Improving Structural Empowerment: Shared to Professional Governance

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Doctor of Nursing Practice Project

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Dedication

To my wife Catherine and my two kids Sophia and Mario for their unconditional love where being a giant is standing tall in a world of oppressive grasses and challenging twigs expressed through resiliency of commitments.

Mom and Dad, you never left as past and future are just memories of now where every instant is an eternal expression of your love. You may rest now as I will see you again in the morning dawn.

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Abstract

Professional governance (PG) is the renewed term describing the transformative four core attributes of accountability, professional obligation, collateral relationships and decision making of shared governance (SG). The primary purpose of this project was to identify the positive core characteristics of a top performer SG interprofessional group via the analysis of their governance process. Further, to identifying transformative steps by which groups wishing to improved SG processes and transition to PG can apply lessons learned into current governance structures.

In the United States, the nursing profession is a multifaceted system filled with numerous clinical and operational complexities developed out of decades-long practices. Shared Governance (SG), established over 30 years ago, was a central concept which was intended to change nursing from a task-based servitude role towards a profession with control and ownership of decisions and actions (Clavelle, Porter-O'Grady, Weston, & Verran, 2016).

I. Introduction to the Organizational Problem and Literature Review

A. Description of the Organizational Problem

Problem statement. Since its inception, SG foundational premises of autonomy and accountability through engagement and structural empowerment have contributed significantly to the nursing profession. Structural empowerment is defined as a "conceptual antecedent of SG, whereby professional staff access to empowerment structures is enabled through authentic and supportive leadership" (Clavelle, 2016, p.308). Clavelle et al. (2016) make the case that the time is right for SG to evolve towards Professional Governance (PG) through its four core attributes of accountability, professional obligation, collateral relationships and decision making. Where the framework of SG is based on the structural empowerment of nurses through autonomy and control over practice, PG enhances SG with dynamic processes better suited to deal with the "complexity of the current healthcare system demands" (Clavelle, 2016, p.312).

Clavelle et al. (2016) recommendations contend that "professional governance structures are grounded in a full understanding of the social mandate and role of professions and their obligation to make a positive contribution to the lives of individuals and communities" (p.309). The old identity of SG, with its narrow methodologies, no longer can keep up with the ever-changing complex systems nurses find themselves working in, where the dynamic challenges of the profession require greater robust interprofessional partnerships (Hess, 2017).

The transformation from SG to PG has the potential to fundamentally change the profession of nursing by allowing interprofessional relationships to take further root into previously limited decision making processes seen in SG (Hess, 2017). The PG attributes of accountability, professional obligation, collateral relationships and decision making strengthen nursing governance by enabling the profession to establish a clear governance structure; rather than being undermined by poor delineation of processes (Clavelle, 2016). As interprofessional relationships become more robust through PG improvements, so will the benefits to the community and the patients Oregon Health & Sciences University (OHSU) seeks to serve (Clavelle, 2016).

The transition from SG to PG as described by Clavelle et al. (2016) is the natural evolutionary process for structural empowerment. After several decades of SG methodologies, the new evolution towards PG allows nursing to gain a deeper understanding of governance practices through role clarity. As PG becomes further established in healthcare systems, nurses will be better prepared to work in interprofessional teams and groups, which will enhance positive patient outcomes (Clavelle, 2016). With this transition, nursing will be able to consistently exercise their autonomous responsibilities in ways that are systematic, coherent and impactful.

Professional governance was first introduced at OHSU through an article published August 2016, in *News To Peruse* by Dr. Dana Bjarnason, Chief Nurse Officer (CNO). In the article, *Creating a Culture of Safety: Professional Governance*, Bjarnason describes OHSU's nursing practice being in strong association with PG core attributes (OHSU, 2016). Further, Bjarnason suggest that perhaps OHSU was ready for the PG transformation (OHSU, 2016).

OHSU does not have SG related policies. However, it has a very comprehensive nursing by-laws document that defines SG as the recognition of nurses' professional autonomy. This autonomy is based on the idea that individual staff members have professional responsibilities within the OHSU organization in achieving its institutional goals and outcomes (OHSU, 2016).

The challenge this Doctor of Nursing Practice (DNP) project seeks to address is the current state of slow-moving progress in SG processes at OHSU. Staff nurses satisfaction scores related to autonomy have been below benchmark for the past eight years. Of the three measures of professionalism, OHSU exceeded benchmarks in nurse quality and nurse patient experience scores, however staff nurses satisfaction scores related to autonomy are stagnate. Further, OHSU lacks a standardized nursing governance framework by which groups can measure and build upon structural empowerment outcomes. In embracing the governance transformation from SG to PG, OHSU has a unique opportunity to establish clear and defined governance foundations based on professional practice and structural empowerment.

Population. The OHSU nursing community was the primary stakeholder group affected by this project, where the subset group was a top performer SG interprofessional group. For this project interprofessional was defined as a SG group with nurses and non-nurses as members.

Epidemiology. Despite extensive research, it was not possible to determine what percentage of US health care systems have SG structures or processes in place or which systems may already be using the PG model.

Purpose of the project. Evaluate current OHSU SG practices through collecting quantitative and quantitative data from a top performer SG interprofessional group and analyze the data to determine where the group resides on the governance continuum. Further, to

extrapolate improvement practices and lessons learned by which results can be applied to current and future SG groups wishing to transition to PG.

