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Nursing Practice Council : literature review, implementation, and evaluation plan

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1. Introduction

The purpose of this paper is to outline an implementation and evaluation plan for the establishment of a Nursing Practice Council (NPC) for the public health and registered nurses in a small rural health unit in southern Ontario. A NPC is a formal, employer-supported structure, consisting of a representative group of front line nurses, and its purpose is to enhance the practice and work environment for nurses by providing access to peer support and creating a forum for discussion and decision making regarding nursing practice issues. The resulting enhanced nursing practice environment may lead to benefits to the patient through improved care and benefits for the organization such as improved nurse recruitment and retention.

In this paper, a health promotion program planning and evaluation framework will be utilized to plan, implement and evaluate a NPC for the Haldimand Norfolk Health Unit (HNHU), located in southern Ontario. As the NPC is not a true health promotion program per se, the evaluation framework for its development and implementation has been modified to suit this project. By using this modified framework, a step by step plan can be developed, which will facilitate the identification of enabling factors and barriers as well as provide information for the implementation evaluation strategies throughout the process. Consequently, timely corrections to the process can be made during implementation which will in turn assist the project to succeed. The evaluation will seek to identify the benefits to the nurses and the organization.

In this paper, information is provided on a review of current literature regarding the status of public health nursing in Ontario and the concepts and models related to NPCs (section 2); the goal of the paper (section 3); an overview of the project (section 4); the project implementation plan (section 5); the proposed evaluation framework (section 6); and the implications for public health practice and policy (section 7).

2. Literature Review

In this section, the literature relevant to the status of public health nursing and the concepts and models related to NPC will be reviewed, including: public health nursing in Ontario, empowerment and power, shared governance, and NPC implementation. In addition, gaps in the literature will be highlighted, and implications of NPC implementation in a rural health unit will be discussed.

2.1 Public Health Nursing in Ontario

Public health nurses (PHNs) represent 50% of all the professionals working in public health in Ontario (Underwood et al., 2007). Public health is "an official agency established by a group of urban or rural municipalities to develop and provide comprehensive community care programs" (Alameddine, Laporte, Bauman & O'Brien-Pallis, 2006, p.83). PHNs practice in homes, schools, shelters, clinics and community agencies, and their primary role is the promotion of health for individuals, families and the community (Underwood et al., 2007). The definition of a public health nurse is further refined by the Community Health Nurses Association of Canada (CHNAC) "a community health nurse synthesizes knowledge from public health science, primary health care (including the determinants of health), nursing science, and theory and knowledge of the social sciences to promote, protect, and preserve the health of populations" (CHNAC, 2003, p.3).

The focus of practice of PHNs is health promotion of populations and communities with the recognition it is linked to the health of individual members, families and groups (CHNAC, 2003). In addition to health promotion, the standards of practice of this group of nursing professionals includes building individual and community capacity, building relationships, facilitating access and equity and demonstrating professional responsibility and accountability. The public health sub-sector has a very high proportion of Registered Nurses (RNs) compared to acute or long term care where the proportion of Registered Practical Nurses (RPNs) and non-regulated care providers is higher (Underwood, et al., 2007); this is due to the complexity and autonomy of public health nursing work and legislative

mandates. For example, RNs have broader scope of practice than RPNs and must be prepared with a baccalaureate degree in nursing compared to the two year diploma program for RPNs (Alameddine et al., 2006). Given that PHNs have the required education, specialized knowledge and skills and the mandate to impact health at a population level it is important that those skills are utilized to their full scope of practice.

A study of employment of nurses by sub-sector in Ontario conducted by Alameddine et al. (2006) found that the number of nurses working in public health remained steady for RNs but decreased 65.4% for RPNs during the ten years between 1993 and 2003. This finding was confirmed by Underwood et al. (2007) who found the total number of RNs employed in public health from 1993 to 2006 had remained stable despite population growth and demands for service. Although most community sub-sectors such as community health centers, mental health and home care have seen an increase in the numbers of nurses they employ, the public health sub-sector has not experienced the same increase (Alameddine et al., 2006). Most of the funding for Public Health in Ontario is provided through the Ministry of Health and Long-Term Care, the Ministry of Health Promotion, and the local tax base (Underwood et al., 2007). In the mid 1990s funding for public health in Ontario was downloaded completely to municipalities (Registered Nurses Association of Ontario [RNAO], n.d.). This shift in funding was followed a decade later with an uploading of a percentage of pubic health funding back to the provincial government beginning in 2005 (Community Action Publishers, n.d.). Unstable funding may help to explain why the number of public health nursing positions has not kept pace with population growth. As the number of public health nursing positions in Ontario is not increasing, it is even more important that every effort be made to retain the PHNs in place as long as possible, and to provide a practice environment that is attractive to new graduates.

In the past twenty years the practice of public health in Ontario has undergone radical changes that were mostly due to the introduction of the Health Promotion and Protection Act (HPPA) in 1990

and the Mandatory Health Programs and Services Guidelines in 1997 (RNAO, n.d.); note that the Mandatory Health Programs Guidelines were replaced in 2009 by the Ontario Public Health Standards (Ontario Ministry of Health and Long-Term Care, n.d.). The result of these changes for PHNs was a major shift in the nursing practice environment. Nursing departments were eliminated as was the Director of Nursing position. PHNs were now practicing in programs rather than within a discipline-specific nursing department, and were often reporting to non-nurse managers. In response to this change RNAO advocated that the HPPA be amended to include the appointment of a Chief Nursing Officer to oversee nursing practice issues in each public health unit as strong leadership is essential to the nursing work environment (RNAO, n.d.). Today only 50% of public health units in Ontario have a Chief Nursing Officer or equivalent position (RNAO, n.d.).

Meagher-Stewart, Underwood et al. (2009) conducted a qualitative study with PHNs to determine what organization attributes need to be present to support them in practicing to their full scope of competencies. In order the answer their research question the authors conducted 23 focus groups across Canada with 156 front line PHNs, policy makers and managers from both urban and rural/remote areas. An Appreciative Inquiry approach was utilized by the focus group facilitators; this approach encourages people to reflect upon what is right and working about an issue versus what is not working or is perceived as deficient (Challis, 2009). The focus group participants were asked to relay a situation is which a public health nursing intervention worked well and what organizational attributes contributed to that intervention's success. Qualitative analysis of the data generated by each of the focus groups was accomplished using thematic analysis which is the pairing down and sieving of data generated to represent major themes or categories that describe the phenomenon being studied (Byrne, 2001). The findings were grouped into three categories of attributes that enhanced PHN practice: (1) government policy (i.e., support and promote public health and PHN as a valuable component of the health care system, coordinate public health planning and development of shared

resources and adequately fund public health), (2) management practices (i.e., provision of clear program planning linked to local and government strategic directions, value and promotion of public health and PHN contributions, support of autonomous PHN practice, demonstration of effective human resource planning , support for community partnership and the PHN community development role, support of internal and external communication and healthy workplace policies, and (3) local organizational culture (i.e., clear vision for public health, effective and visionary leadership, creative and responsive to community needs and creation of learning environments committed to continuing development).

Meagher-Stewart, Underwood et al. (2009) also noted that the initiation of NPCs was considered by a number of focus groups as an important component of a learning environment and "an effective mechanism for devoting time to nursing issues and professional exchange" (p.17). NPCs are structures that support shared governance which provides formal mechanisms to ensure nurses' rights, responsibility and power to make decisions (Kramer et al., 2008). Power and empowerment of nurses are concepts that are at the center of initiatives to improve job satisfaction, decrease turnover, and improve quality of care (Gokenbach, 2007). Bogue, Joseph and Leibold Sieloff (2009) move that NPCs are the definitive means of approaching shared governance as they "enable the practice of power" (p. 5).

2.2 Empowerment and Power

As described by Edmonstone (2000), the concept of empowerment, although ambiguous is frequently addressed in management and organizational literature; since the mid 1990s it is also found in health care organizational literature. The concept of empowerment has been widely applied in nursing and much has been written (Bradbury-Jones, Sambrook & Irvine, 2008).

The many definitions in the literature reflect the ambiguity regarding empowerment. For example, empowerment has been defined as responsible autonomy, where people will lead themselves

given the freedom and resources to achieve organizational goals, if it is in their best interests to do so; it is the leader's role is to assist people to unlock their own potential (Sims, Fineman & Gabriel, 1993). The leader is in-fact giving over power, and empowerment is seen as a means of democratizing management. Empowerment has also been defined as a framework that provides clear boundaries within which people can experiment; although a person can be disempowered, it is not possible to empower someone as empowerment is something that comes from within (Binney & Williams, 1997). A similar vision of empowerment is proposed by Denham, Travers and Ackers (1997), who put forward the idea that the removal of oppressive organizational practices such as unnecessary rules, policies and procedures will assist people to do their job more effectively and assist the organization to reach its goals. Empowerment is also defined as passing decision making authority down the line to those who deal with clients or customers, though it can also be viewed as more responsibility with the same rewards (Herriot & Pemberton, 1995). These concepts are also reflected in the writings of Porter O'Grady (2001) who advances that "empowerment is a dynamic and not a thing" (p.469) that it "involves recognizing the power already present in a role and allowing that power to be expressed legitimately. Empowerment does not give anything to anybody" (p.470).

Bradbury-Jones et al. (2008) propose that empowerment and power must be viewed in context, and that both concepts are tightly interwoven. They expand on the work of previous authors (e.g., Kuokkanen & Leino-Kilpi, 2000) who explore power from three theoretical perspectives (i.e., critical social theory, organization and management theory, and psychological approach), and add a fourth theoretical perspective (i.e., post-structuralism). According to critical social theory power exists within a controlling group in society that has greater prestige and status than the subordinate group that it dominates. Therefore, empowerment of the subordinate group is liberation from the controlling group who will not readily hand over power. Power is *extra-personal* and can only be increased by the corresponding relinquishment of power by another. Daiskie (2004) proposes that nurses are an

oppressed group, that relationships among nurses are hierarchical, and often competitive, and that subordination to those thought of as having more power is common. In summary, critical social theory sees power as repressive force.

Organizational and management theories are concerned with the distribution of power within an organization, particularly in how power is distributed from the top down (Kuokkanen & Leino-Kilpi, 2000). Power is the ability to get things done and empowerment is the ability to execute a certain course of action successfully. Kanter (1993) states that an empowering work environment provides opportunity for advancement, access to information, access to support and access to resources. Attridge (1996) found that nurses reported feeling that they were not in control of their working environment and were therefore were unable to bring about improved patient care.

