

5-1-2013

Evaluating Shared Governance For Nursing Excellence

Evette Michelle Wilson

University of Nevada, Las Vegas, wilsons2@unlv.nevada.edu

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EVALUATING SHARED GOVERNANCE FOR NURSING EXCELLENCE

by

Evette Wilson

Associate in Science in Technical Nursing
University of South Carolina
1993

Bachelor of Science in Nursing
University of South Carolina
1999

Master of Science in Nursing
University of Phoenix
2004

A doctoral project submitted in partial fulfillment
of the requirements for the

Doctor of Nursing Practice

School of Nursing
Division of Health Sciences
The Graduate College

University of Nevada, Las Vegas
May 2013

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THE GRADUATE COLLEGE

We recommend the doctoral project prepared under our supervision by

Evette Wilson

entitled

Evaluating Shared Governance for Nursing Excellence

be accepted in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice

School of Nursing

Nancy Menzel, Ph.D. Committee Chair

Carolyn Yucha, Ph.D. Committee Member

Christopher Cochran, Ph.D. Graduate College Representative

Tom Piechota, Ph.D., Interim Vice President for Research &
Dean of the Graduate College

May 2013

ABSTRACT

EVALUATING SHARED GOVERNANCE FOR NURSING EXCELLENCE

by

Evette Wilson

Dr. Nancy Menzel, Committee Chair
Associate Professor School of Nursing
University of Nevada, Las Vegas

The national challenges of nursing shortages, decreased staffing levels, and increased patient acuities have contributed to nurse's increased workload and job dissatisfaction. Nurses have become frustrated with the professional practice environment. The inability to make decisions about issues that affect their nursing practice and the care provided to their patients results in nurses leaving the work environment in search of higher job satisfaction. Employers are becoming more creative in their strategies to improve the work environment and retain nurses within their organizations. Healthcare leaders have implemented management strategies such as shared governance models. These models focus on providing a satisfying work environment that empowers employees in the decision-making of nursing practice.

This was a descriptive study to evaluate the current state of shared governance in three hospitals in Las Vegas and Henderson, NV. The study used the Index of Professional Nursing Governance (IPNG) survey tool to obtain a baseline measurement of shared governance and a gap analysis using the American Nurses Credentialing Center

(ANCC) Magnet Model[®] and the Forces of Magnetism[®] to evaluate structures and processes that support the infrastructure for shared governance.

The results of the survey indicate that despite having shared governance structures in place, the overall governance scale at each of the three campuses scored below the minimum score of 173, which places the organization in a state of traditional governance, where decisions are primarily made by management and administration. Overall, opportunities exist in the organization to increase shared decision-making across all six subscales of the IPNG tool and to strengthen the infrastructure by closing gaps identified in the Magnet[®] Framework for structural empowerment and exemplary professional practice.

ACKNOWLEDGEMENTS

I first give thanks to the almighty GOD, for with him anything can be accomplished. I extend gratitude to the University of Nevada, Las Vegas, School of Nursing and the School of Community Health Sciences, which provided the educators, mentors, and coaching needed to get me through this project. I give a special thank you to my Project Chair, Dr. Nancy Menzel, for her time and patience helping me to pull together this project and communicate the information in a concise and clear manner. I also give appreciation to my committee members, Dr. Carolyn Yucha, Dr. Gregory Ginn, and Dr. Christopher Cochran. Thank each of you for the time and commitment that you gave to me on this project. To Dr. Antonio Gutierrez, thank you for your assistance and guidance with using SPSS and data analysis. To Elizabeth Gardner, you were like a lighthouse guiding us to the end of our journey; thanks so much for your assistance over the last two years.

Much appreciation is extended to my leadership at the St Rose Dominican Hospitals for allowing me this opportunity, especially Connie Clemmons, CNE, Wendy Lincoln, CNE, and Monica Byers, CNE, for giving me the guidance and autonomy to complete the project. To my wonderful assistant, Charisse Pinkerton, thanks for the assistance you gave me on the project; you are truly talented and greatly appreciated.

The last acknowledgement is given to my wonderful families who have stood by me every step of my educational journey. To my husband, thanks for supporting me; you are truly the best. To my wonderful children, thanks for managing the house and being understanding during these long years. Last, but not least, I extend much gratitude to my

parents for being there for me over and over again. Without my family, this would only be a dream. Thanks so much for your love and support!

TABLE OF CONTENTS

ABSTRACT..... iii

ACKNOWLEDGEMENTSv

LIST OF TABLES.....ix

CHAPTER 1 INTRODUCTION.....1

 Background and Significance.....1

 Problem Statement3

 Scope of Problem5

 Purpose11

 Goals and Objectives.....12

 Policy Implications.....12

CHAPTER 2 THEORETICAL FRAMEWORK.....13

 Kanter’s Structural Theory of Power in Organizations.....13

 Magnet Model[®] and Forces of Magnetism[®]16

CHAPTER 3 LITERATURE REVIEW.....18

 What is Shared Governance?18

 Principles of Shared Governance19

 Types of Shared Governance Models21

 Benefits of Shared Governance.....23

 Measurement of Shared Governance25

 The Cost and Savings of Shared Governance27

CHAPTER 4 METHODOLOGY.....30

 Design, Setting, Sample30

 Procedure.....30

 Data Collection.....30

 Resources/Cost33

 Project Timeline34

 Ethical Considerations.....34

 Data Analysis35

CHAPTER 5 RESULTS.....37

 Analysis by Campus.....38

 Analysis by Gender.....39

 Analysis by Age.....41

 Analysis by Years Practicing Nursing.....41

 Analysis by Unit.....42

 ANCC Magnet Gap Analysis.....44

Structural Empowerment.....	44
Exemplary Professional Practice	46
CHAPTER 6 EVALUATION.....	53
Discussion.....	54
Limitation.....	58
Conclusion.....	59
APPENDIX A SRDH Shared Governance Model	61
APPENDIX B Kanter’s Structural Theory of Power in Organizations.....	62
APPENDIX C Magnet Model [®] and Forces of Magnetism [®]	63
APPENDIX D Index of Professional Nursing Governance Survey Tool.....	64
APPENDIX E Project Timeline.....	68
APPENDIX F Letter of Authorization to Conduct Research	69
APPENDIX G Informed Consent	70
APPENDIX H (Table 4) Descriptive Information of the Demographic Variables of the Sample.....	72
APPENDIX I (Table 9) Descriptive Statistics of Shared Governance by Nursing Unit.....	75
REFERENCES	76
CURRICULUM VITAE.....	83

LIST OF TABLES

Table 1	Cost of Unit Team Councils Activity at Full Capacity at all SRDH Campuses.....	27
Table 2	Cost of Organizational and Specialty Council Activity at Full Capacity at all SRDH Campuses.....	28
Table 3	Cost and Saving of Retaining One RN on Each Unit and Campus	29
Table 4	Descriptive Information of the Demographic Variables of the Sample.....	72
Table 5	Descriptive Statistics of Shared Governance Scales by Campus.....	38
Table 6	Descriptive Statistics of Shared Governance by Gender.....	40
Table 7	Descriptive Statistics of Shared Governance by Age.....	41
Table 8	Descriptive Statistics of Shared Governance by Years of Practicing as a Nurse.....	42
Table 9	Descriptive Statistics of Shared Governance by Nursing Unit.....	75
Table 10	Pearson's Product Moment Correlation Coefficients of the IPNG Scales/Subscales.....	43

CHAPTER 1

INTRODUCTION

Background and Significance

In today's complex healthcare setting, nurses are key contributors on the frontline serving patients to provide quality care and improve outcomes. National challenges of nursing shortages, decreased workforce, and increased patient acuities have refocused attention to the quality of care that nurses provide while meeting increased patient demands. In addition to these challenges, nurses are faced with increased regulations that add to their workload, increase their job dissatisfaction, and lessen their time spent at the bedside with the patient. These new challenges add increasing responsibility and accountability to the role of the professional nurse, but do not add increasing power or authority to address needed changes to affect nursing practice. Nurses become frustrated and dissatisfied with professional practice, because ultimately, the responsibility and accountability fall back on the license of the nurse caring for the patient. Nurses leave their jobs in search of better work environments and job satisfaction.

According to the American Association of College of Nurses (AACN), the American Hospital Association (AHA) reported 135,000 Registered Nurse (RN) vacancies in the United States for a national vacancy rate of 8.1% in 2007 (AACN, 2011). According to the U.S. Bureau of Labor Statistics, healthcare continues to grow rapidly; in 2011, there were 296,900 jobs added to the healthcare sector (AACN, 2011; Bureau of Labor Statistics, 2012). AACN reports that by the year 2020, the demand for nurses is expected to increase by 18% as a result of aging baby boomers, general increase

in population, and technological advances requiring skilled nursing care (AACN, 2011). Replacing a nurse can be expensive for hospitals and can cost between \$22,000 and \$64,000 per nurse (Jones, 2007; Waldman, Kelly, Sanjeev, & Smith, 2004). Nursing shortages affect the hospitals' operations as leaders attempt to manage the shortages by covering with costly agency nurses.

According to Stanton and Rutherford (2004), low staff rates are related to poor patient outcomes. Across the nation, the increased complexity and acuity of patients requiring skilled care, in addition to the vacancies for qualified registered nurses contribute to lower staffing levels (Stanton & Rutherford, 2004). Stanton and Rutherford's research correlates an increase rate of adverse events with lower nursing staffing levels (2004). These studies also show a link between nursing shortages and an increase in nurse workload, burnout, and job dissatisfaction (Stanton & Rutherford, 2004).

The shortage has increased the value of nurses, as they are scarce in the market and essential to a hospital's day-to-day operation for providing safe quality care. Administrators are becoming more creative in their strategies to recruit and retain nurses. They are now focused on providing a satisfying work environment that motivates and empowers their employees, both of which are key factors directly related to nursing satisfaction (Campbell, Fowles, & Weber, 2004; Laschinger, Finegan, & Shamian, 2001).

National organizations are getting involved in nurse recruitment and retention as it relates to improving quality of care and patient safety. Organizations like the Institute of Medicine (IOM) have made recommendations to improve the nursing practice environment, including care models that determine the delivery of care (IOM, 2001). Key

recommendations can be found in the IOM's *Crossing the Quality Chasm* (2001). Its recommendations include creating and designing evidenced-based practice care delivery systems determined by professional standards (Havens & Vassey, 2003). The Nurse Reinvestment Act supports the recognition of nursing workforce issues. The law addresses issues of nursing shortages and job dissatisfaction with the practice environment by providing federal funding as an incentive to hospitals for the promotion of nurse recruitment and retention. The law encourages nursing involvement in decision making in healthcare systems (Havens & Vassey, 2003).

Healthcare executives realize that quality care is best delivered by staffs who are committed to the organization and empowered to practice their profession with no restraints and full autonomy. Successful leaders have been able to achieve these outcomes through the implementation of shared governance. Shared governance models have provided guidance for infrastructure and mechanisms for nurses to assume responsibility for their professional practice and take ownership and accountability for the care they provide to their patients. Shared governance increases nurses' participation in the operations of professional practice and engages them in decision making. It is this engagement that gives nurses the authority, confidence, and assertiveness to make a difference and change nursing practice (Bretschneider, Echardt, Glen-West, Green-Smolenski, & Richardson, 2010; Porter-O'Grady, 2001).

Problem Statement

The shared governance council at the St. Rose Dominican Hospitals once was a thriving model engaging nursing staff in shared decision-making; however, due to lack of infrastructural support and staff engagement, it needed revitalization. Two of the three

campus' nursing councils were active, but one campus had yet to engage staff to participate in shared governance activities. This project allowed for the evaluation of the organization's current state of shared governance. It also informed leaders of concerns and issues within the current structure and provided them priority-focused areas for improvement. Results from the evaluation were used to develop an implementation plan to revitalize and engage staff in shared governance activities, in addition to providing a blueprint for nurse leaders to engage staff decision-making in shared governance across the three campuses.

St. Rose Dominican Hospitals (SRDH), a member of Dignity Health (formerly Catholic Healthcare West), is a not-for-profit, community hospital system religiously sponsored by the Adrian Dominican Sisters. The SRDH consist of three campuses in the Las Vegas and Henderson, Nevada areas. The nursing staffs at the three campuses are represented by the California Nurses Association (CNA). Each campus exhibits different cultures.

The Rose de Lima campus is the oldest campus established in 1947. The campus has 199 acute care and 28 rehabilitation beds and offers a full range of inpatient and outpatient services. The facility has 10 clinical nursing units. In 2009, the campus had four nursing units participating in shared governance activities at the department level. Currently the nursing departments that were previously active in shared governance are now inactive, yielding no clinical units with shared governance council activity.

The Siena campus, which opened in 2000, is the largest and busiest campus. The campus enhanced and expanded services offered by the Rose de Lima Campus. The Siena campus offers 219 beds and also provides a full range of services. The campus has

14 clinical nursing units and has had continual shared governance activity since 2008. At one time, Siena campus had nine active nursing departments out of the 14 participating in shared governance. Currently the Siena campus has three nursing departments actively participating in shared governance.

The San Martin Campus is the newest facility of the three campuses, opening in 2006. San Martin like its sister facilities offers a variety of acute care health services. San Martin has 147 licensed beds and eight clinical nursing units. The San Martin Campus has been active in shared governance activities since 2009, and at one time had seven of the eight nursing units' active. Currently the facility has five nursing units that are active in shared governance at the department level.

Scope of Problem

SRDH began its movement to shared governance in 2007 as part of its journey to Magnet recognition, which is a designation issued by the American Nurses Credentialing Center (ANCC). The Magnet Recognition Program[®] recognizes organizations that strive for and provide quality patient care, excellence in nursing, and continued innovations and advancement of nursing professional practice. The designation is the highest recognition of the ANCC awards.

To assist SRDH to move towards Magnet recognition, a design team developed and implemented the original and current SRDH shared governance and professional practice model (Appendix A). The SRDH shared governance model consists of the following five councils:

- Unit Team Councils (UTC)
- Patient Care Team Councils (PCTC)

- Professional Practice Team Council (PPTC)
- Management Team Council (MTC)
- Executive Team Council (ETC)

The UTCs are where the majority of professional practice changes should begin and end. The UTCs are groups of staff nurses within a department, usually consisting of five to nine elected members. The council has authority for making decisions and recommendations, collaborating, and reporting practice decisions on behalf of its department units. The UTCs are accountable for retention and recruitment, practice, education, and data collection within their departments. Across the three campuses, there are eight active UTCs that meet regularly, with minutes tracked by the Professional Practice Department.

The PCTCs are specialty-based councils that come together to promote consistency of care across the system, share best practices, and develop system strategies. The specialty-based councils include system service line departments from all three campuses such as Critical Care, Maternal Child Care, Surgical Services, and Emergency Department. The PCTC has authority for making decisions and recommendations, collaborating, reporting, and coordinating best practices and strategies on behalf of the specialty service line. The Surgical Services Patient Care Team Council was the only active specialty council. This council has since dissolved. Currently there are no active specialty-based councils.

The PPTC is responsible for nursing practice, quality, education, research, and Magnet recognition at SRDH. The PPTC has authority for making decisions and recommendations, collaborating, and reporting practice decisions in its area of

accountability on behalf of the SRDH nursing staff. The PPTC has been meeting monthly since 2008. The Director of Professional Practice facilitates and chairs this council.

The MTC is responsible for leadership development, facilitation, and guidance within the shared governance structure. The council has accountability for all management decisions not related to practice, quality, and competency such as budget and resources. The MTC has authority for making decisions and recommendations, collaborating, and reporting in its area of accountability. The MTC at one time was active with managerial staff engagement but has since dissolved.

The ETC is responsible for the overall strategic planning of nursing across the three campuses. The team consists of Nurse Executives for each campus and department representatives across the three campuses. The ETC has authority for making decisions and recommendations, collaborating, reporting, and coordinating of strategic goals and planning for the SRDH Nursing Services. The ETC at one time served as the coordinating council for the shared governance infrastructure. In this capacity, the ETC prioritized the activities of the other team councils. The ETC continues to coordinate nursing strategic goals and planning across the three campuses. This group meets every two weeks and has consistently met since its inception in 2007, with strong participation and leadership from its council members.