Ultimately, the purpose is to amplify patterns of SG towards PG, by using an Appreciative Inquiry (AI) model to discover positive core attributes already in existence within the chosen top performer SG interprofessional group. Attributes are intended to complement the overall picture of the inner workings of the chosen top performer SG interprofessional group. Also, this project was developed to help identify the core aspects with the greatest benefits to improving OHSU's current nursing SG processes.

B. Review of Literature

Literature search methodology. The Cumulative Index to Nursing and Allied Health Literature (CINHAL) and the Pubmed MEDLINE databases were searched using the MeSH terms "shared governance," "professional governance," "interprofessional governance," "structural empowerment and nurse," as well as, "culture of safety and Magnet," all in English from 2007 to present. The CINHAL database yielded a total of 838 results; 692 for "shared governance," 14 for "professional governance," zero for "interprofessional governance," 123 for "structural empowerment and nurse," and nine for "culture of safety and Magnet."

The Pubmed MEDLINE database yielded a total of 1,806 results; 441 for "shared governance," 767 for "professional governance," 329 for "interprofessional governance," 215 for "structural empowerment and nurse," and 54 for "culture of safety and Magnet." Excluded studies and articles had common topics specific to clinical applications not relevant to this project, such as osteoporosis and psychiatry.

SG first established in the 1980's intended to provide nurses with the ability to have further independent control and autonomy over nursing practice through the ownership of

decisions and actions (Barden, Griffin, Donahue & Fitzpatrick, 2011). Most SG models engage the participation of staff nurses through unit practice councils, such as, "research, professional practice, quality, safety, and informatics" (Gerard, Owens & Oliver, 2016, p. 478). In the last 30 years, the purpose of SG has remained true to this original intent, but without consistent and well-defined evidence base structures.

Since its inception, SG's intent has been weakened by divergent interpretive fragmentations where the lack of a specific SG framework has allowed staff nurses throughout the decades to define SG on their terms. As an example, it is not uncommon for some staff nurses at OHSU to spend a monthly SG meeting discussing operational and budgetary considerations without tying such needs to enhanced patient outcomes. Without a clear understanding of governance such considerations would be more financially influential through the advocacy of compelling patient care needs and by improving nurse-sensitive outcomes.

According to Hess's Index of Professional Governance (IPG) there are three levels of nursing governance; traditional governance, shared governance and self-governance (Hess, 2011). With the introduction of PG, Clavelle et al. (2016) seem to have created a new governance stage in Hess's IPG model. Where traditional governance systems have always stood for top-down command and control, SG opened the door for a new level of autonomy and control over nursing practices. Now PG builds on SG achievements and creates a foundational structure through its four core attributes of accountability, professional obligation, collateral relationships and decision making.

Magnet Recognition Programs initially developed by the American Academy of Nursing (AAN), and now the American Nurses Credentialing Center (ANCC), distinguish healthcare systems for quality patient care, nursing excellence and innovations in professional nursing

practice (American Nurses Credentialing Center [ANCC], 2017). SG is an integral part of healtcare systems that have achieved Magnet recognition status. This recognition serves as the gold standard of the profession's commitment to excellence through its five components: 1) transformational leadership, 2) structural empowerment, 3) exemplary professional nursing practice, 4) new knowledge, innovations and 6) improvements, empirical quality outcomes (Barden, 2011).

Literature gaps. The limited reporting of outcome benefits of SG models in the literature was identified as a gap in this project, as well as, to the lack of consensus and agreement among structural empowerment experts regarding the next evolutionary phase of SG. Where Clavelle et al. (2016) makes the case that the time has arrived for SG to evolve towards PG, Hess (2017) asserts that the focus should be on creating stronger interprofessional shared governance (ISG) models rather than reusing past terms, such as PG, to describe similar governance processes. Porter-O'Grady's (2017) response to Hess (2017) clarified that the term PG is not a name rebrand. Instead, the renewed PG term describes how far nursing professional governance has come, what it means and stands for at this time (Porter-O'Grady, 2017). The introduction of PG by Clavelle et al. (2016) seems to have started a national dialogue about the next transformative phase in nursing governance.

Relevant sources. Clavelle et al. (2016), Hess (2011; 2017), Tim Porter-O'Grady (2017) are the most relevant sources of this project, given their expertise and their acknowledgment about the need to transform SG. Through PG, Clavelle et al. (2016) recommend nurses stay fully committed to efforts of engagement with all members of their respective teams via the creation of new structural empowerment frameworks given their knowledge, wisdom, and expertise.

Also, nurses' perceptions about SG need to evolve towards PG as the next transformative phase of structural empowerment (Clavelle, 2016).

Hess (2017) asserts that the term PG is not new. Where the next evolutionary phase of SG is in creating ISG models where every professional stakeholder is involved in decision making processes (Hess, 2017). He further contends that ISG "brings every professional stakeholder to the table to create a team, with a focus on realizing goals, enhancing professionalism, and improving patient care together…nursing SG just creates barriers between those with whom we must collaborate" (Hess, 2017, p.2).

Tim Porter-O'Grady, co-author with Clavelle et al. (2016) in-depth-review, further responded to Hess (2017) by stating that "the term professional in place of shared is neither new nor unique…what is new is the requisite to examine nursing professional governance within the full scope of what the term means, without accommodation or equivocation" (p.70).