Empowerment, from a psychological perspective, is a psychological experience of the individual and is seen as a process of personal growth and self-esteem where individual beliefs, views, values and perceptions are key to the experience of empowerment. Kuokken & Leino-Kilpi (2000) state that empowered nurses are described as having personal integrity, courage and tenacity.

The fourth theoretical concept of power put forth by Bradbury-Jones et al. (2008) is called post-structuralism, and it expands on the work of Michel Foucault. Foucault (1980) posited that power is not fixed and can be exercised in different forms by anyone depending on the context. Although nurses may be powerless in some situations, they will be powerful in others; for nurses to become empowered they need to understand the processes and practices through which they are formed as nurses. This concept encourages nurses to both challenge and critically consider how power is used. For example, hierarchical power is wielded by professional colleges who require nurses to self-reflect and document their learning needs and plans (Bradbury-Jones et al., 2008). Normalizing judgment, another form of power, operates when nurses compare themselves to normative standards or the currently accepted concept of the ideal nurse (Bradbury-Jones et al., 2008). Finally, post-structuralism

encourages nurses to question current accepted truths in nursing as well as whose interests are best served by those truths. Therefore, to be empowered, nurses must understand the way power itself operates within the field of nursing.

The concept of accountability, or the willingness to be answerable for one's own actions, is closely associated with the concepts of power and empowerment (Mass, Specht, & Jacox, 1975). Personal accountability develops in environments where people feel they have control over their situation (Laschinger & Wong, 1999). Laschinger and Wong (1999) note that "to be responsible and accountable, nurses must have both the ability to do the job (competency) and the authority to act on the basis of their professional knowledge and judgment" (p. 309). Horsfall (1996) states that full personal accountability involves thinking in terms of the betterment of the entire group rather than just the individual. Shared governance is an organizational structure that encourages and engenders a sense of responsibility and accountability among nurses (O'May & Buchan, 1999).

2.3 Shared Governance

Governance is about power, control, authority and influence or, in other words "who rules" in an organization (Hess, 1998). According to Hess (1998), shared governance in health care extends "who rules" to nursing. Shared governance then, is a managerial innovation that legitimizes nurses' control over their own practice (Hess, 1998), professional development, self-fulfillment and work environment (Edmonstone, 1998). Other definitions of the concept see it as an empowerment process with the structures to support it (Porter O'Grady, 2001). Although these definitions may differ, they do have commonalities in that autonomy, control of practice, accountability, participation and collaboration in decision making are evident in all (Anthony, 2004). Proponents of the implementation of shared governance in health care have advocated that the organization, the work environment and nurse satisfaction can all be positively affected (Anthony, 2004). Green and Jordan (2004) state that

over the past decade, shared governance has attracted the attention of organizations and nurses as a means of maintaining nurse job satisfaction, and encouraging quality care and fiscal viability.

Anthony (2004) reports the theoretical basis for shared governance can be traced back to organizational, management, and sociological theories. She states the theorists of the 1960s saw the organizations' human resources as its most valuable resource. Organizations invested in employee motivation through encouraging autonomy, empowerment and participation in decision making. From a management theory perspective, Kanter (1993) suggested that both formal and informal power permit access to work empowerment structures such as opportunity, resources, support and information which enable individuals to accomplish their work. Finally, according to the sociology of professions perspective, professional autonomy is the basis for managing the care environment (Havens, 1994). Society grants professionals such as nursing the right to control their own activities based on their specialized professional knowledge (Greenwood, 1996). Although these theories are from different eras and from differing perspectives, they all look to how the organization can enhance the ability of the individual to do their work by moving or sharing decision making authority from management to the worker.

As with the assortment of definitions of shared governance there are also a variety of models through which it can be attained, though, all have always focused on nurses controlling their own professional practice (Hess, 2004). O'May and Buchan (1999) report that most of the literature published relates to four types of shared governance models: unit based, congressional, administrative, and councilor models. The *unit based model* is one in which each nursing unit establishes its own system; however with this model, there is no department-wide coordination of activities. In the *congressional model*, all staff belong to a congress and submit work to "cabinet" for action; here, nurses are empowered to vote on issues as a group. In the *administrative model* of shared governance, nursing practice and management structure co-exists and both submit work to an executive council for

decisions. Last, the *councilor model* of shared governance has an overall organizational coordinating council that functions on a department level; this coordinating council integrates decisions made by managers and staff in subcommittees. Nursing unit-based councils also operate in the councilor model, and are designed to be a reflection of the overall department council where staff nurses are responsible for clinical decision making. According to the literature, the councilor model is the most commonly utilized (Hess, 2004; O'May & Buchan, 1999).

2.3.1 Barriers to Shared Governance

Shared governance is a process and a journey; not a project to be implemented (O'May & Buchan, 1999). However, the process of creating shared governance can be disabled by many pitfalls. For example, Edmonstone (2000) cautions that command and control organizations, such as health care institutions, are vulnerable to three fallacies called the 'quick-fix' fallacy, the "single bullet", and the "top down" fallacies. The "quick fix" fallacy represents an unwillingness to accept the sustained effort and investment that are required when initiating change; the "single bullet" fallacy assumes that implementation of shared governance in an organization will fix all organizational problems; and the "top down" fallacy reflects the assumption that management can cascade an idea down, and, through the provision of proper training, change will occur reflecting the top down orientation of command and control organizations.

In a narrative account of difficulties sustaining a NPC, Gokenbach (2007) identified four major themes regarding declining interest in their council through consultations with NPC members. The first theme was related to philosophy, where it was apparent that not all the nurse managers were committed to the concept and did not provide the needed support to the council members from their units. The second theme mentioned was the feeling that members did not necessarily posses the expertise needed for their assigned council. Third, it was mentioned that other departments utilized NPC meeting time to communicate with nursing staff (e.g., informing the nursing staff about the new

programs of other departments), which reduced the amount of time available for nursing practice issues. Finally, the members expressed that they felt that they were not academically or experientially prepared for their roles on the NPC.

Porter O'Grady (2001) reports there may be more fundamental reasons that explain why shared governance may fail. He observed that: (1) there are many powerful nurses despite nursing not being a powerful profession, which means some nurses have power that keeps others from getting it; (2) nurses have developed a culture of co-dependent leadership, where empowered leadership is replaced by the idea that a "hero" will lead the organization where it needs to go; (3) nurses act as an oppressed group, whereby major accomplishments are credited to a few individuals instead of to the nursing profession as a whole; and (4) organizations often create an image of shared governance though important decisions remain in the purview of management. Hess (2004) also points out that not every organization is conducive to shared governance. For example, union, government and legislative restrictions may limit the implementation and effectiveness of shared governance.

2.3.2 Impact of Shared Governance

Reviews of published evaluations of shared governance have been undertaken by O'May and Buchan (1999) and Anthony (2004). O'May and Buchan (1999) conducted a review of 48 articles (from 500 originally identified) published between 1988 and 1998 that described or evaluated the implementation of shared governance and identified four categories of studies: outcomes measures for the organization, outcome measure for the staff, personal gains, and financial impact. These authors report that, from an organizational perspective, the literature generally indicates increased satisfaction with work environment, improved quality of care, increased focus on the patient, improved efficiency, support for innovation, a more proactive approach to quality assessment and improvement, improved communication and increased sense of collegiality as a result of the implementation of shared governance, as well as spreading of shared governance into administrative ranks and between nurses

and physicians. From a staff perspective, a positive effect regarding increased job satisfaction was found for nurses as a result of increased participation and involvement in decision making, reductions in staff turnover, vacancies rates, and intention to leave were also reported. Lower sickness costs were also reported. From a personal perspective, nurses reported an increased sense of personal and professional development and increased autonomy, which in turn resulted in a stronger commitment to the job and the organization. In terms of financial impact, the literature showed no cost increases associated with shared governance; rather, it was determined that shared governance was either cost neutral or provided savings in terms of decreased recruitment and retention costs. In summary, the vast majority of the research reviewed yielded positive results, though these overwhelmingly positive findings may reflect publication bias (O'May & Buchan, 1999).

In her review Anthony (2004) summarized research that focused on the outcomes of shared governance through benefits to the organization, the nurse, and the patient; twenty four articles were reviewed, all of which were published between 1998 and 2001. However, this review did not provide details regarding the databases, search terms or inclusion criteria used. Identified benefits to the organization included cost savings or reductions from decreased use of agency nurses, decreased absenteeism, and reduction in recruitment and orientation costs from reduced turnover. Benefits to the work environment included such things as increased job satisfaction, autonomy, control over practice and a greater sense of cooperation among employees. Other reported benefits to the work environment were increased nurse autonomy, authority and accountability; improvements in management decision-making style and in professional and organizational job satisfaction; and decreased turnover. In the category of nurse satisfaction, however, the benefits were less clear. For example, improvement in nurse satisfaction was reported in some studies while decreased or unchanged levels of satisfaction were reported in others. That said, benefits related to satisfaction with professional work, perception

of providing high quality care, peer support and involvement in decision making were identified. In summary, the research did not consistently support the anticipated benefits of shared governance.

2.3.3 Gaps in Shared Governance Research

Both O'May and Buchan (1999) and Anthony (2004) have highlighted that the research examining the implementation and outcomes of shared governance is, to date, problematic. In particular, variations in theoretical perspectives, lack of shared definitions of terms, lack of common philosophical assumptions and the complexity of the concept itself have made evaluation difficult. They also emphasize that much of what has been published are case studies or implementation stories which are focused on staff reported responses of better relationships, team harmony, job satisfaction, communication and professional growth. Current evaluation of shared governance is highly qualitative and positivistic in nature and may portray and overly optimistic view (Burnhope & Edmonstone, 2003). Few attempts have been made at overall systematic evaluation such as longitudinal repeated and ongoing measures studies. What has been published is context-specific and results may not be generalized to other sites (Burnhope & Edmonstone, 2003; O'May & Buchan, 1999). Further, studies to date have yielded mixed results, leaving questions as to what has really been evaluated and producing few opportunities for cross comparison of results (O'May & Buchan, 1999).

