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Establishment of Unit-Based Council Using a Shared Governance Toolkit for Surgical clinics

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This Manuscript Partially Fulfills the Requirements for the

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Abstract

Practice Problem: Shared governance (SG) is an organizational framework that empowers healthcare professionals by granting them authority over their own professional practice. The absence of a unit-based council (UBC) has been identified as an issue that hinders the collaborative decision-making and problem-solving approach.

PICOT: In four surgical clinics requiring a Unit Based Counsel (UBC) structure (P), what is the impact of implementing a Shared Governance (SG) toolkit (I) compared to not implementing an SG toolkit (C) over eight weeks? (T)

Evidence: The existing literature strongly indicates that shared governance (SG) empowers nurses to collaborate as equal partners with nursing leaders within the organization, fostering a collective effort in problem-solving and seeking effective solutions.

Intervention: The Evidence-Based Practice (EBP) change management project encompassed several key steps, including the formation of a unit-based council (UBC) for Shared Governance (SG) through the utilization of an SG toolkit for education. To assess the success of SG, the Index of Professional Nursing Governance (IPNG) was employed to measure relevant elements both before and after the intervention.

Outcome: The EBP change project was clinically significant in establishing a unit-based council (UBC) as part of the Shared Governance (SG) structure. A notable finding was the difference between male and female nurses regarding their perceptions of SG within the UBC. Female nurses reported significantly higher perceptions of shared governance in personnel matters compared to their male counterparts. Interestingly, although not statistically significant, male nurses reported higher perceptions of shared governance in other subscales except for goals.

Conclusion: Shared Governance (SG) is crucial in healthcare organizations as it fosters shared decision-making among nurses. Ultimately, SG serves as the cornerstone for cultivating a culture of clinical and nursing excellence within high-performing healthcare organizations.

Creating a Unit-Based Council Using a Shared Governance Toolkit

Healthcare organizations are experiencing rapid and dramatic changes. The expectations and the demands related to the quality of care have been intensifying. Creating a positive practice environment and cultivating an engaged workforce is more critical than ever. Shared Governance (SG) is a professional model organization that gives nurses who provide direct patient care the independence to make autonomy and decisions that change policies and how they practice (Gallagher-Ford, 2015). Shared Governance promotes quality patient care, evidence-based nursing practice, improved job satisfaction, and retention of nurses (Guanci, 2018). It also provides structure to healthcare professionals, gives them control over their practice, and allows them to use available resources to influence decision-making, leading to quality outcomes (Weaver et al., 2018). Allen et al. (2018) defines employee engagement as "a positive attitude the employee holds towards the organization and its value. An engaged employee knows the business context and collaborates with colleagues to improve job performance for the organization's benefit. The toolkit will help the organization develop and nurture a relationship between employer and employee." Doing so will increase employee engagement and satisfaction in the workplace. Several departments in a veteran hospital in the south started a Unit Based Council (UBC). However, the surgical clinics do not have a UBC council. Establishing a UBC in four surgical units will identify the fundamental concepts of the shared governance model, show the impact and importance of the model to nursing, and help promote a culture of excellence in healthcare.

Significance of the Practice Problem

Nurses make decisions that favor patient care, which improves job satisfaction and retention, and leads to better patient outcomes (Murray et al., 2016). A surgical clinic manager is the lead decision-maker for most administrative actions. Although some managers consider the feedback of their staff, they can have a partial agreement for the staff to make decisions. Shared Governance is a nursing management model that provides clinical nurses control over their professional practice while increasing their influence over the resources that support it. Quek, et al., (2017) indicated that higher levels of distributed leadership predicted increased employee engagement and job satisfaction while lowering turnover intentions (Quek et al., 2017). Essentially, the more nurses feel like their voices are heard, the more they enjoy and appreciate their work environment. Creating a shared governance environment that supported nurses' decision-making involvement also resulted in a new shift model that led to more excellent staff retention and patient satisfaction (Manyang et al., 2020).

Evidence-Based Practice (EBP) project will allow an organization to pursue the Pathway to Excellence certification (Dans et al., 2017). The Pathway to Excellence was created by the American Nurses Credentialing Center's (ANCC) Pathway to Excellence® Program, which provides a framework for making an ideal work environment and ensures an ongoing focus on quality to sustain excellence (Dans et al., 2017). The Pathway standards consider essential elements of positive practice environments and are continually assessed by the Commission on Pathway to Excellence program staff to ensure applicability and attainability in different settings. Pathway organizations foster supportive leadership, inter-professional collaboration, nurse development, and work-life effectiveness.

Successful implementation of an UBC toolkit can improve structural empowerment, increase staff engagement, and increase positive patient outcomes. Several surveys have been developed to evaluate the strength of professional Governance. The most frequently used tool is Hess’ Index of Professional Nursing Governance (INPG) (Hess, 1998; Kyytsönen et al., 2020). The Index of Professional Nursing Governance (INPG) tool measures the extent of

shared Governance within an organization from traditional, shared to self-governance. Hess et al. (2020a) developed an instrument called the Council Health Survey (CHS) to measure the effectiveness of Governance at the council level, in contrast to his previous tool, which evaluated Governance at the organizational level (Hess et al., 2020a). With the INPG toolkit, the surgical clinics will provide a healthy work environment that proves a commitment to establishing and creating a healthy workplace for staff. It will also lead to clinical excellence, including staff satisfaction, patient satisfaction, and improved patient outcomes (Murray et al., 2016).

PICOT Question

In four surgical clinics requiring a Unit Based Counsel (UBC) structure (P), what is the impact of implementing a Shared Governance (SG) toolkit (I) compared to not implementing an SG toolkit (C) over eight weeks? (T) Nurses in the surgical clinics are identified to participate in the problem-solving approach. These nurses take part in patients' care and daily activities. Application of the EBP includes the introduction of an SG toolkit that allowed nurses to set up a UBC. This toolkit consists of the UBC charter, roles and functions of leaders and members of UBC, agenda creation, conduction of meetings, recording minutes and attendance, and sharing the meeting outcome with unit leaders and staff. The project compared four clinics, two with access to the toolkit and the others without the toolkit or information involving the implementation of SG through UBC in the unit. Lack of knowledge of the SG toolkit was one of the most common problems of not establishing a UBC in the unit (Dans et al., 2017). At the end of the project, both units had an established and well-structured model for nurse empowerment and shared decision-making, which could lead to better decision-making.

Theoretical Framework

Evidence-based practice in nursing was a helpful method for combining the best evidence, expertise, and patient values into clinical practice (Fineout-Overholt et al., 2005). Through this process, the quality of care went beyond the standard practice so that excellence

in care could be accomplished. An EBP model increased the organization's adoption of research-supported practices and was reinforced through education (Fineout-Overholt et al., 2005). Socialization of EBPs encouraged nurses to increase the accountability of their professional practices. Nurses developed a sense of personal responsibility through the knowledge and tools used to create change, enabling them to integrate EBPs into the system. This project utilized the Johns Hopkins EBP (JHEBP) framework. The JHEBP model combined the best scientific evidence from the most modern research and integrated it into practice. The JHEBP model was a three-step process that included the practice question, evidence, and translation (PET) (Philbrick, 2012).

The need for a Shared Governance structure in the surgical clinics prompted finding solutions for implementation strategies in establishing a UBC. The Johns Hopkins EBP model formulated the PICOT question to guide this EBP project. It emphasized collecting the best evidence using different search engines and clinical tools to identify research evidence relevant to EBP. Several research tools were accessible to help find high-quality evidence. Evidence-based practice models had been developed to help nurses move evidence into practice. Using these models led to an organized approach to evidence-based practice, prevented incomplete implementation, and maximized time and resources. No evidence-based practice model met the needs of all nursing environments.

Roger’s Diffusion of Innovation Theory

Roger's Diffusion of Innovation Theory was chosen as the change theory for the EBP project. Diffusion of innovation theory was established in 1962 by E.M Rogers and described the trend and speed of spreading new practices, ideas, and products through a population (Dearing & Cox, 2018). The theory aimed to explain why, how, and the rate at which innovative programs evolved in a society (Dearing & Cox, 2018). The five stages of Rodger's Diffusion of Innovation theory were knowledge, persuasion, decision, implementation, and confirmation (Dearing & Cox, 2018). The first step was the transfer of knowledge about UBC. This step exposed the

nurses to using an SG toolkit to help them understand the UBC structure, process, and outcome for surgical clinics. Doing so eased knowledge transfer, increasing the project's chances of success. The second step, the persuasion phase, was used to share the information with the nurses to increase interest and acceptability of the process, utilizing steps to create a UBC with the toolkit. The third step, the decision phase for this project, was based on the need for and importance of implementing SG. Early adopters were nurses who volunteered to help create UBC. The fourth step was the implementation phase, and surgical clinics had to choose to make a UBC with their supervisor's support. The last step, the confirmation phase, involved the establishment of the UBC. The SG toolkit was a new concept for nurses who worked in surgical clinics. To achieve project outcomes, the nurses had to collaborate with the unit's leaders to ensure appropriate support for the best patient, staff, and clinical outcomes (Dearing & Cox, 2018). Through the diffusion of understanding of Roger's change theory, this new idea increased interest among the nurses in creating a UBC. With all the knowledge, tools for practice change, and support from leaders, surgical clinic nurses (on the number of units effectively implemented the UBC and agreed to meet frequently to continue using the intended innovation within their unit.

