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Nursing Managers' Perceptions, Knowledge and Commitment to Shared Governance

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Disclaimer

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Executive Summary

Nursing Managers' Perceptions, Knowledge and Commitment to Shared Governance

Problem

An important element of professional nursing practice is shared governance. Shared governance refers to a structure allowing the voice of the nurse to be heard. Shared decision-making is the process of making decisions and shared leadership is the intended outcome from this structure and process (Porter O'Grady, nd). The PICO (population, intervention, comparison, outcome) question guiding this capstone project is will a shared governance manager development training program increase the perceptions, knowledge and commitment to shared governance among a group of nurse managers, at one large pediatric hospital setting?

Purpose

The purpose of this capstone project was to assess whether a shared governance management development training program, would increase the perceptions, knowledge and commitment of nurse managers to shared governance in one large pediatric hospital.

Goals

The overall goal for the capstone project was to strengthen nursing managers' ability to create and sustain shared governance on their unit.

Objectives

The objectives for this project included: 1) Develop a shared governance management development training program by January 31, 2014; 2) Conduct three educational sessions for the nurse managers on shared governance with participants completing a pre-test/post-test SGNMS in spring 2014; 3) Analyze the Shared Governance Nursing Manager Survey (SGNMS) pre-test/post-test results and course evaluations to make recommendations for future manager development training by June 2014.

Plan

Utilizing an evidence-based practice project approach, a management development training program on shared governance will be created. Eligible participants are all nurse managers in one large pediatric hospital setting. Perceptions, knowledge and commitment to shared governance will be measured before and after the management training program on shared governance which consists of a series of three educational sessions over three months.

Outcomes and Results

Eleven (11) nurse managers participated in the educational sessions. All participants had greater than 11 years nursing experience, were BSN or MSN prepared and 73% were certified. Statistically significant change ($p \geq .05$) was found between the pre-test/post-test Shared Governance Nursing Manager Survey in 60.5% of questions. The three sub-scales of Perception, Knowledge and Commitment demonstrated statistical significance in two of the three questions in each domain. These results indicate statistically significant change in the perceptions, knowledge and commitment of the nurse managers to shared governance. The manager development training program was beneficial to the group of nurse managers.

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Capstone Project

Nursing Managers' Perceptions, Knowledge and Commitment to Shared Governance

Shared governance is a model of professional nursing practice that engages nurses in decisions that affect their practice (Anderson, 2011). The principles of shared governance, originally proposed by Dr. Tim Porter O'Grady are partnership, equity, accountability and ownership (Porter O'Grady, 2001; Ballard, 2010; Barden, Griffin, Donahue & Fitzpatrick, 2011). Partnership is critical in fostering relationships for nurses and the inter-professional team. Equity implies that each team member is important to the quality patient care. Accountability is the core of shared governance and requires nurses to make the investment in decision-making. Ownership is accepting the professional work, where the work is done and by whom (Hess & Swihart, 2013).

For nursing shared governance to be successful in a health care setting, the nurses need to be engaged in decisional involvement. Kowalik and Yoder (2010) defined decisional involvement as "relating or affecting a judgment or conclusion" and "the pattern of distribution of authority for decisions and activities that govern nursing practice policy and the practice environment (p. 260). The six descriptors of decisional involvement are: distribution of authority, autonomy, empowerment, collaboration, responsibility and accountability (Kowalik & Yoder, p. 260). The original four concepts of shared governance (partnership, equity, accountability, ownership) provided by Porter O'Grady are included in this model of decisional involvement (Porter O'Grady, 2001). Kowalik and Yoder also describe the antecedents to decisional involvement. These antecedents are elements that must exist to produce the expected result. The antecedents include 1) the structure of a shared governance council or committee, 2) the nurse choosing to be involved in decision-making and 3) staff nurse control over practice.

Organizations create the councils and committees to encourage staff nurse participation, but the nurse must choose to engage and take accountability for their participation.

The result of engaging nurses in decisions is not only a shared responsibility for decisions, but can also be described as shared leadership (Watters, 2009). Shared leadership is a concept of management and staff sharing in the responsibility of decision-making. Additionally, benefits of shared governance include improved nurse satisfaction, recruitment and retention as well as decreased nurse absenteeism and turnover (Kowalik & Yoder, 2010).

Successful shared governance takes time and attention to nurture. Shared governance is a journey or a process, and not a project with a clear end date. There is not a "one size fits all" model as each nursing unit and department must find what structure and process works best. The cornerstones of successful shared governance are leadership support, role delineation, decision-making processes, a clear vision, communication methods, education and time to participate (Ballard, 2010). Golanowski, Beaudry, Kurz, Laffey and Hook (2007) described two key elements necessary for shared governance to succeed; 1) decisions need to occur at the point of care and 2) structure the organization from the point of care outward so that all systems and processes support the patient care. Breakdown of shared governance can occur if any of the following occur: poor understanding of purpose and roles, follow-through or communication or lack of support, education or resources (Ballard). Nurse managers' have a critical role in the success or breakdown of shared governance.

