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The Effect of an Educational Intervention on Clinical RN Knowledge and Attitudes Toward Shared Governance Program at Eastern State Hospital

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The Effect of an Educational Intervention on Clinical RN Knowledge and Attitudes
Toward Shared Governance Program at Eastern State Hospital

Submitted in Partial Fulfillment of the Requirements for the degree of Doctor of Nursing
Practice at the University of Kentucky

By

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Lexington, Kentucky

2022

Abstract

Background: Shared governance programs are a popular way to improve Registered Nurse (RN) engagement and retention. These programs are notoriously difficult to garner and maintain participation. However, successful shared governance can improve patient outcomes, patient satisfaction and RN engagement.

Conceptual Framework: The theory of planned behavior was used as the conceptual framework for this study. This theory posits that attitudes, subjective norms, perceived behavioral control and intentions towards a behavior can predict behavioral achievement.

Methodology: Eighty clinical registered nurses were invited to voluntarily complete a survey to determine current attitudes about shared governance and intent to participate in shared governance in a 140-bed state psychiatric hospital. Once the pre-survey was completed, participants received a 10-minute training via voiceover power-point that reviewed the purpose and benefits of a shared governance program. Once the education was delivered, the participants were asked to complete a post-survey to determine their intent to participate in a shared governance program.

Results: A total of 17 participants completed the pre-survey and 14 completed the post-survey. Although knowledge, attitudes, subjective norms, perceived behavioral control and intention scores increased after the intervention, these increases were not statistically significant. In the intention domain, only the willingness to 'make a change in practice' significantly increased after the intervention.

Discussion: The knowledge of participants was already high before the educational intervention was viewed and may not have significantly changed intentions to participate in shared governance council activities.

Conclusion: Although findings of this study were limited by the small sample size, it provides some evidence that a web-based education on shared governance has the potential to improve intentions to participate in shared governance councils. Further research with a larger sample size is recommended.

Acknowledgements

I would like to thank my DNP advisor Dr. Karen Stefaniak for being patient with me and maintaining the positivity I needed to persevere. Dr. Zim Okoli was also extremely helpful throughout this program of study. He was available to me and I value his input. Dr. Amanda Lykins is always supportive. Finally, Marc Woods was my supervisor and cheerleader these last 15 years. He has always encouraged me to push myself to be a better leader and a better nurse. Also thank you to Dr. Amanda Wiggins for her help with the statistical analysis.

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The Effect of an Educational Intervention on Clinical RN Knowledge and Attitudes Toward Shared Governance Program at Eastern State Hospital

Background and Significance

Shared governance (SG) is a popular council system used in healthcare organizations and the nursing profession to give clinical nurses input into their own professional practice (Weaver et. al., 2018). However, a lack of involvement in decisions that affect their work is a consistent concern voiced by clinical nurse in engagement surveys. This common concern persists despite the existence of SG programs at the unit level. The challenge is to have active participation in SG councils on a consistent basis (Wheeler & Foster, 2013).

The problem of low SG council participation affects clinical nurse satisfaction, retention and ultimately patient outcomes (Joseph & Bogue, 2016). Clinical nurses do not recognize council participation as an opportunity to make decisions about their day to day work and as a result may be dissatisfied and disengaged. Research shows that patient outcomes as well as nurse engagement and retention are improved with robust participation in shared governance councils (Moreno, Girard & Froad, 2018). An effective SG program empowers nurses to use evidence-based methods to improve patient care (Olender, Capitulo, & Nelson, 2020).

Strategies identified to encourage nurses to participate in shared governance councils include: providing a clear definition of what shared governance means to nursing as a profession; providing protected and paid time for the councils to meet; and cultivating a sense of ownership (Medeiros, 2018). The first step to increase council engagement is to ascertain the perceptions of the clinical nurse regarding a shared governance structure (Weaver et.al. 2018).

The Eastern State Hospital (ESH) SG program was first launched in 2015. Education was provided at that time via quarterly meeting sessions that explained the SG concepts and

advantages. In the first stages each acute unit had their own council. Gradually due to low attendance the unit councils were combined into 2 councils of 3 units each. To encourage council attendance nursing leadership set up conference call options and arranged for floor coverage during council hours.

