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Building Excellence through Shared Governance and Continuous Process Improvement

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Building Excellence through Shared Governance and Continuous Process Improvement

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Acknowledgement

As a girl, I spent my summers with my grandparents in St. Louis, MO. The summer of my 12th birthday my grandfather fell ill and was hospitalized for 10 days. During his hospitalization, I was in awe of the women dressed in white. They cared for him with kindness and compassion, helping him heal and grow stronger. These amazing women not only cared for my grandfather but recognized that my grandmother was worried and scared. They swooped in and embraced her, comforted her, and reassured her. My grandparents both recovered from this life-changing event because of the care, skill and compassion of the nurses. I owe gratitude and thanks to the women in white, the registered nurses of the past, for inspiring me to pursue a career that has given to me more than I could imagine. My wish is that one day, when I am old and hospitalized, that my granddaughters will be in awe of the nurses caring for me just as I was watching those who cared for my grandfather.

Nursing has fulfilled a calling for me, with the support of many. First, I would like to thank my husband, John, for his tireless support of my goals, aspirations, and dreams. He has been my biggest cheerleader for the last 35 years. Without his love, encouragement, and picking up the pieces along the way, my journey would have been very different.

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Building Excellence through Shared Governance and Continuous Process Improvement

Abstract

Background: Nursing shared governance in the hospital setting is a well-established structure for shared decision-making between staff nurses and nurse leaders to improve nursing practice, quality of care, and patient safety. Establishing effective, shared governance can take several years: new skills must be acquired, new behaviors accepted, and new professional commitments made. Newcomers to shared governance require support, education, and the opportunity to acquire requisite skills; otherwise, interest, commitment, and achievement of desired outcomes cannot be sustained.

Local Problem: A large hospital in California established a shared governance structure in 2018. Performance gaps between two high-performing Nursing Unit Councils (NUC) and the other 11 NUCs indicated the need for education and skill-building in performance improvement.

Context: The sustainability of shared decision-making, nursing ownership of the practice, and nurse engagement in the organization would be threatened without an environment that supports and generates performance improvement.

Interventions: Two comprehensive learning sessions, and a toolkit, introduced shared governance foundational components and a performance improvement framework to engage nurses in process improvement.

Outcome Measures: The outcome measures were greater understanding of the IHI Model of Improvement, increased use of performance improvement methodology, and improved perception of shared governance.

Results: Knowledge of performance improvement methodology and perceptions of shared governance improved in all focus areas. Familiarity with the IHI Model for Improvement

increased by 29%, knowledge of SMART goals by 5%, and utilization of outcome measures by 47%. Staff nurse participation in the development and evaluation of policies rose 18%, staff nurses providing professional and educational programs increased 60%, and staff nurses' access to nursing department goals and objectives improved 17%.

Conclusion: Intentional education and development of nurses in performance improvement and shared governance yields mature shared decision-making and effective problem-solving.

Keywords: shared governance, decision-making, nursing, performance improvement

Section II: Introduction

Nursing shared governance was first embraced by healthcare organizations over 35 years ago. The core concept of shared governance is non-hierarchical decision making, with bedside nurses and nurse leaders collaborating in decisions that directly affect professional practice and patient care. The basic organizational structure of shared governance is nursing unit councils, co-led by a bedside nurse and nurse manager of the nursing unit. The councils are the shared decision-making body for all nursing decisions on the unit. The councils oversee issues related to quality, safety, and nurse satisfaction. In the ensuing three-and-a-half decades, organizations experimented with approaches and infrastructures they theorized would optimize staff nurse engagement and have the greatest impact on nursing practice. The optimal structures and best practices that emerged transformed nursing practice by sharing authority and ownership of patient care practices with staff nurses (Porter-O'Grady, 2019). Shared governance models that were purpose-driven, rather than those that prioritized responsibility and accountability, were the most effective in achieving true shared-decision making, as they encouraged and supported the changes in behavior necessary to assume authority over professional practice decisions (Porter-O'Grady & Clavelle, 2020).

From an organizational perspective, shared decision-making puts a new set of demands on staff nurses. Competencies in governance and knowledge of practice-based quality improvement are expected of those who participate in the councils. Education, training, and ongoing support are needed for staff nurses to understand their new role, learn to bring practice concerns forward, and acquire skills to collectively achieve practice improvements (Porter-O'Grady, 2019).

Background

Shared governance was introduced to the host facility in March 2018. The healthcare system's executive leadership had developed a strategy to introduce shared governance and a professional practice model in the system's 29 California medical centers. The desired outcomes were to improve nurse satisfaction and retention, patient satisfaction, nurse-sensitive indicators of care, and decrease costs. The healthcare system was in the process of applying for Magnet designation. Shared governance was considered essential to Magnet designation criteria, which included continued development of the nursing profession within the organization and quality outcomes and patient care.

The initial focus was on creating nursing unit councils (NUCs) specific to each unit with charters, governance structures, and roles. NUCs were made up of 8-12 bedside staff nurses from that unit, a bedside nurse co-chair, and a unit manager co-chair. A coordinating Governance Council of bedside nurses and nurse leaders was established to serve as the central shared decision-making body for the Nursing Department. Two and a half years after initial implementation, 12 NUCs, each with eight to 12 members, are active and meet regularly. However, the councils have generated only novice projects without focusing on professional practice, competence, or quality care. Membership turnover in the NUCs has averaged 25%, with a high of 50% in one council. High turnover contributes to loss of council momentum and disengagement of remaining members. One NUC disbanded. The reason given was lack of direction due to unit leadership changes and derailment of meetings and council actions due to COVID-19. Two and a half years into executing a shared-governance program designed to empower and inspire nurses to engage in their professional practice, engagement has not been actualized via the NUCs. The hospital has invested heavily in its nursing workforce through the

implementation of shared governance, yet improvements in quality and service have not materialized. Something more is needed to engage and guide the NUCs in achieving nursing practice improvements. This evidence-based quality-improvement project proposes that the "something more" is structure and education built around an innovative model to create a culture of inquiry, elevate professional accountability, and engage nurses in shared clinical decision-making. This project introduces structure, examines nurse-driven metrics, and engages the NUCS through learning sessions on shared governance and performance improvement.

Problem Description

Failure to set direction and expectations around shared governance misaligns council practices and contributes to the derailment of initiatives. Shared governance is challenging and time-consuming; without strategic direction, nurses' efforts supporting the process and initiatives are at risk of dissolving (Porter-O'Grady, 2001). Guanci and Medeiros (2018) observed that unsuccessful councils lacked clear purpose and direction, struggled to determine appropriate projects, and suffered a loss of enthusiasm for the work.

Setting

The host facility is a 340-bed hospital and part of the northern California region of a large healthcare system. The facility is a full-service acute care hospital providing emergency services, adult and pediatric inpatient care, and outpatient services. The hospital provides services to all persons present for care regardless of their insurance status, although most are patients covered under the healthcare system's plan. The average daily census in the hospital is 310 patients. Of the hospital's 2,700 employees, 1360 are registered nurses. The healthcare system is unionized, with all bedside nurses belonging to the California Nurses Association.

Specific Aims

The purpose of this project is to implement a training program that provides opportunities for nurses to positively impact patient experiences and health outcomes through participation in governance councils. The training project is designed with a dual focus on increasing understanding of shared governance and performance improvement to fulfill this purpose.

There are three specific aims, all with a target achievement date of September 30, 2021.

1. Increase understanding of a performance improvement framework by 20%, as demonstrated by completing the PDSA worksheet for all new projects.

2. Encourage the application of performance improvement methodology in new projects, demonstrated by a 20% increase in incorporating outcome measures in new projects.

3. Improve perceptions of shared governance by NUC participants by 10%, demonstrated by an increase in three pre- and post-intervention survey questions taken from the validated Index of Professional Governance (IPNG) tool.

Available Knowledge

The critical concept of nursing shared governance is shared decision-making between the bedside nurse and the nurse leaders. Structures and processes for shared decision-making have been shown to promote positive patient outcomes and contribute to a culture of inclusion, which benefits job performance and satisfaction (McKnight & Moore, 2020). Yet structures and processes alone do not complete the shared governance picture. Shared governance shifts the focus from a top-down management style to a collaborative style that requires continuous improvement (in the form of buy-in, education, training, and process iteration) to be successful. This literature review explores the role of continuous improvement in shared governance and

identifies best practices for continuous improvement approaches in shared governance models. The project aim and PICOT question guided the review.

PICO(T) Question

Do staff nurses who participate in shared governance and continuous improvement education program, as compared prior to participation in the program, demonstrate an increased understanding of shared governance and the application of continuous improvement methodologies by identifying a unit-based problem and incorporating outcome measures in the new improvement at the conclusion of the three-month program?

Search Methodology

A literature review was conducted using EBSCO and CINAHL using the keywords *shared governance, decision making, nursing,* and *performance improvement*. The results were refined by limiting the search to peer-reviewed articles with publication dates of 2015 through 2020. The inclusion criteria included shared governance, decision making, nursing, or performance improvement identified as a subject term of the article. The search yielded 61 articles. A review of titles and abstracts excluded 32 articles that were not relevant to the PICOT question. The remaining 29 articles were reviewed to include only research studies, meta-analyses, and systematic reviews. The five articles selected had the strongest evidence-based ratings using the Johns Hopkins Nursing Evidence-Based Practice Appraisal Tool (Dang & Dearholt, 2018). See Appendix A for the Evidence Evaluation Table.

Integrated Review of the Literature

The five articles that emerged in the systematic review of the literature were organized into three themes: (1) education, coaching, and mentoring, (2) nurse engagement, and (3)

structure and framework. These categories informed an evidence-based approach toward developing an intervention that aims to address the PICOT question.

Education, Coaching, and Mentoring

In a descriptive, correlational, quasi-experimental design, Drexler (2020) studied nurse satisfaction and engagement with nurses who were using newly implemented health information technology (HIT). Despite the benefits of enhanced technology, the transition and implementation of the HIT were fought with resistance due to design failures. Nurses managed the issues by creating workarounds, unintentional avenues for medical errors. A year later, the organization implemented shared governance and incorporated IT into the structure, creating an opportunity for staff nurses to participate in redesigning the documentation system. Shared governance implementation included education and coaching focused on professional obligation, accountability, decision making, and nurse satisfaction. The Iowa Model of evidence-based practice was used to explain steps for changing practice and promoting adherence to the principles of evidence-based practice. A convenience sample of nurses received a survey pre- and post-education to measure improvement in nurse satisfaction and engagement with the shared governance model. Three months of post-education, there was a significant improvement in professional role behaviors suggesting that education and coaching achieved the desired impact.

Brull (2015) conducted a quasi-experimental study to determine if a comprehensive educational plan leads to the effective implementation of shared governance. A convenience sample of 260 nurses was asked to complete the IPNG tool, which measures the governance of hospital-based nurses on a scale of 1 to 430. IPNG baseline data showed that nursing governance was perceived as "traditional" by the staff; these results informed a gap analysis and education

strategy for implementation of shared governance. A focused, comprehensive education plan was enacted, and the IPNG was used at one year and two years post-intervention. Year one showed an increase in IPNG score to 174 within the range of "shared governance," and two years after the education program, the IPNG increased to 183, determined to be a significant change from baseline. The researcher concluded that a comprehensive educational strategy is necessary when developing shared governance over a short time frame.

A quasi-experimental study aimed to determine if a redesign of shared decision-making improved shared governance at a 377-bed hospital was conducted by Dechario-Marino et al. (2018). The researchers used the Index of Professional Nursing Governance (IPNG) tool to measure the level of shared governance and to determine preintervention. Prior to intervention, the IPNG overall mean score was 169.5 and within the IPNG traditional governance range, as were 3 of the 6 subscale scores. These results guided the construct of the intervention, a shared governance redesign, and an education program. The education was crafted to facilitate an environment where more control and influence fell to the staff. Postintervention data were collected within one year. The results revealed that the IPNG overall score elevated to 183.9, within IPNG shared governance range, and 5 of 6 subscale scores increased significantly after the redesign and education and were within the shared governance IPNG range. Concluding, redesign, and education can be effective in improving shared governance; the IPNG tool can be valuable in identifying focus areas during the redesign process.