Needs Assessment. The Director of Professional Practice (the author of this paper) conducted a preliminary needs assessment of present shared governance structure and performance in November and December 2011. New to the organization and to the role, the Director of Professional Practice met individually with nursing leaders to assess the existing infrastructure and the effectiveness of shared governance state. The

assessment included interviews with nursing leadership, shared governance team members, and nursing staff across the three campuses. The assessment also included attending UTC meetings, interviewing shared governance UTC and PPTC members, and soliciting feedback through an analysis of strengths, weaknesses, threats, and opportunities (SWOT) in the current model and infrastructure. A preliminary analysis of the assessment identified necessary strategic improvements to areas that were potentially inhibiting effective governance, successful alignment of organizational goals, and improvement in patient outcome measures.

There were several areas of concern identified with the current shared governance structure, but the most crucial need was for improved horizontal and vertical communication among the UTCs and PPTC. The councils currently function in silos, and information is not shared consistently among nursing leadership or the frontline staff. The assessment found that some councils were creative in how they summarized and disseminated shared governance activities and information (e.g., newsletters), while others did not have a process in place to share information. Nurse managers were not aware of Professional Practice activities, and some thought that shared governance was a thing of the past and were unaware that model continued to exist within the organization.

The PPTC reports verbally to the ETC by way of the Director of Professional Practice. Currently there is no standardized reporting mechanism in place within the organization to report shared governance activities. Shared governance activities are not reported through current reporting structures to the Board of Governors, which has overall leadership accountability.

The assessment also identified that although the organization has attempted to flatten its hierarchy and decentralize decision making at the frontline, there is still a gap in practice. Frontline staffs are not given full authority for decision making for all issues related to nursing practice. These include standards of practice, quality improvement initiatives, evidence-based practices, and self-regulation through peer review processes in clinical practice. Policies and procedures are addressed through a multidisciplinary council. Although this council includes frontline staff as members, UTCs are not involved in policies and procedure development within their individual departments.

Staff are not involved in the development of action plans to improve the quality within their departments. The facility participates in the National Database of Nursing Quality Indicators (NDNQI) and currently collects data and national benchmarks on several nursing quality indicators, such as falls, catheter-associated urinary tract infection, and central line-associated blood stream infection. Staff and council members could speak on the overall hospital's goal of improving these indicators, but they could not speak in detail about their department data or what their units were specifically doing to make improvements. In reviewing meeting minutes and agendas and attending several council meetings, I observed that quality data was not integrated into the UTC activities or discussed routinely at council meetings. The three campuses' Quality Improvement Plan is not specific to the role of the nurse in quality improvement. In addition, the hospital's plan does not integrate nursing-sensitive indicators, nor does it detail how nursing-sensitive indicators or nursing quality integrates within the shared governance model.

It was also observed that the UTCs at SRDH were not aligned with organizational and nursing strategic goals. Council activities focused mostly on department morale-boosting or team-building projects. UTCs did not identify department goals and objectives on an annual basis, or review them at the end of the year to see whether or they met them. Councils did not routinely conduct a self-evaluation of their performance throughout the year, which could assist in identifying areas for continued growth and development for council members.

SRDH does not offer a formal orientation program for new council members. Council members are given a resource manual that includes templates for holding their first several meetings, but no further guidance is given to develop council members into frontline leaders. Outside of the support given by the Director of Professional Practice, there is no ongoing support for professional nursing development for staff members to transition them into their new roles as council members.

Managerial support is extremely crucial for shared governance to be successful. The role of the manager in shared governance is that of both a mentor and facilitator to council members. From observations and discussion with nurse leaders who have functioning shared governance councils and feedback from council members, managers demonstrated a “hands-off approach” to shared governance within the organization. Nurse managers do not routinely attend their department UTC meetings, nor do they routinely monitor UTC activities for accountability of council members, including their attendance, meeting productivity and efficiency, status of goals and objectives, and barriers. In fact, some managers agreed they had little involvement with their UTCs.

In discussion with nurse leaders, I determined that the expectation of shared governance participation has not been set for UTC members or department managers'. In a shared governance model, managers are not excluded from participating in UTC activities. Managers have the opportunity through shared governance to mentor their councils, facilitate innovation, and drive performance improvement at the unit level.

Purpose

The purpose of this project was to further evaluate the state of shared governance at the SRDHs and make recommendations based on those findings to engage staff and revitalize shared governance within the organization. The project assessed the organization's shared governance model, infrastructure, and ongoing support that are fundamental for success and sustainability. The project informed facility leaders about the strengths and weaknesses of shared governance in the organization, provided a baseline measurement of shared governance, and provided priority areas of focus for improvement. This project addressed the following questions:

1. What is the current status of shared governance within SRDH?
2. What are the strengths and weaknesses of shared governance within the organization?
3. What are the primary areas of shared governance the organization need to focus on for improvement efforts?
4. What strategies are recommended to improve shared governance within the organization?

Goals and Objectives

The overall goal of the project was to evaluate the state of shared governance and assess the infrastructure to support shared governance activities at SRDH. The objectives of this project were as follows:

- Obtain a baseline measurement of degree of shared governance using the IPNG;
- Evaluate fundamental infrastructural needs of shared governance using the ANCC Magnet framework source of evidence to conduct a gap analysis;
- Identify strengths and weakness of the current shared governance model; and
- Propose recommendations based on findings to improve and advance shared governance within the organization.

Policy Implications

The policy implications of this project include revising or developing processes across the three campuses of SRDH to standardized best practice strategies for shared governance. Recommended changes to the current shared governance model and processes were made based on the findings of this study and evaluation conducted on this project. The baseline measurement of degree of shared governance, utilizing the Index of Professional Nursing Governance Tool and the ANCC Magnet Framework gap analysis, provided leaders the data to make improvements in the current program and prioritize the needed improvement efforts.

CHAPTER 2

THEORETICAL FRAMEWORK

Kanter's Structural Theory of Power in Organizations

Rosabeth Kanter's Theory of Power in Organizations (Appendix B) is the theoretical framework that supports this project. Kanter's theory postulates that workplace structures influence the behaviors and attitudes of employees (Hauck, Quinn, Griffin, & Fitzpatrick, 2011; Kanter, 1993). According to Kanter (1993), organizations that have structures in place that cultivate empowerment, improve employees' attitudes; and thus employees are more effective within the organization. The literature supports a correlation between work environment and work effectiveness. Structural empowerment is defined as the structures and processes available to staff in the work environment to make decisions and control their practice. Kanter argues that having structures in place that grant employees access to information, provide support, make necessary resources available, and provide opportunities for professional growth cultivates a culture of empowerment (Hauck, Quinn, Griffin, & Fitzpatrick, 2011; Kanter, 1993). Staff experience greater autonomy and increased commitment to the organization if they are able to gain access to these structures in the work environment (Hauch et al., 2011; Lashcinger & Finegan, 2005).

The literature is rich with articles acknowledging the importance of empowerment in a shared governance structure. Ning, Zhong, Libo and Qiujie (2009) conducted a study that looked at the impact of nurse empowerment on job satisfaction among the Chinese nurse population. Nurses who perceived empowerment in their work environments were more likely to provide a higher quality care (Ning et al., 2009). Further, nurses experienced increase satisfaction within their jobs if empowerment was promoted in the

work environment (Ning et al., 2009). Organizations have found increased commitment, better interdisciplinary teamwork, improved staff satisfaction, increased physician collaboration, heightened autonomy, and more control over practice with structural empowerment (Hess, DesRoches, Donelan, Norma, & Buerhaus, 2011).

Kanter's theory also examines formal and informal power structures in the workplace. Kanter (1993) argues that power is dependent upon the position one has within an organization. Power can come from both formal and informal systems. According to Kanter's theory, formal power comes from the ability to be flexible, creative, and adaptive on the job (1993). These powers can also be achieved by gaining recognition on the job, taking risk, and being innovative.

Informal power, on the other hand, is gained by getting to know important people and developing relationships within the organization. Informal and formal power systems influence and facilitate the work of the organization. Access to these power structures creates empowerment in the work environment. Shared governance allows nurses to share power and decision-making that affects their nursing practice. Shared governance gives them access to both formal and informal power structures, and thus increases staff empowerment.

Kanter's theory focuses on three structures that need to be in place in order for work empowerment. The theory describes the *structure of opportunity*, *structure of power*, and *the structure of proportions* as the elements that employees need to have access to in order to be effective contributors to the organization. Workers are more committed to the organization and contribute more effectively to accomplish goals when

given access to resources, information, and support systems in addition to these three structures are available within the work environment.

The structure of opportunity refers to the employee's ability to grow professionally within the organization and the opportunities available to increase knowledge and skills. Kanter's framework guided the project in my review of shared governance processes in place to provide professional development and growth to employees. I reviewed opportunities within the organization for employees to become involved in activities of nursing practice. In addition, I reviewed opportunities for staff to expand upon their current knowledge, gain new skills that will open doors to new experiences, and professional growth.

The structure of power concept focuses on three sources of power that are available to the employee. The first source is the lines of communication. This concept stems from employees having early access to information about changes and decisions within an organization. Vertical and horizontal communication processes within the SRDH shared governance model were included as part of the evaluation. The second source in the concept is lines of resources. This concept is based upon the ability and influence of an employee to obtain the materials, budget, and resources that are needed to perform their job. The last concept of Kanter's theory under power structures is the lines of support. Line of support relates to the ability of the employee to take risks, be innovative, and exercise their own judgment within an organization to bring about change. The evaluation included a review of processes and structures that support council activities and guide the approval of council recommendations and decisions. The

evaluation also reviewed structure processes in place for staff to access resources needed to achieve organizational goals and work expectations.

Lastly, the structure of proportion relates to the composition of employees in the work environment with the equivalent status or in the same position. Kanter's theory (1993) discusses employees who lack the ability to access sources of power in organizations. If employees do not have the ability to gain access to power in organizations, they will fail to achieve empowerment in the workplace. If empowerment is not achieved, employees become frustrated and dissatisfied. The employee feels powerless to make decisions in the organization. Kanter's theory guided the project as the composition of council members were reviewed looking specifically at multidisciplinary team approach to ensure representation on the teams with access to power structures.

Kanter (1993) postulates that if all three of the structures are available to employees, psychological empowerment occurs through increased autonomy, decreased job dissatisfaction, and increased satisfaction and commitment. This empowerment results in the employees becoming more efficient, cooperative, and having increased satisfaction in the work environment.

Magnet Model[®] and Forces of Magnetism[®]

The ANCC Magnet Model[®] was used as a conceptual model to guide the shared governance gap analysis and needs assessment for this project. The ANCC's goal is to promote nursing excellence through a credentialing and recognition program, known as the Magnet Recognition Program[®]. Magnet recognition is considered the gold standard in nursing excellence. According to Swihart and Porter-O'Grady (2006), some consider it "the Nobel Prize of nursing excellence in professional practice environments" (p. 79).

The Magnet program standards align with shared governance in that its standards require structural processes to be in place that allow nursing autonomy and decision making power in an organization (Swihart & Porter-O'Grady, 2006).

Organizations striving for nursing excellence in professional practice must include Magnet and shared governance in the strategic plan (Swihart & Porter-O'Grady, 2006).

The Magnet Model[®] is made up of the five main components:

1. Transformational Leadership
2. Structural Empowerment
3. Exemplary Professional Practice
4. New Knowledge, Innovations, and Improvements
5. Empirical Quality Outcomes

The Forces of Magnetism[®] are the core of the Magnet Model[®] and are the fundamental standards for nursing excellence in a professional practice environment (Swihart & Porter-O'Grady, 2006). The forces are categorized by 14 characteristics attributed to shared decision making and excellence in nursing practice environment (Swihart, & Porter-O'Grady, 2006). The Forces of Magnetism[®] are in Appendix C. There are multiple forces relevant to shared governance and provide the standards against which this project compared the organization's shared governance infrastructure. The Forces of Magnetism[®] relevant to shared governance were reviewed against the organization's policies, procedures, and processes for sources of evidence to support meeting the standards.

CHAPTER 3

LITERATURE REVIEW

What is Shared Governance?

Shared governance was introduced in the 1970s originating from social and behavioral management theories, finding its way into the nursing arena in the 1980s (O'May & Buchan, 1999; Porter-O'Grady, 1992; Swihart & Porter-O'Grady, 2006). The literature describes several terms used interchangeably to describe shared governance such as shared leadership, shared decision making, and collaborative models (Hess, 1995). Tim Porter-O'Grady is well-known for his extensive research and foundational groundwork on shared governance models. He describes shared governance as "a structural model through which nurses can express and manage their practice with a higher level of professional autonomy" (Porter-O'Grady, 2003, p. 251). Porter-O'Grady describes his groundwork in his 1992 landmark book *Implementing Shared Governance: Creating a Professional Practice*. A review of the literature shows Dr. Tim Porter-O'Grady's fundamental concepts of shared governance models are still relevant today and have not changed over the years.

Many definitions are used to describe shared governance, but in summary, the literature defines it as a structure that promotes a culture of empowerment, autonomy, and decision making that occurs at the front line by the staff that performs the work (Doherty & Hope, 2000; George et al., 2002). Shared governance is the extension of power, control, and authority to the frontline staff and nurses over their clinical practice (Fray, 2011).

Principles of Shared Governance

Shared governance focuses on four main principles that serve as the foundation and the cornerstones of the concept. Collectively, when one incorporates the four principles of shared governance (partnership, accountability, equity, and ownership) into a team's behavior, one creates a professional work environment of empowerment (Bates, 2004; Porter-O'Grady, 1992; Swihart & Porter-O'Grady, 2006). These key elements must occur at the point of care to deliver cost efficient and quality care to patients (Swihart & Porter-O'Grady, 2006). Swihart and Porter-O'Grady (2006) maintain that in order for this to be achieved, at least 90% of the decisions for nursing practice need to be made on the patient care units, including choices regarding quality, competence, and professional practice. They further elaborate that only a small percentage, approximately 10%, of decision making should remain with management (Swihart & Porter-O'Grady, 2006). In comparison to a traditional bureaucracy, this will require a major shift in culture to decentralize the hierarchy and shift control of practice to the frontline practitioners. The shift in control of practice is essential for true shared governance to occur.

Partnership. Developing collaboration and healthy partnerships among the healthcare team is essential to teambuilding, relationship development, and strengthening professional practice. Each team member's role is important in helping the organization to meet its overall goals. This importance is further demonstrated when staff are included in practice decisions and process changes. Partnerships development can occur both internally and externally in an organization. Internal partnerships among healthcare team members (e.g., physicians, nurses, laboratory workers, and pharmacists) are important not

only to improve communications among the team, but also to deliver safe patient care. External partners (e.g., community, organizations) can assist to strategically align organizational goals such as expanding services within a community and building strong alliances. Partnering with public and private organizations can also further advance public policy related to nursing practice.

Accountability. Accountability is when all staff members achieve a clear understanding of their role and expectations, and take responsibility for their actions and decisions; this is the core of shared governance. Accountability is usually delegated to a role by someone who has the power to delegate it. In order to operationalize professional accountability there must be autonomy, authority, and control of practice. Porter-O'Grady (1992) states that "the professional must have the right (autonomy) to undertake specified actions, the power (authority) to implement action, and the ability to enforce (control) the action in an ongoing and consistent manner" (p. 31). In a true shared governance environment, nurses have professional accountability within their role and usually convey their accountability in practice, quality, competence, research, and resource management (Porter, O-Grady, 1992). Nurses have to be willing to own their work processes and decisions; in addition, they must be willing to be involved in the evaluation process of their peers on expectations established by the organizations nursing profession (Batson, 2004).

Equity. Equity within a shared governance structure focuses on all members of the team having an equal stake in the outcomes of the care and quality that they provide (Swihart & Porter-O'Grady, 2006). No one role is more important than the other in providing safe and efficient care. Each member has specific knowledge and skills that,

when combined with those of the entire healthcare team, deliver quality to patients in the most efficient way. Collaboration and team effort are essential for healthcare members to achieve optimal outcomes (Bates, 2004). Equity is achieved when team members come prepared to work within their scope of practice and role within the organization to achieve an overall goal (Bates, 2004).

