

The Impact of a Nursing Professional Governance Approach on Nurse Participation and
Satisfaction with Health Information Technology

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Abstract

Professional nurse involvement in shaping the electronic health record continues to be minimal in spite of the presence of shared governance models. The redundancies and nurse dissatisfaction with the electronic health record requires a new approach. The advancement of a shared governance model to a professional governance model has resulted in an increase in professional role involvement in four areas: (1) accountability, (2) professional obligation, (3) collateral relationships, and (4) decision-making. Increased professional nurse involvement results in, nurses more actively engaged in problem solving to improve nurse satisfaction with the electronic health record. Evidence reflects a positive impact on nurse satisfaction when a professional shared governance structure is in place and guides the professional practice of nurses specific to autonomy and accountability. Additionally, evidence also revealed that nurses have a desire to be included in the quality of design, implementation and sustainability of electronic documentation.

Keywords: Shared governance, professional governance, IT, information technology, medical informatics, nurse, nurses, nurse satisfaction, satisfaction, electronic record

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Introduction

Nurses utilizing health information technology (HIT) in an acute care setting is occurring at an unprecedented rate (Debono, et. al, 2013, & Shafer, , 2015). Despite the benefits and financial investment of electronic medical records (EMRs), the transition and implementation has created challenges for nurses (Lalley, 2014, & Shafer, 2015). These challenges are further complicated when nurses fail to communicate documentation issues to the designers of the electronic record. Nurses manage these issues by creating workarounds (Debono, et., al, 2013 & Lalley, 2014). The consequences of workarounds have been noted as negative and potential for medical errors (Lalley, 2014). Nursing leaders are well positioned to address these challenges and facilitate a more effective change process for nurses. Successful nursing leaders have been able to achieve these outcomes through the implementation of professional governance (Slatyer, et, al, 2016). Evidence shows a positive impact on nurse satisfaction when a professional governance structure is in place and guides the professional practice of nurses specific to autonomy and accountability (Wilson, , 2013). Additionally, evidence also revealed that nurses have a desire to be included in the quality of design, implementation and sustainability of electronic documentation (Shafer, 2015). An opportunity existed to evaluate incorporating a professional nursing governance accountability structure into a current shared governance structure to determine the impact on nursing satisfaction and professional role accountability and ultimately action related to the electronic record documentation system.

Problem Statement

In 2013, a shared governance structure was instituted in the nursing division across the organizations two acute care hospitals. A positive impact of nurse satisfaction and engagement has been seen since the implementation. Specifically, each nursing unit has a unit-based council that addresses process and practice issues. This has given the nursing staff a sense of ownership over their processes and practice. Additionally, each unit-based council addresses issues based on evidence based practice. They research the evidence and then apply it to the perspective issue. Nursing leadership has seen an increased sense of nurse engagement and an increase in team work as a result.

The CNO at the organization believed that if nurse professional behaviors were advanced to the newly described Professional Governance model (Clavelle et al, 2016) behaviors, both nurse satisfaction and the challenges with the electronic record would be addressed. Redesigning of the shared governance structure to transition to professional governance and apply the principles associated with professional governance is the desired change to achieve the identified goals. This has led to the problem- solving question: In hospital nurse's does participation in professional governance and exhibiting the characteristics of accountability, team work and professional practice versus no participation in professional governance impact nurse participation and satisfaction with HIT?

Background and Significance

United States per capita healthcare spending is more than twice the average of other developed countries (Organization for Economic Co-operation and Development, 2016). In 2008, the Congressional Budget Office (CBO) reported that about half of all growth in healthcare spending over the past several decades have been associated with changes in medical care due to

technological advances. Healthcare spending will account for more than 30 percent of the GDP by 2035 (Organization for Economic Co-operation and Development, 2016). It is the belief of many policymakers that HIT is necessary to improve the efficiency and quality of health care in the United States (Agency for Healthcare Research and Quality, 2016).

The American Recovery and Reinvestment Act of 2009, established financial incentives to eligible healthcare organizations, and promoted the adoption and meaningful use of interoperable HIT and qualified EHRs (American Recovery and Reinvestment Act, 2013). Meaningful Use Stage 1 set the foundation for electronically capturing clinical data. Stage 2 raised the bar to ensure that the meaningful use of EHRs supported the priorities of the National Quality Strategy, which was to advance clinical processes. The deadline for attestation (acknowledging that all requirements have been met) for Stage 2, was March 13, 2017 (Centers for Medicaid and Medicare Services, 2017). Stage 3 is looking to improve outcomes. Attestation for Stage 3 begins January 1, 2018 (Centers for Medicaid and Medicare Services, 2016). As a result of American Recovery and Reinvestment Act and the financial incentives, EMRs are being used in healthcare organizations; therefore, it is critical that nurses have input in the design and workflow to achieve optimal patient outcomes and assist in the ability for their organization to meet meaningful use requirements.

Two studies, one by the RAND Corporation and one by the Center for Information Technology Leadership (CITL), estimate the potential net benefits from nationwide implementation of EHRs by all providers and healthcare systems. Unfortunately, these studies measured different sources of such savings. The RAND research focused primarily on savings that the use of health IT could generate by reducing costs to providers and healthcare organizations (Rand Corporation, 2016), whereas the CITL study limited its scope to savings

from achieving full interoperability of health IT, which excluded any potential improvements in efficiency with providers or healthcare organizations (Citl Information Technology and Health Technology, 2016). It is telling, however, that both studies, while measuring different variables, arrived at similar conclusions.

The Institute of Medicine report *To Err is Human* (Kohn, Corrigan, & Donaldson, 2000) revealed significant quality of care issues. The majority of medical errors result from system and process issues, rather than clinician negligence or misconduct. The integration of HIT in the nurse's workflow has added another dimension of complexity to their everyday work, creating another venue for process or system issues (Lalley, 2014).

According to a report from the National Patient Safety Foundation (2015), several studies have shown that mortality rates drop at hospitals using advanced EHRs; hence, there is evidence to support improvements in patient outcomes. The report includes eight recommendations towards developing a total system of safety. Two of the eight recommendations focus on the support of the healthcare workforce and ensuring that technology is safe and optimized to improve safety. A venue to achieve these two recommendations is through a shared governance model (Slatyer, et al, 2016).

Shared governance (SG) is recognized in acute care hospitals as a best practice for a professional nursing environment (Slatyer, et al, 2016). The notion of SG is to empower nurses who are closest to the patients to make decisions regarding practice, quality improvement, and process (Wilson, Gabel-Speroni, Jones, & Daniel, 2014 & Slatyer, et al, 2016). The effectiveness of empowering nurses is so impactful on positive patient outcomes that the Magnet Recognition Program® (American Nurses Credentialing Center, 2008) requires some mechanism for shared decision making for designation.

Gerad, Owens, & Oliver (2016) associated shared governance with nursing job satisfaction, decreased turnover and improved patient safety. There is significant evidence that supports a shared decision making model for nursing (Campbell, Fowles, & Weber, 2014). Ott and Ross (2014) investigated a multidisciplinary SG model and concluded that staff had a greater sense of cooperation, even in chaotic times, an increased knowledge about what was happening in the hospital, and increased sense of making a difference.

Nurses in the acute care setting and healthcare organizations have realized the positive impact SG has had on practice, engagement and satisfaction. As healthcare continues to evolve and get increasingly more complex it is imperative that nurses are fully committed and contribute as aligned members of the team. in particular to the advancement of the electronic health record. It is believed that transitioning from a SG structure to a professional governance structure can enhance the emergence of the accountability, professional obligation, collateral relationships, and decision-making that are necessary to improve nursing satisfaction with the electronic health record (Clavelle, J., et., al, 2016).

By incorporating IT into the current existing SG structure, and transitioning to a professional governance structure, staff nurses will be involved in the design, implementation and sustainability of their practice and documentation system. This could result in increased ownership of professional nursing processes, practice and documentation. Nurses would also be active participants in the upgrades to the current EMR by testing and validating the software. All of the councils will report up through the coordinating council for oversight as well as reinforcement that the activities are in line with the healthcare organizations strategic goals. This aligns with Kantor's Theory (1993) which looks at formal and informal structures in the workplace. Restructuring the SG model to incorporate all aspects of nursing and IT gives nurses

shared decision making and access to the power structures within the organization to create empowerment. Additionally, this redesign supports Kanter's Theory (1993) of providing staff the structure for opportunity, power and proportions. This can result in an increase in autonomy for nurses, increased satisfaction and commitment to the healthcare organization. Additionally, increased utilization of healthcare information technology can provide a reduction in healthcare costs, reduction in errors, and improved patient care outcomes.

Internal Evidence

The site for this study is a complex healthcare organization which includes two acute care hospitals, many comprehensive testing centers, outpatient services, inpatient care and wellness programs. In June of 2012, the two acute care hospitals implemented 55 Information Technology applications; which included an electronic medical record (EMR). Since the implementation of their information technology, nursing staff in the acute care hospitals continue to struggle (i.e. having numerous places to document the same information, the large number of items on the task list and unmatched workflow with documentation) with an inefficient system in which redundancies and poorly defined documentation fields impact nursing productivity, timeliness of documentation and increased potential for errors of omission or commission from inaccurate data. Overall satisfaction with existing technology is low (58% satisfaction); as evidenced by an internal survey conducted in Fall of 2016.

Because of a documentation system that does not match clinical practice, nurses frequently use "work arounds" (i.e. having numerous places to document the same information, the large number of items on the task list, unmatched workflow with documentation and ignoring alerts) to navigate the documentation process (Lalley, 2014). Documenting and retrieving patient information is complicated and often results in redundancies and difficulties in finding data

necessary to support the continuum and problem-based nursing care. Using a system that lacks involvement of nurses in the design and maintenance may contribute to inaccurate data and errors.

Nurses are principal stakeholders and users of the electronic medical record. Therefore, including nurses in the development, implementation and sustainability of the EMR could improve the functionality, accuracy, and user satisfaction. The Iowa Model of evidenced based practice (Appendix I) was used to guide the evidence collection and analysis. This model is known for its applicability and ease of use by healthcare teams. The model was selected because the model clearly explains the steps for changing practice and assists users in adhering to the principles of EBP.

Source and Search Strategy

An exhaustive search of the literature was undertaken. Five databases,—ABI/Inform, CINAHL, PubMed, JSTOR and ProQuest,—were searched. The following keywords were used: *shared governance, IT, information technology, medical informatics, nurse, nurses, nurse satisfaction, and satisfaction*. The additional use of the Boolean operators “AND” and “OR” were applied to focus and narrow the search. The search limited studies published between 2010 and 2017. After completion of this initial search, all articles identified underwent manual review by title and abstract for the inclusion of shared governance, information technology and/or nurse satisfaction. When databases yielded unmanageable results, exclusion criteria were applied to focus and narrow the search.

In the CINAHL database search, all keywords, Boolean operators and inclusion criteria were applied. This search yielded 22 articles (Appendix A). After additional review, eight articles were chosen for critical appraisal. The ABI/Inform search used all keywords, Boolean

operators and the inclusion criteria. Initially, this search yielded 3769 results. The search was then limited to peer reviewed, scholarly journals in the healthcare industry published from 2013-2017 in English. This yielded 125 results (Appendix B). After additional review six articles were selected for critical appraisal. The Pubmed database search included the use of Boolean operators with all keywords and the inclusion criteria. This search yielded 4 articles (Appendix C). After further review, one article was chosen for critical appraisal. The JSTOR database was searched using all key words and the use of Boolean operators and the inclusion criteria. This yielded 1527 results. The search was then limited to scholarly journals. As noted in Appendix D, this yielded 169 articles. After manual review by title and abstract, ten articles relevant to the PICOT were found. The ProQuest database search which included the use of all keywords, Boolean operators and the inclusion criteria yielded 17,027 results. The search was then limited to peer reviewed, scholarly journals, dissertations and theses published in English from 2013-2017. This yielded 51 results (Appendix E). After further evaluation, 15 articles were selected for critical appraisal.