Despite several iterations of SG structuring, current clinical nurse understanding of the ESH SG program was unknown and according to council minutes, attendance in councils was low. Often the nursing staff cannot leave the unit to attend for longer than 30 minutes. The goal of ESH nurse leaders is to increase the clinical nurse understanding of the purpose of a successful shared governance program and thus bolster participation. This requires determining the attitudes regarding the current state of the SG program and the creation and dissemination of education to clinical nurses. To reach this goal a survey was sent to all clinical nurses followed by clear and concise education and a post-survey to determine understanding and intent to participate in unit councils.

Conceptual Framework

This project was guided by the theory of planned behavior (TPB), developed by Ajzen (1991). This theory is a frequently applied behavior model used in marketing, health, and psychology fields to predict the likelihood that a person will engage in a specific behavior (Armitage & Conner, 2001). According to the TPB, one's attitudes, perceptions of others' beliefs about the behavior and perceived control over a behavior, influence intentions to engage in a specific behavior.

The TPB is an improvement on the theory of reasoned action (Ajzen & Fishbein, 2010) and has three core components: attitude, subjective norms and perceived behavioral control (Ajzen, 2002). Attitude refers to how a person views the behavior being targeted. Subjective

norms relate to how a person perceives that others feel about the targeted behavior. Perceived behavioral control refers to the degree of difficulty the person ascribes to the proposed behavior. Intent is another important piece in the TPB. If the intent to perform a behavior is strong it is more likely to happen (Ajzen, 1991). The combination of perceived behavioral control and intent are often used to predict the completion of the targeted behavior.

The pre and post surveys used in this study were designed based on the TPB. The surveys measured knowledge, intention, attitudes, subjective norms and perceived behavioral control related to SG. How clinical RNs perceive the program, how their peers perceive their participation in the program and whether the RN thinks that they can successfully participate in the SG council can affect their intent to participate (Secginli et. al., 2021).

Review of the Literature

To create a clear and simple form of education for the clinical nurse about the purpose of participation in shared governance councils a literature review was conducted. Using the PICOT format, the question guiding this review was: In a hospital setting, what education methods have been successful in increasing SG participation among clinical nurses? A CINAHL search of professional journals from the last 10 years was conducted using the keywords “shared governance participation” and “professional governance participation”, “shared governance measurement”, and “shared governance education”.

First a search for studies that implemented an evidence-based tool that ascertained the clinical nurse’ attitudes and understanding about shared governance was conducted. Weaver et al. (2018) and Lamoureux et al. (2013), both employed the Index of Professional Governance (IPNG) to measure clinical nurse attitudes regarding the current shared governance program in their hospitals. IPNG was designed by Hess (2014) to gauge RN attitudes toward SG. Also

included was a search for targeted education that was successful in enhancing the clinical nurse's understanding of shared governance. Weaver et al. administered the IPNG every 2 years from 2013 – 2017 to detect culture change. They had an average of 464 participants each year and found that the hospital had finally reached system-wide nursing shared governance after the third IPNG survey was administered in 2017 (2018). Lamoureux had 76 respondents representing 6 units and found the IPNG reliable and valid.

Regarding preferred method of education, Giambra et al. (2018) and Weaver et al. (2018) surveyed clinical nurses and determined that the preferred method of education and communication was electronic. Giambra et al. (2018) used the Delphi technique which included two rounds of questionnaires, close to 200 nurses participated. Brull (2015) used very comprehensive methods of education before launching a shared governance system including printed materials, electronic communication and in-person lectures.

Based on the evidence, this project was designed to determine if by increasing RN knowledge council participation would increase. Due to time constraints the IPNG was not used to evaluate current RN attitudes toward SG but permission was obtained to use it in future studies. A survey was created using TPB pre and post (Knowles et al., 2015). The education for this study was designed in a voice-over PowerPoint format and was available to participants digitally.