Ownership. Ownership is based on the fact that success of an organization depends on how well each member of the healthcare team performs their jobs. Bates (2004) describes staff paying attention to detail and showing pride in their work as signs of ownership. Ownership is being responsible for the end product or outcome, whether good or bad. In ownership, the individual goals become team goals, because the goal of the team cannot be achieved without each person skillfully performing his or her roles and integrating his or her efforts (Bates, 2004).

Types of Shared Governance Models

The literature describes several different models for shared governance structure. The most common structures discussed are congressional, councilor, administrative, and unit-based council models (Anthony, 2004; Green & Jordon, 2004; Hess, 2004; Porter-O'Grady, 1992; Swihart & Porter-O'Grady, 2006). There was no literature found to support one model over another. The literature did agree that the councilor model was the most frequently implemented (Swihart & Porter-O'Grady, 2006; Porter-O'Grady, 1992).

In a congressional model, which is structured similarly to that of the federal government, all nursing departments belong to the nursing congress. Members are elected into the cabinet or committees that represent the areas of nursing accountability, which typically include: practice, quality, professional development and education, research,

and management. In this model, work is submitted to the committees for action. The various committees of the congress are delegated decision making power in their area of accountability and report back to the cabinet or senate their activities (Swihart & Porter-O'Grady, 2006; Porter-O'Grady, 1992).

The councilor model uses councils that act on behalf of staff to make decisions. Councils are given authority and accountability to make decisions in their area of oversight (Swihart & Porter-O'Grady, 2006; Porter-O'Grady, 1992). The councilor model is difficult to implement due to the dispersion of accountability. The model does provide for a strong basis for behavioral change and the professionalization of nursing within an organization.

Like the congressional model, the councilor model divides nursing accountability into five key areas: practice, quality, education, research, and resource management (Porter-O'Grady, 1992). The accountability is dispersed between staff and management. Typically there is a central council that coordinates the activities of the different councils.

The administrative model uses a traditional hierarchy of management and clinical practice (Swihart & Porter-O'Grady, 2006). Nurse accountability is divided in the same categories as in the congressional and councilor models. The main difference is that this model has two separate tracks, one for clinical practice and one for management (Porter-O'Grady, 1992). The structure allows for work to be completed by committees and then reported to the responsible committees for accountability (Swihart & Porter-O'Grady, 2006). Porter-O'Grady (1992) acknowledges that the "key characteristic of the administrative model is the structural familiarity in discussing, recommending, and moving decisions upward" (p.101).

The unit-based model is the last model discussed in the literature and is rarely used. Swihart and Porter-O'Grady (2006) state "the culture of the unit gives it form." Accountability is defined by the unit and decisions made on the unit typically do not affect the organization outside of the unit (Swihart & Porter-O'Grady, 2006). In a unit-based model, each unit can establish its own individual system; the downfall is that there may be different models within an organization. Unit-based councils are not recommended by literature because they do not integrate with the organization or the nursing executive level. Unit-based councils should not be confused with Unit Team Councils in the councilor model, as they integrate with the organization.

Benefits of Shared Governance

There are several benefits of implementing shared governance models within an organization. Anthony (2004) suggests that there are both direct and indirect financial impacts to an organization with shared governance implementation. The literature is limited in studies that measure the financial impact of shared governance, with the most recent one dated from 1993. These studies show cost savings over time after implementing shared governance. DeBaca, Jones, and Tornabeni (1993) found a \$6,000,000 savings over a five-year period for their organization after implementing shared governance, and that shared governance contributed to the decreased use of agency nurses and decreased costs of orientation and recruitment related to nurse turnover. They also demonstrated improved quality of care, along with increased satisfaction of nurses and physicians. Finkler, Kovner, Knickman, and Hendrickson (1994) reviewed costs related to recruitment and retention in 37 hospitals. The hospitals that implemented shared governance demonstrated a decrease cost per bed in comparison

to other delivery models and a significant decrease in RN hours per patient day. They also showed a decrease in turnover and sick hours per fulltime equivalent (FTE).

There are several studies that look at the work environment of shared governance models. Kennerly (1996) looked at the effect of shared governance of work perceptions and work environment. The study looked at outcomes of job satisfaction, role conflict, and ambiguity, in addition to different work variables in hospital units with and without shared governance. Kennerly found few differences between shared governance hospital units and non-shared governance hospital units. According to Kennerly (2006), “job satisfaction, anticipated turnover, and perceived effectiveness were not significantly influenced by initiating shared governance” (p. 115).

The literature shows job satisfactions is correlated with nurse retention and improved patient outcomes (Sorensen, Seebeck, Scherb, Specht, & Loes, 2009). Job dissatisfaction has also been linked to negative patient outcomes (Aiken, Clark, Sloane, Sochalski, & Silber, 2002; Allen, Bockenbauer, Egan, & Kinnaird, 2006). There are several studies that examine shared governance and its relation to improving the work environment, nurse satisfaction, and nurse retention. Jones and colleagues looked at the work environment pre- and post-implementation of shared governance and found a significant improvement in decision making style of managers over a three-year period (Jones, Stasiowski, Simons, Boyd, & Lucas, 1993). The study also showed improvement in job satisfaction and turnover (Jones et al., 1993). Another study implemented a unit-based councils in the intensive care unit and reported findings of increased nurse perceived autonomy. The same study reported there was an increase in team cohesiveness, communication, and decision making (Edwards et al., 1994). A study

conducted by Hastings evaluated shared governance outcomes by comparing models between nurses working different specialties. The results showed the nurses had a higher job satisfaction, an increased perception of giving high quality care, and increased decision making among the nurses and peer support (Hasting, 1995).

Measurement of Shared Governance

The difficulty of measuring shared governance outcomes is associated with determining whether or not shared governance is truly in place within an organization. The governance structure is necessary to ensure that the principles of shared decision making are upheld, but structure alone is not considered shared governance (Anderson, 2011). According to Anderson, “the concept is more than a structure; the philosophy of professional accountability must be implemented” (p.198). Hence, the measure of governance is critical in the evaluation of outcomes and assessing the level of implementation (Anderson, 2011). Research shows that it takes three to five years for full implementation of shared governance (Porter-O’Grady, 1992).

There are no studies showing consistency between the relationship in shared governance models and their effect on patient outcomes (Hess, 1995; Anderson, 2011). The literature is limited in research that demonstrates the utilization of valid and reliable tools to measure shared governance outcomes (Anderson, 2011). Most studies attempted to capture some measurements of shared governance demonstrated through single case studies and unstructured research (Anderson, 2011). Pruett (1989) designed a questionnaire that attempted to measure the level of shared governance implementation; however, the validity and reliability of the tool was not established. Hitchens and colleagues designed and used a tool to measure the degree of governance (Hitchens,

Capuano, Bokovoy, & Houser, 2005). The tool was found to be applicable only within their organization. Some tools measured only certain characteristics or components of shared governance, such as Minors Shared Governance Survey. This survey measures the components of staff understanding, commitment, and personal perceptions found in shared governance (Minors & White, 1996). The Conditions of Work Effectiveness Questionnaire measures empowerment as it is perceived by staff nurses having access to power within an organization (Erickson, Hamilton, Jones, & Ditomassi, 2003). The Decisional Involvement Scale is a measurement tool that measures the involvement of staff nurses in decisions. This tool measures the degree of actual decision involvement of staff nurses or management on 21 items using a five-point scale (Havens & Vassey, 2003). This tool was found to be valid and reliable for measuring decisional involvement of staff. However, in review of the literature the Index of Professional Nursing Governance (IPNG) has been found to be the most reliable and valid tool and has been used in over 150 healthcare organizations nationally and internationally to measure the degree of shared governance within organizations.

Hess (2011) designed the IPNG tool (Appendix D), which “measures the distribution of control, influence, power, and authority” (p. 236). The IPNG yields an overall score of governance for organizations, in addition to measuring the availability of an aggregate score for individual levels of management, units, and departments (Hess, 2011). The IPNG is an 86-item tool that uses a 5-point Likert scale broken down into 6 subcategories that characterize shared governance within the organization (Hess, 2011). The six subscales include (1) “control over personnel, (2) access to information, (3) influence over resources supporting practice, (4) ability to participate in organizational

decisions, (5) control over practice (6) the ability to set goals,” (Hess, 2011, p. 237). The results are summed to give an overall score for shared governance. The tool is designed to rank an organization as having, in place traditional governance, shared governance or self-governance. According to Hess, organizations implementing shared governance should aim for a minimum score of 173.

The Cost and Savings of Shared Governance

The SRDH shared governance cost center has two fulltime equivalents (FTE) budgeted for supporting shared governance activities. It is expected that with the increased awareness and planned revitalization of the current infrastructure to support unit team council activities, the budgeted hours allotted for shared governance will increase, threatening productive hours and exceeding the budget. Shared governance councils usually average seven to nine individuals, budgeted at four hours per month at an average salary of \$32.00/hr. If council activities were at maximum capacity, the cost of shared governance activities for unit team councils would cost \$442,368 (Table 1). Organizational and specialty-based councils at maximum capacity would cost the organization \$152,064 (Table 2).

Table 1

Cost of Unit Team Councils Activity at Full Capacity at All SRDH Campuses

Campus	Units	Nurses	Rate	Hour/Month	Months	Total
Siena	14	9	32	4	12	\$193,536
San Martin	8	9	32	4	12	\$110,592
Rose de Lima	10	9	32	4	12	\$138,240
Grand Total						\$442,368

Table 2

Cost of Organizational and Specialty Councils Activity at Full Capacity All SRDH Campuses

Campus	Units	Nurses	Rate	Hour/Month	Months	Total
Specialty Councils	5	9	32	4	12	\$69,120
System Councils	6	9	32	4	12	\$82,944
					Total	\$152,064

Both unit team councils and organizational and specialty councils operating at full capacity would cost the organization \$594,432. In reviewing the \$594,432 that would be spent on shared governance activities if all three campuses were at maximum activity, it is necessary to perform a cost benefit analysis and compare it to the cost of replacing and training a nurse. According to the literature, replacing a nurse can cost up to \$64,000 per nurse turnover (Jones, 2007; Waldman, Kelly, Sanjeev, & Smith, 2004).

Assuming staff engagement and commitment to shared governance prevented one nurse on every unit from leaving at each hospital campus. As an organization the cost savings would total \$2,048,000 (Table 3), and if shared governance was implemented instead there would be a net savings of \$1,453,568. This scenario shows evidence of potential savings in the cost of nursing replacement.

Table 3

Cost and Savings of Retaining One RN on Each Unit and Campus

Campus	Units	Nurses	Cost	Total Savings
Siena	14	1	\$64,000	\$896,000
San Martin	8	1	\$64,000	\$512,000
Rose de Lima	10	1	\$64,000	\$640,000
Grand Total				\$2,048,000

CHAPTER 4

METHODOLOGY

Design, Setting, Sample

This project was a descriptive study to evaluate the current state of shared governance within the SRDH. I distributed the IPNG survey tool to 1,418 registered nurses employed at the SRDH's three campuses. The survey was offered through the Intranet with SurveyMonkey[®] and by printed copy through interoffice mail.

The target population for data collection using the ANCC Magnet framework for shared governance included multiple stakeholders to include nurse leadership, hospital employees, and shared governance council members. The data was collected from this target, in addition to the reviewing of hospital policies, procedures, and system processes.

Procedure

The University of Nevada Las Vegas (UNLV) capstone committee approved moving forward with the implementation of the project proposal. I then presented the proposal to the Chief Nurse Executive Council before seeking UNLV and Western Institutional Review Board (IRB) approval. After obtaining approval from the Chief Nurse Executive Council, I obtained a letter of authorization to conduct research from each facility campus giving permission to proceed. The UNLV and Western IRBs deemed the study exempt.

Data Collection

Materials and instruments. Quantitative data was obtained using the IPNG survey tool. The RN-focused IPNG survey tool was developed by Robert Hess (2009). According to Hess (2009):

The IPNG measures professional governance on a continuum ranging from traditional to shared to self governance. *Professional governance* is a multidimensional concept that encompasses the structure and process through which professionals control their professional practice and influence the organizational context in which it occurs. Higher aggregate scores indicate that the professionals, as a group, believe that they have more influence over professional practice and governance decisions in their organization. (p. 2)

The study used all 86 items of the survey. The IPNG contains five subscales and a full scale score encompassing all subscales in one. Participants respond to items on a 5-point Likert scale: “1: Nursing management/administration only,” “2: Primarily nursing management/administration with some staff nurse input,” “3: Equally shared by staff nurses and nursing management,” “4: Primarily staff nurses with some nursing management/administration input,” and “5: Staff nurses only.” Scores for the full scale and subscale are computed by summing the responses of each nurse across all 86 items or items comprising each subscale respectively.

The tool was designed to measure the dimensions of traditional governance, shared governance, or self-governance depending on the respondents answers to the dominant group that controls the domain (Hess, 2011). According to Hess, “An essential goal of hospitals implementing shared governance models is to meet the minimal score of 173” (2011, p. 237).

The ranges for the six subscales were also calculated by summing up each individual item. Subscale 1 included 22 items related to control over personnel and

addressed the organization structures in place related to hiring, evaluating performance, disciplinary actions, and recommendation of salaries and benefits. The range for shared governance in this subscale is between the ranges of 45-88 (Hess, 2010). Subscale 2 included 15 items related to access to information, including budget and expenses, goals and objectives, organizations finances, and opinions of staff, patient, and physicians. The range for shared governance in this subscale is between the ranges of 31-60. Subscale 3 included 13 items that were related to who influences resources that support professional practice within the organization. The range for shared governance in this subscale is between the ranges of 27-52. Subscale 4 included 12 items related to the organizational structures in place to support participation in committees. The goal for shared governance in this subscale is between the ranges of 25-48. Subscale 5 included 16 items related to control over professional practice, specifically patient care policies and procedures, quality and care products, staffing, education, and research in practice. The goal for shared governance in this subscale is between the ranges of 33-64. Subscale 6 included 8 items related to setting goals and conflict resolution within the organization. The goal for shared governance in this subscale is between the ranges of 17-32. Written permission to use the IPNG tool was obtained from its creator, Dr. Robert Hess.

Internal consistency reliability is an index of the consistency of participant responses on the scales. Greater consistency in responses signifies that there was less error in the measurement of the purported construct(s) of interest, which is desirable. Furthermore, high reliability is a crude and initial index that the scale is in fact measuring what it is intended to measure—that is, construct validity. Construct validity is essential because if the items measure the construct the research intends to measure, the inferences

and conclusions one draws from the results are more valid for the sample and population of nurses. However, it is important to note that high reliability is necessary but not sufficient by itself to establish validity. Ideally, researchers seek internal consistency reliability coefficients of at least .70 or greater (Tabachnick & Fidell, 2007). The scales of the survey used in the present study were highly reliable, with the internal consistency reliability coefficients, Cronbach's α , ranging from .90 to .98.

Qualitative data was collected using the ANCC Magnet Framework as a standard to conduct the gap analysis. The ANCC Magnet Framework was used as the standard measurement to conduct the gap analysis relevant to elements of shared governance in comparison to current structure and processes. The Professional Practice Team Council divided up the Magnet elements among council members who were responsible for providing evidence to support their assigned Magnet Component by reviewing policies/procedures and meeting with staff, nurse leaders, and appropriate stakeholders to obtain feedback. A checklist was developed to collect the data and identify the gaps in structure and processes compared to the components of the Magnet framework.

Resources/Cost

Resources specifically related to this project included the costs associated with administering the IPNG survey tool to all RNs at three campuses. This includes paper and ink for the tool to be printed out and distributed in the staff mailboxes. The cost also includes the hours required to upload the data into SurveyMonkey[®]. An administrative assistant inputted the questions into SurveyMonkey[®] and provided a hard copy to nurse leaders for distribution to their nurses via department mailboxes. The largest cost of the study was the cost of a statistician at \$250.00 and Western IRB fees of \$600.00.