A total of 40 articles were collected from these searches, and then critically appraised according to the PICOT, level of evidence and clinical relevancy. Ten final articles were chosen for inclusion in this literature review: eight qualitative studies and two quantitative study (Appendix F).

Critical Appraisal and Synthesis

Ten studies were selected for inclusion in this literature review; all were evaluated using Melnyk and Fineout-Overholt's (2015) rapid critical appraisal and are presented in evidence tables for analysis of data (Appendix F). Overall, the strength of studies were high: two quantitative studies for level three evidence; and eight qualitative studies for level four evidence (Appendix F). Five of the ten studies were dissertations.

According to Melnyk and Fineout-Overholt (2015), reliability and validity of evidence is determined through the use of standardized measuring tools for outcome evaluation and the production of statistically significant data. Each of the studies used a confirmed valid and reliable tool to measure outcomes (Appendix F). Six of the studies evaluated the impact of SG and identified at least one substantial outcome related to RN satisfaction. 100% of those studies resulted in increased RN satisfaction. Four of the studies evaluated the impact of HIT on RNs in the acute settings. 100% of those studies determined that workarounds were the most prevalent as well as, 100% resulted in an RN desire to be involved in HIT. In addition, all studies were retrospective in design and no bias was reported or appreciated (Appendix F).

A large degree of homogeneity was identified among the studies in regards to shared governance and the impact on staff nurses and nurse leaders (Appendix G). The majority of study participants (95%) were bedside acute care registered nurses and a few of the participants (5%) were acute care nurse leaders. The studies were conducted in person with a survey tool or in a phone interview format. 100% of the study participants were currently employed in an acute care setting. The outcomes from the studies on SG are: 100% of the studies showed an increase in RN satisfaction, 100% showed an increase in the development and implementation of best practices and 100% showed an increase in RN empowerment (Appendix G). The emerging

themes from the SG studies are: 100% stated that relationships are essential, 100% stated role based competencies are essential and 100% stated that SG is an evolving process (Appendix G). SG is an evolving process as the expertise of the nurse is expanding with an increase in complexities of healthcare. The emerging themes from the HIT studies are: 100% stated that HIT added challenges to RN workload (challenges identified were primarily workarounds) and 100% of the HIT studies identified that RNs expressed a desire for inclusion in the design, implementation and sustainability of HIT (Appendix G). Three studies tested models on SG and the impact on nursing leadership and RNs. 100% of those studies showed an increase in RN satisfaction, RN empowerment and an increase in the ability to implement best practices. One study tested a tool to measure workarounds in the acute care environment which could serve as a guide when determining issues and interventions (Appendix G).

The recommendation for the SG redesign relies on the positive impact the SG structure has on RN satisfaction and the challenges with HIT, primarily being workarounds and RNs desire to be involved in the HIT process (Clavelle, J., et. all, 2016, Lalley, C., 2014, & Shafer, D., 2015). This redesign is applicable to this project, which aims to integrate the diverse concepts of SG, challenges of HIT (primarily workarounds) and RNs desire to be involved in the HIT process, into one cohesive and innovative model.

Conclusions

There are many benefits of implementing and sustaining a SG model in an acute care setting. Although not every study demonstrated statistically significant outcomes, all studies revealed a positive trend towards increasing RN satisfaction, empowerment and engagement. Additionally, the evidence demonstrates that workarounds after an HIT implementation occur primarily due to lack of RN involvement in the design and implementation. Also, the evidence

showed RNs have a desire to be involved in the design, implementation and sustainability of HIT. Incorporating HIT into a SG model can create RN engagement and ownership of their documentation system. This can create a work environment where nurses are empowered to make decisions about their process, practice and documentation. Current research has demonstrated an increase in nurse satisfaction by implementing and sustaining a SG model, and RNs have expressed a desire to be involved in HIT, therefore, incorporating HIT into an enhanced professional governance model council could benefit the current healthcare systems RN satisfaction. Further, there is no information to date on the impact of a professional governance model.

Purpose

The purpose of this project was to improve nurse satisfaction and engagement in HIT in an acute care setting using a professional governance model which is an enhanced shared governance model. The intervention was educational sessions on transitioning from a shared governance model to a professional governance model to create a workplace culture that supports professional obligation, accountability, decision making and relationships to improve nurse satisfaction. The project included education, training and coaching. The progress was measured with a professional governance survey pre and post education, training and coaching. These strategies were intended to increase professional role involvement in four areas: accountability, professional obligation, collateral relationships and decision making, as well as inclusion of HIT in the enhanced professional governance model.

Project Methodology

Background Information

Setting

The project was conducted in a rural community complex healthcare organization which includes two acute care hospitals, many comprehensive testing centers, outpatient services, and inpatient care and wellness programs in northwest Arizona.

In 2013, a shared governance structure was instituted at the organization. As anticipated, increased nursing staff satisfaction and engagement were documented (employee survey 2015) as a result of SG. While the organization has seen a positive impact from the SG model for nursing staff specific to process and practice, the lack of accountability, decision making and collateral relationships building within nursing, has limited the nursing division from achieving optimal processes and practices. The CNO at the organization believed that if nurse professional behaviors were advanced to the newly described Professional Governance model behaviors, both nurse satisfaction and the challenges with process and practice would be addressed and ultimately increased involvement in health information technology. Redesigning of the shared governance structure to transition to professional governance and apply the principles associated with professional governance is the desired change to achieve the identified goals.

The organization's culture embodies transactional leadership behaviors, utilizing a top down control and decision-making structure (Bass & Riggo, 2006). Information is primarily disseminated through email and/or the organizations intranet. Leaders are expected to manage-by-exception. The staff are monitored by their supervisors, punishment occurs when errors occur, and rewards are given for accomplishing assigned tasks. This does not align with the organizations values of: accountability, integrity, trust, respect and quality.

In 2013, when the CNO introduced shared governance, it was not embraced by the senior leadership team. The CNO had to begin the evolution of shared governance in nursing to demonstrate the positive impact it has on staff and ultimately patients. Since the SG implementation, there has been a decrease in RN turnover, an increase in patient satisfaction and the application of evidence into practice by bedside nurses, hence, there has been organizational support to continue and evolve shared governance to professional governance. An evidenced based practice project was conducted to determine the impact of education, coaching and mentoring on professional role behaviors to improve nurse satisfaction and involvement with HIT.

Study Design

A descriptive, correlational, quasi-experimental pre-test/post-test was used. A convenience sample of all the registered nurses in the healthcare organization from September 2017 to February 2018 was used.

Participants

IRB approval was received from Arizona State University (ASU) utilizing exempt study criteria (Appendix K). Additional approval was received from the Corporate Compliance and Privacy Officer at the facility the project was conducted (Appendix J). Once IRB approval was received, the pre-intervention survey was distributed electronically to all nursing staff in the healthcare organization.

Nurses who met the inclusion criteria were sent two survey monkey invitations to their work email. The first was sent prior to professional governance education, coaching and mentoring, and the second 3 months after the education, coaching and mentoring. The email included a consent declaration and an invitation to participate in the survey with a description of

the project. A receipt was requested which was auto generated by their email. YRMC Nursing leaders reviewed any unread messages and for those who had not read the message, a message was re-sent 1 week later. No personal details were recorded in the data collected. Only the primary and secondary co-investigator had direct access to the data. Data were stored in a secure server that is password encrypted with password change every 90 days and data will be retained for 1 year.

The survey link was sent via an employee portal link secured by Secure Sockets Layer (SSL) encryption and protected by password protection. Participants were asked to include the last 6 digits of their phone # in the survey as a linking ID. Survey data was anonymous.

The participant pool consisted of 860 registered nurses in the organization. This includes all registered nurses providing direct patient care. Nursing leaders participated in the educational training sessions and assisted with the coordination of the unit based educational sessions with staff. Nursing leaders also participated in the coaching and mentoring of the staff. Additionally, once the pre and post survey was distributed to staff, leaders did follow-up with an email from the CNO describing the project and consent process. Agreement to complete the pre and post survey was considered consent to participate.

Theoretical Framework

Kanter's Theory of Power in Organizations (Appendix H) is the theoretical framework used to support this project. The premise of Kanter's theory is that workplace structures influence the behaviors and attitudes of employees (Kanter, 1993). According to Kanter (1993), organizations that have structures in place create an environment for employees to be more empowered and engaged; therefore, contribute more effectively in an organization.

Formal and informal power structures in the workplace are also examined in this theory. Kanter's theory (1993), states that formal power comes from the ability to be flexible, creative and adaptive. Formal power can occur through innovation, achievement of positive outcomes, and willingness to take risks. Informal power can be achieved by developing relationships. The work within an organization is guided through these power structures.

This theory focuses on three structures that need to be in place to enable workplace empowerment. The structures are: structure of opportunity, structure of power, and the structure of proportions. Kanter's theory (1993) states that employee access to these structures are the elements necessary to positively contribute to the organization. The theory implies that if all three structures are accessible to employees, organizations will see an increase in autonomy created through empowerment and an increase in employee satisfaction and commitment. The SG structure allows nurses to share power and decision making that impacts their processes and practice. The theory suited the proposed project as the structure gives nurses access to both formal and informal power structures, which can result in increased nurse satisfaction with HIT.

Procedure

An education program on the principles of professional governance was developed along with a plan to conduct the education. (Appendix O). After 3 months, a post survey was distributed to determine the impact of the education, coaching and mentoring.

A professional governance survey was created for pre and post assessment of the impact of the education, coaching and mentoring. The survey was constructed to include selected items from the current employee satisfaction survey and newly developed items from the published research related to professional governance (Clavelle et al, 2016). In light of the fact that this was an untested survey, this researcher enlisted a panel of 10 professional governance experts to

review the validity content of the items. (Appendix L). 5 of the experts responded and agreed with the content validity of the items. None of the experts recommended changes to the items in this researcher-created survey.

Demographic data were analyzed using descriptive statistics to describe participants. The behavior questions were categorized into three domains which were: 1) professional governance (which included questions on accountability, decision making, collateral relationships and professional obligation), 2) work place environment and 3) patient centered care. (Appendix M). Each participant was asked to rate the professional governance factors on level of agreement. A four point Likert scale was assigned to each corresponding score. Strongly disagree = 1, disagree = 2, agree = 4, and strongly agree = 4. For the work environment domain, each participant was asked to rate the factors on level of agreement. Strongly disagree = 1, disagree = 2, agree = 4, and strongly agree = 4. For the patient centered domain, each participant was asked to rate the factors based on frequency. Never =1, usually = 2, sometimes = 3, and always = 4. (Appendix M). The intervention for this project was education, coaching and mentoring which was the dependent variable. (Appendix O). The independent variables were: professional governance, work environment and patient centered care. The dependent variables were the registered nurses.

Results

Data Analysis

SPSS ® 25 was used to store, manage and analyze the data. Descriptive statistics were used to describe the sample and outcome variables. Inferential statistics were used to analyze the outcome variable, using a two- tailed test statistic and the critical value was set at $p < 0.10$. For the purposes of this study, due to the importance of detecting small to moderate differences with

a small sample size (p values >0.05 but <0.10 are referred to as trend); therefore, significance was tested at the $p < 0.10$ (Fugate Woods Lentz, Mitchell, Heitkemper & Shaver, 1997).

