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Structures and Practices Enabling Staff Nurses to Control Their Practice

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This mixed-methods study uses interviews, participant observations, and the CWEQII empowerment tool to identify structures and attributes of structures that promote control over nursing practice (CNP). Nearly 3,000 staff nurses completed the Essentials of Magnetism (EOM), an instrument that measures CNP, one of the eight staff nurse-identified essential attributes of a productive work environment. Strategic sampling is used to identify 101 high CNP-scoring

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clinical units in 8 high-EOM scoring magnet hospitals. In addition to 446 staff nurses, managers, and physicians on these high-scoring units, chief nursing officers, chief operating officers, and representatives from other professional departments are interviewed; participant observations are made of all unit/departmental/hospital council and interdisciplinary meetings held during a 4 to 6 day site visit. Structures and components of viable shared governance structures that enabled CNP are identified through constant comparative analysis of interviews and observations, and through analysis of quantitative measures.

Keywords: *control over nursing practice; organizational autonomy; shared governance; empowerment; productive work environment; essentials of magnetism*

Control of nursing practice (CNP), one of eight processes identified by magnet hospital staff nurses as essential to a productive and satisfying work environment (Kramer & Schmalenberg, 2002), is consistently cited in the magnet hospital literature as essential to a magnetic work environment (Aiken, Smith, & Lake, 1994; Buchan, 1999; Kramer & Schmalenberg, 1988, 2003; Laschinger & Havens, 1996). CNP is defined by nurses in magnet hospitals as input, including access to and exchange of information, views and judgments, and decision-making on issues of importance—practices, standards, policies, equipment—that affect the nursing profession, the practice of nursing, and the quality of patient care (Kramer, Maguire, & Schmalenberg, 2006; Kramer et al., 2007; Kramer & Schmalenberg, 1993, 2002, 2003). Shared Governance (SG) is a structure that activates, enables, and promotes CNP. It is a nursing management innovation that legitimizes nurses' CNP and decision-making while extending influence to administrative areas previously controlled by management (Hess, 1995). Based on the principles of partnership, ownership, equity, and accountability (Porter-O'Grady, 2003), SG is designed to eliminate traditional hierarchical models that emphasize command and control, thus enabling nurses to control practice and the practice environment (Laschinger & Finegan, 2005). CNP, defined as "decentralized, shared decision-making" is one of the criteria used to evaluate hospitals for magnet status (American Nurses Credentialing Center, 2005).

Implementation of SG does not always or automatically lead to CNP. In two studies involving 34 magnet hospitals, all of which had some type of SG structure, nurses in 3 hospitals reported that the structure was not viable and did not enable CNP (Kramer & Schmalenberg, 2004; Schmalenberg & Kramer, in press). Nor do staff nurses in all magnet hospitals confirm CNP

with scores high enough to be included in the National Magnet Hospital Profile on CNP (Kramer, Schmalenberg, & Maguire, 2004; Schmalenberg & Kramer, in press). When SG is seen by clinical nurses as chiefly structural with nurses on councils and committees but without decision-making authority, the result is cynicism, unwillingness to participate, and reluctance to assume accountability for outcomes (Havens, 1994; Laschinger & Wong, 1999). Others (Porter-O'Grady, George, McDonagh, Crow, & Wilson, 1996) conclude that SG systems are often more structure than substance and urge managers to implement the system over time to better ensure shared decision-making. The issue, then, is the viability of the structure. What components or characteristics of SG enable and promote nurses' CNP?

Donabedian's (1980) Structure-Process-Outcome Paradigm, originally explicated as a framework for assessing quality of patient care, guides the conceptualization of this study. Structures are the policies, programs, standards, and practices that create an environment in which functional care processes, such as clinical autonomy, CNP, and collegial nurse-physician relationships can flourish. Processes lead to patient outcomes such as decreased falls and medication errors, reduced ventilator-associated pneumonia, proper wound healing; and positive nurse outcomes such as job satisfaction, retention, and nurse-assessed quality of patient care. Structures, processes, and outcomes are sequentially and causally related. Structures enable processes that produce outcomes. In the vernacular of the day, structure is "doing the right things," process is "doing them right," and outcome is "achieving desired results when the right things are done correctly." This study focuses on the structure-CNP process linkages paving the way for subsequent empirical study of CNP process-outcomes linkages.