Purpose and Objectives

The purpose of this study was to assess the effect of a targeted voice over PowerPoint education on the Clinical RN's:

- Knowledge of SG
- Attitudes toward SG

- Subjective norms regarding SG participation
- Perceived behavioral control of participation in SG
- Behavioral intention to participate in SG

RNs were asked to complete a brief pre-survey to indicate their attitude, perceptions, and beliefs about the current SG program at ESH. After a twelve-minute clarifying education about the history, purpose and benefits of SG, a post-survey measured knowledge, attitudes and intent to participate in shared governance councils in the future.

Methods

Design of the Study

The design used for this study was pretest- posttest, to examine a shared governance education intervention. The survey was based on the theory of planned behavior and assessed knowledge, attitudes, subjective norms, perceived behavioral control and behavioral intention toward shared governance involvement by the clinical RN. The education was created after a literature review of shared governance education to promote staff involvement. Survey completions were anonymous via Qualtrics.

Description of the Setting

ESH is a 140-bed state inpatient psychiatric facility that is managed by University of Kentucky Healthcare. ESH currently has five acute inpatient units and two COVID units in operation. The hospital employs approximately 600 individuals, 300 of which are in the nursing department, consisting of RNs and Mental Health Associates (MHAs).

The mission of the ESH nursing department is to provide leading-edge patient care while advancing professional nursing practice (UK Nursing Strategic Plan, 2020-2022). ESH received their first Magnet Designation from the American Credentialing Center (ANCC) in 2021.

The stakeholders involved include the hospital's executive leadership, nursing administration, and patient care managers. ESH executive leadership consists of the chief executive officer, the chief nursing officer and the chief medical officer. Nursing administration includes the director of behavior health operations, director of behavior health inpatient, the capacity command manager and the clinical educator. Each inpatient unit and the admission suite have a unit manager who oversees the clinical nursing team.

The barrier to implementation of this project included time to access employee email and complete the survey during work hours. Staffing shortages may have also made it difficult for RNs to take time out to complete the survey.

Sample Population

The target population was psychiatric RNs practicing on inpatient psychiatric units. ESH had 80 RNs employed and eligible to participate at the time of the study. Expected participation was 60% of the target population. Actual participation was 21%. The inclusion criterion was fulltime and part time RNs. Excluded were agency RNs and shift coordinators who do not work on the units.

Procedure

All RNs at ESH received an email from the Unit Managers inviting them to participate in the research study. A letter was obtained from the executive leadership of ESH stating their permission and support of the research study. The Nursing research council at UK Healthcare also reviewed and approved the study. Finally, permission was granted by the University of Kentucky Institutional Review Board (IRB).

The Unit Managers sent an email with a link to the cover letter. The cover letter contained a consent, the pre-survey (see Appendix A), the shared governance education, and a

post-survey. Data were stored on a firewall protected and encrypted computer linked to the UK server.

Upon completion of the study, the primary investigator deleted the password-protected documents using data overwriting software to ensure that the data will not be reconstituted as per IRB protocol. No identifiable data was reported. Data were aggregated and no individual response identified.

The educational intervention was a ten-minute, PowerPoint designed to raise awareness of the purpose of shared governance councils (see Appendix B). The PowerPoint was presented with a voiceover and had the following objectives for participants: to verbalize the history of SG, define SG, verbalize the requirements and principles of SG, verbalize the role of the unit manager in SG, verbalize the benefits of SG in healthcare, understand the structure of a SG council, discuss one example of a positive outcome from an ESH council, and discuss opportunities for improvement in ESH SG. The education also reviewed the professional practice model at ESH and its relationship to the SG structure as well as current council structure.

The survey and educational presentation was open for 2 months. One reminder email was sent by the unit managers after the first month the survey link was available.

The resources for the project included the clinical nurses, email, web-based training and quality databases. The PI had access to technology and data analysis software through the UK College of Nursing. There was no budget allotted for this DNP project.

Measures

The demographic measures obtained from participants included age, sex, ethnicity/race, marital status, and education level. In the pre-survey, knowledge of SG councils was assessed

with 5 true and false questions. Intention was then assessed with 3 Likert scale level of agreement measures ranging from 1-7. Attitude, subjective norms and perceived behavioral control was recorded in the same manner with 4 frequency statements ranging 0-4. Finally, council practice frequency was measured with 5 statements. The post-test survey presented the same items using the same scales.