This doctorate of nursing (DNP) capstone project defines the problem identified at a large pediatric hospital setting of nurse manager perceptions, knowledge and commitment to shared governance.

Problem Recognition and Definition

Statement of Purpose

The purpose of this capstone project was to assess whether a management development training program, an educational intervention on the topic of shared governance, increases the perceptions, knowledge and commitment of nurse managers in one large pediatric hospital.

Problem Statement

An important element of professional nursing practice is shared governance. Shared governance refers to a structure allowing the voice of the nurse to be heard. Shared decision-making is the process of making decisions and shared leadership is the intended outcome from this structure and process (Porter O'Grady, nd). Four types of models for shared governance exist and include unit-based governance, councilor governance (hospital-wide), administrative governance (executive leaders) and congressional governance (all nursing staff) (Overcash, Petty & Brown, 2012). The unit-based governance and councilor models are the most common types (Overcash et al.). Committees and councils have established authority over certain topics and meet on a regular basis for discussion and decisions. Charter documents are common to outline the purpose, function and roles within a committee or council (Haag-Heitman & George, 2010).

The large pediatric hospital in this project does currently have shared governance, but there is variation across units in how governance is actualized. Zaccagnini and White (2011) state that identifying a problem is done through both a needs assessment and literature review. A prior needs assessment done by nursing directors at the hospital revealed an opportunity to improve nurse satisfaction related to their participation in decisions. Data from the 2011, 2012 and 2013 nurse satisfaction survey through the National Database for Nursing Quality Indicators

(NDNQI, 2013) identified that not all departments were outperforming the national pediatric mean benchmark for the question, *Nursing Participation in Hospital Affairs*. This question is a composite of several questions related to communication, decision-making and support of nursing leaders. Anecdotal data from staff nurses also supported the need for this project. Staff shared their frustration in not being allowed to participate in decisions affecting their clinical practice or unit operations. Nursing directors and executives were concerned about whether the nurse managers had the knowledge and skill to advance shared governance in their units.

PICO Question

In order to understand this capstone project, it is necessary to have a clear understanding of the problem. The format utilized in this project is PICO. PICO is comprised of the P, population; I, intervention; C, comparison; and O, outcome. The PICO for this capstone project is:

P: Nurse managers at one large pediatric hospital

I: Shared governance management development training program

C: No current shared governance management development training program

O: Increased perceptions, knowledge and commitment to shared governance as measured by the Shared Governance Nursing Manager Survey (SGNMS)

The PICO question is: Does a shared governance manager development training program increase the perceptions, knowledge and commitment to shared governance among a group of nurse managers, at one large pediatric hospital setting?

Project Rationale, Significance and Scope

An assessment was completed that was comprised of both an analysis of the NDNQI satisfaction data and anecdotal conversations with nursing staff and existing shared governance councils. This assessment revealed an opportunity to improve existing shared governance structures. The vision for shared governance at this pediatric hospital is to have fully engaged nurses, at all levels, making decisions appropriate to their role and expertise. Management knowledge and support of shared governance appeared to vary by department and through anecdotal data collection from nursing staff. Structures and processes for shared governance varied by unit, creating confusion in the flow of communication and decisions. Staff shared examples of the unit council wanting to make decisions, and the manager not allowing that level of authority for the council. Staff and managers expressed concern about what the purpose of shared governance is and what decisions are "allowed" at the unit level.

The project had significance for this organization as it assists in achieving the vision for the division of nursing related to staff engagement in decision-making. Governance is also a foundational element of the Professional Practice Model (PPM), along with values, professional relationships, care delivery system and compensation and rewards (Hoffart & Woods, 1996). The PPM guides the professional practice of nursing and facilitates the culture that is present in the division of nursing. Shared governance is a core element in the Magnet® Program through the American Nurses Credentialing Center (ANCC) (ANCC, 2013). This large pediatric hospital is a Magnet organization and plans to re-designate in 2015.

The scope of the project was limited to one organization and the nurse managers in the division of nursing and patient care services. The organization has nearly 2,000 registered nurses

and approximately seventy nursing units and clinics. The nurse managers report directly to the nursing director and the front-line supervisors, called clinical coordinators, report to the manager. The nurse managers have responsibility for the operations of their unit/clinic, including personnel, finances and patient care. The scope varies depending on the size of the unit or clinic. Each inpatient unit has one nurse manager, but several clinics may be pooled under one nurse manager. The inpatient clinical coordinators have a set of direct reports, but act as the charge nurse for the majority of their shifts. The clinical coordinators are given twelve to twenty-four hours per pay period for non-clinical time. Smaller units or clinics may not have clinical coordinators and in this instance, the nurse manager has all the direct reports. The nurse managers supervise the clinical coordinators and have their own direct reports. Figure 1 is a sample organizational chart for an inpatient medical or surgical unit.