Through this project, I look to contribute to the body of evidence, results that can further bridge the PG transformation as purposed by Clavelle et al. (2016) with Hess's (2017) development of stronger interprofessional governance models.

Other relevant sources. Transitioning nursing from SG to PG will further benefit Magnet Recognition Programs to achieve the required "development, disseminated and enculturate evidence-based criteria that result in a positive work environment for nurses and, by extension, all employees" (ANCC, 2017). Nurse executives will be critical in this transition as they retain the responsibility "for providing the support, resources, and systems to evolve practice within their organizations…that aligns with the structural empowerment model component of the Magnet Recognition Program" (Clavelle, 2016, p.311). This project

acknowledges the ANCC's Magnet SG requirements as a significant source of motivation for research into the future of nursing governance.

Framework models of this project. In the last three decades, SG has served the nursing profession well by creating nursing governance environments of nonhierarchical structures and interdependence with management (Clavelle, 2016). A strong theme bridges the studies and work of Clavelle et al. (2016), Hess (2017) Porter-O'Grady (2017), the imperative need for nursing to strengthen its interprofessional relationships to better cope with the complex challenges ahead. Clavelle et al. (2016) believe that "professional governance recognizes the team's collective contributions to care and builds upon interprofessional duties to one's profession, one another, and the community" (p.311). Similarly, Hess (2017) asserts that "true collaboration among providers from many different professions typifies the exemplary operations ISG is required in today's healthcare systems" (p.2).

Summary purpose of project. The analysis gathered from a top performer SG interprofessional group will benefit the OHSU nursing community by identifying positive core attributes of nursing governance. Combining these positive attributes with structural engagement strategies reported in this project delivers the beginnings of a roadmap that groups can follow to advance empowerment in interprofessional decision making processes. Also, to share the identified new transformative steps of PG analyzed in this project with the OHSU community and beyond.

II. Conduct of the Project

A. Setting

Project setting. As the only academic medical system in Oregon, OHSU has a complex mission related to patient care, research and education. OHSU values the commitment to

empower nursing staff, through autonomy, professional accountability, and collaborative interdisciplinary responsibility for decisions in the practice of nursing (OHSU, 2017). Within this context, OHSU is the ideal site for this project given the CNO's vision to explore PG, in addition to the wide variety of groups practicing SG.

Function of the setting. The interprofessional nature of an academic medical center and the professional foundation of a Magnet hospital create the ideal setting for the design and analyzes of this project.

Organizational readiness to change. Assessing OHSU's readiness to change was not a primary feature or focus of this project. Readiness should be the subsequent initiative upon the conclusion of this project.

Anticipated barriers and challenges. The plan for this project was for all members of the selected top performer SG interprofessional group to answer a qualitative and quantitative survey, where finding the time and a location could have been challenge.

Facilitators. This project's chair Dr. Kristen Crusoe and mentor Dr. Barbara Bonnice were critical in facilitating this project. Dr. Crusoe is an AI certified facilitator and trainer and complex adaptive systems (CAS) expert. Dr. Bonnice has extensive experience with governance processes, professional practice, and qualitative analysis. AI was the primary qualitative research method used in this project via a survey (Appendix A), where Hess's IPG tool served as the quantitative method. In this project, Hess's IPG tool is described as the IPG quantitative survey (Appendix B).

B. Participants

Inclusion and exclusion criteria. In consultation with OHSU's nursing leadership and Dr. Bonnice, the chosen group for this project was the OHSU's Neonatal Intensive Care Unit

(NICU) Vermont Oxford Network (VON) group. The current VON group includes 13 health care professionals and volunteers working together in an interprofessional team whose primary purpose is to affect positive change in neonatal care. Founded in 1988, the VON is primarily based in the NICU of healthcare systems around the world. Its mission is to "improve the quality and safety of medical care for newborn infants and their families through a coordinated program of research, education, and quality improvement projects" (Vermont Oxford Network, 2018).

OHSU's VON group typically works through chapters of initiatives within a given timeline, where its member's constituency changes slightly according to the project improvement process. However, most core members tend to remain in the group in subsequent initiatives. Through interprofessional relationships, each member collaborates and contributes via their expertise. The VON's current initiative is about optimizing nutrition delivery processes to neonates and to decrease the rate of Necrotizing Enterocolitis (NEC). For this DNP project, VON member constituency included provider champions, staff nurses, data coordinators, management, family members and dietician representatives.

Size and rationale. Given their unique perspective, knowledge, and contribution all current 13 members of the VON were invited to complete both the AI qualitative and IPG quantitative surveys. Since past members participated in different groups, they were excluded from the AI qualitative data collection about team dynamics. However they were invited to complete the IPG quantitative survey about the overall experience of governance with the NICU culture.

Recruitment plan. The VON was initially recruited to participate in this project throughout the identification of its interprofessional membership and top performance status by OHSU nursing leadership and Dr. Bonnice. The initial contact was made through the NICU

Nurse Manager, who then invited the investigator to come present this project to the VON group. Members were invited to participate in the project both in person and via email. In addition, a short biography and a project intent summary was also sent to all current and past VON members. The VON benefits from this project by the identification of their current governance status, data analysis and future development challenges, as well as, the unique identification their AI positive core attributes.

Protection of participants. Responses to the surveys were kept anonymous and reported analysis were done through themes and patterns. No individual information was used in this project.