Context and Relationships

Control of Professional Practice

Defined as "self-regulation, self-determination, and control of practice," control of practice is an essential characteristic of a profession distinguishable from clinical autonomy, which is "the freedom to make decisions about the service needs of clients" (Flexner, 1910, p. 3). Control of professional practice requires skills and decision-making abilities that differ from the independent and interdependent decision-making based on profound clinical knowledge that is associated with clinical autonomy (Kramer et al., 2006; Kramer & Schmalenberg, 2003; Kramer et al., 2004). In CNP, decision-making is consensual; group facilitation, conflict resolution, and negotiation

skills are needed; and the issues of concern are the regulation of professional practice and the standards and quality of care and service to clients. The authority for group decision-making emanates from the “office of profession” and its associated concern for the “welfare and benefit of society” (Flexner, 1910). The self-regulatory, self-determining aspect of a profession is usually exemplified by law and medicine, professions that traditionally were not housed within bureaucratic organizations. Self-determination and self-regulation of a profession within a bureaucracy—such as nurses employed in hospitals—is problematic and difficult but aided by the advent of job autonomy. Empirical results from the copious job design theory and research in the latter half of the 20th century gave rise to job-worker autonomy with its premise that an involved worker is a happy and productive worker (Anthony, 1999). The scope of control over practice and its enabling structures for professionals in bureaucracies extends to the clinical unit, the nursing department, and increasingly to the hospital and includes job autonomy as well as CNP; the latter is sometimes referred to as organizational or professional autonomy (Kramer & Schmalenberg, 2003).

Empirical studies of the CNP process are limited, and the results are unclear. The conceptual differences between clinical autonomy and CNP have been cited and empirically documented (Clifford, 1990; Kramer & Schmalenberg, 2003; Mundinger, 1980; Stewart, Stansfield, & Tapp, 2004). These two dimensions of autonomy and hallmarks of a profession continue to be measured with instruments that do not distinguish between them (Tranmer, 2005) or with tools (Aiken & Patrician, 2000; Gerber, Murdaugh, Verran, & Milton, 1990) containing items that bear little relationship to usual definitions or understanding of the CNP concept (Kramer & Schmalenberg, 2003). The relationships thus described are inconsistent, flawed, use variables isolated from unifying theory, and reflect imprecise definition and measurement (Cummings, Hayduk, & Estabrooks, 2006; Hess, 2004; Tranmer, 2005).

In a critique of six magnet hospital studies, Scott, Sochalski, and Aiken (1999) emphasize the need to empirically quantify CNP. The Hess (1994) tool measures CNP defined as augmentation of nurses’ sphere of influence within hospitals but is labor intensive. The Blegen et al. (1993) tool measures nurses’ preferences for decision-making in clinical autonomy and in job autonomy. The Conditions of Work Effectiveness Questionnaire-II (CWEQII), based on Kanter’s (1993) theory of structural empowerment defined as access to lines of power (information, support, resources, and opportunities), measures the input aspect of CNP. The CNP subscale of the Essentials of Magnetism (EOM) is a reliable (alphas range from .89 to .94) and valid tool that measures input and decision-making and is based on a grounded theory of CNP (Kramer & Schmalenberg, 2003, 2004).

A grounded theory of CNP was generated through constant comparative and thematic analysis of individual and focused interviews with staff nurses, managers, and executives in 14 magnet hospitals and week-long participant observations in 12 magnet and magnet-aspiring hospitals (Kramer & Schmalenberg, 1993, 2002, 2004). In brief, CNP requires that some kind of organizational structure such as SG be in place, operative, and productive. CNP requires access to information and to people in positions of power in the organization. It is facilitated through enthusiastic participation of professionals at all levels of the organization. Input and discussion regarding issues of concern to nurses and to nursing practice are sought from nurses at all levels. Issues and outcomes are characterized by nurse ownership of the problem and the solution. Participation is expected by virtue of being a professional and because it results in a better work environment and in higher quality of patient care. Recognition of the structure and the CNP process and use of and participation in the structure by administrators, physicians, and representatives of other professions are evidence of the structure's viability. Evidence of effective group decision-making and productivity at both unit and departmental levels is mandatory. There is pride, enthusiasm, ownership, and accountability for decisions, achievements, and outcomes. Effectiveness of the CNP structure is evaluated through the extensiveness and quality of the patient-centered and care-centered outcomes produced. Increased status, prestige, respect, and recognition of nursing as a profession are outcomes noted with pride. Initially, five ranked categories based on "who owns the problem, issue, and solution" and "degree of viability and recognition of the formal CNP structure" were developed. Ranks were then converted into subscale items that were differentially weighted as to the importance in the CNP process (Kramer & Schmalenberg, 2003, 2004.)