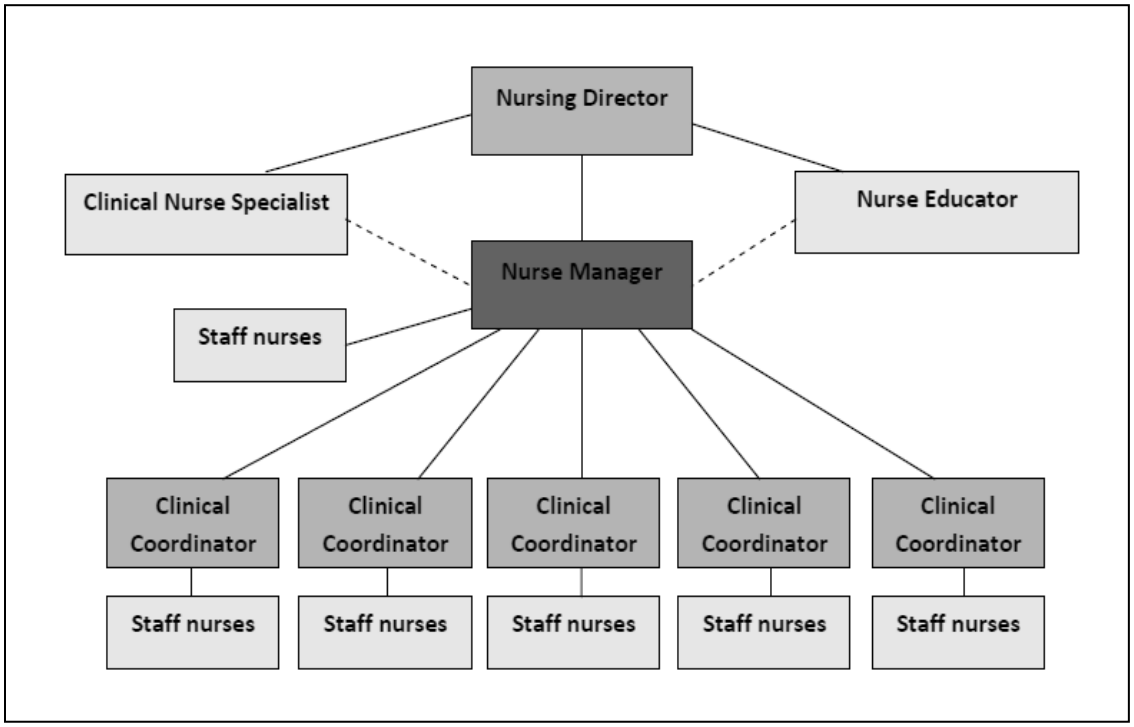

Figure 1. Sample Organizational Chart, Rundquist, 2013

Theoretical Foundation

The use of theory as a foundation for the DNP project fulfills Essential I of the Essentials of Doctoral Education for Advanced Practice Nursing – Scientific Underpinnings (Zaccagnini & White, 2011). The theoretical framework supports the DNP student in conceptualizing the project (Zaccagnini & White). For this capstone project, two theories support the project framework; Kanter's Work Empowerment Theory and Knowles Adult Learning Theory.

Kanter's Work Empowerment Theory. Rosabeth Kanter's work empowerment theory has two components: 1) the structure of opportunity and 2) the structure of power (Kanter, 1977; Laschinger, Gilbert, Smith and Leslie, 2010). The structure of opportunity describes the chance to advance and grow professionally by advancing skills and knowledge. The structure of power relates to access to information, support and resources (Laschinger et al.). Kanter's Theory describes the manager as providing these "power tools" to the staff (Laschinger et al., p. 5).

The structure of opportunity may be high or low depending on the work environment. Laschinger et al. (2010) describe high opportunity organizations as having staff actively participating in problem-solving, change management and innovation. Laschinger et al. describes low opportunity organizations with staff who are resistant to change, cautious and less committed to the organization. The opportunity for growth and development is important to ensure the patient needs are met, as well as the nurse growing professionally. The structure of power in an organization has lines of information, support and resources. Information is a broad term to describe the knowledge staff need to carry out their jobs, including equipment and technology as well as organizational goals. Lines of support include supportive management, who provide feedback, guidance and allow autonomy (Nedd, 2006). Lines of resources are the

organization's ability to provide the supplies, equipment, personnel and financial resources to perform the professional responsibilities (Nedd).

Kanter's theory also describes two types of power: formal and informal. Formal power arises from roles that "allow flexibility, visibility and creativity" (Nedd, 2006, p. 14) and "discretion in decision-making" (Laschinger et al., 2010, p. 6). Informal power is created through networking and relationships with coworkers, supervisors and other team members in the organization (Nedd; Laschinger et al.).

The importance of Kanter's theory as it relates to shared governance is that staff that do not have access to information, support or resources, do not feel empowered. This lack of empowerment can lead to disengagement and dissatisfaction. Nursing managers benefit from empowered nursing staff through their excitement and motivation to achieve the goals of the unit and organization.