III. Proposed Implementation and Outcome Evaluation

A. Intervention and Implementation Procedures

Interventions. For OHSU to develop and transition from SG to PG, nursing leadership must "intentionally assess the existence of structural and cultural elements of professional governance in their organizations, comparing the foundation for SG they may currently have in place with the attributes and characteristics of professional governance behaviors" (Clavelle, 2016, p.311). Ultimately, the findings of this project will be shared with the VON and OHSU nursing leadership, as well as, communicated through other professional settings for intervention considerations.

Teamwork. The collaboration of the NICU Nurse Manager and the Assistant Nurse Manager with the investigator of this project was critical, particularly, in facilitating access to current and past VON group members.

B. Measures and Outcomes

Data collection sources, processes, procedures and rationale. The AI qualitative survey was created and designed in partnership with Dr. Crusoe. Data collection was done via a group setting and email; completion took between five to 10 minutes. The AI qualitative survey focused on exploring the positive core attributes of the VON through six questions. The first two were about SG, and last four were about PG:

1. Briefly describe what is your understanding of Shared Governance?

2. What have you experienced as the positive attributes of your committee?

Think back and describe about a time when you felt your committee:

3. Demonstrated a high degree of accountability?

4. Was in high degree of synchrony in meeting its profession obligation?

5. Was most effective in making a difficult decision (decision-making)?

6. Experienced a high degree of collateral-relationships?

Hess's IPG 3.0 short form tool was the selected quantitative data analysis method (known in this project as the IPG quantitative survey), rather than the Index of Professional Nursing Governance (IPNG). Both surveys created by Hess provide quantitative results with accurate measures of the distribution of control, influence, power, and authority of a given governance group or system (Hess, 2011). The main difference between the IPG and the IPNG surveys is the IPG is a "more generically worded instrument that surveys both nurses and allied health professionals" (Hess, 2011, p.237). The IPNG is used to measure governance of nurse lead processes and structures.

The interprofessional nature of this project made the selection of the IPG quantitative survey version with 50 questions the most appropriate tool to be used, particularly, since Hess's index quantitative surveys have previously been demonstrated to be reliable tools. The most

significant benefit from both the IPG and the IPNG tools is the ability to provide meaningful and specific results (Hess, 2011).

There are six subscales in IPG quantitative survey: 1) personnel, 2) information, 3) resources, 4) participation, 5) practice and 6) goals.

The IPG quantitative survey classifies the following governance distribution (table 1):

Table 1 - Governace Distribution	
Traditional Goveranance	
50-100	Management/administration only
Shared Governance	
101-149	Primarily management/administration with some staff input
150	Equally shared by staff and management/administration
151-200	Primarily staff with management/administration
Self Governance	
201-250	Staff only

The recommended data analysis for the IPG quantitative survey includes calculating the total response rate followed by data clean up. Also, to calculate the reliability coefficient (Cronbach's alpha) scores followed by the identification of the means of governance scales. Finally, to use analysis of variance (ANOVA) to look for differences that may be statistically significant. The IPG quantitative survey interpretation key was shared with the investigator of this project via a private email upon a request made to Dr. Robert Hess. The key is not publically available via open media sources.

The IPG quantitative survey initially comes in paper format, but for ease of use both for the participates and for data analysis, the IPG quantitative survey was faithfully transcribed into an online format through surveymonkey.com. Transcribing the IPG quantitative survey from a paper to an online format did not affect the data results and outcomes of this project. According to surveymonkey.com, survey completion was estimated to take 8 minutes.

Information systems & technology. This project used surveymonkey.com and email.

Accuracy of data collected. The accuracy of the AI qualitative survey was validated through the collaboration and partnership of Dr. Crusoe. The IPG quantitative survey data was validated with the assistance of an OHSU School of Nursing (SON) faculty data expert.

Ethical considerations. Ethical considerations focused on keeping the data collection private, secure, and anonymous. The AI qualitative survey does not include any personal identifiers, such as names and roles of participants/respondents. The IPG quantitative survey, however, does have some generic questions about gender, professional role, and the participant/respondent's age range. However, this information was not divulged in this project and reported information was done via themes and aggregates of information.

Costs. The IPG quantitative survey was free to use after notification was given and permission was granted by Dr. Robert Hess.

IV. Implementation of Project

A. Evolution of Project

Since the initial proposal of this project, several events have taken place, starting with the submission of this project to OHSU's Institutional Review Board (IRB) for evaluation. The IRB decision for this project was that the proposed activity was not considered research involving human subjects; IRB ID: STUDY00017869. Following this decision, this project moved on to identify the top performer SG interprofessional group. The criteria for the final selection of the top performer SG interprofessional group had to include a group with staff nurses as part of decision making processes and be interprofessional.

Upon a brief introduction of this project to the VON group during a monthly meeting, the recommendation by its members was for the AI qualitative survey to be administered at the next

VON group setting. At the next meeting, members present completed the AI qualitative survey individually with ample time given. A few non-present members (logged in via video-teleconference) agreed to complete the AI qualitative survey via email at a later time. Post meeting, three non-present current members received the AI qualitative survey via email. In total 10 out of 13 current VON members completed the AI qualitative survey.

