
<td>- Baccalaureate</td>
<td>184.00 ± 49.56</td>
<td>144.00</td>
<td>132.00</td>
<td>276.00</td>
</tr>
<tr>
<td>- Masters</td>
<td>213.75 ± 58.24</td>
<td>138.00</td>
<td>154.00</td>
<td>292.00</td>
</tr>
<tr>
<td>- Diploma</td>
<td>138.00 ± **</td>
<td>.00**</td>
<td>138.00</td>
<td>138.00</td>
</tr>
<tr>
<td>- Other</td>
<td>165.00 ± **</td>
<td>.00**</td>
<td>165.00</td>
<td>165.00</td>
</tr>
<tr>
<td>Practice Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Emergency</td>
<td>160.00 ± 18.66</td>
<td>50.00</td>
<td>132.00</td>
<td>182.00</td>
</tr>
<tr>
<td>- Medical/Surgical</td>
<td>175.80 ± 24.94</td>
<td>59.00</td>
<td>148.00</td>
<td>207.00</td>
</tr>
<tr>
<td>- Critical Care</td>
<td>193.40 ± 67.99</td>
<td>174.00</td>
<td>118.00</td>
<td>292.00</td>
</tr>
<tr>
<td>- Maternity</td>
<td>213.60 ± 37.92</td>
<td>94.00</td>
<td>182.00</td>
<td>276.00</td>
</tr>
<tr>
<td>- Behavioral Health</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Other</td>
<td>151.50 ± 19.09</td>
<td>27.00</td>
<td>138.00</td>
<td>165.00</td>
</tr>
</tbody>
</table>

* Differences were not statistically significant (p< .05) for any variable comparison.
**Denotes 1 participant

Limitations

The Index of Professional Nursing Governance (IPNG) tool only measures levels of shared governance (distribution of control, influence, power, and authority) as perceived by those completing the survey tool (Hess, 1995). The tool in itself does not measure levels of autonomy, empowerment, and job satisfaction. However, those hospitals having effective shared governance models typically have nurses who perceive higher levels of job satisfaction, autonomy and empowerment (Anderson, 2011; Barden, et al. 2011; Force, 2004; Hess, 1998, 2004, 2011; Hoying & Allen, 2011; Larkin, et al., 2008; Laschinger & Havens, 1996; Newman, 2011; Porter-O’Grady, 2004, 2012; Prince, 1997; & Weston, 2008).
There are a variety of tools available to measure nursing/job satisfaction (Index of Work Satisfaction [IWS], Stamps, 1997; the National Database of Nursing Quality Indicators- RN Satisfaction Survey, Whitt et al., 2011), autonomy (The Index of Work Satisfaction Questionnaire; Stamps, 1997), and empowerment (Psychological Empowerment Questionnaire; Spreitzer, 1995). The length of these surveys is long and requiring considerable time to complete. To have used all of these surveys for this project would have created intolerable respondent burden on working nurses.

Another limitation is the level of knowledge about shared governance and how it can impact the work of the bedside nurse. The low IPNG score (166.00) of those nurses not participating in council structures supports the need for education (Swihart & Hess, 2014). Nursing leadership as well as bedside care nurses need more education on the importance of participation in organization-wide and unit-based council participation. Nursing leaders must identify methods of encouraging staff participation and providing opportunity to attend shared governance council meetings. The survey scores indicated that leadership must develop plans for improvement in order for shared governance to be effective. According to Hess (2011), every environment is not ready for shared governance, the organization must be ready and the nursing leadership needs to be willing and able to share power. More importantly, the nursing staff must be ready to accept higher levels of responsibility and accountability.
Future Recommendations & Conclusions

Future Recommendations

The findings of this project have implications for nurse administrators. Of pragmatic concern for the hospital is the need to provide continuing education about shared governance and the value of how it can strengthen nursing outcomes. Clinical implications for this facility include strengthening the attendance of staff at unit based and organizational council meetings. It’s crucial that staff be encouraged and allowed time away from patient care activities to participate in decisions that affect their practice. The higher Index of Professional Nursing Governance (IPNG) mean score for group one that participates in shared governance councils, indicated these nurses were more engaged. Shared governance provides a forum for vital communication throughout all levels of nursing practice, however, the structure by itself is not shared governance (Anderson, 2011).