Knowles Adult Learning Theory. The adult learning theory developed by Knowles recognizes that adult learners require teaching strategies to meet their needs (Knowles, 1968; Knowles, 1973). Knowles utilized the term Andragogy to describe the teaching strategies for adult learners. There are six assumptions of Andragogy that include the learner's need to know, the learner's self-concept, the role of the learner's experience, a student's readiness to learn, the student's orientation to learning and the students' motivation to learn (Fidishun, circa 2005). The learner's need to know indicates that adult learners want to know why the learning is important and are less likely to accept it otherwise. The learner's self-concept means the adult learner has responsibility over their own learning and can become self-directed in their learning. Application of life experience to learning is the role of the learner's experience. Adults have various school, work and life experiences to apply to new learning. A student's readiness to learn is their

willingness and openness to new learning. The student's orientation to learning is describing the need for adults to apply their learning to real-life situations. Adults prefer goal-oriented learning. Both internal and external factors contribute to the student's motivation to learn. External factors include work promotions or new job opportunities and internal factors may include personal satisfaction and quality of life (Fidishun, circa 2005).

The importance of Knowles Adult Learning Theory to this capstone project is that adult learners are the focus of the educational intervention. Knowles theory guides the development of the educational intervention, the implementation of the teaching plan and the evaluation of the education.

Review of Evidence

Systematic Review of the Literature

The purpose of the literature review was to examine the research evidence on the topic of shared governance in nursing. Five databases were utilized for searching including Cochrane, CINAHL, Pub Med, Business Source Complete and Google Scholar. The inclusion criteria included years 2000 to 2013, English articles, nursing, business or healthcare settings. The exclusion criteria included academic settings and non-English articles. Academic settings were excluded as this project focused on staff nurses in health care settings. The academic setting articles focused more on governance related to curriculum changes within the academic department.

Search terms and the number of articles found included:

Key Terms	Search Results
Shared governance	3,473
Decisional-involvement	125
Staff engagement	706
Nurse satisfaction	238
Staff decision-making	517
Management style	3,650
Manager communication	2,319
Reports Used	31

The initial literature review began very broad, using the search term "shared governance". Adding the search terms of "decisional-involvement", "staff decision-making" and "nurse manager style" narrowed the volume of literature. The project director reviewed 85 articles, removing those that did not align with the project objectives, nor provide evidence for the teaching plan. The final analysis yielded 31 articles which consisted of ten descriptive, six correlational, thirteen case study reports, one qualitative and one meta-analysis.

Themes Emerged from Literature Review

Several themes emerged from the literature review. The first theme is that management style has an effect on the empowerment of staff (Hess & Swihart, 2013; Lacey, Cox, Lorfing, Teasley, Carroll & Sexton, 2007; Stuenkel, Nguyen & Cohen, 2007; Stumpf, 2001). Hess and Swihart (2013) recommend a decentralized management structure to assist in removing barriers to staff involvement in decisions. Decentralization reduces the likelihood of the traditional hierarchical management style and allows for decisions to occur outside of management. Hess

and Swihart propose that ninety percent of decisions should be owned by staff, with only ten percent owned by management. Lacey, Cox, Lorfing, Teasley, Carroll and Sexton (2007) studied the differences among Magnet® hospitals, aspiring Magnets and non-Magnet hospitals regarding organizational support, workload, satisfaction and intent to stay. The results supported the Magnet® framework of recognizing positive work environments for nurses. An interesting finding was that the mean score for manager support was the lowest score in all three types of hospitals. Lacey et al. reasoned this may be due to the workload for nurse managers. Increasing demands on the managers may prevent the manager from providing support for shared governance. Stuenkel, Nguyen and Cohen (2007) found differences among the perception of nurse manager support among nurses with different years of experience. Nurses with less than two years and 21 years or more years had higher mean scores; these findings suggest that additional manager support is desired in nurses with greater than two years experience and less than 21 years. Stuenkel et al. also found that leadership style contributes to nurses' perceptions of manager support. A nurse manager who is in an office the majority of the time and has an authoritative communication style may "undermine staff morale, increase feelings of powerlessness, emotional exhaustion and dissatisfaction" (p. 341). Stumpf reported higher nurse satisfaction in units with shared governance models, versus the traditional hierarchical management governance.

The second theme is that differences in perception exist between staff and management regarding who should make decisions (Hess, 2011; Houston, Leveille, Luquire, Fike, Ogola & Chando, 201; Mangold, Pearson, Schmitz, Scherb, Specht and Loes, 2006; Scherb, Specht, Loes & Reed, 2011). Hess (2011) synthesized multiple organizations' data using the instrument, the Index for Professional Nursing Governance (INPG). Hess found that managers consistently

reported higher scores than staff, indicating that managers believe staff has more control over decisions than the staff perceived themselves. Houston, Leveille, Luquire, Fike, Ogola and Chando (2012) found that managers have differing perceptions of how involved nurses should be in decision-making. Mangold, Pearson, Schmitz, Scherb, Specht and Loes (2006) found a significant difference in actual and preferred decisional involvement, with the nurses preferring to have more decisional involvement than they currently had. Scherb, Specht, Loes and Reed (2011) completed a study that found statistically significant differences in perceptions regarding decision-making between staff and management. Staff was interested in more involvement but managers did not believe the staff needed that same level of involvement. The staff nurse's mean rating of actual decisional involvement was lower than mean rating of preferred involvement. This study indicates that staff was interested in having more authority over decisions, particularly related to resource allocation. Resource allocation is an area managers' find difficult to share the decision-making (Scherb et al.).

