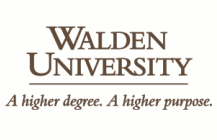

2019

Evaluation of Shared Governance Implementation at a Community Hospital

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This is to certify that the doctoral study by

Teresa Nardontonia

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2019

Abstract

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Teresa Nardontonia MSN, RN, APRN

MSN, University of Pennsylvania, 1991

BSN, York College of Pennsylvania, 1988

DNP Doctoral Project Proposal

Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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July 2019

Abstract

Shared governance is a model in which staff collaborate through a decentralized decision-making structure, sharing ownership and accountability and partnering to make decisions about clinical practice, professional development, patient experience, quality improvement, and research. The hospital shared governance project team aligned its shared governance model with the American Nurses Credentialing Center Pathway to Excellence standards. The purposes of this project were to do a process evaluation of shared governance implementation at one 64-bed community hospital in central Florida and make recommendations for continuous quality improvement. The project followed the plan-do-study-act methodology developed by Deming. Through the collection of meeting minutes and other shared governance documents, semi structured interviews with nurse leaders, and the results of an anonymous survey through SurveyMonkey, the process of shared governance implementation was evaluated. The major themes included the hospitals need to establish an effective communication system to ensure all 185 RNs are aware of its shared governance, restructure of the Nurse Practice Council, and a reinitiating of shared governance. Limitations of the project included the immaturity of the hospital at the time of implementation, nursing lack of knowledge about shared governance, lack of dedicated resources and competing priorities, and nursing leadership and unit turnover, which were barriers to shared governance implementation. Supporting shared governance contributes to social change by creating a nursing culture that promotes quality, nursing excellence, professional decision making, and a healthy work environment, ultimately improving outcomes for all stakeholders.

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Dedication

This is dedicated to the nurses at the medical center where the project took place. I have a genuine passion for involving direct care nurses in decision-making that influences nursing practice, patient care and clinical outcomes. May this quality improvement project enhance the nursing practice at the medical center and promote future improvements to patient care and clinical outcomes.

Acknowledgments

Thank you to my family for their continued support through my personal and professional journey. Without the love and support of my husband Dan, daughters Rachael and Leah, and parents Joe and Carlotta, I would not have accomplished my goal. I am forever grateful to you all.

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Section 1: Evaluation of Shared Governance Implementation at a Community Hospital

Introduction

Shared governance is a model in which staff collaborate through a decentralized decision-making structure, sharing ownership and accountability and partnering to make decisions about clinical practice, professional development, patient experience, quality improvement and research (ANCC, 2016). This hospital's nursing vision statement is: To be committed to providing memorable, patient centered care to our community with empathy, compassion and ownership of our professional practice. This incorporated the concepts of responsibility and ownership of professional practice, aligning with the shared governance framework.

Problem Statement

In order to meet the goal of achieving American Nurses Credentialing Center (ANCC) Pathway to Excellence recognition within 4 years, a community hospital in central Florida is working to develop a shared governance model into the framework, design, opening and operations of the hospital. Achieving the ANCC Pathway to Excellence designation demonstrates quality nursing practice, professional development, and job satisfaction (Swartwout, 2009). Moving to the shared governance model demands a decentralized structure with collaboration and engagement of bedside frontline staff. Centralization and decentralization structures are organizational philosophies about power that pertain to the ordered level of decision-making authority in the institution.

Centralization means that decisions are made at the top levels and decentralization means that decision-making is diffused throughout the organization. The more an organization is decentralized, the more decision-making takes place at lower levels, such as the bedside, with less supervision (Hoying, 2016). The community hospital will have completed its development of a shared governance model by April 2019, and desires to do a process evaluation in order to address concerns and recommendations of all participants.

Purpose Statement

The purpose of this project is to complete a process evaluation regarding the community hospitals shared governance implementation. The evaluation will follow the Walden University Manual for Evaluating Quality Improvement Projects. The practice questions are:

RQ1: What are the results of the process evaluation conducted regarding shared governance implementation at a community hospital?

RQ2: What recommendations will be made to the shared governance project team for continuous quality improvement?

Nature of the Doctoral Project

Shared governance at the nursing department level impacts job satisfaction, nurse retention, and patient satisfaction (Bieber & Joachim, 2016). As practical evidence connects shared governance with outcomes such as nursing empowerment, job and patient satisfaction, and better patient outcomes as evidenced by lower fall rates, decreased pressure ulcer incidence, and improved patient satisfaction, the principles of

shared governance will endure (Hess, 2014). Management and nursing partnership, nursing accountability, nursing ownership of practice, and equity are key to successful shared governance and in turn promote a healthy work environment, open communication, and collaboration (Bieber & Joachim, 2016). This project will be an evaluation of the implementation of shared governance in a 64-bed community hospital in central Florida using the plan-do-study-act (PDSA) framework for quality improvement.

