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Nurses' Perceptions of Structural Empowerment: A Practice Review Process Pilot

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NURSES' PERCEPTIONS OF STRUCTURAL EMPOWERMENT:

A PRACTICE REVIEW PROCESS PILOT

by

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ABSTRACT

NURSES' PERCEPTIONS OF STRUCTURAL EMPOWERMENT:
A PRACTICE REVIEW PROCESS PILOT

Nurses are professionally and morally obliged to monitor and evaluate nursing practice via active participation in review mechanisms that are designed to promote patient safety and care delivery, thereby improving patient care quality (American Nurses Association [ANA], 1988, 2001, 2004; O'Rourke, 2006). The purpose of this Doctor of Nursing Practice (DNP) project was to develop, pilot, and evaluate a nurse practice review process with frontline nurses within Fresno Heart & Surgical Hospital (FHSH), a small specialty hospital, affiliated with Community Medical Centers (CMC) in Fresno, California. A nurse practice algorithm was subsequently developed and structural empowerment was assessed with the *Conditions of Work Effectiveness Questionnaire-II (CWEQ-II)* (Laschinger, Finegan, Shamian, & Wilk, 2001). While there was a small sample size, the DNP project evaluation demonstrated that frontline nurses want to participate in improvement activities within the facility and believed the nurse practice review algorithm would effectively monitor and evaluate nursing practice.

Keywords: transformational leadership, structural empowerment, peer review, practice monitoring, nurse practice review, and quality practice.

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TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

Recently, the Centers for Medicare and Medicaid Services (CMS) began linking Medicare reimbursement for hospitals, based on hospital quality measures of performance and patient satisfaction scores, as legislated by the Patient Protection and Affordable Care Act (ACA) (2010). Quality measures of performance, which include patient safety, quality patient care, and patient satisfaction results, are required by the ACA, as a direct result of two pivotal Institute of Medicine (IOM) reports: *To Err is Human* (IOM, 2000) and *Crossing the Quality Chasm* (IOM, 2001). A third report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011) recommends nurses become full partners, through engagement and empowerment, in transforming health care. As the largest health care work group and primary provider in the hospital setting (American Association of Colleges of Nursing [AACN], 2011), nurses can directly impact patient satisfaction scores and hospital-acquired conditions, leading to reduced health care cost, improved patient safety, and health care quality while making nursing contributions visible within the hospital setting.

There are several principles identified in the *To Err is Human* (IOM, 2000) report that are relevant to the profession of nursing. The principles include: commitment from leadership to move a quality and safety agenda forward; identification of human limits in care processes and strategies to reduce errors; functional and effective team engagement; adopting proactive approaches to ensuring safe care; and creating learning environments. Transformational leadership can facilitate a team process or organized structure to monitor and evaluate nursing practice. Providing nurses with access to information, resources, and support will empower nurses to own, monitor, and evaluate nursing practice by identifying problems or barriers to quality care with potential innovative solutions and recommendations for improvement.

In order to transform patient care delivery, nursing must embrace the six aims that were identified in the *Crossing the Quality Chasm* report (IOM, 2001). The six aims are relevant to nursing because potential solutions and actions can be linked to nursing practice and quality patient care. Examples are:

1. Safe care: Preventing or avoiding injuries to patients, e.g. decreasing or preventing patient falls.
2. Effective care: Utilizing evidence-based practice and/or scientific knowledge to provide patient care.
3. Patient-centered care: Being respectful and responsive to patient values and allowing their values to guide clinical practice decisions.
4. Timely care: Preventing delays in care delivery, e.g. decreasing wait times.
5. Efficient care: Decreasing waste in current practices, e.g. redesigning or improving nurse workflows as technology is implemented.
6. Equitable care: Ensuring there is no disparity in health care by ethnic and socioeconomic groups or due to lack of health insurance or underinsurance.

Problem Statement

The nurses of Community Medical Centers (CMC) went on a professional role development journey in 2008 – 2009 (O'Rourke, 2008). Every nurse within CMC received extensive professional role development training over a year long process, which included continued training for new-hire nurses and development for current nurses. The next step of the journey was to identify methods to monitor nursing practice in relation to improved patient outcomes and quality care. Admittedly, this has been challenging, because there is not a process

in place for bedside nurses to review and discuss nursing practice, specifically, as it relates to hospital measures of performance and patient outcomes.

Historically within CMC, policies and procedures are reviewed systematically via a corporate nurse practice council structure. However, data/indicator results (e.g. pressure ulcer prevalence and incidence, incidence of surgical site infections, etc.) have not be been brought forward for discussion within the nurse practice council structure. In addition, the corporate nurse practice council mainly consists of nurse educators, advanced practice nurses, managers, directors, and the chief nursing officers from each facility. This correlates with Schreuders, Bremner, Geelhoed, and Finn's (2012, p. 196) suggestion that nurses with higher educational levels are more aware of "the impact of nursing care on patient outcomes", because these are the nurses who are primarily involved with nursing policies and procedures or involved in separate meetings discussing adverse events or performance improvement activities. Schreuders et al. also indicate that "there is a need to raise awareness among bedside nurses of the influence of their care on patient outcomes" (p. 196).

However, in order for nurses to be aware of their influence, they have to have access to information, resources, and support. Kanter (1979) describes access to information, resources, and support as the main components of structural empowerment or structures of power. Laschinger, Gilbert, Smith, and Leslie (2010) emphasized that access to these components empowered nurses to contribute effectively to the achievement of their organization's goals. Appropriate structures must be in place for bedside nurses to receive information and support to perform effectively within their work environments. Consequently, the need to have a forum, process, and/or methodology to get information (e.g. data) to the bedside nurse to take "action"

or make decisions that improves nursing-related patient care quality, safety, and outcomes is imperative.

Currently, very few bedside nurses participate on the corporate nurse practice council, even though the council is facilitated by a bedside nurse. The original goal of the corporate nurse practice council was to have more bedside nurses, but that has not been accomplished. Consequently, a hospital-specific nurse practice council was formed at Fresno Heart & Surgical Hospital (FHSH), a hospital affiliated with CMC that is comprised of mostly bedside nurses. But the same challenge exists as there is not a formal process in place for bedside nurses to monitor, discuss, and evaluate nursing practice in relation to hospital measures of performance and patient outcomes or nurse-sensitive quality indicators.

Definitions

Bedside/frontline nurses. Nurses whose primary role accountability is direct patient care.

Nurse practice review algorithm. A process utilizing group identified problems, issues, or concerns via group discussions, brainstorming, planning, and evaluation of nursing practice.

Peer review. A process in which registered nurses assess, monitor, and evaluate the quality of nursing care delivered by their peers in relation to professional nursing practice standards.

Practice review. A process utilizing group identified problems, issues, or concerns to discuss, monitor, evaluate, and provide innovative solutions for improving patient outcomes, nurse-sensitive and hospital quality indicators, and care delivery.

Purpose

The purpose of this Doctor of Nursing Practice (DNP) project was to engage and empower a group of bedside nurses to develop a formalized process to monitor and evaluate nursing practice in relation to patient outcomes, nurse-sensitive and hospital quality indicators, and care delivery. It was anticipated that participation on the project development team would help identify and rectify components of structural empowerment that are deficient within the facility. Over time, this would lead to nursing ownership, monitoring, and evaluation of nursing practice with improved patient care quality, safety, and outcomes.

The initial step was to develop a process to monitor nursing practice and identify potential solutions (e.g. additional education, structures, etc.) or recommendations (e.g. evidence-based policy and procedure review, improved communication of data, etc.). The monitoring process was subsequently documented, approved, and implemented within the selected facility. After process development, the nurses' perceptions of structural empowerment or access to information, resources, and support was evaluated. In the future, measureable goals and outcomes will be identified and linked to health care quality outcomes that nurses have impacted and contributed to improving patient safety and health care quality within the hospital setting.

Conceptual Framework

Donabedian (1988) classified the quality of care under three criteria: structure, process, and outcomes (SPO). Structure refers to resources, such as materials, human, or organizational structures that are put into place to support ongoing services. Processes refer to what is actually done in giving and receiving care. This includes practices in the provision of medical and nursing services. Outcomes are based on the health status of patients and are measured by

various criteria to produce results (Butts & Rich, 2011; Donabedian). Donabedian also implied that there must be an understanding of the linkage between structure and process, and between process and outcomes prior to performing a quality assessment. This insight helps interpret the findings and to question if the findings do not make sense, which leads to a reassessment of the study design or practice environment (e.g. structure), the nursing provision of care, treatments, or accuracy of the data (e.g. processes), and the results (e.g. outcomes). According to Donabedian, structure, process, and outcomes are affected by the variability in cost, patient expectations, and the availability of resources, as well.

Donabedian's (1988) SPO model was utilized in this project to develop a process for nurses to monitor and evaluate their nursing practice. The goal in utilizing Donabedian's SPO model was to produce a structure with a formalized procedure and/or algorithm developed by bedside nurses. The process integrated methodologies to monitor and evaluate nursing practice, incorporating innovative nursing strategies to improve patient outcomes while being linked to quality indicators and patient satisfaction scores (i.e. outcomes).

After developing a process to monitor nursing practice, the *Conditions for Workplace Effectiveness Questionnaire-II* (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001) (Appendix A) was utilized to measure nurses' perceptions of power and structural empowerment. Power is defined as the nurses' perceptions of formal power (i.e. flexibility, adaptability, and creativity) gained from specific job activities and informal power (i.e. development of communication and information channels) gained from social connections. Structural empowerment is defined as the nurses' perceptions of access to information, resources, and support to get things done in their work environment.