According to Hoying and Allen (2011), enhancing shared governance never ends. Shared governance is difficult to implement due to the time commitment, the culture change that must occur, and the education needed by staff and nurse leaders. Shared governance must be evaluated, revised, and supported on an on-going basis. Nurse leaders play a pivotal role in creating and sustaining a professional work environment that promotes autonomy, empowerment and nursing satisfaction (Barden, Griffin, Donahue, & Fitzpatrick, 2011). Reducing barriers to successful implementation and continuation of shared governance requires vigilance, crucial conversations, and continued support from nursing leaders (Hoying & Allen, 2011). Through this capstone project it was evident that nurse managers needed more education on shared governance
and the benefits of staff engagement. Many times nursing staff were unaware of patient
group outcomes since quality improvement data was not always shared at unit based
council meetings. Data and information must be shared with staff. The structure of shared
governance was in place but the process of sharing information and staff involvement in
decision-making was lacking. Shared governance reduces emphasis on hierarchy and
supports a more participative and autonomous practice environment and commitment to
partnership.

Continued development of staff and managers is essential for shared governance
to work. Otherwise, providing a structure and no development of the staff is just
establishing new staff nurse committees (Hess, 1995). Staff nurses must be
knowledgeable about the philosophy of shared governance and how it can improve and
enhance their practice. They must be able to connect that philosophy to the values and
mission of the organization. Using the IPNG as a method to assess the current status of
governance and to evaluate the progress toward increasing the level of shared governance
would be helpful to nursing management.

Nurse leaders can apply the results of this capstone project to support continued
development of processes that enhance the staff nurses’ ability to participate in shared
governance activities. Results of this project also support the need for continued
development of staff through the attainment of baccalaureate degrees and specialty
certifications in nursing.

A concern for the nursing profession is a lack of studies linking shared
governance to positive patient outcomes as well as a lack of studies linking shared
governance to nurse satisfaction, empowerment and nursing autonomy. There is no
parsimonious instrument to measure these concepts and their relationship to shared governance. The IPNG has demonstrated to be an appropriate instrument to measure perceptions of governance, however, it is lengthy and time consuming to complete. It is recommended by this author as well as others (Anderson, 2011; Lamoureux, Judkins-Cohn, Butao, McCue & Garcia, 2014) that further research be conducted with a revised, shortened IPNG instrument.

Conclusions

Hospitals are complex organizations that depend upon the knowledge, skills, behavior and judgment of the nursing staff. According to Swihart and Hess (2014), shared governance is the present and future of healthcare. Shared governance provides structures and processes that facilitate full engagement of nursing staff. This project provides a baseline for future comparison of nurses’ perception of shared governance through the use of the Index of Professional Nursing Governance (IPNG). As more nurses seek and attain a baccalaureate degree, higher levels of knowledge and better patient outcomes will ensue. This in turn will strengthen the support for continued shared governance.
References


http://journals.lww.com/jonajournalftoc/1994/04010
Appendix A

October 16, 2012

Lerae Wilson
PO Box 926
Olive Hill, KY 41164
Dear Lerae:

You have permission to use my instruments, the Index of Professional Nursing Governance (IPNG) and/or the Index of Professional Governance (IPG) to measure governance a St. Claire Regional Medical Center, Moorehead, KY. In return, I require that you:

- Report summary findings to me from the use of the IPNG/IPG, including reliability analysis, for tracking use and evaluating and establishing the validity and reliability of the IPG, 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/IPG.

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

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

Sincerely,

Robert Hess, RN, PhD, FAAN
Founder, Forum for Shared Governance
Appendix B
PROFESSIONAL NURSING GOVERNANCE

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

Today's Date

1. Sex: __ Male __ Female

2. Age: ____________

3. Please indicate your BASIC nursing educational preparation:
   ___ Nursing Diploma
   ___ Associate Degree in Nursing
   ___ Baccalaureate Degree in Nursing

4. Please indicate the HIGHEST educational degree that you have attained:
   ___ Nursing Diploma
   ___ Master's Degree, Non-nursing
   ___ Associate Degree in Nursing
   ___ Doctorate, Nursing
   ___ Baccalaureate Degree in Nursing
   ___ Doctorate, Non-nursing
   ___ Master's Degree in Nursing, Specialty