Nurse Engagement

The objectives of a cross-sectional study performed by Kutney-Lee et al. (2016) were to examine the engagement of nurses in shared governance and determine if patient and nurse outcomes were related to nurse engagement. The researchers surveyed a large, random sample of

over 20,000 nurses from 425 acute care hospitals regarding nurse engagement and quality of care. Nurse engagement in shared governance was measured using three items from the Participation in Hospital Affairs subscale of the Practice Environment Scale of the Nursing Work Index. The results demonstrated that 42% of the hospitals were classified as having the "most engaged" nurses, 36% had "moderately engaged" nurses, 19% had "somewhat engaged" nurses, and 3% had "least engaged" nurses. The data was interpreted into four categories; nurses who responded that they did not have an opportunity to serve on hospital committees were identified as "least engaged," with the scale progressing to those who reported opportunities to participate in policy decisions as "most engaged." Further analysis of the data revealed the poor quality of care was reported with greater incidence, 33 percent, by the "least engaged" nurses versus reported by 8 percent of the "most engaged" nurses. This study reflects that nurses are less likely to report poor ratings of quality and safety when working at a hospital that fosters increased nurse engagement.

Structure and Framework

The purpose of a study by Di Fiore et al. (2018) was the evaluation of nurses' perceptions of shared decision-making over a 3-year period after implementing a shared governance model. A 2-group comparative design was used at a 500-bed community teaching hospital with 734 nurses invited to attend. The IPNG tool was used to assess the nurses' perceptions of shared decision making. Baseline IPNG data showed nurses scored their governance structure as decisions made primarily by leaders. Final study results revealed the IPNG scores increased slightly over the 3-year period reflecting governance was viewed as completed mostly by nurse leaders with some staff input. The results were less than desired, leading the researchers to

conclude that new structures, systems, and processes will be needed to further strengthen shared decision-making beyond the first years after implementation.

Summary/Synthesis of the Evidence

The literature search and review of evidence revealed that while shared governance in healthcare has been written about extensively, the topic has been given little attention in approaches that would yield high-quality evidence, such as systematic reviews, meta-analyses, or critical appraisals. As a result, this review relied on published evidence from quasi-experimental studies and non-experimental studies rated high or good quality using the Johns Hopkins Nursing Evidence-Based Practice Appraisal Tool.

Shared governance provides a structure and context for nurses who are closest to the patients to exert control over decisions related to nursing practice (Dechairo-Marino et al., 2018). Shared governance provides the forum for nurses to be problem solvers within an evidence-based framework, increasing the effectiveness and outcomes of the shared governance teams (Drexler, 2020). When organizations implement and commit to shared governance, they commit to nurses being involved in decisions influencing the design, implementation, and evaluation of practice systems and processes. Performance improvement frameworks incorporated into a shared governance model can augment shared decision-making to exert positive and sustained changes (Drexler, 2020; Flynn and Hartfield, 2016). These findings support giving explicit attention to performance improvement in the design and implementation (or revision) of shared governance models.

Teams working within a shared governance structure that includes education, training, and coaching on performance improvement have been more successful in achieving governance council objectives than teams working within the governance structures alone (Drexler, 2020).

Dechairo-Marino et al. (2018) attributed greater goal achievement in part to a shared governance redesign that promoted behavior changes as both nurse leaders and staff nurses gained confidence in sharing decision-making responsibility.

Rationale

Two complementary frameworks guide this project, a theory of structural and empowerment and a model to develop, test, and implement the quality-improvement project. The first framework is Kanter's Theory of Structural Empowerment (Kanter, 1993). The conceptual foundation of shared governance itself can be found in Kanter's Theory (Kutney-Lee et al., 2016). Kanter theorized that an employee's level of engagement was linked to the level of decision-making authority over their daily work. Distributed, non-hierarchical authority over practice-related decisions is foundational to influencing nursing professional behaviors and practices that improve the work environment and positively impact nursing, patient, and organizational outcomes (Porter-O'Grady & Clavelle, 2020). Kanter theorized that there are six nurse empowering behaviors necessary for empowerment to exist (Laschinger et al., 2010). The six conditions of Kanter's theory—access to information, access to support, access to resources, access to opportunity, informal power, and formal power (Laschinger et al., 2010)—serve as guideposts for the design, development, and implementation of this DNP quality-improvement project.

The second framework is the Model for Improvement developed by Associates in Process Improvement and used by the Institute for Healthcare Improvement (IHI) to guide quality improvement (IHI, n.d.). The model has two components: three fundamental questions and the Plan-Do-Study-Act (PDSA) cycle. The Model for Improvement provides the framework to develop, test, and implement change as the structure and process for the shared governance

councils to participate in performance improvement come to fruition in this project. See

Appendix B for the Model of Improvement and Appendix C for the PDSA Cycle.

Section III: Methods

Context

The key stakeholders are the hospital executive team, the patient care services leadership team, and the nurses and nurse leaders who participate in the existing nursing unit councils and governance council. Two and a half years ago, quality and service improvement were highlighted during the shared governance kickoff event as the targeted improvement outcomes. While the performance has not worsened, the hospital is outside the national benchmark for surgical site infections, hospital-acquired pneumonia, and the nurse communication composite. There are 13 nursing units, 12 active NUCs with a combined participant total constituting 130 bedside nurses and 12 managers. The executive team, patient care services leadership team, and the nurse leaders believe the enculturation of shared governance is necessary to create an environment that supports and generates performance improvement. See Appendix D for the Letter of Support from the Organization. The nurses of the NUCs are engaged and eager to elevate the nursing practice, improve outcomes, and share decision making. However, shared governance has been challenged by the nurses' union, which sparked a campaign of resistance. As demonstrated during previous union strike activities, many nurses will not oppose a position taken by the institutional union. COVID-19 introduced obstacles to progress within the NUCs. Most NUCs did not meet from March through June 2020; the primary focus was addressing the pandemic and ensuring the safety of patients and staff. New workflows were necessary to facilitate virtual NUC meetings. Except for one highly functioning NUC, the remaining NUCs have focused on projects with good intentions but have not measured improvement in performance nursing practice or patient outcomes. The current shared governance structure does

not include a performance improvement framework to provide standardization and guide the councils' improvement initiatives.

Interventions

The interventions for this project were the following: (1) a shared governance learning session for council participants; (2) a performance improvement training program; and (3) a toolkit to support shared governance councils with performance improvement. The DNP project lead developed the curricula and toolkit. The purpose was to provide a formal path forward to strengthen the NUC members' understanding of shared governance processes and intent. Two three-hour comprehensive learning sessions reviewed shared governance foundational components and introduced a performance improvement framework to engage nurses in the improvement process. A toolkit containing roadmap materials to guide the NUCs in performance improvement activities during subsequent council meetings was provided to each participant. The educational event was designed to unite the NUCs around a shared purpose and create an environment where NUC membership is coveted.

Three virtual kickoff meetings were held, one with the senior leaders of the organization, one with the medical center's shared governance council, and one with the participating NUCs. Each meeting reviewed the project aim, proposed interventions, and intended outcomes. Group discussions were held on the importance of innovation in healthcare and the role of shared governance in creating positive practice changes to improve patient outcomes.

For the NUC participants, the kickoff meeting was the first of two learning sessions. It included the meeting agenda, a review of the training program objectives, a PowerPoint presentation of the foundational elements of shared governance, an introduction to the IHI Model of Improvement, and items to be completed prior to the second session. Each NUC participant

was given a toolkit with materials to guide them successfully through the requisite performance improvement activities. See Appendix E for the Toolkit/Worksheet. The second session led the participants through project idea brainstorming, developing a SMART goal, creating PDSAs, and using the toolkit to guide each step in the performance improvement process.

Gap Analysis

The gap analysis addressed the current state of three areas critical to the success of the project: governance infrastructure, shared governance education/training, and performance improvement education/training. Fading staff engagement in the shared governance process, with a loss of momentum in project completion, were key findings. Additional gaps were the lack of incorporating measurable outcome goals or shared decision-making in the NUC's standard council work. See Appendix F for the Gap Analysis.

Shared Governance Infrastructure

NUC membership has experienced a 25% turnover since March 2018, with one council disbanding and no longer meeting. Exit interviews of the council members who gave up their council seats described frustration associated with the lack of direction and limited structure to guide the work. Council expectations are not outwardly evident, and goals are not measured.

Shared Governance Education/Training

In 2018, the facility hosted a 2-day kickoff event to introduce the newly established shared governance structure. The 50 attendees represented bedside nurses, nurse leaders, and nurse educators. The event introduced shared governance, including forming the NUC structure, and presented the organization's professional practice model. The initial meeting of each NUC included a shared governance facilitator to educate members on council structure and processes.

There has been little subsequent education or training on shared governance for new or incumbent NUC members.

Performance Improvement Education/Training

Introductory education on performance improvement was provided at the kickoff event in 2018. Since then, performance improvement education or training has been limited to individual NUC kickoff meetings and leadership development meetings. The leadership development meeting occurs monthly and is offered to NUC co-chairs. Participation is voluntary and has drawn only about 25% participation over two years. The content of the leadership development series varies and is dedicated to performance improvement only once each year.

Gantt Chart

The Gantt chart for this project includes project milestones grouped into four categories: initiation, planning, execution, and evaluation. Key elements contained within the project milestones are: (1) initiation: determining the NUC participants and creating a project charter; (2) planning: determining the project plan; (3) execution: hosting a kickoff meeting with education to key stakeholders and NUC participants; and (4) evaluation: coaching the NUC co-chairs through the performance improvement process and conducting an evaluation post-training. See Appendix G for the Gantt Chart.

Work Breakdown Structure

Examining the work processes necessary to complete this project revealed six in the first level of the WBS: project design, current state assessment, education, communication, finance, and evaluation. Each project objective identified in level 1 was further defined in level 2 and included the deliverables to meet each level 1 work element and objective. See Appendix H for the Work Breakdown Structure.

Responsibility/Communication Plan

The communication strategy for this project involved multiple levels and roles within the facility, including executive leaders, middle management, and shared governance council members. Primary methods of communication will be routine project status updates that include barriers, strategy overview, goals and objectives, and progress with the project plan. Most communication will be completed through virtual meetings to comply with COVID distancing restrictions. See Appendix I for the communication plan.

Executive Leaders

The executive sponsor for this project is the facility's Senior Vice President and Area Manager. She has approved the collection of all data and resources required to propel this project forward. Communication with the executive sponsor will consist of monthly 1:1s to review the project status, discuss barriers, and share updates. Other key executive leaders to be updated at least monthly are the Area Quality leader and the Performance Improvement, Advisor. These individuals are key stakeholders in data collection, patient outcomes, and performance improvement. The Performance Improvement Advisor is a point of contact as a subject matter expert.

Middle Management

Service line directors and managers are key stakeholders whose introduction to the project occurs prior to rollout to the shared governance councils. The primary focus of the communication with the directors and managers is to keep them apprised as the project moves forward and ensure their support of council member participation. Project success requires a commitment from the directors and managers to release the shared governance council members

and ensure uninterrupted time for participation in the educational sessions. Periodic communication serves as a reminder of this need and ensures ongoing support.

Shared Governance Council Members

NUC members selected to participate in the education and training received personalized invitations to create a sense of excitement around the project plan. The invitation provided a brief introduction to the project and objectives, and requested their participation as special guests. Weekly communication provided progress updates and coaching opportunities. A variety of communication forms, such as email, conference calls, and 1:1 discussions were used for frequent communications with the council members.

