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Establishment of Unit Based Council Using a Shared Governance Toolkit

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Abstract

Practice Problem: Shared governance (SG) is an organizational structure that provides healthcare professionals control over their professional practice. Lack of a unit-based council (UBC) was noted as a problem disrupting the shared decision-making and problem-solving approach.

PICOT: In an adult acute care unit lacking a UBC structure (P), what is the effect of the implementation of a SG toolkit (I) compared to no SG toolkit (C) on the establishment of a SG UBC within a period of 10-weeks (T)?

Evidence: The literature evidence suggest that SG enables nurses to engage as a partner with nursing leaders within the organization in seeking solutions to problems.

Intervention: The Evidence-Based Practice (EBP) change management project included the establishment of a UBC for SG using a SG toolkit for education, and the identification of a core group to manage the UBC. The Index of Professional Nursing Governance (IPNG) measured SG success elements pre and post intervention.

Outcome: Overall, this EBP change project was clinically significant as it enabled to establish a SG structure for the unit in the form of UBC to practice shared decision-making regarding the professional governance components of SG. The statistical results were not significant due to a small sample size and short testing period used for the EBP change project.

Conclusion: SG is needed within healthcare organizations because it promotes nurses' shared decision-making. Ultimately, SG is the foundation for a culture of clinical and nursing excellence of top-performing healthcare organizations.

Establishment of Unit-Based Council Using a Shared Governance Toolkit

Modern consumer-focused healthcare is challenging and competitive. It requires consistent teamwork to ensure safe and quality care promoting patient satisfaction and excellent health outcomes (Khan, 2019). Patients' perceptions of their individual healthcare experiences are often reflected based on the interaction of healthcare team members as to whether their concerns, while hospitalized are immediately addressed. These expectations require healthcare leaders and interprofessional team members to work in collaboration as in implementing shared governance (SG) for excellent patient care (Murray et al., 2016).

SG is an organizational structure that provides healthcare professionals control over their professional practice and utilizes available resources to influence decision-making leading to quality outcomes (Weaver et al., 2018). SG is a key component of evidence-based practice (EBP) in terms of a nursing excellence work environment as recognized by the Magnet® Recognition Program. Magnet® is an accreditation awarded by the American Nurses Credentialing Center (ANCC) for quality patient outcomes (American Nurses Credentialing Center, 2017). SG promotes the culture of excellence in healthcare.

Significance of the Practice Problem

Registered nurses (RNs) are the healthcare professionals who are accountable and responsible for various clinical and leadership decisions in their practice environment. SG provides a structure to practice shared decision-making. However, many studies show that nursing leadership and direct care nurses perceive shared decision-making differently. SG empowers nurses, improves job satisfaction, leads to nurse retention, and positive patient outcomes (Murray et al., 2016). Alignment of SG with the Magnet® recognition program and the organization's operating system can lead to clinical excellence including staff satisfaction, patient satisfaction, and improved patient outcomes (Moreno, et al., 2018).

The organization where the EBP change management project was conducted, is a Magnet® accredited hospital. The Magnet® accreditation standards require four of seven categories of RN job satisfaction to outperform a national benchmark. RN job satisfaction promotes nurse retention and clinical excellence. SG enables nurses to engage as partners with nursing leaders within the organization in seeking solutions to problems. SG leads to improved RN engagement and job satisfaction (American Nurses Credentialing Center, 2017). Magnet hospitals promote SG in the units through unit-based councils (UBCs). However, the identified project unit did not have a UBC, and thus did not practice SG. This has negatively influenced the unit, which was found to have poor staff engagement and low RN satisfaction scores. A lack of knowledge by nurses regarding the SG toolkit and a lack of appreciation for the SG role was identified as the gap in practice.

PICOT Question

In an adult acute care unit lacking a UBC structure (P), what is the effect of the implementation of a SG toolkit (I) compared to no SG toolkit (C) on the establishment of a SG UBC within a period of 10-weeks (T)? The population identified in the problem-solving approach were the RNs working in the adult acute care unit. RNs are involved in critical decision-making related to patient care.

Implementation included the introduction of a SG toolkit that enabled the RNs to establish a UBC. This toolkit included the UBC charter, roles, and functions of leaders and members of UBC, agenda creation, conduction of meetings, recording minutes and attendance, and sharing the outcome of the meeting with unit leaders and staff. The comparison group included the existed state of not having a toolkit or knowledge regarding the implementation of SG through UBC in the unit. Lack of knowledge or awareness of the SG toolkit is one of the most common problems identified in not being able to establish the required UBC in the unit.

The expected outcome was the establishment of a formally structured SG model in the unit for nurse empowerment and shared decision-making. A UBC will lead to shared decision-

making as the functional outcome leading to improved staff engagement and patient outcomes. The time frame for the entire project took place over a period of 10-weeks.

Evidence-Based Practice Framework & Change Theory

The identified EBP framework for this change project was the John's Hopkins EBP (JHEBP) framework. The JHEBP model integrates the best scientific evidence from the latest research and incorporates it into practice. The JHEBP model is a three-step process that includes the practice question, evidence, and translation (PET) (Dang & Dearholt, 2017).

Based on the identified problem in the practice area, the practice question helped with formulating the PICOT question that guided the EBP project. The JHEBP model emphasizes gathering the best evidence using various databases and clinical tools to identify the research evidence. Various tools are available to seek high-quality evidence. In order to identify guidelines to resolve the practice problem of the lack of a SG structure on the unit, a literature search was conducted to seek implementation strategies for the establishment of a UBC.

Roger's Diffusion of Innovation Theory

Roger's Diffusion of Innovation Theory was selected as the change theory that best supported the EBP project. An idea or product gains momentum and diffuses through a population or system to adopt the new idea, behavior, or product (Orr, 2003). The implementation of a SG toolkit was a new idea for the RNs working in the acute care unit. Through the diffusion of understanding Roger's change theory, this new idea gained momentum among RNs to establish a UBC. SG is a complex dynamic framework that requires appropriate levels of decision-making with the right groups. The establishment of a UBC to practice SG needs collaboration with organizational leaders to assess and support SG efforts for the maximum outcomes for the patients, staff, and the organization (Gerard et al., 2016).