Significance

The first structural considerations of shared governance were identified by Virginia Clealand in 1975. The ANCC Magnet Excellence program has a significant emphasis on nursing's control of and participation in its own professional nursing activities and influence over the delivery of patient care. The senior nursing leadership of the hospital recognized the high level of staff commitment and motivation for nursing excellence. The opportunity for the hospital to lay the foundation of shared governance with the goal of Pathway to Excellence designation demonstrates the commitment for nursing excellence and a hospital that cares for its nurses. Effective leaders use the structures of shared governance to build a culture of excellence, where nurses have accountability and responsibility for nursing care (AONE, 2018). A dynamic staff-leader partnership encourages equitable opportunities for shared decision-making and accountability for improving quality of care and patient safety and enhancing quality of life (Porter-O'Grady, 1987).

The importance of creating a positive work environment for nurses has a downstream effect on issues such as nursing retention and turnover, productivity, staffing, employee engagement, and nurse-sensitive indicators such as patient falls, pressure ulcer prevention, catheter associated urinary tract infections (CAUTI) and central line associated blood stream infections (CLABSI; Ong, Short, Radovich, & Kroetz, 2017). All of these issues are important to the nursing profession and each patient who entrusts the hospital with their care and life. Shared governance is important to nursing practice in empowering the nurse at the bedside to improve patient care and outcomes and patient safety, increase nurse engagement, and improve nurse retention and the patient experience.

Summary

The Chief Nursing Officer (CNO), administration, and nursing leadership of this community hospital identified nursing's need to establish a framework for shared decision-making. This partnership that would impact nursing practice and care provided by nurses at the bedside. Shared governance brings the voices of nurse clinicians, coordinators, educator, and evaluator to the forefront.

The practice questions are:

RQ1: What are the results of the process evaluation conducted on the shared governance implementation at a community hospital?

RQ2: What recommendations will be made to the shared governance project team for continuous quality improvement?

Section 1 introduced the importance of a shared governance model to this facility. Section 2 describes the model that will frame the project, literature relevant to the project, my role, and the team members involved in the project.

Section 2: Background and Context

Introduction

The community hospital under study is building a foundation for quality and a culture of nursing excellence within a framework of patient- and family-centered care. A cornerstone to this foundation is the embedding of a shared governance model for nursing practice. This DNP project is a quality improvement evaluation. The practice questions are:

RQ1: What are the results of the process evaluation conducted regarding shared governance implementation at a community hospital?

RQ2: What recommendations will be made to the shared governance project team for continuous quality improvement?

Concepts, Models, and Theories

The project will follow the PDSA methodology developed by Deming. Also known as the Deming or PDSA cycle, this quality improvement model has four repetitive steps focused on continuous improvement and learning. The hospital is in the process of completing steps one through three. This project will evaluate the processes from step three and make recommendations for step four.

Table 1

Alignment of PDSA Cycle to Project

Steps in PDSA Cycle	PDSA Activities	Alignment to Project
Step 1 Plan	Plan ahead for the change	Shared Governance project team formed; review of literature on SG Decision to align SG model with the Pathway to Excellence Standards 1: Shared Decision-Making
Step 2 Do	Execute the plan	Implement councils
Step 3 Study	Check, study the result of step 2	Collect minutes and other documents in shared governance folder. Implement surveys for all nursing staff.
Step 4 Act	Take action to improve or standardize the process	DNP project evaluation and written report

Relevance to Nursing Practice

The first structural considerations of shared governance were identified in 1975 by Virginia Clealand. Shared governance models were introduced to improve nurses' work environment, satisfaction, and retention. According to Anthony (2004) responding to this nursing administrators have restructured and evaluated nursing care delivery systems to meet the challenges of maintaining a professional practice in a financially

constrained setting while focusing on achieving positive outcomes. Kanter's theory on structural power influenced the development and formation of shared governance, suggesting that formal and informal power permit access to work empowerment structures (opportunity, resources, support, and information) that enable workers to accomplish their work (Anthony, 2004).

The definitions in the literature for shared governance may differ, there are commonalities, including autonomy and independence in practice, accountability, empowerment, and collaboration in decisions that affect individual patient care. These commonalities of shared governance represent professional nursing ideals. The ANCC defined shared governance as a model in which staff collaborate through a decentralized decision-making structure, sharing ownership and accountability and partnering to make decisions about clinical practice, professional development, patient experience, quality improvement, and research.

Nursing practice models provide the structure and context to organize the delivery of care, and shared governance is a model of nursing practice designed to integrate core values, ideals, and beliefs that professional practice embraces as a means of achieving quality care (Anthony, 2004). According to Swihart and Porter-O'Grady (2006) the American Nurses Association defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations" (p. 1). An operational

component of a shared governance model is to define nursing standards of care and review nursing sensitive indicators.