SWOT Analysis

A SWOT analysis was conducted to help guide project design and implementation. The strengths of this project are that shared governance is in place and ongoing; the shared governance councils have expressed their desire to improve outcomes, and local and regional support exists for shared governance in the context of achieving Magnet designation. The project's organizational weaknesses are a lack of structure to guide shared governance work, a lack of knowledge by council members regarding shared governance processes and performance improvement, and the inability to replace staff nurses while attending council meetings or training.

The organizational opportunities are developing leadership skills of council members applicable to their nursing responsibilities and providing a teachable moment for the entire organization as it pursues Magnet designation. Based on the outcome of the project, there is an external opportunity for it to serve as a model for region-wide replication or adaptation.

External threats to the project are dissipation of interest in shared governance without ongoing implementation of the training; and less-than-optimal engagement due to the physical and social distancing requirements put in place for the COVID-19 pandemic. The organization adheres to the Centers for Disease Control and Prevention's guidance on social distancing; thus, all education was provided virtually until pandemic guidance changes. The greatest threat to this project is the California Nurses Association's (CNA) objection to shared governance. CNA does not support the councils. The organization has attempted to derail shared governance work and discourages the nurses from participating in NUCs. Appendix J shows an example of CNA communication with the medical center's nurses. See Appendix K for SWOT Analysis.

Budget and Financial Analysis

A misconception about shared governance is that it adds expense to healthcare organizations. The main cost of investing in shared governance is a salary expense when staff nurses attend shared governance functions (Rundquist & Givens, 2013). With the structures and processes to support shared governance currently in place for this project, it was expected that the NUC quality improvement projects developed would yield either monetary return or avoid future costs.

Budget

The budget includes indirect and direct costs. The most impactful contribution to the overall cost is council members' salaries to participate in the project's education component and the cost of backfilling any direct-care hours needed to provide patient care. When determining the participant salary costs, an hourly rate of $90 was used for two-thirds of participants, and an hourly rate of $135 was used for one-third of the participants. This budget accounts for the staff nurses who earn premium overtime pay when the education, training, or council meetings occur

before or after a scheduled shift or create a workweek of more than 40 hours. Taxes and benefits are not included in the calculations. See Appendix L for the Proposed Budget.

An unintended benefit of moving the project to a virtual environment was the cost savings of eliminating an in-person event from the project plan. Holding virtual meetings eliminated the need to rent an offsite venue, purchase food and drinks, and reimburse mileage. The total savings was $3,336.

Cost-Benefit Analysis

To determine the costs of the project, personnel, supplies, coaching sessions, outreach, communication, and consultant costs were calculated. The total cost for the implementation of the project, calculated over one year, is $227,408. The largest portion of this spending is generated from salary costs for the NUC participants and the salary costs to backfill them while they attend training. The return on investment is calculated based on cost avoidance of specific hospital-acquired conditions. These were calculated based on the evidence in the literature from other organizations that experienced reductions in hospital-acquired conditions after implementing improvement strategies. The cost savings or avoidance of $361,512 in year one was attributed to reducing hospital-acquired pressure injuries, surgical site infections, and hospital-acquired pneumonia. The improvement in patient outcomes was experienced due to improved processes. See Appendix M for the Cost-Benefit Analysis and Appendix N for the Cost Avoidance Data.

Return on Investment

The predictive cost-benefit analysis demonstrates a 5-year return on investment (ROI) for this innovation at $1,702,700, with the kickoff year being the costliest due to training and year 2 experiencing the most significant avoidance of cost. The ROI is based on reduced spending due

to cost avoidance related to improved patient outcomes and avoidance of surgical site infections, hospital-acquired pressure injuries, and hospital-acquired pneumonia. With project spread, and all Nursing Unit Councils participating with target projects to reduce/eliminate patient harm events, the cost avoidance can be projected to continue to soar as new hospital-acquired conditions are mitigated.

Investment in enhancing the shared governance structure maximizes the opportunities and strengths of performing at or above national benchmarks for nurse-driven quality indicators. The return-on-investment assumptions are based on the NUCs adopting the learned improvement actions to facilitate strategies to reduce hospital-acquired pressure injuries, surgical site infections, and hospital-acquired pneumonia.

Study of the Interventions

The initial intervention consisted of two learning sessions covering the foundational components of shared governance and essential performance improvement elements. A baseline pre-intervention survey was administered to the NUC participants prior to the first learning session. The survey inquired about each participant's perceptions of shared governance as they experienced it at the host medical center and each participant's knowledge of the IHI Model for Improvement elements.

The first learning session was accompanied by a PowerPoint presentation that addressed the history of shared governance, highlights of evidence from the literature review, benefits to nursing practice, and relevance to patient outcomes. Introductory performance improvement information focusing on the initial elements of aim statements, measures, and the PDSA cycle was shared. A review of unit-specific data for each NUC was presented, which sparked a discussion of possible improvement projects for the NUCs. The NUCs were engaged,

particularly during project brainstorming, and were eager to develop their aim statements. After the first learning session, the NUCs were given the assignment before the second learning session, scheduled for the following month. The NUCs had to determine and agree upon a performance improvement project, develop their aim statement, and begin their PDSA worksheet to complete their assignment.

The second learning session was conducted to provide a high-level review of the performance improvement components introduced in the first learning session; further, examine the complexities of the PDSA cycle; and practice working with the PDSA tool.

A toolkit developed for the project and derived from the IHI Model of Improvement framework was provided to each participant. The toolkit is a comprehensive document that includes critical components of performance improvement methodology. It is organized to guide the user step by step by creating an aim statement, developing a SMART goal, determining outcome measures, and outlining related PDSA cycles.

A post-intervention survey was administered after the second learning session. The survey was emailed to the NUC participants to access the survey via an embedded link or QR code. The pre- and post-intervention surveys contained the same questions, except three questions added to the post- survey to glean opinions on the program's overall value. The three added questions were answered using a 5-point Likert scale, with 5 being the highest rating and one being the lowest.

Outcome Measures

The learning sessions were designed to provide opportunities for nurses to positively impact patient experiences and health outcomes through participation in governance councils. To fulfill this purpose, the project was designed with a dual focus on increasing understanding of

shared governance and performance improvement. Four outcome measures gauged project efficacy and achievement of the specific aims: to increase understanding and use of performance improvement methodology by 20% and increase perceptions of shared governance by 10%.

1. **Participants' identification of their knowledge of performance improvement methodology.** Pre- and post-intervention responses to two questions are scored on a Likert scale (1= Not familiar; 3 = Somewhat familiar; 5 = Very familiar).

   a. How familiar are you with the Institute of Healthcare Improvement's 'Model for Improvement'?

   b. How familiar are you with SMART goals?

2. **The number of projects that included specific outcome measures**. The percent change is measured by participants' responses (Yes/No) to a pre- and post- intervention survey question:

   a. Does your NUC have specific outcome measures related to their projects?

3. **Participants' attitudes and perceptions of shared governance.** The percent change from before to after the learning sessions is determined from Yes/No responses to three questions from the Index of Professional Nursing Governance (IPNG) tool. The IPNG is a survey tool that measures the perceptions of governance specific to healthcare personnel.

   a. In your organization, when developing and evaluating policies, procedures, and protocols related to patient care, is it equally shared by staff nurses and nursing management?

b. In your organization, when providing for the professional/educational development of nursing staff, is it equally shared by staff nurses and nursing management?

c. In your organization, is access to information regarding the unit and nursing departmental goals and objectives for the year equally available to staff nurses and nursing management?

4. **Participants' perception of the learning sessions.** Participants responded to two questions administered in surveys after learning session #2. Responses were scored on a Likert scale (1= Lowest rating; 3 = Neutral; 5 = Highest rating) and reported as percent change.

a. Was the content of the learning sessions helpful?

b. Can your NUC apply the content of the learning sessions in their work?

c. Would you recommend these learning sessions to other NUCs?

Data Collection Tools

Aligns to Outcome Measures 1 and 2: An electronic survey was administered to each participant prior to learning session #1 and at the conclusion of learning session #2. See Appendix O for Pre- and Post-training Survey. The electronic surveys recorded the responses and exported them to an Excel spreadsheet. See Appendix P for the Excel Data Collection Spreadsheet. Three data points were recorded using a 5-point Likert scale: how familiar the participants were with the IHI Model for Improvement; how familiar the participants were with SMART goals; and the total number of projects that included a specific outcome measure. Descriptive statistics were used to compare the post-intervention results to the pre-intervention baseline.

Aligns to Outcome Measure 3: The responses to the questions from the IPNG questionnaire were interpreted using pre-and post-intervention quantitative IPNG results and imported into an Excel spreadsheet for analysis. Three data points were evaluated for the equity of information availability by staff and nursing management in policy and procedure development, professional and educational development, and access to departmental goals and objectives.

Aligns to Outcome Measure 4: Quantitative data was reviewed through the lens of participants' experiences and the degree of personal impact participation in the performance improvement learning sessions had on the individual. Responses were compiled, and post-intervention change was determined from the mean of the Likert scale ratings.

Analysis

The quantitative analysis was initiated by reviewing the descriptive statistics related to the trending number of projects using PDSA over time. An Excel spreadsheet was used to record three data points of outcome measures #1 and #2 prior to and following the learning sessions. Descriptive statistics were used to compare the post-intervention results to the pre-intervention baseline or previous projects, including the mean and percentage variance. For outcome measure #3, the results of the questions taken from the IPNG questionnaire (Hess, 2004) were interpreted using pre-and post-intervention quantitative IPNG results and imported into an Excel spreadsheet for analysis. For outcome measure #4, survey responses were collected at the conclusion of the second learning session, compiled, analyzed, and results reported as the mean of the Likert scale ratings.

Ethical Considerations

The focus of this project was to implement a quality improvement initiative. The project was determined to be an evidence-based quality improvement project that did not require an Institutional Review Board (IRB) approval for implementation. See Appendix Q for Research Determination Committee Letter. There were no conflicts of interest. Data collection was anonymized, participants' privacy was protected, and data were reported in aggregate.

Ethics is a foundational element in the profession of nursing. The American Nurses Association (ANA) Ethical Standard number 3 states: "The nurse promotes, advocates for, and protects the rights, health, and safety of the patient" (ANA, 2015, p.9). The project support of this standard is demonstrated by the autonomy and speak-up culture provided by nurses participating in shared governance to improve the care of the patient.

The ethical principle of nonmaleficence, avoiding harm or doing no harm, is a foundational element to this project. Grace (2018) refers to harm as either avoidable distress caused to the patient while care is provided, or harm caused by the inaction of a healthcare provider. Through the learning sessions, the NUCs examined their unit-specific patient harm data and determined performance improvement plans to reduce harm events. Success in eliminating harm will only come when healthcare workers feel compelled to speak up to elevate concerns and spark action (Cooper et al., 2019). The NUC participants addressed patient harm events through the performance improvement process with the goal of harm reduction. Project design supported the ethical principle of nonmaleficence, while its implementation fostered nurses' ability to speak up, address the issue at hand, and reduce patient harm.

The University of San Francisco's (USF) Jesuit values were considered as the USF's value statement describes their respect "for every individual's intellectual, physical, and spiritual

and health autonomy" (University of San Francisco, 2019). The addition of a performance improvement framework to the existing shared governance structure promotes nurse-driven improvements in the care of patients. Improvements developed by the collaboration of frontline nurses, those closest to the patients, exemplify the values of USF.

The project was evaluated and approved as a quality improvement project through the University of San Francisco School of Nursing and Health Professionals and determined to be an evidence-based quality improvement project. See Appendix R for Statement of Non-Research Determination.

Section IV: Results

The project scope was the implementation of a training program that provided opportunities for nurses to participate in shared governance councils to have a positive impact on patient experiences and health outcomes. The training program had a dual focus of increasing understanding of shared governance and improving the evidence-based performance of the NUCs. Literature supports focused, comprehensive education plans to increase nurses' understanding of shared governance (Brull, 2015) and augment shared decision-making by incorporating a performance improvement framework into a shared governance model (Drexler, 2020; Flynn and Hartfield, 2016).