Evidence Search Strategy

An evidence-search strategy facilitated development and implementation of a new, more efficient standard approach to practice. A literature search focused on establishing a UBC for nurses was conducted to support the PICOT for this project. Databases used to search for articles to support the PICOT are CINAHL Complete, ProQuest Central, PubMed, and DynaMed. Medical subject headings (MeSH) included the UBC toolkit. The application of limiters included advanced searches of articles published from 2010 to 2021, with abstracts available, in English, which reduced the articles yielded to 300, of which 50 that met eligibility for review were selected. Database search terms in adhered Governance and shared decision-

making in nursing through the University of Saint Augustine for Health Sciences Library and Google Scholar resulted in more than 16,000 published articles.

Boolean connectors and keywords such as shared Governance, unit-based councils, and staff engagement were used to help narrow the search to multiple phrases or terms in a single search expression. Those terms were AND, ANY, and NOT. The inclusion criteria considered quantitative and qualitative peer-reviewed articles addressing shared Governance as an intervention to increasing nurses' involvement in decision-making, nurse satisfaction, and nurse autonomy resulting in more specific articles. The exclusion criteria included public Governance, patient-shared decision-making, creating human-caring environments, studies with employee engagement unrelated to nursing turnover and retention, ambulatory and acute care settings, and nurse executives or nurse leaders.

Evidence Search Results

According to research, implementing an evidence-based practice (EBP) model throughout hospital systems could improve patient outcomes and the overall work environment (Speroni et al., 2020). The Johns Hopkins EBP Model's tool was used to measure the strength and quality of the articles (Dang & Dearholt, 2017). Twenty articles were thoroughly evaluated. Seven articles were classified as qualitative studies, and five as quantitative studies. All the evidence was of good grade quality because it was subject-oriented (Ebell et al., 2017). Nine peer-reviewed articles were selected because of their high level and quality grade. These articles showed the most support for the SG structure, shared decision-making, and shared leadership.

Design Level

A PRISMA diagram (Figure 1) was used to summarize evidence search results. The chart shows the flow of information in separate phases of a systematic review. It maps out the number of records identified, included, and excluded and the reasons for exclusions (Moher et al., 2009). The PRISMA literature search diagram showed sixteen thousand articles with

another thirty-seven thousand from other sources. After thorough reading and comparing, eight-four articles were recognized as duplicates. In addition, the articles were screened for terms such as UBC, and SG. During this process, fifty-four articles were considered eligible, and some were excluded. Twenty articles were deemed suitable because of their quantitative and qualitative attributes. These articles were graded as Level I, II, and III, and some were noted as A and B-level quality-grade articles.

The articles selected and kept, along with their description, level of strength, and quality, are shown in Appendix A. Establishing an SG council and its importance to individuals, organizations, and the profession is highly evident in the literature. Identified outcomes of establishing an SG council were staff engagement, empowerment, professional development, and professional autonomy.

Themes with Practice Recommendations

SG positively affects RNs in improving work experiences, nursing practice, and patient outcomes. SG includes the concept of structural empowerment, enabling RNs to feel empowered in shared decision-making (Murray et al., 2016). The themes chosen for implementing SG included a theory-driven approach, the need for facilitators promoting SG attendance, UBC implementation without an SG toolkit, and implementation using the SG toolkit.

Theory-driven Approach to Share Governance

The General Theory for Effective Multilevel Shared Governance (GEMS) was chosen as the theoretical approach to SG. The GEMS theory provides a higher level of nursing empowerment and analyzes how some toolkits foster support between nurses and their leaders. The effectiveness of an SG implementation is beneficial in creating unit-level nursing practice councils using different styles of survey instruments called the Nursing Practice Council Effectiveness Scale (NPCEs) (Joseph & Bogue, 2016). The Nursing Practice Council

Effectiveness Scale (NPCES) can help assess the effectiveness of shared Governance and ways to improve the practice of shared Governance in each setting (Joseph & Bogue, 2016).

Nurse Engagement and Autonomy

Farley et al. (2019) concluded that a unit's employee engagement results improved from 71% (2016) and 78% (2017) after participating in huddles implementation through shared Governance. An integrative review by Pursio and his colleagues revealed that understanding the multidimensional nature of professional autonomy was essential to creating attractive work environments. Empowering nurse participation in decision-making and developing nursing through shared leadership increased retention and satisfaction (Pursio et al., 2021).

Unit-Based Council Implementation

Unit-Based Council Implementation of a UBC should support chairpersons, team members, and nurse managers (Jordan, 2016). The involvement of the Chief Nursing Officer (CNO) and other senior nurse leaders can encourage the implementation of a UBC because it shows trust in their staff and hence encourages the continuity of the UBC (Olender et al., 2020). The Index of Professional Nursing Governance (IPNG) is a decision-making measurement scale used to measure SG before and after implementing the SG model. This scale will be used during the performance of the UBC toolkit. RN-focused Index of Professional Nursing Governance (IPNG) measures the perceptions of Governance of healthcare personnel. Shared Governance is a management innovation that legitimizes staff members' decision-making control over their professional practice while extending their influence on administrative areas previously exclusively controlled by management. When a shared governance model is implemented, a left-to-right shift usually occurs on the governance continuum, allocating more control and influence on staff.

Leadership can use the IPNG tool to identify areas for SG improvement that will make intervening and changing nurses' units easy (Dechairo-Marino et al., 2018). Lamoureux et al.

(2014) reported high reliability for each of the six sub-scale scores for IPNG (Cronbach alphas of 0.94 and higher). The validity of the IPNG was supported by linking the IPNG score with job enjoyment ($r = 0.437$, $p = 0.002$) and the desire to recommend the hospital as a place of employment ($r = 0.442$, $p = 0.001$).

Professional Governance Scale (IPNG) Survey

The concept of Shared Governance (SG) is a model of professional nursing governance that emphasizes collaboration, partnership, and shared decision-making between nurses and management/administration in healthcare organizations. In this model, nurses have input into decision-making processes that affect their work environment, such as staffing, scheduling, and resource allocation. Robert G. Hess Jr. (1998) developed the Index of Professional Nursing Governance (IPNG) to assess the extent of shared Governance (SG) within healthcare organizations (Hess, 1998). The IPNG measures the perceptions of nursing professional Governance using a 5-point Likert scale ranging from 1 "traditional governance," 2 "traditional SG, 3 "SG," 4 "shared self-governance," to 5 "self-governance using a 5-point Likert scale, with higher scores indicating greater levels of self-governance. The IPNG encompasses six subscales, including control over nursing practice, resources, personnel, participation in Governance, access to information, and conflict and goal management. The IPNG is widely used to evaluate SG and identify areas for improvement (Dechairo-Marino et al., 2018; Di Fiore et al., 2018; Weaver et al., 2018). Hess recommended using the IPNG to identify deficits in Governance and develop recommendations to support UBC. While the personnel subscale was viewed initially as critical, recent studies suggest that it may not be as vital to the success of PG implementation as initially thought. To address concerns about the length of the original IPNG, a shorter version with 50 questions, IPNG 3.0, was developed in 2017 (Dechairo-Marino et al., 2018; Lamoureux et al., 2014). Even though there are changes in terminology, the term SG continues to be used in reference to the IPNG's findings, given its focus on detecting SG within

healthcare organizations. Using an SG toolkit to measure the effectiveness of a UBC is essential for leaders and nurses to effectively implement SG (Hess et al., 2020).

The development of a UBC as part of the SG model required leaders to give the nursing staff the autonomy to make decisions and to accept responsibility (Meyers & Costanzo, 2015). Using an SG in the nursing practice environment can drastically enhance the professional practice environment of nurses (Kanninen et al., 2019). A structured toolkit helped guide, shape, and give the UBC purpose (Capitulo & Olender, 2019). Finding the proper structure for the SG council promotes clinical excellence (Moreno et al., 2018). Ultimately, the SG toolkit benefited nurses as it helped increase their participation in decision-making and their ability to practice within a high level of autonomy. Also, a staff-driven approach improved performance improvement. The participant received the toolkit during the second UBC meeting. The nursing staff anonymously completed the survey.

A 5-point Likert scale allowed participants to express how much they agree or disagree with a particular statement. In addition, the Likert Scale ensured that participants did not simply answer yes/or no to the questions but allowed them to voice their opinion and even no opinion. The 5-point Likert scale ranged from “nursing management/administration only” to “equally shared by clinical RNs and nursing management/administration” to “clinical RNs only” (Weaver et al., 2018). The items below were the main topic of discussion in the survey.

1. **Personnel** – who controls personnel and related structures.
2. **Information –** who has access to information relevant to governance activities.
3. **Resources** – who influences resources that support professional practice.
4. **Participation** – who creates and participates in committee structures related to governance activities.
5. **Practice** – who controls professional practice; and
6. **Goals** – who sets goals and negotiates conflict resolution at various organizational levels. (See Appendix E).

UBC Toolkit Development

IPNG is a reliable and valid tool to measure nursing governance. According to Weaver et al. (2018), IPNG measured different types of Governance, such as nursing governance, traditional Governance, shared Governance, and self-governance. The IPNG comprises six professional governance sub-scales: personnel, information, resources, participation, practice, and goals. The INPG has been assessed for validity by a review panel of 14 content experts. The Mean Individual Content Validity Index (I-CVI) score was used to measure the interrater reliability agreement of the review panel. The relevancy means I-CVI of the final 45 items ranged from .79 to 1.00 for each of the six domains (Weston et al., 2018).