The Independent Samples t Test, parametric test which compares the means of two independent groups in order to determine whether there is statistical evidence that the associated population means are significantly different was selected to test the change in professional role behaviors post intervention.

Demographics

The average age of respondents was 46.5 ($SD=10.75$) years of age and the ages ranged from 26 to 65 years old. The average number of years the respondents had been practicing as registered nurses was 4 years ($SD = 1.14$) and the number of years ranged from < 2 years to > 20 years. Eighty-eight (88%) of the respondents were female and the remainder were male twelve (12%). Sixty nine (69%) had a specialty certification and thirty-one (31%) did not.

Quantitative Results

The pre survey sample consisted of 86 nurses. The average score on the pre survey professional governance domain was 12.91($SD=2.56$) and the scores ranged from 4-16 points. The average pre survey work environment domain was 13.36 ($SD=1.99$) and the scores ranged from 7-16 points.. The average pre survey patient centered care domain was 12.65 ($SD=2.30$) and the scores ranged from 7-17 points. The average for the pre survey professional governance total scores was 39 ($SD=5.3$) and the scores ranged from 22-48 points. The post survey group consisted of 34 participants. The average post survey professional governance domain was 13.11 ($SD=2.53$) and the scores ranged from 4-16points. The average post survey work environment domain was 13.09 ($SD=1.96$) and the scores ranged from 8-16 points. The average post survey patient centered care domain was 10.82 ($SD=.87$) and the scores ranged

from 8-12 points. The average for the post survey professional governance total scores was 37.03 ($SD=4.11$) and the scores ranged from 27-43 points. (Appendix N).

One hundred and twenty nurses completed both surveys. The average number of professional role behaviors exhibited before the program was 39 ($SD=5.3$) and the scores ranged from 22-48 points. The average number of professional role behaviors exhibited after the educational program was 37.1 ($SD=4.1$) and the points ranged from 27-43 points. There was a significant difference found in professional role behaviors demonstrated 3 months after the educational program ($t(118)=1.95, p=.05$). (Appendix N). These results suggest that the education, coaching and mentoring conducted on professional role behaviors did have the desired impact.

Qualitative Results

The questions on the survey that related to professional role behaviors (accountability, professional obligation, collateral relationships and decision making) contained 2 parts. One was about the RNs perceptions about professional practice and the second part was examples that supported their response. That analysis identified the most commonly used examples were: 1) their participation in organizational shared leadership councils, 2) their participation in unit based councils, 3) their participation in process improvement projects and 4) their participation in the electronic medical record committee—Care Net. Of the 120 participants, 75 of the participants gave these examples to support their response.

Discussion

The purpose of this project was to improve nurse satisfaction and engagement with HIT in an acute care setting through advancement of the SG model. These project results suggest that the education, coaching and mentoring conducted on professional role behaviors did have the desired impact. Although there is no information to date on the impact of a professional governance model on professional role behaviors, this project supports the foundation to create the framework for ensuring that the unique knowledge, wisdom, and expertise of nurses are fully utilized, including HIT (Clavelle, et al, 2016). This aligns with the literature search conducted on SG and nurses desire to be involved with HIT. Nurses do have a desire to be involved in decision making regarding their processes and practice and HIT. However, organizations need to the structure and framework for this to occur. Additionally, nurse leaders who currently have SG structure in place need to transition to professional governance as a framework for structural empowerment in organizations (Clavelle, et. al, 2016)

Three observations by this researcher were made during the educational and coaching sessions with staff and leaders. First, the staff that are currently involved in SG councils were actively more engaged in the education sessions and could apply the learnings into practice. For example, one registered nurse who is a member of the nurse practice council gave specific examples on how they have incorporated evidenced practice to guide policy and procedures (i.e. use of the Aldrete scoring tool for conscious sedation). Another example was a registered nurse who is a member of the process improvement council spoke about a process improvement they were currently working on regarding heart failure patients. She gave examples of how they have incorporated evidenced based practices to their process and practice and how they have

expanded the team to include our ACO and physician office practices. Additionally, nurses who are currently involved in the shared governance councils and unit based councils voiced the fulfillment of owning your practice and being actively involved to improve it.

The second observation based on the education and coaching sessions, was regarding the level of experience of the leaders with shared leadership councils. The Critical Care Nursing Director spoke about transitioning the staff self scheduling and how that has increased the satisfaction of the nursing staff and has saved her a significant amount of time. The Emergency Room Nursing Director gave the example of he is utilizing his unit based councils to address the patient hand off concerns from ED to the inpatient units. The unit based councils conducted a literature search and determined to use an evidenced based hand off tool. They conducted the staff education and have implemented the tool. The councils improved care and increased staff satisfaction.

A final observation made was while attending the daily bed huddles. The ownership the charge nurses were taking on addressing staffing issues when the organization was at capacity. This year has been a particularly challenging one due to the impact of the flu. The charge nurses understand the expectations, knew what parameters they had to work within and acted accordingly. For the past 4 months, the organization did not have to transfer any patients out of their community due to this leadership by the charge nurses. They have developed creative and innovative ways to accommodate the patients in our community. This has been another area of empowerment the CNO had been working on for the past 5 years.

These observations align with the literature which states the time it takes for a self-selected behavior changes to become automatic vary greatly among individuals, taking from 18-254 days (Lally, Van Jaarsveld, Potts, & Wardle, 2010). With the progress that SG this

organization has experienced in nursing, the CNO's desire to advance to a professional governance model, and the senior leadership team embracement of SG, this could be transitioned to all areas of the organization. This would change the top down led culture of the organization. Behavior change is also influenced by the organizational culture and by colleagues (Bandura, 1986)

Strengths and Limitations

One strength of the project was this researcher's familiarity with the organization and the organizations willingness to participate in the project. Another strength was the SG structure that had already been established. Utilizing members of the SG council assisted significantly in the education, coaching and mentoring of 860 nurses.

Currently a validated and published survey tool to measure the impact of a professional governance model is not available. A limitation of the project was the use of a newly created survey tool; however content validity was determined.

Participants were asked to include the last 6 digits of their phone # in the survey as a linking ID. In analyzing the post survey data this researcher discovered that there were no matches, which is a limitation of this study. This could be due to the large population the survey was distributed to (860 nurses). Based on this; the independent t sample t test was selected to analyze the data versus the matched paired t test. Both check to see if a difference between two means is significant. Paired-samples t tests compare scores on two different variables but for the same group of cases; independent-samples t tests compare scores on the same variable but for two different groups of cases. A recommendation for the organization to match the IDs each year to strengthen the validity and reliability of the study.

Although the timeframe was short between pre and post survey, the outcome was positive. This could be due to the organization's existing shared governance council, which has been in place for four years. Observations noted a higher degree of engagement and application on staff nurses and leaders who had and are continuing to be actively participating in a shared leadership council. This could be an opportunity for the organization to utilize staff nurses and leaders who have the current knowledge educate, coach and mentor those who do not.

The lower sample size post survey (N=36) was also a limitation. The initial rollout for this project was September, October and November. There was initial excitement about the project and the pre survey responses are reflective of that. That timeframe is also the end of the organizations fiscal year and volumes are low. The post survey timeframe was February, which is the organizations busiest time of the year. The organization saw the highest volumes they have ever seen partially due to the flu impact as well as new programs. This may have impacted staff nurses not taking the time to participate.

Conclusions

The project did find a statistically significant difference in the participant's professional role behaviors after the education, coaching and mentoring intervention. This finding aligns with the literature, which supports the positive impact of shared leadership on nursing satisfaction and nurses desire to participate in the design and sustainability of the EHR. Using this as a foundation, advancing to a professional governance model can change nurse engagement and involvement in their process and practice, including HIT in an acute care setting. Kanter's theory (1993) states that employee access to formal and informal structures are the elements necessary to positively contribute to the organization. Leaders and staff nurses can be educated, coached and mentored and have the infrastructure present to fully evolve to a professional

governance model. The organization can realize many benefits of this advancement.

Specifically an increase in professional role behaviors relating to: (1) accountability, (2) professional obligation, (3) collateral relationships, and (4) decision-making. Ultimately, with the increased professional nurse involvement, nurses can be more actively engaged in problem solving to improve nurse satisfaction with the electronic health record. Their engagement and involvement in the sustainability of HIT could result in increased adoption, optimization and utilization. Many other benefits could be realized from this model, such as improved nursing practice and processes, improved nurse satisfaction and improved recruitment and retention.

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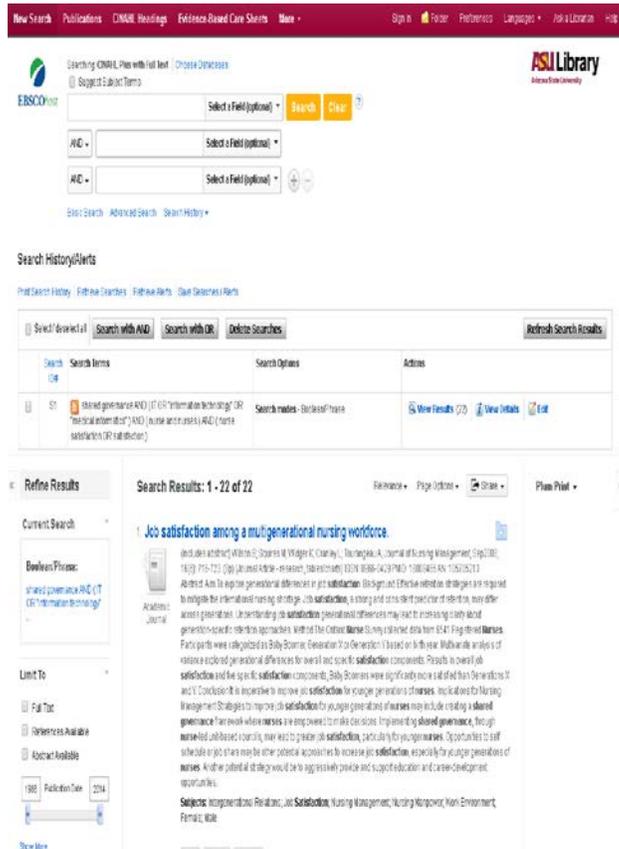
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Appendix A

Database Search Strategy

CINANL Plus



Appendix B

Database Search Strategy

ABI/Inform

ABI/INFORM Collection
Basic Search | Advanced Search | Publications | Browse | About

(shared governance) AND (IT OR "information technology" OR "medical informatics") AND (nursing OR nurses) AND (nurse satisfaction OR satisfaction)

Full text | Peer reviewed | Additional limits - Date After 2010, Source type Scholarly Journals, Document type Article, Show all

Related searches: information technology AND medical informatics

125 results Search within

Relevance | Sort | Select 1-20 | 0 Selected items | Brief view | Detailed view

Narrow results:

- Applied filters: Clear all filters
- Publication date: 2013-2017
- Classification: Health care industry
- Full text: [v]
- Peer reviewed: [v]
- Source type: Scholarly Journals (125)
- Publication date: 2013 - 2016 (year)

1 Designing a unit practice council structure
Jordan, Barbara Ann, DNP, RN, NEA-BC. *Nursing Management*, Chicago 47.1 (Jan 2016): 15.
Shared governance structure will increase their nurses' satisfaction with job satisfaction and retention. One method of nurse engagement is through a nurse satisfaction survey indicated that nurses in an organization were only
Cited by (1)
Abstract/Details | Link to full text | [Open @ ABI](#) | Preview