Roger's theory emphasizes the importance of including stakeholders interested in the change, using the strength of the group, and managing challenges as a new process, idea, or product. The five stages of Roger's theory include knowledge, persuasion, decision,

implementation, and confirmation (Orr, 2003). The desired outcome for this EBP change management project was the establishment of a UBC for SG. The various steps of Roger's change theory were used in this EBP project. Knowledge included exposing the RNs to the innovational idea of applying an easy-to-use SG toolkit to help understand the details of the structure, process, and outcome of the UBC. Persuasion included sharing information about the change to generate interest, enabling the RNs to understand the process and the easy steps to form a UBC.

The decision was founded upon the understanding of the importance of implementing SG. The early adopters were motivated and volunteered to take steps to establish a UBC. Working as a team the RNs decided to establish a UBC with the support of their leaders. Confirmation was the actual establishment of the UBC. Equipped with knowledge, tools for the practice change, and support from leaders, the RNs successfully established the UBC and proceeded to meet frequently to continue using the intended innovation within their unit.

Evidence Search Strategy

A comprehensive and systematic search for scientific literature was conducted to find the information related to the PICOT question: In an adult acute care unit lacking a unit-based council structure (P), what is the effect of the implementation of a SG toolkit (I) compared to no SG tool kit (C) on the establishment of a SG UBC within a period of 10-weeks (T)? The initial search using keywords were *shared governance* and *shared decision-making in nursing* through the University of St. Augustine for Health Sciences (USAHS) library and Google Scholar led to more than 500,000 articles using a combination of databases such as Medline, CINAHL Complete, and PubMed.

To narrow the search, keywords and Boolean operators were used such as *shared governance AND unit-based councils* AND *staff engagement*. The alternate term *nurse autonomy* helped to retrieve more specific articles. Advanced search criteria were used to narrow the results to academic journals, peer-reviewed, English language, published within last

five years, and hospital settings. Excluded were terms such as public governance and patient shared decision-making.

An aggregate of 86 articles were identified as usable, and 34 non-duplicate citations were further screened. After reviewing the titles and abstracts, seven articles were excluded. This resulted in 27 articles which related to the PICOT question. Google Scholar was used to retrieve full-text articles from databases. Browsing the content, four articles were excluded. Finally, this resulted in 23 articles in a further review for grading the evidence strength.

Evidence Search Results

The Johns Hopkins EBP Model's synthesis process and recommendation tool was used to assess the strength and quality of the articles (Dang & Dearholt, 2017). Twenty-three articles were thoroughly reviewed. Five were identified as qualitative studies and five as quantitative studies. A total of 10 articles were preserved due to their high level and quality grade. These were found to be the most supporting of the SG structure, shared decision-making, and shared leadership. The Johns Hopkins EBP Model's synthesis process and recommendation tool was used to assess the strength and quality of the articles (Dang & Dearholt, 2017).

A PRISMA diagram (Figure 1) shows the summary of evidence search results. One article was graded as Level I, three articles Level II, and six articles Level III. All were noted to be A and B-level quality grade articles. The keeper articles along with their description, level of strength, and quality are shown in Appendix A. The establishment of a SG council and its importance to individuals, organizations and the profession is highly evident in the literature. Identified outcomes of the establishment of a SG council were: staff engagement, staff empowerment, professional development, and professional autonomy.

Themes with Practice Recommendations

SG has positive effects for RNs in improving work experiences, nursing practice, and patient outcomes. SG includes the concept of structural empowerment, enabling RNs feel empowered in shared decision-making (Murray et al., 2016). Themes that were located for

implementing SG included the theory driven approach, the need for facilitators promoting SG attendance, UBC implementation without a SG toolkit, and with using the SG toolkit.

Theory-driven Approach to SG

The theoretical approach to SG implementation is application of the General Theory for Effective Multilevel Shared Governance (GEMS). The GEMS theory is designed to stipulate the ultimate level of nursing empowerment and examines how certain toolkits promote alignment between RNs and nursing leadership. The evidence on the effectiveness of SG implementation has been by having unit-level nursing practice councils using various versions of survey instruments called the Nursing Practice Council Effectiveness Scale (Joseph & Bogue, 2016).

Facilitators Promoting SG Attendance

Opportunities provided by an organization can promote participation and attendance in SG meetings, thus improving professional development. Paid time spent in participating in SG, and opportunities to become more active professionally enhance job satisfaction. The structure in place that encourages RNs to participate in shared decision-making at the unit and organizational levels empowers RNs and increases satisfaction in the nursing profession. All these components facilitate SG attendance by nurses (Cai et al., 2021).

Unit-Based Council Implementation

Implementation of a UBC should have the encouragement and support from chairpersons, team members, and nurse managers (Jordan, 2016). Support of the Chief Nursing Officer (CNO) and senior nurse leaders promote implementation of a UBC that gains the trust of the staff and facilitates longer sustainment (Olender et al., 2020). A targeted decision-making measurement scale called the Index of Professional Nursing Governance (IPNG) measures SG before and after the implementation of the SG model.

Leadership can use the IPNG tool in identifying areas for SG improvement that will enable them to hardwire the intervention (Dechairo-Marino et al., 2018). Lamoureux et al., (2014) reported high reliability for each one of the six subscale scores for IPNG (Cronbach

alphas of 0.94 and higher). Concurrent validity was supported by a correlation of the IPNG score with job enjoyment ($r = 0.437$, $p = 0.002$) and the desire to recommend the hospital as a place of employment ($r = 0.442$, $p = 0.001$).