Shared Governance

Born on the heels of the participative management and decentralization themes of the early 1980s, SG is an organizational structure through which nurses control their practice and are allowed and expected to participate in decision-making processes affecting that practice (Hess, 1995). SG structures provide formal mechanisms that ensure nurses' right, responsibility, and power to make decisions. In his 25-year overview of SG, Hess (2004) described the major areas of shared decision-making as hiring, promotion and firing, scheduling, performance appraisals, creation of new positions, salaries and benefits, and supplies and budgeting. Areas of concern and decision-making evidenced through interviews and observations in council

meetings include review and alterations in standards, research study approval, review of policies regarding issues such as patient transfer mechanisms, and job activities delegated to patient care technicians (Kramer & Schmalenberg, 1993, 2002, 2003).

The SG structure and the CNP process are about authority, power, and influence. Power is the capacity to cause change, influence events, initiate action, and control outcomes (Lee, 2000). Traditional theories described power as a fixed mass, a finite quality; if you have it, someone else has lost it. A newer concept is that power has an infinite exponential quality that can be released, distributed, and shared to the mutual benefit and growth of all involved (Kosowski et al., 1990). It is this sense of power that is the essence of empowerment through which SG structures can be activated to enable nurses to control their practice (Lee, 2000). A positive link between CNP and empowerment has been demonstrated by Laschinger and Havens (1996).

Purpose

The purpose of this research is to answer the question: What are the characteristics and components of SG structures that are essential to their viability, thus enabling nurses to control practice? Identification of viable structures and evaluation of their effectiveness in promoting CNP will provide health care executives, nurse leadership, and educators with the information needed to design effective strategies for improving practice work environments, nurse satisfaction and retention, and quality of patient care.

Method

Design and Sample

A nonexperimental, descriptive design with strategic sampling was used in this interview and participant observation study. Scores on the EOM containing the CNP subscale were used to locate the strategic sample. From a total group of 76 EOM-tested magnet hospitals, the 8 highest or second-highest scoring hospitals by region of the country (northeast, southeast, north central, south central, midwest, mountain west, northwest and southwest) were selected and agreed to participate. "High-EOM scoring" means that the hospital scored above the National Magnet Hospital Profile mean (Kramer et al., 2007; Kramer et al., 2004). The selection between highest

or second highest scoring hospital by region of the country was made on the basis of whether the hospital was a community or an academic hospital and which type was needed to obtain a balanced sample between community and academic hospitals.

This is a study of “excellent” unit work environments in “excellent” hospitals. To select excellent clinical units within each hospital, we followed Verran, Gerber, and Milton’s (1995) recommendation of a 50% sample for aggregation of individual data to unit level and an RN complement of at least five nurses. In four instances in which the sample was less than 50% but more than 35%, one of three checks for reliable and valid aggregation (Leveck & Jones, 1996) was used. Staff nurse experience, certification, and education for the total unit were correlated with that of the sample; the unit was included if differences in the three sets of correlations were not significant. In addition to adequate RN representation, staff nurses’ reported CNP scores had to be above the hospital mean for the unit to be considered “excellent” and included in the interview aspect of this study.

Procedures and Data Collection

In this mixed-methods but predominantly qualitative study, the on-site co-investigators (coauthors) in each hospital obtained approval from the Institutional Review Board, oriented and interpreted the goals of the research to management and staff, facilitated the identification and participation of the expert and knowledgeable professionals on each unit, scheduled and coordinated the interviews, arranged for the participant observations, and administered the CWEQII. The latter was done 4 to 6 weeks before or after the on-site interviews to lessen the potential for contamination between the instrument and the interview responses. The first and second authors conducted all on-site interviews during a 4- to 6-day visit between March and July of 2006.

Expert interviews. Tape-recorded interviews were conducted with the expert sample: two to four staff nurses, one to two physicians, and the nurse manager from each high-scoring unit in the eight study hospitals. In units with a large RN workforce, usually the critical care unit, several more nurses were interviewed. If additional nurses from any unit requested an interview, or if several appeared as a group, they were accommodated. The goal was saturation rather than standardization. Different methods were used to select the expert sample. After the presentation of the study, nurses and physicians were invited to participate. There were many volunteers. In

most hospitals, the unit council or nurse manager identified staff nurses and physicians whom they thought would best represent the unit. In nearly all hospitals, some nurses came in during off-duty times for the interviews. Either they were the chairs of councils or they had been nominated by their peers. Interviews were held in a private office or conference room, either on the unit or in a central location. A semistructured interview schedule, pretested in two nonstudy magnet and two nonmagnet hospitals, was used. Questions were standardized, but interviewers were free to probe and explore.