5. Employment Status:
   ___ Full-time, 36-40 hours per week
   ___ Part-time, less than 36 hours per week (specify number of hours/week) __________

6. Please specify the number of years that you have been practicing nursing ____________

7. Please indicate the title of your present position ____________________________

8. Please indicate the type of nursing unit that you work on:
   ___ Medical
   ___ Surgical
   ___ Critical Care
   ___ Operating Room
   ___ Recovery Room
   ___ Quality Management
   ___ Education
   ___ Nursing Management
   ___ OCN, NCS
   ___ Other (please specify) __________________

9. Please specify the number of years you have worked in this institution ____________

10. Please specify the number of years you have been in this present position ____________

11. Have you received any specialty certifications from professional organizations? ___ Yes ___ No

    If YES, please specify the type of certification and year received ____________

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

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

PART I

1. Determining what nurses can do at the bedside
   1 2 3 4 5

2. Developing and evaluating policies, procedures and protocols related to patient care.
   1 2 3 4 5

3. Establishing levels of qualifications for nursing positions.
   1 2 3 4 5

4. Evaluating nursing personnel (performance appraisal and peer review).
   1 2 3 4 5

5. Determining activities of auxiliary nursing personnel (assistants, technicians, secretaries).
   1 2 3 4 5

6. Conducting disciplinary action of nursing personnel.
   1 2 3 4 5

7. Assessing and providing for the professional/educational development of the nursing staff.
   1 2 3 4 5

8. Making hiring decisions about RNS and other nursing personnel.
   1 2 3 4 5

9. Promoting RNs and other nursing personnel.
   1 2 3 4 5

10. Appointing nursing personnel to management and leadership positions.
    1 2 3 4 5

11. Selecting products used in nursing care.
    1 2 3 4 5

12. Incorporating evidence-based practice into nursing care.
    1 2 3 4 5

13. Determining models of nursing care delivery (e.g. primary, team).
    1 2 3 4 5

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## Professional Nursing Governance

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

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

### Part II

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<td>Determining how many and what level of nursing staff is needed for routine patient care.</td>
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<td>Adjusting staffing levels to meet fluctuations in patient census and activity.</td>
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<td>Making daily patient care assignments for nursing personnel.</td>
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<td>Monitoring and procuring supplies for nursing care and support functions.</td>
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<td>Regulating the flow of patient admissions, transfers, and discharges.</td>
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<td>Formulating annual unit budgets for personnel, supplies, equipment and education.</td>
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<td>Recommending nursing salaries, raise and benefits.</td>
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<td>Consulting and enlisting the support of nursing services outside of the unit (e.g. clinical experts such as psychiatric or wound care specialists, dietician educators).</td>
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<tr>
<td>Consulting and enlisting the support of services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance).</td>
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<td>Making recommendations concerning other departments’ resources.</td>
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<td>Determining cost-effective measures such as patient placement and referrals or supply management (e.g. placement of ventilator-dependent patients, early discharge of patients to home health care).</td>
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<td>Recommending new services or specialties (e.g. gerontology, mental health, birthing centers).</td>
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<td>Creating new clinical positions.</td>
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<td>Creating new administrative or support positions.</td>
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### Part III

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<tr>
<td>Written policies and procedures that state what nurses can do related to direct patient care.</td>
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<tr>
<td>Written patient care standard/protocols and quality assurance/improvement processes.</td>
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<td>Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises.</td>
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<td>Written process for evaluating nursing personnel (performance appraisal, peer review).</td>
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<td>Organizational charts that show job titles and who reports to whom.</td>
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<td>Written guidelines for disciplining nursing personnel.</td>
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<td>Annual requirements for continuing education and inservices.</td>
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<tr>
<td>Procedures for hiring and transferring nursing personnel.</td>
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<tr>
<td>Policies regulating promotion of nursing personnel to management and leadership positions.</td>
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<tr>
<td>Procedures for generating schedules for RNs and other nursing staff.</td>
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<td>Acuity and/or patient classification systems for determining how many and what level of nursing staff is needed for routine patient care.</td>
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</table>
### Professional Nursing Governance

39. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity.  
40. Procedures for determining daily patient care assignments.  
41. Daily methods for monitoring and obtaining supplies for nursing care and support functions.  
42. Procedures for controlling the flow of patient admissions, transfers and discharges.  
43. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.  
44. Procedures for adjusting nursing salaries, raises and benefits.  
45. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. clinical experts such as psychiatric or wound care specialists, diabetics educators).  
46. Formal mechanisms for consulting and enlisting the support of services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance).  
47. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass).  
48. Location, design and access to office space, staff lounges and charting areas.  
49. Access to office equipment (e.g. smart phones, computers, copy machines) and the internet.

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

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

### Part IV

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

**In your organization, please circle the group that has Access to information about the following activities:**

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

**PART V**

| 60. The quality of nursing practice in the organization. | 1 2 3 4 5 |
| 61. Compliance of nursing practice with requirements of surveying agencies (The Joint Commission, state and federal government, professional groups). | 1 2 3 4 5 |
| 62. Unit’s projected budget and actual expenses. | 1 2 3 4 5 |
| 63. Organization’s financial status. | 1 2 3 4 5 |
| 64. Unit and nursing departmental goals and objectives for this year. | 1 2 3 4 5 |
| 65. Organization’s strategic plans for the next few years. | 1 2 3 4 5 |
| 66. Results of patient satisfaction surveys. | 1 2 3 4 5 |
| 67. Physician/nurse satisfaction with their collaborative practice. | 1 2 3 4 5 |
| 68. Current status of nurse turnover and vacancies in the organization. | 1 2 3 4 5 |
| 69. Nurses’ satisfaction with their general practice. | 1 2 3 4 5 |
| 70. Nurses’ satisfaction with their salaries and benefits. | 1 2 3 4 5 |
| 71. Management’s opinion of the quality of bedside nursing practice. | 1 2 3 4 5 |
| 72. Physicians’ opinion of the quality of bedside nursing practice. | 1 2 3 4 5 |
| 73. Nursing peers’ opinion of the quality of bedside nursing practice. | 1 2 3 4 5 |
| 74. Access to resources supporting professional practice and development (e.g. online resources, CE activities, journals and books, library). | 1 2 3 4 5 |

**PART VI**

| 75. Negotiate solutions to conflicts among professional nurses. | 1 2 3 4 5 |
| 76. Negotiate solutions to conflicts between professional nurses and physicians. | 1 2 3 4 5 |
| 77. Negotiate solutions to conflicts between professional nurses and other healthcare services (respiratory, dietary, etc.). | 1 2 3 4 5 |
| 78. Negotiate solutions to conflicts between professional nurses and nursing management. | 1 2 3 4 5 |
| 79. Negotiate solutions to conflicts between professional nurses and the organization’s administration. | 1 2 3 4 5 |
| 80. Create a formal grievance procedure or a process for resolving internal disputes. | 1 2 3 4 5 |
| 81. Write the goals and objectives of a nursing unit. | 1 2 3 4 5 |
| 82. Write the philosophy, goals and objectives of the nursing department. | 1 2 3 4 5 |
| 83. Formulate the mission, philosophy, goals and objectives of the organization. | 1 2 3 4 5 |
| 84. Write unit policies and procedures. | 1 2 3 4 5 |
| 85. Determine nursing departmental policies and procedures. | 1 2 3 4 5 |
| 86. Determine organization-wide policies and procedures. | 1 2 3 4 5 |
Appendix C

Wright State University – Miami Valle College of Nursing and Health

AGENCY PERMISSION FOR CONDUCTING STUDY

THE St. Claire Regional Medical Center GRANTS TO
____________________ Kathleen Lerae Wilson ________________ , a student enrolled in the joint
Doctor of Nursing Practice Program at Wright State University – University of Toledo, the privilege of
using its facilities in order to conduct the following project:

The Relationship of Shared Governance to Nurses’ Perception of Autonomy, Empowerment, and Job
Satisfaction

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.

2. The names of consultative or administrative personnel in the agency (may) (may not) be
identified in the final report.