SG Toolkit

The use of a SG toolkit and measurement of the effectiveness of SG is important for leaders and nurses for effective implementation of SG (Hess et al., 2020). The formation of a UBC as part of SG model requires leaders to give authority to staff to make decisions and requires staff to accept responsibility (Meyers & Costanzo, 2015). Applying SG in the nursing practice environment significantly improves the professional practice environment of nurses (Kanninen et al., 2019). Having a structured charter helps to guide the formation and function of a UBC (Capitulo & Olender, 2019). Realignment of the SG council structure with the Magnet® program recognition model promotes clinical excellence (Moreno et al., 2018). Ultimately, the SG toolkit provides a structure for RNs in decision-making, and the ability to practice within a high level of autonomy. Staff-driven approaches yield performance improvement.

Practice Recommendations

Based on the literature that answers the PICOT question: “In an adult acute care unit lacking a unit-based council structure (P), what is the effect of the implementation of a SG toolkit (I) compared to no SG tool kit (C) on the establishment of a SG unit based-council within a period of (T) 10-weeks?” A UBC is a structure for SG that promotes shared decision-making, which is a process leading to shared leadership. The intervention included implementing a SG tool kit that met the Magnet® program requirements in the adult acute care unit that lacked a UBC structure. This intervention led to the establishment of a new UBC as a structure for shared decision-making.

Setting, Stakeholders, and Systems Change

The Setting, Organizational Structure, and Organization Need

This EBP change project was implemented in an acute care unit of a 368-bed acute care hospital located in the north Texas area within the United States. The organization is a part of one of the largest healthcare systems in the area and is Magnet® accredited. The organizational structure consists of the president, CNO, and Chief Medical Officer (CMO). The mission of the organization is to improve the health of the people in the communities served. The vision is to partner with the consumer for a lifetime of health and well-being.

Stakeholders and Organizational Support

Magnet® accreditation requires standards of excellence including empowering the RNs through SG. SG through UBCs is a strategy for enhancing the work environment as it promotes collaboration, shared decision-making, and accountability (Brennan & Wendt, 2021). Due to nursing staff shortage, the Covid19 pandemic, and busy shift work, a lack of nurse engagement and participation in the unit and organizational activities were noted. The work environment was affected as staff felt they are not included in decision-making. The clinical manager and service line director identified the problem was due to the lack of a UBC in the unit. The identified stakeholders involved were the organizational leaders: the CNO, the clinical manager, the director of the service line, and the unit nursing staff. Other stakeholders were the interprofessional healthcare team members including respiratory therapists, occupational therapists, physical therapists, and patient care technicians.

Organizational Need and Strength, Weakness, Opportunities and Threats (SWOT) Analysis

The SWOT analysis of the organization identified that the unit is a busy medical-surgical unit with experienced and expert RNs, supportive leaders, and having adequate resources. The weaknesses noted were staff shortage, lack of staff engagement, and lack of a UBC. Opportunities included the Magnet culture of excellence, incentives being offered for participation in committees, and having a robust nursing career advancement program. The

major identified threats were due to the effects of the Covid19 pandemic which resulted in a staff shortage partly due to market competition and RNs leaving the organization (Table 1).

Interprofessional Collaboration

Interprofessional collaboration requires all stakeholders to participate and take an active role in maintaining a positive workplace environment. The interprofessional staff were a part of the UBC and SG. However, for this EBP project, only the RNs on the unit were included for pre and post survey.

A healthcare change can be divided into various levels of impact. The patient care level is the micro-level, the healthcare organization is the meso level, and healthcare policy decision making is considered as the macro-level (Sawatzky et al., 2021). Change strategies within healthcare needed to be effective at the patient care level where we find bedside nurses. Thus, this EBP change project was implemented at the micro-level in the unit.

Implementation Plan with Timeline and Budget

Project Overview

The EBP change management project included the establishment of a UBC for SG following a schedule (Appendix B), using a SG toolkit (Appendix C) for education, and the identification of a core group to manage the UBC. The plan was for the project manager (PM) to approach the RNs in the acute care adult unit selected for the EBP project. A pre-project survey was implemented using the IPNG (Appendix D). The IPNG scale evaluates staff opinions regarding the decisions made in their unit. Written permission was acquired from the SG forum by the PM to use the IPNG (Appendix E).

RNs on the project unit were educated on the importance of SG by participating in a UBC. The knowledge was shared using an easy-to-use SG toolkit to help understand the details of the structure, process, and outcomes of the UBC. Following this, the persuasion stage began to identify seven to eight interested staff to formulate the UBC. The unit manager and unit RNs were involved in the decision to identify a chair, vice-chair, secretary, and member roles.

Once a core team for the UBC was identified, the PM organized the first inaugural meeting with the team. In this meeting, basic information on SG and tools for the practice change were shared. The next step was confirming dates for the monthly UBC meetings, which confirmed the establishment of the UBC. At this time, the risks involved were noted to be poor RN participation due to Covid19 pandemic challenges. Another risk was staff shortage and work overload which may have prevented staff from participating in the pre-SG survey. Incentives in the form of applause points (digital recognition system in the organization attached with monetary value) were offered for survey promotion and motivation. The post survey also had similar challenges and needed an extension of the survey period by one week to ensure adequate participation. As per the project plan, the post-intervention survey was conducted using the IPNG tool after the second UBC meeting was successfully completed by members of the established UBC.

Project Objectives

The project objectives included:

1) At least 80% of the RNs of the acute care unit will complete the pre-implementation survey using the IPNG scale.

2) Approximately 80% of the RNs of the acute care unit will have exposure to the SG toolkit by the end of the second week of the project.

3) About 80% of the RNs of the acute care unit will have a basic knowledge and understanding regarding the importance of UBC.

4) The unit will have an established UBC with identified members to conduct the first meeting using the SG tool kit by week three.

5) The UBC team members will create a UBC board displaying UBC activities that recognize active participants by the end of week six.

6) At least 80% of the acute care unit RNs will complete the post-implementation survey using the IPNG scale by the end of week 10.