Organizational structures that link Donabedian's (1988) SPO with the CWEQ-II are structures of opportunity and structures of power. Structures of opportunity provide nurses a chance to advance within the organization and to develop their knowledge and skills. Structure of power (e.g. formal and informal) and empowerment (e.g. access to information, resources, and support), are necessary for nurses to understand organizational goals.

As Donabedian (1988) emphasized, there must be an understanding between the linkage of structure (e.g. power) and processes (e.g. nursing provision of care), and between processes and outcomes (e.g. quality indicators). Measuring nurses' perceptions of power and structural empowerment post participatory engagment of this process development project is an approach that can be utilized to assess nursing quality improvement initiatives within the hospital environment. Nurses working in empowered work environments were shown to have positive effects on nursing quality indicators and problems identified through group processes (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

CHAPTER 2: REVIEW OF THE LITERATURE

Peer Review Perspectives

Nurses are professionally and morally obliged to monitor and evaluate nursing practice (American Nurses Association [ANA], 1988, 2001, 2010; O'Rourke, 2006) and consequently be able to correlate their contributions to health care quality (Kurtzman, 2010). The ANA published the *Peer Review Guidelines* in 1988, which currently remain unrevised. According to the 1988 guidelines, peer review is "one mechanism through which the profession acts to assure quality nursing care, and quality assurance [that] is essential to the profession's advocacy of access to and recognition of nursing services" (p. 1) and its primary focus in quality nursing practice. Peer review is defined as "the process by which practicing registered nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers [and/or during practice] as measured against professional standards of practice" (p. 3).

The *Code of Ethics* (ANA, 2001, p. 13) stipulates that nursing is responsible "to implement and maintain standards of professional nursing practice" by developing and evaluating mechanisms designed to protect patients, such as a peer/practice review process or committee. Additionally, nurses are to be active participants in review mechanisms that are designed to promote patient safety and reduce medical errors, thereby improving quality. The *Nursing: Scope and Standards of Practice* (ANA, 2010) states "the nurse evaluates her or his own nursing practice in relation to professional practice standards and guidelines" (p. 59). This refers to nurses holding nurses accountable to professional practice standards and not relying upon another professional entity to do so. Maria O'Rourke (2008) refers to this as "looking at oneself in the mirror".

The nurse peer review guidelines were established more than 20 years ago and still remain elusive in many hospitals. This is due to lack of formalized structures and processes in which to evaluate nursing practice. Likewise, the nurse peer review process is a confusing concept for many nurses, because it has been associated with performance evaluations, annual evaluations, and/or 360 evaluations (Harrington & Smith, 2008). However, the nurse peer review process can be redefined as taking professional accountability, in a non-punitive, blameless environment (Morath & Leary, 2004) and "just culture" (Weiner, Hobgood, & Lewis, 2008), to monitor nursing practice compared to professional nursing standards and practices.

Nurses must monitor their practice in a way that allows for self-reflection while holding each other accountable to promote safe patient care (e.g. speaking up when nursing practice has been compromised), and promoting the professional nursing obligation to monitor and evaluate nursing practice (O'Rourke, 2006). In order to monitor nursing practice, there must be a process in place to identify potential or actual nursing practice issues and/or concerns (e.g. adverse events or poor performing nurse-sensitive quality indicators) and the process has to be perceived as blameless and safe.

Transformational Leadership

Transformational leadership is described as a relational leadership approach in which the leader ascertains opportunities for change, crafts a vision to guide the change through staff engagement and empowerment, and executes the change with staff commitment (Marshall, 2011). Marshall further describes the transformational leadership process as a manner for developing leadership capacity in teams who have been engaged and inspired with each other, and results in shared visions, values, and common purpose for organizational change. The

process includes four transformational leadership skills that are utilized by transformational leaders to engage staff at the grassroots level.

The four transformational leadership skills are: idealized influence, inspirational motivation, intellectual stimulation, and individual consideration (Bamford-Wade & Moss, 2010; Doody & Doody, 2012; Marshall, 2011). Idealized influence is described as having the ability to inspire others for something greater or a common purpose and commitment to a cause. Inspirational motivation is a beneficial skill that sets the standard for achieving the goal or the future desired state within the team. Intellectual stimulation allows the leader to promote creativity, challenge boundaries, and apply various approaches to find solutions within diverse teams. Individual consideration describes a leader who can look to the mission of the organization and value the work of others by listening, coaching, supporting, and recognizing the work of others (Doody & Doody; Marshall) for staff buy-in at the grassroots level.

Staff buy-in at the grassroots level is key to developing a successful process in which nurses monitor quality nursing practice. Davis, Capozzoli, and Parks (2009) recommended guidelines for designing a nurse peer review process. The process recommended was divided into the following phases: introducing the ideas/getting staff engaged, creating the design team, piloting the process, staff education, and evaluation/keeping it going. These phases align with three of the four transformational leadership skills (Doody & Doody, 2012), specifically idealized influence, inspirational motivation, and intellectual stimulation, in which common purpose, staff engagement, and design creativity are employed for process development. In addition to the recommended guidelines, Davis et al. suggest that selecting a diverse team with differing perspectives would result in a stronger and sustainable review process developed by an engaged and empowered team.

Branowicki, Driscoll, Hickey, Renaud, and Sporing (2011) described a process in which nursing leadership engaged staff to develop a process to critically evaluate nursing performance that was linked to significant adverse events. Initially, committee participants were anonymous members, while the process was in development and until the participants were comfortable with their roles. This aligns with individual consideration, one of the four transformational leadership skills, because the staff requested anonymity during the development process until a level of comfort was achieved.

Donabedian's (1988) structure-process-outcomes (SPO) model provided the framework for the Branowicki et al. formalized process that was developed for this DNP project. The governance structure or council established the structure for improving patient care and optimizing patient outcomes via reporting mechanisms. A formalized algorithm was created, based on an identified need, to establish the peer review process. Once the review process was completed, recommendations for improvements were made and forwarded to appropriate committees for action. Outcomes have been limited with future recommendations to study the impact of nursing performance and the quality of bedside nursing care. Branowicki et al. concluded that peer review cultivates a culture of accountability and staff participation that ensures quality nursing care, optimized patient outcomes, and patient safety.

In addition to the four transformational leadership skills, Haudan (2008) describes engagement and empowerment attributes that connects the team or staff participants to being a part of something big, having a sense of belonging, knowing their contributions make a difference, and going on a meaningful journey that results in organizational change. A transformational leader understands how to connect these attributes with transformational leadership skills to facilitate innovation, maximize opportunity, inspire and develop others, while

moving towards the future in a transformed healthcare environment (Marshall, 2011). The Davis et al. (2009) and Branowicki et al. (2011) articles are excellent exemplars of Haudan's attributes for team facilitation.

Structural Empowerment

Structural empowerment is described as the capacity to get things done within the work environment by mobilizing resources, accessing information, and obtaining support to meet organizational goals (Kanter, 1979; Laschinger et al., 2010; Yang, Liu, Huang, & Zhu, 2013). Kanter identified 3 sources of power: lines of supply (e.g. resources), lines of information, and lines of support (Kanter; Laschinger, Sabiston, & Kutszcher, 1997). Lines of supply referred to being able to obtain the resources (e.g. materials, money, staff, etc.) needed to get the job done. Accessing information refers to having the knowledge, information, and/or data needed to do the job and make decisions that benefit the organization. The lines of support refers to allowing for innovative and effective decision-making to take actions that accomplish the goals of the organization. While Kanter described these sources of power at the management level, Kanter also implied that sharing this power leads to improved organizational performance.

Impact on Quality Nursing Care

Nurses are not only in the best position to impact quality nursing care, nurses are in the best position to review, monitor, and evaluate care processes within healthcare organizations that impact overall hospital care quality. Consequently, frontline nurses are closer to the everyday care processes that occur within healthcare organizations and have discernment into care processes that affect care quality and patient outcomes (McHugh & Stimpfel, 2012). A few examples include: patient-provider interactions, patient and family education, integration of technology, and inter-professional collaboration. In this position, nurses can provide information

on what hinders quality care and prevents sustainability in quality improvement processes and organizational or hospital initiatives.

Nurses' perceptions of quality care has been associated with the following indicators of quality and patient outcomes: mortality, failure to rescue, patient satisfaction, and process of care measures (McHugh & Stimpfel, 2012). In a study by McHugh and Stimpfel, nurses in various practice environments (e.g. good, mixed, and poor) in four states: California, Florida, Pennsylvania, and New Jersey, were asked to gauge their perceptions of quality of care that was reflective of patient outcomes and process of care measures within their hospitals. Nurses in good practice environments reported higher perceptions of excellent quality, statistically significant higher median proportions, compared to those who were employed in mixed and poor practice environments. In addition, McHugh and Stimpfel's findings were associated with quality indicators and outcome measures that are reported to The Joint Commission, Centers for Medicare and Medicaid Services, The Leapfrog Group, and the American Nurses Association's National Database of Nursing Quality Indicators ™. However, a limitation of this study is that the authors were only able to study an association of nurses' reported perceptions of quality and patient outcomes and not relationships between their perceptions and actual outcomes.

A review process in the context of quality and patient safety can increase recognition of nurses' contributions to care quality and optimization of patient outcomes (Davis, Kenny, Doyle, McCarroll, & von Gruenigen, 2013). Davis et al. applied a quality improvement method to a peer review process. Although, the researchers specifically studied fetal heart rate monitoring, the conclusions can be made for nursing practice in general. The general nursing conclusions implied from this quality improvement project was that nursing competence is an element of nursing practice and should be measured against nursing standards in all nursing arenas. In

addition, bedside nurses should be intimately involved and engaged in the process, while working in collaborative healthy work environments that promote a "just" and safe culture. Limitations acknowledged by the authors are related to facility support and cost. Facility support referred to nursing leadership and bedside nurses' beneficial involvement in sharing a common purpose that would result in patient safety and change. Cost implied the resources dedicated for project development, implementation, and on-going evaluation, even during times of financial constraints.