Key Demographics

Demographics were collected on all nurses who were surveyed using the IPNG. This included leadership level within the surgical clinics, Unit-Based council member or non-council member status, length of time as a nurse, national nursing certification status, level of education, and age. A descriptive analysis of the age, sex, years of experience, education, and RN certification of the participants was also collected. The levels of education and leadership level were assessed as ordinal variables (associate degree, bachelor's degree, and Master's degree or higher; clinical nurse, charge nurse, supervisor/manager, and director). The length of time in the organization was assessed as a dichotomous variable, less than or equal to five years or greater than five years. The length of time as a nurse and age were assessed as interval variables (0-2 years, 3-5 years, 5-10 years, > ten years; 20-30 years, 31-40 years, 41-50 years, >50 years).

Part I – Controls

Part one of the IPNG tools, focused on the administration’s role in the units. Nurses could choose their answer in the list below using the Likert scale Who determines levels of

qualifications for nursing positions, activities of ancillary nursing personnel (assistants, technicians, secretaries), who conduct disciplinary action against nursing personnel, and also assesses and provides for the nursing staff's professional/educational development. Lastly, who is responsible for Selecting products used in nursing care and determining nursing care delivery models (e.g., primary, team)?

Part II – Influences

Part two follows the same pattern of questions on who influences daily patient care assignments for nursing personnel, regulation of patient flow for admissions, transfers, and discharges, formulating annual unit budgets for personnel, supplies, equipment, and education, recommendation on nursing salaries raises and benefits, Consulting and enlisting the support of nursing services outside of the unit (e.g., clinical experts such as psychiatric or wound care specialists, diabetic educators), consulting and enlisting the support of services outside of nursing (e.g., dietary, social service, pharmacy, human resources, finance), and creating new clinical positions and new administrative or support positions.

Part III – Official Authority

The nurses selected the group that makes the most decisions in several categories, such as nurses' credentialing levels, organizational charts that show job titles and who reports to whom in writing guidelines for disciplining nursing personnel, procedures for hiring and transferring nursing personnel, policies regulating the promotion of nursing personnel to management and leadership positions, procedures for determining daily patient care assignments, daily methods for monitoring and obtaining supplies for nursing care and support functions, procedures for controlling the flow of patient admissions, transfers, and discharges process for recommending and formulating annual unit budgets for personnel, supplies, major equipment, and education. Furthermore, the nurses can choose who they think is in charge of procedures for adjusting nursing salaries, raises, and benefits and whom to contact to recruit

support for nursing and support services outside the unit (e.g., clinical experts such as psychiatric or wound care specialists, and diabetic educators).

Part IV – Participations

The question in part three covers administrative/staff participation in activities such as nursing unit and departmental administration matters for staffing and budgeting. In addition, which part of the administration participates in the Interprofessional committee for collaboration practices, forming a new unit, departmental, interprofessional, and administration committees for the organization.

Part V - Access to information

Part five focuses administrative access to information on compliance of nursing practice with requirements of surveying agencies (The Joint Commission, state, and federal government, professional groups and other regulatory groups), unit and nursing departmental goals and objectives for the year, organization's strategic plans for the next few years, results of patient, physicians and nursing satisfaction surveys, current status of nurse turnover and vacancies in the organization, nurses' satisfaction with their salaries and benefits to name a few.

Part VI – Ability

Part six focuses on identifying who has the ability to negotiate solutions to conflicts among professional nurses, conflict solutions between professional nurses and physicians, conflict solutions between professional nurses and other healthcare services (respiratory, dietary), conflict solutions between professional nurses and nursing management and conflict solutions between professional nurses and the organization's administration.

Practice Recommendations

Based on the literature that answers the PICOT question: In four surgical clinics requiring a Unit Based Counsel (UBC) structure (P), what is the impact of implementing a Shared Governance (SG) toolkit (I) compared to not implementing an SG toolkit (C) over eight weeks? (T) A unit-based council is a structure for shared Governance that promotes shared

decision-making. Implementing an SG toolkit that meets the clinical pathway to Excellence program requirement in the adult acute care unit lacking a UBC structure will create a new UBC structure for shared decision-making. This process leads to shared leadership.

Settings, Stakeholders, and Systems Change

Settings

The evidence-based project occurred in the four surgical clinics in a Veteran hospital in Northeast Georgia and Western South Carolina. The surgical clinics provide various medical services for patients throughout Georgia and South Carolina. The four clinics are orthopedic urology, plastics, and general surgery. The surgical patients were seen for pre- and post-surgical procedures.

Organization Mission

The organization's mission is “To care for him who shall have borne the battle, and for his widow, and his orphan” by serving and honoring the men and women who are America’s veterans (Veterans Affairs, 2005). The organizational structure is comprised of the Associate Director of Patient Care Services, the Nursing Chief Nursing of the clinics, and the Chief Financial Officer. The project aimed to help nurses and patients with autonomy and shared decision-making abilities to better meet the organizational goals and objectives.

Stakeholders and Organizational Support

Establishing an SG through UBCs is an approach that promotes collaboration, shared decision-making, and accountability (Dans et al., 2017). The stakeholders involved were the Nursing Chief of the surgery clinics, the clinic nurse manager, and the unit nursing staff. The surgical clinics were selected because they were fully staffed. However, busy shift work and a need for nurse engagement and participation in the unit and organizational activities were noted. There was a need for increased Staff participation when it came to decision-making. The lack of staff decision input resulted in high staff turnover and low participation in the clinics' improvement projects. The charge nurse and the nurse manager associate the lack of nurses'

involvement with decreasing patient outcomes and nursing satisfaction due to the lack of a UBC in the unit.

System Change

A SWOT analysis was completed to identify the project's strengths, weaknesses, external opportunities, and threats. The strength of support included the hospital administrator, supportive leaders, experienced nurses, and adequate resources. The EB project created new protocols and policies of shared Governance to strengthen the concepts of professional governance partnerships, equity, ownership, accountability, incentives for committee participation, and nursing career advancement. The project produced nurses ready to challenge the process creating innovative solutions for existing problems, bringing others to share in the vision of new and better possibilities, inspiring others to act, and taking an active role in change as transformational leaders (Browder et al., 2019). The weaknesses were poor staff engagement, lack of autonomy in practice, decreased patient outcomes, and high turnover. The organization is in a competitive nursing market surrounded by three large hospitals and many clinics, resulting in a significant recruitment and retention problem since a large pool of hospitals all vie for the same limited pool of nurses. (Table 1)

Implementation Plan with Timeline and Budget

Project Outline

The implementation of the EBP project consisted of establishing a UBC for SG following a schedule (Appendix B), using an SG toolkit (Appendix E) for education, and identifying a core group to manage the UBC. The EB project manager (PM) approached the RNs in the clinics selected for the EBP project. A pre-project survey was implemented using the IPNG to measure the demographic, level of education, work schedule, clinic role, and satisfaction level (Appendix E). The IPNG scale assessed staff opinions related to decisions made in their unit. The QI project manager obtained written permission from the SG forum to use the IPNG. Nurses who decided to participate in the project were informed of the significance of SG by participating in a

UBC. The information was shared using a simple SG toolkit to help them understand UBC's structure, process, and outcomes.

Next, interested staff chose to create the UBC. The unit manager and the surgical clinic nurses involved in the decision-making voted to identify a chair, vice-chair, secretary, and member roles.

Once the UBC was formed, the project manager scheduled the first Meeting with the other members through Google Teams. During this Meeting, the team members introduced themselves and the goal of the Meeting. Also, information on SG and tools for the practice change was given. In addition, meetings were conducted on a bi-monthly basis meeting.

The post-survey had the same challenges as mentioned above. One issue that may arise is that some team members will not be present during the Meeting because of staff days off and/ or the workload of the clinics, which will prevent staff from participating in the pre-SG survey. Snacks for the members of the UBC were left on the unit every meeting day. The project manager had eight weeks to ensure maximum participation. The post-intervention survey was performed using the IPNG tool and distributed after the second UBC meeting.

Project Objectives

1) At least 50% of the nurses in the surgical clinics will complete the pre-implementation survey using the IPNG scale.

2) At least 50% of the nurses in the surgical clinics will demonstrate knowledge of the SG toolkit by the end of the second week of the project.

3) At least 50% of the nurses in the surgical clinics will be educated on the importance of UBC.

4) The unit will have an established UBC with critical members to conduct the first Meeting using the SG tool kit by week six.

5) The UBC team members will create a UBC board displaying activities recognizing active participants by week thirteen's end.

6) At least 50% of the nurses will complete the post-implementation survey using the IPNG scale by the end of the second Meeting that will be held.

Activities and Timeline

I. Week 1 - 2: A meeting was held with the EB project's unit manager and nurses in the surgical clinics. The nurses were asked to complete a pre-implementation survey using the IPNG scale via Survey Monkey shared through email. The surgical toolkit was shared with the nurses.

II. Week 3: Identify nurses selected for the UBC and give them an explanation of their role, Distributed the UBC toolkit in the second Meeting and educated the members on how to use the toolkit to build a strong UBC.