The third theme is that staff can demonstrate empowerment, autonomy and accountability with shared governance (Barden, Griffin, Donahue & Fitzpatrick, 2011; Graham-Dickerson, Houser, Thomas, Casper, ErkenBrack, Wenzel & Siegrist, 2013; Kowalik & Yoder, 2010; Weston, 2008). Barden, Griffin, Donahue and Fitzpatrick (2011) reported that empowered nurses who make decisions is "a strong indicator of excellence" and that nurses perceived a connection between shared governance and empowerment (p. 213). Graham-Dickerson, Houser, Thomas, Casper, ErkenBrack, Wenzel and Siegrist (2013) found seven themes about nurse involvement in decisions: 1) collaboration, 2) increased involvement, 3) problem identification, 4) formal/informal communication, 5) accountability, 6) autonomy in decision-making, 7) empowerment. Similarly, Kowalik and Yoder (2010) found six attributes of decisional

involvement, 1) distribution of authority, 2) autonomy, 3) empowerment, 4) collaboration, 5) responsibility and 6) accountability. Weston (2008) describes a continuum of staff participation in decisions from passive to autonomous. Passive participation includes sharing information or providing input; whereas autonomous participation includes decisions about what work is done and how it is done.

The fourth theme is that staff engagement and empowerment improves nurse satisfaction (Fransson Sellgren, Ekvall, & Tomso, 2008; Houser, ErkenBrack, Handberry, Ricker and Stroup, 2012; Laschinger, Leiter, Day & Gilin, 2009; Moore & Hutchinson, 2007). Fransson Sellgren, Ekvall and Tomso (2008) studied the leadership behaviors of managers as predictors of nurse satisfaction. Fransson Sellgren et al. found lower job satisfaction among nurses with "invisible" managers versus high performing managers and "middle of the road" managers (p. 582). Houser, ErkenBrack, Handberry, Ricker and Stroup (2012) found a strong statistically significant association between both formal and informal systems for involvement and intent to stay. The higher the involvement scores, the lower the intent to leave, indicating that staff who are involved in decisions are less likely to leave the organization. Interestingly, the authors did not find a difference between formal methods of involvement, such as committees and councils, versus informal methods. Laschinger, Leiter, Day and Gilin (2009) found that a significant predictor of job satisfaction and retention was an empowering practice environment and low levels of incivility. Increased satisfaction, commitment to the organization and intent to leave the organization were all linked to higher empowerment, low incivility and low burnout. Moore and Hutchinson (2007) found that two important strategies in maintaining nurse retention are improving the work environment by increasing involvement in decision-making and encouraging nurses to stay in the profession.

The final theme found in the literature is that an empowered nursing workforce leads to improved patient outcomes (Golanowski, Beaudry, Kurz, Laffey and Hook, 2007; Houser, ErkenBrack, Handberry, Ricker & Stroup, 2012; Institute of Medicine, 2004; Kalisch, Curley & Stefanov, 2007; Profitt Newman, 2011; Stumpf, 2001). Golanowski, Beaudry, Kurz, Laffey and Hook (2007) reported a reduction in length of stay across their hospital system by 0.3 days, through engaging their system-wide shared governance teams in a discharge initiative. Houser, ErkenBrack, Handberry, Ricker and Stroup (2012) published a study that evaluated the relationship between nurse involvement in decisions and patient outcomes. The study also found lower incidence of catheter-associated blood stream infections and pressure injuries with units with high levels of perceived involvement. The Institute of Medicine (IOM) published that an empowered and engaged staff achieves quality in patient care (IOM, 2004). Kalisch, Curley and Stefanov (2007) conducted an intervention to improve nurse teamwork and engagement and found that after the intervention, the unit had a statistically significant lower patient fall rate (7.73 per 1,000 patient days to 2.99 per 1,000 patient days after the intervention; $P < .001$). Profitt Newman (2011) reported a significant reduction in patient falls with an increase in patient satisfaction following a unit-based council quality initiative. Stumpf (2001) reported patient satisfaction among unit with different types of nursing governance structures. Stumpf found higher patient satisfaction in units with shared governance versus the traditional hierarchical type of governance/management.

Gaps Identified from Literature Review

Based on the review of the literature, gaps were identified related to shared governance. A considerable gap is the lack of evidence on which organizational structures promote the highest level of nurse engagement and autonomy. Individual organizations created their own

structure and process for shared governance, but these vary among organizations (Bretschneider, Eckhardt, Glenn-West, Green-Smolenski & Richardson, 2010; Golanowski, Beaudry, Kurz, Laffey & Hook, 2007; Hess & Swihart, 2013; Hoying & Allen, 2011; Moore & Wells, 2010). Further study is needed to understand the best types of organizational structures for supporting shared decision-making between staff nurses and management.

Other gaps noted in the literature were minimal evidence on the nurse manager's role in shared governance and manager satisfaction with shared governance. The nurse manager plays a crucial role in the success of their clinical area so their participation in shared governance is important. Administration may encourage the manager to include staff participation in decisions, while the managers themselves may not be allowed to do so from their own supervisors. Cost of staff nurse turnover is evident in the literature (Buffington, Zwink, Fink, DeVine & Sanders, 2012; Stuenkel, Nguyen & Cohen, 2007) however the cost of turnover for a nurse manager is not reported as extensively. Nurse manager dissatisfaction with their work environment can contribute to turnover, which is costly to organizations.