Activities and Timeline

- Week 1 - 2: A meeting was held with the unit manager and RNs of the acute care unit to initiate the project.
    - RNs were asked to complete a pre-implementation survey using the IPNG scale via Survey Monkey shared through email. Share the SG toolkit.
- Week 3: RNs were identified who would be part of UBC with specific roles. Conduct the first UBC meeting using the information from the SG toolkit shared with the UBC members.
- Week 4- 6: The UBC leader-maintained meeting minutes and share them with the rest of the RNs in the unit. Develop a UBC information board and display in the unit.
- Week 7- 10: The UBC leader prepared for the second UBC monthly meeting. RNs in the unit will then complete the post-implementation survey using the IPNG scale.

Resources and Budget

Resources required for the project were stationery items, a display board to showcase the UBC activities, snacks for the inaugural meeting, and gift cards for motivational activities. Administrative support fund and unit budget supported the project. Expenses involved project delivery which is budgeted under salary and benefits (Table 2).

Project Manager (PM)

The EBP change project requires excellent project management skills by the project manager (PM). A skillful PM has effective communication skills to engage with others, understands the team dynamics, possesses planning and organizational skills, focusing on project objectives (Harris et al., 2020). This project was led by the PM under the executive sponsorship of the CNO and guidance of the on-site preceptor. Communication occurred with unit staff in unit meetings and one-on-one interactions. The PM inspired and motivated the team using the “why behind the project” notion to state the importance of the UBC and shared decision-making. To recognize the effort of the involved staff, timely applauses, rewards, and

recognition were used by the PM during unit huddles, staff meetings, and email communications. Both leadership and RNs were kept informed regarding the progress of the project. The overall plan for the project were shared with the stakeholders.

Implementation

The goal to establish a unit-based SG structure was accomplished by the implementation of this EBP change project. Additionally, the structure was meant to measure how RNs perceived the situation regarding SG. Institutional Review Board (IRB) approval of this EBP project was obtained from the organization. The facility approval to conduct the EBP change project was obtained from the organization's CNO. The verification of all approval processes was further reviewed by the University of Saint Augustine for Health Science's Evidence-Based Practice Review Council.

The recruitment of the volunteer participants who worked on the project unit, a mid-sized acute care medical-surgical unit, was done by the PM with the assistance of the unit manager. The inclusion criteria for the participants in this EBP project were being an RN working in the project unit for more than 3-months. Two project champions, who were the team members of the UBC, promoted the surveys on the day and the night shifts. Pre- and post- implementation data was collected from the RNs using the IPNG tool, which also has an initial section for the collection of demographic data. The data was collected using paper surveys from the day and night-shift RNs and were collected by charge nurses. The completed surveys were placed in the unit manager's locked room. The unit manager provided the completed surveys in a sealed envelope to the PM, thus maintaining the integrity of the data collection process. Participants were assured of confidentiality and anonymity of their responses. The participation in pre- and post- survey was incentivized in the form of applause points (the organization's digital recognition program with monetary values) and drawings for digital gift cards.

SG is associated with staff engagement, job satisfaction, staff empowerment, and an improved professional practice environment. Pre-implementation surveys were conducted

before the UBC was established. Post-implementation surveys were conducted after the second UBC meeting. Monthly meetings were conducted by the UBC independently of the PM, twice over a period of two months. The IPNG tool was used to survey how RNs perceived the effectiveness of the UBC influencing SG. Aligning supportive evidence of project interventions to an intended outcome concerning clinical significance is important in project management (Harris et al., 2020). The clinical significance of SG is associated with patient outcomes such as falls rate, falls with injury rate, medication management, patient identification, etc.

Results

Process Measures

This EBP change project, intending to establish a unit-based SG structure, was conducted by measuring the nurses' perceptions of SG in the unit using a SG measurement tool called IPNG, a reliable and valid tool to measure nursing governance. According to Weaver et al (2018), IPNG 3.0 measures nursing governance along a spectrum from traditional governance (administration/ management primarily makes decisions), to shared governance, to self-governance (staff members primarily make decisions). The IPNG has six subscales representing the dimensions of professional governance: personnel, information, resources, participation, practice, and goals. Participants responded using a 5-point Likert scale, ranging from "nursing management/administration only" to "equally shared by clinical RNs and nursing management/administration" to "clinical RNs only" (Weaver et al, 2018). The intervention was successful in identifying the practice problem of lack of a formal structure to practice shared decision-making and supported establishment of a UBC with the SG toolkit.

Statistical Analysis

Intellectus Statistics (2021) was used to conduct statistical analyses and to evaluate the data. Demographic data from the IPNG tool included gender, age, education, years of experience, relationship, and expertise. A two-tailed independent samples t-test was conducted to examine the staff's perception of shared decision-making in the unit. Response rates noted

were to be 75%. Eighteen of 24 eligible RNs participated respectively in the pre- and post-implementation survey. However, they were not the same participants pre and post survey completion. It should also be noted that six data points regarding participant age were missing. Nevertheless, this data had minimal bearing on the final results

Outcome Measures

The demographic data for the effects of personal and work-related nurse characteristics on the IPNG scores using descriptive statistics were tested separately for pre-intervention and post-intervention data (Table 3 and Table 4). Both pre and post- intervention respondents reported high satisfaction with the organization at 4.17 and 4.11 scores out of 5 on the Likert scale. SG level was determined using IPNG scale and subscale scores with two-tailed independent samples t-tests. The respondent's perception was that of a traditional governance (meaning professional governance decision were made predominantly by nursing management/administration only). Whereas for the practice and goals dimensions, the respondents perceived there was more shared governance (meaning that shared decision-making was equally shared by clinical RNs and nursing management/administration) (Table 5).

Implementation of changes to SG can take 2 to 5 years or more for staff to realize an actual change in the perception of a traditional governance model to a SG environment for shared decision-making (Dechairo-Marino et al., 2018). The results of the two-tailed independent samples t-test conducted for this project was not significant based on the alpha value of .05 for all six sub scales (Table 6). This result was anticipated, because of a small sample size and a short testing period of 10-weeks used for the EBP change project. In addition, since a paired t-test could not be used, this may have affected the results. However, this EBP change project was clinically significant as it enabled the establishment of a SG structure for the unit in the form of UBC to practice shared decision-making regarding the professional governance components of SG. Both staff and management members will collectively benefit from the use of the implemented intervention model to practice SG leading to

improvement in outcomes related to safety, quality and overall patient satisfaction and staff satisfaction.