III. Week 4-5: The UBC leader kept meeting minutes and shared them with the rest of the nurses in the unit. The Champion developed and displayed a UBC information board in the unit.

IV. Week 5-8: The UBC leader prepared for the second UBC twice-a-month meeting. Nurses in the unit completed the post-implementation survey using the IPNG scale.

Resources and Budget

Resources required for the project included stationery items, a display board to showcase the UBC activities, snacks for the inaugural meeting, and snacks for the bi-monthly meetings. Funds from the project managers and preceptors initially supported the project, but it was hoped that the administration would budget money for UBCs. The project included the project manager's salary and staff participation time, which were budgeted under salary and benefits (Table 2).

Implementation

The implementation of this EBP change project achieved the goal of establishing a unit-based SG structure. The inclusion criteria for the participants in this EB project were the nurses

in the surgical clinics. The excluded participants were nurses not part of the surgical clinics. The goal was to measure how nurses felt about UBC implementation.

The surgical clinic's Chief nursing officer was aware of the need for the approval of the facility to conduct the EBP. An Institutional Review Board (IRB) approval of this EBP project was needed from the organization. An expedited review was requested concerning the IRB decision. The University of Saint Augustine Health Science's Evidence-Based Practice Review Council also reviewed the project verification for approval processes.

There was one project champion from UBC to promote the survey. The pre-and post-implementation surveys were collected from the nurses using the IPNG tool. The first section of the tool consisted of demographic data. The data was collected using paper surveys from all four clinics. The champion nurse collected the surveys and turned them to the project manager who locked them in her office. The completed surveys were placed in a sealed envelope for the Project manager to maintain the reliability of the data collection process. Participants were ensured confidentiality and anonymity of their responses. Pre-implementation surveys took place before the UBC was established. Post-implementation surveys also took place after the second UBC meeting. The UBC conducted monthly meetings independently of the project manager once a month for two months. The IPNG tool given at the end of the two months was surveyed by the nurses' perceived effectiveness of the UBC in influencing SG in their work units.

Statistical Analysis

Intellectus Statistics (2021) was used to conduct statistical analyses and evaluate the data. Demographic data from the IPNG tool included gender, age, education, years of experience, relationship, and expertise. Descriptive statistics were used to characterize the sample, including means and standard deviations for continuous variables and percentages and frequencies for categorical variables. A student’s t-test was used to determine if a statistically significant difference (p= < 0.05) existed between the dichotomous participants’ characteristics,

the length of time in practice, and the SG scores. Correlational analyses were performed to analyze the relationships between the strength of Governance and nurse engagement. A two-tailed independent samples t-test will examine the nursing staff's perception of shared decision-making in the unit. 24 surveys out of 40 were completed and returned in the pre - and post-implementation survey to the project manager, which made the response rates higher than fifty percent.

Ethical Considerations

The University of St. Augustine for Health Sciences Doctor of Nursing Practice Evidence-Based Practice Review Council (EPRC) reviewed and approved the project. The project was determined not to meet the requirements for research as defined in the Federal Register. (Appendix G). The project facility (Appendix H) and the surgical clinic manager (Appendix I) granted approval for project implementation. The confidentiality of participants was maintained as all data collected from the surveys was unanimous. The surgical clinics and the UBC council members also gathered data. The project facility's project leader, an employee, performed data extraction. Data was entered on Excel spreadsheets and in Intellectus Software. The computer was always in possession of the project leader, with only the project leader having access. Authorizations for the survey for this project were obtained from the author (Appendix F).

Results

This EBP project was based on six aims described in previous paragraphs. This project aimed to require a Unit Based Counsel (UBC) structure by implementing a Shared Governance (SG) toolkit. Of the forty nurses who received the INPG toolkit, 25 responded (62.5%). All 24 surveys were completed and included in the analysis—the response rate for the demographic characteristics (Table 3). The participants who completed the survey were used to compute the project results. Of note, there were different participants in the pre and post survey.

The surgical units represented the most significant groups who completed the survey, as this was the cohort with the highest number of respondents from all the units. Most of the survey participants held a college degree. 41.6 percent of the participants held a bachelor's degree, 33.3 percent held a master's degree, and 8.3 percent held an associate degree. Less than 12 percent held a diploma (LPN) (Table 3). These findings are reflective of the population from which the sample was drawn. Many of the respondents were employed as RNs for five years or more (70.5 percent). Most respondents (90.5 percent) were 31 or older and reported significantly higher perceptions of shared Governance than younger nurses. Younger nurses tended to report lower perceptions of overall shared Governance. Specifically, nurses who have practiced for less than five years reported significantly lower perceptions of overall shared Governance than nurses who have practiced for 10 to 25 years. Nurses practicing for over 26 years reported greater perceptions of shared Governance (see Table 4).

There was a significant difference between males and females in the surgery clinic when it pertained to UBC. Females reported significantly higher perceptions of shared governance in personnel matters than male nurses. Although not reaching statistical significance, male nurses reported a higher perception of shared governance in all other subscales.

Descriptive statistics were utilized to examine the demographic data related to the impact of personal and work-related nurse characteristics on the IPNG scores. Separate analyses were conducted for the pre-intervention and post-intervention data, as presented in Table 3 and Table 4. Both sets of respondents, prior to and after the intervention, expressed high levels of satisfaction with the organization, scoring 4.11 and 4.23 out of 5 on the Likert scale. The IPNG scale and subscale scores were employed, along with two-tailed independent samples t-tests, to determine the Shared Governance level. The respondents' perception indicated a traditional governance approach, where professional governance decisions were primarily made by nursing management/administration alone. However, in terms of the practice

and goals dimensions, the respondents perceived a higher degree of shared governance, meaning that decision-making was equally shared between clinical RNs and nursing management or administration (Table 5). A student's t-test was used to determine if a statistically significant difference ($p = < 0.05$) existed between the dichotomous participants' characteristics, the length of time in practice, and the SG scores (Table 6). The two-tailed paired samples t-test result was significant based on an alpha value of .05, $t(23) = -4.49$, $p < .001$, indicating the null hypothesis can be rejected. This finding suggests that the difference in the mean for each of the subscales of the IPNG was significantly different from zero.

According to Dechairo-Marino et al. (2018), it typically takes 2 to 5 years, or even longer, for staff to observe a tangible shift from perceiving a traditional governance model to embracing a Shared Governance (SG) environment for shared decision-making. The results of the two-tailed independent samples t-test conducted for this project did yield significant findings, considering the alpha value of .05, across all six subscales (refer to Table 6). This outcome was expected due to the small sample size and the short 10-week testing period utilized for the Evidence-Based Practice (EBP) change project. The ability to employ a paired t-test might have influenced the results. This EBP change project held clinical significance as it facilitated the establishment of a SG structure within the unit, in the form of Unit-Based Council, fostering shared decision-making regarding the professional governance aspects of SG. Both the staff and management members collectively benefited from the implementation of this intervention model to practice SG, leading to improvements in outcomes related to safety, quality, patient satisfaction, and staff satisfaction. The project allowed nurses to become more autonomous while creating a positive work environment (Wei et al., 2018).

Impact

The Evidence-Based Practice (EBP) project was conducted in four surgical clinics, with the formation of a Unit-Based Council (UBC) being the most noteworthy outcome. This marked the first time such a council was established in the clinics, enabling the identification of practice

issues through shared decision-making and a problem-solving approach. Both staff and management members reaped the benefits of Shared Governance (SG), leading to improvements in safety, quality, overall patient satisfaction, and staff satisfaction.

For the UBC, staff nurses were selected as champions, while experienced nurses who were engaged, respected, and displayed an interest in enhancing their unit became members. The implementation of the UBC resulted in an increase in staff engagement and satisfaction, as reported verbally by the nurses in the unit. This impact was significant for the organization as a whole. The nurses expressed their happiness with the project, as it guided them in initiating a UBC and collaborating with managers to enhance nursing practice and patient care. It also helped the manager of the surgery clinic recognize the need for further collaboration with nurses.

To ensure the ongoing success of the committee, the SG champions will continue to actively participate in meetings, providing ongoing education, tools, and assistance to new members as required. Additionally, regular monthly touchpoints will be established between the coach and the UBC chair to document the committee's decisions and improvements over the initial 12-month period. These documented outcomes will be reported to both the nurse executive and the Shared Governance Committee. Moreover, the SG coach will play a crucial role in facilitating the recognition of the UBC staff, manager, and collaborators for their significant achievements. Recognition efforts will be tailored appropriately to acknowledge and appreciate their contributions to the committee's accomplishments. By implementing these strategies, the committee can sustain its achievements by ensuring continuous support, knowledge sharing, and reporting. The emphasis on recognition further enhances motivation and fosters a positive and collaborative environment.

Limitations

The data collection process presented challenges, as the staff had to submit their paper surveys, and some nurses chose not to complete them. Furthermore, the approval for the facility

took longer than expected. Additionally, the nurses' busy schedules due to fully booked clinics posed difficulties in their attendance at meetings. It is important to note that the duration of data collection significantly affects the measurement of outcomes (Feely et al., 2020).