Education to Improve Shared Governance

The review of literature supported the concept that education and training for both staff and nursing managers can improve their knowledge and support of shared governance (Ballard, 2010; Bretschneider, Eckhardt, Glenn-West, Green-Smolenski & Richardson, 2010; Duncan & Hunt, 2011; Moore & Wells, 2010; Overcash, Petty & Brown, 2012; Profitt Newman, 2011; Watters, 2009). The literature served as the basis for the teaching plan for the manager development training program. Each of the three sessions in the training program consisted of evidence found in the literature, as well as evidence internal to the organization.

The literature provided evidence on the history and purpose of shared governance and the theoretical framework. The themes found in the review of the literature were incorporated into the training program, as were the benefits of shared governance. Success factors and barriers to successful shared governance were also gleaned from the literature. Roles and responsibilities in shared governance came from the literature as well as internal documents to the pediatric hospital. Both the literature and internal evidence to the pediatric hospital provided information on types and ranges of decisions as well as decision-making techniques. Internal evidence included nurse satisfaction data, division of nursing bylaws, charters and a shared governance resource manual. Specific case studies from the pediatric hospital were also utilized to illustrate the benefits of staff engagement in the organization.

Project Plan

Market and Risk Analysis

The market and risk analysis portion of this project included an assessment of strengths, weaknesses, opportunities and threats (SWOT), identification of driving and restraining forces, assessment of needs, resources and sustainability of the project, identification of stakeholders and the project team and a cost / benefit analysis. The focus of the market and risk analysis was both the pediatric hospital setting and participant population (nurse managers) in this project. The SWOT analysis was also conducted specific to this setting and population.

Project Strengths, Weaknesses, Opportunities, Threats

A SWOT analysis was conducted to assess the internal and external environments. The SWOT analysis focused on internal strengths and weaknesses, as well as external opportunities and threats (Fortenberry, 2010). The SWOT analysis was helpful in understanding the factors

that may promote or restrain the project success. The strengths of this project included the knowledge and experience of the participants (nurse managers) as all participants had a minimum of 11 years experience as a nurse. The commitment of the organization to creating and sustaining successful shared governance was also a strength, as was the evidence-based content in the manager development training program. A weakness of this project included the self-selection process for participating in the shared governance nurse manager development training program as the nurse managers volunteered to participate. Other weaknesses included the inability to generalize the project findings outside this single large pediatric hospital setting and the relatively short timeframe for completing this project.

The opportunities identified for this project included the opportunity to reduce waste in the healthcare system. Including staff in decisions that affect their practice has the ability to reduce waste by not duplicating work, nor having to redo work if it does not fit the work flow for the staff nurses. By reducing waste, the organization can maintain good use of precious resources. Nurses leading change was another opportunity as nurses are often catalysts for change and can facilitate successful change. Reducing turnover through staff engagement was evident in the review of literature so this was identified as another opportunity for this project. The nurse manager participants also had the opportunity to participate in a training program that could improve their leadership related to shared governance. Threats to this project included changes in healthcare reform, the economy and funding sources, which may have affected the ability to provide the manager development training program. If a hospital does not receive reimbursement for care provided, or a reduction in reimbursement, it can cause a financial short-fall in the budget. Education and training opportunities may be reduced in an effort to maintain a healthy financial margin. Sustainability of this training program is another threat, due to

finances, as well as competing priorities in the organization. See Table 1 for the SWOT analysis for this capstone project.

Table 1

SWOT Analysis

Internal	**STRENGTHS**	**WEAKNESSES**
	1. Knowledge and experience of the participants 2. Commitment of organization to shared governance 3. Content of manager development training program	1. Self-selection of project participants 2. Not able to generalize outside the pediatric hospital in the project 3. Timeframe for project intervention
External	**OPPORTUNITIES**	**THREATS**
	1. Reduction of waste in healthcare 2. Good stewards of resources 3. Nurses to lead change 4. Low turnover rates 5. Strong leadership among nurse managers	1. Healthcare reform 2. Economy / funding 3. Sustainability of training program

Driving and Restraining Forces

Zaccagnini and White (2011) describe driving and restraining forces as part of Kurt Lewin's change theory (p. 470). The driving force for this capstone project was the need to improve the nurse managers' knowledge and commitment to shared governance. There was sufficient data and anecdotal evidence to be the catalyst for change at the large pediatric hospital. In contrast, the restraining forces were the time to conduct the educational intervention and the commitment of the nurse managers to the training program. For change to occur, the driving forces needed to outweigh the restraining forces (Zaccagnini and White).