Impact

The EBP project was a pilot project in a 24-bed acute care medical-surgical unit. The greatest impact was on the identified practice problem which was a lack of a UBC which disrupted the shared decision-making and problem-solving approach for nurses. Both staff and management members will now collectively benefit from SG leading to improvement in outcomes related to safety, quality and overall patient satisfaction and staff satisfaction.

Staff nurses selected as chair, vice-chair, and members of the UBC were experienced nurses who were engaged, respected, and expressed an interest in improving their unit. An increase in staff engagement and satisfaction after the implementation of the UBC was stated verbally by the staff in the unit. This has had a huge impact within the organization. The nurses said they were “happy they now have a forum where they could finally work on projects to improve nursing practice and patient care.” Another important impact of the project was the improved relationship between management personnel and the staff nurses.

Limitations

Project implementation went as planned. However, there was a problem noted of competing surveys in the organization on staff engagement and RN satisfaction. To promote participation and to ensure the staff was not confused with multiple surveys, a paper survey method was the best option.

Statistically, there was not much change in pre- and post- implementation survey results. This was anticipated due to the limitations of the study which included a small sample size and a short testing period of ten weeks. The project kicked off the establishment of other UBC’s led by staff nurses who successfully conduct the UBC meetings. The ongoing evaluation will be closely monitored by the unit manager, who will be responsible for ensuring the staff has the support and resources for the function of the UBC. The future implication of the project is that

the toolkit used for the establishment of the UBC will be used for similar units in the organization to create a functional UBC. In addition, the same participants will be solicited to complete both the pre and post intervention IPNG, and a paired t-test would be used for statistical analysis.

Dissemination Plan

The initial project results were shared in the form of a brief report within the facility in the unit staff meeting where the project was conducted. A slide presentation was prepared and delivered to the senior nurse leadership team and the preceptor. Further, this presentation will be shared internally within the organization and externally to the University of St. Augustine for Health Sciences (USAHS) institutional repository called SOAR (Scholar Works Open Access Repository). Arrangements were made for a brief presentation to be given during the organization's research, innovations, and new knowledge council (RINK) in a monthly meeting. A digital poster including EBP interventions, methodology, results, practice recommendations is planned to be presented on the SharePoint of the organization during their Fall poster fair. The abstract will be submitted to the system level annual EBP and research symposium for potential podium or poster presentation.

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

Conclusion

SG is an important component of professional practice. Studies demonstrate that SG improves staff engagement, job satisfaction, staff retention, and overall clinical outcomes. Magnet designation which validates nursing and clinical excellence emphasizes the importance of shared decision-making through SG. Using the JHEBP Model's synthesis process and

recommendation tool, evidence gathered to support that implementation of a SG toolkit helped to bridge the gap of knowledge for front-line staff to establish a viable UBC. For this project, UBCs were led by clinical RNs who discussed pertinent unit, patient, and staff-related concerns for practical solutions and recommendations

This EBP project was successful in establishing SG through a UBC with the implementation of a SG toolkit. Project implementation was done in various stages. Evaluation of the project was completed using the IPNG scale - a SG measurement tool pre and post intervention. Analysis of the data was done to evaluate the effect using Intellectus Statistics. Statistically, there was not much change in pre and post implementation survey results. However, the results of the project were clinically significant as the UBCs are expanding within this healthcare system. The project results were compiled and shared with stakeholders internally and through professional events externally. SG is needed within the current complex healthcare organizations that promote shared decision-making ultimately promoting safety, quality, and consumer satisfaction - including staff and patients. Ultimately, SG is the foundation for a culture of excellence and nursing excellence of top-performing healthcare organizations.

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Table 1

SWOT Analysis

Strengths	Weakness	Opportunity	Threats
Busy Medical-Surgical Unit	Nursing Shortage	Magnet culture	Covid19 Pandemic Potential surge
Experienced and expert nursing staff	Pandemic Covid19 pandemic challenges leading to increased turnover rate	Incentives available for committee participation	Market competition due to nursing shortage
Rated as number one hospital in the county	Poor staff engagement	Robust nursing career advancement program	RN shortage
Supportive leaders	Lack of staff participation in organizational committees		

Table 2

Budget

EXPENSES		**REVENUE**	
Direct		Billing	
Salary and benefits: Project team RNs	$ 500.00	Grant from system Nurse Excellence Fund	$ 500.00
Supplies: Gift cards Stationaries Snacks for inauguration	$ 200.00	Department fund	$ 150.00
Total Expenses	$ 700.00	Total Revenue	$ 650.00
Net Balance			($50.00)

Table 3

Pre-intervention and Post-intervention Demographic Data of Respondents

Variable	Pre-intervention	Post-intervention
Sex		
Female	18 (100.00%)	16 (88.89%)
Male	0 (0.00%)	2 (11.11%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Educational Degree		
Associate Degree	3 (16.67%)	2 (11.11%)
Master's Degree	3 (16.67%)	4 (22.22%)
Baccalaureate Degree	12 (66.67%)	12 (66.67%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Employment Status		
Full-time, 36-40 hours per week	17 (94.44%)	16 (88.89%)
Part-time, less than 36 hours per week	1 (5.56%)	2 (11.11%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Title		
RN II	18 (100.00%)	17 (94.44%)
Nurse navigator	0 (0.00%)	1 (5.56%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)

Table 4

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

Variable	*M*	*SD*	*n*	Min	Max
Age					
Pretest	46.21	8.49	14	34.00	58.00
Posttest	44.06	9.49	16	30.00	64.00
Years Practicing					
Pretest	14.06	6.46	18	4.00	29.00
Posttest	14.97	10.14	18	3.50	40.00
Years in Organization					
Pretest	6.92	5.24	18	0.50	15.00
Posttest	6.33	6.05	18	0.50	20.00
Years in Position					
Pretest	8.64	5.47	18	0.50	17.00
Posttest	7.75	7.33	18	0.50	30.00
Overall Satisfaction					
Pretest	4.17	0.62	18	3.00	5.00
Posttest	4.11	0.68	18	3.00	5.00

Note. '-' indicates the statistic is undefined due to constant data or an insufficient sample size.