A paired sample t-test was performed via SPSS to measure any improvements in knowledge, attitudes, subjective norms, and perceived behavioral control and intention to participate in a council after completing the SG education.

Data Analysis

Analysis of data was performed using the SPSS software version 26. Descriptive statistics were used to analyze participant demographics. Paired sample t-tests were used to compare pre and post data to determine the effectiveness of the education provided on the main outcomes of interest.

Results

Sample Characteristics

The study had 17 participants who completed the pre-survey and 14 who completed the post-survey. The average age of the RN participants was 43.5 years of age (ranging from 32 years to 65 years). Ethnicity responses reveal 88.2% participants indicating white non-Hispanic, 5.9% Black, non-Hispanic and 5.9% Asian/Pacific Islander. Of respondents, 70% were female (Table 1). The average length of RN career was 14 years.

Knowledge

Knowledge was measured using 5 true or false statements. The same statements were presented in the pre and post surveys. No significant changes were noted in the scores. The pre-survey scores were 4.78 (.80) while the post-survey scores were 5 (.00).

Intent, Attitudes, Social Norms and Perceived Behavioral Control

There were 3 statements regarding intent to participate in SG followed by 4 statements about attitudes, social norms and perceived behavioral control toward SG. Likert scales were provided ranging from 1 to 7, with 1 being strongly disagree and 7 being strongly agree. No significant changes were noted following the SG education (Table 2).

Practice/Role

The only statistically significant result was from the area of practice/role. The statement was “in your role, how often do you anticipate that you will make changes in practice as a result of council participation?” The change from the pre-survey was significant with a p value of 0.02 (Table 3). This result may be due to the education and the discussion of possible changes to the SG program at ESH.

Discussion

Literature supports dissemination of education through electronic means (Giambra, Morath, & Morris, 2018; Brull, 2015). Electronic (email) delivery of the SG education was deemed the preferred method to receive information in this study. The focus of this study was to provide education about the benefits of SG and to predict intent to participate after the education was provided using the TPB. The pre-survey served to gauge the current attitudes of RNs regarding SG. Only one difference was found after the education was provided. The SG

program was implemented at ESH in 2015 perhaps the education provided at inception and in nursing orientation is effective.

Although not statistically significant, we found an increase in scores on knowledge, attitudes, subjective norms, perceived behavioral control and intentions to participate in SG Councils. The non-statistically significant findings are likely due to the low sample size from participants. However, other studies have shown that education on SG can also increase knowledge and willingness to participate in SG (Brull, 2015). Importantly, we found that after the educational intervention, participants, on average, were more willing to make changes in their role because of practice participation. This finding might indicate that the educational intervention improved the respondents' self-efficacy or desire to make such changes. However, future studies with larger sample sizes are needed to better clarify these findings.

Implications

This study implies that clinical RNs are aware of the benefits of SG but may have different factors that hinder their participation. Studies have shown that getting time away from patient care and lack of manager support are factors known to hinder the participation in unit councils and SG among nurses (Giambra et. al., 2018). A change in the way SG councils are scheduled and the work is prioritized may be the answer to increased participation. Giambra et al. recommend scheduling all council work to be done once a month in an 8 hour day, this is something to consider (2018). In addition, because intent to change practice based on SG participation was shown in this study, it is important for nurse managers to: support clinical RN participation in SG activities; ensure that patient care doesn't suffer as a result of SG participation and make sure that RN's are paid for their participation (Wilson & Jones, 2014). In

the past leaders sent out a quarterly SG newsletter highlighting council work, this practice can be renewed to support SG accomplishments.

Limitations

The low number of participants may be due to minimum staffing, high census and meeting challenges presented by COVID. Only 20% of clinical RNs participated in the full study, perhaps due to a lack of time to complete during work hours. The use of a pre-survey, education, and immediate post-survey all in one sitting could have affected results. There was also a limited time during which the study was available to complete, a longer time frame may have increased participation.