Need, Resources and Sustainability

Zaccagnini and White (2011) describe the importance of conducting an assessment early in the project. A needs assessment gathers the necessary information to plan the project and includes identification of resources to complete and sustain the project (Zaccagnini & White). The educational intervention in this project was a manager development training program, conducted as a series of three sessions over three months. For sustained change to occur and to continue to build the perception, knowledge and commitment of nurse managers to shared governance, the concepts shared in the training program needs to be reinforced and/or repeated over time. Ideally, the training program will be offered to all new nurse managers within the first six-months. To achieve this, a partnership with human resources is necessary to place this content into the new manager training program at this large pediatric hospital. For experienced nurse managers, additional training should be offered on an annual basis. This can be accomplished through additional educational sessions, short "refresher" classes on specific topics, computer-based learning modules, and education at existing councils or shared governance retreats. Content expertise is needed to create these additional sessions, as well as a commitment from the organization to schedule the education.

Stakeholders and Project Team

According to Zaccagnini and White (2011), the stakeholders are those with a vested interest in the outcome of the capstone project. The internal stakeholders for this capstone project were the chief nursing officer (CNO), associate chief nursing officer (ACNO), nursing directors, nursing managers and nursing staff. Nurses at all levels in the organization have a stake in the success of shared governance. The CNO provided the vision for shared governance. The ACNO,

directors and managers are responsible for providing the structures to support the work and the staff is responsible to engage in decisions that affect their practice. The primary external stakeholders are the patients and families served by the pediatric hospital. The patients and families are the core of the mission and vision of the organization. Nursing practice very much affects the experience and outcome for patients and families.

The project director was the student, Jeanine Rundquist. The project team was led by Jeanine Rundquist and had several members. Members included the clinical mentor, Dr. KC Clevenger (Director of Nursing Research), the capstone chair from Regis University, Dr. Diane Ernst, Dr. Kelly Johnson, (Chief Nursing Officer) and a program assistant.

Cost-Benefit Analysis

To build confidence in the project from the stakeholders and project team, a cost-benefit analysis was conducted. A cost-benefit analysis is done to justify, or promote, the project to the sponsors and stakeholders (Zaccagnini & White, 2011). The analysis consisted of adding the costs of the project and subtracting them from the benefits; the intent being to highlight that the benefits outweigh the cost (Zaccagnini &White). The cost of this project was calculated in salary costs of the nurse managers participating in the nurse manager development training program as well as the project director's time to develop the program and facilitate the sessions. Handouts were printed to facilitate learning for the participants for all three educational sessions in the manager development training program. Refreshments and food were provided for the participants. Statistician time was an anticipated expense in the budget.

The primary benefit of this project was the increase in perception, knowledge and support of shared governance by the nurse managers. This in turn improves the retention of nursing staff.

Stuenkel, Nguyen and Cohen (2007) reported that nursing salaries are the largest expense in an organizational budget, so the ability to save on turnover costs is crucial to the financial success of the organization. The average turnover rate for nurses is estimated at 15% to 36% (Buffington, Zwink, Fink, DeVine & Sanders, 2012). While it is not possible to attach a cost to employee disengagement, it is estimated that it costs $42,000 to $64,000 for turnover of one registered nurse (Buffington et al.). Greenfield (2004) reported that "employee disengagement is almost incalculable" (p. 16). Another benefit was the reduction of waste. This is supported by the concept that engaging the people who do the work in making decisions produces the right decision, and an organization may improve productivity and reduce waste in their system (Ballard, 2010; Greenfield, 2004; Overcash, Petty & Brown, 2012).

The literature supports other benefits of shared governance, such as nurse engagement, empowerment and autonomy (Barden, Griffin, Donahue & Fitzpatrick, 2011; Graham-Dickerson, Houser, Thomas, Casper, ErkenBrack, Wenzel & Siegrist, 2013; Kowalik & Yoder, 2010; Weston, 2008). These are difficult to measure and in most cases, nurse satisfaction represents the outcome of these benefits. Building knowledge and commitment of nurse managers' to shared governance is another benefit that is challenging to measure. With the changing healthcare environment, it is becoming clear that effective leadership combined with a competent and committed nursing workforce are crucial to any organization's success.

Mission/Vision

Jha, Vasudevan, Joshi and Sankarasubramanyan define a mission "as aspect of purpose and meaning for the organization" and vision as "a dream or a future state for the organization" (2013, p. 53). The vision statement for this capstone project was, transforming nursing practice

through empowered work environments. A mission statement is a description of why the capstone project is being conducted (Zaccagnini and White, 2011). The mission statement provides clarify for the purpose of the project. The mission statement for this project was:

> The mission of this capstone project was to implement a manager development training program, utilizing an evidence-based educational intervention. The intended outcome is to improve the perceptions, knowledge and commitment of nursing managers to shared governance at one large pediatric hospital. The intervention is a series of three training programs focused on shared governance.

Goals and Objectives

Goals are defined by Zaccagnini and White as "broad statements that identify future outcomes, provide overarching direction to the project and point to the expected outcomes (2011, p. 468). The overall goal for the capstone project was to strengthen nursing managers' ability to create and sustain shared governance in their unit. Objectives are statements of action that assist in achieving the overall goal of the project (Zaccagnini &White).