The nurses needed to comprehend the significance of their role in the project's success, as evidenced by their hesitation in suggesting ideas for change. While there were some minor changes in the implementation survey results, the response rate exceeded expectations. However, a limitation of the results was the inability to distinguish between the scores of nurse leaders and staff nurses. Since the survey was anonymous, the project manager required assistance in determining the manager's response to the IPNG. This limitation is compounded by the fact that only nurses from the four surgery clinics were included in the sample. Currently, the IPNG focuses on the perception of shared governance among patient care nurses, but it is important to recognize that they are not the sole point of care providers. Therefore, this study can only contribute to the usability of the IPNG in nursing, and the perceptions of shared governance among other healthcare professionals could have been considered.

To ensure future success, it is recommended to implement an ongoing evaluation conducted by the clinic manager to monitor upcoming UBC meetings and ensure that the staff receives the necessary support and resources. Furthermore, the participants will be requested to complete both the pre- and post-intervention IPNG surveys. A paired t-test will be employed for statistical analysis of the data. It would be beneficial to establish a means of differentiating between nurse leaders and staff nurses in order to facilitate the identification of these specific groups during result analysis. Additionally, it is important to broaden the scope of nurse surveys beyond surgery clinics to include other clinic types. This will enable a comprehensive assessment of the VA hospital's entire nurse workforce, determining whether the current findings accurately represent their perspectives on shared governance or if variations in clinical environments influence their outlook.

Dissemination Plan

The EBP project results were shared with the unit staff in the surgical clinics, Ambulatory Surgery clinic (ASC), and PACU. The project was presented orally to the nursing staff during their huddle time of fifteen minutes. The staff were intrigued about the project and asked a few questions on how to create their own UBC council in ASC and PACU. The complete report was sent to the unit manager and the preceptor. The project manager was available for questions via email or phone call. The information was also shared internally within the facility via a PowerPoint presentation to the Chief Nurse Executive, the clinic's nurse manager. The result was also reported in the newsletter for the surgical clinics. In addition, this presentation will be shared internally within the organization and externally to the University of St. Augustine for Health Sciences (USAHS) institutional repository called SOAR (Scholar Works Open Access Repository). l poster including EBP interventions, methodology, results, and practice recommendations was presented on the SharePoint of the organization's website. However, It has not been approved by the nursing administration.

The project manuscript will be submitted for publishing through the USAHS-organized event for an oral poster presentation. The abstract for both the poster and a podium presentation will be submitted to the American Organization of Nurse Leaders for regional and national conferences. Project dissemination will also be completed through the university's Sigma Theta Tau Chapter Alpha, Alpha, Alpha meeting.

Conclusion

Shared Governance is an essential component of nursing practice. Many findings prove that SG increases staff engagement and the need to be heard in sharing decision-making in the four surgical units and overall patient clinical outcomes. The clinical pathway of excellence, which certifies nursing and clinical excellence, highlights the significance of shared decision-making through Share Governance. Using the JHEBP Model's synthesis process and recommendation tool, evidence was collected to support the implementation of an SG toolkit that helps connect knowledge for the acute care nurse staff in the surgical clinics to create their

own UBC. The UBC for this project was led by nurses determined to analyze patient and staff-related matters and bring forth reasonable solutions and recommendations.

The EBP project successfully established SG through a UBC using a shared governance toolkit. Implementation of the project was completed in several steps. The project used the IPNG scale – an SG measurement tool to establish a UBC in surgical clinics tool pre- and post-intervention. Analysis of the data was done using Intellectus Statistics software. The project results were significant as the UBCs grew within the surgical clinic. The project allowed nurses to become more autonomous while creating a positive work environment (Wei et al., 2018). The project outcomes were collected and shared with stakeholders within the hospital and through professional events. Nurses will use the survey as a guide to increase nurse decision-making within their clinics. Our healthcare is complex and needs Shared Governance which supports decision-making that promotes safety, quality, and patient and staff satisfaction.

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Table 1 - SWOT Analysis

Strength	Weakness	Opportunities	Threats
Significant support from the Assistant Director chief and Chief Nursing Clinics	Poor staff engagement No UBC council	Clinical Pathway to Excellence recognition Incentives available for committee participation	Nurses Shortage Lower Retention High Turnover
Experience and expert nursing staff	Low to no participation of the nursing staff and meetings and committees.	Nursing career advancement opportunities	Competitive nursing Markets

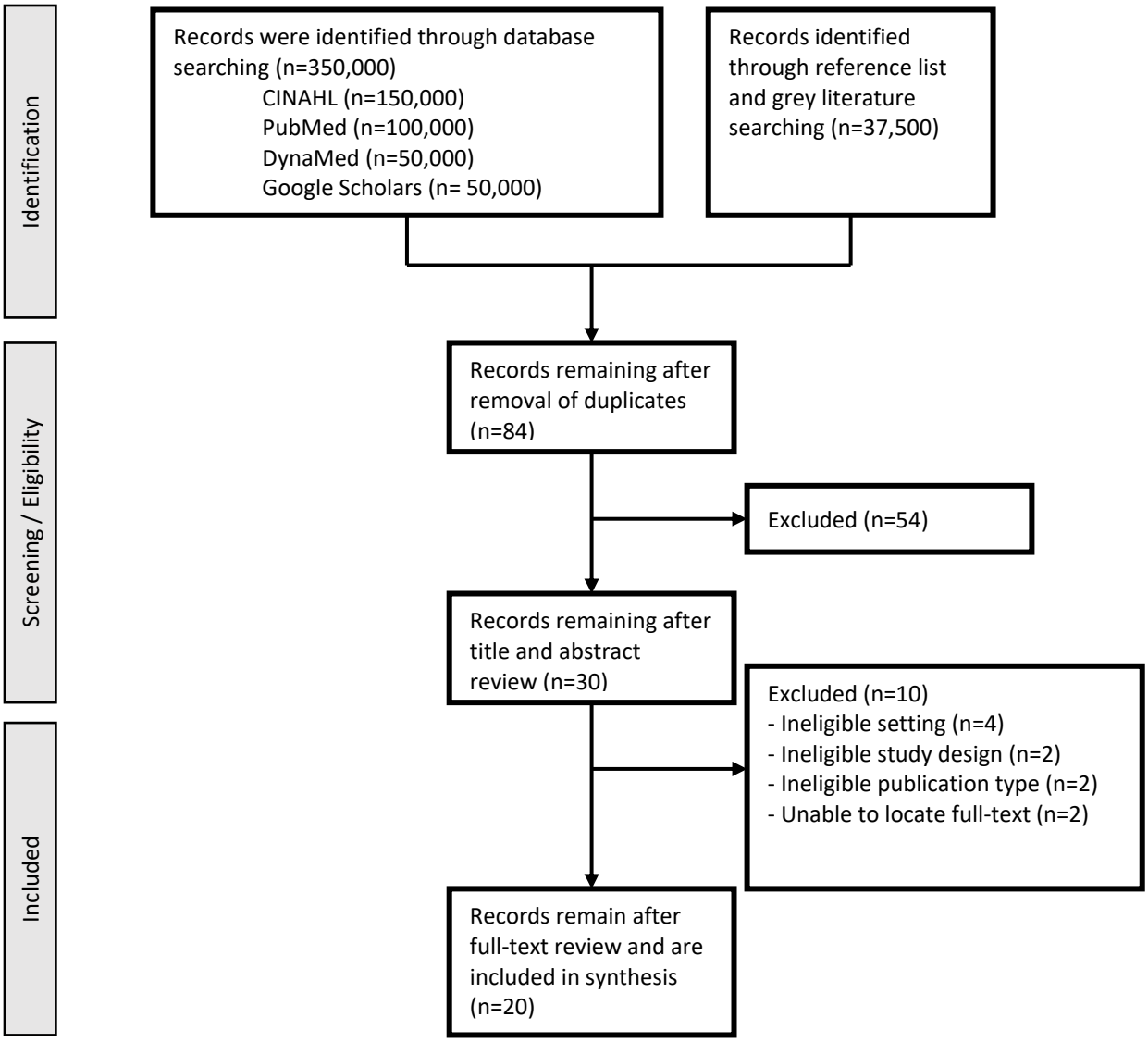
Table 2

Implementation of EBP Project Budget

Expenses		Revenue	
		Billing	
Project team nurses	$ 200.00	Preceptor gifts	$ 50.00
Supplies	$ 60.00		0
Snack	$ 150.00		
Estimate Total Expenses	$ 410.00	Estimate Total Revenue	$50.00
Net Balance			$470.0

Note: All budget entries are estimates. Expenses are based on means. Revenue estimates do not include potential cost avoidance due to realized outcomes. All costs associated with salary and benefits, patient care supplies, and overhead are fixed indirect expenses unrelated to this project. Project costs are nominal for printing and laminating, under $100.