According to Porter-O'Grady (2004) "there is little question that empowering models such as shared governance are good and valuable corollaries to professional practice and good leadership" (p. 1). Porter-O'Grady adds what is missing is the research and data related to its impact to professional practice and value with regard to advancing care outcomes. The formation of shared governance with a focus on its impact on professional practice and patient outcomes is the foundation of this DNP project.

Implementing and sustaining shared governance is not easy and requires the direct care nurse be competent of making their own decisions about practice and the nursing leaders' ability to facilitate them (Porter-O-Grady, 2004). The CNO, hospital administration, and nursing leadership were committed to providing a framework that empowers nurses to have a voice in decision-making that affects the care of patients as well as their work. Unit Practice Councils (UPCs) represent the unit-based aspect of the shared governance model in nursing and facilitates decision making participation at the staff level. The UPCs will go on to identify unit projects that will impact three specific areas (clinical practice, professional development and patient experience) and will base changes on published evidence based practice (EBP), aligning with the Pathway to Excellence evidence of performance (EOP) 1.3 Nurse-sensitive indicators, or patient outcomes dependent upon nursing care, such as CAUTI and CLABSI reduction strategies

could lead to a change in practice the UPC could present under the clinical practice area aligning with EOP 1.4.

Local Background and Context

The setting for this doctoral project is a community hospital in the central Florida that opened January 2017. The hospital provides comprehensive healthcare services in a state-of-the-art environment and is known as a hospital of the future. The campus includes a 64-bed hospital and 22-bed emergency department as well as a medical office building. Services include medical and surgical inpatient units, intensive care, medical cardiology, telemetry, cardiac catheterization, inpatient and outpatient surgery, women's services including labor and delivery, cardiopulmonary services, comprehensive diagnostic imaging, and physical, occupational, and speech therapy. The organizational structure for nurses includes the CNO and nursing directors for emergency, periop, surgical, medical, critical care, and women's services.

The CNO must be masters-prepared, with the expectation of enrollment in a DNP program. The nursing directors must be at least BSN-prepared, and currently three of the five directors hold a masters level degree MSN or MBA. There are approximately 115 RN full-time equivalents (FTEs) within the six nursing departments, and of those approximately 42% are BSN prepared. Each RN is encouraged to continue their education, using the robust tuition and certification reimbursement program offered by the organization. As the organization is just 2 years old, nursing leaders continue to hire

RNs to bring staffing up to core standards and support the fluctuating and growing average daily census of the hospital.

Role of the DNP Student

I am the chief nursing officer of the 64-bed community hospital in central Florida that is the setting of this doctoral project. I serve as a transformational leader who supports quality patient care and excellence in nursing. This quality improvement project will help facilitate the continued success of shared governance at the hospital. By using transformational and participative leadership I support the shared governance coordinator and shared governance project team to grow a vision of nursing excellence into the foundation of this hospital.

Role of the Project Team

A shared governance project team was assembled to discuss the formation of shared governance. The CNO and Directors of Emergency Services, Surgical Services, Medical-Surgical, Critical Care, and Women's Services are members of the project team. This team will be provided with the results of the project evaluation and recommendations for continuous improvement.

Summary

The opportunity to plan, design and implement shared governance and start the Pathway to Excellence designation journey demonstrates the hospitals commitment for nursing excellence. Section 2 described the model framing this project, relevance to

nursing practice, my role, and the role of the project team. Section 3 will discuss the sources of evidence supporting this project.

Section 3: Collection and Analysis of Evidence

Introduction

A 64-bed community hospital is building a foundation for quality and a culture of nursing excellence within a framework of patient-and family-centered care. A cornerstone of this foundation is embedding the shared governance model into the framework, design, opening, and operations of the hospital. Shared governance at the nursing department level impacts job satisfaction, nurse retention, and patient satisfaction (Bieber & Joachim, 2016).

Practice-focused Questions

The practice questions are:

RQ1: What are the results of the process evaluation conducted regarding shared governance implementation at a community hospital?

RQ2: What recommendations will be made to the shared governance project team for continuous quality improvement?