Project Timeline

The first project milestone was completion of the proposal and defense in April 23, 2012. Permission was obtained in June 2012 from the Chief Nurse Executives of the participating facilities (Siena, San Martin, and Rose de Lima) in the form of a “Letter of Authorization to Conduct Research.” The application for UNLV IRB was submitted in June 2012 and granted exempt status in July 2012. The application was submitted to WIRB in August 2012 and granted exempt status in August 2012. The distribution of the surveys was delayed several weeks due to the organization’s implementation of a new Electronic Health Record system and at the request of the Chief Nurse Executives. During this timeframe in August 2012, the Professional Practice Team Council began performing a gap analysis using the ANCC Magnet Gap Analysis & 14 Forces of Magnetism as a framework. The gap analysis was completed in February 2013. The distribution of the IPNG Tool survey began October 27, 2012 and ended November 30, 2012. Data analysis of the IPNG Tool Survey was performed in December 2012 and January 2013 with the assistance of a statistician. The final results of the gap analysis and IPNG data results were completed at the end of February 2013. A summary of the capstone project and findings was presented to stakeholders with recommendations based on project findings. The final milestone was a final defense of the project on March 4, 2013. See Appendix E for Project Timeline.

Ethical Considerations

To maintain privacy and confidentiality, participants’ personal identification information was not required. Participants solicited for feedback as part of the Magnet gap analysis were not individualized, but their feedback was used to make an overall

assessment of the program's strengths and weaknesses. In addition, the researcher completed the required CITI course and complied with all ethical principles to protect the rights, safety, and welfare of participants in the study.

Data Analysis

Quantitative data were analyzed by IBM SPSS version 19, including descriptive statistics, summarized demographics, and total score. Descriptive statistics described sample characteristics in frequencies, means and standard deviations. The overall governance score was calculated by summing up the individual item scores.

Qualitative data were collected from a review of hospital policies and procedures and system processes, and feedback from staff and nurse managers/directors. Elements with weak or limited sources of evidence were considered as a gap needing further development.

Data preparation. Quantitative data were cleaned by removing all incomplete surveys, defined as four or more questions with missing data. Original survey respondents totaled 342 out of 1418, with 88 deleted due to being incomplete. Forty seven outliers were detected and eliminated from the cleaned dataset containing 254 cases, thus yielding 207 cases available for analysis. If not eliminated, outliers undermine the trustworthiness of the data because they unduly influence the group means and the normality of the data by affecting skewness and kurtosis.

Furthermore, data were tested for univariate and multivariate assumptions, including normality (skewness and kurtosis), collinearity, and homogeneity of error variance/covariance among the groups with respect to the outcomes in order to proceed with data analysis. Regarding normality, the data approximated a normal distribution at

the univariate and multivariate level after the removal of the 47 outliers, with kurtosis values ranging from 0.01 to -0.81 and skewness values ranging from 0.01 to -0.42, both > (Tabachnick & Fidell, 2007), which is ideal. Therefore, data transformation procedures were not performed. All other assumptions were also met, and thus, data analysis proceeded without any statistical adjustments to the data.

Analysis. A series of one-way multivariate analyses of variance (MANOVAs) were conducted to ascertain whether there were differences among key independent variables (e.g., campus, unit, age, gender, etc.), with the six subscales serving as the dependent variables in each analysis.

The full scale score served as the dependent variable in separate one-way analyses of variance (ANOVAs). This analytical approach was selected because including the full scale score with the five subscales would have resulted in multicollinearity (i.e., a situation in which variables are very highly correlated, leading to problems in the convergence and stability of statistical solutions) because the subscales comprise the full scale score. The Bonferroni adjustment was made to obviate the experiment wise Type I error rate inflation, which occurs when conducting multiple analyses ($.05/6 = .01$).

CHAPTER 5

RESULTS

After 30 days, 342 surveys were returned for an overall response rate of 24%. However, only 207 surveys were useable in the analysis, due to the removal of incomplete surveys and outliers in the data. Demographically, the sample consisted of full-time, part-time nurses, and per diem nurses. The number of years in nurses' current position ranged from 3 months to 31 years ($M = 5.27$, $SD = 5.57$). Table 4 in Appendix H contains other descriptive information.

Table 5 contains the means and standard deviations for the full scale and the six subscales by campus. According to the guidelines established by Hess (2009), all three campuses exhibit traditional governance tendencies in which management/administration make the decisions. However, the San Martin campus is the closest to achieving early implementation of governance innovation. The San Martin campus reported the highest mean scores across all scales, including the full scale. Conversely, the Siena campus reported the lowest mean scores across all scales, with the Rose de Lima campus reporting mid-range scores across all scales. Nevertheless, for all scales, no campus reached shared governance.

Table 5

Descriptive Statistics of Shared Governance Scales by Campus

Scale	Siena		San Martin		Rose de Lima	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Full Scale	135.27	28.92	149.54	29.22	140.63	24.80
Personnel	26.20	4.00	28.97	6.05	27.37	3.89
Information	25.47	7.89	28.53	7.84	27.33	7.36
Resources	23.08	7.43	25.11	6.80	23.26	8.32
Participation	20.05	5.90	22.95	5.68	21.15	5.78
Practice	26.80	7.02	29.34	6.89	27.78	5.55
Goals	13.66	4.39	14.65	3.99	13.74	4.04

Analysis by Campus

In the first analysis, campus served as the independent variable. Results of the one-way MANOVA indicated that the difference in nurses' perceptions of shared governance was statistically significantly different between campuses, multivariate $F_{(12,384)} = 3.44, p < .01, \eta^2 = .04$, suggesting a modest strength of association between campus and the linear combination of dependent variables. The Bonferroni adjustment was made to obviate the familywise Type I error rate inflation ($.05/6 = .01$).

Follow up results showed that the significant differences between campuses were in the Personnel subscale, $F_{(2,196)} = 6.85, p < .01, \eta^2 = .07$, and the Participation subscale, $F_{(2,196)} = 5.26, p < .01, \eta^2 = .05$. The effect of campus on nurses' perceptions of shared governance was not statistically significant, $p > .01$, for the Information, Resources, Practice, and Goals subscales. Nurses at the Siena campus reported lower perceptions of shared governance in personnel matters ($M = 26.20, SD = 4.00$) and participation ($M = 20.05, SD = 5.90$) than nurses in the San Martin campus (Personnel: $M = 28.97, SD = 6.05$; Participation: $M = 22.95, SD = 5.68$). None of the other pairwise comparisons reached statistical significance, all p -values $> .01$.

Results of the one-way ANOVA with campus as the independent variable and full scale score serving as the dependent variable demonstrated that there were statistically significant differences between the three campuses regarding nurses' perceptions of overall shared governance, $F_{(2,196)} = 5.29, p < .01, \eta^2 = .05$. Like the previous results, the post hoc follow up analyses demonstrated that there were significant ($p < .01$) differences between the Siena ($M = 135.27, SD = 28.92$) and San Martin ($M = 149.54, SD = 29.22$) campuses, with the San Martin campus reporting higher overall perceptions of shared governance than the Siena campus.

Analysis by Gender

In the second MANOVA, gender (male, female) served as the independent variable. Results indicated that the difference in nurses' perceptions of shared governance as a function of gender was statistically significantly different, multivariate $F_{(6,188)} = 2.57, p < .01, \eta^2 = .08$, suggesting a moderate strength of association between gender and the

linear combination of dependent variables. The Bonferroni adjustment was made to obviate the familywise Type I error rate inflation ($.05/6 = .01$).

The univariate results showed that the significant difference between male and female nurses was in the Personnel subscale, $F_{(1,194)} = 6.95, p < .01, \eta^2 = .04$. The effect of gender on nurses' perceptions of shared governance was not statistically significant, $p > .01$, for the remaining subscales. Male nurses reported significantly higher perceptions of shared governance in personnel matters than female nurses. Although none of the other pairwise comparisons reached statistical significance, all p -values $> .01$, it is interesting to note that male nurses tended to report higher shared governance perceptions except in the Goals subscale, in which females reported a marginally higher sense of shared governance. Table 6 contains descriptive statistics for this analysis.

Table 6

Descriptive Statistics of Shared Governance by Gender

Scale	Male		Female	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Full Scale	149.57	29.42	140.51	29.07
Personnel	30.00	6.91	27.04	4.67
Information	29.45	7.56	26.51	7.91
Resources	23.95	5.77	23.86	7.62
Participation	21.41	5.51	21.17	5.97
Practice	29.55	6.95	27.65	6.90
Goals	13.68	3.67	14.06	4.32

Analysis by Age

The one-way ANOVA with age (21-30, 31-40, 41-50, 51-60, > 61) serving as the independent variable and the full scale score as the dependent variable showed that differences in age significantly influenced full scale score, $F_{(4,193)} = 3.18, p < .01, \eta^2 = .06$. Post hoc analyses indicated that nurses in the 21-30 age range reported significantly higher perceptions of overall shared governance than nurses in the 41-50 age range. Although none of the other pairwise comparisons reached statistical significance, all p -values $> .01$, it is interesting to note that as nurses became older, they tended to report lower and lower perceptions of overall shared governance. Table 7 contains the descriptive statistics for this analysis.

Table 7

Descriptive Statistics of Shared Governance by Age

Scale	21-30		31-40		41-50		51-60		> 60	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Full Scale	156.13	31.98	145.04	27.19	132.85	27.10	141.38	29.53	134.40	29.45

Analysis by Years Practicing Nursing

The one-way ANOVA with years of practicing nursing (1-5, 6-10, 11-15, 16-20, 21-26, and > 26) serving as the independent variable and the full scale score as the dependent variable revealed statistically significant differences in full scale score as a function of years of practicing nursing, $F_{(5,190)} = 3.20, p < .01, \eta^2 = .08$. Post hoc analyses indicated that nurses who have practiced between 1-5 years reported significantly higher

perceptions of overall shared governance than nurses who have been practicing between 21-26 years. Additionally, nurses who have been practicing more than 26 years reported greater overall perceptions of shared governance than nurses who have been practicing between 21-26 years. No other pairwise comparisons reached statistical significance, all p -values $> .01$.

Table 8

Descriptive Statistics of Shared Governance by Years of Practicing as a Nurse

Scale	1-5		6-10		11-15		16-20		21-26		> 26	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Full Scale	151.28	28.89	137.86	26.54	143.79	29.60	140.08	27.77	118.94	27.31	143.53	29.12

Analysis by Unit

Finally, the one-way MANOVA with unit (see Table 9 in Appendix I for a list of all units) as the independent variable indicated that the difference in nurses' perceptions of shared governance as a function of the unit they work in was statistically significantly different, multivariate $F_{(72,941)} = 3.40, p < .01, \eta^2 = .09$, suggesting a moderate strength of association between unit and the linear combination of dependent variables. The Bonferroni adjustment was made to obviate the familywise Type I error rate inflation ($.05/6 = .01$).

The univariate results showed that the significant difference between units was in the Information subscale, $F_{(12,177)} = 2.28, p < .01, \eta^2 = .13$. The effect of unit on nurses' perceptions of shared governance was not statistically significant, $p > .01$, for the

remaining subscales. Nurses in the IMC unit reported significantly higher perceptions of shared governance in information-related matters than nurses in the SDS unit. Moreover, nurses in the IMC unit reported significantly higher information-related shared governance than nurses in the NICU. None of the other pairwise comparisons reached statistical significance at the $p < .01$ level of significance. Table 9 in Appendix I contains the descriptive statistics for this analysis.

Table 10 contains the correlation coefficients for the full scale score and the six subscale scores. All correlations were within normal bounds, positive, and statistically significant, ranging from .40 to .82. Thus, all correlations were moderate to strong. This indicates that as one score increases, the corresponding score does as well. As was expected, the strongest correlations were between the six subscales and the full scale score; this was the case because each subscale is part of the full scale score.

Table 10

Pearson's Product Moment Correlation Coefficients of the IPNG Scales/Subscales

Scale	1	2	3	4	5	6	7
1. Personnel	-	.51*	.40*	.57*	.63*	.45*	.74*
2. Information		-	.52*	.62*	.50*	.63*	.82*
3. Resources			-	.52*	.56*	.42*	.77*
4. Participation				-	.54*	.59*	.81*
5. Practice					-	.45*	.80*
6. Goals						-	.72*
7. Full Scale							-

* $p < .01$ (one-tailed)
 $N = 207$

ANCC Magnet Gap Analysis

The ANCC Magnet Framework was used as the standard measurement to conduct the gap analysis. The gap analysis focused on structural empowerment and exemplary professional practice, two of five elements of the Magnet Model that contained large components of structure and process that support shared governance.

Structural Empowerment

The Magnet Model Components for Structural Empowerment was reviewed for structures and processes that support a shared governance environment. The categories reviewed included: Professional Engagement, Commitment to Professional Development, Teaching and Role Development, Commitment to Community Involvement, and Recognition of Nursing.

Professional Engagement. In the Professional Engagement category, structure, processes, and outcomes were reviewed for description and demonstration of nurses' engagement in organizational decision making including committees, councils, and task forces. This category also looked at structures, processes, and outcomes for nurses' engagement outside of their organization in professional organizations at the local, state, and national levels. The results from the gap analysis identified that the organization has a number of formal structures in place to engage staff in decision making; however, participation is primarily by nurse leaders with few direct-care nurses. The gap analysis also identified that the organization has a shared governance structure in place for staff participation, in addition to a number of committees outside the shared governance model, but not all nursing departments participate. The gap analysis identified that while some nurses within the organization are engaged in professional organizations at the

local, state, and national level, the organization does not have a formal structure or process in place to engage participation.

Commitment to Professional Development. In the Commitment to Professional Development category, the structure, processes, and outcomes were reviewed for description and demonstration of the organization's commitment to staff development, expectations that support lifelong professional learning, role development, career advancement, and community partnerships to encourage educational progression. The analysis identified that the organization has robust structures and processes in place to support professional development in formal education. The analysis also revealed the organization to have strong community partnerships to advance education. However, a gap was identified for further development of structures and processes to consistently track and trend and measure outcomes of the organization's goals for formal education and professional certifications.

Teaching and Role Development. In the teaching and role development category, the structure and processes were reviewed related to the teaching role of nurses within the organization. The analysis identified that the organization has strong structures and processes in place that demonstrate the nurses teaching role, involvement educational community events, and support academic practicum as preceptors, instructors, and faculty. No gaps were identified in the teaching and role development components.

Commitment to Community Involvement. In the commitment to community involvement category, the structures and processes were reviewed to describe and demonstrate the allocation of resources for affiliation with schools of nursing's, consortiums, and community outreach programs. The gap analysis identified that SRDH

has a partnership with a number of the local schools of nursing and is involved in a number of local consortia and community outreach programs that demonstrate commitment to the community. No gaps were identified in the component demonstrating commitment to the community.

Recognition of Nursing. In the recognition of nursing category, the structure and processes were reviewed that described and demonstrated how the organization recognizes and makes visible the contributions of nurses. The analysis identified that the organization has strong structures and processes in place to recognize nursing contributions both within the organization and in the community. No gaps were identified in the component of recognition of nursing; however, further development of recognizing nursing specific categories (i.e. education, research, practice, quality, leadership, etc.) should be considered to entice and engage nurses to contribute back to the profession.

Exemplary Professional Practice

In addition to reviewing structures and processes for Structural Empowerment, the committee also reviewed the Magnet Model Components for Exemplary Professional Practice for components found to be relevant to shared governance. These components were identified as Professional Practice Model; Care Delivery Systems; Staffing, Scheduling, and Budgeting; Processes; Interdisciplinary Care; Accountability, Competence, and Autonomy; Ethics, Privacy, Security, and Confidentiality; Diversity and Workplace Advocacy; Culture of Safety; and Quality Care Monitoring and Improvement.

Professional Practice Model. The professional practice model category was reviewed for structures and processes to describe and demonstrate how nurses developed,

applied, evaluated, and modified the Professional Practice Model. In addition, this component looked for demonstration of application of the professional practice model in nursing practice, collaboration, communication, and professional development activities. The analysis identified a gap in this component. Although the organization has adapted Dr. Jean Watson's Human Caring Theory, there is not a formal professional practice model in place that integrates the theory, care delivery systems, organizations, and nursing mission and vision into one framework or model that guides nursing practice within the organization, nor is there any formal measurements of a professional practice model. The structures and processes were reviewed related to the nurse's involvement in standards of practice, standards of care, and the direct-care nurse's involvement in tracking and analyzing nursing satisfaction or engagement data and outcomes. The organization has a number of structures and processes in place for nurses to be involved in standards of practice and care. Opportunities exist in the structure for direct-care nurses to be involved in tracking and analyzing nurse satisfaction and engagement data. Nursing involvement in developing action plans for nursing satisfaction and engagement is managed mostly at the managerial/director level.