3. The agency (wants) (does not want) a conference with the student when the report is
completed.

4. Other:

____________________
Date

____________________
Signature of Agency Personnel/Title

____________________
Student Signature

____________________
Project Chair Signature
Appendix D

DATE: March 06, 2014

TO: Kathleen L. Wilson, PI, Doctoral Student
    College of Nursing
    Anne Russell, Ph.D., Faculty Advisor

FROM: B. Laurel Elder, Ph.D. 
    Chair, WSU-IRB

SUBJECT: SC#5398

'Capstone Project: The Relationship of Shared Governance to Nurses' Perception of Autonomy, Empowerment and Job Satisfaction'

This memo is to verify the receipt and acceptance of your response to the conditions placed on the above referenced human subjects protocol/amendment.

These conditions were lifted on: 03/06/2014

This study/amendment now has full approval and you are free to begin the research project. If this is a VA proposal, you must still receive a letter of approval from the Research and Development Committee prior to beginning the research project. If this is a MVH proposal, you must still receive a letter of approval from the Human Investigation and Research Committee (HIRC) prior to beginning the research project. This implies the following:

1. That this approval is for one year from the approval date shown on the Action Form and if it extends beyond this period a request for an extension is required. (Also see expiration date on the Action Form)

2. That a progress report must be submitted before an extension of the approved one-year period can be granted.

3. That any change in the protocol must be approved by the IRB; otherwise approval is terminated.

If you have any questions concerning the condition(s), please contact Jodi Blacklidge at 775-2974.

Thank you!

Enclosure
Title: 'Capsule Project: The Relationship of Shared Governance to Nurses' Perception of Autonomy, Empowerment and Job Satisfaction'

Principal Investigator: Kathleen L. Wilson, PI, Doctoral Student
Anne Russell, Ph.D., Faculty Advisor

Department: College of Nursing

Expedited Category:

The Institutional Review Board has approved the use of human subjects on this proposed project with conditions previously noted. The conditions have now been removed.

REMEMBER: FDA regulations require prompt reporting to the IRB of any changes in research activity, changes in approved research during the approval period may not be initiated without IRB review (submission of an amendment), and prompt reporting of any unanticipated problems (adverse events).

Signed Chair, WSU-IRB
Expedited Review Date: January 31, 2014
IRB Meeting Date: April 21, 2014

This approval is effective only through: January 31, 2015
To continue the activities approved under this protocol you should receive the appropriate form(s) from Research and Sponsored Programs (RSP) two to three months prior to the required due date. If you do not receive this notification, please contact RSP at 775-2425.
Appendix E

NOTICE OF IRB APPROVAL

Date March 24, 2014

Name of Principle Investigator: Kathleen Leake Wilson

Address: 283 Medical Circle

City, State, Zip: Morehead KY 40351

Concerning the following study:
St. Clare IRB Study #: 2014-03-001-1-1

Protocol Title: The Relationship of Shared Governance to Nurses Perception of Autonomy, Empowerment, and Job Satisfaction

Item(s) submitted for review (include version numbers and dates, if applicable): protocol clarifying emails, support letter, qualifications

For Federally-supported research, include the grant, contract, or cooperative agreement number (if applicable):

PLEASE READ THIS LETTER CAREFULLY IN ITS ENTIRETY. It contains important information about your research proposal and your responsibilities as an investigator. The IRB is required by Federal Law to report all serious or continuing noncompliance with these requirements to Federal agencies.

This study/items were:
☑ Approved by expedited review by Anthony D Weaver MD Date: March 24, 2014

This qualifies for expedited review based on Category(ies): 7

-OR-

At the IRB meeting held on members of the St. Clare IRB voted to approve the submitted items.

Your research plan has been granted [ ] Initial or [ ] Continuing approval. Approval extends for a period of one year. Subjects may be enrolled in your project from the date of approval through March 24, 2015. At that point all research must have been ceased (including activities such as enrollment, data collection, data analysis, etc.) and a closure report submitted to the IRB. If you close this research activity earlier, please notify the IRB within 30 days of ceasing research activity. This approval includes and IS LIMITED TO the items submitted for review as listed above.