Although there are many qualitative studies and descriptions for developing and evaluating a nurse peer review process, there were two articles that were relevant for translation and utilization for this DNP project. In the first article, Raia (2011) acknowledges the role that nurse peer review has played in addressing findings from sentinel events, root cause analyses, and in discipline specific peer reviews. However, Raia aligns with the *To Err is Human* report (IOM, 2000) which is to "shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the [health care] system" (p. 5). The process that was described by Raia provides opportunity for nurses to monitor, discuss, and evaluate nursing practice, as a profession, in a nonpunitive and caring environment. Raia's described process elucidated inconsistent gaps in practice or best practices that could be utilized by nurses to improve nursing practice.

In the second article, Rice, Slobbe, and Rathgeber (2007) evaluated nursing practice using an expert panel process. Ultimately, Rice et al. employed various methodologies (e.g. chart audits, observations, focus groups, etc.) already used in nursing practice to monitor and evaluate nursing practice, to identify gaps in practice, obtain innovative strategies of excellence, and make recommendations to improve patient outcomes and provide quality nursing care. Once

the information from the various methodologies were obtained, the results were summarized and presented to the expert nursing panel for discussion, recommendations, and prioritization that were later presented to their nursing leadership. Information, feedback, and outcomes flowed bi-directionally between the bedside nurses and their nursing leadership, this included providing an opportunity for the bedside nurses to comment, question, and ruminate upon the results.

The implications and findings of frontline nurses addressing issues or poor quality indicators can impact healthcare quality within their organizations (Davis et al., 2013; McHugh & Stimpfel, 2012; Raia, 2011; Rice et al., 2007). Nurses are already at the frontlines and as participants in peer/practice review processes can provide insight, innovative solutions, and recommendations to decrease adverse events and improve healthcare quality, safety, process measures, and patient outcomes. In addition, frontline nurse can improve or make recommendations for care that is effective, efficient, equitable, timely, and patient-centered (IOM, 2001).

Summary

Peer review is a confusing concept for nurses in general with varying negative connotations. As a result, the word "peer" review will be referred to as "practice" review for this DNP project. Transformational leadership strategies that engage and empower bedside nurses to develop a formal process or methodology to review, monitor, and evaluate nursing practice has the potential to effectively improve nursing care delivery, patient outcomes and nursing quality indicators. Additionally, working with frontline nurses at the grassroots level as the process is developed, can lead to greater staff participation, acceptance, and buy-in. It is anticipated that nurses participating on the formalized team will be empowered to identify problems, solutions, and recommendations for improvement and implementation based on reported data (e.g. quality

indicators, care processes, measures of performance, etc.). The nurse practice review process will lead to increased nursing awareness of bedside nurses' contributions to and influence on health care quality within the hospital setting. This will eventually enhance patient safety, and improve patient care quality and measures of performance within the hospital setting.

CHAPTER 3: METHODS

Project Design

The purpose of this DNP project was to engage and empower a group of bedside nurses to develop and pilot a formalized process to monitor and evaluate nursing practice in relation to patient outcomes, nursing-sensitive and hospital quality indicators, and care delivery. There were five project team meetings and two nurse practice council meetings, over an 8 month timeframe, structured to permit open dialogue between and among the nursing participants. Various transformational leadership strategies, as previously described, were employed during group meetings and discussions to engage and empower the bedside nurse participants. The DNP facilitator also provided guidance and structure to keep the group focused on the project's intended purpose. In addition, group ideas and recommendations were written on large Post-It Sticky Notes for visual tracking, meeting follow-up, and next steps for each meeting. Meeting minutes were provided to each participant via email for review and approval prior to each meeting, as well.

Setting

Community Medical Centers (CMC), a complex health care organization located in central California, consists of three main hospitals: Clovis Community Medical Center (CCMC), Community Regional Medical Center (CRMC), and Fresno Heart & Surgical Hospital (FHSH). Clovis Community Medical Center is a rural hospital with approximately 200 beds; CRMC is a university teaching facility with approximately 600 beds and is a Level 1 Trauma and Burn Center; and FHSH is a specialty hospital with 57 beds. The hospital systems operate under a corporate hierarchical structure, which includes a corporate: chief executive officer, chief nursing officer, chief financial officer, chief operating officer, chief informatics nursing officer,

chief medical informatics officer, and chief information technology officer, all referred to as the C-Suite (Porter-O'Grady & Malloch, 2011).

Each hospital also has their version of the C-Suite, but on a smaller scale. For example, FHSH (the specialty hospital) has a chief executive officer, a chief nursing officer, and a chief financial officer. The additional C-Suite officers do not exist within FHSH, but are a shared entity within the corporate organizational system. This provides for a top down leadership approach by an entity that is far removed from the hospitals and specifically, the point of service staff. As Porter-O'Grady and Malloch (2011) point out "the farther away from the point of service a decision about what goes on there is made, the higher the risk, the greater the cost, and the lower the sustainability" (p. 30). Although, there are nursing directors, managers, and charge nurses within this top down structure within each hospital, there are also various corporate and facility specific committees and council structures in existence. The setting for this project occurred within FHSH, the small 57- bed hospital that specializes in bariatric, heart, vascular, general surgeries, and procedures.

Population and Sample

Permission was received from both the corporate and facility-specific chief nursing officers (CNOs) to implement this DNP project within FHSH. Institutional Review Board (IRB) approval was acquired from both CMC and California State University, Fresno (CSUF). Once CNO and IRB approvals were obtained, the project was presented to the facility-specific (FHSH) Nurse Practice Council (NPC). The NPC group approved the project's implementation and recommended the inclusion of night shift nurses.

Since the in-patient nurses were managed by one manager, the DNP project facilitator met with the in-patient manager to discuss the proposed DNP project. After informing the in-

patient manager, feedback was solicited by the DNP project facilitator to determine the best methods to recruit nurses to participate on the project development team. The in-patient manager recommendations included: sending an email to all nurses with information pertaining to the DNP project's purpose, participation timeframes and expectations, and benefits of project or team participation for individual development in group processes and relationship building, potential advancement in the clinical ladder program, and leadership development. Moreover, it was an opportunity for nurses to understand their influence in developing a process that recognizes their contributions to quality patient care. In addition to the in-patient manager's recommendations, the email included: the project start and potential end dates, the DNP project proposal, invitation to seek additional information and to participate on the project team, and a request to inform the DNP project facilitator if they had a willingness to participate.

It is important to disclose that the DNP project facilitator is a cardiovascular clinical nurse specialist and the NPC chairperson within the specialty hospital setting. In the past, the FHSH NPC committee had questioned developing a nurse peer review process due to negative association or misunderstanding of the process. Consequently, this hospital setting was chosen based on the DNP facilitator's knowledge of the nurses, hospital, and CMC organizational structure. Therefore, nurse participation may have resulted from the relationship that had been established between the DNP project facilitator and the nurse participants.

Facilitation Strategy

The DNP project facilitator utilized transformational leadership skills, as described by Doody and Doody (2012) and Marshall (2011), to energize and create an environment where creativity and innovation could emerge and where the staff could extend their boundaries of thinking and doing something different, safely, and risk free. Four transformational leadership

skills were utilized: idealized influence, inspirational motivation, intellectual stimulation, and individual consideration (Bamford-Wade & Moss, 2010; Doody & Doody; Marshall).

As applied to this project, idealized influence resulted in establishing a sense of purpose for the DNP project facilitator and the project development team. Inspirational motivation enabled goal setting and encouraged others to be receptive to a changing paradigm including shared vision for creating a high performing hospital. Intellectual stimulation facilitated critical thinking, creativity, and analysis of new perspectives during times of financial constraints and workforce reductions within the hospital system. Finally, individual consideration supported the need for individual achievement and growth during times of hospital financial uncertainty. Together, these skills were utilized to create a sense of purpose, creativity, and innovation, while examining different perspectives and providing opportunities for individual achievement and growth through participation on the project development team.

The engagement and empowerment process comprised Haudan's (2008) attributes that connected the team participants to being a part of something big, having a sense of belonging, knowing their contributions make a difference, and going on a meaningful journey throughout the project development process. The goal was to allow the participants to gather additional data, ideas, feedback, identify barriers and challenges, and to ask questions as they informed their decision on how best to develop a nurse practice review process. Utilizing a combination of transformational leadership skills (Bamford-Wade & Moss, 2010; Doody & Doody, 2012; Haudan; Marshall, 2011), as described above produced a team that was energized and inspired to participate on the project development team and formulate a process to review and monitor nursing practice.

Transformational leadership strategies were employed to facilitate the project development team and to demonstrate team value. One of the transformational leadership strategies utilized to engage and facilitate the team throughout the design and development process were innovative coaching and thriving in complexity (Porter-O'Grady & Malloch, 2011). Utilizing leadership strategies to engage bedside nurses and to create conditions for teamwork where issues are complex, supports involvement in decision making, professional autonomy, and creativity in ensuring achievement of positive patient outcomes (Haudan, 2008; Porter-O'Grady & Malloch). Consequently, due to the bedside nurses' proximity to the action and patient care, nurses are in the best position to: observe issues, problems, or concerns; engage in decisions and actions to improve patient care; and develop a process to monitor the practice of nursing.

Instrumentation

The *Conditions for Workplace Effectiveness Questionnaire-II* (CWEQ-II) (Appendix A) (Laschinger, Finegan, Shamian, & Wilk, 2001) was utilized post participatory engagement after receiving permission to use the tool from the questionnaire developer (Appendix B). The questionnaire has been used in various nursing staff research since 2000. The CWEQ-II measures six components of structural empowerment. The structural empowerment components are defined as the extent to which employees perceive they have access to information, resources, support, opportunity, formal power, and informal power to get things done in their work environment. The questionnaire contains 19-items and a 2-item global empowerment scale, which is used for construct validation purposes only. The questionnaire is a Likert-scaled survey with scores ranging from 1 (never) to 5 (a lot). The dependent variable is the sum of the

mean score range, 6 to 30, with higher scores correlating with stronger perceptions of structural empowerment.