Prisma Literature Flowchart



Note. Adapted from Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLOS Medicine,* 6(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Table 3

Pre- and Post-intervention Demographic Data of Respondents

Variable	Pre-intervention	Post-intervention
Sex		
Female	16 (66.7%)	16 (66.7%)
Male	8 (33.3%)	8 (33.3%)
Missing	0 (0.00%)	0 (0.00%)
Total	**24 (100.00%)**	**24 (100.00%)**
Educational Degree		
Associate Degree	3 (8.3%)	2 (11.11%)
Master's Degree	3 (29.2%)	4 (22.22%)
Baccalaureate Degree	13 (41.7%)	13 (41.7%)
Diploma	3(12.5%)	3 (12.5%)
Other Degrees (MS, MHA)	2 (8.3%)	2 (8.3%)
Missing	0 (0.00%)	0 (0.00%)
Total	**24 (100.00%)**	**24 (100.00%)**
Employment Status		
Full-time, 36-40 hours per week	24 (100.00%)	24 (100.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	**24 (100.00%)**	**24 (100.00%)**
Title		
RN	21(87.5%)	21 (87.5%)
LPN	3 (12.5%)	3 (12.5%)
Missing	0 (0.00%)	0 (0.00%)
Total	**24 (100.00%)**	**24 (100.00%)**

Table 4

Pre- and Post-intervention Age and Professional Experience Data of Respondents

Variable	*M*	*SD*	*n*	Min	Max
Age					
Pretest	45.42	10.32	24	32.00	59.00
Posttest	13.04	3.69	24	28.00	63.00
Years Practicing					
Pretest	14.06	6.46	24	4.00	18.00
Posttest	14.97	10.14	24	3.50	20.00
Years in Organization					
Pretest	6.92	5.24	24	0.50	15.00
Posttest	6.33	6.05	24	0.50	30.00
Years in Position					
Pretest	8.64	5.47	24	0.50	20.00
Posttest	7.75	7.33	24	0.50	40.00
Overall Satisfaction					
Pretest	4.11	0.62	24	3.00	5.00
Posttest	4.23	0.68	24	3.00	5.00

Table 5

Pre- and Post-intervention IPNG scores

Variable	Pre-intervention	Post-intervention
Personnel Governance		
Traditional	15 (62.5%)	17 (70.8%)
Shared	9 (37.5%)	7 (29.2%)
Missing	0 (0.00%)	0 (0.00%)
Total	24(100.00%)	24 (100.00%)
Information Governance		
Traditional	11 (45.8%)	12 (50.00%)
Shared	13 (54.2%)	12 (50.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	24 (100.00%)	18 (100.00%)
Resources Governance		
Traditional	12 (50.00%)	8 (33.3%)
Shared	12 (50.00%)	16 (66.7%)
Missing	0 (0.00%)	0 (0.00%)
Total	24 (100.00%)	24 (100.00%)
Participation Governance		
Traditional	9 (37.5%)	14 (58.3%)
Shared	15 (64.5%)	10 (41.7%)
Missing	0 (0.00%)	0 (0.00%)
Total	24 (100.00%)	24 (100.00%)
Practice Governance		
Traditional	14 (58.3%)	15 (62.5%)
Shared	10 (41.7%)	9(37.5%
Missing	0 (0.00%)	0 (0.00%)
Total	24 (100.00%)	24 (100.00%)
Goals Governance		
Traditional	13 (54.2%)	2 (50.00%)
Shared	11 (45.8%)	22 (50.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	24 (100.00%)	18 (100.00%)

Table 6

Two-Tailed Independent Samples t-Test for Six Sub-scales by Testing Period

	Pre-intervention		Post-intervention				
Variable	*M*	*SD*	*M*	*SD*	*t*	*p*	*d*
Personnel Score	14.54	3.32	17.17	4.78	3.04	.006	0.62
Information Score	13.04	3.69	17.17	4.78	3.87	.001	0.79
Resources Score	14.54	3.32	13.04	3.69	1.72	.102	0.35
Participation Score	9.00	4.20	14.70	5.14	4.49	.001	0.92
Practice Score	14.71	5.14	17.17	4.78	1.76	.091	0.36
Goals Score	14.32	3.45	14.70	5.14	2.04	.006	0.65

Note. N = 24. Degrees of Freedom for the *t*-statistic = 23. *d* represents Cohen's *d.*

Appendix A

Citation	**Design, Level** **Quality Grade**	**Sample** **Sample size**	**Intervention** **Comparison**	**Theoretical Foundation**	**Outcome Definition**	**Usefulness** **Results** **Key Findings**
Cai et al., 2021	Descriptive Comparative Design, survey methodology Level II Quality Grade B	N- 511	SG participation and attendance survey	N/A	SG participants more satisfied with nursing career	Clinical nurses active and participate in decision-making
Capitulo & Olender, (2019).	Descriptive Level III Quality Grade B	N/A	Creation of interprofessional councils	Watson's theory of human caring and appreciative	Staff engagement and empowerment	Creations of interprofessional councils and staff engagement and empowerment

Hess et al., 2020	4-phase experimental Level II Quality Grade A	N – 93	Index for professional governance and Index for professional nursing governance	Donabedian's Structure Process and outcome	Implementation of a new tool for Shared Governance	Effective SG unit councils that result in high-reliability, quality improvement, professional competence, and leadership
Joseph & Bogue, 2016	Experimental, quantitative study, Systematic Review Quality Level 1 Grade A	N – 175	Implementation of unit level nursing practice councils	Lipsey's Implementation Theory Method to formalize a general effectiveness model of nursing SG, GEMS	Nurse Retention Needed Resources	Survey instrument – Nursing Practice Council Effectiveness Scale A first theory-driven approach to SG
Jordan, (2016).	Nonexperimental, Quality Level III	N/A	Designed unit. Practice councils	N/A	Nurse satisfaction	Improved nurse satisfaction, decision-making, and autonomy

	Quality Grade B					

Legend: GEMS-General Theory for Effective Multilevel SG; IPNG – Index of Professional Nursing Governance

Appendix B

Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/ Recommendation/ Implications
Qualitative descriptive study Quality Level III Grade B	N – 12	Semi-structured interviews	N/A	Nurse engagement Development of nurse's career	SG contributes to the quality of care, harmonizes nursing practices, and informs decision-making.	SG improves patient care and promotes nurses' autonomy.
Qualitative study Level III Quality Grade A	Numerous stakeholders	SG implementation	Empowerment theory	Implementation of SG structure a clinic in the hospital	Shared decision-making between staff and administration	Shared decision-making between staff and administration
LEAN methodology Qualitative study Level III Quality Grade B	N/A	Shared Leadership Council	N/A	Creation of a new Shared Governance structure	Shared leadership, shared decision-making, succession planning.	Shared leadership, shared decision-making, succession planning.

Legend: GEMS-General Theory for Effective Multilevel SG; IPNG – Index of Professional Nursing Governance

Appendix C

Project Schedule

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor	X																							
Prepare project proposal		X																						
Meet with the unit manager.		. X																						
Identify RNs and interprofessional team members with specific roles to be part of the UBC.			X																					
Education and sharing of the toolkit with UBC members										X														
Implementation of the first UBC inaugural meeting in the unit																X								
Develop a UBC information board to display																				X				
UBC leaders prepare for second meeting using SG toolkit Nurse manager and UBC leader led the meeting													X			X								
Nurse manager led meeting with														X										

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
UBC leaders for sharing UBC experience and documentations																								
RNs to complete post-implementation survey using the IPNG scale																X								
Evaluation of effect of implementation of SG toolkit and UBC														X	X	X	X							
Completion of Evaluation and compilation of results as needed																		X						
Review of project results, dissemination of results, internally to unit meetings and hospital leadership, externally submitting abstracts to professional organizations at local, regional, and national level																			X	X	X	X	X	X
Completion of SG																			X	X	X	X	X	X

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
establishment project																								

Appendix D

SG Toolkit for UBC

CHARTER: Unit Based Council (UBC)

General Purposes:

The Unit Based Council (UBC), as part of the SG structure, uses the process of shared decision-making, thus empowering nurses and interprofessional partners to convene with each other, working toward making clinical and operational decisions affecting the delivery of patient care, outcomes, clinical work environment, and nurse/staff engagement within the unit.

Membership:

- Representative body of staff members to reflect the diversity of the unit/department. Effective UBCs usually have representative membership between 7 and 15 persons but should be determined based on unit size.
- May include representatives from a variety of interprofessional clinical departments reflecting those disciplines regularly providing care to the defined unit/department patient population.
- May include representatives from support service departments, whose relationships are necessary to carry out the unit's mission.
- May include invited ad hoc members, such as clinical educator.
- Manager/Supervisor, as representative of operational expertise and resource

Core Council Responsibilities:

- Establish and support interprofessional relationships for the purpose of enhancing patient-family centered care across the continuum.
- Cultivate a workplace culture that drives clinical excellence, primarily focusing on patient-family-centered care.
- Promote collaboration and communication ensuring staff are informed, educated, and engaged in unit-based decisions.
- Utilize the Texas Health Resources and entity strategic plan to develop goals by reviewing:
    - Key Performance Indicators
    - Nurse Sensitive Indicators, i.e., CAUTI, CLABSI, national benchmarks, etc.
    - Patient Satisfaction
    - Nurse Engagement
    - Evidence-Based Practice and Nursing Research
    - Work Environment Concerns
    - Employee Recognition
    - Professional Development
        - BSN, Certifications, NCAP
        - Mentorship and succession planning
        - Preceptorship and Educational offerings

Scope of Work: Surgical Clinics

Serve Internal Customers: Employees and volunteers.

Serve External Customers: Patients, families, physicians, visitors.

Goal Parameters:

- Goals should directly align with clinical Key Performance Indicators (KPIs) and/or Texas Health and entity-specific Strategic Plans.
- Each goal of the council will be structured as SMART (Specific, Measurable, Achievable, Realistic, Time-sensitive) goals.
- The goal includes [to decrease/increase] [what] [by how much] [within what timeframe] [where].