Sources of Evidence

Plan

After a review of the literature, the shared governance project team decided to align the hospital shared governance model with the Pathway to Excellence standards 1: Shared Decision-Making framework to guide nursing quality, engagement, and ownership of professional practice. Within Pathway to Excellence standard 1 are nine

EOP that were used as the framework for the formation of the shared governance model. To meet the EOP 1.1 the hospital must describe how it promotes a culture of interprofessional decision making and provide an example that demonstrates the culture. To meet EOP 1.2 the hospital describes its shared governance structure that demonstrates shared decision-making and provides a graphic depiction and supporting documentation to explain this structure. To meet EOP 1.3 the hospital must provide one example of a direct care nurse presenting an idea to the shared governance project team, including an explanation of what was presented, how did the shared governance project team evaluate the idea, and whether the idea was implemented. To meet EOP 1.4 the hospital must provide one example of a change in practice as a result of a shared governance initiative and how that change was based on published EBP, as well as explain why the nursing practice change was recommended, describe the new practice, and reference the EBP used to make this change. To meet EOP 1.5 the hospital must describe how it obtains input from direct care nurses prior to implementation of changes that affect care delivery or work flow and provide one example of how this input impacted the implementation of those changes. To meet EOP 1.6 the hospital must describe the interprofessional process that addresses how ethical concerns are managed and provide an example of a specific situation. To meet EOP 1.7 the hospital must describe how direct care nurses are made aware of support processes in place for situations where they are faced with ethical concerns and provide a narrative written by a direct care nurse who used those processes. To meet EOP 1.8 the hospital must describe how direct care nurses are involved in the

decision-making process regarding product evaluation and provide one example. To meet EOP 1.9 the hospital must describe how direct care nurses are included in the hiring process for new staff and provide an example, including the outcome of the decision. Hospital administration and nursing leadership supported nurses' freedom to fully participate in the practice of nursing, shaping the work environment in which patient care occurs, and making decisions needed to carry out their scope of work to perform their professional tasks.

Do

The corporation that owns this hospital has set expectations that each eligible nursing unit apply for the Unit of Distinction (UOD) nursing program. This program is dedicated to driving continuous performance improvement and achieving clinical outcomes by focusing on professional nursing practice and recognizing top performing nursing units. One of the UOD-requirements is the formation of a professional practice council or shared governance. This community hospital shared governance model is a decentralized decision-making structure and consists of three major councils: nurse leadership council (NLC), nurse practice council (NPC) and unit practice councils (UPC), supporting the Pathway to Excellence EOP 1.2. Each council has a committee and workgroups within them to support shared governance and teamwork.

The CNO held a nursing leadership retreat to share the nursing vision, the Pathway to Excellence EOP standards for shared-decision making and shared governance. The retreat was designed to be educational and build teamwork and talent

recognition of the leaders and be fun. A draft of the shared governance bylaws, council structure, and charters for the focused areas of clinical practice, professional development and patient experience was created, supporting Pathway to Excellence EOP 1.6, EOP 1.7 and EOP 1.9. The CNO hosted nursing forums to introduce to nursing the concept of shared governance, gauge the readiness of the nursing staff to embrace this practice model, and identify staff members interested in serving on their UPC. Applications for chairs for each UPC were solicited. The NLC reviewed the applications and identified the UPC chairs. A meeting, hosted by the CNO and the nursing leaders, was set with all of the selected UPC chairs. This meeting educated the UPC chairs on how to facilitate a meeting, create agendas, and post meeting minutes to the hospital shared governance folder. The selected UPC chairs became the members of the NPC. The unit chairs selected one member to be the UPC representative on the NLC. Shared governance scheduling included monthly UPC meetings, quarterly NPC meetings, and quarterly NLC meetings. The councils are focused on strengthening the staff nurses' participation in decision-making regarding nursing practice. This includes the UPC identifying and presenting to the NLC initiatives within their scope of influence that fall within the focused areas of clinical practice, professional development, and patient experience, supporting Pathway to Excellence EOP 1.3, EOP 1.4, and EOP 1.5.

Study

The hospitals nursing dashboard is used to help the UPCs identify nurse-sensitive indicators such as CAUTI and CLABSI reduction strategies to focus their projects. A

quarterly report is presented to the nurse leadership council from each of the UPCs detailing their projects, including their impact on nursing practice. The UPCs can also create poster presentations reflecting their projects and display them at various times during the year, supporting Pathway to Excellence EOP 1.8. Documents generated during the planning and implementation of the shared governance will be filed within a secure folder on a designated drive on the facilities secure network. The CNO, NLC members, and chairs of the UPC will have access to the secured shared governance folder maintained on the drive. The NLC will also request nursing staff at all levels to respond to an anonymous survey through SurveyMonkey (Appendix A). Semi structured interviews were conducted with participating nurse leaders. Deidentified transcripts were provided to me for analysis.

Act

Upon completion of the analysis and synthesis, a written report will be presented to the NLC. The written report is to include identified themes and recommendations for further improvement of shared governance. The NLC and shared governance project team will formulate an action plan based on the results.

Analysis and Synthesis

Deidentified data from the shared governance folder and surveys were analyzed. Themes were identified and summarized and recommendations on further actions to improve or standardize the shared governance process were identified. A written report was prepared to be presented to the NLC and shared governance project team.