As a basis for definition and understanding between the interviewer and the interviewee, the interview commenced with the request: "On a 10-point scale with 10 being high, rate the extent of CNP on this unit" (similar to a pain rating scale). Completion of the rating often resulted in spontaneous description of unit and central council activities, participation in them, and reasons for the rating. The primary interview questions were: What supports, encourages, or enables you and your peers to exercise CNP? Describe three important outcomes achieved by the council this past year.

Interviews with nurse managers, the chief nursing officer, the chief operating officer, and other professionals. At each hospital, as close to the beginning of the visit as schedules would permit, the primary investigators conducted a 2-hour group orientation and interview with the nurse manager and/or director group in each hospital. Individual interviews were conducted with the chief nursing officer (CNO) on all aspects of the practice environment, but specifically the SG structure and CNP process. The chief operating officer (COO) and representatives from departments such as respiratory, rehabilitation, and pharmacy were individually interviewed to obtain their perspective on the quality and the degree of collaboration among departments, the extent to which nurses controlled practice, and the culture of the organization.

Participant observations. These were conducted by the primary investigators at all central and unit council meetings held during the on-site visit. Investigators attended all unit and service operations meetings, quarterly operations meetings, and as many interdisciplinary (ID) rounds and meetings as the schedule would permit. In six hospitals, lunch meetings were held with informants whom the on-site investigators thought had pertinent information. These included human resource staff, research and evidence-based practice (EBP) facilitators, and nurses in charge of preceptor and residency programs.

Operational and evaluation data. Each on-site investigator collected organizational charts, criteria for Clinical Ladder programs, sample performance appraisals, and SG models, pictorials, and by-laws. Interviewees frequently suggested additional items, such as the products of EBP teams or particular studies or initiatives accomplished by central or unit councils.

CWEQII. This tool was administered to staff nurses on all units in the eight study hospitals. It measures perceived empowerment—the extent to which staff nurses reported that they had access to lines of power—specifically, access to information, opportunity, support, resources, formal power (the power that resides in a job or position), and informal power (the power derived from relationships with peers, managers, physicians, and other disciplines). The CWEQII consists of 19 items, 3 for each component of empowerment and 4 for informal power. Items are rated on a 5-point Likert-type scale from 1 (*none*) to 5 (*a lot*). Subscale scores result from summing and averaging scale items; total empowerment is the sum of the six subscale means. A higher score indicates higher empowerment. Laschinger and Wong (1999) report Cronbach's alphas of .80 to .88. In this study, they ranged from .72 (resources) to .90.

Data Analysis

Categorical and constant comparative strategies were used to analyze interview transcripts and participant observation notes (Strauss & Corbin, 1990). Open-ended questions invited interviewees to cite many characteristics, components, and examples of SG structural viability and of CNP. Most participants provided two or three responses. Data were analyzed using the percentage of responses rather than the number of respondents. Two independent analyses were done with each of the primary investigators proposing potential categories. After identification of common categories, data were reanalyzed to ascertain categorical fit. Responses that fit more than one category were assigned on the basis of context. The fewer than 5% of the responses that did not fit the identified categories were excluded. Operational and evaluation data from each study site were considered nominal-level data and analyzed by frequency count. Parametric techniques were used for CWEQII and CNP ratings.

Findings

Description of Samples

Hospital. The eight study hospitals (three academic and five community) were located in medium ($n = 2$), large ($n = 3$), and very large cities ($n = 3$). Two of these hospitals were on their third magnet designation, three were on their second, and three on their first. The strategic sampling resulted in CNP high-scoring hospitals. Staff nurses in the study hospitals reported a mean CNP score of 75.89 compared to the National Magnet Hospital Profile mean of 71.63 (Kramer et al., 2004) and the Nonmagnet Hospital Profile mean score of 63.35 (Kramer & Schmalenberg, 2004). Eighty-seven percent of the 2,990 staff nurses completing the EOM strongly agreed or agreed that a visible, viable SG structure was operative in their workplace. The percentage of completion of the EOM ranged from 38% to 72% of the RN staff nurse population in each hospital, with a median of 56%.

Unit. Two hundred and six units in the eight hospitals had an RN complement greater than five and a representative sample of RNs responding to the EOM. The 206 units are a 95% to 100% sample of all units in six of the eight hospitals. The other two hospitals had a number of outpatient clinics both on and off campus as well as small in-patient units on satellite campuses that were not eligible for the sample. One hundred and one units met the representative and size criteria, scored above their hospital mean on the CNP subscale and were included in the sample. All types of inpatient units and outpatient care and procedural clinics were represented; critical care and oncology units were over-represented in the sample. Not all eight hospitals had psychiatric, obstetric, or pediatric units. The mean CNP score of 79.32 on the EOM confirmed that the strategic sampling resulted in identification of high-scoring clinical units.