Member Roles/Responsibilities:

- *Chairperson & Vice Chairperson*:
  - The chairperson and vice chairperson are direct care providers and will be elected by the UBC members.
  - The chairperson and vice chairperson will each serve a three-year term (first year as vice chairperson, second year as chairperson, and third year as mentor to the incoming chairperson).
  - At the end of the chairperson's term, the vice chairperson will move to chairperson and the nomination and election process for a new vice chairperson will occur.
  - Administrative time will be budgeted for the chairperson and vice chairperson to perform the duties of the UBC, up to 8 hours per pay period, depending on the needs of the UBC.
  - An annual work plan will be developed to meet the objectives of the UBC. The plan will be reviewed quarterly to ensure completion of objectives.
- *Manager/Supervisor Champion:*
  - Unit/Department Leader Mentor facilitates the work of the UBC in collaboration with the chairperson and vice chairperson, e.g., set agenda, oversight of minutes, reporting of activities, member accountability.
  - Facilitate election or assignment of a chairperson, vice chairperson, and recording secretary to the UBC.
- *Chairperson*:
  - Attend entity **Professional Governance Council** (PGC)
  - Seek monthly updates from unit representatives of **Clinical Excellence Council** (CEC) and **Research Innovations and New Knowledge** (RINK)
  - Meet monthly, or more frequently as needed, with the vice chairperson and manager/supervisor champion to coordinate the work of the UBC.
  - Establish agenda and distribute with pertinent information to UBC members prior to the Meeting.
  - Ensure completion of Meeting minutes and distribution of such as soon after the Meeting as possible.
  - Provide ongoing updates on goals and projects.
  - Appoint UBC members and task forces, as needed to facilitate UBC objectives.
  - Serve as a resource to members and task forces, as needed to facilitate the goals and objectives. Of the UBC

- Inform members of roles and responsibilities and set expectation for UBC members
- *Vice Chairperson:*
  - Assume the duties of the chairperson in the absence of the chairperson.
  - Assist the chairperson in completing the business of the UBC, as needed and as requested by the chairperson or manager/supervisor champion.
  - Serve as liaison member to other councils as requested by the chairperson or manager/supervisor champion.
- *Voting Members:*
  - Attend 80% of UBC meetings.
  - Obtain pertinent information from the recording secretary or chairperson in the event of absence.
  - Carry out delegated UBC assignments, provide feedback and advice.
  - Notify chairperson of agenda items two weeks prior to Meeting for inclusion in the agenda
  - If unable to attend may arrange a representative to attend the Meeting in their place
- *Recording Secretary:*
  - Each UBC will elect or assign a recording secretary to record and document UBC activities.
  - Distribute minutes of Meeting to members of the UBC as soon after the UBC meeting as possible
- *Members at Large:*
  - Non-voting unit staff members are encouraged to attend UBC.
  - Non-voting members may bring forth topics that impact their work environment for discussion and consideration.
  - Share ideas for unit improvements and can be a part of decision-making

Reporting Relationship:

- UBCs are a clinical shared decision-making body accountable for the process, implementation, communication, coordination, and outcome of decisions.
- The UBCs report through their chain of command and are encouraged to share best practices at the entities **Professional Governance Council** (PGC).

Authority and Accountability:

- The UBC is scheduled monthly and is expected to meet 10 times per year or as needed to conduct business of the UBC.
- UBC members are accountable to their chain of command and entity Executive Team for all goal work. Goals should reflect evidence-based practice or better practice.
- Voting members have recommending authority to their chain of command and Chief Nursing Officer (CNO) and/or Executive Team for clinical implementations.
- Goals should directly align with clinical Key Performance Indicators (KPIs) and/or THR/entity Strategic Plans and should be reported to the Professional Governance Council continuously.

Decision-Making / Voting (method, e.g., consensus, majority vote):

- Consensus is the preferred method for decision-making. If consensus is not achieved, the decision will be by simple majority vote.
- The Chairperson or Vice Chairperson will vote as needed for a tiebreaker.

- All decisions are based on patient-family centered care with a strong consideration for the direct care nurse perspective, if applicable.
- When an issue comes to vote, at least 75% of core members need to vote, which may be done in person during the Meeting or electronically.

Appointments and Elections:

- Depending upon the evolution of the UBC structure, the chairperson may be appointed by the manager or selected through traditional voting or via a consensus process. It is highly recommended to have a vice chairperson to share the workload and to create a natural mentorship.
- Members make minimal one-year commitments to the responsibilities and expectations of UBC. Depending upon the evolution of the UBC, members may either be appointed, recruited, or volunteer to become participants.

Appendix E

Index of Professional Nursing Governance 3.0

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

Today's Date _____

1. Sex: ____Male ____Female 2. Age: _____
3. Please indicate BASIC nursing education preparation:

    ____Nursing Diploma ____associate degree in nursing

    ____Baccalaureate Degree in Nursing

4. Please indicate the HIGHEST educational degree you have attained:

____Associate degree in nursing _____master's degree

____Baccalaureate Degree in Nursing ____Doctorate, Nursing

____Master's degree in nursing, Specialty ____Doctorate, Non-nursing

5. Employment Status:

____Full-time, 36-40 hours per week

    ____Part-time, less than 36 hours per week (specify number of hours/week): ____

6. Please specify the number of years that you have been practicing_____
7. Please indicate the title of your present position _____
8. Please indicate your clinical specialty:

    ____Case Management ____Maternity ____Psychiatry

    ____Clinic ____Medical/Surgical ____Quality Management

    ____Critical Care ____Operating Room ____ Recovery Room

    ____Education ____Pediatrics ____Rehabilitation

    ____Emergency Room ____Other (specify):

9. Please specify the number of years you have worked in this organization _____

10. Please specify the number of years you have been in your present position _____

11. Have you received any specialty certifications from professional organizations?

    ____Yes ____No

    Type of certification and year received: _____

12 Please rate your overall satisfaction with your professional practice within the organization (1 = lowest, 5 = highest): 1 2 3 4 5

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

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

PART I

1. Determining what nurses can do at the bedside 1 2 3 4 5
2. Developing and evaluating policies, procedures, and protocols related to patient care 1 2 3 4 5.
3. Establishing levels of qualifications for nursing positions. 1 2 3 4 5
4. Determining activities of ancillary nursing personnel (assistants, technicians, secretaries) 1 2 3 4 5
5. Conducting disciplinary action of nursing personnel 1 2 3 4 5
6. Assessing and providing for the professional/educational development of the nursing staff 1 2 3 4 5
7. Selecting products used in nursing care 1 2 3 4 5
8. Determining models of nursing care delivery (e.g., primary, team) 1 2 3 4 5

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

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

PART II

9. Making daily patient care assignments for nursing personnel 1 2 3 4 5

10. Regulating the flow of patient admissions, transfers, and discharges 1 2 3 4 5

11. Formulating annual unit budgets for personnel, supplies, equipment and education 1 2 3 4 5

12. Recommending nursing salaries, raises, and benefits 1 2 3 4 5

13. Consulting and enlisting the support of nursing services outside of the unit (e.g., clinical experts such as psychiatric or wound care specialists, diabetic educators) 1 2 3 4 5

14. Consulting and enlisting the support of services outside of nursing (e.g., dietary, social service, pharmacy, human resources, finance) 1 2 3 4 5

15. Creating new clinical positions 1 2 3 4 5

16. Creating new administrative or support positions 1 2 3 4 5

According to the following indicators in your organization, please circle which group has OFFICIAL AUTHORITY (i.e., authority granted and recognized by the organization) over the following areas that control practice and influence the resources that support it:

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

PART III

17. Mandatory RN credentialing levels (licensure, education, certifications)

for hiring, continued employment, promotions and raises 1 2 3 4 5.

18. Organizational charts that show job titles and who reports to whom 1 2 3 4 5

19. Written guidelines for disciplining nursing personnel 1 2 3 4 5

20. Procedures for hiring and transferring nursing personnel 1 2 3 4 5

21. Policies regulating promotion of nursing personnel to management

and leadership positions 1 2 3 4 5

22. Procedures for determining daily patient care assignments 1 2 3 4 5

23. Daily methods for monitoring and obtaining supplies for nursing care

and support functions 1 2 3 4 5

24. Procedures for controlling the flow of patient admissions, transfers

and discharges 1 2 3 4 5

25. Process for recommending and formulating annual unit budgets
for personnel, supplies, major equipment and education 1 2 3 4 5

26. Procedures for adjusting nursing salaries, raises and benefits 1 2 3 4 5

27. Formal mechanisms for consulting and enlisting the support of nursing

services outside of the unit (e.g., clinical experts such as psychiatric

or wound care specialists, diabetic educators) 1 2 3 4 5

28. Formal mechanisms for consulting and enlisting the support of services

outside of nursing. (e.g. dietary, social service, pharmacy,

human resources, finance) 1 2 3 4 5

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

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

PART IV

29. Participation in unit committees for administrative matters,

such as staffing, scheduling and budgeting 1 2 3 4 5.

30. Participation in nursing departmental committees for administrative

matters such as staffing, scheduling, and budgeting 1 2 3 4 5.