Following the group meeting, an email with a link to surveymonkey.com was sent to the current 13 VON group members for the completion of the IPG quantitative survey. An additional 13 past VON group members were sent the same surveymonkey.com link for the IPG quantitative survey. The idea behind reaching previous members of the VON to complete the IPG quantitative survey was to increase the n sample size since the survey explores broad concepts of governance.

Two weeks were given for the VON members to complete the online IPG quantitative survey. In total, 11 members from the initial 26 members completed the IPG quantitative survey; which equates to a response rate of 42%. Given the anonymous and confidential nature of this survey, it was not possible to determine if the current responses were from current or previous members of the VON group.

B. Unintended Consequences

There were no unintended consequences in this project.

C. Details of Missing Data/Information

The completion rate for the AI qualitative survey was 77%, as 10 out of 13 current VON members returned the survey. Also, three out of 10 VON members returned the AI qualitative survey with questions three, four, five and six, not answered; citing the present meeting as their first meeting attended. Questions three, four, five, and six were focused on the four attributes of

PG, as in accountability, professional obligation, decision making, and collateral relationships. The AI qualitative survey was not returned by three out of the 13 current VON group members. In total, the IPG quantitative survey was sent to 26 current and past VON members, but only completed by 11 members; the response rate was 42%. Meaning, 15 current or past VON group members did not complete the IPG quantitative survey.

D. Key Findings

AI qualitative survey. Post-completion, the AI qualitative survey was analyzed and reviewed with answers aggregated by themes and concepts with the assistance of Dr. Crusoe. The first two survey questions pertained to SG and the last four to PG.

Question one, *Briefly describe what is your understanding of Shared Governance?* augmented the positive feelings of mutual respect through people coming together to help create something new via their passion of patient care. Question two *What have you experienced as the positive attributes of your committee?* augmented feelings of coherence by members' willingness to participate and where their voices were heard and respected.

Questions three through six asked members to think back and reflect on previous inner working dynamics of the committee. Question three, *Demonstrated a high degree of accountability?* described members showing up to meetings, making decisions together, where everyone's voice was considered an essential and vital consideration to the group. Themes of sharing leadership also emerged, in addition to collective synchrony as related to the accountability and trust of decision-making processes. Question four, *Was in high degree of synchrony in meeting its profession obligation?* described participation by members in the discussions to be a vital link in the committee's ability to meet its professional obligation. In question five, *Was most effective in making a difficult decision (decision-making)?* responses

focused on members being present and having time to participate in decision-making processes. Question six, *Experienced a high degree of collateral-relationships?* responses described the interprofessional collaborative nature of the VON group as a pivotal element to problem-solving.

The key augmented positive core attributes and themes from the AI qualitative survey could be summarized as follows: collaboration, interprofessional, present, active participation, mutual respect, passion for the topic, accountable to the process and others, and coherence of actions and the sharing thoughts. One can extrapolate from the VON's most frequent described themes that collaboration, active participation, and mutual respect are consistent with the core principle of collateral relationships of PG.

The VON group members' response was also in alignment with the four core principles of PG. By following the accountability principle, members understand and embrace their responsibility to actively participate in the group's inner dynamics, as the professional obligation of such participation demands full commitment by all its members. Through interprofessional collaborative processes, members report being engaged in decision making processes that illustrate the collective convergence of reported collateral relationships.

IPG quantitative survey. The IPG quantitative survey data was validated with the assistance of an OHSU SON faculty data expert. The VON group IPG quantitative survey was completed by 11 out of 26 potential respondents with a sample n=11. The mean ± standard deviation for the full sample was 113.45 ± 34.38 with a 95% confidence interval of 90.35-136.96. A sensitive analysis was also conducted with similar results. The reliability coefficient (Cronbach's alpha) scores for the full n=11 sample was 0.97; which suggests relatively high internal consistency. Unfortunately, ANOVA could not be used in this project due to the small sample size and the lack of similar groups for analysis.

According to the IPG quantitative survey classification key (table 2), a mean score between 101-149 is classified as a group that is primarily lead by management and administration with some staff input. The VON group reported a mean score of 113.45, which places them at the SG introductory level out of three potential levels. The previous category 50-100 is the traditional category where decisions are made top-down, and processes are managed exclusively by management/administration. For the VON group, aspirational direction would include processes equally shared by staff and management/administration or primarily lead by staff with some management/administration input.

Table 2 - Governace Distribution	
Traditional Goveranance	
50-100	Management/administration only
Shared Governance	
101-149	Primarily management/administration with some staff input
150	Equally shared by staff and management/administration
151-200	Primarily staff with management/administration
Self Governance	
201-250	Staff only

The IPG quantitative survey aggregate of questions (table 3) lowest mean score was 1.49 for personnel (who controls personnel and related structures) primarily lead by management/ administration. The highest mean score aggregate of questions was 3.72 for resources (who influences resources that support professional practice) primarily lead by staff with some management/administration input. Question number five for personnel had the lowest mean score of 1.27. The participants identify the group that at OHSU controls *conducting disciplinary actions of colleagues within your discipline.* The mean score of 1.27 reflects a response indicating that this process is only performed by management/ administration only. Question number 14 under resources had the highest mean score of 3.72. The participants identify the

group at OHSU that influences *Consulting and enlisting the support of services outside of your own discipline (e.g., dietary, social service, pharmacy, human resources, finance).* The mean score of 3.72 indicates this process is primarily done by staff with some management/ administration input.