Summary

Creating a culture that promotes quality, nursing excellence, and professional decision-making can be demonstrated within the structure of shared governance. With the partnership between administration, management, and direct care nurses, the formation of a shared governance model can be realized in a new community hospital, giving voice to direct care nurses and empowering them to change and improve nursing practice. The purpose of this project is to complete a process evaluation regarding the current shared governance process. The evaluation will follow the Walden University Manual for Evaluating Quality Improvement Projects.

Section 3 described the components of the PDSA initiative. The evaluation of shared governance implementation for the DNP project was described. Analysis and synthesis of the results are presented to the NLC and shared governance project team and reported in Section 4.

Section 4: Findings and Recommendations

Introduction

The purpose of this project was to complete a process evaluation regarding the implementation of shared governance process at a community hospital. The evaluation followed the Walden University Manual for Evaluating Quality Improvement Projects. The practice questions were:

RQ1: What are the results of the process evaluation conducted regarding shared governance implementation at a community hospital?

RQ2: What recommendations will be made to the shared governance project team for continuous quality improvement?

This project was an evaluation of the implementation of a shared governance model in a 64-bed community hospital in central Florida using the PDSA framework for quality improvement. Also known as the Deming or PDSA cycle, this quality improvement model has four repetitive steps of plan, do, study, and act, focused on continuous improvement and learning. Analysis and synthesis of the results of the PDSA were presented to the NLC and shared governance project team.

Findings and Implications

Plan

Commencing in spring 2017, the organization began work designing a shared governance framework that would enhance clinical practice, professional development, patient experience, clinical outcomes, and quality improvement. A shared governance

project team was assembled to discuss the formation of shared governance. The CNO and the Directors of Emergency Services, Surgical Services, Medical-Surgical, Critical Care, and Women's Services are members of the project team. After a review of the literature, the project team decided to align the hospital shared governance model with the Pathway to Excellence standards 1: Shared Decision-Making framework to guide nursing quality, engagement, and ownership of professional practice. Within this standard are nine EOP that were used as the framework for the formation of the shared governance model.

Do

The corporation that owns this hospital set expectations that each eligible nursing unit apply for the UOD nursing program. One of the UOD- required elements was the formation of a professional practice council or shared governance supporting EOP 1.1. The size of the organization and limited resources played a key factor in its structure, which consists of three major councils: NLC, NPC, and UPCs, supporting EOP 1.2. Each council has a committee and workgroups within them to support shared governance and teamwork.

Study

The process of shared governance implementation was evaluated in three ways. UPC and NPC activity were evaluated through the collection of meeting minutes and other documents in the hospital shared governance folder. Semi structured interviews were conducted with nurse leaders who participated in the planning and implementation of the hospital shared governance. The anonymous survey through SurveyMonkey

provided RN's an opportunity to provide their opinion on the shared governance implementation.

Following is an analysis and evaluation of the implementation steps noted in Section 3. The nursing leadership retreat was hosted by the CNO to share the nursing vision, the Pathway to Excellence EOP standards for shared-decision making and shared governance. The retreat revealed the nursing leaders were not familiar with Pathway to Excellence and only two of the five directors had any prior experience with shared governance. The Director of Women's Services had experience implementing shared governance, and was therefore appointed as the hospitals shared governance coordinator. Discussions demonstrated that nursing leaders valued nursing excellence, collaboration, and shared-decision making. Since the retreat, two of the initial nursing leaders received promotions to go to other hospitals and left the organization, leaving a gap in unit support and leadership, thus impacting any momentum the councils may have achieved.

The project team created a draft of the shared governance bylaws, council structure, and charters for the focused areas of clinical practice, professional development, and patient experience, supporting Pathway to Excellence EOP 1.6, EOP 1.7, and EOP 1.9. The drafts were later presented to the UPC chairs for review and approval and were adopted as originally presented.

Nursing forums were hosted by the CNO in October 2017 to introduce the concept of shared governance, gauge the readiness of the hospital nursing staff to embrace this practice model, and identify staff members interested in serving on their

UPC. Reviewing the sign-in sheets from the four nursing forums, attendance at these forums was limited; however, the forums had representation from day and night shift nursing units. Each nursing unit had nurses who were either familiar with shared governance or served on a UPC in the past, and those in attendance were supportive of moving shared governance forward. During November and December 2017, nursing leaders discussed the principles of shared governance during staff meetings in order to elicit questions and provoke staff interest in serving on a council. During this timeframe, information was also carried over to the nursing units daily shift huddles in order to keep shared governance on the RNs mind as applications for UPC chairs were being solicited. Formal applications for chairs for each UPC were due by December 15, 2017 and then reviewed by the NLC. By December 22, 2017 the NLC selected the UPC chairs. Congratulatory certificates were presented to each UPC chair by the CNO. A UPC chair was identified before the actual UPC membership was formed, and the NLC selected the chair rather than the UPCs electing their own chair. This approach did not give sufficient time to identify leadership skills among the unit staff. It also did not support empowering the staff to make decisions about their UPC.