Porter-O'Grady (2003) offers a completely different perspective regarding research into shared governance. He finds that researching shared governance is a "futility of focus" (p.251), because it has no substance, does not stand alone, and does not represent an exacting or definable set of characteristics upon which any disciplined research can be based. Shared governance serves as a means to pave the way to autonomy, equity, accountability and partnership and that any shared decision making model that embraces partnership, equity, accountability and ownership is destined to show a positive relationship between the organization and the worker.

Anthony (2004) suggests that to increase the scientific rigor of the research of shared governance we must first clarify the theoretical perspective, the antecedents, attributes and consequences and come to a common understanding of the concept. Ideally, shared governance research and evaluation would include measures of processes and outcomes, be longitudinal with repeated measures before, during and after implementation (O'May and Buchan, 1999).

In truth, the work of O'May and Buchan (1999) was the only article that described the development and implementation of an evaluation strategy for the planning phase of the shared governance process. In particular, they developed financial and process evaluation strategies and used pre and post qualitative research methods with both with nurses and non-nurses to determine whether anticipated outcomes had been achieved. O'May and Buchan (1999) also emphasized that the institutional-specific goals of shared governance should be the focus of the evaluation and, where possible, models and validated instruments already in use should be utilized to permit comparisons.

Hess (2004) points out that many questions regarding shared governance are yet to be answered. For example, does shared governance ward off union activity? Is there any association between shared governance and improvement in patient outcomes? Can nurses' perceptions of control and power in a shared governance organization be correlated with acquisition and control of scare organizational resources? Are there certain shared governance implementation designs that produce consistent outcomes in similar and different organizational settings? What theoretical models and conceptual frameworks should guide the investigation of shared governance? Is shared governance different when other professionals beyond nurses are involved? Is care more cost effective where nurses participate in shared governance? Also, published literature regarding the implementation and evaluation of shared governance outside the acute hospital care setting is very limited. Of the many articles located for this review only one case study was identified that discussed implementation of NPC within a public health setting (Rietdyk, 2005).

2.4 Nursing Practice Council Implementation

The establishment of a NPC as a means of providing a structure for effective shared governance in any health care organization requires careful planning. There are many examples of implementation of shared governance through NPCs in the literature (Burnhope & Edmonstone, 2003; Church, Baker & Barry, 2008; Edmonstone, 1998; Gokenbach, 2007; McDonagh, Crow, Wilson & Krueger, 1996; O'May & Buchan, 1999; Thompson et al., 2004). However, only one published article by Rietdyk (2005) discussed the initiation of an NPC in a public health setting.

More generally, the first step in implementation for many planners is to conduct a literature review (Burnhope & Edmonstone, 2003; Rietdyk, 2005), followed by the development of a strategic or detailed implementation plan which includes the proposed shared governance model (Burnhope & Edmonstone, 2003; McDonagh et al., 1996). Next, the development of a vision and goals for shared governance occurs through visioning exercises with senior nursing management (Church, et al., 2008; Edmonstone, 1998; Gokenbach, 2007; O'May & Buchan, 1999, Thompson et al., 2004), as continued and sustained commitment of all levels of management is vital to the success of the implementation of shared governance. This includes not only those directly involved in the NPC itself but their managers, middle managers, top managers in the organization and those considered opinion formers (Burnhope & Edmonstone 2003; McDonagh et al., 1996). Educating and getting "buy in" from management and other stakeholders through retreats, workshops and seminars is often the next phase in shared governance implementation (Church, et al., 2008; Edmonstone, 2003; Gokenbach, 2007). Rietdyk (2005) advocates for planners to create a stakeholder grid, with a review of various stakeholder support and influence in order to anticipate and manage resistance to change. McDonagh et al. (1996) emphasize the need for management team support, and advocate for the application of a change management theory to both introduce and sustain the required shift in the way of thinking and

operating that will be brought about by implementation of shared governance. Once these steps have been taken, the actual NPCs are established and initial meeting are held.

The methods of recruiting nurses to participate and sit on the organizations' NPC vary from appointment by managers (Rietdyk, 2005) to election by peers (Burnhope & Edmonstone, 2003). Once recruited, members take part in training sessions designed to assist new council members to function in their new role. Topics addressed during training include: definitions of shared governance, role of the NPC, mechanics of conducting a meeting, conflict management, as well as facilitation, and communication skills (Burnhope & Edmonstone, 2003; Church et al., 2008; Edmonstone, 1998; Gokenbach, 2007; McDonagh et al., 1996; O'May & Buchan, 1999; Thompson et al., 2004). In large organizations (e.g., acute care facilities) there are often several councils or sub-committees created to deal with different areas of practice (e.g., operations, policies and procedures, research and education, quality assurance), all of which report back to the larger NPC. (Gokenbach, 2007; Thompson et al., 2004). After forming the NPC and training its new members, sustaining the NPC is the next step in the implementation process.

O'May & Buchan (1999) suggest clarifying and refining the roles and structure of the NPC after six months and again after a one year of the initial start up to ensure that the structures that have been put into place support the vision. Sharing news of the activities and achievements of the NPC is also important. For example, Thompson et al. (2004) held a shared governance symposium to share their achievements with nurses and senior managers one year after creation of the NPC, and then every eighteen months thereafter. Burnhope and Edmonstone (2003) launched a traveling "road show" as part of their plan to ensure nurses were informed regarding the ongoing activities of the NPC. Rietdyk (2005) also developed a formal communication plan to inform staff and other stakeholders of the functions of the NPC and its ongoing importance to the organization.

3. Goal of the Paper

The goal of this paper is to describe the development, implementation, and evaluation framework for a NPC in a small, rural district health unit. The vast majority of published literature regarding shared governance and NPCs is derived from the experiences in the acute care/hospital sector. Therefore, most authors are reporting on implementation of shared governance in very large organizations with many levels of management, who employ many different health care disciplines, often operating at multiple sites; this is very different than smaller organizations with a more specific focus and smaller staff – namely, a rural district health unit. However different, there are ideas, concepts, experiences and lessons learned from larger organizations that can be generalized to assist in the planning, implementation and evaluation of shared governance through a NPC in a small rural health unit. In particular, the idea that decision making in nursing practice should be in the hands of nurses – which is the basis for the establishment of a shared governance model, seems to be universal to all types of nursing work environments. Therefore, this standard can be applied wherever nurses are employed, regardless of the size of the organization. The ultimate goal of shared governance is improved patient care which is also the ultimate goal in the field of public health nursing; however in the field of public health nursing care is provided not only to individuals, but to families, targeted groups (e.g., pregnant women, youth) and whole communities.

As stated earlier in this paper, many PHNs report to a manager who is not a nurse and this is also true of the targeted rural district health unit – i.e., the Haldimand Norfolk Health Unit (HNHU). Therefore, providing a shared governance structure in the form of a NPC would further provide a forum for nurses to discuss nursing practice issues. Again, a quality nursing practice environment is key to nursing job satisfaction, recruitment and retention (Canadian Nurses Association, 2006).

The following sections of this paper will describe the necessary steps required to establish a NPC for the HNHU based on a health promotion program planning and evaluation framework. A

clear understanding of the philosophy of shared governance through an NPC is vitally important so the first stage in this project will involve identifying the stakeholders and developing a shared vision. Because the HNHU mimics most health care institutions as a command and control organization, planning will begin by obtaining a commitment from management; without this commitment, the shared decision making aspect of shared governance cannot be realized (and therefore, the project should be abandoned). The conceptual framework (i.e., based on planned change theory) will be described, followed by the short and long-term goals of the project and the logic model. Utilization of a change theory in the planning stages will assist with identifying potential barriers and the means to overcome them. Following the logic model, the organizational plan and project timelines will be presented. Details of the process, impact and outcome evaluation will be provided. Note that as it is anticipated that the development and implementation of the NPC at the HNHU will take nine or ten months, it is outside the scope of this paper to do an actual evaluation. Rather, this paper will provide a framework for evaluation. The impact evaluation will utilize validated and widely used survey tools used in conjunction with qualitative methods, while the outcome evaluation will utilize broad indicators of community health that are impacted by public health nursing programs. Strategies for the disseminating the results of the evaluation will be suggested and, finally, implications for public health practice and policy will be discussed.

4. The Project

In this section information is provided on the vision and mission of the organization, the overall goal of the project, the stakeholders, the HNHU and the population it serves.

4.1 Vision and Goal

The HNHU is small progressive health unit governed by the Haldimand and Norfolk Board of Health. The vision states "We seek optimal health for our communities". The mission states "We

work with our communities to promote and protect health" (HNHU, 2009). The overall goal of the NPC program is, therefore, to improve the health of the people of Haldimand and Norfolk Counties

4.2 Stakeholders

The HNHU Chief Nursing Officer will lead the project team for the NPC project, which will also consist of the Family Health Coordinator, the Clinical Services Coordinator and the HNHU Epidemiologist. Decision-making for the implementation of shared governance through utilization of the councilor model will be by consensus of the project team with input from stakeholders.

Typically, the planning process begins with a review of the literature; as this paper has already accomplished this, it will be shared with the planning group and NPC to familiarize members with the various concepts of empowerment and shared governance. Next, all potential stakeholders with a vested interest will be identified and consulted. This will enable to the planning group to: (1) to begin the communication process as early as possible; (2) anticipate and plan for potential resistance: and, (3) begin the change process by creating knowledge of the project at its onset. It is anticipated that the following individual (or positions) will be consulted as stakeholders with a vested interest in the NPC: the Medical Officer of Health; the Manager of Public Health; various Program Coordinators (e.g., for the Communicable Disease Program, Healthy Environment Program, Population Health Program); a local representative from the Ontario Nurses Association (ONA); a Public Health Nurse representative; a Registered Nurse representative; and, a community representative (for example, a member of the Health and Social Services Advisory Committee).

4.3 Description of the Haldimand Norfolk Health Unit

The Haldimand Norfolk Health Unit (HNHU) serves a population of approximately 105,000 individuals living in Haldimand and Norfolk Counties. The counties are situated on the north shore of Lake Erie, and represent one of the largest geographical areas in Ontario, covering 2894.2 square kilometers. The population is spread out and there are small communities where people are quite

isolated (for example, there is no public transportation within or between communities). The area has a diverse mix of rural farming communities, small urban areas, as well as a growing senior population (HNHU, 2006).The HNHU has 103 employees, of which 30 are registered nurses (RNs) who practice in a variety of public health programs and management roles.