Care Delivery System. The care delivery system category was reviewed for structures and processes that described and demonstrated how the care delivery system involves patients and their support system to plan care. This gap analysis explored how the care delivery system was used to make patient-care assignments ensure continuity, quality, and effectiveness of care. Structures and processes were reviewed that demonstrated how regulatory and professional standards were incorporated within the delivery system, including the use of internal and external experts and consultants. The

organization uses a patient-centered approach to the delivery of care and has expanded the involvement of patients and families through the implementation of a Patient Family Advisory Committee. In addition to the Patient Family Advisory Committee, the organization has a variety of structures and processes in place that demonstrates the magnet component of care delivery systems. No gaps were identified in this component.

Staffing, Scheduling, and Budgeting Processes. The staffing, scheduling, and budgeting category was reviewed for structures and processes that described and demonstrated how nurses trend data from staffing plans to gain resources to consistently apply the care delivery system. It also reviewed how direct-care nurses participate in staffing and scheduling processes, including developing and implementing action plans for unit-based staff recruitment and retention. The gap analysis identified that the organization has a number of structures and processes in place for staff involvement of staffing and scheduling processes, but opportunities exist to further involve direct-care nurses in the staffing processes. The analysis identified a gap in nurse's involvement in unit-based staff recruitment and retention and the developing, implementing, and evaluation of action plans. A gap was also identified for structure and process to include direct-care nurses in decisions regarding unit and department budget formulation, implementation, monitoring, and evaluation. The two gaps identified are performed primarily at the nurse director/manager level with little input from direct-care nurses.

Interdisciplinary Care. The interdisciplinary care category was reviewed for structures and processes that described and demonstrated how nurses were involved in interdisciplinary collaboration in leadership roles, developing policies, determining standard of care, evaluating quality and process improvement, and developing patient

education programs. The analysis reviewed interdisciplinary structures and process that were in place to ensure continuity of care across multiple settings and collaboration with information technology used in clinical care. The gap analysis identified that the organization has many structures and processes in place for interdisciplinary care and collaboration. There were no gaps identified in this component.

Accountability, Competence, and Autonomy. The accountability, competency, and autonomy category was reviewed for structures and processes that described and demonstrated how nurses are able to access routine and current literature, professional standards, and references to support autonomous practice. The organization has a number of resources available to staff including an internal intranet site that is available to staff with online access to evidence-base practice references and resources. The gap analysis identified that not all staff members are aware of the resources or how to use the resources to integrate them in supporting autonomous practice and decision making at the bedside. The structures and processes within the organization were reviewed for nursing involvement in self-appraisal performance reviews, peer review, including annual goal setting for competency and professional development. The gap analysis identified that although the majority of nurse leaders use a self-appraisal process and obtain peer review feedback, the process is not consistent throughout the organizations.

The structures and processes were reviewed in this component to support shared leadership/participative decision making and promoting nursing autonomy. The gap analysis identified that the organization has structures and process in place to support shared leadership and participative decision making, but all nursing departments are not engaged in participation. The gap analysis also identified that in the councils that are

participating, decision making does not address all aspects of nursing practice. The analysis identified that further processes need to be developed to guide new council members, mentor old council members, and provide professional development to teach councils how to align council activities with organizational goals, set outcome measures, and evaluate council activities. The gap analysis also identified increased turnover among council members has made it difficult for unit team councils to keep any momentum in council activities and has contributed to council's inactivity. The last elements of this component were reviewed for structures and processes that were in place for nurses to resolve patient care and operational issues. The gap analyses identified there were structures and processes in place, but they primarily involve participation at the managerial/director level with little involvement by direct-care nurses.

Ethics, Privacy, Security, and Confidentiality. The ethics, privacy, security, and confidentiality category was reviewed for structures and process that described and demonstrated how nurse use resources, such as the ANA code of Ethics for Nurses, to address complex ethical issues and how nurses resolved issues related to patient privacy, security, and confidentiality. The analysis revealed that the organization has many processes in place that are available to staff for resources to address ethical issues and resolve patient privacy, security, and confidentiality issues they may encounter in the clinical setting. The gap analysis identified no gap in this component.

Diversity and Workplace Advocacy. The diversity and workplace advocacy category was reviewed for two of the five elements that included structures and processes that described and demonstrated how the organization identified and managed problems related to incompetent, unsafe, or unprofessional conduct. In addition, this component

was reviewed for structures and processes that demonstrated and described workplace advocacy initiatives for caregiver stress, diversity, rights, and confidentiality. The gap analysis identified that the organization has many resources in place that demonstrates this magnet component, and no gaps were identified.

Culture of Safety. The culture of safety category was reviewed for structures and processes that demonstrated and described how the organization improves workplace safety for nurses, uses a facility-wide approach for proactive risk assessment and error management, and supports a culture of patient safety. The gap analysis identified the organization has a robust workplace safety, risk management, and patient safety program in place that supports a culture of safety. The structures and processes in this component were also reviewed to describe and demonstrate nursing-sensitive indicators, participation, and evaluation of outcome measures. The gap analysis identified that although the hospital participates NDNQI for nursing sensitive indicators, all nursing units do not participate.

Quality Care Monitoring and Improvement. The quality care monitoring and improvement category was reviewed for structures and processes that describe and demonstrate how the organization allocates resources to monitor and improve the quality of nursing and patient care. This component also reviewed how nurse leaders disseminate quality data to direct-care nurses and how the nurses use data to identify significant findings and trends in overall patient satisfaction. The gap analysis revealed the organization has many structures and processes to ensure the appropriate allocation of resources for quality of nursing and patient care. The gap analysis identified an inconsistent process across the organization for the dissemination of quality data to

direct-care nurses. The analysis identified that quality data are not routinely incorporated into activities of UTCs. The analysis also identified the current structure to monitor and evaluate nursing quality is addressed primarily at the managerial/director level through their house-wide Interdisciplinary Patient Care Team Committee (Quality Council) and does not involve direct-care nurses.

CHAPTER 6

EVALUATION

The Centers for Disease Control and Prevention (CDC) framework for program evaluation was used to guide the evaluation process of this project. The framework consisted of six steps to guide the evaluation (Mateo & Kirchoff, 2009):

1. Engage stakeholders
2. Describe the program
3. Focus the evaluation design
4. Gather credible evidence
5. Justify the conclusions
6. Ensure use and share lessons learned

The stakeholders were engaged through one-on-one and group meetings, written feedback, and open forums to review the current shared governance state, infrastructure, and processes. The stakeholders provided feedback on the organization's strength and weakness in the current shared governance model. The program's current state was compared to the desired state utilizing the ANCC Magnet Framework and 14 Forces of Magnetism and the IPNG survey tool. The evaluation documented how well the program was running and documented areas for improvement based on the feedback from stakeholders, the gap analysis, and the IPNG survey tool, which was used as credible evidence to support the process. The combined findings of the evidence, IPNG survey tool, and the gap analysis results using the Magnet Framework provided answers to the research questions.

In addition to answering the research questions, the findings provided justification to support conclusion with the following project outcomes:

1. Data analysis of the IPNG tool measured the current state of shared governance in the facility as traditional governance. The goal was to demonstrate organizational structure and culture reflective of shared governance by achieving an overall mean score of greater than or equal to 173. The results from this tool was able to give a composite score under the 6 domains that are characteristic of shared governance allowing for the organization to determine what their strengths and weaknesses were in their current structure.
2. Completed gap analysis using ANCC Magnet framework for Exemplary Professional Practice & Structural Empowerment related to elements of shared governance. The goal with this measurement was to meet all element standards of the Magnet framework that referenced shared governance by demonstration of supportive documents, processes, or projects as sources of evidence. This measurement identified areas of improvement and strategies that need to be in place to meet standards.

The dissemination of findings was documented in an executive summary. The summary contained findings of both the gap analysis and the IPNG survey tool results. The summary was shared with nurse leadership and provided recommended changes to advance shared governance within the organization.

Discussion

The overall purpose of the study was to evaluate the current state of shared governance at SRDH and make recommendations based on those findings to strengthen

and improve processes to engage staff in shared decision making. In doing so, the study did meet its objectives and answered the research questions it set out to address.

The first question the study set out to answer was “What is the current status of shared governance within SRDH?” Despite having a shared governance infrastructure in place since 2007, the organization has not yet achieved a baseline measurement within the shared governance range. In the overall governance scale each of the three campuses scored below the minimum score of 173, which places the organization in a state of traditional governance score range, where decisions are primarily made by management and administration only. Although, the San Martin campus did not score in the shared governance range, the San Martin campus nurses reported higher perceptions of overall shared governance than the other campuses. Interestingly, the Rose de Lima campus currently does not have any unit team councils currently, but it scored higher than the Siena campus for overall shared governance. The Siena campus has three active unit team councils. These findings support the fact that achieving full implementation of shared governance is a lengthy process and can take from three to five years to achieve or longer (Hess, 2011; Porter-O’Grady, 1992).

Analysis of the six subscales showed that SRDH scored in the traditional range for the following domains: control of personnel, access to information, influence over resources, and participation in committee structures, control over professional practice, and goal setting and conflict resolution. These findings aligned with the gap analysis, which identified organizational structures in place for nurses to participate in shared decision making, but staff engagement was low and attendance was inconsistent at both the department-level and hospital-wide councils. The findings of the study also identified

that nurses in the 41-50 age range have a lowered perception of shared governance. Nurses that have been in their roles between 21-26 years also demonstrated a lowered perception of shared governance. The older the nurse and longer they have been in the organization, the lower the perception they had of shared governance.

The second research question the study addressed was “What are the strengths and weaknesses of shared governance with the organization?” Using the ANCC Magnet Gap Analysis as the standard, the overall strength of the shared governance program was identified as having strong structures and processes currently in place that supported shared governance, along with support by the nursing leadership. Findings of the analysis identified weaknesses or gaps in the following categories for structural empowerment: professional engagement and commitment to professional development. In addition, gaps were identified in the Exemplary Professional Practice component in the following categories professional practice model; staffing, scheduling, and budgeting process; accountability; competence; autonomy; and quality care monitoring and improvement. The gaps that were identified could be contributing factors to the organizations not achieving a state of shared governance. As the standard for nursing excellence, the characteristics of the 14 Forces of Magnetism, which is the core of the Magnet Model, aspires to shared decision making and an the development of an excellent practice environment (Swihart & Porter-O’Grady, 2006). Closing the identified gaps would support an infrastructure for shared governance.

The third research question was “What are the primary areas of shared governance the organization needs to focus on for improvement efforts?” The survey identified all three campuses achieved traditional governance in all six subscales, with a

significant finding between the campuses in the Personnel subscale and the Participation subscale. Overall, improvements in all six subscales need to be achieved to score in the shared governance range. Of the three campuses, the San Martin campus is the closest to achieving early implementation of shared governance.

The last research question was “What are recommended strategies to improve shared governance within the organization?” The following recommendations are proposed to improve and advance shared governance within the organization. The recommendations promote structural empowerment and an exemplary professional practice environment that supports the full engagement of shared governance.

The first recommendation is that the organization should consider redesigning the current shared governance model in the development of their strategic plan. The redesign of the current model should include councils that encompass all aspects of nursing practice (i.e. quality, education, practice, research, resources, and finances). In addition, a coordinating council should be included to coordinate and oversee all council activities and align council activities with the organizations goals and objectives. These recommendations are supported by Kanter’s Theory (1993), which examines formal and informal power structures in the workplace. Redesigning the current model to address all aspects of nursing in shared decision making gives nursing staff access to these power structures that create empowerment in the work environment. In alignment with Kanter’s Theory, a redesign will provide staff with the structure for opportunity, structure for power, and structure of proportions, which provide staff increased autonomy, decreased job satisfaction, and increased commitment.

A second recommendation is to engage more direct-care nurses in committees and councils by reducing barriers by adjusting schedules to allot time for participation and allocating resources for covering a replacement at the bedside. Ballard (2010) acknowledges those leaders who do not support meetings or allot time for projects in their planning of their budget send a message that the shared governance process is not important or valued within the organization. One way of achieving greater professional engagement from the nursing staff is for the organization to consider implementing a formal professional advancement structure, such as clinical ladders, to further engage nurses in participation of shared decision making and commitment to professional development. Literature supports that clinical ladders not only encourage staff participation, but improve nursing satisfaction and positively impact nursing retention, resulting in reduced cost related to staff turnover (Drenkard & Swartwout, 2005).

The third recommendation includes assembling a multidisciplinary workgroup to review the findings of the Magnet gap analysis and the IPNG survey results. This workgroup would develop strategies to close the structure and process gaps and advance the IPNG survey scores into the shared governance range. It is also recommended that the IPNG survey be repeated in 2-3 years to evaluate outcomes of implemented strategies to improve shared governance within the organization (Hess, 2011).

Limitations

The overall response rate was 29%, which may not be representative of all nurses working across the organization. The low response may be due to the length of the survey which some staff members commented on. This feedback would explain the large number of incomplete surveys. An incentive might have generated a better response.

Another limitation of the study was that data were not collected as to how many of the respondents were engaged in hospital-wide or department-level councils and work groups. It would have been of interest to compare responses from those who were or were not engaged in council activities. Moreover, 20% of the respondents were removed because they were considered outliers. Although a relatively large proportion, it is essential that data be properly screened for univariate and multivariate outliers, as these individuals unduly influence group means and may lead to erroneous, inaccurate conclusions (Tabachnick & Fidell, 2007). However, to add legitimacy to the results, all of the analyses were conducted with all of the outliers included; the results of these analyses changed neither the statistical nor practical significance of the substantive interpretations. In spite of these limitations, the present investigation contributes substantively to the literature on shared governance.

Conclusion

Overall, the combination of the IPNG survey tool and the ANCC Magnet gap analysis to evaluate the current shared governance state was beneficial in identifying areas for improvement and achieving nursing excellence. The results of the survey and the gap analysis indicate that SRDH, although having shared governance structures in place, remains in traditional governance, with decisions being made primarily by management and administration. Opportunities exist to increase shared decision making across all six subscales of the IPNG tool.

The IPNG survey tool and the ANCC Magnet gap analysis can be used in the future as an outcome measure for the implementation of strategies to address the subscales that scored below the shared governance range. Future studies using the IPNG

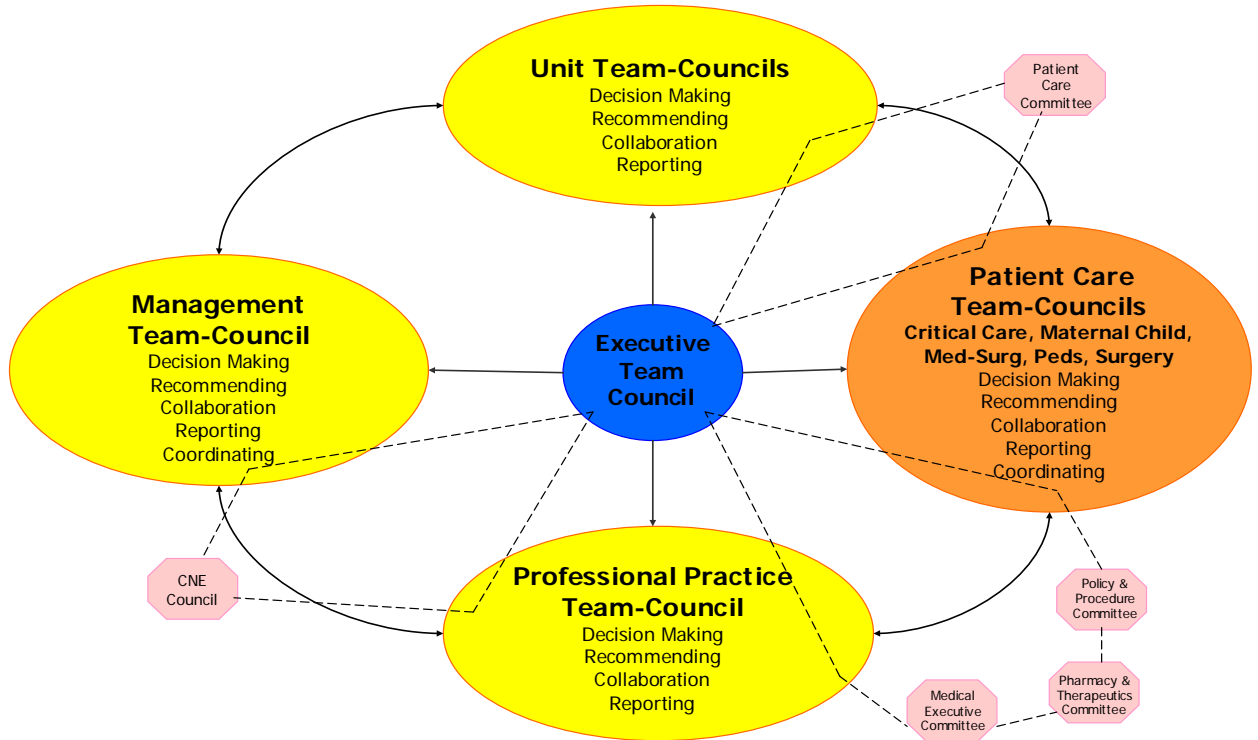
survey tool should focus on comparing staff who are involved in shared governance with those who are not. In addition, studies can further examine comparison of departments that are performing well against those that are low performers and look at strategies to bring low performing departments to higher levels. Findings from this study will guide the leadership team in developing strategies to advance nurse professionals in improving structures and processes to support shared governance.