The CNO, shared governance coordinator, and shared governance project team hosted a meeting with the UPC chairs in January 2018. This meeting reviewed the bylaws, council structure and charters, and educated the chairs on how to facilitate a meeting, create agendas, and post meeting minutes to the hospital's shared governance folder. These selected UPC chairs became members of the NPC. The UPC chairs were

given 2 weeks to select one member from the NPC to be their representative in the NLC, based on criteria in the bylaw documents. This was the only meeting held with all stakeholders, and while they heard how to run a meeting, there was no additional prescribed guidance on how to form a UPC or identify unit projects.

Unit directors were expected to take lead and help support their UPCs; however, some of the UPCs struggled. The semi structured interviews with the nursing leaders revealed their own lack of knowledge contributed to this and it was an unrealistic expectation for some of them given the organization's overall stage of growth and development. The two medical-surgical units shared staff and their UPCs came to realize they were more alike than different, and in an attempt to keep their UPCs meaningful, they decided to merge. This was supported by nursing leadership as it gave voice to direct care nurses and empowered them to join together to impact nursing practice. The ICU and ED UPCs were challenged but were committed and able to remain engaged and active. The Women's Services UPC floundered as their chair had overcommitted herself and the Surgical Services UPC stopped meeting when their chair changed work schedules and no one stepped up to take the lead.

The UPC chairs met face-to-face one time as an NPC and were able to select the representative for the NLC. According to NLC meeting minutes, the NPC representative reported out for two quarters and by the third quarter report it was apparent the NPC was struggling to take root. NPC meetings were not being held and ongoing communications by the NPC members about UPC specific activities were communicated via e-mail. The

meeting minutes demonstrated the NPC did not understand its scope and role in shared governance.

Shared governance was a standing agenda for the NLC, which met monthly as planned. UPC meetings were coordinated and scheduled by the UPC chair and the meeting minutes revealed attendance and participation was good for ICU, ED, and Women's Services but sparse for medical-surgical and surgical services. By April 2018, the original medical-surgical nursing leader received a promotion, and although this was positive for the leader, it was disruptive to the unit, RN turnover increased and any traction the UPC had gained was lost. The ICU and ED UPCs continued to meet and focused on strengthening the staff nurses' participation in decision making about nursing practice and process improvement initiatives.

While some UPCs struggled with formal meeting attendance, the engaged unit nurses continued to focus on improving nursing practice and patient outcomes. On November 14, 2018, a year after the hospital shared governance implementation, the UPCs accomplishments were recognized with a celebratory reception hosted by the shared governance project team. This reception was open to all the staff within the hospital, not just nursing, and was attended by many of the departments in the hospital. Each active UPC exhibited a poster presentation depicting their project. UPC members manned their presentation and as staff stopped at each table they proudly spoke of their accomplishments and impacts to professional practice and patient outcomes. A memo from the CNO clearly reflected nurses' work collaboratively with patients, families,

physicians, and members of the interdisciplinary team to care for those who need services. The hospital understands and values the critical role nurses play in the successful outcome of each patient's recovery.

Following this celebration, the shared governance project team met in December 2018 to reflect on the year since implementing shared governance. The shared governance project team recognized opportunities for improvement and decided to elicit feedback from the nursing staff on the implementation and obtain recommendations for improvement. With the help of the hospital educator an anonymous survey through SurveyMonkey was created, following Elton, Otte & Rapson (2001), to analyze and evaluate the shared governance implementation. The IT Director created the icon with a link on the facilities intranet page. The shared governance coordinator sent an e-mail to the RN distribution list of 80 RNs requesting their participation in the survey. The survey was also added to the nursing units daily shift huddle report. The staff had 3 weeks to participate in the survey. Nine responses were received from the survey yielding a 0.1125% response rate. While the response rate was dismal, it is noteworthy that each respondent answered all 10 questions yielding a 100% completion rate. The main themes of the shared governance survey are described:

1. Understanding – the respondents had a basic understanding of shared governance, which was reflected in these responses: staff have a voice in developing new policy and procedures; working to make a better work environment with nurses and patients; we work as nurses alongside of

management and other departments to help improve processes and patient outcomes.

2. Awareness – one respondent heard we have one; however, the majority of respondents had not heard anything about shared governance activities.
3. Implementation – with the limited awareness of the organization's shared governance, the respondents noted it had not been implemented very well; "I think it never got off the ground; looking forward to a reboot."
4. Involvement – seven of the respondents had not been involved at all, but nine respondents were interested in getting involved or being more involved, and one preferred to share ideas for improvement of processes with someone who could actually affect change, "I have shared concerns/observations directly with CNO and seem to have better outcomes and action."