5. Project Plan

This section describes the conceptual framework and target audience for the development and implementation of the NPC in the HNHU. The strategies, activities, resources and short and long term goals are identified and placed into a logic model format. A description of the data collection for the impact and outcome evaluation is provided and project implementation is detailed through the organizational plan and project timelines.

5.1 Conceptual Framework

The formation of a NPC to implement a shared governance process at the HNHU will involve change. The primary planning framework is the project logic model; however, the use of a change theory to guide the planning process will provide a secondary framework for planning. According to Swanson-Fisher (2004) the adoption of a new behavior by health professionals and the system they work in depends on many factors. Diffusion of innovations is a theoretical approach to managed change that describes the stages an individual goes through to eventually change or reject a new behavior or practice (Rogers, 1983). The stages involved in this process are: (1) knowledge of the innovation; (2) formation of an attitude toward the innovation; (3) the decision to accept or reject the innovation; (4) implementing the innovation; and, (5) confirmation of the decision to adopt the innovation (Rogers, 1983). Use of this framework will help the planning group to ensure the change is adopted and maintained through identification of barriers and facilitators of the planned change. The planning group will also pay special attention to the stage related to the formation of an attitudes (stage 2 above), also known as the 'persuasion stage' (Landrum, 1998). The planning group will assist

the stakeholders to consider and reconcile, these five aspects of the planned change; (1) the relative advantage of the NPC (e.g., is it better than what is currently in place?); (2) compatibility of the NPC (e.g., is it compatible with existing values, past experiences, and the needs of the organization?); (3) complexity (e.g., will shared governance through a NPC be perceived as difficult to understand or put into practice?); (4) trialability (e.g., to what degree can shared governance through the NPC be trialed and modified?); and, (5) observability (e.g., how will the outcomes of the NPC be made visible to others in the organization?).

5.2 Target Audiences

The key target audience for this process is the nurses employed by the HNHU (i.e., 23 PHNs and 7 RNs). To ensure the process is successful, there are also secondary target audiences; these include all the management staff at the HNHU and the nurses union. In terms of management staff, all levels are considered, including seven program managers (four of whom manage nurses), the public health manager, the general manager, as well as the Board of Health through the Health and Social Service Advisory Committee. Regarding the nurses union, there is a local branch that has an executive committee consisting of a president and a vice-president.

5.3 Activities, Responsibilities, and Resources

To implement a shared governance structure through a NPC, the following three strategies will be undertaken: (1) planning and promoting the NPC; (2) forming the NPC: and, (3) modifying and maintaining the function of the NPC. The activities involved, the responsibilities, and the resources required in each of these areas are further described below.

5.3.1 NPC Planning and Promotion

NPC planning and promotion activities are focused on those needed to obtain the necessary background information (i.e., literature review), to identify stakeholders (i.e., stakeholder grid), identify potential barriers (i.e., consultation with stakeholders), and promote the adoption of a change

in practice (i.e., to self-govern through a NPC). Table 1 below shows who is responsible for completing each type of activity, as well as the resources required.

Table 1. Planning and Promotion: Activities, Responsibilities and Resources

Activities	Responsible	Resources
Review Literature • Conduct a literature review • Divide articles among the project team • Team members to review and summarize the article and present to project team members • Develop a shared vision to share with the stakeholders	All project team members	• Utilization of the City of Hamilton – Central West Library Network and librarian to conduct literature search • Epidemiologist to review critical appraisal of research techniques with project members
Stakeholder Grid • Conduct informal interviews with key stakeholders to inform the stakeholder grid • Develop a stakeholder grid • Develop strategies to overcome barriers and utilize facilitators	All project team members	• Epidemiologist is has experience with qualitative data collection methods for interviews
Stakeholder Consultation • Meet with each stakeholder individually to introduce the concept and discuss the planning and implementation process • Share goals and objectives of the program plan and modify if necessary with the input of the stakeholders	Chief Nursing Officer and Epidemiologist	• Other health units have already established NPCs so we can draw upon their experiences
Promotion to Stakeholders • Deliver presentation at management group meeting • Deliver presentation at all program team meetings • Deliver presentation to nurses union executive members • Set up "Question and Answer" page on workplace intranet and monitor daily • Develop one page electronic newsletter to provide monthly updates as to status of the development of the NPC and to reinforce the vision of shared governance	All project team members	• Nurses in the health unit have expressed a need for a forum to address nursing practice issues

5.3.2 NPC Formation

NPC formation activities are focused on those related to recruiting members, establishing training needs, and provision of training to members. Table 2 below shows who is responsible for completing each type of activity, as well as resources required.

Table 2. NPC Formation: Activities, Responsibilities and Resources

Activities	Responsible	Resources
Recruit NPC members • Meet with all program managers to discuss a selection process for members • Contact all members put forth by the program managers to ensure willingness to participate and answer questions • Set date and location for first meeting	Chief Nursing Office	
Establish Training Needs • Review skills necessary for effective council participation with members • Members to rank priority of needs and training sessions to be established accordingly	All project team members	• Public health nurses have skills regarding how to effectively run a meeting (e.g., preparing agendas, chair person skills) due to their work with community groups and coalitions
Provide training • Contact appropriate trainers for needed skills • Book space for training sessions for NPC members • Notify managers of training dates to ensure NPC members are freed up to attend • Monitor NPC member attendance at training sessions	Chief Nursing Officer	• Human resources department has staff skilled in many areas (e.g., conflict negotiation, managing effective teams) • Health Unit has established a budget for the NPC to pay for any outside facilitators/trainers needed

5.3.3 NPC Function

NPC function activities are focused on those related to modifying and maintaining its function, including establishing terms of reference. Table 3 below shows who is responsible for completing each type of activity, as well as the resources required.

Table 3. NPC Function: Activities, Responsibilities and Resources

Activities	Responsible	Resources
Establish Terms of Reference • Provide NPC members with key literature on shared governance prior to first meeting • Provide NPC members with terms of reference of NPCs from other health units • Document Terms of Reference and post on the workplace intranet site and in the NPC electronic newsletter	NPC members facilitated by Chief Nursing Officer	Health Unit administrative assistant will provide secretarial support to the NPC to record minutes and work with technical support to update the workplace intranet
Establish NPC Communication Plan • Brainstorm what, when, why and how to communicate activities of the NPC to the rest of the organization • Include updates from the NPC at all team meeting and all management meetings • Utilize workplace intranet and NPC newsletter to provide regular updates to all stakeholders	NPC members	Graphic designers employed by the health unit can develop a "look" for NPC related communications so the NPC is identifiable
• Hold a NPC "lunch and learn" for all stakeholder in 8 to 10 months to highlight the accomplishments of the NPC	NPC members	Health Unit has established a budget for the NPC "lunch and learn" session
Establish NPC projects • NPC members to survey their colleagues regarding nursing practice issues that require addressing • Prioritize project list • Begin work on first project	NPC members	
Monitor NPC • Monitor attendance at council meetings to ensure nurses are freed up to attend and follow up with non-attending members • Monitor group functioning to ensure adherence to terms of reference • Assist the NPC to modify how it functions and the work it does as required	Chief Nursing Officer	

5.4 Short Term and Long Term Objectives

Information on the NPC's short (Table 4) and long term (Table 5) objectives are presented below, as are details on the performance indicators and targets to be used to measure progress toward or accomplishment of those objectives.

Table 4 NPC Short-term Objectives, Indicators and Targets

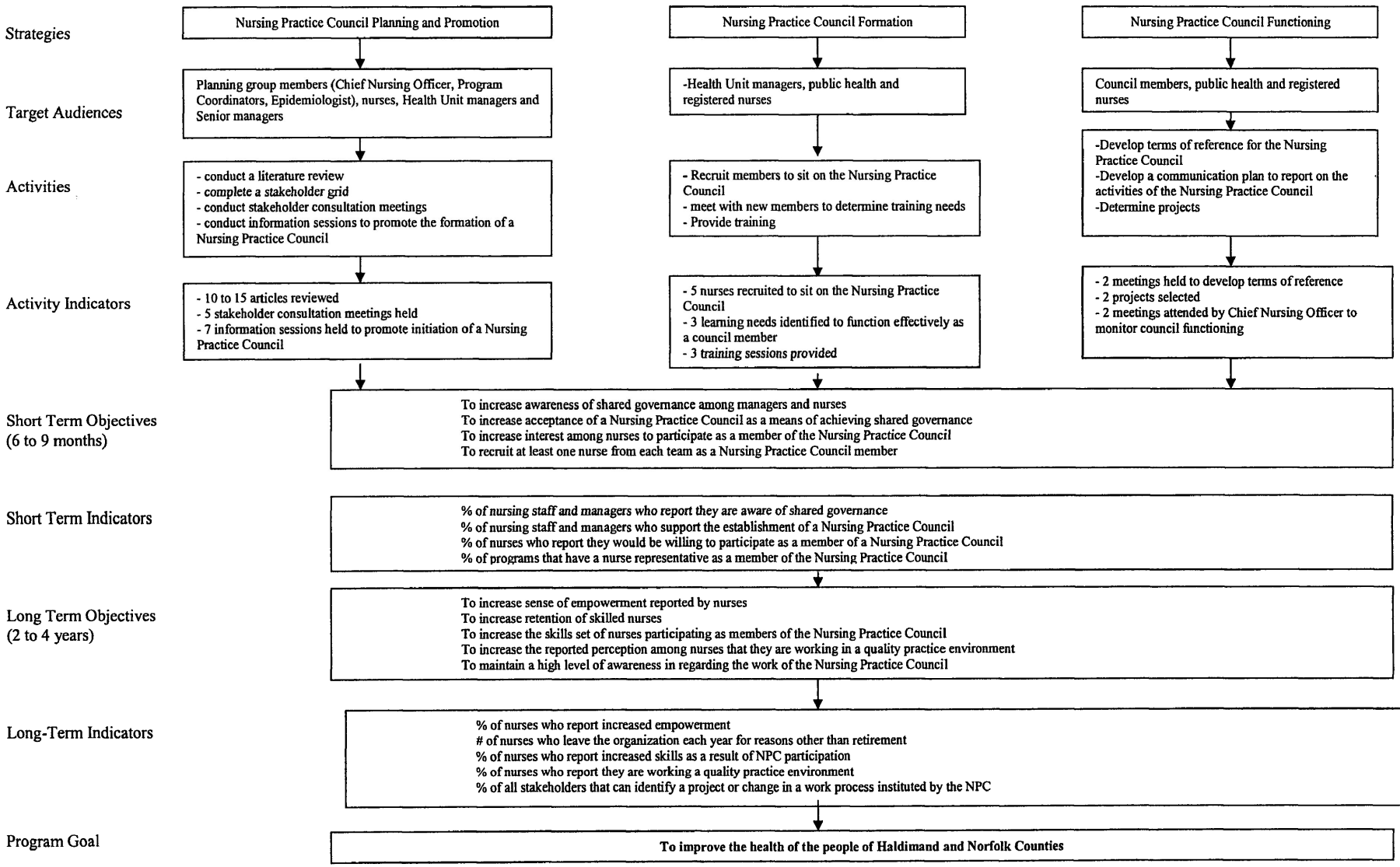
Short Term Objectives (2 to 9 months)	Performance Indicators	Targets
To increase awareness of shared governance	% of staff and managers aware of shared governance	100% of nurses and managers are aware of the concept and benefits of shared governance
To increase the acceptance of a NPC to achieve shared governance	% of nurses and managers who support the initiation of a nursing practice council	100% of managers report they will free up a nurse from their team to participate on the NPC
To increase the interest among nurses to be a member of the NPC	% of nurses who indicate they would be willing to participate as a NPC member	80% of nurses say they would participate on the NPC if asked
To increase participation of nurses on the NPC	% of programs with a nurse representative on the NPC	100% of programs are represented on the NPC