Evolution of the Intervention

The training program was envisioned to be a one-day learning session held offsite. Six NUCs were invited to join, with 65-75 participants anticipated, due to social distancing requirements imposed due to the COVID-19 pandemic. The training program could no longer be held in-person and was hosted virtually, with two three-hour learning sessions held one month apart. Virtual learning has been described as creating a decentralized learning process that requires a more robust course structure and content (Boulton et al., 2018). The content of the virtual training program was split and delivered into two shorter sessions to address potential engagement barriers proactively. The curriculum was adapted to include activities for better learning outcomes in a virtual environment.

The host medical center experienced consecutive surges in COVID-19 patients, which contributed to relentless increases in the overall patient census during the project's development, implementation, and evaluation. Staff nurses were needed at the bedside to meet the extraordinary patient volumes for direct patient care, reducing the number of NUCs participating

in the learning sessions from six to two, with 26 council members attending the learning sessions.

Outcome Measure Results

Knowledge of Performance Improvement Methodology

The project evaluated changes in participants' knowledge of performance improvement methodology and attitudes and perceptions of shared governance. The outcomes were measured as changes in responses to questions in pre- and post-intervention surveys. Participants' performance improvement methodology responses improved in three focus areas:

1. Familiarity with the IHI Model for Improvement: improved by 29% (from 2.82 to 4.25)

2. Familiarity with SMART goals: goals improved by 5% (from 4.0 to 4.25)

3. Incorporating outcome measures into each NUC project: improved by 47% (45% yes pre-intervention; 92% yes post-intervention).

    See Appendix S for Project Data Summary.

Perceptions of Shared Governance

Participants' attitudes/perceptions of shared governance improved in three focus areas:

1. Involving staff nurses in the development and evaluation of policies and procedures: improved by 18% (36% pre-intervention; 54% post-intervention).

2. Involving staff nurses in the development of staff-level professional and educational programs: improved by 60% (18% pre-intervention; 78% post-intervention)

3. Staff nurse having access to nursing department goals and objectives: improved by 17% (45% pre-intervention; 62% post-intervention).

Post Intervention

Drexler (2020) described how shared governance provides the forum for nurses to be problem solvers within an evidence-based framework, increasing effectiveness and outcomes. Post-implementation, one of the NUCs observed initial reductions in mislabeled specimens in their unit concurrent with the first project PDSA implementation, which fostered a plan to implement subsequent PDSAs until mislabeled specimens are eliminated. One NUC focused on reducing patient falls through improved communication between nurses and patient care technicians. The project was developed using the toolkit provided during the learning sessions. The NUC plans to regroup and implement its first PDSA as soon as the COVID-19 census surge subsides. These results are what the DNP student expected. Still, due to the recurring COVID-19 surges, the scope was reduced, fewer projects and PDSA cycles were generated, yielding a lower number of results than expected.

Section V: Discussion

Summary

This project's findings are consistent with the literature demonstrating that a shared governance structure that includes education and training on performance improvement is more successful in achieving objectives (Drexler, 2020). Greater goal achievement can be attributed to shared governance promoting behavior changes that support participation in shared decision-making responsibility (Dechairo-Marino et al., 2018).

The project aimed to increase understanding of a performance improvement framework, increase the application of performance improvement methodology and improve perceptions of shared governance through the implementation of educational learning sessions accompanied by a toolkit; after attending the learning sessions, the level of performance improvement understanding, and the application of outcome measures improved in all categories. The NUC participants experienced a 29% increase in the familiarity of the IHI 'Model for Improvement', a 5% increase related to SMART goals, and a 47% increase in the use of outcome measures related to their projects. Perceptions of shared governance revealed increases in all areas with an 18% rise in nurses' participation in policy development, a 60% elevation in professional development/education provided by nurses, and a 17% increase in access to departmental goal information available to nurses.

The learning sessions and structured toolkit developed by the DNP student enhanced understanding and were essential components to achieving the project's aim. The learning sessions provided an overview of the concepts of shared governance and introduced the IHI 'Model for Improvement'. The toolkit accompanied the learning sessions and provided quick access and reference to the performance improvement tools from the IHI 'Model for

Improvement', one of the two frameworks for this project. These tools supported the NUC

participants through the foundational elements of performance improvement methodology,

created standardization of performance improvement processes, and led to increased success of

the development and evolution of projects.

The NUC participants were queried upon completion of the second learning session if the

content of the learning sessions was helpful. Using a 1-5 Likert scale, the NUC participants rated

the learning sessions 4.7. When asked if they would recommend the learning sessions to other

NUCs, they rated 4.9.

Interpretation

The literature review explored the role of continuous improvement in a shared

governance model, highlighted best practices, and addressed the PICOT question asking if

participants in a shared governance and continuous improvement educational program had

increased understanding of related concepts after the program than prior to the program? The

literature mirrored outcomes found in the DNP project results. Teams working within a shared

governance structure that includes education, training, and coaching on performance

improvement are more successful in achieving governance council objectives than teams

working with the governance structure alone (Drexler, 2020). Nurses who are provided an

opportunity to learn, and provided tools to apply what they learned, will surprise organizational

leadership with achievements derived from the nurses' newly acquired knowledge.

Dechairo-Marino et al. (2018) identified that shared governance provides structure and

context for nurses around decisions related to nursing practice. The DNP project lead observed

palpable positive energy from the council members in both participating NUCs. An unsolicited

comment from a participant at completion of the project highlighted appreciation of the learning

sessions: "Thank you! It helped give us direction." "A nursing leader who observed the sessions shared, "It was like observing a higher level of thought around professional practice evolve *right there* during the meeting!"

The conceptual foundation of shared governance is found in Kanter's Theory (Kutney-Lee et al., 2016). NUC participants demonstrated high levels of engagement in the DNP project and greater goal achievement while participating in performance improvement activities within the share governance model. The learning sessions incorporated aspects of Kanter's theory that identified six conditions necessary for empowerment to exist – access to information, access to support, access to resources, access to opportunity, informal power, and formal power (Laschinger et al., 2010).

Project spread is currently underway, with one NUC completing their learning sessions in October 2021. The remaining NUCs are scheduled to participate in the learning sessions beginning January 2022, with a planned completion date for all NUCs by April 30, 2022. Anticipating COVID restrictions will be necessary for 2022; the learning sessions will be conducted using a virtual platform requiring attendance to be staggered, with two NUCs attending each learning session. The content of the learning sessions will remain consistent throughout the project spread. Each NUC will be provided the toolkit to enhance their understanding of shared governance and introduce them to the IHI 'Model of Improvement' framework.

Continuation of additional projects and PDSA cycles is imperative to the sustainability of this project. The NUCs that participated in the project are continuing their PDSA cycles and are on the agenda to present their progress at a monthly oversight shared governance council

meeting. Performance improvement becoming standard work of shared governance, will provide the framework to develop, test, and implement change moving forward.

Limitations

The literature review was limited by a lack of high-quality evidence, such as systematic reviews, meta-analyses, or critical appraisals. Although shared governance entered the literature in the 1980s, documentation of high-quality evidence was not found. The project relied on published evidence from quasi-experimental studies and non-experimental studies rated high or good quality based on the Johns Hopkins Nursing Evidence-Based Practice Appraisal Tool.

COVID-19 was an additional limitation due to the imposed safety restrictions described earlier in this document. The pandemic has led to chaos and stress, causing the inability of nurses to focus on council activities. The COVID-19 restrictions required converting the learning sessions to a virtual environment, and the COVID-19 census surge required reducing the number of nurses who could participate in the project.

The virtual learning sessions potentially contributed to bias reflected in the limited pre- and post-intervention survey responses. There was a total of 26 surveys distributed for both the pre- and post-intervention surveys. Twelve surveys (46%) were returned containing the pre-intervention responses, and 16 surveys (62%) containing the post-intervention responses. The surveys were distributed in conjunction with the virtual learning sessions, and responses were received anonymously. The electronic method of delivery and collection of survey data was a possible limitation; in-person learning sessions would have allowed for paper surveys to be distributed to each participant and collected from each participant while ensuring anonymity and one hundred percent survey return. The low response rate may reflect a selection bias of those who chose to respond and may not represent all nurses who are members of a NUC.

Conclusions

This project evaluated the understanding of a performance improvement framework and perceptions of shared governance through the implementation of educational learning sessions accompanied by a toolkit. The elevation of knowledge and perception experienced because of this project must be considered a support for utilizing the IHI 'Model of Improvement' as the framework for shared governance.

Intentional education and development of nurses in performance improvement and shared governance yields mature shared decision-making. Use of the performance improvement tools included in the toolkit, accompanied by focused education, produces effective PDSAs providing nurses a pathway to work collectively as problem-solvers.

The toolkit creates standardization that supports the potential spread of this project to hospitals outside of the project site. There are no obvious generalized limitations for use elsewhere. The toolkit will be provided to the organization's regional team for consideration across the remaining medical centers to implement or enhance shared governance.

Section VI: Funding

This project was supported by the organization's Senior Vice President and Area Manager. The local medical center did not fund the development of the learning session content and creation of the toolkit; it was completed on the DNP student's time. The DNP student conducted the learning sessions during business hours and was funded and supported by the Senior Vice President and Area Manager. The nursing units funded the NUC participants' time to attend the kickoff meeting, the learning sessions, and subsequent related NUC meetings. The funding of this project was justified by the medical center's pursuit of Magnet designation.

Section VII: References

Allen-Gilliam, J., Kring, D., Graham, R., Freeman, K., Swain, S., Faircloth, G., & Jenkinson, B.

(2016). The impact of shared governance over time in a small community hospital. *The*

Journal of Nursing Administration, *46*(5), 257-264.

https://doi.org/10.1097/NNA.0000000000000340

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*.

Author.

Boulton, C., Kent, C., Williams, H. (2018). Virtual learning environment engagement and

learning outcomes at a 'bricks-and-mortar' university. *Computers & Education,* 126, 129

142. https://doi.org/10.1016/j.compedu.2018.06.031

Brull, S. (2015). Successful shared governance through education. *Nursing Economics*, *33*(6),

314-319.

Burkoski, V. & Yoon, J. (2013). Continuous quality improvement: a shared governance model

that maximizes agent-specific knowledge. *Nursing Leadership*, *26*, 7-16.

10.12927/cjnl.2013.23363

Clavelle, J. & Porter-O'Grady, T. (2016). Evolution of structural empowerment: moving from

shared to professional governance. *The Journal of Nursing Administration*, *46*(6), 308-

312. doi.10.1097/NNA.0000000000000350

Cooper, M., Holmes, A., Seid, A., Gonzalez, C., & MacDonald, L. (2019). Celebrating the 20th

anniversary of To Err is Human. *American Journal of Medical Quality*. *34*(5), 519-520.

doi.org/10.1177/1062860619870639

Cox Sullivan, S., Norris, M.R., Brown, L.M., & Scott, K.J. (2017). Nursing manager perspective

of staff participation in unit level shared governance. *Journal of Nursing Management*,

25(8), 624-631. https://doi.org/10.1111/jonm.12500.

Dang, D. & Dearholt, S.L. (2019). *Johns Hopkins nursing evidence-based practice: Model and guidelines.* Dustin Sullivan.

Dechairo-Marino, A.E., Collins Raggi, M.E., Mendelson, S.G., Highfield, M.E. & Hess, R.G. (2018). Enhancing and advancing shared governance through a targeted decision-making redesign. *Journal of Nursing Administration*, *9*, 445. doi.10.1097/NNA.0000000000000647

DiFiore, T., Zito, A., Berardinelli, A., Bena, J.F., Morrison, S.L., Keck, D.E., Kennedy, K., Stibich, A., & Albert, N.M. (2018). Staff perceptions of decision-making in a shared governance culture. *Journal of Nursing Administration*. *48*(11), 561-566. https://doi.org/10.1097/NNA.0000000000000680.