Recommendations

Act

Several recommendations emerged from this evaluation of the shared governance implementation. Likewise, several of the initial strategies presented with this implementation were successful and therefore are recommended to continue. Recommendations were as follows:

1. Establish an effective communication system to ensure that all members of staff are aware of the organizations shared governance (e.g., update RN distribution list for e-mail communications, nursing forums, town halls, flyers,

posted meeting schedules, display to show case activities, structured communication to be used by all departments).

2. Retire the original guidance documents and adopt the corporation's professional practice council toolkit, bylaws, and charter (HCA Nursing, 2018).
3. Restructure the Nurse Practice Council to include UPC members, informal leaders (educator, sepsis/stroke/chest pain coordinator, house supervisor, clinical informaticist) who, based on their job responsibilities, can support the efforts of the NPC and the shared governance coordinator.
4. Identify a project that the new NPC can all work on as a team (e.g., common clinical documentation opportunities admission assessment, pain assessment/reassessment, plan of care).
5. Establish a recurring standing monthly meeting for the new NPC, including an agenda, meeting minutes, and deliverables for each meeting.
6. Support the NPCs and its project for at least 4 to 6 months, or until the council members have gained confidence in their ability to lead and facilitate. Then, perhaps UPCs could be resurrected and unit specific initiatives identified.
7. In the future, outcomes in nursing excellence and nursing practice could be analyzed and measured by the organization's operational data bases, including the Nursing Dashboard, Clinical Excellence Dashboard, and Press Ganey data for HCAHPS, and nurse leader rounding (Press Ganey Associates, Inc, 2019).

The nurse-sensitive indicators within these data bases could be used to help the UPC identify their unit initiatives within the focus areas of clinical practice, professional development or patient experience and align with the corporation UOD program. To help the newly formed UPCs understand the principles and approach to shared governance, the CNO would propose that the UPC utilize one of the nurse-sensitive measures within the Nursing Dashboard as their first UPC initiative. Therefore, the UPC could select C-Difficile, CLABSI, or CAUTI as a clinical practice initiative. The key performance indicators within the selected initiative would identify the nursing practice changes on which the direct care nurses will need to focus to improve outcomes. Partnering with the UPC, the members of the Nurse Practice Council would help them formulate the process improvement initiatives using the DMAIC model.

The DMAIC model (ASQ, 2018), a rapid change approach to process improvement, is an acronym for the five phases that make up the process. The process is to define the problem, measure the process performance, analyze the process, improve process performance and control the improved process. The DMAIC model and EBP literature would be used to structure the tactics that would drive the practice changes needed to impact nursing practice.

The Nursing Dashboard could be accessed daily, or as needed, by members of the UPCs to review the key indicators and evaluate progress of

their practice change efforts. The NPC and UPC could meet at least monthly to discuss and evaluate their progress and, on a quarterly basis, the UPC chairs could update the NLC regarding their projects, including impact to nursing practice. Once the practice change has achieved the desired outcome for the key indicator for a quarter the UPC would then be eligible to create a poster presentation reflecting their project and display it during the hospitals Nurses Week celebration. The UPC may then select another nurse-sensitive measure to work on while they continue to monitor the original measure and the cycle continues again.

Strengths and Limitations of the Project

The evaluation of shared governance 18 months after implementation was a useful process. The major strength of this project was the genuine commitment from administration, the shared governance project team, and the staff to continue a system of shared governance at this organization and support a reboot. Several limitations that impacted the shared governance implementation were identified. The immaturity of the organization at the time of implementation was a limiting factor. The organization had opened just 9 months prior to launching shared governance and was as a whole working to stabilize its foundations. Ramping up staffing to meet increasing volumes meant continuous new hires, orientation, and onboarding of nursing staff. Staff nurses were still learning processes and work flow, and discovering items that were missed or that needed enhanced since the opening. The nursing units were in a continuous process

improvement mode at a time when team was still being built on the nursing units. The units were engaging in many aspects of shared governance without recognizing it or structuring their efforts within the framework of a UPC.

The lack of shared governance knowledge by nursing leaders and staff, as well as zero dedicated resources impacted this implementation. Many competing priorities also limited the nursing leaders' abilities to facilitate or support the young UPCs. Harris and Cohn (2014) write about the design and opening of a new hospital with a culture and foundation for magnet and it is evident that knowledge and dedicated resources are key components to a successful implementation.

Changes in nursing leadership personal was a limiting factor too. Nursing leadership transitions on the medical-surgical units lead to instability, shifting priorities, and the inability to support a strong formation for these UPCs. Overall RN turnover was high for this new hospital; however, it was critically high on the two medical-surgical units, leading to the lack of knowledge and awareness of the hospital shared governance, and overall engagement by this nursing staff.