Table 3 - IPG Quantitative Survey Subscales

Subscales	**Question Nunber**	**Mean** *Subscale*	**Min**	**Max**	**Lowest Mean** *Single Question*	**Highest Mean** *Single Question*
Personnel *Who controls personnel & related structures*	**5**,11,12,15,16,17,18, 19,20,21,25,26	**1.49**	**1**	**5**	**1.27** *Personnel #5*	
Information *Who has access to information relevant to governance activaties*	37,38,39,40,41,42, 43,44,45	2.32	**1**	**5**		
Resources *Who influences resources that support professional practice*	9,10,13,**14**,22,23, 24,27,28	**2.94**	**1**	**5**		**3.72** *Resources #14*
Participation *Who creates and participates in committee structures related to governance activaties*	29,30,31,32,33,34, 35,36	2.46	**1**	**5**		
Practice *Who controls practice*	1,2,3,4,5,6,7,8	2.25	**1**	**5**		
Goals *Who sets goals and negotiates the resolution of conflict at various organizational levels*	46,47,48,49,50	2.5	**1**	**5**		

V. Outcomes

A. Comparison of Findings to Literature & Expected Results

Structural empowerment processes via SG and professional practice models first created in the 1980's established a framework for nurses to exercise their autonomous clinical practice independent of management and hospital administrators' considerations. The VON's mean score 113.45 in the IPG quantitative survey classifies this group as being driven primarily by management/administration with some staff input. With this mean score the VON group is beyond traditional governance and has met the minimum score to be classified as a shared governance group.

Despite the best design of OHSU SG model and the VON inner interprofessional structure, the group members still perceive management/administration as the primary decision maker. This was also seen in VON group's lowest mean score (1.49) of control over personnel. This is consistent with Hess's (2017) description that bureaucracy still dominates health care systems and SG groups continue to struggle when dealing with management/administration to acquire necessary resources for optimal patient care.

Hess (2017) reports that interprofessional governance creates a diverse team focused "on realizing goals, enhancing professionalism, and improving patient care together" (p.2). Similarly, the VON interprofessional group reported equally shared decision making resources about professional practice as their highest aggregate mean score at 2.97. The VON next two top highest mean scores (2.46 and 2.5) were about participation in decision making and goal setting. The AI qualitative survey findings of collaboration and active participation equally demonstrate the positive impact of collateral relationships for the VON group.

B. Explain Differences Between Expected & Observed Results

The VON was selected for this project in part because of improved quality outcomes since joining the interprofessional network and forming an interprofessional committee. Hess (2011) described that systems subscribing to SG structures and processes produce quality patient outcomes. This lead to an assumption that the group decision making would be at least equally shared (150) in Hess's IPG quantitative survey. While the overall mean score was lower than anticipated (113.45) the subscales demonstrate at least one category of equally shared decision making.

C. Impact of Project on System Including Costs

The impact of this project has the potential to create a substantial positive change in the VON group. With the reported results, the VON has a unique opportunity to evaluate their current state of governance, as well as, to build upon lessons learned. Also, the reported AI qualitative survey themes allow for the VON group to have unique access to their positive core attributes, as well as, to establish a framework by which they can continue to evolve more deeply into the four core attributes of PG. In sum, the VON benefits from this project by having an in-depth analysis of their current state of governance, in addition to augmenting to the OHSU community what makes them a highly functional SG interprofessional group.

The timing of this project coincided with OHSU SG structure to be under review and redesign in response to clinical nurses critique about the need for more visibility by leadership in nursing units and further opportunities to frontline staff nurses to voice their legitimate concerns to upper leadership. As OHSU nursing leadership looks for different governance processes to establish frameworks that are in alignment with clinical nurses' professional desire for more significant influence and independent decision making. With this project, OHSU has a unique opportunity to incorporate lessons learned into a new SG structure that is consistent with the four core attributes of PG.

The cost for the implementation of the lessons learned in this project likely will include greater communication and education about the concept of PG and the recruitment of interprofessional team members into SG groups. Given that OHSU nursing leadership is currently reviewing and redesigning its SG structures, the cost of this project could be included in the implementation planning.

VI. Practice-Related Implications/Recommendations/Limitations

A. Conclusions

Seldom do professions have the opportunity to reinvent themselves while reaffirming their social mandate of autonomous governance. With the enhanced structural empowerment processes of PG, nursing has a unique opportunity to make a renewed commitment to patient quality, excellence, and enhanced professional practice governance. The time is now for nursing to transform the slow-moving models of SG to the new governance structure of PG through its four core attributes of accountability, professional obligation, collateral relationships and decision making (Porter O'Grady, 2017).

To make this shift, nurse leaders will want to intentionally assess the existence of the structural and cultural elements of professional governance in their organizations. This can be accomplished by comparing the SG foundations they may already have in place with the attributes and characteristics of PG. The IPG quantitative survey is a valuable tool to access the current state of an SG group, which can help guide improvement. For example, the VON group could study how to augment further equal decision making in the areas of access to information, participation in the committee, control over practice and goal setting. Perhaps the group could elect to develop a charter that is more in line with PG, such as, having a staff nurse and a dietician co-lead the committee. Also, the VON group could explore best practices for increase shared decision making about control over personnel.