The questionnaire has shown consistent Cronbach's alpha reliabilities coefficients between 0.79 to 0.82 (Laschinger, Finegan, Shamian, & Almost, 2001), and 0.78 to 0.93 in studies conducted between 1996 and 2008 (Purdy et al., 2010). Content validity was established by a panel of experts (Laschinger, Finegan, Shamian, & Wilk, 2001). Construct validity was supported in confirmatory factor analyses and correlates highly with nurses' perception of structural empowerment in the work environment. Therefore, the reliability and validity of this tool have been established making this a valid questionnaire to measure the perceptions of structural empowerment post participatory engagement of the project development team.

Data Collection

Nurse practice review pilot. The DNP project facilitator obtained approval to draft an algorithm (Appendix C) for the nurse practice review process from the DNP project team. The draft algorithm was presented to the DNP project team and after much discussion, team consensus was obtained to use the draft algorithm to monitor and evaluate an issue identified by the project development team participants. The project development team chose to pilot the algorithm on assessing frontline nurse participation in meetings where information (e.g. data, quality indicators, etc.) are presented within the facility and within CMC. The project team participants, in essence became the focus group for the pilot, in which the following 2 issues were identified: Nurses do not know what committees they can participate on and nurses do not know what information or data is presented at each meeting for action planning or staff engagement (Appendix D).

Application of the algorithm led to the development of a survey grid (Appendix E) to query the current FHSH leadership meeting participants and their connection to the corporation. The survey grid was sent to a cross section of managers, service leaders, clinical coordinators, house supervisors, and program coordinators within the specialty hospital, which totaled 10 people. Respondents had 4 weeks to respond to the survey during the month of September. Email reminders were sent 5 times during the specified timeframe.

Nurse practice review project survey. The survey was created using SurveyMonkey.com, an on-line software program. The survey was emailed to nurses post participatory engagement on a practice review development team within FHSH during the month of November. However, responding to the email was voluntary, confidential, and anonymous. The timeframe for the participants to respond to the questionnaire was 2 weeks. Email reminders were sent every Monday and Thursday for 2 weeks during the specified timeframe.

Data Analysis

The developed and piloted practice review process was evaluated using a survey developed by the DNP project facilitator (Appendix F). A summary of the pilot recommendations and the project evaluation were reported to nursing leadership. Results were also disseminated and presented at various hospital-specific and corporate quality meetings.

The CWEQ-II (Laschinger, Finegan, Shamian, & Wilk, 2001) is a Likert-scaled questionnaire, scored from 1 to 5. The scores were summed and averaged for each sub-scale. The structural empowerment score was calculated by summing the sub-scales together. Higher summed average scores correlated with higher perceptions of structural empowerment. For example, scores ranging from 6 to 13 have low perception levels of structural empowerment, 14

to 22 have moderate perception levels of structural empowerment, and 23 to 30 have high perception levels of structural empowerment.

Ethical Consideration (Human Subject Protections)

This project received "exempt" status from the CMC's Institutional Review Board (IRB) and "minimal risk" status from the IRB program at California State University, Fresno, since the project and data collection did not contain any patient health information (PHI) and used usual care and/or monitoring methods already in place to identify and monitor the quality of nursing practice. In addition, the participants completed an on-line questionnaire that was voluntary, confidential, and anonymous. Completion of the CWEQ-II survey constituted informed consent (Appendix G). There were no consequences associated with this project, if there had been a loss of privacy or if someone decided to not participate on the project development team and/or complete the CWEQ-II survey and project evaluation.

Trustworthiness

The DNP project facilitator emailed the DNP project invitation to all in-patient nursing departments and the facility-specific NPC committee members. Nurses who agreed to participate, responded in person or in an email sent directly to the DNP project facilitator. The DNP project facilitator acknowledged each agreement in person or in an email sent directly back to the participant. Since there were no exclusionary criteria, all who agreed to participate were permitted to join the project development team. The aim was to create a diverse and dynamic group, with different perspectives and experiences, to develop a sustainable nurse practice review process. An email distribution list for the project development team participants was developed to facilitate communication. The list was used to send meeting invitations, minutes,

agendas, and discussions, updates, and/or meeting reminders to all project development team members, even those who could not make it to every meeting.

During each meeting, the DNP project facilitator wrote ideas, recommendations, and next steps on the large Post-It Sticky Notes. During the first meeting, for example, after discussing the purpose of the project and informing the group of the current literature, the project team requested additional information. The project team wanted to know if a process had been developed anywhere and could the original author of the expert review panel process be contacted. Their recommendation to identify if a process had been developed anywhere was to send an email to the CNS-Listserv, ask if a process has been developed, and to see if anyone would be willing to share their process.

Their recommendation for contacting the original author was to contact the journal publisher, since the DNP project facilitator was unable to contact the original author directly via email. These recommendations became the follow-up for the next meeting. There was no response from anyone on the CNS-Listserv. However, there was a response from the journal publisher, in that they would try to make contact with the co-authors of the article. There was never a response from the journal publisher afterwards. The emails and resulting information was shared with the project development team during the second meeting to demonstrate active listening and responsiveness to their ideas and recommendations.

Summary

The DNP project facilitator engaged and empowered a group of bedside nurses within a small specialty hospital to develop, pilot, and evaluate a nurse practice review process by employing various transformational leadership strategies. All nurse participants who agreed to participate were included, leading to a diverse and dynamic project development team. Post

nurse practice review pilot evaluation, the project development team members were asked via email to voluntarily complete the on-line CWEQ-II survey. The summary recommendation of the piloted process and the perceptions of structural empowerment scores post participatory project development team engagement will be presented in the next section.

CHAPTER 4: RESULTS

Sixteen nurses agreed to participate on the project development team via email response or personal confirmation. Fifty percent of the nurses had 10 years or less of nursing experience and 50% had 11 years or more of nursing experience (Appendix H). In addition, the project development team was represented by both FHSH Nurse Practice Council members and non-members (Appendix I). The results indicate almost 86% of the participants were FHSH Nurse Practice Council members and 14% were non-members. Team participants were represented by both FHSH Nurse Practice Council members and non-members. The majority of the nurse participants provided direct care at the bedside, however, one nurse participant was a clinical data abstractor. Although, there were 16 frontline nurse participants who agreed to participate, actual nurse participants ranged from 5 to 9 participants for each monthly project meeting. Based on sign-in sheets, there were 1 to 2 more FHSH Nurse Practice Council members compared to non-members for each DNP project team meeting.

Nurse Practice Review Process Pilot

The response rate for the survey grid that was sent to a cross section of FHSH nursing leadership (N=10) was 70%. The respondents identified 30 meetings that they routinely attended. Information (e.g. data) is reported in 40% of the meetings and in 92% of these meeting the information is reported higher (e.g. facility and organizational leadership, and/or to the Board) (Appendix J). In relationship to participation in meetings where information is presented, frontline nurses routinely participate in only 25% of the meetings, while 17% rarely participated even when invited, and the remaining 58% does not have frontline nurse participation. (Appendix K). In addition, 50% of the identified meetings have a similar or counterpart meeting

within the corporation that are not connected, 25% do not have corporate oversight, and 25% do not have a corporate (i.e. similar or counterpart meeting) connection (Appendix L).

As the meeting assessment data was discussed and summarized, the project development team/focus group subsequently identified the following issues, as well:

- There are many meetings in which data is presented, but frontline nurses are not present.
- No centralized forum to disseminate data to frontline nurses for discussion and problem solving exists.
- There are many similar CMC or facility-type meetings, but they're not allied with their counterparts (e.g. Quality Patient Heart Committee, Quality Patient Safety Committee, etc.).
- As a whole, very few meetings connected with corporate CMC.
- Meetings within FHSH, specifically and within CMC, as a whole, need to have streamlined reporting processes and alignment to standardize the practice environment within the organization.
- The feedback loop between nursing and management will delay strategies to improve processes.
- Frontline RNs don't always have access to information (e.g. data).
- Frontline RNs are not engaged in discussions to identify solutions to improve patient care quality.

The data from the algorithm pilot and the focus group discussion generated many recommendations (Appendix M) that were reported to the FHSH Nurse Practice Council, FHSH leadership, and the corporate Chief Nursing Officers group.

Structural Empowerment Survey

Fourteen of the 16 DNP project team participants responded to the CWEQ-II/structural empowerment survey. Forty-two percent were Bachelor of Science degree nurses, 28% were associate degree nurses, and 28% were Master of Science degree nurses. The independent variable was years of nursing experience: 50% had 10 years or less and 50% had 11 years or more. The dependent variable was the structural empowerment score. For the group overall, the structural empowerment score was 18.73, indicating a moderate structural empowerment perception level (i.e. 14 to 22 out of 30 points total). Cronbach's alpha for each subscale ranged from 0.74 to 0.80 (Appendix N) indicating good reliability (i.e. Cronbach's alpha greater than 0.70). The calculated standard error of measurement (SEM) (Appendix N) was less than half the standard deviation for each structural empowerment subscale indicating a good SEM. The structural empowerment subscale averages ranged from 2.69 for Job Activities to 3.67 for Access to Opportunity (Appendix O). Each subscale had moderate levels of perceptions between 2.5 and 4. None of the subscales scored low (i.e. 2.5 or less) or high (i.e. 4 or greater) levels of perception.