Table 5 NPC Long-Term Objectives, Indicators and Targets

Long Term Objectives (2 to 4 years)	Performance Indicators	Targets
To increase sense of empowerment among the nurses	% of nurses who express an increased sense of empowerment	80% of all nurses score high on the empowerment measurement tool
To increase the retention of skilled nurses	% of nurses that identify practice environment as a reason they stay in their current positions	80% of nurses score high on the organizational commitment questionnaire
To increase the skill set of the nurses participating on the NPC	% of new skills identified by NPC members since joining the council	100% of NPC members can identify one new skill they have developed as a result of their participation on the NPC
To increase the perception among nurses that they are working in a quality practice environment	% of nurses who can identify examples of improvements to their practice environment since the establishment of the NPC	80% of nurses can identify one example of the work of the NPC
To maintain a high level of communication within the organization of the accomplishments of the NPC	# of communications to the organization regarding the work of the NPC	90% of nurses report they refer to the workplace intranet and read the NPC newsletter for information regarding the activities of the NPC

5.5 Logic Model

Logic models are useful in program planning in that they provide a systematic process to logically connect planning, development, implementation and evaluation (Page, Parker & Renger, 2009). The Health Communication Unit's Logic Models Workbook (2001) was used to facilitate the development of the logic model. The program logic model (shown below) was created, reviewed and finalized through a joint effort of the project planning team and the stakeholders.


Strategies
Nursing Practice Council Planning and Promotion
Nursing Practice Council Formation
Nursing Practice Council Functioning
Target Audiences
Planning group members (Chief Nursing Officer, Program Coordinators, Epidemiologist), nurses, Health Unit managers and Senior managers
-Health Unit managers, public health and registered nurses
Council members, public health and registered nurses
Activities
- conduct a literature review
- complete a stakeholder grid
- conduct stakeholder consultation meetings
- conduct information sessions to promote the formation of a Nursing Practice Council
- Recruit members to sit on the Nursing Practice Council
- meet with new members to determine training needs
- Provide training
-Develop terms of reference for the Nursing Practice Council
-Develop a communication plan to report on the activities of the Nursing Practice Council
-Determine projects
Activity Indicators
- 10 to 15 articles reviewed
- 5 stakeholder consultation meetings held
- 7 information sessions held to promote initiation of a Nursing Practice Council
- 5 nurses recruited to sit on the Nursing Practice Council
- 3 learning needs identified to function effectively as a council member
- 3 training sessions provided
- 2 meetings held to develop terms of reference
- 2 projects selected
- 2 meetings attended by Chief Nursing Officer to monitor council functioning
Short Term Objectives (6 to 9 months)
To increase awareness of shared governance among managers and nurses
To increase acceptance of a Nursing Practice Council as a means of achieving shared governance
To increase interest among nurses to participate as a member of the Nursing Practice Council
To recruit at least one nurse from each team as a Nursing Practice Council member
Short Term Indicators
% of nursing staff and managers who report they are aware of shared governance
% of nursing staff and managers who support the establishment of a Nursing Practice Council
% of nurses who report they would be willing to participate as a member of a Nursing Practice Council
% of programs that have a nurse representative as a member of the Nursing Practice Council
Long Term Objectives (2 to 4 years)
To increase sense of empowerment reported by nurses
To increase retention of skilled nurses
To increase the skills set of nurses participating as members of the Nursing Practice Council
To increase the reported perception among nurses that they are working in a quality practice environment
To maintain a high level of awareness in regarding the work of the Nursing Practice Council
Long-Term Indicators
% of nurses who report increased empowerment
# of nurses who leave the organization each year for reasons other than retirement
% of nurses who report increased skills as a result of NPC participation
% of nurses who report they are working a quality practice environment
% of all stakeholders that can identify a project or change in a work process instituted by the NPC
Program Goal
To improve the health of the people of Haldimand and Norfolk Counties

5.6 Data Collection

The project logic model defines the short and long term program objectives of the NPC as well as its' overall goal. Data must be collected and analyzed to determine whether the objectives and goals have been met, and this (i.e., evaluation questions, instrumentation, and methods) should be designed concurrently with the project plan not after it is up and running (Issel, 2004). Details of data collection for evaluation of the organizational plan are discussed in the evaluation section of this paper, as are specific details of the impact and outcome evaluation. Described here are the tools used to evaluate two of the project objectives; namely, the effect of the project on nurse empowerment and nurse retention. In both cases, a pre test post test design will be employed. Information on measures that will be used to measure achievement of the overall program goal – i.e., health status of people in Haldimand and Norfolk counties, is also presented.

5.6.1 Nurse Empowerment

The Condition of Work Effectiveness Questionnaire II (CWEQII) is a based on the original CWEQ, and it measures nurses' perceptions of their access to six work empowerment structures such as: opportunity, information, support, resources, formal and informal power (Kanter, 1993) using 19 items (3 items for each of the six structures) that are rated on a 5-point Likert scale. Consequently, six subscales that measure nurses' perception of empowerment structures may be generated. Mean scores are calculated for each subscale by summing and averaging responses to the items; the resulting scores for each subscale range from one to five. An overall total empowerment score may be calculated by summing the means of the six subscales (range 6 to 30), where higher score indicates higher levels of empowerment. Scores

ranging from 6 to 13 are considered low, scores from 14 to 22 are moderate, and scores from 23 to 30 are considered indicative of high levels of empowerment.

A two item global empowerment scale is used for construct validation purposes (Spence-Laschinger, Finegan, & Shamian, 2001) - i.e., comparison of the instrument being evaluated and other established measures (Guyatt, Rennie, Meade & Cook, 2002). The CWEQII has demonstrated reliability. Cronbach's reliability coefficient for the overall tool is .93, and .89, .80, .84, and .81 for the support, information, resources, opportunity and global empowerment subscales, respectively (Spence-Laschinger, et al., 2001).

In addition to the data regarding nurse empowerment obtained from the CWEQII a question that rates the nursing practice environment at the HNHU will be added to the standard organization exit interview for nurses. Exit interviews are done by Human Resource staff who will ask departing nurses to rate the nursing practice environment of the HNHU on a scale of one to 10, one being very poor quality to 10 being very high quality. Nurses will be encouraged to explain their rating. Results will be sent to the epidemiologist for inclusion in the overall evaluation report.

5.6.2 Nurse Retention

Nurse retention will be measured using the Affective and Continuance Organizational Commitment Subscales of the Organizational Commitment Questionnaire (OCQ) (Meyer, Allen & Smith, 1993). Three distinct forms of commitment an individual feels toward their organization have been identified – i.e., affective, continuance and normative commitment (Meyer & Allen, 1991). Affective commitment is a person's emotional attachment, identification with, and involvement in a particular organization. Nurses with a strong affective commitment to their organization work there because they "want to". Continuance commitment is the level of

need to remain with the organization. Employees identify they have accumulated investments they would lose if they left the organization or they identify that the availability of comparable alternatives is limited; they work there because they "have to". Normative commitment is the level of obligation an employee feels towards the organization based on their own norms and values; they work there because they "ought to". For the purposes of this evaluation, we will use the affective and continuance commitment subscales. Each subscale consists of six items rated on a 7-point Likert scale. Scores from each subscale are derived by summing and averaging item scores, and therefore range from one to seven, where higher scores are indicative of higher levels of commitment. The OCQ has acceptable reliability, with Cronbach's reliability coefficient ranging from .82 to .93 (Spence-Laschinger et al., 2001).

5.6.3 The Health of the People of Haldimand and Norfolk Counties

Through increased empowerment, it is the overall goal of the NPC to improve the health of the residents of Haldimand and Norfolk Counties. Indicators of health for PHN specific program areas (i.e., teen pregnancy, influenza immunization and youth suicide) will obtained prior to the development and implementation of the NPC (i.e., pre-study) and afterward (i.e., post-study).

Teen pregnancy rates are the number of live births, still births and therapeutic abortions in women 15 to 19 years of age in any given year per 100,000 population. Teen pregnancy rates by health unit jurisdiction can be obtained from the Better Outcomes Registry & Network (BORN) data base and are calculated annually. Influenza immunization rates for persons 12 years of age and over in Haldimand Norfolk who had their last influenza immunization less that one year ago are obtained by the Canadian Community Health Survey (CCHS) and are published every two years (Statistics Canada, 2009). Influenza immunization is also provided through

HNHU clinics each fall. Age, sex and risk status data is collected. Youth suicide rates and youth emergency room visits for attempted suicide rates in Haldimand Norfolk can be obtained from the Provincial Health Planning data base through membership in the Association of Public Health Epidemiologists of Ontario (APHEO). Trend analysis of these indicators for the next three to 5 years will be used to monitor change.

5.7 Implementation

Implementation of the NPC project includes both an organizational plan that details the input and outputs of each component of the plan and the development of timelines.