Drexler, D. (2020). Using a nursing professional governance approach to improve nurse satisfaction and participation with health information technology. *Nurse Leader, 18*(3), 276-280. https://doi.org/10.1016/j.mnl.2020.03.003.

Flynn, R. & Hartfield, D. (2016). An evaluation of frontline led quality improvement initiative. *Leadership in Health Services, 29*(4), 402-414. DOI: 10.1108/LHS-11-2015-0039

Grace, P. (2018). *Nursing ethics and professional responsibility in advanced practice*. Jones & Bartlett.

Guanci, G., Medeiros, M. (2018). Shared governance strategic planning retreat: A best practice. *Nursing Management*, *49*, 36-40. https://doi.org/10.1097/01.NUMA.0000542296.59754.61

Hannele Kanninen, T, Haggman-Laitila, A., Tervo-Heikkinen, T, & Kvist, T. (2019). Nursing

    shared governance at hospitals–it's Finnish future? *Leadership in Health Services*, *32*(4),

    558-568. https://doi.org/10.1108/LHS-10-2018-0051

Hess, R. G. (2004). From Bedside to Boardroom – Nursing Shared Governance. *Online Journal*

    of Issues in Nursing, 9(1), 95-106. http://www.nursingworld.org/ojin/

Hess, R. (2020). Shared governance is everywhere*! Insight: The Journal of the American Society*

    of Ophthalmic Registered Nurses, 45(3), 37-39. https://sharedgovernance.org/wp-

    content/uploads/SharedGovernanceOverview2020.pdf

Huntington, K. & Goodyear, C. (2018). Integrating Lean with shared governance. *Nursing*

    Management,*49*(9), 14-19. doi 10.1097/01.NUMA.0000544460.58581.c6

Institute for Healthcare Improvement. (n.d.). *Improving health and health care worldwide.*

    http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Joseph, M.L., & Bogue, R. (2016). A theory-based approach to nursing shared governance.

    Nursing Outlook, 64(2016), 339-351. doi 10.1016/j.outlook.2016.09.001

Khraisat, O., Al-awamreh, K., Hamdan, M., AL-Bashtawy, M., Khwaldeh, A.A., Alqudah, M.,

    Qaddummi, J.A.S., & Haliq, S. (2020). Shared governance: A children's hospital journey

    to clinical nursing excellence. *Journal of Research in Nursing*, *25*(4), 347-358.

    https://doi.org/10.1177/1744987120905620

Kutney-Lee, A., Germack, H., Hatfield, L., & Kelly, S. (2016). Nurse engagement in shared

    governance and patient and nurse outcomes. *The Journal of Nursing Administration*,

    46(11), 605-612. DOI: 10.1097/NNA.0000000000000412

Lamoureux, J., Judkins-Cohn, T., Butao, R., McCue, V. & Garcia, F. (2014). Measuring

    perceptions of shared governance in clinical practice: psychometric testing of the RN-

    focused index of professional governance (IPNG). *Journal of Research in Nursing*, *19*(1),

    69-87. https://doi.org/10.1177/1744987113504409

Laschinger, H.K., Gilbert, S., Smith, L. & Leslie, K. (2010). Towards a comprehensive theory of

    nurse/patient empowerment: applying Kanter's empowerment theory to patient care.

    Journal of Nursing Management, 18(1), 4-13. DOI 10.1111/j.1365-2834.2009.01046.x

Mederios, M. (2018). Shared governance councils: 10 essential actions for nurse leaders. *Nursing*

    Management, *49*(7), 12-13. doi 10.1097/01.NUMA.0000538920.83653.9b

Meyer-Laverentz, D. & Kumm, S. (2017). Concept evaluation using the PDSA cycle for

    continuous quality improvement. *National League for Nursing*, *38(*5), 288-290. DOI

    10.1097/01.NEP.0000000000000161

Miller, E. (2002). Shared governance and performance improvement: a new opportunity to build

    trust in a restructured health care system. *Nursing Administration Quarterly*, *26*(3), 60-

    66. doi 10.1097/00006216-200204000-00009

Mitchell, M., Brooks, F., & Pugh, J. (1999). Balancing nurse empowerment with improved

    practice and care: an evaluation of the impact of shared governance. *NT Research*, *4(*3),

    192-200.

Moreno, J., Girard, A., & Foad, W. (2018). Realigning shared governance with Magnet and the

    organization's operating system to achieve clinical excellence. *The Journal of Nursing*

    Administration, *48*(3), 160-167. doi 10.1097/NNA.0000000000000591.

Murray, K., Yasso, S., Schomburg, R., Terhune, M., Beidelschies, M., Bowers, D., & Goodyear-Bruch, C. (2016). Journey of excellence: implementing a shared decision-making model. *American Journal of Nursing*, *116*(4), 50-56. doi 10.1097/01.NAJ.0000482137.12424.51.

Nembhard, I.M. & Tucker, A.I., (2011). Deliberate learning to improve performance in dynamic service settings: Evidence from hospital intensive care units. *Organization Science*, *22*(4), 907. https://doi.org/10.1287/orsc.1100.0570

Panayotou, M., Cefaratti, D., Hanscom, H., Petto, P, Turner, R., Tailey, L. (2019). Shared governance strategic plan creation and implementation. *Nursing Management*, *50*, 9-12. doi 10.1097/01.NUMA.0000605184.05221.8b

Porter-O'Grady, T. (2001). Is shared governance still relevant? *Journal of Nursing Administration*, *31*(10) 468-473. doi 10.1097/00005110-200110000-00010.

Porter-O'Grady, T. (2019). Principles for sustaining shared/professional governance in nursing. Nursing Management, *50*, 36-41. https://doi.org/10.1097/01.NUMA.0000550448.17375.28

Porter-O'Grady, T. (2009). Creating a context for excellence and innovation: comparing chief nurse executive leadership practices in magnet and non-magnet hospitals. *Nursing Administration Quarterly*, *33*(3), 198-204. https://doi.org/10.1097/NAQ.0b013e3181acca44

Porter-O'Grady, T., & Clavelle, J. T. (2020). The structural framework for nursing professional governance: foundation for empowerment. *Nurse Leader*, *18*(2), 181-189. https://doi.org/10.1016/j.mnl.2019.08.004

Rankin, V. & Rose, R. (2020). President of nursing staff: reinvigorating shared governance. Nurse Leader, https://doi.org/10.1016/j.mnl.2020.08.009.

Robles, V. D. (2018). Visualizing certainty: what the cultural history of the Gantt chart teaches technical and professional communicators about management. *Technical Communication Quarterly, 27*(4), 300-321. https://doi.org/10.1080/10572252.2018.1520025.

Rundquist, J. M. & Givens, P. L. (2013). Quantifying the benefits of staff participation in shared governance. *American Nurse Today*, *8*(3), 38-42. https://www.myamericannurse.com/quantifying-the-benefits-of-staff-participation-in-shared-governance/

Sendelbach, S., Zink, M. & Peterson, J. (2011). Decreasing pressure ulcers across a Healthcare system: Moving beneath the tip of the iceberg. *The Journal Nursing Administration*, 41(2), 84-89.

Suhermin, S. (2019). Applying the Kanter Empowerment Theory to improve organizational commitment [PDF]. *ASEAN/Asian Academic Society International Conference Proceeding Series*. http://aasic.org/proc/aasic/article/view/484

Van Katwyk, S., Thavorn, K., Coyle, D. Moloo, H., Forster, A., Jackson, T., & Schramm,D. (2018). The return of investment of hospital-based surgical quality improvement programs in reducing surgical site infection at a Canadian tertiary care hospital. *Infection Control & Hospital Epidemiology*, 40(2), 125-132. doi:10.1017/ice.2018.294.

Wennerholm, L., Rubin Perez, N., Abt, S., Fon, K., & Elsabrout, K. (2021). Development of an oral care multidisciplinary Initiative in an acute care community hospital: Framework, timeline, and outcomes. American Journal of Speech-Language Pathology, 30(2), 517 531. https://doi.org/10.1044/2020_AJSLP-20-00159

Zecheru, V. & Olaru, B. G. (2016). Work breakdown structure (WBS) in project management

[PDF]. *Review of International Comparative Management*, *17*(1), 61-69.

http://rmci.ase.ro/no17vol1/06.pd

Appendix A – Evidence Evaluation Table

Evidence Number	APA Citation	Purpose of Article or Review	Design	Methodology	Findings	Conclusion	Critical Appraisal
Evidence #1	Brull, S. (2015). Successful shared governance through education. *Nursing Economics*, 33(6), 314-319.	To determine if implementation of shared governance could be done more efficiently and effectively using a comprehensive educational plan.	Quasi-experimental Study	Used the Index of Professional Governance (IPNG) tool to measure governance	Increase in shared governance scores after one and two years respectively	Organizations should use a comprehensive educational strategy when implementing shared governance	Level II Good
Evidence #2	Dechairo-Marino, A.E., Collins Raggi, M.E., Mendelson, S.G., Highfield, M.E.F., & Hess, R.G. (2018). Enhancing and advancing shared governance through a targeted decision-making redesign. *Journal of Nursing Administration*, 9, 445.	Determine if a targeted redesign of shared decision making improved shared governance.	Quasi-experimental, pretest/posttest design, Qualitative	researchers electronically distributed the Index of Professional Nursing Governance (IPNG) to convenient sample of RNs in a Magnet hospital.	Before to after intervention, IPNG scale increased significantly, except the access to information subscale.	The significant change from respondent perception of a traditional governance model to a shared governance environment was remarkable. Implementation of changes to SG can take 2 to 5 years to realize a difference.	Level II, High/Good

						Nursing leadership is responsible for the environment in which RNs practice and in SG, nursing staff and leaders share the responsibility for managing professional practice.	
Evidence #3	DiFiore, T., Zito, A., Berardinelli, A., Bena, J.F., Morrison, S.L., Keck, D.E., Kennedy, K., Stibich, A., & Albert, N.M. (2018). Staff perceptions of decision-making in a shared governance culture. Journal of Nursing Administration. 48(11), 561-566. https://doi.org/10.1097/NNA.0000000000000680.	To evaluate differences in the shared decision-making perceptions of clinical nurses between initial implementation of a shared governance model and perceptions 3 years later, after the model had matured.	Qualitative	2-group comparative design and survey methods	Only one area of the IPNG had statistically significant change (structure for decisions).	Perception of shared decision making by nurses was lower than desired, reflecting the need to develop new structures, systems and processes that may strengthen decisional involvement by clinical nurses. Total IPNG scores increased despite a decrease in hospital and	Level III, High/Good

					unit SG participation. Nurse leaders need to emphasize and increase clinical nurse decisional involvement to enhance shard decision making.	
Evidence #4	Drexler, D. (2020). Using a nursing professional governance approach to improve nurse satisfaction and participation with health information technology. *Nurse Leader,* 18(3), 276-280. https://doi.org/10.1016/j.mnl.2020.03.003.	To improve nurse satisfaction and engagement in HIT in an acute care setting using a professional governance model	Descriptive, correlational, quasi-experimental pretest/posttest was used Intervention was education, coaching, and mentoring	A convenience sample of all registered nurses in the health care organization received the survey The independent variables were professional governance, work environment, and patient centered care. The dependent variables were the	There was significant difference found in the professional role behaviors demonstrated 3 months after the educational program.	The project did find a statistically significant difference in the participants professional role behavior after the intervention. Supports the positive impact of shared leadership on nurse satisfaction and desire to participate in design. These results suggest that the education, coaching, and mentoring	Level II; high/good

				registered nurses.		conducted on professional role behaviors did have the desired impact (improve nurse satisfaction and engagement with HIT).	
Evidence #5	Kutney-Lee, A., Germack, H., Hatfield, L., & Kelly, S. (2016). Nurse engagement in shared governance and patient and nurse outcomes. The Journal of Nursing Administration, 46(11), 605-612.	Examine differences in nurse engagement in shared governance to determine the relationship between nurse engagement and patient and nurse outcomes.	Cross-sectional observational Study	A secondary analysis of linked cross-sectional data was conducted using nurse, hospital, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data	Higher levels of nurse engagement were associated with higher HCAHPS scores	Shared governance may serve as a valuable intervention for organizations to promote optimal patient and nurse outcomes.	Level II High/Good