31. Participation in interprofessional committees (physicians, other

healthcare professions and departments) for collaborative practice 1 2 3 4 5

32. Participation in hospital administration committees for matters

such as employee benefits and strategic planning 1 2 3 4 5

33. Forming new unit committees 1 2 3 4 5

34. Forming new nursing departmental committees	1 2 3 4 5
35. Forming new interprofessional committees	1 2 3 4 5
36. Forming new administration committees for the organization	1 2 3 4 5

In your organization, please circle the group that has ACCESS TO INFORMATION about the following activities:

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

PART V

37. Compliance of nursing practice with requirements of surveying agencies

(The Joint, state and federal government, professional groups) 1 2 3 4 5

38. Unit and nursing departmental goals and objectives for this year 1 2 3 4 5

39. Organization's strategic plans for the next few years 1 2 3 4 5

40. Results of patient satisfaction surveys 1 2 3 4 5

41. Physician/nurse satisfaction with their collaborative practice 1 2 3 4 5

42. Current status of nurse turnover and vacancies in the organization 1 2 3 4 5

43. Nurses' satisfaction with their general practice 1 2 3 4 5

44. Nurses' satisfaction with their salaries and benefits 1 2 3 4 5

45. Management's opinion of the quality of bedside nursing practice 1 2 3 4 5

In your organization, please circle the group that has the ABILITY to:

1 = Nursing management/administration only

2 = Primarily nursing management/administration with some staff nurse input

3 = Equally shared by staff nurses and nursing management/administration

4 = Primarily staff nurses with some nursing management/administration input

5 = Staff nurses only

PART VI

46. Negotiate solutions to conflicts among professional nurses	1 2 3 4 5
47. Negotiate solutions to conflicts between professional nurses and physicians	1 2 3 4 5
48. Negotiate solutions to conflicts between professional nurses and other healthcare services (respiratory, dietary, etc)	1 2 3 4 5
49. Negotiate solutions to conflicts between professional nurses and nursing management	1 2 3 4 5
50. Negotiate solutions to conflicts between professional nurses and the organization’s administration.	1 2 3 4 5

Appendix F

FORUM FOR Shared Governance LLC
P.O. Box 8132
Hobe Sound, FL 33475
info@sharedgovemance.org
www.sharedgovemance.org

Fica Etienne, MSN, RN, DNP Student
School of Nursing, Post Professional Programs
Universit;y of Saint Augustine for Health Sciences
Saint Augustine FL, 32086
(828) 332-0464
F.Etienne@usa.edu

January 12, 2023

Dear Fica:

You have permission to use my instruments, the Index of Professional Nursing Governance (IPNG) or the Index of Professional Governance (IPG), 2.0 or 3.0, at the August VA, Augusta, GA for the DNP Program at University of Saint Augustine for Health Sciences.

In return, I require that you, upon request:

- Report summary findings to me from the use of the IPNG/IPG surveys, including the translation and a reliability analysis (if performed), for tracking use and evaluating and establishing the validity and reliability of the IPN/IPG, and for possible research publication without identification of the institutions.
- Credit the use and my authorship of the IPNG/IPG in any publication of the research involving the IPNG/IPG.

I will email Word documents of the current versions of the IPNG/IPG survey, along with Scoring Guidelines. Because of your student status, I will waive all charges to register use of the instruments and scoring guidelines. You might want to revise the demographic section to reflect the organization and/or units you're surveying. You do not have permission to alter the individual items in any way or use them separately or in part, which would invalid the measurement of governance.

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

Sincerely,

Robert Hess, PhD, RN, FAAN
Founder & **CEO, Forum** for **Shared** Governance

Appendix G

UNIVERSITY of ST. AUGUSTINE for HEALTH SCIENCES

SCHOOL OF NURSING

Doctor of Nursing Practice Program
Evidence-Based Practice Review Council
1 University Blvd.
St. Augustine, FL 32086

March 2, 2023

Dear Fica Etienne,

Your proposal titled "Establishment of Unit-Based Council Using a Shared Governance Toolkit for Surgical Clinics" has been reviewed by the University of St. Augustine for Health Sciences Doctor of Nursing Practice Evidence-Based Practice Review Council (EPRC). The project was determined to not meet the requirements for research as defined in the Federal Register.

Your proposal reflects an evidence-based practice change project and is approved. The proposal must be implemented as submitted (changes are not permitted). You may proceed to obtain approvals from the facility where the project will be implemented as soon as the primary course faculty member has reviewed and approved all facility application materials. Implementation may not begin until you have submitted the EPRC approval letter and the facility approval letter to NUR7802 and are notified in writing by practicum course faculty that you may implement the project.

Questions regarding the USAHS approval process should be addressed to Dr. Sarah Cartwright at scartwright@usa.edu. Questions regarding the facility approval process should be addressed to course faculty.

Sincerely,

Sarah M. I. Cartwright, DNP. MSN-PH, BAM, RN-BC, CAPA, FASPAN
Evidence-based Practice Review Council Chair
Interim Assistant Program Director- Nursing Operations
DNP Program Coordinator
School of Nursing at University of St. Augustine for Health Sciences

Appendix H

Department of Veterans Affairs **Memorandum**

Date: March 13, 2023

From: Associate Chief of Staff, Research and Development (ACOS/R&D) (24)

Subj: Publication of Non-Research findings in Peer-Reviewed Journals

To: Fica Etienne, MSN-RN

Thru:

Your activity entitled: “Shared Governance Toolkit” has been determined to be a non-Research Activity.

1. Any publication in ***peer-reviewed journals*** of findings from non-research activities ***REQUIRES*** documentation of author attestation ***prior*** to publication.

2. Publication in non-peer reviewed journals and professional presentations of findings from non-research activities do not ***REQUIRE*** documentation prior to publication or presentation.

3. Documentation is **strongly encouraged** whenever there may be **doubt** or **misunderstanding** about the nature of the activity. The following templated attestation should be completed:

Title of Proposed Publication:

Author Attestation:
As an author of the publication referenced above (copy attached), I attest that the findings reported in the publication were not derived, in whole or part, from activities constituting research as described in VHA Handbook 1058.05.

Provide for each VA Author and Co-Author:

Author Signature: Date:

Author Name: VA Duty Station:

6. Each VA author and coauthor must retain a copy of the documentation for a minimum of 7 years after publication and in accordance with any applicable records retention schedules.

X

Stephanie Baer, MD

Department of Veterans Affairs
Charlie Norwood VAMC

Determination of Non-Research Activity

Instructions: This form is to be filled out when requesting a determination that an operational activity was a non-research activity for the purposes of publication or presentation.

Project Title: Shared Governance Toolkit	
Responsible Project Lead: Fica Etienne MSN-RN	**Role Title:** RN
Department: Surgery clinics	**Email:** Fica.etienne@va.gov

Please fill out the chart below based on the proposed project

	TRUE	FALSE
1) The project is designed and/or implemented for internal VA purposes in support of the VA mission(s).	☑	☐
2) The findings are designed to be used by and within VA (or by entities responsible for overseeing VA).	☑	☐
3) The project is not designed for the purpose of contributing to generalizable knowledge.	☑	☐
4) The project is not designed to produce information that expands the knowledge base of a scientific discipline (or another scholarly field)	☑	☐
5) The project is not funded or otherwise supported as research by the Office of Research and Development (ORD) or any other entity (including the Center for Healthcare Equity Research and Promotion [CHERP] or the VISN 7 Competitive Pilot Project Funding [CPPF] program, National Institutes of Health [NIH] or Department of Defense [DoD]).	☑	☐
6) The project does not involve administration, dispensing and/or use of any drugs, devices and/or biologics.	☑	☐
7) The project does not involve design characteristics typically reflective of research: • Double-blind interventions • Use of placebo controls • Prospective patient-level randomization to clinical interventions not tailored to individual benefit.	☑	☐
8) The proposal includes provisions to ensure that the safety, rights, and welfare of patients and staff are appropriately protected as applicable. **Potential risks (including physical, psychological, social, financial, privacy, and confidentiality, and other foreseeable risks) associated with non-research operations should be evaluated and appropriate protections established to mitigate them.**	☑	☐
9) The project is not intended to meet the requirements set forth by an educational program that requires "research" be conducted.	☑	☐

Department of Veterans Affairs
Charlie Norwood VAMC

Determination of Non-Research Activity

If the project is deemed Quality Improvement, the Project Lead must contact the Administrative Officer of Quality Management Service for possible project tracking and further follow up.

ACOS Research & Development Determination
This study as presented to the ACOS on the date of this form has been determined to be: ☐ Research ☑ Quality Improvement
CNVAMC ACOS/R&E Signature: Stephanie L Baer 224655 Digitally signed by Stephanie L Baer 224655 Date: 2023.03.03 12:56:51 -05'00'

Appendix I

Department of Veterans Affairs

Memorandum

Date: March 14, 2023

From: Carolyn Wells, RN, MSN

Subj: UBC Toolkit Project, Outpatient Surgery

To: Department Head, University of St. Augustine

The purpose of this memorandum is to address a request made by Fica Etienne to implement a project to develop and test a UBC Toolkit in the Outpatient Surgery Clinics. Please accept this letter as my approval of the project.

CAROLYN WELLS

Digitally signed by CAROLYN WELLS
Date: 2023.03.14 13:10:56 -04'00'

Carolyn Wells, Nurse Manager
Outpatient Surgery Clinics