5.7.1 Organizational Plan

In order to implement any program adequate resources must be acquired and monitored to ensure that they are utilized as intended (Issel, 2004). Three types of management accountability relate to the organization plan including fiscal accountability, legal accountability and efficiency accountability (Issel, 2004). Keeping track of the hours spent planning and implementing this program will be important as time spent involved in the NPC will not be spent in other programs. Managers will want to know the amount of time staff is spending in the NPC.

The NPC project planning group was able to secure a yearly budget of $750.00 to be used at their discretion as NPC becomes functional. There are no salary dollars allocated to the NPC, as planning falls within the scope of the responsibilities of the planning group members and no replacement hours will be required for the nurses who will eventually be members of the NPC. It is anticipated that the NPC will use its' funds to purchase reference material, cover meeting expenses, and purchase promotional items to be used during provincial nurses' week. However, the NPC, once established, will determine how its' budget will be utilized. Table 6

provides additional information on the components, inputs, and outputs of the organizational plan. Figure 1 shows the organization of the HNHU (i.e., organizational chart).

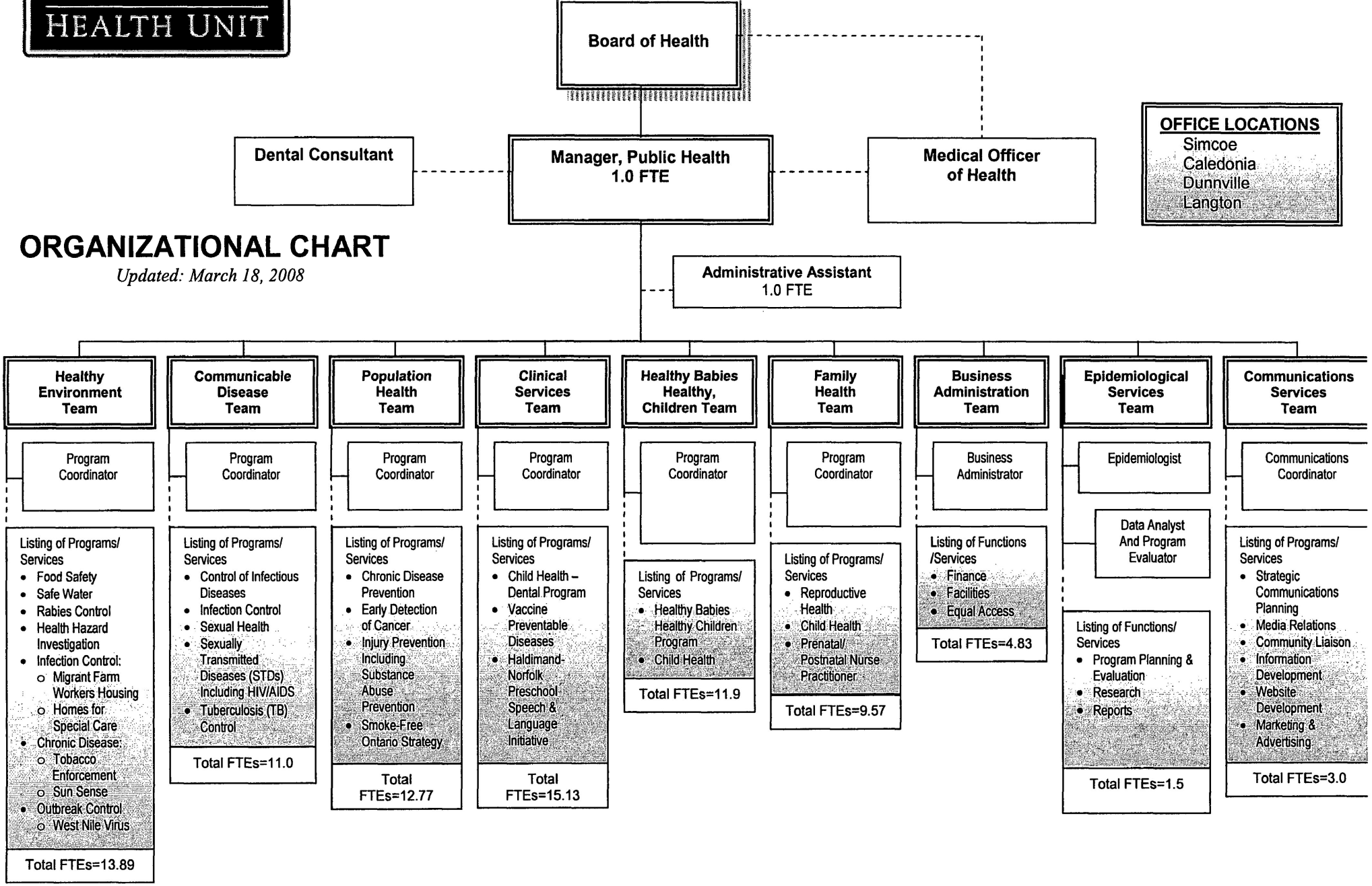
Table 6. Components, Inputs and Outputs of the Organizational Plan

Components	Inputs	Outputs
Human Resources	• FTE requirements of the team • Chief Nursing Officer (20% of time) • Family Health Program Coordinator (10% of time) • Clinical Services Program Coordinator (10% of time) • Epidemiologist (10% of time) • Nurses (5% of time)	• % of time of FTEs required with appropriate skills and expertise for the project • # of hours worked project planning group • # of hours worked NPC members • degree of commitment of project planning staff • degree of commitment of NPC members
Physical Resources	Meeting room space for project planning group and NPC meetings	# of times meeting space that is needed is available
Informational Resources	• Organization's intranet site • Formatting and Posting of NPC electronic newsletter • Software for analysis of evaluation data	• # of NPC information updates posted on intranet site • capacity to analyze evaluation data • # of NPC newsletters formatted and posted on intranet • # of hits to NPC documents on the intranet site • assessment of system's capacity to analyze evaluation data
Time	Timelines for implementation and completing of activities (see Project Timelines)	• Track progress using implementation plan • alterations in timelines
Managerial Resources	Extend to which project manager (Chief Nursing Officer) used communication, negotiation, team building, leadership & technical skills	Changes made to the implementation plan by the project manager
Monetary Resources	Extent to which NPC budget was able to meet requirements of the project	• Budget variance • Requests from NPC for additional funds

HEALTH UNIT

ORGANIZATIONAL CHART

Updated: March 18, 2008



5.7.2 Project Timelines

Table 7 below shows the project timelines which details the main activities of the NPC described earlier in this paper – namely, NPC planning and promotion; NPC formation; and NPC function. Any alterations in timelines will be discussed by the project team and the NPC, and strategies to keep the program on track will be developed.

Table 7. Project Timelines

Strategies	Months											
	S	O	N	D	J	F	M	A	M	J	J	A
NPC Planning/Promotion												
Conduct literature review												
Stakeholder consultations												
Develop a stakeholder grid												
Promotion to stakeholders												
NPC Formation												
Recruit practice council members												
Hold initial meeting/establish training needs												
Provide training												
NPC Functioning												
Establish terms of reference												
Develop communication plan												
Determine and prioritize projects												
Commence work on first project												
Monitor group functioning												

6. Evaluation

Health promotion program evaluation is the systematic gathering, analysis and reporting of data about a program to assist in decision making about that program (Porteous, Sheldrick & Stewart, 1997). The goal of a health promotion program is to enable people to increase control over and to improve their own health (World Health Organization, 1998). The planning and implementation of a NPC with the nurses at the HNHU is not a health promotion program per se, but due to its potential impact on the health of the community the time and resources it will require, it is a project that should be evaluated. Further rational for evaluation of the NPC include: determination of the degree to realization of the program objectives; determination of the generalisability of the program; provision of information about the program to stakeholders and knowledge gained (O'Connor-Fleming, Parker, Higgins & Gould, 2006). Conducting an evaluation will allow the planning group to determine if the NPC was implemented as planned, to identify any weaknesses, and to determine if the anticipated benefits to the nurses and the organization are realized. Results of the evaluation of the implementation of the NPC will be important to internal stakeholders, but will also be relevant to other public health units.

6.1 Process Evaluation

A process evaluation reveals how a program was implemented or delivered, and should be conducted throughout the program's implementation. Information gathered can assist planners to make corrections in the delivery of the program, if and as needed. Components of the process evaluation include information on: (1) the organizational requirements, (2) operational resources, and (3) program delivery (Issel, 2004). The process evaluation of the implementation of the NPC will assist in the identification of enabling and factors and barriers not already anticipated and

will allow the project team to make midcourse corrections to help to ensure the success of the process.

6.1.1 Organizational Plan Evaluation

The evaluation of the organizational plan will determine the extent to which organizational resources identified in the organizational plan were available and were used to support implementation of the project (Issel, 2004). Table 8 below shows the organizational plan component, the purpose of the evaluation, the output measures and data collection methods.

Table 8. Organizational Plan Component Evaluation

Component	Purpose	Output Measures	Data Collection
Human Resources: Both the quantity and the quality of the human resources available to the program should be assessed. The degree to which the program staff are committed to the program provides information on the implementation of the program.	To ensure project staff provided the required time and commitment to the program	• Number of hours worked on the program • Degree of commitment of the program staff	• Time sheets: To track the number of hours worked on planning, implementing and the functioning of the NPC • Observation: Participation of planning members in all planning meetings and completion of assigned tasks • Participation of NPC members during committee meetings. • Activity logs: Planning group members to document number of consultations and activities related to the NPC
Physical Resources: The extent to which meeting space is available for the NPC to convene will be important to sustain the momentum of the project	To ensure the NPC is fully implemented	• # of times meeting space is not available • # of times changes are required for meeting due to space issues	Activity logs: planners and NPC members to note "yes" or "no" regarding the availability of meeting space
Informational Resources: Use of the organizations intranet site as a vehicle for NPC communications to the organization is vital as communication about the project and has been identified as a major component required for successful implementation. Also, software capable of analyzing evaluation data must be available	To ensure intranet site and statistical software is utilized to implement and evaluation the NPC	• # of communications regarding NPC posted on the intranet site • # of hits to NPC posts on the intranet site • current software's ability to complete the analysis of evaluation data and the ability to generate required reports	• Minutes of planning meetings to determine number of communications to be posted on the intranet sites • "Hit counter" installed on the NPC section of the intranet site • Excel database system will be used to collect data and evaluation data which will then be transferred to statistical software programs for analysis

6.1.2 Program Delivery Evaluation

Issel (2004) states that service utilization, referred to in this project as program delivery can be thought of as the point of service aspect of the program. The Program Implementation Plan below details program delivery. Elements include marketing of the program, who will receive or participate in the program, and delivery of the program itself. Issel (2004) describes five program delivery outputs; coverage, units of service, service completion, workflow, and materials produced; process evaluation of program delivery should occur as soon as possible after the completion of the outputs. Again, the NPC is not a health promotion program per se, but measurement of program delivery can be used to determine if the program is being implemented as planned.