Interview. “Consensus of expert” interviews were conducted with 446 professionals—244 staff nurses (55%), 105 (23%) nurse managers, and 97 (22%) physicians from the 101 high-scoring units. Staff nurses had 16 mean years of experience and 11 mean years of tenure at the hospital. Nurse managers had 22 mean years of experience and 15 mean years of tenure. Physicians had 19 mean years of experience and 13 years of tenure. Sixty percent of the staff nurses were prepared at the baccalaureate level; an almost equal percent (59%) of the nurse managers were prepared at the master’s or PhD level. Eight CNOs, 7 COOs (1 individual held both CNO and COO positions), and 46 (4 to 5 per hospital) departmental representatives were interviewed.

Participant Observations

The primary investigators jointly attended and observed 26 meetings (3 to 4 per hospital) at the unit, department, or hospital level. Examples included Charge and Staff Nurse Councils, Quality Practice Councils, Neonatal Intensive Care Unit and Obstetric ID Practice and Operations, Creating Our Culture Council, Coordinating Councils, and departmental and hospital executive committees.

Structures and Attributes Enabling CNP

Structures

Two structures, SG and career ladders, were identified by interviewees in all hospitals as enabling CNP. Five components or attributes—access to power, participation, recognition, accomplishments, and EBP initiatives—indicated viability of the SG structure, thus facilitating nurses' CNP.

SG. "Our council structure," "shared leadership," and "collaborative governance" were the most frequently cited responses by nurse interviewees to the question: "What enables you to have control over your practice?" All eight hospitals had such structures, all followed the councilor model, and all had a combination of unit and central councils. The latter were usually organized by functions—Practice, Education, Quality Improvement, Informatics, and Research—although in some hospitals, councils were organized by professional role (staff, charge, advanced practice, or nurse manager) as well as functions. Replication of central councils at the unit level varied within and among hospitals, depending largely on the number of RNs on the unit. Small units and clinics with a similar focus often had combined unit councils. Central council activities focused on safety, quality care, improvement, standards of care, the environment, personnel policies, documentation, education, and best practices.

Study hospitals varied in the degree and depth of ID participation in SG. The Silo model, in which the SG structure was housed in and operated out of individual departments, prevailed in five hospitals. The Integrated model, in which the structure was housed in the hospital, not in any one department, was characteristic of three hospitals. The latter was described as follows, and unless otherwise noted, all excerpts are from interviews and observations conducted in the course of this study. The professional role of the speaker is noted only when it is not clear from the quote:

The Integrated model is based on a synergy model (i.e., additional energy is derived from the synthesis of people and activities). When nurses, physicians, and other disciplines collaborate and work together as equals and as a team, you get a synergistic effect due to interaction. The whole is greater than the sum of its parts (CNO).

Career ladders. The criteria for advancement on the Clinical Ladder program were frequently cited by nurses and managers as promoting CNP. They do this by delineating that participation or leadership in council activities is a criterion for career advancement. "I can't say that the Career Ladder bonus is not a motivator and is not appreciated. It is, but as a professional, I would probably participate in council, but the extra pay helps." Seven of the eight hospitals had Clinical Ladder programs; in the eighth hospital, staff nurses preferred a Professional Recognition Incentives for Development and Excellence program based on collegial and egalitarian relationships with a value-added bonus system that enabled and fostered CNP.

Attributes of SG Structures Enabling Viability

Access to power. The input aspect of nurses' definition of CNP was measured by the CWEQII, a tool that defines empowerment as access to lines of power. The CWEQII does not measure shared decision-making actions or outcomes. The opportunity for collaborating with physicians and seeking out or being sought out by peers, managers, and other professionals are the sources of informal power measured by the CWEQII. Although not mentioned or tested on the CWEQII, comments indicated that interviewees perceived SG structures as a source of formal power. Nurses in this study report a fairly high degree of empowerment with mean scores of 21.35. The three hospitals with Integrated SG models score higher ($M = 22.8$) than do the five hospitals with Silo structures ($M = 20.59$). Table 1 presents a comparison of CWEQII scores for the Silo and Integrated study subsamples and a Canadian sample of 600 male and female nurses in a number of urban hospitals in Ontario. The presence of SG structures in the Canadian hospitals is unstated.

Staff nurses seldom used the word *empowerment*, but many made comments such as

We can make a difference. . . .Administration listens to us. . . I'm not just an employee; I am a professional.