2 Nursing governance and clinical error control
Tsun, Liu Tsing. *International Journal of Pharmaceutical and Healthcare Marketing*, Bradford 2 (2015): 136-155.
governance which influences nurses' competency to lead nursing practice
2015. **nursing governance** issues **nurses' job participation** in hospital
nursing governance is a critical feature. **nursing governance** helps advances
Abstract/Details | Full text | Full text - PDF (367 KB) | Preview

3 The Impact of Internal Marketing and the Moderating Role of Organizational Culture on Nurse Job Satisfaction
Janja, Saier Rashid, Ahmad, Hafiz Mustaq, Afzal Amari. *Journal of Business & Economics*, Islamabad 12 (Jan-Dec 2016): 203-204.
work and shared values are important antecedents of nurse satisfaction (Miles
2015). **nursing governance** issues **nurses' job participation** in hospital
nursing governance is a critical feature. **nursing governance** helps advances
Abstract/Details | Full text | Full text - PDF (219 KB) | Preview

ProQuest
All databases | Change databases

ABI/INFORM Collection
Basic Search | Advanced Search | Publications | Browse | About

(shared governance) AND (IT OR "information technology" OR "medical informatics") AND (nurse OR nurses) AND (nurse satisfaction OR satisfaction)

Full text | Peer reviewed | Modify search | Recent searches | Save search/alert

Related searches: information technology AND medical informatics

3,769 results Search within

Relevance | Sort | Select 1-20 | 0 Selected items | Brief view | Detailed view

Narrow results:

- Full text: [v]
- Peer reviewed: [v]
- Source type:
 - Dissertations & Theses (1,337)
 - Scholarly Journals (1,069)
 - Reports (934)
 - Trade Journals (240)
 - Wire Feeds (106)

1 Empowerment, Job satisfaction, and professional governance of nurses in hospitals with and without shared governance: A descriptive correlational and comparative study
Anderson, Elva Faye Fryar. Louisiana State University Health Sciences Center School of Nursing, ProQuest Dissertations Publishing, 2000. 9906756.
satisfaction among staff nurses who practice in a hospital with a shared satisfaction in both groups. The results of this research suggest that shared governance is a
Cited by (1)
Abstract/Details | Preview - PDF (531 KB) | Full text - PDF (6 MB) | Preview

2 Designing a unit practice council structure
Jordan, Barbara Ann, DNP, RN, NEA-BC. *Nursing Management*, Chicago 47.1 (Jan 2016): 15.
Shared governance structure will increase their nurses' satisfaction with job satisfaction and retention. One method of nurse engagement is through a nurse satisfaction survey indicated that nurses in an organization were only
Cited by (1)

Appendix C

Database Search Strategy

PubMed Advanced

The screenshot displays the PubMed Advanced Search Builder interface. At the top, there is a navigation bar with 'PubMed Home', 'More Resources', and 'Help'. Below this, the 'PubMed Advanced Search Builder' section includes a search input field with the text 'Use the builder below to create your search', an 'Edit' button, and a 'Clear' button. The 'Builder' section features two search criteria fields, both set to 'All Fields', with 'AND' as the operator. Below the builder are 'Search' and 'Add to history' buttons. The 'History' section contains a table with columns for 'Search', 'Add to builder', 'Query', 'Items found', and 'Time'. The table lists several search queries with their corresponding results and timestamps.

Search	Add to builder	Query	Items found	Time
#2	Add	Search ((shared governance) AND (IT OR "Information technology") AND (nursing OR nurses))	4	15:57:57
#6	Add	Search ((shared governance) AND (electronic medical record OR "information technology" OR "IT") AND (nurse OR nursing))	3	15:57:19
#7	Add	Search ((IT governance structure) AND electronic medical record) AND hospital AND ("last 5 years" [PDa])	6	15:55:07
#5	Add	Search (electronic medical records) AND healthcare AND ("last 5 years"[PDa] AND Humans[Mesh])	4730	15:54:19
#5	Add	Search ((shared governance) AND (IT OR "Information technology") AND (nursing OR nurses))	4	15:53:43
#4	Add	Search ((shared governance) AND (IT OR "Information technology") AND (nursing OR nurses))	4	15:51:58
#3	Add	Search ((shared governance) AND (IT OR "Information technology" OR "medical informatics") AND (nurse OR nurses))	1	15:50:37
#2	Add	Search ((shared governance) AND (IT OR "Information technology" OR "medical informatics") AND (nurses OR nurse)) AND (nurse satisfaction OR satisfaction) Schema: all	0	15:49:49
#1	Add	Search ((shared governance) AND (IT OR "Information technology" OR "medical informatics") AND (nurses OR nurse)) AND (nurse satisfaction OR satisfaction)	0	15:49:48

At the bottom of the page, there is a footer with the text 'You are here: NCBI > Literature > PubMed' and a 'Support Center' link. The page also includes sections for 'POPULAR', 'FEATURED', and 'NCBI INFORMATION'.

Appendix D

Database Search Strategy

JSTOR

This screenshot shows the JSTOR search results page for 169 items. The search query is: (((shared governance) AND (IT OR "information technology" OR "medical informatics")) AND (nurses OR nursing)). The results are displayed in a list format with filters on the left and action buttons on the right.

Search Results: 169 Search Results

Filter Results: Showing 1-25 of 169

Content Type: Journals (169)

Subject: Health Sciences (169), History (13), History of Science & Technology (13), Labor & Employment Relations (0), Public Health (36)

Publication Date: From 2010 To 2017

Access Level: All Content, Read and download, Read online only, JPASS subscription content, Purchasable content

Results:

- PRACTICAL NURSES' HEALTH AND SAFETY IN NURSING HOMES**
MARY VAL PALUMBO, VICKI MCLAUGHLIN, BARBARA MCINTOSH, BETTY RAMBUR
Journal of Health and Human Services Administration, Vol. 34, No. 3 (WINTER 2011), pp. 271-301 [Journal]
Topic: Nursing homes, Medical practice, Workforce, Emotion, Older adults, Registered nurses, Age, Health promotion
- Poverty, Philanthropy, and Professionalism: The Establishment of a District Nursing Service in Wellington, New Zealand, 1903**
Pamela Wood, Keri Arcus
Health and History, Vol. 13, No. 1 (2011), pp. 44-64 [Journal]
Topic: Philanthropy, Nursing, Professional services, Nursing education, Ambulances, Registered nurses, Charities, Home nursing, Poverty
- Nurse leadership and patient safety: Rounding can enhance but not ensure patient safety; better to focus on appropriate training**
Çağrı Ağhew, Rhona Fin, Jane Reid
BMJ: British Medical Journal, Vol. 345, No. 7871 (25 August 2012), p. 9 [Journal]
Topic: Nurses, Patient safety, Leadership, Leadership training, Patient care, Industrial psychology

This screenshot shows the JSTOR search results page for 1,527 items. The search query is: (((shared governance) AND (IT OR "information technology" OR "medical informatics")) AND (nurses OR nursing)). The results are displayed in a list format with filters on the left and action buttons on the right.

Search Results: 1,527 Search Results

Filter Results: Showing 1-26 of 1,527

Content Type: Journals (1,527)

Subject: African American Studies (18), African Studies (14), American Indian Studies (2), American Studies (73), Anthropology (47), Aquatic Sciences (3), Archaeology (12), Architecture & Architectural History (7), Art & Art History (16), Asian Studies (37), See more

Publication Date: From 2010 To 2017

Results:

- PRACTICAL NURSES' HEALTH AND SAFETY IN NURSING HOMES**
MARY VAL PALUMBO, VICKI MCLAUGHLIN, BARBARA MCINTOSH, BETTY RAMBUR
Journal of Health and Human Services Administration, Vol. 34, No. 3 (WINTER 2011), pp. 271-301 [Journal]
Topic: Nursing homes, Medical practice, Workforce, Emotion, Older adults, Registered nurses, Age, Health promotion
- Nurses' Impoliteness as an Impediment to patients' rights in selected Kenyan hospitals**
Benson Oduor Ojwang, Emily Atieno Ogutu, Peter Maina Matu
Health and Human Rights, Vol. 12, No. 2, Social conditions of health: Convergences and disjunctures (December 2010), pp. 101-117 [Journal]
- Annals of HSR: Nurse/Physician Communication Through a Sensemaking Lens: Shifting the Paradigm to Improve Patient Safety**
Milica Manojlovich
Medical Care, Vol. 48, No. 11 (November 2010), pp. 941-946

Appendix E

Database Search Strategy

ProQuest Advanced

ProQuest
Basic Search | Advanced Search | Publications | Browse | Databases (60)

(shared governance) AND (IT OR "information technology" OR "medical informatics") AND (nurses OR nursing) AND (nurse satisfaction OR satisfaction)

Full text | Peer reviewed | Modify search | Recent searches | Save search/alert

Additional limits: Date From 2010 to 2017. Source type: Dissertations & Theses. Show all

Related searches: information technology AND medical informatics

51 results | 0 Ebook Central results

Search within

Relevance | Sort

Narrow results

Applied filters: Clear all filters

Publication date: 2010-2017

Location: United States-US

Full text

Peer reviewed

Source type: Scholarly Journals (5)

Publication date

1. Comparing **Nurses' Perceptions of Governance** Related to Hospital Journeys to Excellence Status in the Midwest East. Moore, Stacie. Tampa, Fla.: Belle Glade, Fla.: Health Management Press, Nursing Governance Forum 31:4 (Jul/Aug 2015): 1040. **shared governance**, **nursing management**, **administration** and staff, **nurses**, **nurses**. **shared governance** of a variety of **nurses' Law** ownership in making **shared** success + **shared governance** environment in the workplace. Setting. Cited by 2 | References (30) | Abstract/Details | Full text | Full text - PDF (2x) | Preview
2. Designing a unit graduate course structure. Jeter, Barbara Ann. DNP, RN, NE-BC. Nursing Management Chicago 47:1 (Jan 2016): 15. **shared governance** structure will increase the **nurses' satisfaction** with **job satisfaction** and **work on the front of nurse engagement** through **shared** success + **shared governance** environment in the workplace. Setting. Cited by 0 | Links to full text | **Open Access** | Preview
3. Use of Electronic Health Record Documentation by Healthcare Workers in an Academic Hospital System/PRACTITIONER APPLICATION. Poyner, Julie. Eugene, OR, ProQuest Publishing. 2015. 1040. **shared governance**, **nursing management**, **administration** and staff, **nurses**, **nurses**. **shared governance** of a variety of **nurses' Law** ownership in making **shared** success + **shared governance** environment in the workplace. Setting. Cited by 0 | Links to full text | **Open Access** | Preview

ProQuest
Basic Search | Advanced Search | Publications | Browse | Databases (60)

(shared governance) AND (IT OR "information technology" OR "medical informatics") AND (nursing OR nurses) AND (satisfaction OR nursing satisfaction)

Full text | Peer reviewed | Modify search | Recent searches | Save search/alert

Related searches: information technology AND medical informatics

17,027 results | 12,936 Ebook Central results

Search within

Relevance | Sort

Narrow results

Applied filters: Clear all filters

Publication date: 2010-2019

Full text

Peer reviewed

Source type: Dissertations & Theses (1,472) | Reports (1,322) | Scholarly Journals (919) | Trade Journals (110)

1. A Phenomenological Study of the **Shared Governance** Experience for **Nurses** Working in the Pharmaceutical Industry. Nusier, Adele. Northcentral University. ProQuest Dissertations Publishing, 2016. 10129099. **nursing practice**, the existence of **shared governance** or the change in the **insurance of shared governance** and to understand how **shared governance** affected **of 10 nurses** explored the **shared governance** experience from the perspective of **Abstract/Details** | Preview - PDF (259 KB) | Full text - PDF (1 MB) | Preview
2. Organizational context, **shared governance** structure, and outcomes in Veterans Affairs hospitals. Charland, Bonnie J. University of Rhode Island. ProQuest Dissertations Publishing, 2015. 3702738. **of the effects of shared governance** on **nurse** and patient outcomes. The purpose **of the relationship between organizational context, nursing, shared governance,** and in-patient turbulence. **Nurse** executives reported on **shared governance**. References (233) | Abstract/Details | Preview - PDF (160 KB) | Full text - PDF (2 MB) | Preview
3. The Relationship Between **Nurse Manager Leadership Style** and Enculturation of **Shared Governance**.