Conclusion

Despite the limitations in the sample size, there were non-statistically significant increases in knowledge, attitudes, subjective norms, perceived behavioral control, and intention to participate in SG after participating in the educational intervention. Although it cannot be concluded that the educational intervention was effective, these findings can provide the basis for further exploration on the use of educational interventions to improve SG participation. For example, future studies with a greater sample size may garner different results. In addition, the use of a different tool and a series of open-ended questions to evaluate RN attitudes toward SG may be used. Such studies can provide more information on ways to better increase SG participation through the use of educational interventions among nurses.

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Tables

Table 1

Pre-Survey: Demographic Variable Data (n = 17)

Demographic Variable	Mean (SD) or n (%)
Age	43.5 (8.75)
Gender	
Male	29.4
Female	70.6
Ethnicity/Race	
White, non-Hispanic	88.2
Black, non-Hispanic	5.9
Asian/Pacific Islander	5.9
Years of experience	14 (11.4)
Education Level	
Some college/vocational	5.9
College graduate	94.1

Table 2*Changes in Theory of Planned Behavior Constructs (n=14)*

	Potential range	Pre-intervention Mean (SD)	Post-intervention Mean (SD)	<i>p</i>
Intentions	1-7	4.46 (2.15)	5.21 (2.03)	.14
Attitudes	1-7	4.88 (1.82)	5.67 (1.35)	.13
Subjective norms	1-7	4.34 (1.71)	5.02 (1.76)	.15
Perceived behavioral Control	1-7	5.68 (1.54)	6.43 (.68)	
Knowledge	0-5	4.78 (.80)	5.0 (.00)	.34

Table 3*Intention To Participate (n=14)*

	Pre-intervention	Post-intervention	<i>p</i>
Join a meeting	2.3 (1.1)	2.7 (1.2)	.14
Attend a meeting	2.7 (.95)	3.0 (1.3)	.22
Participate in a meeting	2.3 (1.2)	2.7 (1.3)	.21
Serve as an officer	1.9 (1.1)	2.3 (1.3)	.14
Make changes in practice	2.3 (1.1)	2.9 (1.3)	.02

Note: Responses range from 0) “Never” to 3) “Very Often”

Appendix A

Shared Governance Pre-Survey

SECTION A: DEMOGRAPHICS

A1. What year were you born?

A2. Are you?

Male

Female

A3. What is the highest grade or year of school you completed?

Less than high school

High school graduate or GED

Some college/vocational/trade school degree

College Graduate

A4. What is your ethnicity/race?

White Non-Hispanic

Black, Non-Hispanic

Hispanic

Asian/Pacific Islander

Other

A5. For how many years/months have you worked in you discipline? (Please type in below)

Years

Months

SECTION B: KNOWLEDGE AND ATTITUDE QUESTIONS

B1.

Please answer the following questions about council participation

- a. Shared governance councils can improve the practice of nursing T or F
- b. Shared governance councils improve nurse satisfaction and engagement in the discipline T or F
- c. Shared governance councils do not improve patient outcomes T or F
- d. Hospitals with effective shared governance systems enhance nursing engagement T or F
- e. Allocating paid time for shared governance council meetings can improve attendance T or F

SECTION C: INTENTIONS, ATTITUDES, SOCIAL NORMS AND PERCEIVED BEHAVIORAL CONTROL

We would like to know some of your thoughts about attending shared governance council meetings

C1: INTENTION

Indicate to what extent you agree or disagree with the following questions on a scale of 1 to 7 with 1 being 'strongly disagree' and 7 being 'strongly agree'.

- 1. I expect to attend a council meeting in the next six months
- 2. I want to attend a council meeting in the next six months
- 3. I intend to attend a council meeting in the next six months

C2: ATTITUDE

1. Attending a council meeting in the next six months would be beneficial
2. Attending a council meeting in the next six months would be good
3. Attending a council meeting in the next six months would be pleasant for me
4. Attending a council in the next six months would be useful for me

C3: SUBJECTIVE NORMS

On a scale of 1 being 'strongly disagree' and 7 being 'strongly agree' please respond to the following questions.