Table 1
Conditions of Work Effectiveness Questionnaire
Scores for Designated Samples

CWEQII	Canadian Sample: ^a SG Structures Unknown		Five Study Hospitals With Silo SG Structures		Three Study Hospitals With Integrated SG Structures	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Opportunity	3.72	.98	3.79	.42*	4.42	.47*
Information	2.54	.85	3.35	.33*	3.86	.33*
Support	2.66	.95	3.80	.38*	3.76	.47*
Resources	2.86	.06	3.14	.46	3.20	.45
Formal power	2.46	.12	3.04	.36*	3.33	.31*
Informal power	3.79	.11	3.37	.37*	4.20	.30*
Total empowerment	18.04	3.07	20.49	2.00*	22.77	1.77*

Note: SG = shared governance.

a. CWEQII mean scores and standard deviations in the Canadian sample are averaged from data reported in Laschinger, Finegan, Shamian, and Wilk (2001).

*Mean scores of hospitals with Integrated SG structures were significantly higher ($p \leq .001$) than those for hospitals with Silo structures.

I know that nursing administration wants us to give our input and to make decisions by what our nurse manager says and does. And it works. I feel like what I do in council or staff meetings makes a difference. I have the power, the right, and the responsibility to participate and to make changes.

Managers, physicians, and executives frequently used the “sharing power” concept of empowerment rather than the “exerting power over someone” concept when they described what they did to enable CNP. Staff nurses perceived power as emanating from the SG structure, from nurse managers and leaders, but also from peers and ID relationships:

The CNO has the power of her position and the Board of Trustees and all that, but when it comes to the care of patients in the ICU, my peers and I make the decisions; we have the power of knowledge and experience and of the team behind us, the docs, respiratory therapist and so on.

A director said,

The biggest challenge I have is to help staff nurses realize the power they do have.

Both staff nurses and managers cited the power emanating from the ID team:

When we make rounds and decide as a group on a plan of care, every aspect of that care is going to be what's best for that patient; that's power! It comes from a group decision. The attending [physician] came in and he was going to order something different, and I told him what we had decided on rounds and he agreed, said that the group's decision was much better than his, because it had input from the respiratory therapists' etc. [goes on to give many examples of power derived from group decisions].

The following is an example of power, how it is shared and accepted, and the pride and self-respect that emanates from it:

One of the study hospitals that had been invited to participate in this study declined because of a busy schedule of up-coming activities. A week after receiving the declination, the investigator was informed that the administrative group had been hasty in their decision and that the request was being sent to the SG Nursing Research Council for disposition. The Council contacted the investigators, sought additional information, endorsed the study, expedited the IRB process and secured one of the highest participation rates of any hospital. In a follow-up meeting, the Council chair said, "We have power. We have to use it well and wisely." There are times when something is brought to Council and the administrator will say: "I would like your input, your thoughts, your ideas and suggestions, but for this and this reason, the final decision will be mine." And that's OK. We are all right with that. You have to be accountable for the decisions you make, and if you can't control all the factors in a decision, it's difficult to maintain that accountability.

Breadth and depth of participation. Interviewees' ratings of the extent of CNP on the unit ranged from 1 to 10 with a mean of 7.8 (10 being high). Nurses who were council chairs or very active in SG often rated CNP as a 10. Rating benchmarks were not provided to the interviewees, but it was possible to construct benchmarks from an analysis of the responses and comments that interviewees provided (see Figure 1). An analysis of these benchmarks indicates that the primary theme is the degree of participation in council and CNP activities. There were no significant differences in ratings by clinical unit, professional role, education, or type of hospital; managers and master's-prepared nurses tended to rate CNP higher than all others. There were significant differences in CNP ratings by experience ($p \leq .01$) and by tenure ($p \leq .04$). The direction of the difference was the same in both; more experienced nurses and particularly the 11-year to 19-year group rated CNP higher than did nurses with 10 or fewer years of experience.

Figure 1

Possible Benchmarks for the CNP Rating Scale

- 9-10: "It is an individual's professional responsibility to express their concerns and beliefs and to make decisions that affect our work environment and help do a quality job." "My opinion counts! I'm heard and am responded to." "It is as important to participate in council activities as it is to maintain your clinical expertise." "At some time in my 25 year tenure, I have actively participated on all Councils and committees."
- 8: "Council meetings are great! The front line knows if the thing proposed is going to work." "I know what each council does and I have been a member in the past but I am not right now. I still make it a point to know what's going on and to give input to my representative. I know it works and we (nurses on this unit) feel it to be very effective." "I love our unit council; we have a board for posting information and it's always being read and referred to."
- 6-7: "I'm looking for a committee that interests me and in which I can really get involved." "Democracy of any kind is hard. You have to want it and be socialized into it, and we never were in school. Many nurses are accustomed to being told what to do. But, we're getting there; our input is valued and we are making decisions."
- 4-5: "I'm involved at least to the point of giving input." "You can be as involved as you want to be."
- 2-3: "I'm not interested and am not part of any council." "I'm vaguely aware that there is something out there, but I don't have the time or interest." "We are too short staffed for the nurses to participate."
- 0-1: "The system is good but it doesn't work. They say we have input, but we really don't. It's all lip service."
-