Appendix A

SRDH Shared Governance Model

Professional Nursing Team-Council Organization Model

The Unit Based Team Council is where the majority of professional practice changes begin and end.



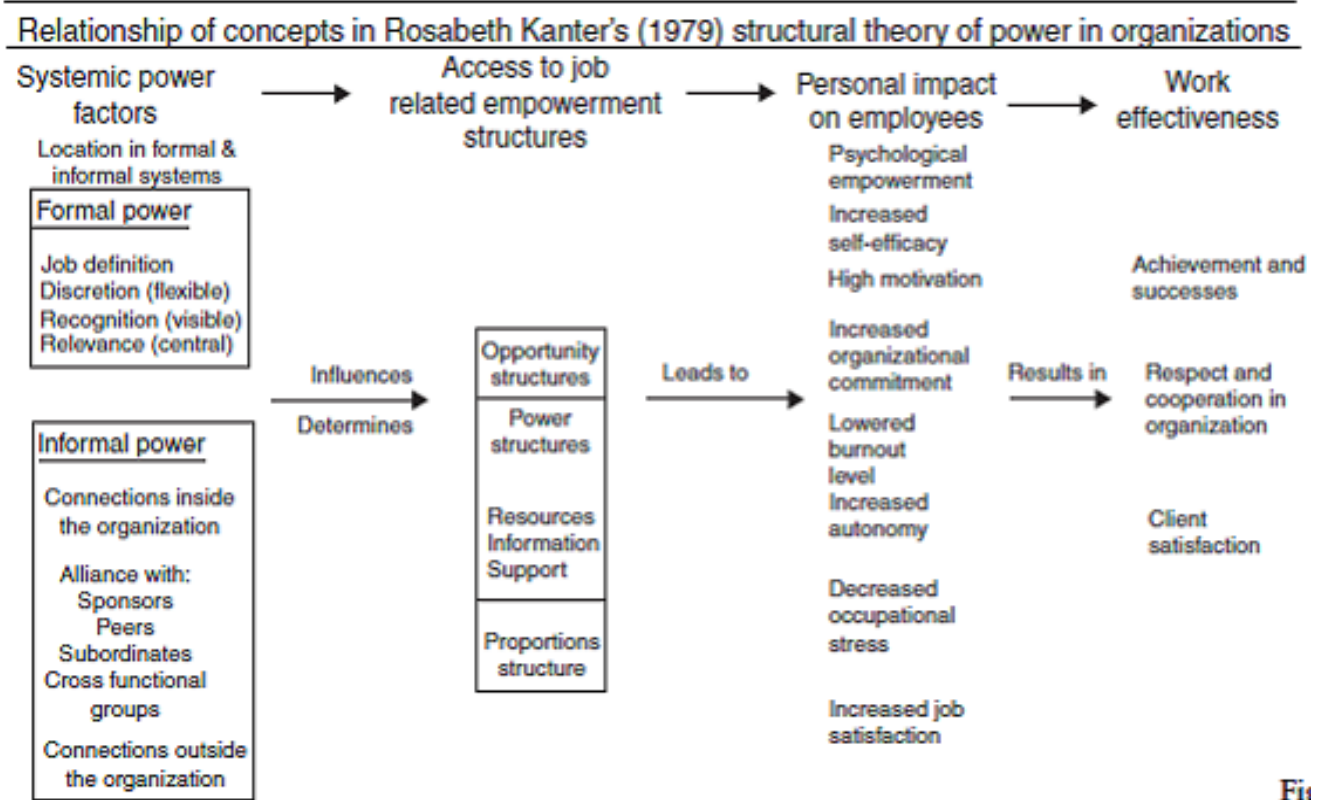
CC: ICU, Neuro, IMC, ER, Trauma ER, Trauma Services, Cardiology, Cath Lab, Cath Lab Recovery, Radiology **MCC:** L&D, NICU, Level II Nursery, MCC
Med Surg: Med-Surg, JRU, Oncology, Home Health, Wound Care, Palliative Care **Peds:** Peds, PICU, Peds ER **Surgery:** OR, PACU, SDS, GI

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Appendix B

Kanter's Structural Theory of Power in Organizations

Theoretical framework

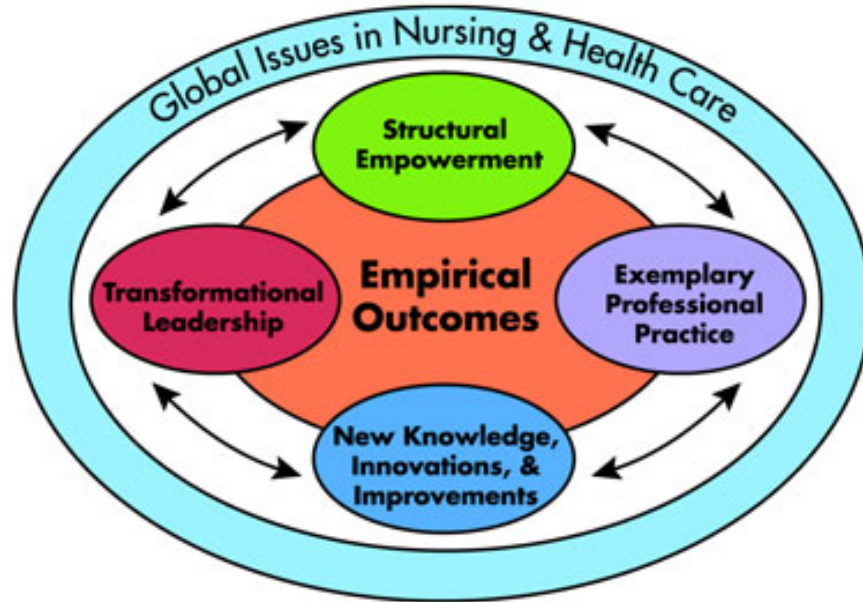


Fig

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Appendix C

Magnet Model[®]



Forces of Magnetism[®]

MODEL COMPONENTS	FORCES OF MAGNETISM
Transformational Leadership	>> Quality of Nursing Leadership <i>Force #1</i> >> Management Style <i>Force #3</i>
Structural Empowerment	>> Organizational Structure <i>Force #2</i> >> Personnel Policies and Programs <i>Force #4</i> >> Community and the Healthcare Organization <i>Force #10</i> >> Image of Nursing <i>Force #12</i> >> Professional Development <i>Force #14</i>
Exemplary Professional Practice	>> Professional Models of Care <i>Force #5</i> >> Consultation and Resources <i>Force #8</i> >> Autonomy <i>Force #9</i> >> Nurses as Teachers <i>Force #11</i> >> Interdisciplinary Relationships <i>Force #13</i>
New Knowledge, Innovations, and Improvements	>> Quality Improvement <i>Force #7</i>
Empirical Quality Outcomes	>> Quality of Care <i>Force #6</i>

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Appendix D

Index of Professional Nursing Governance Survey Tool

PROFESSIONAL NURSING GOVERNANCE	
<p><i>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.</i> Today's Date _____</p> <p>Campus <input type="checkbox"/> Siena <input type="checkbox"/> San Martin <input type="checkbox"/> Rose de Lima</p> <p>1. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female 2. Age: _____</p> <p>3. Please indicate your BASIC nursing educational preparation: <input type="checkbox"/> Nursing Diploma <input type="checkbox"/> Associate Degree in Nursing <input type="checkbox"/> Baccalaureate Degree in Nursing</p> <p>4. Please indicate the HIGHEST educational degree that you have attained at this point in time: <input type="checkbox"/> Nursing Diploma <input type="checkbox"/> Master's Degree in Nursing, Specialty <input type="checkbox"/> Associate Degree in Nursing <input type="checkbox"/> Master's Degree, Non-nursing <input type="checkbox"/> Baccalaureate Degree in Nursing <input type="checkbox"/> Doctorate, Nursing <input type="checkbox"/> Baccalaureate Degree in Nursing, Non-nursing <input type="checkbox"/> Doctorate, Non-nursing</p> <p>5. Employment Status: <input type="checkbox"/> Full-time, 36-40 hours per week <input type="checkbox"/> Part-time, less than 36 hours per week (specify number of hours/week): _____</p> <p>6. Please specify the number of years that you have been practicing nursing _____</p> <p>7. Please indicate the title of your present position _____</p> <p>8. Please indicate the type of nursing unit that you work on: <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Obstetrics/L&D <input type="checkbox"/> NICU <input type="checkbox"/> JRU <input type="checkbox"/> Pediatrics <input type="checkbox"/> Peds ICU <input type="checkbox"/> ICU <input type="checkbox"/> IRF/rehab <input type="checkbox"/> Same Day Surgery <input type="checkbox"/> Operating Room <input type="checkbox"/> Radiology <input type="checkbox"/> Cardiology <input type="checkbox"/> Recovery Room <input type="checkbox"/> Quality Management <input type="checkbox"/> Emergency Room <input type="checkbox"/> Case Management <input type="checkbox"/> IMC <input type="checkbox"/> Other (please specify): _____</p> <p>9. Please specify the number of years you have worked in this institution _____</p> <p>10. Please specify the number of years you have been in this present position _____</p> <p>11. Have you received any specialty certifications from professional organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify the type of certification and year received _____</p>	<p><i>In your hospital, please circle the group that CONTROLS the following areas:</i></p> <p>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</p> <hr/> <p>PART I</p> <p>1. Determining what activities nurses can do at the bedside. 1 2 3 4 5</p> <p>2. Developing and evaluating patient care standards and quality assurance/improvement activities. 1 2 3 4 5</p> <p>3. Setting levels of qualifications for nursing positions. 1 2 3 4 5</p> <p>4. Evaluating (performance appraisals) nursing personnel. 1 2 3 4 5</p> <p>5. Determining activities of ancillary nursing personnel (aides, unit clerks, etc.). 1 2 3 4 5</p> <p>6. Conducting disciplinary action of nursing personnel. 1 2 3 4 5</p> <p>7. Assessing and providing for the professional/educational development of the nursing staff. 1 2 3 4 5</p> <p>8. Making hiring decisions about RNs and their nursing staff. 1 2 3 4 5</p> <p>9. Promoting RNs and other nursing staff. 1 2 3 4 5</p> <p>10. Appointing nursing personnel to management and leadership positions 1 2 3 4 5</p> <p>11. Selecting products used in nursing care. 1 2 3 4 5</p> <p>12. Incorporating research ideas into nursing care. 1 2 3 4 5</p> <p>13. Determining methods of nursing care delivery (e.g. primary, team, case management). 1 2 3 4 5</p>

Appendix D (continued)

PROFESSIONAL NURSING GOVERNANCE	
<p><i>In your hospital, please circle the group that INFLUENCES the following activities:</i></p> <p>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</p> <hr/> <p>PART II</p> <p>14. Determining how many and what level of nursing staff is needed for routine patient care. 1 2 3 4 5</p> <p>15. Adjusting staffing levels to meet fluctuations in patient census and acuity. 1 2 3 4 5</p> <p>16. Making daily patient care assignments for nursing personnel. 1 2 3 4 5</p> <p>17. Monitoring and procuring supplies for nursing care and support functions. 1 2 3 4 5</p> <p>18. Regulating the flow of patient admissions, transfers, and discharges. 1 2 3 4 5</p> <p>19. Formulating annual unit budgets for personnel, supplies, equipment and education. 1 2 3 4 5</p> <p>20. Recommending nursing salaries, raises and benefits. 1 2 3 4 5</p> <p>21. Consulting nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical). 1 2 3 4 5</p> <p>22. Consulting hospital services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance). 1 2 3 4 5</p> <p>23. Making recommendations concerning other departments' resources. 1 2 3 4 5</p> <p>24. Determining cost effective measures such as patient placement and referrals (e.g. placement of ventilator-dependent patients, early discharge of patients to home health care). 1 2 3 4 5</p> <p>25. Recommending new hospital services or specialties (e.g. gerontology, mental health, birthing centers). 1 2 3 4 5</p> <p>26. Creating new clinical positions. 1 2 3 4 5</p> <p>27. Creating new administrative or support positions. 1 2 3 4 5</p>	<p><i>According to the following indicators in your hospital, please circle which group has OFFICIAL AUTHORITY (i.e. authority granted and recognized by the hospital) to control practice and influence the resources that support it:</i></p> <p>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</p> <hr/> <p>PART III</p> <p>28. Written policies and procedures that state what nurses can do in direct patient care. 1 2 3 4 5</p> <p>29. Written patient care standards and quality assurance improvement programs. 1 2 3 4 5</p> <p>30. Mandatory RN academic levels (licensure, education, certifications) for hiring, continued employment, promotions and raises. 1 2 3 4 5</p> <p>31. Written process for evaluating nursing personnel (performance appraisal). 1 2 3 4 5</p> <p>32. Organizational charts that show job titles and who reports to whom. 1 2 3 4 5</p> <p>33. Written guidelines for disciplining nursing personnel. 1 2 3 4 5</p> <p>34. Annual requirements for continuing inservices. 1 2 3 4 5</p> <p>35. Procedures for hiring and transferring nursing personnel. 1 2 3 4 5</p> <p>36. Policies regulating promotion of nursing personnel to management and leadership positions. 1 2 3 4 5</p> <p>37. Procedures for generating schedules for RNs and other nursing staff. 1 2 3 4 5</p>

Appendix D (continued)

PROFESSIONAL NURSING GOVERNANCE					
<p><i>In your hospital, please circle the group that PARTICIPATES in the following activities:</i></p> <p>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</p>					
38. Acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care.	1	2	3	4	5
39. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity.	1	2	3	4	5
40. Procedures for determining daily patient care assignments.	1	2	3	4	5
41. Daily methods for monitoring and obtaining supplies for nursing care and support functions.	1	2	3	4	5
42. Procedures for controlling the flow of patient admissions, transfers and discharges.	1	2	3	4	5
43. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.	1	2	3	4	5
44. Procedures for adjusting nursing salaries, raises and benefits.	1	2	3	4	5
45. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	1	2	3	4	5
46. Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy).	1	2	3	4	5
47. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass).	1	2	3	4	5
48. Location of and access to office space.	1	2	3	4	5
49. Access to office equipment (e.g. phones, personal computers, copy machines).	1	2	3	4	5
PART IV					
50. Participation in unit committees for clinical practice.	1	2	3	4	5
51. Participation in unit committees for administrative matters such as staffing, scheduling and budgeting.	1	2	3	4	5
52. Participation in nursing departmental committees for clinical practice.	1	2	3	4	5
53. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting.	1	2	3	4	5
54. Participation in multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice.	1	2	3	4	5
55. Participation in hospital administration committees for matters such as employee benefits and strategic planning.	1	2	3	4	5
56. Forming new unit committees.	1	2	3	4	5
57. Forming new nursing departmental committees.	1	2	3	4	5
58. Forming new multidisciplinary professional committees.	1	2	3	4	5
59. Forming new hospital administration committees.	1	2	3	4	5

Appendix D (continued)