Appendix B – IHI Model of Improvement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do
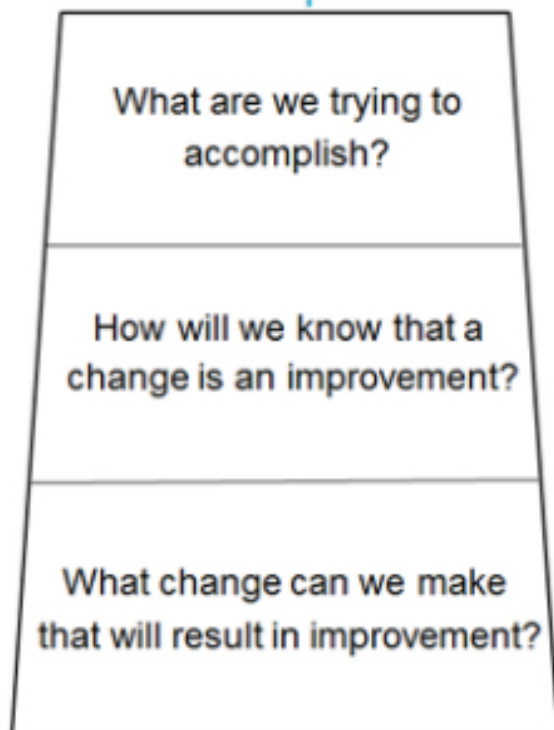
Setting Aims

The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

Ideas for change may come from those who work in the system or from the experience of others who have successfully improved.

Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

Appendix C – Plan Do Study Act (PDSA) Cycle

Institute *for*
Healthcare
Improvement

QI Essentials Toolkit:
PDSA Worksheet

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change — you develop a plan to test the change (Plan), carry out the test (Do), observe, analyze, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Fill out one PDSA worksheet for each change you test. In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file (either electronic or hard copy) of all PDSA cycles for all the changes your team tests.

IHI's QI Essentials Toolkit includes the tools and templates you need to launch and manage a successful improvement project. Each of the nine tools in the toolkit includes a short description, instructions, an example, and a blank template. NOTE: Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

- Cause and Effect Diagram
- Driver Diagram
- Failure Modes and Effects Analysis (FMEA)
- Flowchart
- Histogram
- Pareto Chart
- **PDSA Worksheet**
- Project Planning Form
- Run Chart & Control Chart
- Scatter Diagram

Instructions

Plan: Plan the test, including a plan for collecting data.

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect.

Do: Run the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyze the data.

Study: Analyze the results and compare them to your predictions.

- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.

Act: Based on what you learned from the test, make a plan for your next step.

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

Example: PDSA Worksheet

Objective: Test using Teach-Back (a closed-loop communication model, in which the recipient of information repeats the information back to the speaker) with a small group of patients, in hopes of improving patients' understanding of their care plans.

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

- How much more time will it take to use Teach-Back with patients? It will take more time at first (5 to 10 minutes per patient), but we will start to learn better communication skills and get more efficient.

- Will it be worthwhile? The extra time will feel worthwhile (and possibly prevent future rework).

- What will we do if the act of "teaching back" reveals a patient didn't understand the care plan? If a patient is not able to explain his or her care plan, we will need to explain it again, perhaps in a different way.

Who, what, where, when:

On Monday, each resident will test using Teach-Back with the last patient of the day.

Plan for collecting data:

Each resident will write a brief paragraph about their experience using Teach-Back with the last patient.

2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

Three residents attempted Teach-Back at the end of the day on Monday. Two residents did not find anything they needed to ask patients to Teach-Back. Jane found that her patient did not understand the medication schedule for her child. They were able to review it again and, at the end, Jane was confident the mother was going to be able to give the medication as indicated.

3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

- Prediction: It will take more time at first (5 to 10 minutes per patient), but we will start to learn better communication skills and get more efficient. *Result: Using Teach-Back took about 5 minutes per patient.*

- Prediction: The extra time will feel worthwhile (and possibly prevent future rework). *Result: Jane felt the time she invested in using Teach-Back significantly improved the care experience.*

- Prediction: If a patient is not able to explain his or her care plan, we will need to explain it again, perhaps in a different way. *Result: After a second review of the medication orders, the patient was able to Teach-Back the instructions successfully.*

In addition to the team confirming all three predictions, Jane realized the medication information sheets she had been handing out to parents weren't as clear as she thought. She realized these should be re-written — maybe with the input of some parents.

4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

Jane is planning to use Teach-Back any time she prescribes medication. Although it may take more time, she now understands the importance. The other residents are going to work on using Teach-Back specifically for medications for the next week.

They would like to pull together a team to work on some of the medication information sheets with parent input, but they are first going to gather more information through more interactions in the coming days.

Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: PDSA Worksheet

Objective:

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

-
-

Who, what, where, when:

Plan for collecting data:

2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

Appendix D – Letter of Support from Organization

KAISER PERMANENTE®   Kaiser Foundation Hospitals

September 28, 2020

University of San Francisco
101 Howard Street
San Francisco, CA

Re: DNP Project Letter of Support from Agency

To Whom it May Concern:

This is a letter of support for Deborah Reitter to implement her DNP Comprehensive Project, Building Excellence through Shared Governance and Continuous Process Improvement. The focus of the project will be enhancing the existing shared governance structure by introducing and incorporating a performance improvement model for use during Nursing Unit Council projects.

Sincerely,

Kimberly Menzel, RN, MHA
Sr Vice President and Area Manager
Kaiser Permanente Roseville Medical Center

1600 Eureka Road
Roseville, California 95661-3027
(916) 784-4000

08272-30 (REV. 6-00)

Appendix E – Project Toolkit/Worksheet

Medical Center
NUC Project PDSA Worksheet

NUC: _____

Date: _____

Project Title: _____

What are we trying to accomplish? (SMART Goal)
S: Specific (one activity)
M: Measurable ((track and measure)
A: Attainable (clear tasks & actions to achieve goal)
R: Relevant (realistic)
T: Time Bound (amount of time to achieve goal)

SMART Goal: _____

_____

_____

_____

Plan: Plan the test, including a plan for collecting data
Develop a plan to test the change. What changes can we make that will result in an improvement? (Who? What? When? Where?)

Plan

List the tasks needed to set up this test of change	Person Responsible	When to be done	Where to be done
1-			
2-			
3-			
4-			
5-			

Communication Plan

List the tasks needed to communicate this test of change	Person Responsible	When to be done	Where to be done
1-			
2-			
3-			
4-			
5-			

Predict

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1-	1-
2-	2-
3-	3-
4-	4-

Summary of PDSA Cycles

Describe your planned tests of change *(add more rows if needed)*	Person Responsible *(e.g., who will test)*	When to be done *(e.g., day, shift)*	Where to be done *(e.g., unit)*	Measure
PDSA #1				
PDSA #2:				
PDSA #3:				
PDSA #4:				

Do: Run the test on a small scale
Carry out the test and document observations, collect data and begin to analyze.

Describe your planned tests of change (add more rows if needed)	Observations	Measures
PDSA #1		
PDSA #2		
PDSA #3		
PDSA #4		

Study: Analyze the results and compare them to your predictions
Compare the data to your prediction; summarize what you learned.

Act: Based on what you learned from the test, describe the modifications that will be made, plan for next step
Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea). Prepare a plan for next PDSA.

Appendix F – Gap Analysis

	Current State	Desired Future State	Identified Gap	Action Plan
Focus area	*Where are you now?*	*Where would you like to be?*	*Impact to the organization*	*Projects to undertake*
Shared Governance Infrastructure	- Currently, 130 staff nurses participate in Nursing Unit Councils - Started with 13 Nursing Unit Councils 12 NUCs currently meeting 1 no longer meeting; regrouping 1 new Float Pool NUC starting in October 2020 25% turnover in NUC membership - One NUC did not experience any turnover in two years	- Active NUCs in every nursing unit - Reduce NUC membership turnover to less than 10% during membership term of two years - Create a shared governance environment where NUC membership is a coveted council seat and is not given up until the council member's term is expired	- Decreased or fading staff nurse engagement in shared governance process - Decreased return on investment when staff drop out of council membership; councils lose momentum or potential project delays	- Create a Shared Governance/Performance Improvement Toolkit that includes templated documents, the mission of shared governance, the expectations of council members and each Nursing Unit Council - Educate and train to the toolkit
Shared Governance Education and Training	Initiated shared governance in 2018 with a 2-day kickoff event focusing	Increase NUC member understanding of the purpose and	Most Nursing Unit Councils lack structured meetings	Conduct an educational event for NUC members that provides the foundation of shared

			Most NUCs are not incorporating shared decision making into their standard council work	governance and promotes ownership of practice, accountability of practice outcomes and aligns with organizational goals
(competence, knowledge, practice-based, quality/evidence)	education on the organization's professional practice model and formation of shared governance • Initiated a local shared governance model which includes a Nursing Unit Council (NUC) on each nursing unit	principles of shared governance • Comprehensive educational program focused on shared governance foundational components provided to all NUC members • Structured monthly NUC meetings with defined agendas	• Most NUCs are not incorporating shared decision making into their standard council work	governance and promotes ownership of practice, accountability of practice outcomes and aligns with organizational goals
	Current State	**Desired Future State**	**Identified Gap**	**Action Plan**
Performance Improvement Education and Training	• Limited performance improvement education and training during kickoff event • Limited follow up performance improvement information provided to NUC co-chairs during Leadership Development Council (attendance not required)	• Comprehensive performance improvement education provided to every NUC member • NUC co-chairs receive training and coaching on conducting performance improvement work with validated competency • 1-3 Measurable improvement outcomes demonstrated yearly by each NUC	• Most NUCs have not received formal education regarding performance improvement • Most Nursing Unit Councils are not producing measurable performance improvement outcomes	• Conduct an educational event for NUC members that provides a model for performance improvement that can be replicated in council work

Appendix G – Gantt Chart

Shared Governance and Continuous Process Improvement

University of San Francisco, DNP Project
Debbie Reitter

| Project Start: | Sun, 11/1/2020 |
| Display Week: | 1 |

| Nov 1, 2020 | Dec 1, 2020 | Jan 1, 2021 | Feb 1, 2021 | Mar 1, 2021 | Apr 1, 2021 | May 1, 2021 | Jun 1, 2021 |

TASK	ASSIGNED TO	PROGRESS	START	END
Initiation				
Assessment of NUC Shared Governance (INPG)		0%	11/1/20	11/30/20
Determination of NUC Participation in Project		0%	11/30/20	12/15/20
Development of Project Charter		0%	11/15/20	11/22/20
Introduction of Project Charter to Governance Council		0%	11/23/20	11/23/20
Project Charter Signed/Approved		0%	12/15/20	12/31/20
Planning				
Determine Project Team		0%	12/16/20	12/20/20
Project Team Kick Off Meeting		0%	12/18/20	12/23/20
Create Project Plan		0%	12/23/20	12/26/20
Determine Educational Content		0%	12/23/20	12/25/20
Develop/Organize SG/PI Toolkit		0%	11/15/20	1/5/21
Execution				
Project Kickoff Meeting and NUC Training			1/11/21	1/11/21
Observations in Nursing Unit Councils (NUC)			1/12/21	4/30/21
Identify Coaching Opportunities for NUC Co-chairs			1/12/21	4/30/21
Evaluation				
Distribute Post-Training Shared Gov NUC Assessment (INPG)			5/1/21	5/31/21
Evaluate Post-Training NUC Project Implementation/Completion			5/1/21	5/31/21
Assimilate results of Post-Training Assessment			6/1/21	6/30/21