For viable SG structures to positively affect nurses' CNP, nurses have to want to participate. Some people want, desire, and enjoy group decision-making, whereas others do not. Others recognize it as a professional obligation, but family obligations prevent full participation. The major reasons cited for nonparticipation are contained in the following group of quotes:

If there aren't enough staff or if I can't get to a meeting without overloading the other nurses, I won't go.

I prefer giving direct patient care to sitting in a meeting. I'm not interested in the big meeting stuff. You're talking to a guy on the front line with a rifle; my interests don't lie in that direction. I'm a meat and potatoes kind of guy.

I'm caring for elderly parents as well as my children. I just don't have time for additional meetings.

In all study hospitals, increasing staff nurse participation in council activities was a stated goal of the department and organization. Strategies designed to increase participation while acknowledging individual differences were financial compensation or compensatory time off to attend council meetings plus being staffed well enough to do so, extended day-long or half-day council meetings, play areas for children adjacent to meeting sites, and council members soliciting their own replacements. Increasing the quantity, quality, and the scope of EBP initiatives were viewed as a way of securing interest and participation of the more clinically focused nurses in council activities.

Recognition of SG structure and activities by nurses, physicians, and other professionals. Nearly 90% of nurse interviewees could describe the SG structure and the extent of their participation. This does not mean that 90% actually participated, but they knew of the councils, what they did, and how they could contribute if they chose to do so. Nearly two thirds (72%) of the physicians interviewed could describe various aspects of the SG structure. Some knew the names of the council representatives from their unit. About half of the physicians had attended councils to present research and discuss standards, protocols, or pathways. All of the COOs and 93% of the departmental representatives were knowledgeable of the SG councils and activities. In the hospital with Integrated SG models, interviewees were from many disciplines and departments and were "by-law prescribed," integral members of the councils.

Pride in accomplishment, effective outcomes, and action. These components of viability were cited by many interviewees in all hospitals: "It's got to work. . . . You've got to accomplish something, and feel good about it. . . . Your efforts have to mean something. . . . By your actions, they will know you." Slightly more than half ($n = 131$; 54%) of the staff nurses cited outcomes that had been achieved by central and unit councils. (Interviewees were asked to cite three things that councils had accomplished during the past year.) About half (48%) of the physicians interviewed could cite council achievements. All nurse managers, CNOs, COOs, and departmental representatives described many council achievements, particularly in the hospitals with the Integrated SG structures. Examples of effective outcomes included sedation and restraints protocols, barcode for patient identification, mobile phones for direct contact between nurses and their patients, changing holiday and weekend staffing directives, and planning "open peer review" sessions for evaluating

clinical autonomy decisions. Many decisions such as changing the visitation policy to allow parents' presence during cardiopulmonary resuscitation, comparison of three different mattress overlays for patients on high pressure risk units, and comparison of three methods for measuring temperatures in postpartum mothers and infants were the results of EBP initiatives.

EBP teams and activities. This component of viability spans and is related to the power, participation, and accomplishments attributes. As a nurse manager explained,

EBP teams are an essential source of power and control of practice here. The results of EBP increase nurses' knowledge and collaboration with physicians. They know what and why they are doing something, and other professionals respect that. EBP teams are a bridge between clinical autonomy, making decisions for the benefit of the patient, and the decision-making power of the group. They are an avenue for getting the clinician involved in shared decision-making at the unit, service, and organizational level.

The SG structure in all eight hospitals included EBP councils. In some, EBP activity was evident only on some units or services; in others, it was pervasive. In one hospital, new graduates in a well-established nurse residency program were not only taught the fundamentals of EBP, but singly or in small groups, each was expected to initiate, complete, and present a project during their year's residency program. All eight hospitals had educational programs in the conduct of EBP. In some hospitals, ID sessions were held to teach, conduct, and execute EBP initiatives. Others hosted or sent nurses to ID "boot camps" where they learned, along with physicians and therapists, how to conduct EBP. The Champion model, consisting of clinical nurse representatives who formed champion teams for key nurse-sensitive indicators such as skin, falls, restraints, pain, and vascular access, was active in two hospitals. Champions were coached and mentored in the acquisition of EBP skills by critiquing research and EBP articles, not only for their own understanding and practice but also to help them guide their peers. In other hospitals, clinical nurse specialists or advanced practice nurses educated team members and led ID EBP team efforts.