Project team participants who had 10 years or less of nursing experience had a structural empowerment score of 20.11, indicating moderate structural perception levels. The subscales ranged from 2.86 for Job Activities to 4.0 for Access to Opportunities. The project team participants who had 11 years or more of nursing experience had a structural empowerment score of 17.37, also indicating moderate structural perceptions levels. The subscales for this group ranged from 2.48, which is just below the moderate perception level for Access to Support to 3.33 for both Access to Opportunity and Access to Information. Structural empowerment subscale average comparisons were calculated among the overall group, participants with 10

years or less of nursing experience, and participants with 11 years or more of nursing experience (Appendix P). In addition, independent t-tests were calculated between the group with 10 or less years of nursing experience and the group with 11 years or more of nursing experience. The independent t-test results indicated no statistical significant difference between groups.

Nurse Practice Review Project Evaluation

Twelve of the 16 nurse participants responded to the two Likert-scaled questions for project evaluation. The first question was: How effective do you believe the nurse practice review algorithm will be in helping nurses MONITOR nursing practice? The second question was: How effective do you believe the nurse practice review algorithm will be in helping nurses EVALUATE nursing practice? Both questions had a mean score of 2.67, scores ranged from 1 to 3. Cronbach's alpha for both was 0.63, which is considered less than reliable (i.e. less than 0.7). The low Cronbach's alpha may be due to the small sample size, only 2 items on the survey, and/or the 3-point versus 5-point Likert-scaled items. However, the total Cronbach's alpha score was 0.77, which is an acceptable level of reliability.

There were 5 open ended questions that several of the nurse participants responded to. There were 7 responses to the following question: What facilitated your participation?

- Possible quest for DNP myself.
- This project will help to bring some positive outcomes which can be applied in practice.
- Practice improvement.
- Desire to be more present and active in my role in the facility.
- Invitation.
- Meetings were prior to NPC on the same days.

- Interest in the project and convenience of the meetings.

The themes identified suggests that nurses are interested, want to participate in improvement activities within the hospital, and meeting convenience facilitates participation.

The second question asked: What hindered your participation? There were 6 responses to the question:

- Work schedule.
- Busy schedule.
- Late schedule changes to meeting dates or times.
- Deadline pressure earlier in the year resulted in difficulty feeling prepared for meetings, not sure of how I could prepare for upcoming discussions.
- I usually worked the days prior and was exhausted.
- Nothing.

The main theme identified was the nurses' work schedule hindered participation in the meetings, mostly due to work schedules, changes to meeting times (e.g. there was 1 meeting rescheduled due to the Joint Commission Survey), and other deadline pressures.

There were 5 responses to the third question: How might the practice review algorithm be improved?

- Effective communication will be necessary for the algorithm to work.
- It will open windows of opportunity for the front line staff to participate more in delivery of patient care.
- N/A
- I think it's great the way it is.

- Only through the extent to which it is implemented.

The main theme identified for practice review algorithm improvement will be through effective communication and in how the algorithm is implemented. In addition, one respondent indicated "It will open windows of opportunity for the front line staff to participate more in delivery of patient care."

There were 6 responses to the fourth question: If you were a DNP Project Team participant, what did you learn?

- That collaboration of bedside nurses can truly make changes happen.
- I need to inform, share information to the front line staff.
- N/A
- A bit about the process of pursuing DNP. Interesting- Andrea is the first person I know to be in this program.
- That we need more communication and more frontline nurses attending meetings. They are the ones who know firsthand what is happening on the floors.
- How helpful and effective it is to involve nurses in the process of improving nursing practice.

The main theme reported was staff engagement: collaboration with bedside nurses, communicate more with the nurses, and involve nurses in the process for practice improvement. One of the respondents indicated nurses "are the ones who know firsthand what is happening on the floors."

There were 6 responses to the final question: Additional comments, observations, or thoughts about the DNP project process, algorithm, etc.

- The process will work if all parts are implemented and encouraged!
- N/A

- Thank you to Andrea for being such an energetic, positive facilitator in both groups. You are invaluable :-)
- Translating the algorithm into a concrete model, potentiates its long term effect, good work
- Go Andrea!! Proud of you and all your hard work and effort!
- I look forward to participating in the process.

The main theme identified for the last question was associated with implementation of the algorithm for long term effect. In addition, the DNP project leader received positive feedback for team facilitation from 2 respondents.

CHAPTER 5: DISCUSSION

Summary and Interpretation of Findings

Nurse practice review pilot. Data or information is presented in many meetings within the facility. However, frontline nurses are not involved nor present in the majority of the identified meetings, specifically those in which data is presented. Similarly, there is no centralized forum to disseminate data to frontline nurses for discussion and problem solving, which results in frontline nurses not being engaged to identify solutions to improve patient care. Simply stated, nurses do not have access to information to make informed decisions.

Many of the meetings have a counterpart or similar meeting, but are not connected within the corporation nor is there corporate oversight. Consequently, there isn't a streamlined process within the facility or corporation for meetings nor is there a streamlined process for meeting reporting structures. In addition, the feedback loop between nursing and management delays strategies to improve patient care processes.

Recommendations from the piloted process included streamlining the meetings and meeting reporting structure both within the facility and the corporation. Also, suggested was development of a centralized forum for presenting data to frontline nurses that includes frequency of data reporting, a 30-day feedback loop between nursing and management, and increasing bi-directional communication between frontline nurses and management.

One of the goals of this DNP project was to develop a process for nurses to monitor and evaluate their nursing practice. Donabedian's (1988) SPO model was utilized as the foundation to develop a formalized algorithm (e.g. the structure or process). Although a nurse practice review process was developed, frontline nurses identified disconnected organizational meeting structures both within the facility and the corporation that require oversight and alignment. As

Donabedian had implied an understanding between structure and process, and between process and outcomes facilitates interpretation of findings that do not make sense. For example, similar non-connected meetings within the corporation are unable to share innovative strategies that improve care delivery and/or quality indicators, which can lead to differences in the practice environment within the corporation.

Structural empowerment survey (i.e. CWEQ-II). The DNP project development team had moderate structural empowerment score levels. The sub-scales in order from lowest to highest were: job activities or formal power**,** access to support, organizational relationships or informal power, access to resources, access to information, global empowerment, and access to opportunity. Job activities, access to support, and organization were perceived to be the 3 lowest categories overall as measured on the structural empowerment survey.

Job activities measured physician collaboration with patient care, being sought out by peers, managers, and other professional disciplines for help with problems or ideas in the present job. Access to support measured information regarding what one does well, needs improvement in, and problem-solving advice provided in the present job. Organization relationships measured rewards for innovation, the amount of flexibility and visibility of work-related activities within the facility. However, they were all within the moderate perception level. Nevertheless, the DNP project development team perception scores may indicate there is an improvement opportunity for frontline nurses to make decisions, be visible, and gain information from or dialogue with other disciplines and/or leadership within the practice environment.

It is important for nurses to perceive high levels of power and empowerment within the practice environment. Per Purdy et al. (2010), nurses who worked in empowered practice

environments had positive effects on nursing quality indicators and problem identification through group processes.

There were two groups identified within the DNP project development team, those who had 10 years or less of nursing experience and those who had 11 years or more of nursing experience. For those who have 10 years or less of nursing experience, the sub-scales in order from lowest to highest were: job activities, access to support, access to resources, access to information, organizational relationships, global empowerment, and access to opportunity. For the group with 11 years or more of nursing experience, the sub-scales in order were: access to support, job activities, organizational relationships, global empowerment, access to resources, access to information, and access to opportunity. Although, the group with more years of nursing experience had overall lower structural empowerment perception levels, the group remained within the moderate level. The perception level was similar to both the DNP project development team and to the group with 10 years or less of nursing experience.

Nurse practice review project evaluation. Participants of the DNP project development team believe the nurse practice review algorithm will effectively assist nurses in monitoring and evaluating nursing practice. Participants learned staff engagement via collaboration, communication, and involvement in practice improvement processes would be helpful, effective, and make change happen. However, effectiveness will be dependent upon how it is communicated and implemented within the facility. Additionally, the participants are interested and want to participate in improvement activities within the hospital setting. The participants thought the meeting times were convenient, but conversely thought work schedules hindered participation.

Nurses are on the frontlines and "know firsthand what is happening on the floors", as one respondent wrote. Nurses are closer to the everyday care process that occur within healthcare facilities and due to this position, nurses can provide timely information that improves quality care and patient care outcomes (McHugh & Stimpfel, 2012). For this reason, frontline nurses need to be in attendance at meetings in which quality or performance indicators are discussed.

The DNP project facilitator utilized transformational leadership skills: idealized influence, inspirational motivation, intellectual stimulation, and individual consideration (Bamford-Wade & Moss, 2010; Doody & Doody, 2012; Marshall, 2011) to engage and empower the DNP project development team participants. As anticipated, the DNP project development team participants were engaged and empowered to identify problems, solutions, and recommendations, as evidenced by what the DNP project development team selected to pilot the nurse practice review algorithm on.

Originally, the plan was to pilot the nurse practice review algorithm on hand-off communication. However, as the team progressed, they became motivated, passionate, and enthusiastic about investigating frontline nurse participation on various committees. The DNP project development team desired a better understanding of what meetings were in existence, who the frontline nurse participants were, and what data/information was being presented. This may have been a result of the workforce reductions that had occurred about 2 months earlier within the project facility. Idealize influence (e.g. sense of purpose) and inspirational motivation (e.g. goal setting), for example, resulted in a shared vision to investigate frontline nurse participation on various committees. Intellectual stimulation (e.g. creativity) and individual consideration (e.g. individual achievement and growth), for example, is evidenced by the change

in course on what the DNP project development team wanted to evaluate. Participants wanted to know where frontline nurses were contributing to quality patient care.