Issel (2004) reports failed program delivery can be due to three issues; (1) non-program, issues, where the program was not provided due to staff or resource issues; (2) non-robust intervention, which occurs when an intervention other than the one that is planned is delivered; (3) un-standardized intervention, where program personnel are not providing a the same planned intervention to program participants. For process evaluation of program delivery for the NPC, both the measures of coverage outputs and service completion output will be evaluated. Monitoring of the degree of participation or measure of coverage and service completion in a health program are basic aspects of evaluation (Issel, 2004). Table 9 below shows the program delivery measures of coverage outputs, the purpose of the evaluation, output measures, and data collection methods.

Table 9. Program Delivery Evaluation

Measures of Coverage Outputs	Purpose of the Evaluation	Output Measures	Data Collection
Promotion to Stakeholders: Support of all stakeholders is required if an NPC at the HNHU is to be successfully implemented.	To determine how many stakeholders participate	• # of stakeholders who participate in consultation • # of stakeholders who attended promotional sessions • % of stakeholder who participate	Attendance at all consultation and promotional events will be recorded. The number attending will be divided by the number invited to determine % of participation versus non-participation
Recruiting NPC Members: Nurses must be willing to participate as members of the NPC for the program to be implemented.	To determine if nurses are willing to join the NPC	• # of nurses who put their name forward as willing to participate • % of programs that have a nurse willing to participate	Count the number of nurses who volunteer and match with number of programs in the health unit where nurses work to determine % of nurses and programs represented
Monitoring NPC Function: Once the NPC is established it will be important to monitor attendance at the meetings. If attendance drops it will be imperative to determine why and to correct or deal with the reasons why.	To monitor attendance at NPC council meeting	• % of meeting that have full attendance • % attendance at each meeting for each member	Overall attendance and attendance for each member will be monitored at each meeting

In health promotion program evaluation, service completion refers to the program participants who complete the program (Issel, 2004). The NPC members, once recruited, will undergo training and will then complete projects of their own as a council. Should this not occur the planners must determine why they have not completed the program. Monitoring member

participation in training and productivity with their first projects could be considered service completion for this evaluation. Table 10 below shows the program delivery output of service completion, the purpose of the evaluation, the output measures, and data collection methods

Table 10. Service Completion Evaluation

Service Completion Output	Purpose of the Evaluation	Output Measures	Data Collection Methods
Service Completion: This includes training, development and implementation of the communication plan, identification and start of first project.	To monitor completion of the various components of the project	• # of training needs identified • # of training sessions provided • % attendance at training sessions • Communication plan completed and implemented • First project is agreed upon and work commences	• Minutes from meeting where training needs were identified • Chief Nursing Officer log book where training session and attendance were noted • Minutes from NPC meetings

6.2 Impact and Outcome Evaluation

Impact evaluation of a health promotion program measures the immediate effect of the program by assessing what changes, if any, have occurred in the predisposing, reinforcing and enabling factors, target behaviors and the environment (Issel, 2004). It is the measurement of the immediate effects of the intervention and usually relates to the program objective (O'Connor-Fleming et al., 2006). Conducting an impact evaluation will assess what impact the NPC had on both the members of the committee and the other stakeholders.

Outcome evaluation measures the long-term effects of the program by determining what changes, if any, have occurred in health status and quality of life. It is assessment of the longer-term effects of the intervention and typically relates to the program goal (O'Connor-Fleming et al., 2006). The impact and outcome evaluation of the NPC for the HNHU will consist of both

qualitative and quantitative methods. Through impact and outcome evaluation changes required to enhance to effectiveness of the NPC will be determined and implemented. The evaluation will provide information to key stakeholders and will fulfill fiscal and accountability requirements to the HNHU.

6.2.1 Evaluation Questions

Issel (2004) recommends that planners look to their logic model to develop evaluation questions and to stay focused on key impact objectives. The following evaluation questions for the NPC are taken from the logic model developed for this project, and include:

1. What did participants learn about shared governance?
2. What changes regarding their sense of empowerment occurred among the nurses?
3. What effect did the NPC have on nurse retention?
4. What were the changes in skill level among NPC members?
5. What were the changes to the perceptions of a quality nursing practice environment experienced by the nurses?
6. What is the level of awareness of the work of the NPC in the organization?
7. What was the effect of the NPC the health of the people of Haldimand and Norfolk Counties?

Issel (2004) also recommends that planners choose an evaluation design that is both scientifically the best option and realistically feasible for the program. The goal of evaluation is ultimately to determine if the program participants have changed more than might happen by chance. An impact documentation evaluation strategy was selected using the evaluation decision tree developed by Issel (2004). Documentation evaluation asks to what extent were the impact objectives met. This design is not complicated, it is comparatively inexpensive but it is weak in

being able to attribute the change or differences to the health promotion program or, in this case, implementation of the NPC (Issel, 2004). The evaluation will be used to measure the key impact variables of empowerment and nurse retention and involves a one group, pre-test and post-test design using the CWEQII and the Affective and Continuance Commitment scales of the OCQ that can continue into the future using the same instruments as a repeated measures design.

Because the impact documentation evaluation design is not experimental, a research sample of participants is not required. Participants for the qualitative evaluation strategies will be purposeful samples and will be chosen based on their involvement in the program (Issel, 2004).

6.2.2 Impact Evaluation

As stated, the impact evaluation will assess the impact the NPC had on its members and other stakeholders. Measurement of nurse empowerment and nurse retention using the CWEQII and the Affective and Continuance subscales of the OCQ has already been discussed. The impact evaluation will also measure nurses' NPC experience and the observability of the NPC.

To learn about the nurses' experience regarding the NPC, members will be asked to discuss their perceptions during focus groups; focus groups will also be held with nurses who do not sit on the NPC to capture their perceptions. These perceptions will be documented and will undergo thematic analysis. Group interviews can be used to obtain opinions and feelings of small groups of participants about a problem, experience or other phenomena (Farquhar, Parker, Schulz & Israel, 2006). The advantages of this method of data collection is the group dynamic can lead to new revelations, some people find groups less intimidating than a one to one interview and focus groups are relatively inexpensive to conduct (Issel, 2004).

Thematic analysis depends on constant comparative analysis processes (Thorne, 2000). This process involves taking one piece of data, which could be one interview, one statement, or

one theme and comparing it with all others that may be similar or different. This allows the researcher to develop conceptualizations of the possible relations between various pieces of data (Thorne, 2000). This phase of the evaluation occur will after the NPC has successfully completed one or two projects.

As noted in the program plan, observability of an innovation is an important aspect of the change process (Rogers, 1983). NPC members will develop a communication plan that reports on the activities of the NPC. To evaluate the effectiveness of this plan a questionnaire will be developed and will be made available to all health unit staff members via the organizational intranet site. Evaluating how successfully the communication plan of the NPC informed the nurses and other stakeholders of the work of the NPC will provide an indicator of sustainability of the NPC.

Table 11 below shows the long term (impact) objectives, the corresponding evaluation question, the data sources, the data collection tools and indicators.

Table 11. Impact Evaluation

Long Term Objectives	Evaluation Questions	Data Sources	Data Collection Tools	Indicators
To increase the sense of empowerment reported by nurses	What changes regarding their sense of empowerment occurred among the nurses?	Nurses	CWEQII	• % of nurses who report increased empowerment • Mean score of pre test and post test questionnaire
To increase the retention of skilled nurses	What effect did the NPC have on nurse retention?	Nurses	Affective and Continuance Organizational Commitment Subscales of the OCQ and Exit interview questionnaire	• % of nurses who score in the mid to high range (4 to 7) for the OCQ subscales • Mean score of pre test and post test questionnaire
To increase the skills set of nurses participating as members of the NPC	What were the changes in skill level among NPC members?	Nurses	Focus groups	• % of nurses who report increased skills as a result of NPC participation
To increase the reported perception among nurses that they are working in a quality practice	What were the changes to the perceptions of a quality nursing practice environment experienced by the nurses?	Nurses	Focus groups	% of nurses who report they are working a quality practice environment
To maintain a high level of awareness in the organization regarding the work of the NPC	What is the level of awareness of the work of the NPC in the organization?	All stake-holders	NPC Awareness Questionnaire	% of all stakeholders that can identify a project or change in a work process instituted by the NPC

6.2.3 Outcome Evaluation

Program goals are often broad, encompassing statements about health outcomes or status, and it can take a long time to observe the outcomes of interventions (Issel, 2004). Teen

pregnancy, influenza vaccination coverage and teen suicide are areas of public health in which PHNs provide programming and interventions. It is anticipated that the NPC will empower PHNs who will in turn utilize best practice public health nursing interventions to modify these indicators. A direct cause and effect cannot be stated as many factors can impact upon these indicators however the PHNs of the HNHU will have an opportunity to expand their program planning to include population based indicators. Table 12 below shows the overall program goal, the evaluation question, and the data sources. Analysis of the data has already been described.

Table12. Outcome Evaluation

Overall Program Goal	Evaluation Question	Data Sources
To increase the health of the people of Haldimand and Norfolk Counties	What was the effect of the NPC on rates of teen pregnancy, immunization, and youth suicide in Haldimand and Norfolk Counties?	• Influenza Vaccination coverage in the general population (12 years and older) in Haldimand and Norfolk from the Canadian Community Health Survey • Influenza Vaccination data from annual HNHU clinics (age, sex, risk status) • Youth (age 15 to19) suicide rates and emergency room visits for youth attempted suicide in Haldimand and Norfolk from the Ontario Provincial Health Planning Data Base • Adolescent or teen pregnancy rate in young women aged 15 to 19 in Haldimand and Norfolk which is live birth data, stillbirth data, and therapeutic abortions using population estimates expressed per 100,000. Ontario Provincial Health Planning Data Base

6.3 Data Analysis

The assistant to the epidemiologist will be in charge of evaluation data flow. They will receive all completed survey instruments and questionnaires. They will be responsible for data cleansing and entering survey and questionnaire data into the data base. They will also be responsible for taking notes during group interviews. They will transcribe the notes and assist in coding the data, generating categories and labeling the categories.