Table 5

Pre-intervention and Post-intervention IPNG scores

Variable	Pre-intervention	Post- intervention
Personnel Governance		
Traditional	15 (83.33%)	15 (83.33%)
Shared	3 (16.67%)	3 (16.67%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Information Governance		
Traditional	10 (55.56%)	9 (50.00%)
Shared	8 (44.44%)	9 (50.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Resources Governance		
Traditional	10 (55.56%)	9 (50.00%)
Shared	8 (44.44%)	9 (50.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Participation Governance		
Traditional	9 (50.00%)	10 (55.56%)
Shared	8 (44.44%)	8 (44.44%)
Self	1 (5.56%)	0 (0.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Practice Governance		
Traditional	8 (44.44%)	9 (50.00%)
Shared	10 (55.56%)	9 (50.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)
Goals Governance		
Traditional	7 (38.89%)	9 (50.00%)
Shared	11 (61.11%)	9 (50.00%)
Missing	0 (0.00%)	0 (0.00%)
Total	18 (100.00%)	18 (100.00%)

Table 6

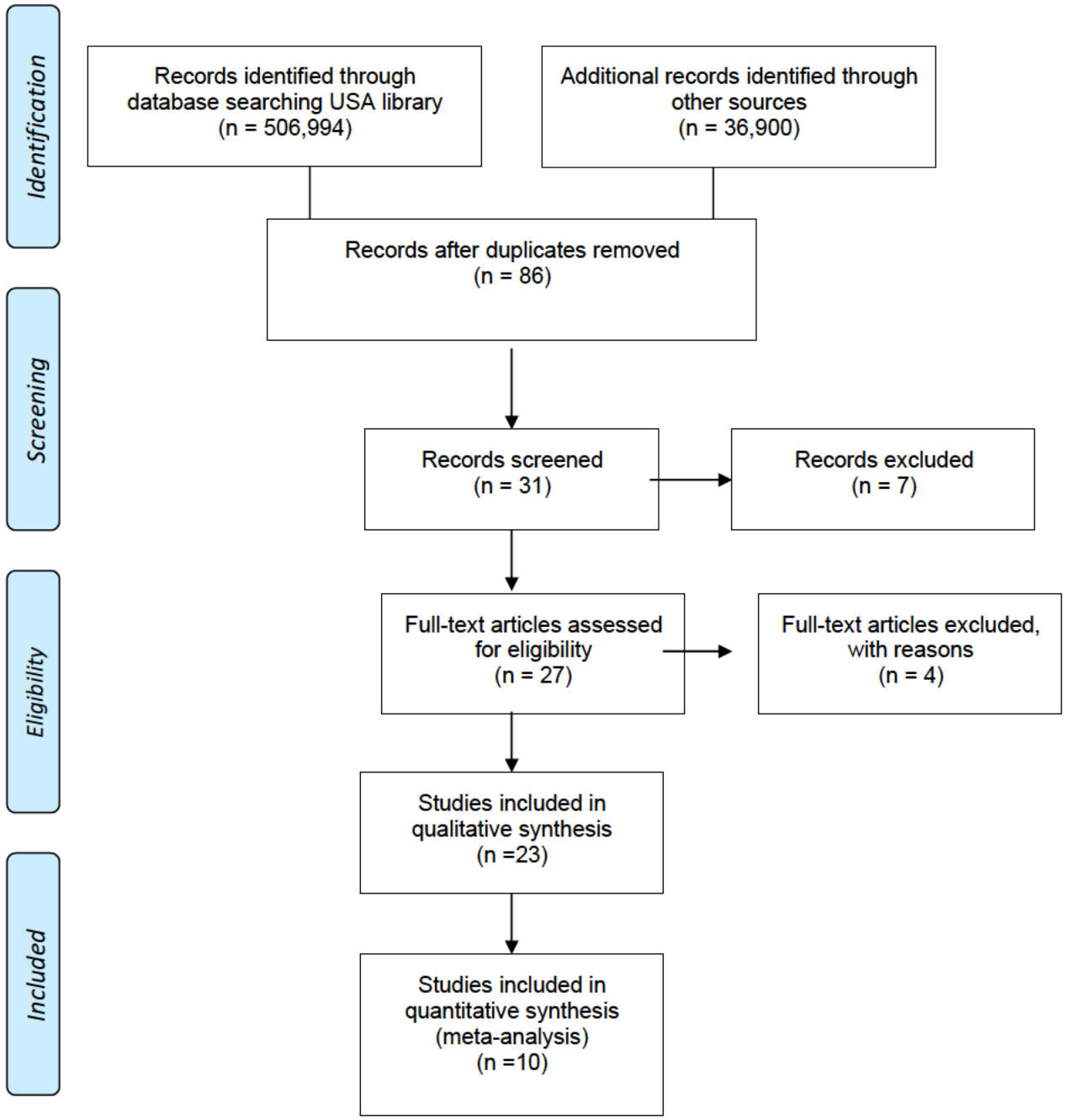
Two-Tailed Independent Samples t-Test for Six Sub-scales by Testing Period

	Pre-intervention		Pot-intervention				
Variable	*M*	*SD*	*M*	*SD*	*t*	*p*	*d*
Personnel Score	18.50	10.07	16.39	5.55	0.78	.441	0.26
Information Score	19.67	8.28	19.33	5.82	0.14	.890	0.05
Resources Score	20.67	8.12	19.06	6.16	0.67	.507	0.22
Participation Score	18.00	8.17	16.33	5.04	0.74	.466	0.25
Practice Score	17.00	4.67	14.44	4.49	1.67	.103	0.56
Goals Score	11.39	5.29	10.56	4.54	0.51	.615	0.17