Appendix F

Table 1

Evaluation Table

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
Cohen, C. (2015) Leveraging the power of shared governance Country: USA Funding: None listed Conflict/Bias: None reported or appreciated	Kotter’s Contemporary Change Theory	Design: Qualitative Review Method: Descriptive pre- and post-intervention survey analysis Purpose: The aim of this study was to assess the current state of SG in a community hospital and the impact on RN satisfaction	Sample: N = 150 n = 84 completed Demographics: All RNs where SG was in place Time: 3 mon Setting: Community hospital	IV: SG DV1: NL only DV2: NL with some RN input DV3: Equal share RN and NL DV4: Primary RN some some NL input DV5: RN only	IPNG Survey (CVR) NDNQI nursing survey (CVR)	SPSS ANOVA	Total Governance mean score was 151.04 (SD 35.38) 173 score that marks the achievement of a functioning SG using to the IPNG instrument DV1: 86-72 DV2:173-257 DV3: 258 DV4:259-344 DV5:345-430	LOE: IV ST: Large sample size, used IPNG and NDNQI survey WK: Convenience sample of one location Feasibility: NL can use SG to address factors linked to retention such as autonomy and control over practice and process.
Collins, et al (2015) Nursing domain	Grounded Theory	Design: Qualitative, cross sectional study Method: Telephone semi	N=12 NI leaders n=6 CNOs n=4 DONIs n=1 CCLO	IV-CI governance DV-NI leader	Telephone survey semi-structured interviews that	Iteratively analyzed, NVIVO qualitative	4 themes emerged: (1) interprofessional	LOE: IV LT: small sample size

ANCC- American Nurses Credentialing Center; **CI-**clinical informatics; **CIHR-**Canadian Institutes of Health Research; **CCLO-**chief clinical officer; **CE** – care environment; **CIO-**chief information officer; **CNIO-**chief nursing information officer; **CNO-**chief nursing officer; **CRP-** complexity response process; **DI-** decisional involvement; **CVR-**confirmed validity and reliability; **DONI-**director of nursing informatics; **DV-**dependent variable; **EC** – electronic charting; **EMR-** electronic medical record; **FT-** full time; **HL-** healthcare leaders; **HIT-**health information technology; **IHS-**integrated health system; **IPNG-**Index of professional nursing governance; **IV-** independent variable; **LOE-** level of evidence; **LT-** limitations; **MRC-**medical research council; **NDNQI-** national database of nursing quality indicators; **NH-**national health; **N-**number of studies; **n-** number of participants; **NI-**nursing informatics; **NM-**nurse manager; **PPM-**professional practice model; **PT-**part time; **RN-**registered nurse **SN-**staff nurse; **SG-** shared governance; **SRDH-**St. Rose Dominican Hospitals; **ST-** strengths; **SW-**southwest; **WK-** weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
of CI governance: recommendations for health IT adoption and optimization Country: USA Funding: None listed Conflict/Bias: None reported or appreciated		structured interviews Purpose: Cross sectional study to understand existing CI/SG governance structures and provide a model with recommended roles, partnerships, and councils based on perspectives of nursing informatics leaders	n=1 CIO N=12 IHS Demographics: All NIs have a clinical nursing background Setting: IHS in the US Time: June 2102- Nov 2012 Inclusion criteria: 1. NI leader in the role of executive director that had at least one acute care hospital 2. Enterprise wide EMR adoption		were audio-recorded and transcribed	data analysis software Diagrams of each HIS's org CI structure	partnerships are essential (2) critical role-based levels of practice and competencies need to be defined (3) integration into existing clinical infrastructure facilitates success (4) CI governance is an evolving process	Feasibility: The proposed model can be used to understand, shape and standardize roles, competencies, and structures within CL practice for nursing
Enuenwosu-Aki, (2015). Nurses' perceptions of electronic	The nursing role effectiveness model	Design: Qualitative Descriptive Case Study Method: Semi structured recorded phone interviews	N=26 RNs n = 6 did not meet inclusion criteria n = 2 had less than 5 years'	IV=RNs DV1=electronic charting DV2=workload	Individual Semi-structured recorded phone interviews	NVivo 10® qualitative software	Four major themes emerged: 1. EC provided support to	LOE: IV ST: Described lived experiences of SN who had

ANCC- American Nurses Credentialing Center; CI-clinical informatics; CIHR-Canadian Institutes of Health Research; CCLO-chief clinical officer; CE – care environment; CIO-chief information officer; CNIO-chief nursing information officer; CNO-chief nursing officer; CRP- complexity response process; CVR-confirmed validity and reliability; DI-decisional involvement; DONI-director of nursing informatics; DV-dependent variable; EC – electronic charting; EMR-electronic medical record; FT- full time; HL- healthcare leaders; HIT-health information technology; IHS-integrated health system; IPNG-Index of professional nursing governance; IV- independent variable; LOE- level of evidence; LT- limitations; MRC-medical research council; NCVR – no confirmation of validity and reliability; NDNQI-national database of nursing quality indicators; NH-national health; N-number of studies; n- number of participants; NI-nursing informatics; NM-nurse manager; PPM-professional practice model; PT-part time; RN-registered nurse SN-staff nurse; SG- shared governance; SRDH-St. Rose Dominican Hospitals; ST- strengths; SW-southwest; WK-weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
<p>charting and the impact on their workloads.</p> <p>Country: USA</p> <p>Funding: None listed</p> <p>Conflict/Bias: None reported or appreciated</p>		<p>Purpose: Explore nurses' perceptions of how electronic charting impacted their workloads and the delivery of health care services</p>	<p>experience n=3 no longer working in direct patient care n = 1 worked less than 24 hrs/week n =20 selected for study n= 1 did not participate in interview n = 19 actual participants</p> <p>Setting: Acute care health care organization Site=Atlanta, Georgia and Houston, Texas</p> <p>Inclusion criteria: RNs with 8 or more experience, who worked a minimum of 36 hrs/week, worked with both paper and electronic charting and direct care givers</p>				<p>SN in the CE 2. EC added to the challenging demands of the CE 3. EC did not have any bearing on the SN workload. 4. SN expressed the need for inclusion in the EC processes</p>	<p>used both paper and EC and were able to describe the impact on workload WK: small sample size, sample demographics, locations of the SN in the study, methodology, design and mode of data collection Feasibility: NL understand the importance of skill enhancement, system improvements and collaboration among depts. and inclusion of SN in design</p>

ANCC- American Nurses Credentialing Center; **CI-**clinical informatics; **CIHR-**Canadian Institutes of Health Research; **CCLO-**chief clinical officer; **CE** – care environment; **CIO-**chief information officer; **CNIO-**chief nursing information officer; **CNO-**chief nursing officer; **CRP-** complexity response process; **CVR-** confirmed validity and reliability; **DI-**decisional involvement; **DONI-**director of nursing informatics; **DV-**dependent variable; **EC** – electronic charting; **EMR-** electronic medical record; **FT-** full time; **HL-** healthcare leaders; **HIT-**health information technology; **IHS-**integrated health system; **IPNG-**Index of professional nursing governance; **IV-** independent variable; **LOE-** level of evidence; **LT-** limitations; **MRC-**medical research council; **NCVR** – no confirmation of validity and reliability; **NDNQI-**national database of nursing quality indicators; **NH-**national health; **N-**number of studies; **n-** number of participants; **NI-**nursing informatics; **NM-**nurse manager; **PPM-**professional practice model; **PT-**part time; **RN-**registered nurse **SN-**staff nurse; **SG-** shared governance; **SRDH-**St. Rose Dominican Hospitals; **ST-** strengths; **SW-**southwest; **WK-**weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
Gerard, et al (2016) Nurses' Perception of Shared Decision-Making Processes. Quantifying a Shared Governance Culture Country: USA Funding: None listed Conflict/Bias: None reported or appreciated	Kanter's theory of power in organizations	Design: Quantitative Method: Decisional Involvement Scale Survey Purpose: The purposes of this study are to (1) report a model to identify specific areas of SG contributing to a gap in perceived versus desired decision making (dissonance) and (2) investigate if there is a correlation between involvement in SG councils and dissonance among clinical nurses	N=776 RNs n=266 returned n=162 valid surveys Setting -476-bed community medical Inclusion Criteria: Has had an SG culture for 10 years. Sample characteristics- Years in nursing, years in organization, work status, participation in clinical advancement program, area of clinical work, actual unit, academic degree, participation in council within last 5 years and the number of councils involved in.	IV-RNs DV1-status (FT/PT) DV2=clinical advancement DV3-Degree DV4-council participation >5 years	Decisional Involvement Scale Survey (CVR) regarding desired and perceived decision making on 21 topics related to nursing practice	Independent <i>t</i> tests	DV1- FT:P=.044 PT: P=.008 DV2: Yes: P=.920 No: P=.896 DV3: AD: P=.788 BSN: P=.754 MSN: P=.599 DV4: Yes: P=.028	LOE: III ST: Large sample size; used decisional involvement survey LT: Convenience sample of one medical center Feasibility: Utilization of a valid and reliable tool can be used by NL to give insights into the perception of SG to enhance structure

ANCC- American Nurses Credentialing Center; **CI-**clinical informatics; **CIHR-**Canadian Institutes of Health Research; **CCEO-**chief clinical officer; **CE** – care environment; **CIO-**chief information officer; **CNIO-**chief nursing information officer; **CNO-**chief nursing officer; **CRP-** complexity response process; **CVR-** confirmed validity and reliability; **DI-**decisional involvement; **DONI-**director of nursing informatics; **DV-**dependent variable; **EC** – electronic charting; **EMR-** electronic medical record; **FT-** full time; **HL-** healthcare leaders; **HIT-**health information technology; **IHS-**integrated health system; **IPNG-**Index of professional nursing governance; **IV-** independent variable; **LOE-** level of evidence; **LT-** limitations; **MRC-**medical research council; **NCVR** – no confirmation of validity and reliability; **NDNQI-**national database of nursing quality indicators; **NH-**national health; **N-**number of studies; **n-** number of participants; **NI-**nursing informatics; **NM-**nurse manager; **PPM-**professional practice model; **PT-**part time; **RN-**registered nurse **SN-**staff nurse; **SG-** shared governance; **SRDH-**St. Rose Dominican Hospitals; **ST-** strengths; **SW-**southwest; **WK-**weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
Halbesleben, J. et al (2013). Measuring Nursing Workarounds: Tests of the Reliability and Validity of a Tool. Country: USA Funding: None listed Conflict/Bias: None reported or appreciated	The technology acceptance model	Design: Quantitative Method: Survey Purpose: The objective of this research was to address the need for better measures of workarounds by developing a literature-based measurement tool and measuring the validity and reliability of the tool	N=14065 RNs n=416 women Mean age: 43.9 years Worked for a facility an average of 9.32 years Worked an average of 35.7hours/week Inclusion criteria: RN direct patient care Exclusion criteria: Retired RN Not currently employed as an RN	IV: Validate workaround tool DV1: Scale of workplace deviance DV2: Measure of job crafting	Validity of workaround tool was determined by conducting a survey of RNs that included the newly developed tool of workarounds, and measure of deviance and job crafting	Content validity- relevant survey (CVR) Factorial validity: Multitrait, multimethod framework Discriminant validity: comparing scores with those on the job crafting and deviance scales	DV1 Correlation between job crafting and workarounds were positive but not significant ($r = 0.045$) DV2 Correlation between workarounds and deviance was significant and negative ($r = -0.10$, $P < .05$)	LOE: III ST: Large sample size; used 3 surveys to analyze data LT: RN sample not representative of all nursing staff, response rates small Feasibility: Good, this tool will provide NL with a valid option of capturing workarounds in their organizations, which then can be used to design and evaluate patient safety interventions