Discussion

SG structures are effective in enabling nurses to CNP, that is have input and make decisions regarding issues of importance to nurses, patients, and the

organization. The viability of SG is expedited when such structures provide access to power, are characterized by wide participation, and are recognized as effective in achieving important outcomes as a result of shared decision-making. Such achievements garner respect and are manifested by pride in outcomes. EBP teams and ID initiatives increase participation, recognize individual differences, and provide additional access to power. Career ladder structures that recognize participation and achievement in SG activities are also effective in enabling CNP. Access to power, one of the viability components of SG structures was measured through empowerment scores. In most studies using the CWEQII, staff nurses report only moderately empowering work settings, with limited access to information, opportunity, resources, and support (Laschinger & Havens, 1996; Laschinger & Wong, 1999; Laschinger, Wong, & Greco, 2006; Matthews, Laschinger, & Johnstone, 2006; Sabiston & Laschinger, 1995; Piazza, Donahue, Dykes, Griffin, & Fitzpatrick, 2006). Moderate total empowerment scores range from 14 to 22; scores from 23 to 30 indicate high levels of empowerment (Piazza et al., 2006). Nurses in this study reported fairly high empowerment ($M = 21.35$), with more access to power when SG structures follow an Integrated model than when they follow a Silo model. Because input or access to power is a vital component of CNP, conversion to integrated SG models would seem advisable. Hess (2004) contends that Silo models that include only nurses can become exclusionary and eventually ineffectual by focusing on the goals of a single profession instead of the organization. The CWEQII is a useful measure of the "access to power" aspect of viable SG structures. In a recent study using the EOM and the CWEQII to measure CNP and empowerment of staff nurses in four hospitals in the same corporate group, Church (2007) found that nurses in the two magnet hospitals with viable SG structures reported significantly higher CNP and empowerment scores than did their counterparts in the two nonmagnet hospitals.

Nurses' enthusiasm, pride, and respect when describing effective outcomes obtained through shared decision-making was as moving and evident in these interviews as it was in 2001 (Kramer & Schmalenberg, 2002, 2003). It is also evident in Burke's (2005) description of CNP outcomes in one of the participating hospitals. Two components of SG structures that were different between 2001 and 2006 were involvement and domination of proceedings by only a small group of staff nurses and CNP at only the unit or only at the central level. Both of these appear to be start-up characteristics. Participation is now more generalized and includes both unit and central councils. The problem of insufficient numbers of nurses to staff unit councils when all central councils are replicated at the unit level was resolved by having fewer unit councils and combining the charges to those councils.

The scheduling, selection of equipment and supplies, job requirements, and hiring that once were the focus of central councils as cited by Hess (2004) are now handled in unit operations meetings.

The mean unit CNP rating for the 446 interviewees of 7.8 is lower than the 8.5 to 9 ratings reported for the other essentials in high EOM-scoring hospitals (Kramer et al, 2007; Schmalenberg et al., 2005). Analysis of the CNP benchmarks (Figure 1) indicates that ratings are tied primarily to the extent of participation; as participation increases, CNP ratings should also. That only half of the nurses and physicians on these high-scoring units were able to cite specific outcomes achieved through councils was surprising. This finding might also be related to the “depth and breadth of participation” component of SG viability. Interviewees said, “I know Council does good things; I listen to the reports our rep gives, but I can’t tell you the specifics. I don’t know the particulars, because I can’t go to the meetings and wasn’t involved in the decision.” Nonetheless, soliciting specific outcomes is probably an excellent method for evaluating the viability and effectiveness of the council in enabling CNP.

Instituting a SG structure that will effectively enable CNP is a journey, not an event. It requires a culture change, time, and commitment. The 10-point rating scale used in this study is a rapidly administered, user-friendly way of periodically checking on the progress of structural implementation over time. By changing the stem of the scale to reflect different characteristics, (e.g., “Rate the extent to which you think the SG structure produces effective and important outcomes”), progress over time can be assessed. Just as excellence is not a static achievement but a constant becoming, so also are SG and CNP. Clinically proficient, mature nurses are known to seek out work environments that foster professional practice, which includes shared decision-making (Laschinger & Wong, 1999). The SG-CNP journey also provides the opportunity to nurture and develop excellent professional practice from within the organization.

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