Limitations

This DNP project had several limitations. The DNP project facilitator was very familiar with the project facility, the corporation, and chairs the facility-specific nurse practice council. This may have led to some bias in the project, since the DNP project facilitator knew the members of the DNP project team. In addition, the majority of the participants were members of the facility-specific nurse practice council. The DNP project participants may have had higher power and structural empowerment perception levels due to their participation on the facility-specific nurse practice council compared to those who are not participants on any committees. Therefore, it would have been interesting to have a comparative group, who do not routinely participate on committees, complete the structural empowerment survey to ascertain their power and structural empowerment perception levels and to identify differences and/or associations between groups. Statistical tests for differences and relationships between the group with 10 years or less of nursing experience and the group with 11 years or more of nursing experience could not be calculated due to the small sample size. Only the *Conditions for Workplace Effectiveness Questionnaire-II* (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001) was utilized, however, other nursing empowerment and engagement tools could have been of value. Finally, the project pilot findings are only generalizable to the project facility and to the CMC organization due to the nature of the pilot (e.g. frontline nurse participation on facility committees and connections at the organizational level).

Implications for Nursing Practice

Frontline nurse participation was key to developing and piloting the nurse practice review algorithm. Ultimately, the problem selected to pilot the nurse practice review algorithm was a result of the diversity of the DNP project development team, who wanted to know where frontline nurses could make their contributions visible in quality patient care, rather than piloting the algorithm on one quality initiative. This relates to the original problem described for this DNP project. Currently, within the CMC system, frontline nurses are not represented on the corporate nurse practice council, but are represented on the hospital-specific nurse practice council at Fresno Heart & Surgical Hospital, the DNP project facility. Data is not presented in either meeting, but as a result of this DNP project, data will be presented in meetings in which frontline staff are currently participating at FHSH. Frontline nurse participation on various committees may lead to increased awareness of the influence nurses have on patient outcomes, as indicated by Schreuders et al. (2012).

The DNP project participants want to be involved and engaged in addressing issues or poor quality indicators that impact quality care within their facility, but they need to be a part of the discussions. These findings are in agreement with the: ANA's *Peer Review Guidelines* (1988), *Code of Ethics* (2001), and the *Nursing: Scope and Standards of Practice* (2010), in that nurses are to be active participants in review mechanisms that are designed to improve quality care while comparing nursing care delivery to professional nursing standards and practices; recognition of nurses' contribution to care quality and patient outcomes (Davis et al., 2013); role nurses play in addressing findings from sentinel events, root cause analyses, and in nurse practice reviews (Raia, 2011); and evaluating nursing practice using an expert panel process (Rice et al.,

2007), for example, involving and engaging frontline nurses in the evaluation of nursing practice and in improving quality care.

Although, the purpose of this DNP project was to develop a structure (e.g. nurse practice review process) utilizing Donabedian's (1988) SPO model, another structure needing refinement was identified through the nurse practice review pilot process. There are many meetings at the facility and corporate level that need to be aligned, possibly restructured to include frontline nurses, and clearly defined with purpose and reporting processes or oversight. Creating the proper committee structures lays the foundation to improve and align the practice environment, standardize processes (e.g. provision of nursing care, accuracy of data), and improve outcomes (e.g. results, quality indicators) between and among the facilities. In addition, best practices and innovative ideas can be readily shared within the corporation and among the frontline nurses.

Alignment with DNP Essentials

This DNP project demonstrated mastery of the American Association of Colleges of Nursing's *The Essentials of Doctoral Education for Advanced Practice Nursing* (AACN, 2006). Transformational leadership strategies provided frontline nurse engagement and empowerment that resulted in identifying facility and organizational system issues. System issues were assessed and evaluated utilizing a nurse practice review algorithm designed by the DNP project facilitator with consensus from the DNP project team. Intra-professional communication and collaboration resulted in many recommendations to improve organizational alignment and structures within a complex organization based on findings that has been disseminated within the specialty hospital and the CNO group. Ultimately, engaged and empowered frontline nurses will lead to ensuring patient safety and improved patient and hospital outcomes, and care delivery

within a high-performing organization that is based on scientific, theoretical, ethical, and economic principals of nursing practice in a transformed healthcare environment.

Conclusion

Frontline nurses are in prime positions to monitor, evaluate, and develop innovative strategies to improve patient care quality. They are on the frontline lines everyday observing the interactions and connections between and among peers, patients, and other disciplines within our complex healthcare environments. They know firsthand what is and is not working in the practice environment. However, they are not at the table dialoguing and identifying innovative strategies and solutions. Frontline nurses want to be aware of their contributions to quality patient care and therefore it is imperative that they be engaged to seek innovative solutions and at the table during the discussions.

Working with frontline nurses at the grassroots level led to an engaged and empowered team, who were able to identify a novel issue within their facility that they were able to evaluate utilizing the nurse practice review algorithm. Facilities and organizations who want to improve their practice environments with frontline nurse engagement and empowerment should consider evaluating their current committee structures to determine if there is frontline nurse participation. In addition, and although not a focus of this DNP project, many facilities are going on the American Nurses Credentialing Center's Journey to Magnet Excellence, in which frontline nurse structural empowerment is a major component.

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APPENDICES

APPENDIX A

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE-II (CWEQ-II)

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

	No Knowledge		Some Knowledge		Know A Lot
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

IN MY WORK SETTING/JOB:	None				A Lot
1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in my job is	1	2	3	4	5
3. The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

		None				A Lot
1.	Collaborating on patient care with physicians.	1	2	3	4	5
2.	Being sought out by peers for help with problems	1	2	3	4	5
3.	Being sought out by managers for help with problems	1	2	3	4	5
4.	Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1	2	3	4	5

		Strongly Disagree				Strongly Agree
1.	Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2.	Overall, I consider my workplace to be an empowering environment.	1	2	3	4	5

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APPENDIX B

Signed permission to use the Conditions of Work Effectiveness Questionnaire-II Survey

NURSING WORK EMPOWERMENT SCALES & Request Form

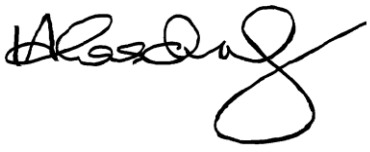
I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:
Conditions of Work Effectiveness-I (includes JAS and ORS):
Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes
Job Activity Scale (JAS) only:
Organizational Relationship Scale (ORS) only:
Organizational Development Opinionnaire or Manager Activity Scale:

Date: May 8, 2013
Name: Andrea Lee-Riggins
Title: Working title: A nurse developed peer/practice review process utilizing transformational leadership as a guide.
University/Organization: NorthCAL DNP Collaboration
California State University, Fresno and San Jose State University
Address: Andrea Lee-Riggins, 1873 Everglade Ave. Fresno, CA 93619
Phone: 559 325-0470 (home) or 559 433-8049 (office)
E-mail: dreajan5@comcast.net (home) or andreale@csufresno.edu (school)

Description of Study: To evaluate nurses' perceptions of workplace empowerment post development of a nurse peer/practice review process working in a small specialty hospital.

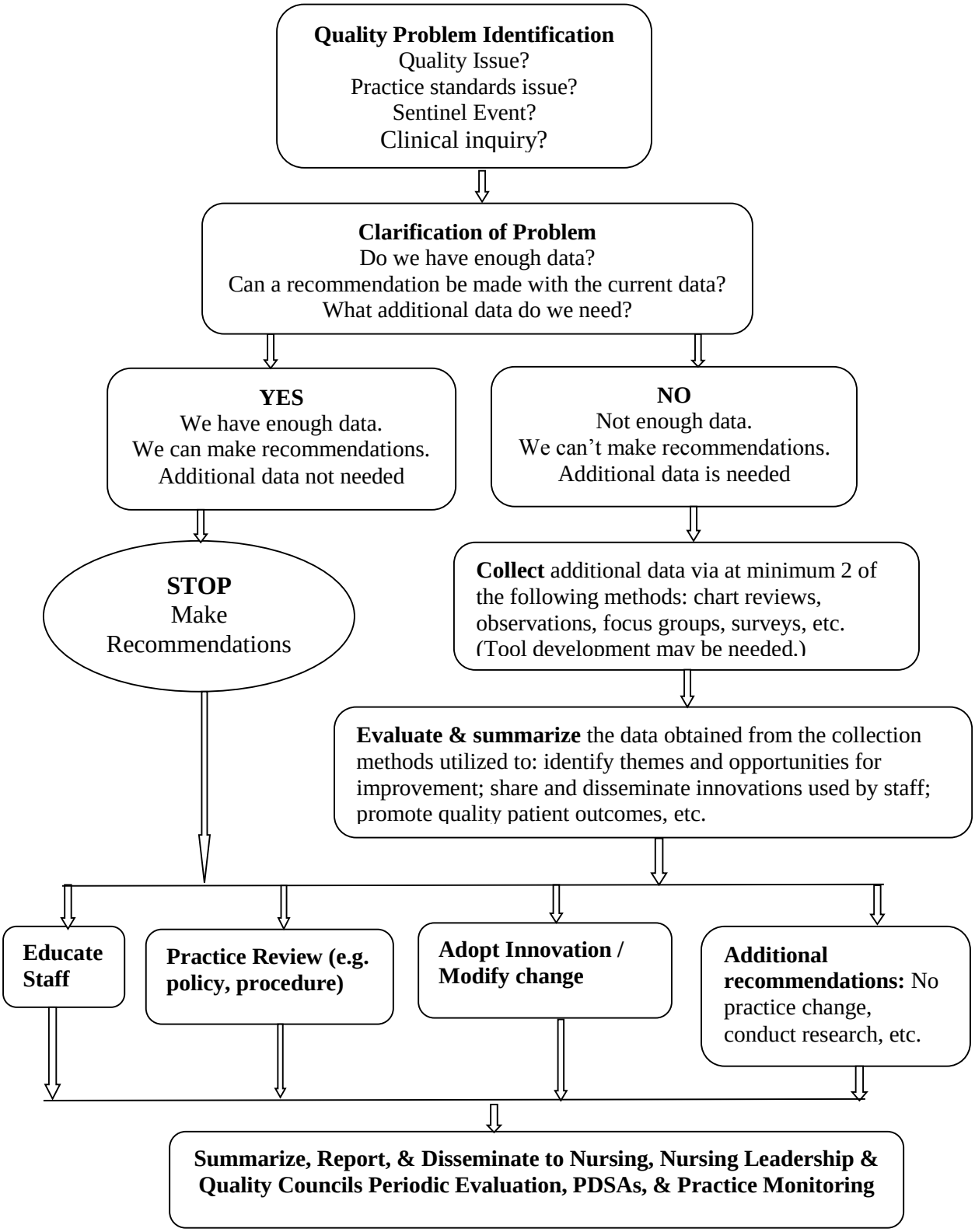
Date: May 8, 2013



Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel: 519-661-2111 ext.86567 Fax: 519-661-3410
E-mail: hkl@uwo.ca