PROFESSIONAL NURSING GOVERNANCE					
<p><i>In your hospital, please circle the group that has ACCESS TO INFORMATION about the following activities:</i></p> <p>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</p> <hr/> <p>PART V</p> <p>60. The quality of hospital nursing practice. 1 2 3 4 5</p> <p>61. Compliance of hospital nursing practice with requirements of surveying agencies (Joint Commission, state and federal government, professional groups). 1 2 3 4 5</p> <p>62. Unit's projected budget and actual expenses. 1 2 3 4 5</p> <p>63. Hospital's financial status. 1 2 3 4 5</p> <p>64. Unit and nursing departmental goals and objectives for this year. 1 2 3 4 5</p> <p>65. Hospital's strategic plans for the next few years. 1 2 3 4 5</p> <p>66. Results of patient satisfaction surveys. 1 2 3 4 5</p> <p>67. Physician/nurse satisfaction with their collaborative practice. 1 2 3 4 5</p> <p>68. Current hospital status of nurse turnover and vacancies. 1 2 3 4 5</p> <p>69. Nurses' satisfaction with their general practice. 1 2 3 4 5</p> <p>70. Nurses' satisfaction with their salaries and benefits. 1 2 3 4 5</p> <p>71. Management's opinion of bedside nursing practice. 1 2 3 4 5</p> <p>72. Physicians' opinion of bedside nursing practice. 1 2 3 4 5</p> <p>73. Nursing peers' opinion of bedside nursing practice. 1 2 3 4 5</p> <p>74. Access to resources concerning recent advances in nursing practice (e.g. journals and books, library). 1 2 3 4 5</p>	<p><i>In your hospital, please circle the group that has the ABILITY to:</i></p> <p>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</p> <hr/> <p>PART VI</p> <p>75. Negotiate solutions to conflicts among professional nurses. 1 2 3 4 5</p> <p>76. Negotiate solutions to conflicts between professional nurses and physicians. 1 2 3 4 5</p> <p>77. Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc). 1 2 3 4 5</p> <p>78. Negotiate solutions to conflicts between professional nurses and nursing management. 1 2 3 4 5</p> <p>79. Negotiate solutions to conflicts between professional nurses and hospital administration. 1 2 3 4 5</p> <p>80. Create a formal grievance procedure. 1 2 3 4 5</p> <p>81. Write the goals and objectives of a nursing unit. 1 2 3 4 5</p> <p>82. Write the philosophy, goals and objectives of the nursing department. 1 2 3 4 5</p> <p>83. Formulate the mission, philosophy, goals and objectives of the hospital. 1 2 3 4 5</p> <p>84. Write unit policies and procedures. 1 2 3 4 5</p> <p>85. Determine nursing departmental policies and procedures. 1 2 3 4 5</p> <p>86. Determine hospital-wide policies and procedures. 1 2 3 4 5</p>				

Appendix E

Project Timeline

Project Task	Dates
First Milestone	
1. Complete Project Proposal	April 7, 2012
2. Turn Proposal in to Project Chair	April 8, 2012
3. Present and Defend Proposal to Committee	April 23, 2012
4. Obtain Letter of Approval to conduct research from all campuses	June 15, 2012
5. Obtain UNLV IRB approval/Exempt Status	August 28, 2012
6. Obtain WIRB approval/Exempt Status	August 21, 2012
Second Milestone	
7. Once IRB approval is obtained distribute IPNG Survey tool	October 27, 2012
8. Begin Magnet Gap Analysis	August 2012- February 2013
9. Hire Statistician to help with data analysis	February 15, 2013
10. Data Analysis of IPNG data	December-February 2013
11. Summarize findings of gap analysis for needs assessment	February, 2013
12. Present summary findings to stakeholders	March , 2013
13. Summarize and Write Final Project	February 21, 2013
Third Milestone	
14. Final Project Defense	March 4, 2013

Appendix F

Letter of Authorization to Conduct Research



Office of Research Integrity – Human Subjects
University of Nevada Las Vegas
4505 Maryland Parkway Box 451047
Las Vegas, NV 89154-1047

Subject: Letter of Authorization to Conduct Research at St. Rose Dominican Hospitals

Dear Office of Research Integrity – Human Subjects:

This letter will serve as authorization for the University of Nevada, Las Vegas (“UNLV”) researcher/research team, Dr. Nancy Menzel to conduct the research project entitled

“EVALUATING SHARED GOVERNANCE FOR NURSING EXCELLENCE”

at the ST ROSE DOMINICAN HOSPITALS (the “Facility”).

The Facility acknowledges that it has reviewed the protocol presented by the researcher, as well as the associated risks to the Facility. The Facility accepts the protocol and the associated risks to the Facility, and authorizes the research project to proceed. The research project may be implemented at the Facility upon approval from the UNLV Institutional Review Board.

If we have any concerns or require additional information, we will contact the researcher and/or the UNLV Office of Research Integrity – Human Subjects.

Sincerely,

Facility’s Authorized Signatory

Date

Printed Name and Title of Authorized Signatory

Appendix G



TITLE OF STUDY: EVALUATING SHARED GOVERNANCE FOR NURSING EXCELLENCE

INVESTIGATOR(S): Nancy Menzel, PhD, RN, PHCNS-BC, COHN-S, CPH, CNE
CONTACT PHONE NUMBER: 702-895-3404

Purpose of the Study

You are invited to participate in a research study. The overall purpose of this study is to evaluate the current state of the St Rose Dominican Hospital shared governance model. Shared governance is defined as organizational structures in place that support decision making on the frontline at the point of care. This project will aim to meet the following objectives:

- 1) obtain a baseline measurement of the degree of shared governance
- 2) Evaluate fundamental infrastructural needs of shared governance utilizing the American Nurse Credentialing Magnet framework to conduct a gap analysis against standards
- 3) Identify strengths and weakness of current shared governance model
- 4) Propose recommendations based on findings to improve shared governance structure.

Participants

You are being asked to participate in the study because you fit these criteria: You are a professional registered nurse working at the St. Rose Dominican Hospital

Procedures

If you volunteer to participate in this study, you will be asked to do the following: Take an 86 question survey

Benefits of Participation

There will not be direct benefits to you as a participant in this study. However, indirectly it may benefit you as we hope to learn what weaknesses we have in our current shared governance model. We will be able to make recommendations to improve the model and

ultimately the work environment as Shared Governance encourages empowerment of staff and improves nursing satisfaction.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. These risks include minimal discomfort in answering the survey questions.

Cost /Compensation

There will not be financial cost to you to participate in this study. The study will take 90 minutes of your time. You will not be compensated for your time.

Contact Information

If you have any questions or concerns about the study, you may contact Evette Wilson at **702-492-8347**. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794 or toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality

All information gathered in this study will be kept completely confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for 5 years after completion of the study. After the storage time the information gathered will be destroyed.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me. If I do not sign this consent form and proceed to take the survey and return it by interoffice mail or responding to survey monkey consent will be implied.

Signature of Participant

Date

Participant Name (Please Print)

Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.

Appendix H

Table 4

Descriptive Information of the Demographic Variables of the Sample

Variable	N† (%)
Gender	
Male	23 (11.1)
Female	180 (87.0)
Unit	
Administration	7 (3.4)
MedSurg	27 (13.2)
JRU	15 (7.2)
ICU	29 (14.0)
IMC	17 (8.2)
Cardiology	13 (6.3)
OR	15 (7.2)
Recovery/PACU	11 (5.3)
SDS	11 (5.3)
ED	23 (11.1)
MCC/L&D	5 (2.4)
NICU	10 (4.8)
Peds	7 (3.4)
Peds ICU	1 (0.5)
IRF/Rehab	3 (1.4)
Quality/Risk	2 (1.0)
Case Management	3 (1.4)
Years in Current Hospital	
≤ 5 years	100 (48.3)
6-10 years	69 (33.3)
11-15 years	27 (13.0)
16-20 years	1 (0.5)

Appendix H (continued)

Table 4 (continued)

Descriptive Information of the Demographic Variables of the Sample

Variable	N† (%)
21-26 years	2 (1.0)
≥ 27 years	2 (1.0)
Employment Status	
Full-time	178 (86.0)
Part-time	29 (14.0)
Job Title	
Clinical Nurse	165 (79.7)
Non-Clinical Nurse	11 (5.3)
Administrative Nurse	25 (12.1)
Years as a Nurse	
≤ 5 years	37 (17.9)
6-10 years	31 (15.0)
11-15 years	30 (14.5)
16-20 years	37 (17.9)
21-26 years	18 (8.7)
≥ 27 years	51 (24.6)
Highest Degree Held	
Nursing Diploma	9 (4.4)
Associate Degree in Nursing	101 (49.0)
Bachelor's in Nursing	62 (30.1)
Bachelor's in Non-Nursing	15 (7.2)
Master's in Nursing	11 (5.3)
Master's in Non-Nursing	8 (3.9)

Appendix H (continued)

Table 4 (continued)

Descriptive Information of the Demographic Variables of the Sample

Variable	<i>N</i> † (%)
Basic Nursing Education	
Nursing Diploma	21 (10.1)
Associate Degree in Nursing	113 (54.6)
Bachelor's in Nursing	73 (35.3)
Certifications	
Yes	74 (35.7)
No	127 (61.4)
Age	
21-30 years	24 (11.7)
31-40 years	56 (27.2)
41-50 years	57 (27.7)
51-60 years	54 (26.2)
≥ 61 years	15 (7.3)

† *N* = 207, after the removal of 88 incomplete surveys and 47 outliers.

Appendix I

Table 9

Descriptive Statistics of Shared Governance by Nursing Unit

Unit	Personnel		Information		Resources		Participation		Goals		Practice	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Admin	28.00	2.82	28.71	8.86	26.57	9.03	22.29	3.45	13.86	3.72	29.00	4.32
MedSurg	27.11	5.74	26.52	8.94	24.30	7.74	20.19	5.95	13.85	4.58	28.15	7.18
JRU	26.73	3.83	28.33	6.44	22.47	5.54	21.00	4.11	15.60	4.32	26.27	5.57
ICU	28.38	5.70	30.07	8.52	24.07	6.76	22.76	5.48	13.66	3.85	28.62	6.34
IMC	31.71	5.22	32.18	6.38	23.71	6.34	25.76	5.30	16.24	4.10	32.76	5.41
Cardiology	26.38	3.82	27.54	6.05	24.85	9.27	21.15	5.87	15.31	5.22	27.77	7.56
OR	28.87	5.29	26.40	8.32	23.87	7.82	21.27	7.17	13.73	3.90	29.40	8.87
PACU	26.45	5.48	26.27	7.36	22.73	7.07	18.00	6.71	14.27	4.61	25.55	7.09
SDS	26.09	6.82	21.64	7.58	21.27	5.87	18.36	7.23	12.64	3.83	26.09	8.25
ED	27.39	4.47	26.13	6.43	25.22	8.19	22.96	5.09	13.91	3.82	26.83	5.56
MCC/L&D	25.00	2.74	22.00	4.47	25.00	10.12	19.20	6.61	12.20	4.27	29.80	11.54
NICU	25.40	3.31	21.30	7.30	20.20	8.51	21.60	7.15	13.80	4.57	26.30	8.99
Peds	25.88	3.29	27.14	7.69	27.71	7.39	19.86	6.07	15.43	6.68	28.29	3.04

Key: Admin= Administration ,Medsurg=Medical/Surgical, JRU=Joint Replacement Unit ,ICU=Intensive Care Unit, IMC=Intermediate Care Unit
 OR=Operating Room, PACU=Post Anesthesia Care Unit, SDS=Same Day Surgery, ED=Emergency Department, MCC/L&D=Maternal Child Center/ Labor & Delivery, NICU=Neonatal Intensive Care Unit, Peds=Pediatric/Peds Intensive Care Unit

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EVETTE M. WILSON, RN, MSN, DNPc

4969 Dulce Norte Street•North Las Vegas, NV 89031

Mobile: (702) 538-1219•Email: evettenurse@yahoo.com

HEALTHCARE NURSE EXECUTIVE

Project Management/Cross Functional Team Leadership/Strategic Planning/Process Improvement/Survey & Accreditation Audits/Reviews/Program Design & Development/Team Building & Leadership/Performance Improvement Methodology/Joint Commission & CMS Performance Measures/RCA & FMEA Facilitation/Tracer Methodology/National Quality Initiatives/Sentinel Event Analysis

- Seasoned health care executive licensed registered Nurse with 20 years of experience across various clinical areas in acute care hospital setting to include senior leadership.
 - Motivated by challenges presented and rewarded through implementation of key corporate initiatives that aid profitability, productivity, patient safety and quality outcomes.
 - Acknowledged for vigorously managing multifaceted accreditation projects, applying stringent standards and rallying cross-functional teams that serves to elevate marketplace status as a leading competitor in quality healthcare.
 - Highly visible projects consistently delivered on-time and on-budget.
 - Developed streamlined policies/procedures and championed the integration of quality improvement principles, standards and practices within the healthcare organization.
 - Trains and uses the proper statistical quality tools to find optimal solutions to problems with proven results across all phases of process improvement.
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PROFESSIONAL EXPERIENCE

ST. ROSE DOMINICAN HOSPITALS, Las Vegas, NV Oct 2011 – Present

Director of Professional Practice (Market Position) San Martin Campus, Rose De Lima Campus, Siena Campus

Responsible for facilitating the standardization of Nursing Practice activities at three campuses. Designs, implements, coordinate and monitor the quality of Nursing Practice that leads to the planning, implementation and evaluation of the necessary steps toward Magnet Hospital Recognition. Such responsibilities encompass not only the nursing department's internal functioning but also how it is integrated into the organization's overall operation. Responsible for creating a professional practice environment and magnet culture that enables the hospital to fulfill its mission, and meet or exceed its goals.

- Oversee the quality of nursing practice at three campuses, coordinate NDNQI database and reporting for the St. Rose Dominican Hospital Las Vegas Market.
- Revised nursing job descriptions and standards of practice to align with ANA scope of practice
- Coordinate and oversee shared governance activities for all three campuses
- Implemented Shared governance inforums to provide professional development to shared governance unit team councils.
- Co-Investigator for Nursing Research & Evidence Based Practice Projects on Shared Governance

- Currently in the process of developing Nursing Research & Evidence Based Practice model and organizational infrastructure to guide nursing research and Evidence Based Practice
- Restructured Shared governance councils infrastructure and processes to align with organization and nursing strategic goals.
- Coordinated and guided the facility in strategic planning of Magnet Recognition activities.
- Currently in the process of implementing a Nursing Peer Review Process for three campuses
- Coordinated system nurses week activities at three campuses
- Developed a website for professional practice and shared governance for the facility intranet page.

UNIVERSAL HEALTH SERVICES, INC., Las Vegas, NV May 2007 – August 2012

*Centennial Hills Hospital Medical Center, Administrative Director Quality Outcomes & Patient Safety Officer
April 2008-August 2012*

Promoted to senior executive role of newly opened 171 beds acute care hospital in July 2008. The role reports to the Chief Executive Officer/Managing director. The position is responsible for the strategic planning, organizing and direction of all administrative and functional activities related to the hospital's patient safety, quality improvement, risk management, medical staff, infection control, case management and regulatory compliance programs.

- Acts as Administrator on Call on a regular rotational schedule for after hours issues requiring administrative guidance.
- Coordinate facilities Joint Commission and state survey accreditation process. The facility received full accreditation from the Joint Commission in 2008 and licensed with the State of Nevada.
- Coordinated facilities 2011 Full State survey with no deficiencies cited.
- Coordinated facilities Chest Pain accreditation process, obtaining the Chest Pain accreditation with PCI from the Society of Chest Pain centers after only 1 year of opening (2009).
- Coordinated the facilities state accreditation process receiving license for Level II NICU after 1 year of opening.
- Facilitated Core Measures/Leapfrog /Joint Commission outcomes and data analysis
- Developed and implemented the "Opportunity For Improvement Program" quality improvement initiative through employee education and behavior modification resulting in greater compliance with core measures and National Patient Safety Goals.
- Lead Core Measure teams in multidisciplinary approach to systematically improve core measure scores from the 50th percentile to the >99th percentile with the implementation of concurrent review abstraction, ancillary and case management involvement.
- Overseen the Implementation of the Service Excellence employee recognition program, which improved employee engagement scores by 30% over baseline.
- Developed and implemented patient satisfaction and HCAHPS action plan, working through cross functional teams improving Gallup scores for the facilities Emergency Room to the 99th percentile, Outpatient Surgery 99th percentile, and Inpatient Services improvement from the >50th percentile to the 90th percentile.
- Developed and implemented the facilities first ongoing and focused professional practice Evaluation program.
- Facilitate facilities performance improvement initiative to reduce Length of Stay and Avoidable Days.
- Coordinated the implementation of the facilities first utilization review committee.