ANCC- American Nurses Credentialing Center; **CI-**clinical informatics; **CIHR-**Canadian Institutes of Health Research; **CCLO-**chief clinical officer; **CE** – care environment; **CIO-**chief information officer; **CNIO-**chief nursing information officer; **CNO-**chief nursing officer; **CRP-** complexity response process; **CVR-** confirmed validity and reliability; **DI-**decisional involvement; **DONI-**director of nursing informatics; **DV-**dependent variable; **EC** – electronic charting; **EMR-** electronic medical record; **FT-** full time; **HL-** healthcare leaders; **HIT-**health information technology; **IHS-**integrated health system; **IPNG-**Index of professional nursing governance; **IV-** independent variable; **LOE-** level of evidence; **LT-** limitations; **MRC-**medical research council; **NCVR** – no confirmation of validity and reliability; **NDNQI-**national database of nursing quality indicators; **NH-**national health; **N-**number of studies; **n-** number of participants; **NI-**nursing informatics; **NM-**nurse manager; **PPM-**professional practice model; **PT-**part time; **RN-**registered nurse **SN-**staff nurse; **SG-** shared governance; **SRDH-**St. Rose Dominican Hospitals; **ST-** strengths; **SW-**southwest; **WK-**weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
<p>Lalley, C. (2014)</p> <p>A Narrative Study of Nurses' Interactions When Using Health Information Technology</p> <p>Country: USA</p> <p>Funding: None listed</p> <p>Conflict/Bias: None reported or appreciated</p>	<p>Complexity Science and complexity responsive process (CRP)</p>	<p>Design: Qualitative narrative</p> <p>Method: Direct observation and in person interviews</p> <p>Purpose: This study aims to better understand and describe nurses' use of HIT and ways they work around HIT obstacles.</p>	<p>Site: 92 bed acute care hospital in SW that received Magnet designation and had a commercial EMR in place</p> <p>Setting: 28 bed medical/surgical/telemetry unit</p> <p>Sample: n = 9 RNs n=4 support staff (clinical manager, pharmacist, quality RN & project manager)</p> <p>Attrition: 0</p>	<p>DV=HIT IV1=RN's IV2=support staff</p>	<p>Direct observation, in person individual interviews that were transcribed and stored in a word document</p>	<p>Mindmap, Dedoose qualitative software, CRP methodology</p>	<p>4 themes:</p> <ol style="list-style-type: none"> 1. Innovation emerged from HIT obstacles 2. SN interact with co-workers when they encounter HIT obstacles to find ways to continue patient care activities 3. SN interactions with patients and co-workers are influenced by ideology 4. SN interactions with patients and co-workers are influenced by power relations 	<p>LOE: IV</p> <p>ST: recommendations for SN and HL and future research can help improve HIT implementation for safety and quality outcomes for patients</p> <p>LT: results limited to interactions and experiences of those observed and interviewed in the study</p> <p>Feasibility: Information provided in the study can be used to improve quality outcomes for patients</p>

ANCC- American Nurses Credentialing Center; CI-clinical informatics; CIHR-Canadian Institutes of Health Research; CCLO-chief clinical officer; CE – care environment; CIO-chief information officer; CNIO-chief nursing information officer; CNO-chief nursing officer; CRP- complexity response process; CVR-confirmed validity and reliability; DI-decisional involvement; DONI-director of nursing informatics; DV-dependent variable; EC – electronic charting; EMR-electronic medical record; FT- full time; HL- healthcare leaders; HIT-health information technology; IHS-integrated health system; IPNG-Index of professional nursing governance; IV- independent variable; LOE- level of evidence; LT- limitations; MRC-medical research council; NCVR – no confirmation of validity and reliability; NDNQI-national database of nursing quality indicators; NH-national health; N-number of studies; n- number of participants; NI-nursing informatics; NM-nurse manager; PPM-professional practice model; PT-part time; RN-registered nurse SN-staff nurse; SG- shared governance; SRDH-St. Rose Dominican Hospitals; ST- strengths; SW-southwest; WK-weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
<p>Ott, J., & Ross, B., (2014). The journey toward shared governance: the lived experience of nurse manager and staff nurses</p> <p>Country: USA</p> <p>Funding: None listed</p> <p>Conflict/Bias: None reported or appreciated</p>	Caring Theory	<p>Design: Qualitative</p> <p>Method: In person interviews</p> <p>Purpose: To explore 3 aims for NM and SN: (1) to describe experience since the implementation of shared governance, (2) to describe perception of their roles and (3) to examine the effect that the shared governance model has on the delivery of patient care</p>	<p>N=11 RN n= 5 NM n= 6 SN</p> <p>Setting: Community Hospital</p> <p>Inclusion Criteria:</p> <ol style="list-style-type: none"> 1. Location practiced SG 2. NM employed at the hospital for at least 1 year prior to implementation of SG 3. Site willing to participate 	<p>IV = SG DV1 = NM DV2 = SN</p>	<p>In person individual interviews (60-90 min) that were audio taped</p> <p>Themes were coded to category and validity and assed and checked for consistency in coding and category with the qualitative researcher</p>	Thematic analysis	<p>4 themes emerged from NM: (1) patient satisfaction (2) empowerment (3) self-management (4) wellness</p> <p>4 themes emerged from SN: (1) development and implementati on of best practice (2) provide quality patient care (3) the work of nursing (4) variety of challenges</p>	<p>LOE: IV</p> <p>ST: study supports when NM partner with SN they can develop an environment of empowering SG</p> <p>LT: small sample size and participating units were in differing stages of SG</p> <p>Feasibility: positive implications for NM and SN to create an empowered staff, better patient outcomes, and increased nurse satisfaction</p>

ANCC- American Nurses Credentialing Center; CI-clinical informatics; CIHR-Canadian Institutes of Health Research; CCLO-chief clinical officer; CE – care environment; CIO-chief information officer; CNIO-chief nursing information officer; CNO-chief nursing officer; CRP- complexity response process; CVR- confirmed validity and reliability; DI-decisional involvement; DONI-director of nursing informatics; DV-dependent variable; EC – electronic charting; EMR- electronic medical record; FT- full time; HL- healthcare leaders; HIT-health information technology; IHS-integrated health system; IPNG-Index of professional nursing governance; IV- independent variable; LOE- level of evidence; LT- limitations; MRC-medical research council; NCVR – no confirmation of validity and reliability; NDNQI-national database of nursing quality indicators; NH-national health; N-number of studies; n- number of participants; NI-nursing informatics; NM-nurse manager; PPM-professional practice model; PT-part time; RN-registered nurse SN-staff nurse; SG- shared governance; SRDH-St. Rose Dominican Hospitals; ST- strengths; SW-southwest; WK-weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
<p>Schaffer, D. (2015)</p> <p>The relationship between nursing workaround performance and elements in the acute care practice environment</p> <p>Country: USA</p> <p>Funding: None listed</p> <p>Conflict/Bias: None reported or appreciated</p>	<p>Donabedian’s Structure Process Outcome Theory and Orlando’s Nursing Process Discipline Theory</p>	<p>Design: Predictive, Correlational Research</p> <p>Method: Survey</p> <p>Purpose: To explore the relationships among workarounds, the practice environment and factors that affect the acute care practice environment</p>	<p>N=345 RNs n = 234 met criteria</p> <p>Inclusion Criteria: RNs practicing at the bedside in an acute care setting that were FT, PT or per diem</p> <p>Exclusion Criteria: RNs who did not provide direct patient care</p>	<p>IV: RNs</p> <p>DV1: Workarounds</p> <p>DV2: Factors that affect practice environment</p>	<p>Workaround Instrument Practice Environment Scale of Nursing Workaround Index (CVR)</p>	<p>Descriptive, correlational, and regression statistics</p>	<p>There is a significant inverse relationship between workarounds and acute care practice environments. Staffing and resource adequacy was the best predictor of workarounds</p>	<p>LOE: IV</p> <p>ST: large sample size; used descriptive, correlational and regression for analysis</p> <p>LT: participation was voluntary, Workaround index tool</p> <p>Feasibility: NIs need to understand the acute care practice environment and the use of workarounds to implement interventions to increase patient safety and RN satisfaction</p>

ANCC- American Nurses Credentialing Center; **CI-**clinical informatics; **CIHR-**Canadian Institutes of Health Research; **CCLO-**chief clinical officer; **CE** – care environment; **CIO-**chief information officer; **CNIO-**chief nursing information officer; **CNO-**chief nursing officer; **CRP-** complexity response process; **CVR-** confirmed validity and reliability; **DI-**decisional involvement; **DONI-**director of nursing informatics; **DV-**dependent variable; **EC** – electronic charting; **EMR-** electronic medical record; **FT-** full time; **HL-** healthcare leaders; **HIT-**health information technology; **IHS-**integrated health system; **IPNG-**Index of professional nursing governance; **IV-** independent variable; **LOE-** level of evidence; **LT-** limitations; **MRC-**medical research council; **NCVR** – no confirmation of validity and reliability; **NDNQI-**national database of nursing quality indicators; **NH-**national health; **N-**number of studies; **n-** number of participants; **NI-**nursing informatics; **NM-**nurse manager; **PPM-**professional practice model; **PT-**part time; **RN-**registered nurse **SN-**staff nurse; **SG-** shared governance; **SRDH-**St. Rose Dominican Hospitals; **ST-** strengths; **SW-**southwest; **WK-**weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
Wilson, E. (2013) Evaluating shared governance for nursing excellence Country: USA Funding: None listed Conflict/Bias: None reported or appreciated	Rosabeth Kanter’s theory of power in organizations The ANCC Magnet Model© was used as a conceptual model	Design: Qualitative Descriptive Study Method: IPNG survey Purpose: To further evaluate the state of SG at the SRDHs and make recommendations based on those finds to engage staff and revitalize SG with the organizations	Sample: N=1418 RNs n = 342 returned surveys (24% response rate) n=207 usable surveys due to incomplete surveys and outliers in the data Demographics of RNs: full time, part time and per diem Mean number of years in position 5.27 years Setting: SRDH – 3 campuses, nursing unionized Tool: IPNG survey Time: Oct 2012- Nov 2012	DV: SG IV: RNs	IPNG survey (CVR)	Descriptive statistics	Overall governance scale at each of the 3 campuses scored below the minimum score of 173- which places the organization in a state of traditional governance, where decisions are primarily made by management	LOE: IV ST: Large sample size; used descriptive statistics for analysis LT: low response rate and not representative of all nurses across the organization, Feasibility: Findings from this study will assist NL to develop strategies to advance nursing professionals in improving structures and processes to support SG