The quantitative data generated by the CWEQII and the OCQ subscales (i.e., affective commitment and continuance commitment) in the pre and post tests will be analyzed using SPSS software. Analysis will be undertaken to determine change over time. Comparison of the mean scores for test one and test two of the CWEQII will be examined to see if a change in the sense of empowerment has occurred in the nurses. The same analysis will be undertaken using the mean scores for test one and test two of the OCQ subscales (i.e., affective commitment and continuance commitment). The data from the two questionnaires (i.e., NPC awareness and exit interview) will be analyzed to determine what extent were the long term objectives were met.

Should a significant increase or decrease in the overall empowerment score be demonstrated by the CWEQII a factor analysis for the six subscales (i.e., opportunity, information, support, and resources formal and informal power) will be performed. Conducting a factor analysis will provide details as to which empowerment subscales are influencing the overall empowerment scores (Neuman, 1997). The same factor analysis can be performed for the two subscales of the OCQ (i.e., affective commitment and continuance commitment), should the results of the overall score be considered high or low.

6.4 Potential Limitations

The CWEQII and the OCQ subscales (i.e., affective commitment and continuance commitment) have not been used in a pre test post test design and the validity and accuracy of the results may be of concern. The pre-post design is subject to threats to validity which can change the way the participant responds to the questionnaire. These threats to validity and hence the results include: history (i.e., events not related to the program intervention which occur between pretest and posttest); maturation (i.e., changes measured in the subjects that would have occurred anyway); regression toward the mean (i.e., the tendency of extremes to revert toward averages; and testing (i.e., the learning effect on the posttest of having taken the pretest) (North Carolina State University, n.d.).

Also, there may be nurses and others who will not respond to all questions. Non-response to any of the evaluation questionnaires can occur through attrition or refusal to participate (Issel, 2004). Use of an incentive, such as a draw for a gift certificate could be utilized to increase participation (Issel, 2004). Survey results could also be influenced by response bias (i.e., participants may answer the question the way they think the interviewer wants them to or the participant may just give the same response regardless of the question or their true opinion or feelings) (Issel, 2004).

The exit interview question and the NPC awareness questionnaire designed by the health unit epidemiologist will not be validated; however, they will be reviewed by the planning group to ensure they are asking the appropriate questions to answer the evaluation questions (i.e., face validity).

6.5 Final Evaluation Report and Dissemination Strategies

The final evaluation report will provide stakeholders with a document outlining the activities of the NPC, its successes, and areas requiring improvement. It will shed light on whether devoting PHN time and other resources to a NPC is worthwhile, and whether it is worth replicating in other health units. The report will include a detailed description of the project, a description and the results of the impact evaluation, and a summary and recommendations (Issel, 2004).

Hard copies of the evaluation report will be shared with the stakeholders. Electronic copies will be sent to chief nursing officers in all the health units in southwest Ontario. In addition, the report will be shared with RNAO which is the professional organization for nurses in Ontario and Community Health Nurses Interest Group (CHNIG) which is a nursing interest subgroup of group within RNAO. An abstract detailing the project and evaluation will be submitted to provide a poster or concurrent session at upcoming conferences of provincial and national nursing organization (i.e., CNA, CNHAC, and RNAO).

Our stakeholders include members of ONA, RNAO, CHNAC and CHNIG. The stakeholders will provide a summary report of the NPC to post on web-sites of those organizations.

7. Implications for Public Health Practice and Policy

The introduction of NPCs as a means of approaching shared governance and enabling the practice of power by nurses began to take place in the acute care, hospital sector of health care in the early 1990s (Bogue et al., 2009). Hospitals began to recognize that creating work environments that would attract and retain nurses and improve patient care were essential to the delivery of cost effective, quality health care. Hospitals created policies and structures that

ensured nurses were supported as patient advocates, made decisions regarding nursing practice issues, had opportunities to grow professionally, and gained professional autonomy. These "magnet hospitals" were considered to be employers of choice when nurses were looking for work (Coile, 2001). Public health institutions, like hospitals must also attract and retain nurses and provide quality services. However, public health agencies and hospitals are recruiting from the same pool of nurses; therefore public health must create attractive nursing practice environments if they are to compete with hospitals. Research has shown that NPCs are a means of shared decision making, empowerment and support which in turn enable nurses to function at their highest scope of practice (Bogue, et al, 2009). They are also associated with employee engagement, job satisfaction, improved patient outcomes and increased retention and recruitment. Therefore, the adoption of NPCs as a means of governing in health units may help to create a practice environment that is attractive to nurses, and therefore increase the ability of health units to attract, recruit, and retain nurses.

The mandate of public health in Ontario is to prevent disease, respond to public health threats, and to improve the health of populations through initiatives that promote and encourage healthy living (CHNIG/RNAO, 2005). Nurses are an essential component of Ontario's system because of the work they do, and they represent 47% of the front-line public health program delivery staff in the province (CHNIG/RNAO, 2005). As previously noted, PHNs possess the education, experience and skills to promote, protect and preserve health on multiple levels (i.e., individual, family, group, community, and population). PHNs also act as the link between the health of the individuals and groups within a community to that of the community as a whole. Furthermore, because of the multi-partnered, multi-sectoral, and multilevel surveillance networks, PHNs are often the first to note changes in the social determinants of health in their clients' lives;

be alerted to the needs of vulnerable populations; and, to sense the readiness for change in a community. The development of NPCs will provide a means of improving the nursing practice environment in health units by ensuring that PHNs have the opportunity to discuss relevant research findings and best practices, and to determine the feasibility and need to implement these within their own health unit. Therefore, their impact on the health of the population they serve will be greater. NPCs engender nurse empowerment and shared decision making which enable nurses to drive the implementation of new evidence based program while ensuring nurses have input into the allocation of financial and human resources needed for those new program initiatives. In other words, NPCs support innovation in nursing practice and can do so for PHN practice also. PHN practice innovations that result in improved patient outcomes on a population level can have major financial and societal impacts. For example, supporting nurses working in public health to work effectively could enhance efficiency of health care dollars spent through upstream illness and injury preventions (Meagher-Stewart, Edwards, Ashton & Young, 2009).

The NPC evaluation and implementation plan outlined here will examine the effect of implementing a NPC on population health indicators. Should a positive effect be noted and PHN programs demonstrate benefits to health at population level, public health units should ensure the creation of an NPC within their organization. The creation of a NPC in each health unit and a Chief Nursing Officer to guide it could be mandated by amending the HPPA. The Chief Nursing Officer should report directly to the Medical Officer of Health or executive director of the heath unit. This would formalize the authority of the NPC to direct nursing practice. In some health care organizations the NPC is also the ultimate decision making authority for nursing program operational budgets and distribution of nursing human resources. Providing direct line authority

to the organizational NPC and the Chief Nursing Officer would change the organizational structure of health units across Ontario.

Ongoing concerns regarding the health care workforce, such as shortages and misdistribution of professionals, have raised fears among the public regarding the system's ability to provide adequate service (Baumann, Hunsberger, Blythe & Crea, 2008). This is true of the PHN workforce also. As Underwood and colleagues (2007) have noted, the number of PHNs in Ontario has not increased to keep pace with population growth leading to relatively few new hires and an aging workforce. However, as PHNs retire there will be positions available for younger nurses provided current levels of funding are maintained.

Unfortunately, as previously noted, there is a paucity of research regarding PHNs, their practice environments, and effective PHN recruitment and retention strategies. Lack of research may be related to the overall lack of a consolidated approach to community health nursing (Schofield, 2010). The incredible diversity of community nursing practice settings (e.g., public health, home health care and primary care), funding sources, and PHN roles all challenge attempts to conduct research. For example, in Ontario, home health, public health and primary care nurses all work under the umbrella term of 'community health nurse', but they are funded through separate branches of the Ontario government (Schofield, 2010).

Due to the fact that they are small and rural, a number of health units – like the HNHU, have additional recruitment and retention problems; a limited pool of nurses exists locally to draw upon, and few nurses are willing to move to rural areas (Baumann, et al., 2008). In addition, government funding initiatives and polices to recruit and sustain the healthcare workforce often cannot be implemented in rural settings as many of these are urban focused and aren't a good fit in rural settings (Baumann, et al., 2008). However, research is indicating that NPCs, at least in

the acute care, hospital sector, can have a positive impact on nurse retention and recruitment. That said, health care agencies including public health agencies who have a NPC and who ensure their NPC is the decision making mechanism for nursing practice issues will be attractive to nurses seeking employment. NPCs can also empower existing PHN staff to become engaged and enthusiastic about their work as they will exert more control over their nursing practice. The NPC evaluation and implementation plan outlined here is examining the effect of implementing a NPC to determine if there is PHN retention.

NPCs also support nurses in that they provide a venue for PHNs to discuss nursing practice issues and find peer support. Peer support is especially important in public health because, as previously stated, the public health nursing environment in Ontario has undergone radical changes in the past twenty years and many PHNs now report to non-nurse managers. Also, nurses cannot resolve nursing practice issues with a non-nurse manager; however a NPC can meet this need and therefore enhance the nursing practice environment for nurses managed by non-nurses.

Given the importance of PHN practice to the public health system and the challenges associated with recruiting nurses to a rural setting, creating a quality practice setting for nurses at the HNHU or any rural health unit is essential. As suggested in previous work, the establishment of an NPC demonstrates a commitment on behalf of the employer to creating a learning environment where professional development is valued (Meagher-Stewart, Underwood, et al., 2009). Therefore, the establishment of NPC at the HNHU may aid in recruitment of PHNs and enhance quality of the nursing practice environment. Results of the evaluation of NPC project at the HNHU will be shared with other health units in an effort to increase awareness and knowledge of the importance of considering the nursing practice environment as a means of

recruiting and retaining nurses. Depending on the results of the evaluation, the establishment of a NPC may also result in improved health of the community through effective, evidence based public health nursing interventions. This may stimulate research in the areas of PHN recruitment.

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