1. People who are important to me want me to participate in a council
2. It is expected of me that I participate in a council
3. I feel under social pressure to participate in a council
4. Most of my peers think it is important to participate in a council

C4: PERCEIVED BEHAVIORAL CONTROL

On a scale of 1 being 'strongly disagree' and 7 being 'strongly agree' please rate your response to the following statements:

1. I am confident that I could join a council
2. For me to join a council is easy
3. I am able to join a council
4. Whether I join a council is entirely up to me

SECTION D: PRACTICE/ROLE

D1

Please indicate how often you do the following activities based on the following scale:

0=Never 1=Seldom 2=Occasionally 3=Very Often

In your role, how often do you

1. Join a council
2. Attend a council meeting
3. Actively participate in a council (e.g., volunteering to work spearhead initiatives)
4. Serve as an officer on a council
5. Make changes in practice as a result of council participation

Appendix B

Shared Governance Education



OBJECTIVES

- 
- 
- 
- 

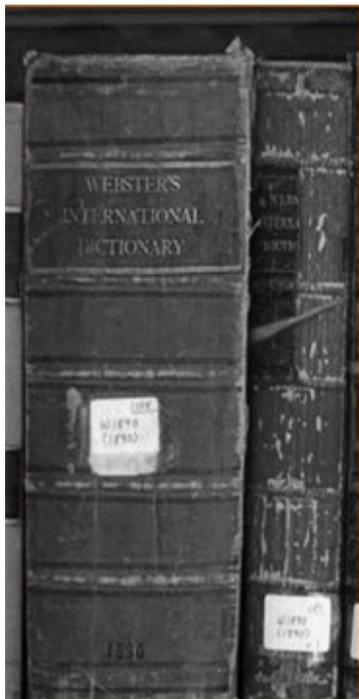
After reviewing this presentation, participants will be able to do the following:

- Verbalize the history of Shared Governance
- Define Shared Governance
- Verbalize the requirements and principles of Shared Governance
- Verbalize the role of the unit manager
- Verbalize the benefits of Shared Governance in healthcare
- Understand the structure of a Shared Governance Council
- Discuss one example of a positive outcome from an ESH Council
- Discuss opportunities for improvement in ESH Shared Governance



HISTORY

- Popularized in 1980s by an article titled *Shared Governance for Nursing: A Creative approach to Professional Accountability*
- Authored by Tim Porter-O'Grady
- Is now a necessary ingredient for Magnet hospitals nationwide



DEFINITION

- Shared governance is an organizational model that provides a structure for shared decision-making among professionals about practice and clinical outcomes (Giambra, Morath & Morris)
- Shared governance is a venue for clinical staff members to have a voice in decisions regarding practice and the practice environment (Medeiros)
- Shared governance is a model that allows for decentralized decision-making, increased ownership and accountability in nursing practice and empowerment within an organization (Medeiros)
- Shared governance empowers nurses to practice their profession, to participate in decision-making in the delivery of patient care. It is a system of accountability that relies on individual autonomy, authority and control. (Tim Porter-O'Grady)

SHARED GOVERNANCE

MUST HAVE THESE COMPONENTS

Responsibilities for nursing care delivery must reside with clinical staff.

Authority for nurses to act must be recognized by the organization.

Accountability for quality patient care and professionalism must be accepted by the clinical staff.

Wilson, Speroni, Jones & Daniel



PRINCIPLES OF SHARED GOVERNANCE

Decision Making

Right decision
Right person
Right place
Right time
Right purpose



Staff Driven

The power of any profession is in its practice.
Shared Governance by expectation not invitation.
Driven at the Unit Level

Porter-O'Grady



PRINCIPLES OF SHARED GOVERNANCE

Obligations of Membership

Profession is a membership community.
 Participation is a requisite of membership.
 Participation is not an option for members.
 Participation must be a part of the structure.
 Participating in Shared Governance should be built into staffing.