Note. N = 36. Degrees of Freedom for the *t*-statistic = 34. *d* represents Cohen's *d.*

Figure 1

PRISMA Literature Search Strategy Diagram



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

Appendix A

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Cai et al., 2021	Descriptive Comparative Design, survey methodology Level II Quality B Grade	N- 511	SG participation and attendance survey	NA	SG participants more satisfied with nursing career	Clinical nurses active and participate in decision-making
Capitulo & Olender, 2019	Descriptive Level III Quality grade B		Creation of formal infrastructure of interprofessional councils	Watson's theory of human caring and appreciative inquiry	Engaged and empowered staff	Interprofessional councils, staff engagement and empowerment
Dechairo-Marino et al., 2018	Quasi-experimental, cross-sectional design Level II Quality Grade A	N- 344	IPNG tool to promote SG	NA	Nursing engagement ad empowerment	Chief nursing officer an important driver of SG, play key role in transforming the work environment through engaging leaders and staff
Gerard et al., 2016	Quantitative study Level II Quality Grade A	N- 162	Decision Involvement Scale	NA	Shared decision making	Evaluation of shared decision making
Hess et al., 2020	4-phase experimental Level II Grade A	N- 93	Index for professional governance and Index for professional nursing governance	Donabedian's Structure Process and Outcome	Implementation of new tool for SG	Effective SG unit councils that result in high-reliability, quality improvement, professional competence, and leadership
Joseph & Bogue, 2016	Experimental, quantitative study, Systematic review	N-176	Implementation of unit level nursing practice councils	Lipsey's Implementation Theory Method to formalize a general	Nurse Retention Needed Resources Care Quality Self-Efficacy	Survey instrument - Nursing Practice Council Effectiveness Scale First theory driven approach to SG

	Level 1 Quality A Grade			effectiveness model of nursing SG, GEMS		
Jordan, 2016	Non-experimental, Quality Level III Quality B	N- Not specified	Designed unit practice councils	NA	Nurse Satisfaction	Improved nurse satisfaction, decision-making and autonomy
Kanninen et al., 2019	Qualitative descriptive study Level III Grade B	N-12	Semi-structured interviews	NA	Nurse engagement Development of nurse's career	SG contributes to quality of care, harmonizes nursing practices and informs decision-making
Moreno et al., 2018	LEAN methodology Qualitative study Level III Quality Grade B		New shared leadership council	NA	Establishment of new SG structure	Shared Leadership, shared decision-making, succession planning
Meyers & Costanzo, 2015	Qualitative study Level III Quality Grade A	Various stakeholders	SG implementation	Empowerment theory	Implementation of SG structure a clinic in the hospital	Shared decision making between staff and administration

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

Appendix B

Project Schedule

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 10	Week 13	Week 15
Meet with preceptor	X																							
Prepare project proposal							X																	
Meeting with the unit manager Meeting with staff Implement pre-survey using IPNG scale									X															
Identify RNs and interprofessional team members to be part of UBC with specific roles Education and sharing of SG Toolkit the UBC members										X														
Implementation of first UBC inaugural meeting in the unit Develop UBC information board to display											X													
UBC leaders prepare for second meeting using SG toolkit Nurse manager led meeting with												X												

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 10	Week 13	Week 15
UBC leaders for sharing UBC experience and documentations																								
Update UBC information display board in the unit RNs to complete post-implementation survey using the IPNG scale													X											
Nurse manager led meeting with UBC leaders for sharing UBC experience and documentations														X										
Evaluation of effect of implementation of SG toolkit and UBC																								
Post implementation evaluation of SG using DIS scale															X									
Evaluation - collection and review of statistics results																X								
Completion of Evaluation and compilation of results as needed																	X	X	X					

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 10	Week 13	Week 15
Review of project results, dissemination of results, internally to unit meetings and hospital leadership, externally submitting abstracts to professional organizations at local, regional, and national level																			X	X	X	X	X	X
Completion of SG establishment project																			X	X	X	X	X	X

Appendix C

SG Toolkit for UBC

CHARTER: Unit Based Council (UBC)

General Purposes:

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

Membership:

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

Core Council Responsibilities:

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

Scope of Work: Unit/department

Serve Internal Customers: Employees, volunteers

Serve External Customers: Patients, families, physicians, visitors, community representatives

Goal Parameters:

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

Member Roles/Responsibilities:

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

- Inform members of roles and responsibilities and set expectation for UBC members

- *Vice Chairperson:*
  - Assume the duties of the chairperson in the absence of the chairperson
  - Assist the chairperson in the completion of the business of the UBC, as needed and as requested by the chairperson or manager/supervisor champion
  - Serve as liaison member to other councils as requested by the chairperson or manager/supervisor champion

- *Voting Members:*
  - Attend 80% of UBC meetings
  - Obtain pertinent information from the recording secretary or chairperson in the event of absence
  - Carry out delegated UBC assignments, provide feedback and advice
  - Notify chairperson of agenda items two weeks prior to meeting for inclusion in the agenda
  - If unable to attend may arrange a representative to attend the meeting in their place

- *Recording Secretary:*
  - Each UBC will elect or assign a recording secretary to record and document UBC activities
  - Distribute minutes of meeting to members of the UBC as soon after the UBC meeting as possible

- *Members at Large:*
  - Non-voting unit staff members are encouraged to attend UBC
  - Non-voting members may bring forth topics that impact their work environment for discussion and consideration
  - Share ideas for unit improvements and can be a part of decision-making

Reporting Relationship:

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

Authority and Accountability:

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

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

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

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

Appointments and Elections:

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

Appendix D
Index of Professional Nursing Governance 3.0

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

Today's Date _____

1. Sex: ____Male ____Female 2. Age: _____

3. Please indicate your HIGHEST educational degree:

____Diploma ____Master's Degree

____Associate Degree ____Doctorate

____Baccalaureate Degree

4. Employment Status:
____Full-time, 36-40 hours per week

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

5. Please specify the number of years that you have been practicing _____

6. Please indicate the title of your present position _____

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

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

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

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

1 = Management/administration only

2 = Primarily management/administration with some staff input

3 = Equally shared by staff and management/administration

4 = Primarily staff with some management/administration input

5 = Staff only

PART I

1. Determining what your professional colleagues can do in their daily practice. 1 2 3 4 5

2. Developing and evaluating policies, procedures & protocols related to patient care. 1 2 3 4 5

3. Establishing levels of qualifications for positions within your own discipline. 1 2 3 4 5

4. Determining activities of ancillary personnel (aides, assistants, technicians, secretaries). 1 2 3 4 5

5. Conducting disciplinary actions of colleagues within your discipline. 1 2 3 4 5

6. Assessing and providing for the professional/educational development of professionals within your own discipline. 1 2 3 4 5

7. Selecting products used in your professional practice. 1 2 3 4 5

8. Determining methods or systems for accomplishing the work of your discipline. 1 2 3 4 5

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

1 = Management/administration only
2 = Primarily management/administration with some staff input

3= Equally shared by staff and management/administration
4 = Primarily staff with some management/administration input

5 = Staff only

PART II

9. Making work assignments for professional and support staff. 1 2 3 4 5

10. Regulating the flow of services or patients/clients within the organization. 1 2 3 4 5

11. Formulating annual unit budgets for personnel, supplies, equipment, and education for your own unit or work group. 1 2 3 4 5

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

13. Consulting and enlisting services outside of your own unit or work group. 1 2 3 4 5

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

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

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

1 = Management/administration only
2 = Primarily management/administration with some staff input
3 = Equally shared by staff and management/administration
4 = Primarily staff with some management/administration input
5 = Staff only

PART III

17. Mandatory credentialing levels of professionals (licensure, education, certifications) for hiring, continued employment, promotions and raises. 1 2 3 4 5
18. Organizational charts that show job titles and who reports to whom. 1 2 3 4 5
19. Written guidelines for disciplining personnel. 1 2 3 4 5
20. Procedures for hiring and transferring your discipline's personnel. 1 2 3 4 5
21. Policies regulating promotion of professional personnel to management and leadership positions. 1 2 3 4 5
22. Procedures for determining work assignments. 1 2 3 4 5
23. Daily methods for monitoring and obtaining supplies that support the practice of your professional group within the organization. 1 2 3 4 5
24. Procedures for controlling the flow of services and patients/clients within the organization. 1 2 3 4 5
25. Process for recommending and formulating annual budgets for personnel, supplies, equipment, and education for your own work group. 1 2 3 4 5
26. Procedures for adjusting professional personnel' s salaries, raises, and benefits. 1 2 3 4 5
27. Formal mechanisms for consulting and enlisting the support of other professionals within your discipline who work outside of your work group. 1 2 3 4 5
28. Formal mechanisms for consulting and enlisting support of organizational services outside of your work group (e.g., dietary, social service, pharmacy, human resources, finance). 1 2 3 4 5

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

1 = Management/administration only
2 = Primarily management/administration with some staff input
3 = Equally shared by staff and management/administration
4 = Primarily staff with some management/administration input
5 = Staff only

PART IV

29. Participation in unit or work-group committees that deal with administrative matters such as staffing, scheduling, and budgeting. 1 2 3 4 5

30. Participation in departmental committees that deal with administrative matters such as staffing, scheduling, and budgeting. 1 2 3 4 5

31. Participation in interprofessional committees (physicians, other healthcare professions) for collaborative practice. 1 2 3 4 5

32. Participation in organizational administrative committees for matters such as employee benefits and strategic planning. 1 2 3 4 5

33. Formatting new unit or work-group committees. 1 2 3 4 5

34. Forming new departmental committees within your own discipline. 1 2 3 4 5

35. Forming new interprofessional committees. 1 2 3 4 5

36. Forming new administration committees for the organization. 1 2 3 4 5

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

1 = Management/administration only
2 = Primarily management/administration with some staff input
3 = Equally shared by staff and management/administration
4 = Primarily staff with some management/administration input
5 = Staff only

PART V

37. Compliance of your organization with requirements of surveying agencies (e.g., The Joint, state, and federal government, professional groups). 1 2 3 4 5

38. Your work group and departmental goals and objectives for this year. 1 2 3 4 5

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

40. Results of clients' satisfaction surveys. 1 2 3 4 5

41. Professionals' satisfaction with their interprofessional collaboration. 1 2 3 4 5

42. Turnover and vacancy rate of professionals within your discipline in the organization. 1 2 3 4 5

43. Colleagues' (within your discipline) satisfaction with their general practice. 1 2 3 4 5

44. Colleagues' (within your discipline) satisfaction with their salaries and benefits. 1 2 3 4 5

45. Management' s opinion of the quality of professional practice provided by your discipline. 1 2 3 4 5

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

1 = Management/administration only
2 = Primarily management/administration with some staff input
3 = Equally shared by staff and management/administration
4 = Primarily staff with some management/administration input
5 = Staff only

PART VI

46. Negotiate solutions to conflicts among your professional colleagues. 1 2 3 4 5

47. Negotiate solutions to conflicts between your professional colleagues and other professional groups. 1 2 3 4 5

48. Negotiate solutions to conflicts between your professional colleagues and other organizational departments. 1 2 3 4 5

49. Negotiate solutions to conflicts between your professional colleagues and their immediate managers. 1 2 3 4 5

50. Negotiate solutions to conflicts between your professional colleagues and the organization' s administration. 1 2 3 4 5

Appendix E
Permission to use IPNG tool

FORUM FOR Shared Governance LLC
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Viji George, MA, BSN, RN, RNC-NIC
School of Nursing, Post Professional Programs
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November 26, 2021

Dear Viji:

You have permission to use my instruments, the Index of Professional Nursing Governance (IPNG) or the Index of Professional Governance (IPG), 2.0 or 3.0, at Texas Health Presbyterian Hospital Plano for the DNP Program at University of Saint Augustine for Health Sciences.

In return, I require that you, upon request:

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

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

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

Sincerely,

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