ANCC- American Nurses Credentialing Center; **CI-**clinical informatics; **CIHR-**Canadian Institutes of Health Research; **CCLO-**chief clinical officer; **CE** – care environment; **CIO-**chief information officer; **CNIO-**chief nursing information officer; **CNO-**chief nursing officer; **CRP-** complexity response process; **CVR-** confirmed validity and reliability; **DI-**decisional involvement; **DONI-**director of nursing informatics; **DV-**dependent variable; **EC** – electronic charting; **EMR-** electronic medical record; **FT-** full time; **HL-** healthcare leaders; **HIT-**health information technology; **IHS-**integrated health system; **IPNG-**Index of professional nursing governance; **IV-** independent variable; **LOE-** level of evidence; **LT-** limitations; **MRC-**medical research council; **NCVR** – no confirmation of validity and reliability; **NDNQI-**national database of nursing quality indicators; **NH-**national health; **N-**number of studies; **n-** number of participants; **NI-**nursing informatics; **NM-**nurse manager; **PPM-**professional practice model; **PT-**part time; **RN-**registered nurse **SN-**staff nurse; **SG-** shared governance; **SRDH-**St. Rose Dominican Hospitals; **ST-** strengths; **SW-**southwest; **WK-**weaknesses

Citation	Conceptual Framework	Design/ Method/	Sample/Setting	Major Variables &Definitions	Measurement	Analysis	Findings	Decision for use
<p>Wong, C., & Laschinger, H. (2013)</p> <p>Authentic leadership, performance, and job satisfaction: the mediating role of empowerment</p> <p>Country: United Kingdom</p> <p>Funding: The University of Western Ontario, Academic Development Fund New Research and Scholarly Initiative Awards competition, Spring 2008</p> <p>Conflict/Bias: None reported or appreciated</p>	<p>Authentic leadership theory</p>	<p>Design: A non-experimental, predictive survey</p> <p>Method: Questionnaire/survey</p> <p>Purpose: The purpose of this study was to test a model linking authentic leadership of managers with acute care nurses' perceptions of SG, performance, and RN job satisfaction</p>	<p>Sample: N=600 RNs n = 280 final surveys (48% response rate)</p> <p>Setting: Ontario, Canada</p> <p>Demographics: RNs working in an acute care setting</p> <p>Exclusion Criteria: RNs in a manager, charger or educator position</p> <p>Time: Over 4 months</p>	<p>IV: Authentic Leadership Questionnaire</p> <p>DV1: Performance</p> <p>DV2: Structural empowerment</p> <p>DV3: Job satisfaction</p>	<p>Authentic Leadership Questionnaire (CVR) used to measure nurses' perception of manager authentic leadership</p> <p>Structural empowerment-measured using The Conditions of Work Effectiveness Questionnaire II (CVR)</p> <p>Job satisfaction-The 6-item Global Job Satisfaction Survey (CVR)</p> <p>Performance - An 8-item General Performance scale(NCVR)</p>	<p>Descriptive statistics, reliability estimates, and Pearson correlations were computed for all study variables using the Statistical Program for Social Sciences</p>	<p>DV1: $\beta=0.17, P <0.01$</p> <p>DV2: $\beta=0.46, P <0.01$</p> <p>DV3: $\beta=0.41, P <0.01$</p>	<p>LOE: IV</p> <p>ST: Large sample size; used 3 valid and reliable surveys</p> <p>LT: Design used limits interpretations of causality to the evidence of co-variation in the study variables</p> <p>d Feasibility: NL who emphasize transparency, also effectively increase nurses' perceptions of workplace empowerment, which in turn enhances their performance and job satisfaction</p>

ANCC- American Nurses Credentialing Center; CI-clinical informatics; CIHR-Canadian Institutes of Health Research; CCLO-chief clinical officer; CE – care environment; CIO-chief information officer; CNIO-chief nursing information officer; CNO-chief nursing officer; CRP- complexity response process; CVR-confirmed validity and reliability; DI-decisional involvement; DONI-director of nursing informatics; DV-dependent variable; EC – electronic charting; EMR-electronic medical record; FT- full time; HL- healthcare leaders; HIT-health information technology; IHS-integrated health system; IPNG-Index of professional nursing governance; IV- independent variable; LOE- level of evidence; LT- limitations; MRC-medical research council; NCVR – no confirmation of validity and reliability; NDNQI-national database of nursing quality indicators; NH-national health; N-number of studies; n- number of participants; NI-nursing informatics; NM-nurse manager; PPM-professional practice model; PT-part time; RN-registered nurse SN-staff nurse; SG- shared governance; SRDH-St. Rose Dominican Hospitals; ST- strengths; SW-southwest; WK-weaknesses

IT NURSING GOVERNANCE

Appendix G

Table 2

Synthesis Table

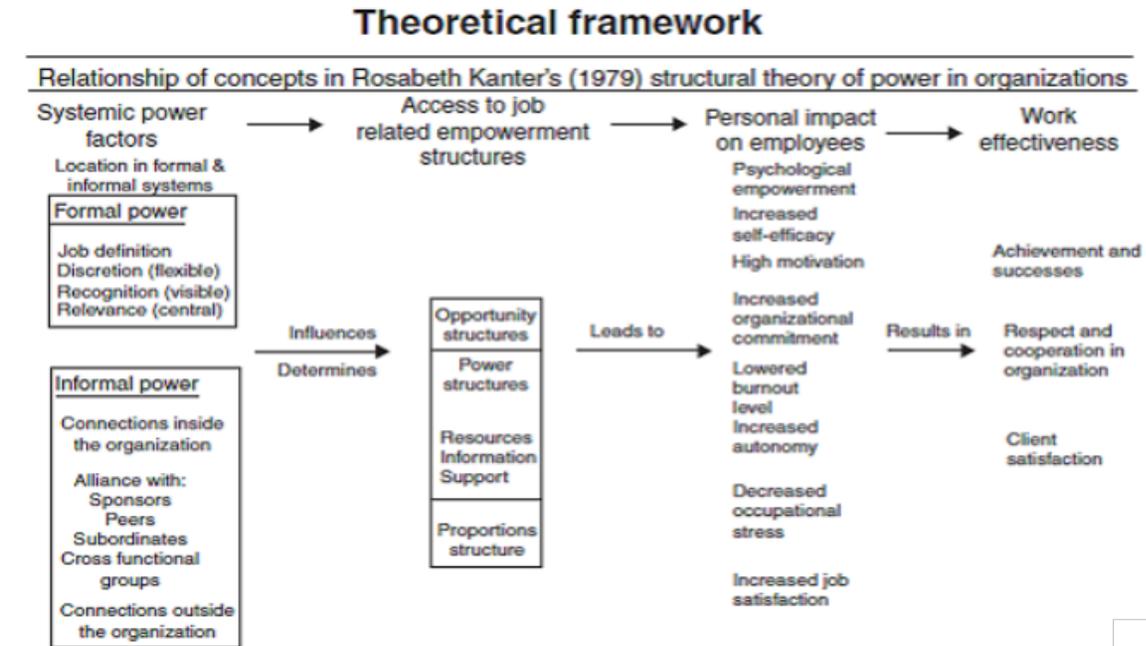
Author										
	Cohen	Collins	Enuenwosu-Aki	Gerad	Halbeslenben	Lalley	Ott	Schaffer	Wilson	Wong
Study Characteristics										
Year	2015	2015	2015	2016	2013	2014	2014	2015	2013	2013
Design										
Qual	X	X	X			X	X	X	X	X
Quant				X	X					
LOE	IV	IV	IV	III	III	IV	IV	IV	IV	IV
Setting:										
Acute Care Hospitals	X	X	X	X	X	X	X	X	X	X
Population Demographics										
Sample:										
N	84 S	12 NL	20RNs	162 S	416RNs	9RNs	11RNs	234RNs	207RNs	280RNs
Variables										
SG										
Nurse satisfaction	↑	↑		↑			↑		↑	↑
Evolving	X	X		X			X		X	X
HIT										
RN desire involvement			X		X	X		X		
Workarounds			X		X	X		X		
Emerging Themes / Outcomes										
Themes										
RNs desire for involvement in HIT		X	X		X	X		X		
HIT added challenges-WKA		X	X		X	X		X		
SG evolving process	X			X			X		X	X
Outcomes										
SG = RN satisfaction/empowerment/development of best practice	↑			↑			↑		↑	↑

Key: HIT-health information technology, N- sample size (people), NL-nurse leaders, RNs-registered nurses, S-studies, SG-shared governance, QualR-qualitative review, QuantR-quantitative review, WKA-workaround

Appendix H

Figure 1

Kanter's Structural Theory of Power in Organizations



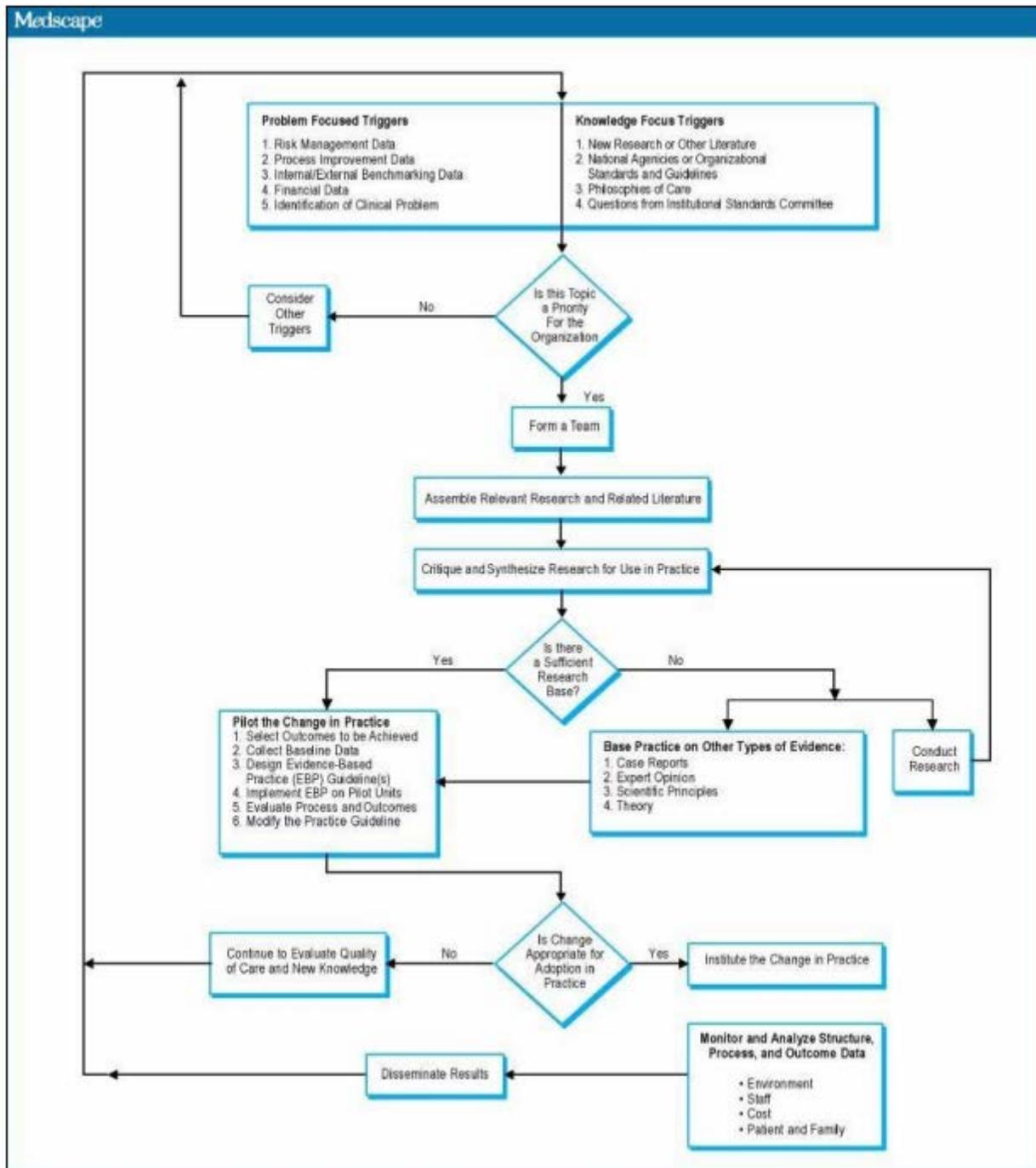
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Appendix I