If you need additional time to complete your research, you can apply for a continuing review. To apply for a continuing review, you must have all elements required in a continuing review report in this IRB office no later than 2/15/15. As the Principle Investigator, it is your responsibility to assure that your continuing review request is
St. Claire Regional Medical Center

submitted no later than that date, otherwise your research approval will expire. Although a continuing review request may have been submitted, you still must cease all research activity by the above expiration date until you have received written confirmation that your expiration date has been extended.

If you wish to modify an ongoing research study, you must submit a request to the IRB and receive IRB approval in writing before implementing the proposed modification, unless the change is designed to eliminate an apparent immediate hazard to subjects. If you change the research in order to eliminate apparent immediate hazards to subjects without prior IRB approval, you must report these changes to the IRB within 5 days.

Please be reminded that you need to promptly (within 5 days of your becoming aware) report to this IRB any unanticipated problems (which include but are not limited to adverse events) that are directly or probably related to the research and suggests that the research poses subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized. Note that this report to the IRB does not substitute for any other reporting obligations (i.e. to the sponsor or other institutional committee/official).

Failure to report these unanticipated problems is a serious violation of IRB requirements and possibly reportable to federal authorities.

Institutional Review Board approval is contingent upon the following conditions:
1. The Principal Investigator accepts responsibility for the scientific and ethical conduct of this research study.
2. Subjects may not be enrolled prior to Institutional Review Board approval, nor after the expiration date.
3. The Continuance/Final Review Form must be completed and reviewed by the IRB before the expiration date of the study.
4. Adverse events and/or unanticipated effects on subjects must be reported to the Institutional Review Board on the next working day.
5. Modifications to protocol or informed consent must be approved prior to implementation unless they reduce immediate danger to subjects.
6. All protocol deviations must be reported to the Institutional Review Board on the next working day.
7. All advertisements must be approved prior to use and conform with St. Claire Regional Medical Center's policy.
8. You are required to notify the IRB of any new advertisements or recruiting material, change of Investigator or site location, serious adverse events, amendment or changes in the protocol, significant protocol deviations, patient death or termination of the study. Please note that you must submit all protocol amendments and/or advertisements to the IRB, prior to implementing the amendment and/or advertisements.
9. It is a requirement for you to use the IRB-approved informed consent form. An approved, stamped copy is attached to this letter.

A signed copy of the Signature Assurance Sheet showing that you have read and agree to the above statements is attached. A copy will be kept on file with the IRB.

Failure to comply with any of the conditions stated in this letter may result in the Principal Investigator not being eligible to participate in future research at St. Claire Regional Medical Center.

If you have any questions or concerns, please feel free to contact the IRB at (606)-783-6600.

Signature
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### Appendix F-2

#### Step 3: Order Confirmation

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**Order Date:** 01/05/2015

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#### Payment Information

Lerae Wilson  
kwilson@st-claire.org  
+1 (560)7936653  
Payment Method: n/a

#### Order Details

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**Title of your thesis/dissertation:** Nuraas perception of shared governance two years post implementation of a counselor shared governance model  
**Expected completion date:** Jan 10:15  
**Estimated size/pages:** 74
Appendix G

Dear Nurse Participant:

I am in the process of completing the requirements of a capstone project for degree requirements from Wright State University, Dayton, Ohio. The focus of this project is to explore the effects of a shared governance model in nursing service. I am asking that you provide me with your perception of shared governance for this project. There is no right or wrong answer.

You are being asked to complete the enclosed questionnaire:

Professional Nursing Governance (Hess, 1994) an 86 item, 5 point Likert Scale questionnaire.

It is important that you understand that your responses will not be shared with anyone other than those faculty that are part of my academic committee. Your identity will be kept confidential at all times and will not appear on any part of this information. At any point you feel uncomfortable nor wish to continue, you may stop and return the questionnaire. Completion and return of the enclosed questionnaire is your indication of consent to be a part of this project. It will take approximately 30 to 45 minutes to complete. As your response is crucial for this project, I am asking that you place the completed questionnaires in the enclosed envelope and return it to the person that distributed it to you. It is not necessary that you place your name either on the questionnaire or on the envelope so that your responses are kept anonymous.

I appreciate your assistance and cooperation in completing the necessary information for my project. If you have questions or would like results of my project, please contact me at (606) 783-6853 or 783-6600.

Sincerely,

Lerae Wilson, MSN, RN, NEA-BC