APPENDIX C

Nursing Quality Practice Review Algorithm



APPENDIX D

Nurse Practice Review Algorithm Pilot used to evaluate

Fresno Heart & Surgical Hospital (FHSH) Facility-specific Meetings

Problems Identified:

1. Nurses do not know what committees are in existence that they can participate on.
2. Nurses do not know what information or data is presented at each meeting for action planning.

Clarification of the problem:

1. Do we have enough data or know what exists?

   Answer: No

2. Can a recommendation be made with the current data or known information?

   Answer: No

3. What additional data/information do we need?

   Answer: Nurses need to know what committee exist that they can participate on and what data/information is shared, in order to make informed decisions regarding additional data collection and/or recommendation for practice improvement.

Collect the following information at the facility level:

1. What committees exist?
2. What can nurses participate on (or are there meetings that nurses are NOT allowed to attend)?
3. Is there a monthly meeting calendar available or accessible to nurses?
4. Who are the chairpersons for each committee?
5. Who and what job title represents nurses on each committee?

6. What is presented (e.g. data, practice, etc.) at each meeting?
7. What projects, initiatives, etc. are each committee responsible for?
8. What is the formal place or committee for specific departments (e.g. cardiac evaluation center, cardiology/cath lab) to present their information?

Collect the following information at the corporate level:

1. What are the corporate committees?
2. Is Fresno Heart & Surgical Hospital represented at each meeting or on each committee?
3. Are there similar issue identified at the corporate level? If so, what did they do (e.g. action plan)?
4. Where is the corporate information/data shared?

APPENDIX E

Meeting Survey Grid

Meeting	Purpose of the Meeting	If data is reported, what data is reported?	Which meeting is this data reported to next?	If nurses are present, are they: 1. Frontline nurses or 2. Clinical Supervisor /Coordinator and above	Which corporate meeting(s), if any, is/are connected?	If not connected, but IS similar to a corporate meeting, then which corporate meeting?

APPENDIX F

DNP Project Evaluation Survey Questions

1. Years of nursing experience:
   0 to 5 years
   6 to 10 years
   11 to 15 years
   More than 15 years

2. I (person completing the survey) participate/ed on the following;
   DNP Project Team
   Nurse Practice Council
   Both DNP Project Team and Nurse Practice Council
   None of the above

	Not Effective	Somewhat Effective	Very Effective
3. How effective do you believe the nurse practice review algorithm will be in helping nurses MONITOR nursing practice?	1	2	3
4. How effective do you believe the nurse practice review algorithm will be in helping nurses EVALUATE nursing practice?	1	2	3

5. What facilitated your participation?

6. What hindered your participation?

7. How might the practice review algorithm be improved?

8. If you were a DNP Project Team participant, what did you learn?

9. Additional comments, observations, or thoughts about the DNP project, process, algorithm, etc.

APPENDIX G

SURVEY CONSENT

Dear Nurse Participants:

I am working toward a Doctorate of Nursing Practice (DNP) degree from the NorthCAL CSU, Fresno / San Jose State University Joint DNP Program. My DNP project is empowering nurses to monitor, discuss, and evaluate the practice of nursing. The purpose of this survey is to measure your perceptions of structural empowerment: access to information, support, and resources AND to provide an evaluation of the project post participatory engagement.

Would you please take a few minutes (less than 15 minutes) to answer a short survey on "structural empowerment" and to evaluate the project. The results and the analysis of data will be shared once completed and reported in the final DNP project paper.

I would truly appreciate your help in completing this survey by December 6th, 2013. Your decision to complete and submit your responses constitutes informed consent.

If you have any questions, please contact me at alee@fresnoheartandsurgical.org

Thank you,

Andrea Lee-Riggins, DNP(c), APRN-CNS, CCNS, CCRN

APPENDIX H

Years of Nursing Experience

Years of nursing experience?	
Answer Options	Response Percent
0 to 5 years	21.4%
6 to 10 years	28.6%
11 to 15 years	0.0%
More than 15 years	50.0%

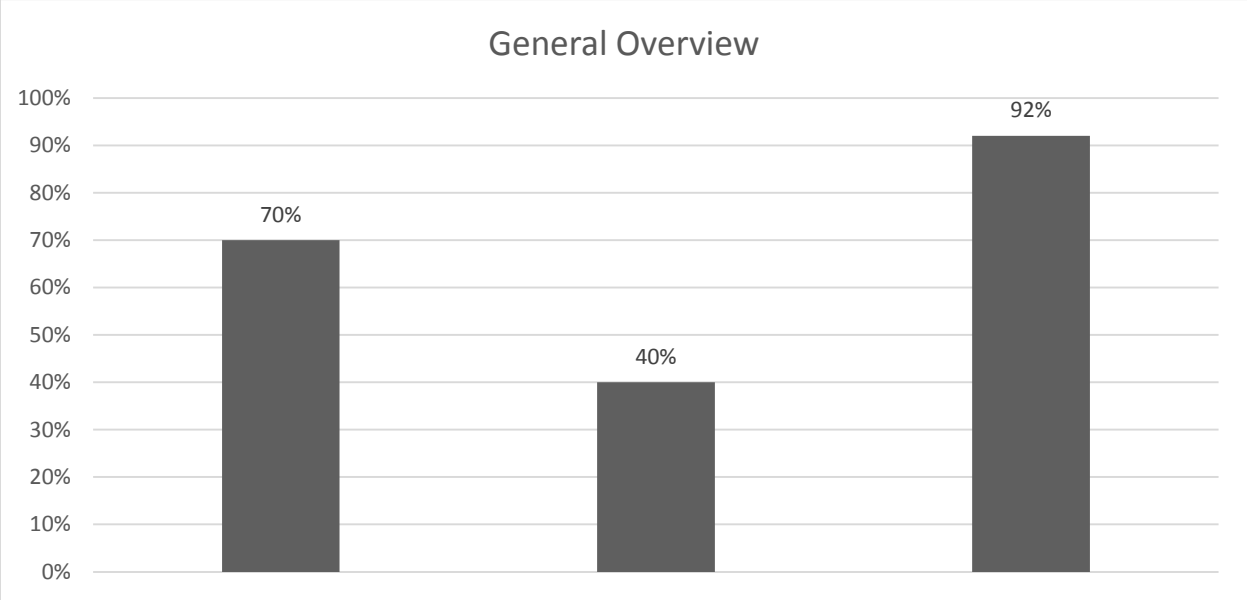
APPENDIX I

DNP Project Team Participants

I participate/ed on the following:	
Answer Options	Response Percent
DNP Project Team	14.3%
FHSH Nurse Practice Council	35.7%
Both: DNP Project Team & FHSH Nurse Practice	50.0%
None of the above	0.0%