At OHSU there are two internal opportunities that should be considered. The adult Perianesthesia Department has an established quality matching committee where clinical nurses consistently evaluate nurse candidates and collaborate with the nurse manager in making hiring decisions. Secondly, OHSU leadership has a professional practice review board that peer reviews nurse leaders' practice. This group might serve as a resource for expanding peer review for clinical nurses, so they gain skills for evaluating professional practice and conduct.

Since SG is an essential component in any hospital system wishing to achieve or retain the coveted "Magnet" designation, the results of this project can be a resource to OHSU nurse leaders responsible for implementing and evaluating Magnet standards. The replacement of traditional governance models of management/administration towards PG can enhance nurse satisfaction and nurse-sensitive outcomes (Hess, 2011).

It is clear in the literature that both Clavelle et al. (2016) and Hess (2017) agree in the need for SG to evolve towards governance that is stronger and better apt in handling collateral and interprofessional relationships. However, despite claims by Hess (2017) that the new term of PG and its four core attributes are not new, the reality is that nurses still struggle to understand the basic concepts of nursing governance as evidenced by OHSU VON group. In incorporating the four core attributes of PG into the planning of operational projects, nurse leaders can learn how to change their traditional and bureaucratic approaches when it comes to governance.

Hess (2017) further believes that interprofessional models are the current and future requirements of clinical governance models, where allied professionals coming together in the same process is the optimal collaborative approach to address the current challenges of our healthcare system. OHSU currently has limited care delivery models that facilitate physician and interdisciplinary participation on interprofessional practice and governance committees. Investigating how other organizations have successfully developed interprofessional structures can optimize collateral relationships.

The VON group is indeed a group driven by management and administration with some staff input with its co-leads being an assistant nurse manager and a physician. The themes of collaboration and active participation that emerged from the AI qualitative survey indicate that

the VON group is heading in the right direction towards a more equal and shared governance structure.

The VON accountability of actions reflected through the AI qualitative survey responses demonstrated a group that is working in being more coherent as seen with emergent design patterns taking place. The VON's understanding of professional obligation is still evolving from a place of collective synchrony towards their responsibility as a group to optimize organizational engagement. Despite the small sample size n=11 with non-nurse allied professionals <7 the VON shines is in their collateral relationship model. The VON group clearly understands that every member coming together in an interdisciplinary system of collective convergence and relational coordination is vital significance (Clavelle, 2016). Finally, the VON's decision making abilities were also quite mature, notably in their understanding of gathering feedback from unit staff nurses in the identification of problems and opportunities (Clavelle, 2016).

In sum, the VON group's journey towards PG is ongoing, with several positive themes and findings by which SG groups can draw inferences from. First, a low score in the IPG quantitative survey merely states wherein the governance journey a given SG group currently stands, and may not be indicative of the quality of the outcomes they produce. In the VON's case, the reliability coefficient (Cronbach's alpha) for the full sample size n=11 was 0.97, which was very accurate in the IPG key category scale; meaning lead by management/administration with some staff input.

The AI qualitative survey helped to frame the VON current understanding of SG and PG four core attributes. One point was clear above all others, the VON group values their governance structure of autonomy and interprofessional convergence. Future SG groups can also infer from the VON group that collaboration and mutual respect are vital aspects of professional

governance where everyone has a voice. Further, collective synchrony also means to actively participate in the group initiatives, as well as, to trust the collective decision making process of its members.

This project most significant limitation was the small sample size of returned responses n=10 for the AI qualitative survey, in addition, to several VON group members declined to answer questions three through six, citing the present meeting as their first. Also, the sample size of n=11 in the IPG quantitative survey did not allow for the ANOVA test to be conducted. Further, group members were not asked to elaborate which positive core attributes they thought to be the most beneficial in interprofessional collaboration and collateral relationships. An initial significant limitation was also the availability of top performer SG interprofessional groups to choose from.

VII. Summary & Next Steps

A. Summary

SG first established in the 1980's has served nurses well throughout the last three decades, by providing a system by which nurses come together in shared processes and exercise to the full extent possible autonomous governance over their practice. In the midst of the ever-increasing complexities in the healthcare systems of this country, nurses have been forced to adapt towards the new realities of limited access, increased demand of services and produce higher quality in patient outcomes.

Clavelle et al. (2016) propose a transformation in nursing governance as a means to deal with ever-increasing complexities, which will enable nurses to be better prepared for the challenges ahead. Through PG the boundaries and processes are well defined, as seen with the collective convergence of thoughts and relational coordination of actions of collateral

relationships (Clavelle, 2016). Hess (2017) suggest that nursing governance models nowadays are akin to parochial concepts were the real emphasis should be in further developing and strengthening interprofessional governance models.

Through the analysis of the positive core attributes of an interprofessional group at OHSU, this project analyzed where in the governance journey a top performer SG found themselves being categorized. The improvement idea behind this project was that through the analysis of a top performer SG interprofessional group, others groups aspiring to reach PG could apply the meaningful lessons learned from this group into current their governance structures.

The AI qualitative and IPG quantitative surveys provided many meaningful conclusions and reflections from the VON group. Noteworthy, is the need for current SG groups to evolve and become more interprofessional via collateral relationships. Further, SG groups need to enable environments where all group members can adequately express their thoughts and ideas in a respectful manner. Finally, to seek and gather feedback from different sources where collaboration and participation in governance are vital. In sum, the VON group was an ideal candidate for this project given their commitment to excellence, interprofessional collaboration, and diversity in membership and constituency requisites.