Appendix H – Work Breakdown Structure

Shared Governance and Continuous Performance Improvement

Project Design
- Literature Search
- Selection of Performance Improvement model
- Define Measurement of Success of Performance Improvement model
- Define Expected Project Outcomes (ROI)

Current State Assessment
- Index of Professional Nursing Governance (IPNG)
- Number of NUC Projects 2018-2020

Education
- Determine Education Plan for NUC Participants
- Develop Participant Education Plan based Shared Governance fundamentals and Performance Improvement model
- Develop Toolkit
- Host Kickoff Event

Communication
- Stakeholders and Participants
- NUC Nursing Leader Co-Chairs
- Governance Council

Finance
- Analysis of NUC Participant Time in Hourly Rate
- Determine cost of Kickoff expenses

Evaluation
- Determine Perception of Shared Governance by NUC participants(Repeat IPNG)
- Examine NUC Productivity

Appendix I – Communication Plan

Communication	Frequency	Goal	Route
Executive Leadership Team/Key Stakeholders			
Area Manager/Sr Vice President (CEO)	Monthly	Review project status, discuss barriers and updates, share progress	Email, 1:1 In-person meetings
Senior Leadership Team	Monthly	Review project status, discuss barriers and updates, share progress	Senior Leadership Team meetings
Area Quality Leader	As Needed	Review project status, discuss any quality and safety impacts	Email, In-person meetings, Senior Leadership Team meetings
Performance Improvement Advisor	As Needed	Review project goals and objectives, discuss educational support and resources, discuss barriers and updates, share progress	Email, 1:1 In-person meetings
Services Line Directors/Managers			
Adult Services Director, MCH Director, Perioperative Services Director	Weekly	Review project from a clinical perspective and strategize about implementation and barriers	Email and conference calls
Director of Clinical Education, Practice and Informatics; Manager of Clinical Education (also serving as Magnet Coordinator)	Twice Weekly	Review project from an education perspective and strategize about clinical content, skills and training	Email and conference calls
Administrative Services Director and Staffing Office Manager	Monthly	Review project from a staffing plan perspective, considering appropriate coding and tracking	Email and conference calls
Managers with Staff Nurses involved in training	Weekly	Review project from resource and staffing plan perspective	Email and conference calls
NUC Council Members/Governance Council			
NUC Co-Chairs involved in training	Weekly	Introduce the project plan and request participation in education/training. Provide coaching after training.	Email, conference calls, 1:1 discussion
NUC Staff Nurse Members involved in training	Weekly	Introduce the project plan and request participation in education/training. Provide coaching after training.	Email, conference calls, 1:1 discussion
Manager NUC Co-Chairs involved in training	Monthly	Introduce the project plan and request participation in education/training. Provide coaching after training.	Email, conference calls, 1:1 discussion
Governance Council	Monthly	Review project status, discuss barriers and updates, share progress	Governance Council meeting

Appendix J – California Nurses Association Communication

California
Nurses
Association

WHAT IS MAGNET?

Healthcare corporations promote Magnet accreditation as desirable for hospitals to achieve in spite of the great effort and expense involved, because it is supposed to signal to registered nurses that Magnet-accredited hospitals are excellent workplaces. However, the evidence that Magnet hospitals are superior to non-Magnet hospitals is far weaker and more inconclusive than Magnet advocates would like nurses to believe. Magnet hospitals have been found to have worse patient outcomes than non-Magnet hospitals and there is little variation in working conditions.

Does Magnet improve patient care?

- Magnet hospitals have been found to have worse patient outcomes than non-Magnet hospitals. A 2011 study[1], found that non-Magnet hospitals had better patient outcomes than Magnet hospitals. Magnet hospitals had worse outcomes for infections, post-operative sepsis and post-operative metabolic derangement than non-Magnet hospitals, while Magnet hospitals had only slightly better outcomes for pressure ulcers.

- A 2015 systematic review of the literature on Magnet hospitals[2] found that "... based on the mixed results and poor quality in the research designs ... it was not possible to conclude that Magnet accreditation has effects on nurse and patient outcomes." In other words the best available evidence is that the evidence is inconclusive.

How does Magnet affect staffing?

- Magnet hospitals studied had less total staff and a lower RN skill mix than non-Magnet hospitals. A 2010 study of ICU nurses[3] similarly found a lower skill mix of RNs in Magnet than in non-Magnet hospitals.

- A 2010 study[4], found little variation in the working conditions between Magnet and non-Magnet hospitals. "We've noticed that the Magnet hospital emphasis has little to do with nurse working conditions — work schedules, such as hours, and job demands," lead study author Alison M. Trinkoff, ScD, RN, stated.

- Meg Johantgen, Ph.D., RN, co-author of the study, believes that Magnet status has become primarily a marketing approach "... to promote a hospital's appeal to both consumers and the nursing workforce."

- Goode, et al.'s 2011 study noted that Magnet hospitals had less total staff than non-Magnet hospitals. As noted above, the essential point is that the Magnet system is designed to allow hospitals to claim that they voluntarily have improved staffing as a tactic to avoid increased scrutiny and regulation, and to seek to gain the public's trust under what may well turn out to be false pretenses.

References:

1 C. Goode, et al., "Comparison of Patient Outcomes in Magnet and Non-Magnet Hospitals," Journal of Nursing Administration (JONA), Vol 41, Number 12 (December 2011) 517-523.

2 Odessa Petit, et al., "JP Do Magnet-Accredited Hospitals Show Improvements in Nurse and Patient Outcomes Compared to Non-Magnet Hospitals," A Systematic Review, JBI Database of Systematic Reviews and Implementation Reports, Vol 13, Issue 6 (June 2015) 168-219

3 P. Hickey, et al., "The Relationship of Nurse Staffing, Skill Mix, and Magnet Recognition to Institutional Volume and Mortality for Congenital Heart Surgery," Journal of Nursing Administration (JONA), Vol 40, Number 5, 226-32

4 Trinkoff et al., "A Comparison of Working Conditions Among Nurses in Magnet and Non-Magnet Hospitals," Journal of Nursing Administration (JONA), Vol 40, Number 7/8 (July/August 2010) 309-315

CNA: A Voice for Nurses. A Vision for Healthcare.

Appendix K – SWOT Analysis

Strengths	Weaknesses
- Shared governance implemented locally in 2018 - Local hospital leadership support with prioritization as an "important" initiative toward the organization's true north - Regional CNE endorsement of organizational trajectory/movement toward Magnet designation - Existing shared governance council members' desire to be successful - Dedicated staff nurse council co-chairs - A few councils who have experienced success or "wins"	- Lack of structure to guide shared governance councils in their work - Lack of knowledge by council members regarding shared governance process - Lack of knowledge by council members regarding performance improvement methodologies - Lack of dedicated council/committee time required to create change - Inability to replace staff nurses to attend council meetings or trainings - Lack of dedicated budget for shared governance processes - Vacancies in some councils
Opportunities	**Threats**
- Teachable moment as the organization works toward Magnet application - Council members engaged in enthusiastic learning - Increase in leadership skills of council members participating in the education - Development of a spreadable process that will transcend the organization region-wide - Increase ability to apply for Magnet designation	- Lack of Outpatient and Emergency Department participation - California Nurses' Association (CNA) resistance - Meetings held virtually due to new COVID restrictions requiring social distancing - Interest in shared governance will potentially dissipate without adequate training or achievement of successful shared decision-making

Appendix L – Proposed Budget

Expense	Cost
Project Planning and Development DNP Student, Shared Governance Co-Chairs	$179/hour x 35 hours x 1employee = $6,264 $90/hour x 8 hours x 2 employees = $1,440 **$7,704**
Total Planning and Development Costs	**$7,704**
Staff Shared Governance and Performance Improvement Training NUC Staff Nurse Members, NUC Manager Co-Chairs	$90/hour x 8 hours x 22 employees = $15,840 $135/hour x 8 hours x 10 employees = $10,800 **$26,640**
Backfill for Training Participants	$90/hour x 8 hours x 9.5 employees = $6,840 **$6,840**
Final Printed Materials and Supplies	$10/copy x 60 copies = $600 **$600**
Total Personnel/Supply Costs for Kick-off events	**$32.640**
NUC Co-Chair Coaching Sessions	$90/hour x 8 hours x 4 employees = $2,880 $135/hour x 8 hours x 1 employee = $1,080 **$3,960**
Consultation on Unit-based Performance Dashboards (Area Quality Leader)	$100/hour x 4 hours x 1 employee = $400 **$400**
Personnel Training to Support Coaching Sessions	$90/hour x 4.5 hours x 1 employee = $405 $90/hour x 5.1 hours x 1 employee = $459 **$864**
Total Training/Support Outside of Kick-off events	**$5,224**
Total Initial Project "Launch" Costs	**$45,568**
Ongoing Operation and Maintenance Costs Post Training (cost delineated represent 2-month timeframe) NUC Staff Nurse Members, NUC Manager Co-Chairs	$90/hour x 8 hours x 22 employees = $15,840 $135/hour x 8 hours x 10 employees = $10,800 **$26,640 per 2 months**
Ongoing Backfill Costs Post Training (cost delineated represent 2-month timeframe)	$90/hour x 8 hours x 9.5 employees = $6,840 **$6,840 per 2 months**
1-year Ongoing Personnel Operation Costs	**$160,200**
1-year Ongoing Support Costs	**$ 21,640**
1-year TOTAL Costs	**$227,408**

Appendix M – Cost Benefit Analysis

Category of Cost	Implementation Costs by Stage of Improvement Action				Total Costs Year 1	Total Costs Year 2	Total Costs Year 3	Total Costs Year 4	Total Costs Year 5
	Planning and Development	Training	Kickoff	Ongoing Operation and Maintenance					
Personnel	$1,440	$864	$32,040	$160,200	$194,544	$14,400	$14,400	$14,400	$14,400
Supplies			$600		$600	$400	$400	$400	$400
Co-Chair Coaching Sessions	$4,824	$3,960		$19,800	$28,584	$3,960	$3,960	$3,960	$3,960
Outreach and Communication	$1,440			$1,440	$2,880	$720	$720	$720	$720
Consultant Costs		$400		$400	$800	$400	$400	$400	$400
TOTAL COSTS	**$7,704**	**$5,224**	**$32,640**	**$181,840**	**$227,408**	**$19,880**	**$19,880**	**$19,880**	**$19,880**
Return on Investment/Cost Avoidance				Total Cost of Hospital Acquired Condition at host hospital in 2020	Total Costs Avoided Year 1	Total Costs Avoided Year 2	Total Costs Avoided Year 3	Total Costs Avoided Year 4	Total Costs Avoided Year 5
ROI HAPI (Hospital Acquired Pressure Injury) Reduction 58% decrease *				$1,209,040	$701,243	$294,522	$123,699	$51,954	$21,820
ROI SSI (Surgical Site Infection) Reduction 2.88% **				$1,135,960	$32,716	$31,773	$30,858	$29,969	$29,106
ROI HAP (Hospital Acquired Pneumonia) Reduction 1.75 events per quarter ***				$1,336,472	$258,672	$258,672	$258,672	$258,672	$258,672
TOTAL COST AVOIDANCE					**$361,512**	**$584,967**	**$413,229**	**$340,322**	**$309,598**
EBITA (Earnings Before Interest, Taxes, Amortization)					$134,104	$565,087	$393,349	$320,442	$289,718

* Sendelbach et al. (2011)
** Van Katwyk et al. (2018)
***Wennerholm et al. (2021)

Appendix N – Cost Avoidance Data

Cost Avoidance

Harm Event	Expense Per Event	Total Events in 2020	Total Expense in 2020
Falls with injury	$14,056	25	$351,400
Hospital Acquired Pneumonia	$43,112	31	$1,336,472
Cesarean Section Surgical Site Infection	$3,842	18	$69,156
All Surgical Site Infections	$20,285	56	$1,135,960
Hospital Acquired Pressure Injury	$43,180	28	$1,209,040
Central Line and Blood Stream Infections	$47,644	8	$381,152
Catheter Acquired Urinary Tract Infection	$34,519	3	$103,557
TOTAL		169	$4,586,737

*Host facility harm numbers (actual) as per Quality and Safety Department (5/2021)

Appendix O – Pre- and Post-training Survey

NUC Performance Improvement

1. Today's date:

   > Enter your answer

2. Please specify number of years you have been practicing.

   > Enter your answer

3. Please indicate your clinical specialty.

   ○ Critical Care

   ○ Education

   ○ Maternity

   ○ Medical / Surgical

   ○ NICU

   ○ Operating Room

   ○ Pediatrics

   ○ PACU

   ○ PICU

   ○ Other

4. Please specify the number of years you have worked for this organization.

   > Enter your answer

5. How familiar are you with the principles of performance improvement (1 being not familiar to 5 being very familiar)?

   | 1 | 2 | 3 | 4 | 5 |
   | ○ | ○ | ○ | ○ | ○ |

6. Did your NUC have specific outcome measures related to your projects?

   ○ Yes

   ○ No

7. Before the NUC learning session, how familiar were you with the Institute of Healthcare Improvement's "Model for Improvement" (1 being not familiar to 5 being very familiar).