Accountability

Essence at the core of Shared Governance.
 Facilitates partnerships for sharing decisions.
 Elements include:

- Autonomy or the right to decide and act
- Authority or the power to decide and act
- Competence or the ability to decide and act

Porter-O'Grady

PROFESSIONAL PRACTICE MODEL

- ESH nursing encourages interaction at all levels of nursing practice
- Based on Jean Watson's theory of caring
- Patient and family-centered care is at the center of the model
- 4 circles with "I" statements
 - I am a leader committed to evidence-based practice
 - I am empowered to ask, act and decide
 - I am accountable for decisions and actions
 - I am inspired to learn, innovate and excel
- Each circle is surrounded by teamwork





MANAGER ROLE

- Model willingness and the skills to make shared governance work
- Assure competence and a good process of unit staff decision-making
- Presence and monitor unit council and the staff role in decisions and actions
- Evaluate and guide performance and impact of staff skills, decisions and actions

Porter-O'Grady

BENEFITS

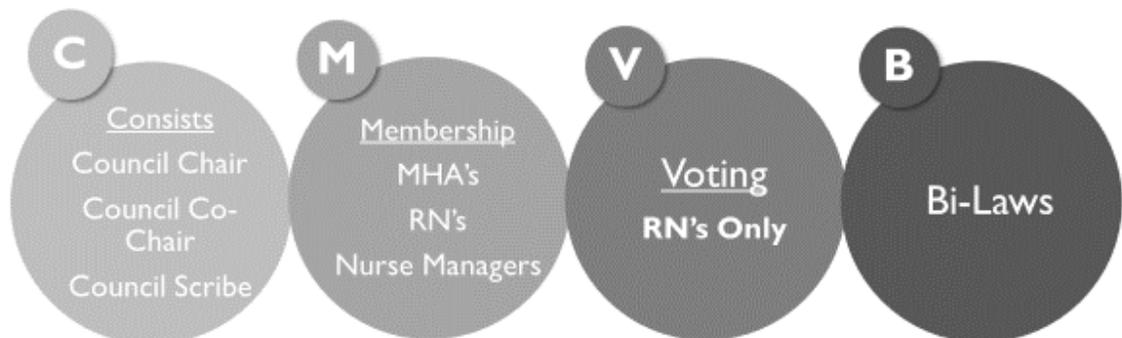
- | | |
|---|------------------------------|
| 1 | Professional Development |
| 2 | Creates nurse empowerment |
| 3 | Increase in job satisfaction |
| 4 | Develops leadership skills |
| 5 | Increases knowledge |
| 6 | Increased nurse retention |
| 7 | Increased patient safety |
| 8 | Improved clinical outcomes |



WHY HAVE A SHARED GOVERNANCE PROGRAM

			
Engagement in the profession of nursing. To fully participate in the nursing profession	I am involved in decisions that affect my work. The answer is you can be! Shared Governance councils provide you with the opportunity to do exactly that.	My ideas and suggestions are seriously considered. Yes they are! Shared governance councils are serious business. Their work can positively impact patient care outcomes.	My work unit uses evidence-based practice in providing patient care. This is how you can ensure that all nursing processes are evidence-based. The professional practice council examines practice changes monthly

COUNCIL STRUCTURE



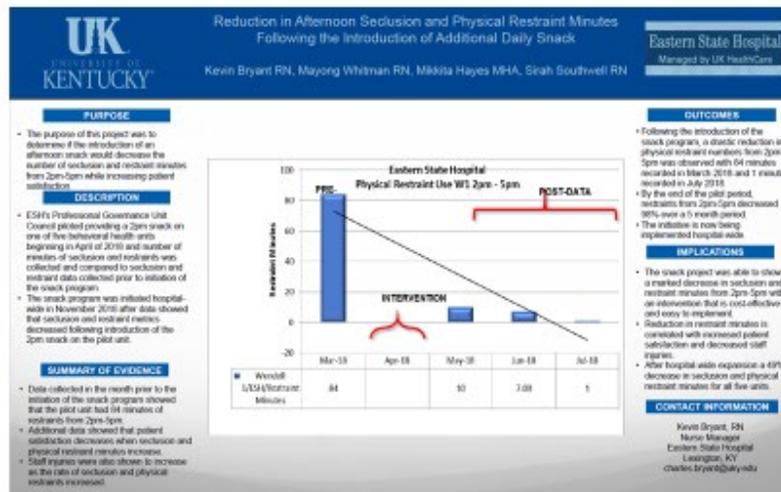


ESH
COUNCIL
SUCCESS STORY

Unit Council

- Planned and implemented the 2pm snack that the patients now receive.
- This intervention reduced physical hold minutes hospital wide
- Recognized nationally by the American Psychiatric Nurses Association
- Recognized by UK Healthcare: winner of the Quality and Safety Poster Day