B. Next Steps

Much remains to be done to advance structural empowerment in nursing as this project only touched the surface of what nursing governance stands for. The next steps for this project are to spread its message throughout the OHSU community and beyond while describing PG as a transformative process that gives nurses a clear roadmap for dealing with current and future complexity challenges. This can be accomplished by facilitating dialogue among nurse leaders,

such as OHSU's Coordinating Council, with a proposal of how they can use the information in this project to assess current state and analyzed the data to advance PG at OHSU.

Another critical step is to return to the VON group to celebrate the findings of this project and invite its members to evaluate if there is interest in making future changes. These changes would be in-line with advancing the group towards Hess's next governance classification score with governance distribution being more equally shared by staff and management.

Throughout my career as a nurse leader, I have been exposed to many non-clinical leaders who are making significant decisions in health care with insufficient understanding and awareness of nurses' responsibility to self-governance. These leaders often do not consider nurses autonomy when creating and implementing strategic plans that affect nursing practice. As a consequence nurses lose faith in a system that does not recognize their values, obligations, and responsibilities. This project inspired me to experiment and talk with non-clinical healthcare leaders about nursing governance. As a direct result, I have a submitted an abstract to be a guest speaker at the next OR Business Management Conference with the following learning:

- Acquire introductory knowledge about the practice of nursing governance.
- Maximize productivity processes via broader understanding of nursing interprofessional and collateral relationships.
- Leverage nursing labor through a greater in-depth comprehension of values, obligations, and responsibilities.

Through doing these next steps, I will gain greater experience and knowledge about the roadmap of transforming SG to PG. Moving forward I will continue to advocate for more interprofessional governance at all levels of the OHSU organization and beyond. But, primarily my personal goal is to educate nurses on the concept of PG through the core attributes of

autonomy, professional obligations, decision-making and most importantly the need to strengthen interprofessional and collateral relationships.

My motivation and passion for nursing governance as taken me this far, now I feel more than ever inspired to continue to apply into practice the great works of Drs. Robert Hess and Tim Porter O'Grady, implicit mentors of this project. Throughout this DNP project, I have also found a consideration above all to be self-evident. Nursing practice seems to have been on a parallel journey with nursing governance throughout the last few decades; with these two processes coming ever so close to each other. In my opinion, when these two processes finally meet, nursing will have reached its maximum potential under current state. Thus, starting the next transformative phase in interprofessional governance with broader autonomous licensure methodologies of self-determination; perhaps even with a new name to describe a new role.

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Appendix A

Qualitative Data Questionnaire – Governance

OHSU School of Nursing / Researcher: David M. Silva, RN, MN, DNP Student

Briefly describe what is your understanding of Shared Governance?

_____

_____

What have you experienced as the positive attributes of your committee?

_____

_____

Think back and describe about a time when you felt your committee:

Demonstrated a high degree of accountability?

_____

_____

Was in a high degree of synchrony in meeting its professional obligations?

_____

_____

Was most effective in making a difficult decision (decision-making)?

_____

_____

Experienced a high degree of collateral-relationships?

_____

_____

Appendix B

PROFESSIONAL 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 profession:
   - ☐ Accountant
   - ☐ Dietician
   - ☐ Pharmacist
   - ☐ Physical Therapist
   - ☐ Other:
   - ☐ Physician
   - ☐ Registered Nurse
   - ☐ Respiratory Therapist
   - ☐ Social Worker

4. Please indicate your HIGHEST educational degree:
   - ☐ Diploma
   - ☐ Associate Degree
   - ☐ Baccalaureate Degree
   - ☐ Master's Degree
   - ☐ Doctorate

5. Employment Status:
   - ☐ Full-time, 36-40 hours per week
   - ☐ Part-time, less than 36 hours per week (specify number of hours/week):

6. Please specify the number of years that you have been practicing:

7. Please indicate the title of your present position:

8. Please indicate the type of nursing unit that you work on:
   - ☐ Case Management
   - ☐ Clinic
   - ☐ Critical Care
   - ☐ Education
   - ☐ Emergency Room
   - ☐ Maternity
   - ☐ Medical/Surgical
   - ☐ Operating Room
   - ☐ Pediatrics
   - ☐ Psychiatry
   - ☐ Quality Management
   - ☐ Recovery Room
   - ☐ Rehabilitation
   - ☐ Other (please specify):

9. Please specify the number of years you have worked in this institution:

10. Please specify the number of years you have been in this present position:

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

PROFESSIONAL GOVERNANCE 3.0	
PART I	
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 nurses only***	
1. Determining what your professional colleagues can do in their daily practice.	1 2 3 4 5
2. Developing and evaluating policies, procedures and protocols related to patient care.	1 2 3 4 5
3. Establishing levels of qualifications for 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
PART II	
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***	
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

PROFESSIONAL GOVERNANCE 3.0	
PART III	
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***	
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
PART IV	
In your hospital, 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***	
29. Participation in unit or work-group committees that deal with professional practice.	1 2 3 4 5
30. Participation in departmental committees that deal with professional practice.	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. Formating 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

PROFESSIONAL GOVERNANCE 3.0	
PART V	
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***	
37. Compliance of your organization with requirements of surveying agencies (e.g. The Joint Commission, 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
PART VI	
In your hospital, 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***	
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