- Lead facilities performance improvement initiative to reduce readmission rates.
- Coordinated and facilitated the facilities implementation of TeamSTEPPS training safety initiative

Valley Hospital Medical Center, Director of Risk Management/Patient Safety Officer May 2007-April 2008

The facility is a 499 bed teaching acute care hospital. This position reports to the Chief Executive Officer/Managing director and the role is responsible for directing the organizations risk management program staff members.

- Coordinated systems necessary for identification, evaluation, monitoring, reduction and/or elimination of professional and general liability risk exposure for the facility.
- Provided counseling, education, and leadership to administrative, clinical personnel, board of governors, and medical staff members relate to risk exposures including prevention and risk reduction.
- Participated in the investigation of clinical adverse events, Root Cause Analysis, Sentinel Event, and support of professional liability litigation.
- Chair of the patient Safety Council, responsible for overseeing the patient safety activities within the organization.
- Responsible for Reporting patient safety activities to the Medical Executive Committee, Board of Governors, Department meetings and Quality Council.
- Redesigned the Risk Management Plan to incorporate an Enterprise Risk Management Model, fostering a culture of safety, and improving incident reporting by 30%.
- Designed and implemented a service recovery policy and process for staff members that decreased patient complaints and grievances within the facility.
- Streamlined the patient complaint/grievance process from a manual logging to an electronic database improving regulatory compliance.
- Implemented a contract data base with electronic tickler to prevent contracts from expiring prior to review date.

UNITED STATES AIR FORCE NURSE CORPS, Las Vegas, NV July 2004 – May, 2007

Nellis Air Force Base, Captain, Charge Nurse/Emergency Department (Peacetime)

Veterans Administration/Air Force Joint Venture 118 bed facility. Assisted Nurse Manager in overseeing and directing the 24 hour operation of the Emergency room. Managed 60 employees, and assisted with over sight of budgetary process of \$10 million dollar budget. The position reported to the Nurse Manager of the Emergency Department.

- Assisted Nurse Manager in overseeing and directing the 24 hour operation of the Emergency room.
- Awarded the Air Force commendation Medal for meritorious service performed in the Emergency Services Flight, 99th Medical Operations Squadron, 99th Air Base Wing, Nellis AFB in 2007.
- Participated on cross functional teams and oversaw the improvement process of the Emergency Department throughput process improving patient flow by 25%.
- Facilitated the reduction of patients leaving the Emergency Department without physician intervention from 4.9% to less than 1%, which shattered the community average of 10%.
- Key contributor to the 99th Medical Group being fully accredited by Joint Commission receiving an “Excellent” rating during the 2006 Health Services Inspections.

Nellis Air Force Base, Captain, Critical Care Air Transport Team (Wartime) Balad, Iraq and Bagram, Afghanistan

- Awarded the Air Medal in April 2007 for meritorious achievement while participating in sustained aerial flight as Critical Care Air Transport Team Nurse, 332d Expeditionary Operations Support Squadron, 332d Expeditionary Operations Group, 332d Air Expeditionary Wing, Balad Air Base, Iraq.
- Flew 20 combat missions, resulting in the aeromedical evacuation of more than 35 critical patients in support of Operations ENDURING FREEDOM and IRAQI FREEDOM.

- Managed three wounded United States soldiers suffering from second and third degree burns over 80 percent of their bodies, ensuring these critical patients had adequate pain control, essential fluid resuscitation, and provided close monitoring of the function their vital organs which enable them to survive the 4 ½ hour flight from Balad, Iraq to Lundstul, Germany in stable condition.
- Nursing skills were crucial when quickly responded to an in-flight emergency of a severely injured soldier suffering from cardiac arrest in flight mid way between Iraq and Germany. Cardiopulmonary resuscitation along with advanced cardiac life support protocols were implemented, stabilizing patient and safely managing patients care until safely transported to receiving hospital in Lundstul, Germany.
- Clinical skills were instrumental to the 98% survival rate for injured patients reaching the United States Air Force Theater Hospital at Balad Air Base.

HEALTH MANAGEMENT ASSOCIATES, INC., Gaffney, South Carolina 2003-2004

Upstate Carolina Medical Center, Education Coordinator

Responsible for directing and overseeing the administrative functions of this 125 bed acute care facilities educational program.

- Collaboratively worked with Department Directors, to identify training needs through educational needs assessment and provide educational programs to meet staff needs
- Revamped and facilitated the hospitals educational annual skills fair and competency validation process, engaging maximum staff participation and obtaining 100% compliance annual training requirements.
- Developed and implemented a core curriculum in-house educational program to train Patient Care Assistants I to cross train to newly designed job description of Patient Care Assistant II.
- Coordinated the facilities American Heart Association training and education program
- Developed a Manual for standard operating procedures within the Education department to provide for consistency in training of newly hired staff.

SPARTANBURG REGIONAL MEDICAL CENTER, Spartanburg, South Carolina 2001-2003

Staff Registered Nurse, Cardiovascular Intensive Care Unit

- Provided quality care for critically ill open heart cardiovascular, thoracic, and vascular patients, demonstrating strong observation, assessment, and intervention skills.
- Assess patients' clinical conditions utilizing invasive and non-invasive monitoring equipment including ICP, CVP, EKG, SPO2, A-line, Swan-Ganz catheter, IABP, ventilator and defibrillator.
- Facilitate the recovery process by educating surgical patients and their families in pre- and post operative, CAT scan and nuclear medicine procedures, medications and pain management.
- Act as team leader on a weekly basis, overseeing unit responsibilities in areas of assignment delegation, direct patient care and employee scheduling.
- Develop and implement nursing care plans for admissions and transfers.
- Work collaboratively with medical staff and auxiliary personnel to address problems and concerns
Provide verbal reports on patients at close of shift.

PHARMACEUTICAL PRODUCT DEVELOPMENT, Wilmington, North Carolina 2001-2002

Clinical Research Associate

- Managed clinical study protocols, clinical study reports, study agreements applications and other study documentation such as newsletters and study presentations.
- Monitored study progress such as patient recruitment and protocol compliance with FDA compliance and Good Clinical Practice.

- Tracked and managed studies to agreed timeline, budget and resource
- Train internal and external study personnel in study specific procedures.
- Interpret data arising from studies and assess potential consequences for development program. .
- Recommend choice of study placement and participate in negotiations with liaison.

GREENVILLE MEMORIAL HOSPITAL, Greenville, South Carolina 1997-2001

Clinical Trials Research Program Coordinator 1999-2001

Site Management and study coordination of clinical trial activities including site initiation, monitoring, and training of investigative sites.

- Knowledgeable in all areas of research including budgeting, GCP, IRB protocol submissions, on-going regulatory and IRB phases and IND safety reporting
- Demonstrated competencies in managing clinical trials data, formulating source documents and data collection charts and severe adverse event reporting.
- Proven project management abilities with capacity to design, plan and implement ideas from conception through completion; able to manage multiple responsibilities without compromise to detail or quality.
- Outstanding interpersonal skills; equally comfortable communicating one-on-one or addressing large audiences. Solid ability to translate technical information and provide training to staff, physicians and patients.
- Committed to quality patient care; frequently recognized by physicians for strict attention to detail, patient advocacy and decision making abilities in critical situations.

Staff Registered Nurse, Greenville Memorial Hospital/ Neurological-Trauma Unit 1997-1999

- Provided quality care for critically ill neurological or trauma patients demonstrating strong observation, assessment, and intervention skills.
- Assess patients' clinical conditions utilizing invasive and non-invasive monitoring equipment including ICP, CVP, EKG, SPO2, A-line, Swan-Ganz catheter, intracranial pressure monitoring, ventilator and defibrillator.
- Performed comprehensive neurological testing and monitoring of neurological status of patients.
- Provided a broad range of general nursing care services in areas of vital signs, EKG, phlebotomy, catheters, feeding tubes, IV and central lines.
- Prioritized and delegated assignments, contributing to a higher standard of patient care and staff retention.

LIBERTY MUTUAL INSURANCE COMPANY, Spartanburg, South Carolina 1996-1997

Medical Case Manager

- Manage assigned caseload of medical and disability workers compensation claims.
- Communicate with injured employees, medical professionals, claims staff and others to obtain information necessary to make sound medical assessments regarding diagnosis and prognosis.
- Assess injury severity, extent of disability, treatment plans, functional abilities and physical job requirements to establish target return to work plans and/or strategy to manage future medical exposure.

SPARTANBURG REGIONAL MEDICAL CENTER, Spartanburg, South Carolina 1993-1996
Staff Registered Nurse, Neonatal Intensive Care Unit 1995-1996

- Level III-IV NICU providing service to critically ill pre-term and term neonates with complex medical problems, respiratory illness (HFOV) neonate with surgical needs (general and neurosurgical).
- Special skills included triage, IV insertion and initiating IVF, blood extraction of CBC, Blood Culture and Sensitivity, DBIB (either heel prick, peripheral or arterial line).
- Completing blood transfusion, blood glucose monitoring, nebulizing treatments, chest compressions, placing pressure dressing
- Assessment, vital signs, doing routine newborn care on babies at all level of care.

Staff Registered Nurse, Post Coronary Care Unit 1993-1995

- Assign accounts of patient, patient care, unit operation and staff care to the team members.
- Ensure the management of the staff members and organization of patient care programs.
- Develop and maintain the patient care programs. .
- Responsible for the close monitoring of patient's pre and post operative open heart, MI screening, cardiac and peripheral diagnostic procedures.
- Provided the patient care and prepare patient for stress and echocardiogram testing.
- Monitored various drainage devices and chest tube with the pump and pacer wires

CONSULTANT EXPERIENCE

HEALTHCARE RESOURCE ASSOCIATES, LLC., Las Vegas, NV September 2010 – Present
Chief Executive Officer

Founder and Managing Director of a healthcare-consulting firm focused on bridging the gaps in healthcare by providing specialized medical resources to clients through a network of nationally recognized experts and consultants in fields to include: Legal Nurse Consultants, Quality Improvement, Risk Management, Patient Safety, Regulatory Compliance, Education/Training, and Clinical Research. The company provides a range of consultant services including healthcare advocacy, medical record review, litigation support services, and assist healthcare organizations with ongoing compliance audits, and quality improvement initiatives.

PER DIEM CLINICAL EXPERIENCES

University Medical Center, Las Vegas, NV
Staff Registered Nurse, Trauma Resuscitation Emergency Room, (11/2009-5/2010)

College of Southern Nevada, Las Vegas, NV
Clinical Nursing Instructor, Adult Health (2008--present)

Nevada State College, Las Vegas, NV
Clinical Nursing Instructor, Adult Health (2005-2006)

University of South Carolina, Spartanburg, SC
Clinical Nursing Instructor, Adult Health (2001-2002)

Medical Staffing Network Nursing Agency, Spartanburg, SC
Staff Registered Nurse, Critical Care Services (2001-2002)

Mary Black Memorial Hospital, Spartanburg, SC
Staff Registered Nurse, Coronary Care-Intensive Care (1998-1999)

Department of Health and Environmental Control, Spartanburg, SC
Staff Registered Nurse, Pediatric Home Health Service (1995-1996)

Upstate Carolina Medical Center, Gaffney, SC
Staff Registered Nurse, Emergency Department (1993-1994)

EDUCATION

Doctor of Nurse Practice, University of Nevada Las Vegas, currently enrolled,(tentative graduation May 2013)

Master's Degree Nursing, University of Phoenix, July 2004

Bachelor's Degree Nursing, University of South Carolina, Spartanburg, August 1999

Associate Degree Nursing, University of South Carolina, Spartanburg, May 1993

American Society of Risk Management, Barton Certificate in HealthCare Risk Management, Essentials Module, Chicago, IL. October 2007

Legal Nurse Consultant Course, Vicki Millazo Insitute, July 1995, November 2010

Center for Sustainment of Trauma and Readiness Skills (C-STARS), The University Hospital of Cincinnati, Ohio, July 2006

Critical Care Air Transport Team Course (CCATT), Brooks City Base, San Antonio, TX, June 2006

CERTIFICATIONS

Basic Cardiac Life Support (BCLS)

Advanced Cardiac Life Support (ACLS)

Pediatric Advanced Life Support (PALS)

Trauma Nurse Core Curriculum (TNCC)

National Incident Management System (NIMS) 100,200, 700, 800

LICENSURE

STATE OF NEVADA BOARD OF NURSING

PROFESSIONAL ASSOCIATIONS AND ACTIVITIES

American Association of Critical Care Nurses(AACN)

Sigma Theta Tau, International Honor Society, Zeta Kappa Chapter

American Association of Legal Nurse Consultants(AALNC)

Emergency Nursing Association (ENA)

Nevada Association for Healthcare Quality (NvAHQ)

American Society for Healthcare Risk Management (ASHRM)

National Alliance of Certified Legal Nurse Consultants (NACLNC)

American Nurses Association (ANA)

Nevada Nurses Association (NNA)

Nevada Nurses Association Legislative Committee Member

HONORS AND AWARDS

- Awarded the Air Force commendation Medal for meritorious service performed in the Emergency Services Flight, 99th Medical Operations Squadron, 99th Air Base Wing, Nellis AFB in 2007.
- Awarded the Air Medal in April 2007 for meritorious achievement while participating in sustained aerial flight as Critical Care Air Transport Team Nurse, 332d Expeditionary Operations Support Squadron, 332d Expeditionary Operations Group, 332d Air Expeditionary Wing, Balad Air Base, Iraq.
- Nominated for 2007 March of Dimes Nurse of the Year
- President Elect 2010 National Association For Healthcare Quality

RESEARCH EXPERIENCE

Clinical Trials Research Coordinator

- Randomized Double-Blind Comparative Study of the Efficacy and Safety of Synercid® Monotherapy Regimens and Synercid® in Combination with Ampicillin in the Treatment of Infection Caused by Vancomycin-resistant *Enterococcus faecium* (VREF).
- A Study of the pharmacokinetics and safety of seven days intravenous intraconazole nanocrystals in Intensive Care Unit subjects (USA)
- A Multicenter Clinical Evaluation of the Cordis Nitinol Carotid Stent and Delivery System for the treatment of Obstructive Carotid artery Disease. (SAPPHIRE)
- A Multicenter, open-Label, Noncomparative Trial of a Single Dose of 30mg/kg Azithromycin in the Treatment of Acute Otitis Media in Pediatric Subjects
- Azithromycin for the secondary prevention of coronary heart disease events. The WIZARD study: A randomized controlled trial.
- Randomized Trial of the IntraStent™2 Endoprosthesis for Iliac Artery Suboptimal Angioplasty, Study Comparing Use of the Bifurcated EXCLUDER Endovascular Prosthesis to Open Surgical Repair in the Primary Treatment of Infrarenal Abdominal Aortic Aneurysms (AAA).
- Insulin Lispro Low Mixture Plus Metformin Compared to NPH Insulin Plus Metformin in Patients with Type 2 Diabetes with Inadequate Glycemic Control on Oral Therapy.
- A Prospective, Randomized, Observer-Blinded Evaluation of Application of Phenytoin on the Healing of Diabetic Foot Ulcers. (Mylan Pharmaceuticals).
- Propafenone treatment of symptomatic paroxysmal supraventricular arrhythmias. A randomized, placebo-controlled, cross-over trial in patients tolerating oral therapy (RAFT)
- A Study to Determine the Dose Requirements of Rocuronium Bromide (Zemuron®) in Pediatric and Adolescent Subjects

PRESENTATIONS

TeamSTEPPS Master Trainer: Hospital Implementation of TeamSTEPPS Centennial Hills Hospital
2011

Evaluating Shared Governance for Nursing Excellence, doctoral project presentation to Doctoral
Committee, March 4, 2013.