Conclusion

These recommendations and strategies will guide administration, the shared governance project team, and nursing staff in enhancing or rebooting shared governance at the hospital. Supporting and enforcing shared governance throughout the hospital will contribute to creating a culture that promotes nursing quality, nursing excellence, and

professional decision making. Shared governance can ultimately create a healthy work environment and improve outcomes for all stakeholders.

Section 5: Dissemination Plan

Introduction

There are two main venues for research dissemination, verbal or written. The dissemination plan to the hospital stakeholders will be verbal. Direct care nurses will be informed over the course of several days as part of the nursing units daily shift huddles. This approach offers the best opportunity to update a largest number of RNs, including rotating shifts and weekend staff. Talks with direct care nurses during nursing unit rounds provides the opportunity for one-on-one discussion and time for questions and clarification. A power point presentation of the findings will be shared at one of the of the hospital's monthly leadership meetings, as well as at a monthly NPC and NLC meeting, and nursing unit staff meetings. The power point presentation will also be shared with the medical staff and board of trustees during a monthly meeting, ensuring these stakeholders are aware of the hospital efforts as well.

Analysis of Self

I have seen this implementation of shared governance during the last 18 months. As the inaugural CNO of this community hospital, I have a vested interested in the overall success of the organization. I have had the pleasure of interviewing and supporting the hiring of over 90% of RN staff and 100% of the NLT. I have developed close working relationships with stakeholders at various levels of the organization. Through my leadership and commitment to the organization, I have gained the respect, trust, and support of the team. I have come to realize not to consider it a failure when a

plan or timeline does not come to fruition, but rather to see it as an opportunity to pause, seek out why, and learn from the issue.

The goal of a quality improvement project is to improve healthcare outcomes, organizational processes, and workplace and patient satisfaction (Walden University, 2017). The Essentials of Doctoral Education for Advanced Nursing Practice, an American Association of Colleges of Nursing (AACN) publication, articulates competencies for all nurses practicing at the DNP level, preparing them for the highest level of leadership in practice and scientific inquiry, as well as for specialized nursing practice. Quality improvement goals will be realized even more as shared governance and its councils mature at the hospital. Reflecting on quality improvement goals and the AACN essentials, this project has enabled me to incorporate five of the essentials into this work while achieving quality improvement goals. AACN Essential I, scientific underpinnings for practice, provides the highest academic preparation for nursing practice with the discipline of nursing focused on the nursing actions or processes by which positive changes in health status are affected. Essential II, organizational and systems leadership for quality improvement and systems thinking, are critical for the DNP nurse to improve patient and healthcare outcomes and be skilled working within organizational and policy by themselves and/or with others. Essential III, clinical scholarship and analytical methods for evidence-based practice, prepares the DNP nurse to design and implement processes to evaluate outcomes of practice, practice patterns, and systems of care within a practice setting, design, direct, and evaluate quality

improvement methodologies to promote safe, timely, effective, efficient, equitable, and patient-centered care, and apply relevant findings to develop practice guidelines and improve practice and the practice environment. Essential VI, interprofessional collaboration for improving patient and population health outcomes, prepares the DNP nurse to learn effective communication and collaborative skills in the development and implementation of practice models, practice guidelines, and standards of care, as well as lead intraprofessional teams in the analysis of complex practice and organizational issues and create change for healthcare and its delivery systems. Essential VIII, advanced nursing practice, prepares the DNP nurse to guide, mentor, and support other nurses to achieve excellence in nursing practice. As a quality improvement initiative, this project provided me the privilege to partner with the shared governance project team, shared governance coordinator, and direct care nurses to experience both successes and opportunities in the implementation of shared governance at a community hospital.

Summary

The final DNP project integrates the practice experience of the advanced practice nurse with the foundation of future scholarly practice. It challenges the DNP nurse to assess and evaluate nursing practice in his/her environment and identify opportunities for change and improvement of patient care. This final DNP project produced a tangible and deliverable product that is derived from the practice immersion experience and summarizes my growth in knowledge and expertise.

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Appendix A

Evaluating the Implementation of Shared Governance

1. What does shared governance mean to you?
2. Is your understanding of shared governance reflected in the structure currently in place?
3. How much have you been involved in shared governance?
4. How do you feel about being involved?
5. How do you feel the implementation of shared governance has been handled by the NLC?
6. What areas of decision making do you feel are important for nurses to have input and control?
7. Are these areas reflected in the current shared governance structure?
8. Have you experienced any individual changes as a result of this shared governance implementation?
9. Do you feel that communication about shared governance activities and your invitation to participate are working?
10. What strengths or weaknesses have you identified during this implementation?
11. What recommendations could you make for improvement?

Adapted from: Elton, S., Otte, D., & Rapson, C. (2001). Evaluating a system of shared governance. *Nursing Management, 8(4), 28-32.*