Figure 2

IOWA Model of Evidence Based Practice



The Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al., 2001)

Appendix J*Organization Site Authorization Letter***YAVAPAI REGIONAL MEDICAL CENTER WEST CAMPUS**1003 WILLOW CREEK ROAD • PRESCOIT, AZ 86301-1668 • (928) 445-2700 • www.yrmc.org

August 30, 2017

Arizona State University Institutional Review
Board Office of Research Integrity and
Assurance

ASU Centerpoint

660 South Mill Avenue, Suite 312

Mail Code: 6111

Tempe, AZ 85281-6111

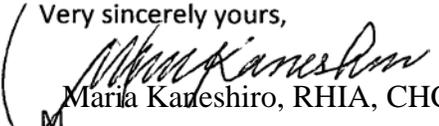
Site Permission Letter

Dear Arizona State University IRB:

On behalf of Yavapai Regional Medical Center, I am writing to grant permission for Diane Drexler, a student at Arizona State University, to conduct her research titled, "**The Impact of a Nursing Professional Governance Approach on Nurse Satisfaction in an acute care setting**". I understand that Diane will recruit up to 100 participants and distribute electronic surveys to collect data over the next four months. We are happy to participate in this study and contribute to this important research.

If you have any questions or would like additional information, please feel free to contact me at 928-771-5688.

Very sincerely yours,


Maria Kaneshiro, RHIA, CHC

Corporate Compliance & Privacy Officer

Yavapai Regional Medical Center

Appendix K

IRB Approval Letter



EXEMPTION GRANTED

Kathy Malloch
 CONHI - Administration
 602/617-1261
 Kathy.Malloch@asu.edu

Dear Kathy Malloch:

On 9/5/2017 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	The Impact of a Nursing Professional Governance Approach on Nurse Satisfaction in an acute care setting
Investigator:	Kathy Malloch
IRB ID:	STUDY00006742
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> • Professional Governance Survey, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Reminder for participation in professional governance survey.pdf, Category: Recruitment Materials; • Moving from shared governance to professional governance, Category: Other (to reflect anything not captured above); • ASU site PermissionLetter.82017.pdf, Category: Off-site authorizations (school permission, other IRB approvals, Tribal permission etc); • IRB application, Category: IRB Protocol; • IRB COVER LETTER.pdf, Category: Consent Form;

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (1) Educational settings, (2) Tests, surveys, interviews, or observation on 9/5/2017.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Diane Drexler
Diane Drexler

Appendix L

Expert Panel Validation Survey

**Professional Governance Survey
Expert Panel Validation**

Ms Drexler is a co-investigator for a study to measure professional governance characteristics at a rural community hospital in Arizona. She and her co-investigator are the only individuals who will have access to your responses. Your responses will be utilized to adjust the survey. Select the descriptor that most closely represents the item.

1. My practice includes working with my colleagues on identified issues and strategies to resolve them?

Accountability _____
Decision Making _____
Professional Obligation _____
Collateral Relationships _____
None of the above _____

2. Do your professional role/behaviors include the legal, ethical, professional involvement and involvement of the community as a whole?

Accountability _____
Decision Making _____
Professional Obligation _____
Collateral Relationships _____
None of the above _____

3. Does your practice include sharing goals and coordinating work through relationships with your peers and other disciplines?

Accountability _____
Decision Making _____
Professional Obligation _____
Collateral Relationships _____
None of the above _____

4. Does your decision making include identifying issues and using evidence to guide your solutions?

Accountability _____
Decision Making _____
Professional Obligation _____
Collateral Relationships _____
None of the above _____

- 5. My work environment inspires me to perform at my very best.
 - Accountability** _____
 - Decision Making** _____
 - Professional Obligation** _____
 - Collateral Relationships** _____
 - None of the above** _____

- 6. At work, I am able to do what I do best everyday
 - Accountability** _____
 - Decision Making** _____
 - Professional Obligation** _____
 - Collateral Relationships** _____
 - None of the above** _____

- 7. I have great relationships with others I work with
 - Accountability** _____
 - Decision Making** _____
 - Professional Obligation** _____
 - Collateral Relationships** _____
 - None of the above** _____

- 8. I look for opportunities to support other I work with
 - Accountability** _____
 - Decision Making** _____
 - Professional Obligation** _____
 - Collateral Relationships** _____
 - None of the above** _____

- 9. The people I work with treat each other with respect
 - Accountability** _____
 - Decision Making** _____
 - Professional Obligation** _____
 - Collateral Relationships** _____
 - None of the above** _____

- 10. Communication among the people that I work with at YRMC is never a problem
 - Accountability** _____
 - Decision Making** _____
 - Professional Obligation** _____
 - Collateral Relationships** _____
 - None of the above** _____

11. We flag and follow up with all “at risk” patient/residents after they leave our care.

- Accountability** _____
- Decision Making** _____
- Professional Obligation** _____
- Collateral Relationships** _____
- None of the above** _____

12. Our clinical/nursing staff communicates very well

- Accountability** _____
- Decision Making** _____
- Professional Obligation** _____
- Collateral Relationships** _____
- None of the above** _____

13. According to our policies, there is consistency among nursing staff when providing patient care.

- Accountability** _____
- Decision Making** _____
- Professional Obligation** _____
- Collateral Relationships** _____
- None of the above** _____

Thank you for evaluating the survey. Please return via e-mail to ddrexler@ymc.org by 8/20/2017.

Appendix M

Instrument: Measure Professional Practice

Professional Practice Survey

The following is a survey about professional nursing practice at Yavapai Regional Medical Center. Your participation is voluntary. Completion of the survey is your consent to participate in this study. There is no known risk involved in your participation. All survey answers will be kept completely confidential. Your answers will never be linked to your name and will never be used in a way that could identify you. The survey is anonymous, voluntary and should take no longer than 10 minutes to complete. Please circle and/or write in your responses.

Thank you for your willingness to participate in this survey.

Demographics: About You

1. What are the last 6 digits of your cell phone?

2. What level of nurse education have you had?
Advanced practice
BSN
ADN

3. How long have you been a nurse?
Less than 2 years

2 to 5 years
6 to 10 years
11 to 20 years
More than 20 years

4. What is your gender
Female
Male

5. Do you have a certification in your specialty
Yes
No

6. Do you provide direct patient care?
Yes
No

7. What is your age?

Each question has 2 parts; one is about your perceptions about professional practice and the second part of the item is about examples that support your response.

Please circle the response that most closely reflects your perceptions about your current practice environment and include at least two specific examples:

14. My practice includes working with my colleagues on identified issues and strategies to resolve them?

Strongly disagree

Disagree

Agree

Strongly Agree

Example 1:

Example 2:

15. Do your professional role/behaviors include the legal, ethical, professional involvement and involvement of the community as a whole?

Strongly disagree

Disagree

Agree

Strongly Agree

Example 1:

Example 2:

16. Does your practice include sharing goals and coordinating work through relationships with your peers and other disciplines?

Strongly disagree

Disagree

Agree

Strongly Agree

Example 1:

Example 2:

17. Does your decision making include identifying issues and using evidence to guide your solutions?

Strongly disagree

Disagree

Agree

Strongly Agree

Example 1:

Example 2:

Please circle the response that reflects your opinion of the following:

18. My work environment inspires me to perform at my very best.

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

19. At work, I am able to do what I do best everyday

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

20. I have great relationships with others I work with

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

21. I look for opportunities to support other I work with

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

22. The people I work with treat each other with respect

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

23. Communication among the people that I work with at YRMC is never a problem
- Strongly disagree
 - Disagree
 - Neither agree nor disagree
 - Agree
 - Strongly Agree
24. We flag and follow up with all “at risk” patient/residents after they leave our care.
- Never
 - Sometimes
 - Usually
 - Always
 - Does not apply
25. Our clinical/nursing staff communicates very well
- Never
 - Sometimes
 - Usually
 - Always
 - Does not apply
26. According to our policies, there is consistency among nursing staff when providing patient care.
- Never
 - Sometimes
 - Usually
 - Always
 - Does not apply

Appendix N

Statistical Analysis

Pre-group Descriptives Domains

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Prof Gov Domain TS	86	4.00	16.00	12.9186	2.56774
Wk Envir Domain TS	85	7.00	16.00	13.3647	1.99313
Pat Cent Domain TS	86	7.00	17.00	12.6512	2.29458
Valid N (listwise)	85				

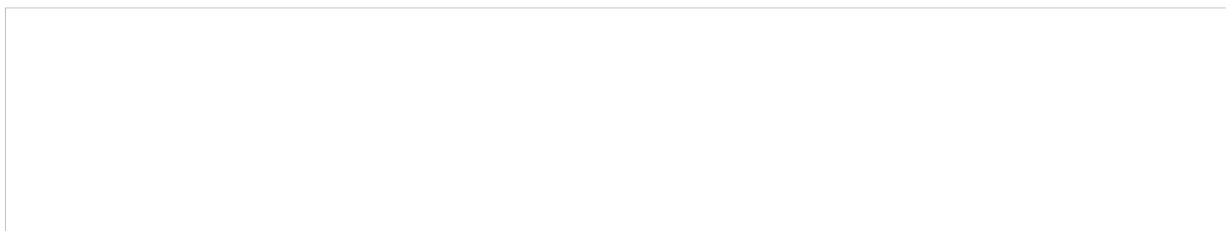


Descriptives Pre-group outcome variable

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Professional Governance Total Score	86	22.00	48.00	39.0000	5.30704
Valid N (listwise)	86				

Post group Descriptives Domains

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Prof Gov Domain TS	34	4.00	16.00	13.1176	2.53179
Wk Envir Domain TS	34	8.00	16.00	13.0882	1.95971
Pat Cent Domain TS	34	8.00	12.00	10.8235	.86936
Valid N (listwise)	34				



Post Group Descriptives outcome variable



Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Professional Governance Total Score	34	27.00	43.00	37.0294	4.10827
Valid N (listwise)	34				

Group Statistics

	Group	N	Mean	Std. Deviation	Std. Error Mean
Professional Governance Total Score	PRE GROUP	86	39.0000	5.30704	.57227
	POST GROUP	34	37.0294	4.10827	.70456

Independent Samples Test

		Levene's Test for Equality of Variances			t-test for Equality of Means			
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Professional Governance Total Score	Equal variances assumed	2.017	.158	1.945	118	.054	1.97059	1.01308
	Equal variances not assumed			2.171	77.765	.033	1.97059	.90769

Appendix O

Education on Professional Role Behaviors



Moving From Shared
to Professional Gover