1	2	3	4	5
○	○	○	○	○

8. Before the NUC learning session, how familiar were you with SMART goals (1 not familiar to 5 extremely familiar)?

1	2	3	4	5
○	○	○	○	○

9. Was the content of this learning session helpful (1 not very helpful to 5 extremely helpful)?

1	2	3	4	5
○	○	○	○	○

10. Can your NUC apply the content of this learning session in their work (1 very little, 3 somewhat, 5 absolutely)?

1	2	3	4	5
○	○	○	○	○

11. Would you recommend this learning session to other NUCs (1 no, 3 somewhat, 5 absolutely)?

1	2	3	4	5
○	○	○	○	○

12. In your organization, when developing and evaluating policies, procedures and protocols related to patient care, is it equally shared by staff nurses and nursing management?

    ○ Yes

    ○ No

13. In your organization, when providing for the professional/educational development of the nursing staff, is it equally shared by staff nurses and nursing management?

    ○ Yes

    ○ No

14. In your organization, is access to information regarding the unit and nursing departmental goals and objectives for this year equally shared by nursing staff and nursing management?

○ Yes

○ No

Appendix P – Excel Data Collection Spreadsheet

Today's date	Please specify number of years you have been practicing.	Please indicate the title of your present position.	Please indicate your clinical specialty.	Please specify the number of years you have worked for this organizatio	How familiar are you with the principles of performance improvement (1 being not familiar to 5 being very familiar)?	Did your NUC have specific outcome measures related to your projects?	Before the NUC learning session, how familiar were you with the Institute of Healthcare Improvement's "Model for Improvement" (1 being not familiar to 5 being very familiar).	Before the NUC learning session, how familiar were you with SMART goals (1 not familiar to 5 extremely familiar)?	Was the content of this learning session helpful (1 not very helpful to 5 extremely helpful)?	Can your NUC apply the content of this learning session in their work (1 very little, 3 somewhat, 5 absolutely)?	Would you recommend this learning session to other NUCs (1 no, 3 somewhat, 5 absolutely)?	In your organization, when developing and evaluating policies, procedures and protocols related to patient care, is it equally shared by staff nurses and nursing management?	In your organization, when providing for the professional/ educational development of the nursing staff, is it equally shared by staff nurses and nursing maangement?	In your organization, is access to information regarding the unit and nursing departmental goals and objectives for this year equally available to staff nurses and nursing

Appendix Q – Research Determination Committee Letter

KAISER PERMANENTE

Date:	September 17, 2021
Subject:	RDO KPNC 21 – 032
Title:	Building Excellence through Shared Governance and Continuous Process Improvement (for Debbie Reitter (student) project)

Dear Ms. Menzel:

The Research Determination Committee for the Kaiser Permanente Northern California region has reviewed the documents submitted for the above referenced project. The project, created by Debbie Reitter for her USF DNP program, does not meet the regulatory definition of research involving human subjects as noted here:

Not Research

The activity does not meet the regulatory definition of research per 45 CFR 46.102(d): Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. The word "research" should not appear in any posters or publications resulting from this project. Further, if publications, presentations or posters are generated from this project the following wording must be used to reference to the project research determination outcome:

"The Research Determination Committee for the Kaiser Permanente Northern California region has determined the project does not meet the regulatory definition of research involving human subjects per 45 CFR 46.102(d)"

You are expected, however, to implement your study or project in a manner congruent with accepted professional standards and ethical guidelines as described in the Belmont Report (http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html).

Additionally, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed.

Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Sincerely,

The Research Determination Committee
KPNC-RDO@kp.org

Research Determination Office
KPNC-RDO@kp.org

Appendix R – Statement of Non-Research Determination

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Doctor of Nursing Practice
Statement of Non-Research Determination (SOD) Form

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

General Information

Last Name:	Reitter	**First Name:**	Deborah
CWID Number:	20600479	**Semester/Year:**	Summer/2020
Course Name &			
Number:	N791: Practicum: Micro Systems		
Chairperson Name: Dr. Elena Capella		**Advisor Name:**	Dr. Elena Capella

Project Description

1. Title of Project

Toolkit for Implementing Performance Improvement in Shared Governance Structure

2. Brief Description of Project

Clearly state the purpose of the project and the problem statement in 250 words or less.

Problem Statement: The shared governance unit councils do not have a framework to guide their work toward creating and sustaining performance improvement.

Project Purpose: Create a performance improvement shared governance training and implementation model, with the intention of spreading to all unit and hospital councils. The PDSA methodology will be utilized to provide performance improvement training to a shared governance unit council. The goal is to demonstrate an improved understanding of performance improvement and improved quality outcome performance.

3. **AIM Statement: What are you trying to accomplish?**

- What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well-defined, and at a minimum describe the target population, the desired improvement, and the targeted timeframe.
- To improve (your process) from (baseline)% to (target)%, by (timeframe), among (your specific population)

Aim Statement: Design and implement a training program toolkit for a Shared Governance Council to increase pre- and post-test understanding of performance improvement framework (PDSA) by 50 percent, and increase the application of PDSA methodology in new projects 100 percent by September 1, 2021. This project is a trial with the ultimate goal of training the Shared Governance Councils of the remaining units.

4. **Brief Description of Intervention (150 words).**

This project will include the development and implementation of a Performance Improvement training program. The program will be developed with a shared governance unit council as the intended audience. The assumption is that the unit council has very limited knowledge of performance improvement methodology. Through this training, they will learn the fundamentals of successful performance improvement management to incorporate as the foundation of the work addressed within their unit council. The training will be based on the IHI's Plan-Do-Study-Act (PDSA) performance improvement framework. If successful, this will be spread to all shared governance unit councils at the Roseville Medical Center.

This project will include the development of a cu

4a. How will this intervention be implemented?

- Where will you implement the project?
- Attach a letter from the agency with approval of your project.
- Who is the focus of the intervention?
- How will you inform stakeholders/participants about the project and the intervention?

The project will be implemented at the KP Roseville Medical Center. It will focus the intervention with one select shared governance unit council. The key stakeholders will be the KP Roseville Magnet Coordinator, the Department Manager of the selected Unit Council, the Staff Co-Lead of the selected Unit Council, the KP Roseville Shared Governance Council, and the KP Roseville Senior Leadership Team. The project will be shared with these key stakeholders via in-person meetings providing the background and goals of the project.

5. Outcome measurements: How will you know that a change is an improvement?

- Measurement over time is essential to QI. Measures can be outcome, process, or balancing measures. Baseline or benchmark data are needed to show improvement.
- Align your measure with your problem statement and aim.
- Try to define your measure as a numerator/denominator.
  - What is the reliability and validity of the measure? Provide any tools that you will use as appendices.
  - Describe how you will protect participant confidentiality.

1. Increased knowledge of performance improvement methodology by 50% by the unit council. Measurement will occur via pre and post-tests/surveys that will test the council member's understanding of basic performance improvement concepts and how to apply them. (I am currently looking for such test or survey).
2. Improvement of a measure that the unit council decides to focus on after the performance improvement education. I will compare their "pre-education" performance around the measure and then their "post-education" performance around the measure.
3. Increase new Shared Governance Council projects, based on PDSA methodology, to 100 percent.

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Evidence-Based Change of Practice Project Checklist*

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

Utilizing Performance Improvement in Shared Governance Structure

Mark an "X" under "Yes" or "No" for each of the following statements:	Yes	No
The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. <u>All</u> participants will receive standard of care.	X	
The project is <u>not</u> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <u>not</u> follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <u>not</u> develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <u>not</u> seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has <u>no</u> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <u>not</u> a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	X	

Answer Key:
- If the answer to <u>all</u> of these items is "Yes", the project can be considered an evidence-based activity that does <u>not</u> meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files.
- If the answer to <u>any</u> of these questions is "No", you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: http://answers.hhs.gov/ohrp/categories/1569

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DNP Statement of Determination

Evidence-Based Change of Practice Project Checklist Outcome

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

Utilizing Performance Improvement in Shared Governance Structure

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). **Student may proceed with implementation.**

☐ This project involves research with human subjects and **must be submitted for IRB approval before project activity can commence.**

Comments:

Student Last Name: Reitter	**Student First Name:** Deborah
CWID Number: 20600479	**Semester/ Year:** Summer 2020
Student Signature: *Deborah Reitter*	**Date:** July 5, 2020
Chairperson Name: Dr. Elena Capella	
Chairperson Signature: *Elena Capella*	**Date:** 07/31/20

DNP SOD Review Committee

Member Name:

11-1-21

DNP SOD Review
Committee
Member Signature:

DNP Statement of Determination
Date:

Appendix S – Project Data Summary

Survey Item	Key: 1 = Not familiar/Lowest rating 2 = Barely familiar/Low rating 3 = Somewhat familiar/Neutral rating 4 = Moderately familiar/Medium-High rating 5 = Very familiar/Highest rating		
Performance Improvement	**Pre-Intervention Assessment (Mean)**	**Post-Intervention Assessment (Mean)**	**Variance**
1. How familiar are you with the IHI "Model for Improvement"?	2.82	4.25	**29%**
2. How familiar are you with SMART goals?	4.0	4.25	**5%**
3. Does your NUC have specific outcome measures related to their projects (yes/no)?	45% yes	92% yes	**47%**
	Key: Yes = Equally shared No = Not equally shared		
Shared Governance	**Pre-Intervention Assessment (Mean)**	**Post-Intervention Assessment (Mean)**	**Variance**
1. In your organization, when developing and evaluating policies, procedures and protocols related to patient care is it equally shared by staff nurses and nursing management?	36% yes	54% yes	**18%**
2. In your organization, when providing for the professional/educational development of nursing staff is it equally shared by staff nurses and nursing management?	18% yes	78% yes	**60%**
3. In your organization, is access to information regarding the unit and nursing departmental goals and objectives for the year equally available to staff nurses and nursing management?	45% yes	62% yes	**17%**
	Key: 1 = Lowest rating 2 = Low rating 3 = Neutral rating 4 = Medium-High rating 5 = Highest rating		
Post Learning Sessions Evaluation	**Post-Intervention Assessment (Mean)**		
1. Was the content of the learning sessions helpful?	4.7		
2. Can your NUC apply the content of these learning sessions in their work?	4.9		
3. Would you recommend these learning sessions to other NUCs?	4.9		