APPENDIX J

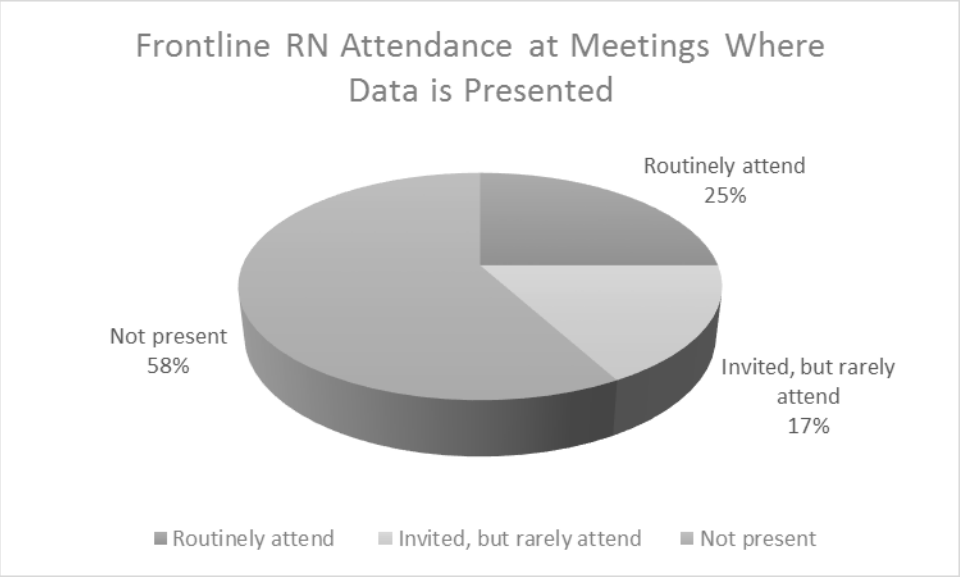
Meetings General Overview



Respondents:	Meetings Data Reported	Data Reported Higher
N = 10	N = 30	N = 12

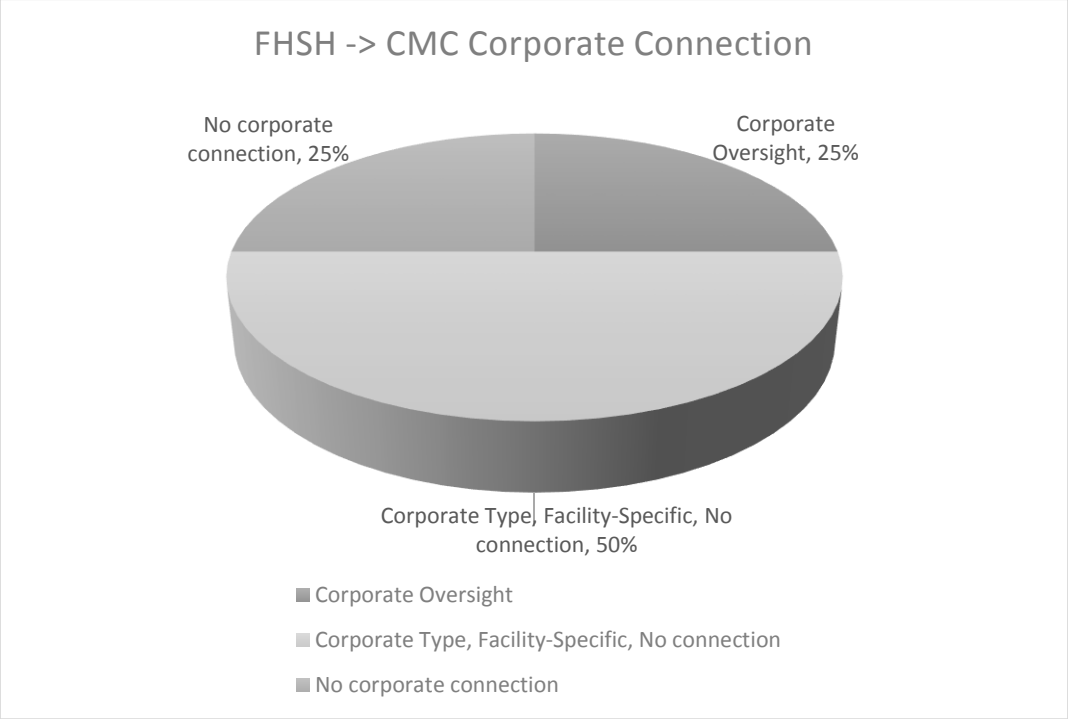
APPENDIX K

Frontline RN Attendance in Data Meetings



APPENDIX L

FHSH Corporate Meeting Connection



APPENDIX M

Meeting Assessment Recommendations from the Nurse Practice Review Algorithm Pilot

I. Report nursing data in a centralized forum (e.g. council meetings), shares minutes on-line for staff access, etc.

II. Streamline the reporting process to other meetings both within FHSH and the organization.

III. Develop reporting frequency for nursing quality indicators.

IV. Feedback loop is 30 days between frontline RNs and administration, so as not to delay taking action (empowerment).

V. Increase bi-directional communication with frontline RNs (3 ideas):

    a. Quarterly nursing forums with frontline nurses:

        i. Nursing quality indicators identified prior to the meeting.

        ii. Share data with those in attendance.

        iii. Frontline nurses identifies barriers and challenges for improvement.

        iv. Frontline nurses identifies innovative solutions.

        v. Information gathered and reported within the nursing forum.

    b. Nurse representatives from the centralized forums (e.g. Nurse Practice Council, Cardiovascular Nurse Practice Council, etc.)

        i. Share information with peers.

        ii. Gathers feedback, ideas from their peers.

        iii. Reports feedback to the centralized forum.

    c. Add Data agenda item to meetings in which RNs are currently present for discussion and problem-solving.

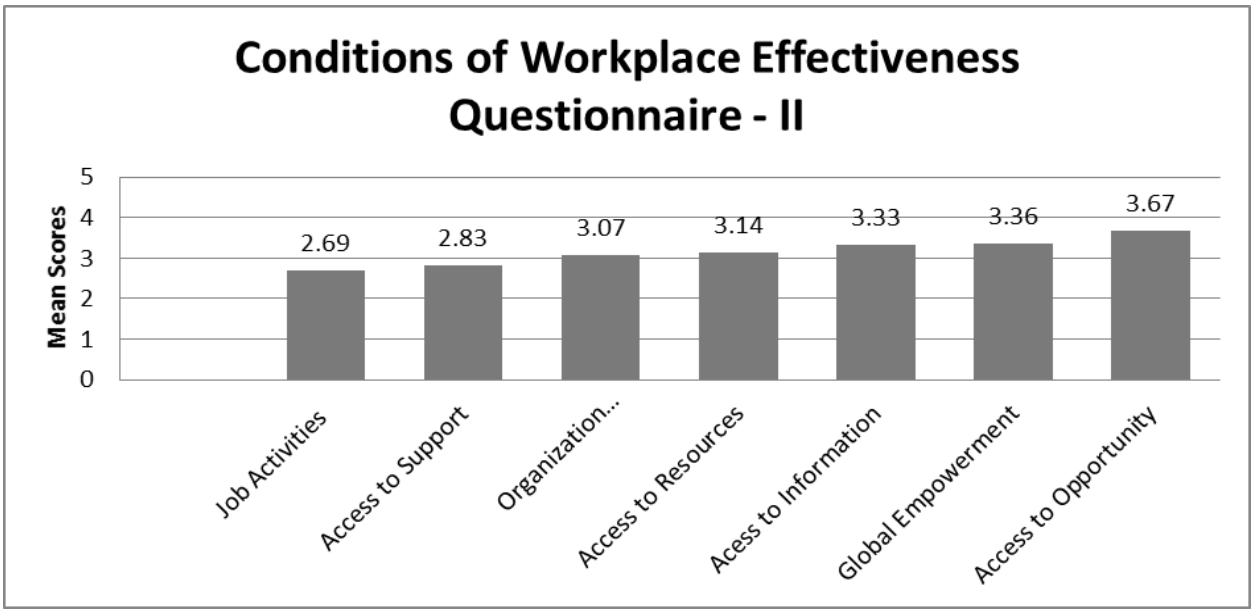
APPENDIX N

Cronbach's Alpha and Standard Error of Measurement

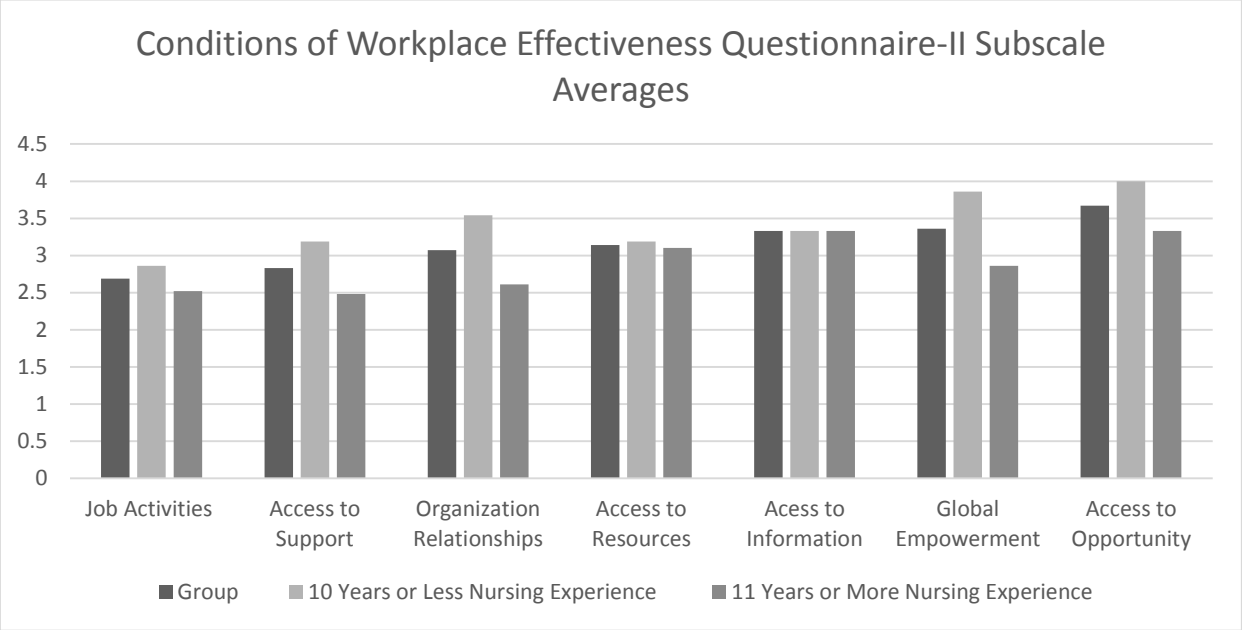
Items	Cronbach's Alpha	SEM	STDV
Opportunity	0.77	0.40	0.8269
Resources	0.77	0.19	0.3860
Information	0.74	0.49	0.9608
Support	0.80	0.40	0.8843
JAS	0.77	0.34	0.7097
ORS	0.74	0.43	0.8403
GE	0.80	0.43	0.9693

APPENDIX O

Conditions of Workplace Effectiveness Questionnaire – II Results



APPENDIX P


Conditions of Workplace Effectiveness Questionnaire-II Subscale Averages
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Job Activities
Access to Support
Organization Relationships
Access to Resources
Acess to Information
Global Empowerment
Access to Opportunity
Group
10 Years or Less Nursing Experience
11 Years or More Nursing Experience