SUCCESSFUL COUNCIL WORK





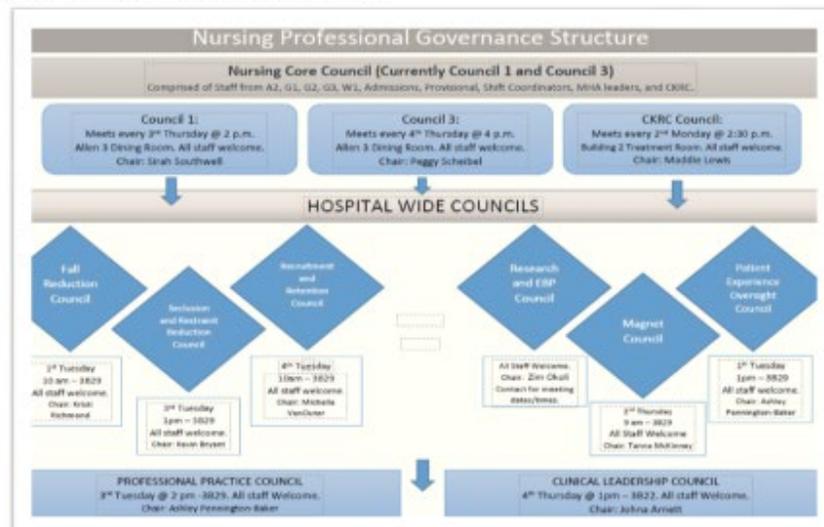
RESTRUCTURE IDEAS

- Dedicated paid time for all day council activity
- Increased manager Support
- Regular dissemination of council activities to entire hospital

Moreno, Girard, & Foad

Giambra, Morath, & Morris

ESH COUNCIL OPPORTUNITIES



THANK YOU

TANNA MCKINNEY MSN RN-BC

Appendix C

SHARED GOVERNANCE POST-TEST SURVEY

Now that you have watched the video we would like to wrap up with a few questions about your knowledge and attitudes about council involvement. Please answer the following questions.

E1

Please answer the following questions about council involvement

- a. Shared governance councils can improve the practice of nursing T or F
- b. Shared governance councils improve nurse satisfaction and engagement in the discipline T or F
- c. Shared governance councils do not improve patient outcomes T or F
- d. Hospitals with effective shared governance systems enhance nursing engagement T or F
- e. Allocating paid time for shared governance council meetings can improve attendance T or F

E2: INTENTION

Indicate to what extent you agree or disagree with the following questions on a scale of 1 to 7 with 1 being 'strongly disagree' and 7 being 'strongly agree'

1. I expect to attend a council meeting in the next six months
2. I want to attend a council meeting in the next six months
3. I intend to attend a council meeting in the next six months

E3: ATTITUDE

1. Attending a council meeting in the next six months would be beneficial
2. Attending a council meeting in the next six months would be good
3. Attending a council meeting in the next six months would be pleasant for me
4. Attending a council meeting in the next six months would be useful for me

E4: SUBJECTIVE NORMS

On a scale of 1 being 'strongly disagree' and 7 being 'strongly agree' please respond to the following questions:

1. People who are important to me want me to participate in a council
2. It is expected of me that I participate in a council
3. I feel under social pressure to participate in a council
4. Most of my peers think it is important to participate in a council

E5: PERCEIVED BEHAVIORAL CONTROL

On a scale of 1 being 'strongly disagree' and 7 being 'strongly agree' please rate your response to the following statements:

1. I am confident that I could join a council
2. For me to join a council is easy
3. I am able to join a council
4. Whether I join a council is entirely up to me

E6: PRACTICE/ROLE

Please indicate how often you do the following activities based on the following scale:

0= Never 1= Seldom 2= Occasionally 3= Very Often

In your role, how often do you anticipate that you will

1. Join a council
2. Attend a council meeting
3. Actively participate in a council (e.g., volunteering to work spearhead initiatives)
4. Serve as an officer on a council
5. Make changes in practice as a result of council participation