Project Objectives:

1. Develop a shared governance management development training program by January 31, 2014.

2. Conduct three educational sessions for the nurse managers on shared governance with participants completing a pre-test/post-test SGNMS in spring 2014

3. Analyze the SGNMS pre-test/post-test results and course evaluations to make recommendations for future manager development training by June 2014.

Evaluation Plan

Logic Model

A logic model was developed for this capstone project. A logic model is a diagram of the intended flow of the project and links the steps of the project into a whole (Zaccagnini & White, 2011). (See Appendix A for the Logic Model). In this model, the inputs, constraints, activities and outputs are outlined for the capstone project.

Population / Sampling Parameters

The population for this evidence-based practice improvement project was nursing managers at one large pediatric hospital. All nursing managers were included in the invitation to participate in the educational intervention. Exclusion criteria included nursing directors, clinical coordinators and non-nursing managers in the division. The total sample size was 38 nurse managers.

Setting

The setting for the capstone project was one large pediatric hospital. The manager development training program on shared governance was conducted at the hospital, in a scheduled conference room. The program sessions were scheduled on days convenient for the nursing managers. Refreshments and food were offered.

Evidence-based Practice Methodology

The project was internal to one large pediatric hospital and informed the organization of issues related to implementing an employee shared governance program. The results of this project were not meant to generate new knowledge or be generalizable across settings but rather

to address the specific project population at a specific time at this large pediatric hospital. This project translated and applied the science of nursing to the greater health care field. This evidence-based practice improvement project consisted of three components: 1) development of a manager development training program on the topic of shared governance, 2) provision of three educational sessions to complete the training program to include completion of a pre-test/post-test SGNMS and 3) evaluation of effectiveness of the three educational sessions using the SGNMS and course evaluations with recommendations for improvement of existing shared governance structures and processes.

The nurse managers were contacted in person by the project director at an existing manager council to announce the opportunity to participate in this project. Following the council meeting, the managers received an email with the introductory letter (See Appendix B for the Introductory Letter). The link for the electronic SGNMS was provided within the body of the email. The introductory letter was attached to the email and included the purpose of the survey and information about confidentiality and protection of the subjects. After reading the introductory letter, the nurse manager chose to participate by completing the electronic survey using the link provided in the letter. As stated in the introductory letter, completion of the electronic survey was provision of consent to participate in the manager development training program.

The manager development training program consisted of three educational sessions, scheduled over three months; one session per month for two hours each. The sessions were scheduled on days convenient for the nurse managers to attend. The dates and times of the educational sessions were included in the introductory letter. The nurse manager was agreeing to participate in all three educational sessions by completing the electronic SGNMS; therefore

providing consent to participate. Once the nurse manager consented to participate, a calendar invitation was sent utilizing the existing calendar software at the pediatric hospital. The nurse manager accepted the invitation and it served as a reminder on his/her calendar. A reminder email was sent to each nurse manager participant one week prior to each educational session (See Appendix C for the Reminder Email).

A teaching plan was developed that provided the learning objectives, teaching strategies and content outline for each of the three educational sessions. (See Appendix D for the Teaching Plan). The development of the plan was guided by Kanter's Work Empowerment Theory and Knowles Adult Learning Theory (Kanter, 1977; Knowles, 1968; Knowles, 1973). The evidence-based content was divided between the three educational sessions. Session One included a review of the history and purpose of shared governance (Ballard, 2010; Hess & Swihart, 2013; Profitt Newman, 2011; Overcash, Petty & Brown, 2012; Scherb, Specht, Loes & Reed, 2011; Weston, 2008), benefits of shared governance identified in the literature (Ballard, 2010; Barden, Quinn-Griffin, Donahue, Fitzpatrick, 2011; Hess & Swihart, 2013; Kowalik & Yoder, 2010; Mangold, Pearson, Schmitz, Scherb, Specht & Loes, 2006; Stuenkel, Nguyen & Cohen, 2007), Kanter's Work Empowerment Theory (Kanter, 1977; Laschinger, Gilbert, Smith & Leslie, 2010; Moore and Hutchinson , 2007; Moore & Wells, 2010), the vision for shared governance and connection to the professional practice model and the current state of shared governance at this pediatric hospital. (See Appendix E for Session One Power Point Slides).

Session Two reviewed Session One briefly and then discussed roles and responsibilities in shared governance (Ballard, 2010; Hess & Swihart, 2013), types and ranges of decision-making and techniques for decision-making (Graham-Dickerson, Houser, Thomas, Casper, ErkenBrack, Wenzel & Siegrist, 2013; Haag-Heitman & George, 2010; Scherb, Specht, Loes &

Reed, 2011) and benefits and barriers of staff engagement. (See Appendix F for Session Two Power Point Slides and Handout). Two participants were unable to attend the scheduled Session Two, due to last minute obligations, so a make-up session was offered the following week to allow their continuation in this project.

Session Three began with reviewing the content from Sessions One and Two. The majority of Session Three included case studies for open discussion and problem-solving. The case studies focused on real-life decisions such as clinical practice, staffing and scheduling and policy and procedure. Time was allotted for the nursing managers to discuss and plan for improvement of shared governance in their respective units. (See Appendix G for Session Three Power Point Slides). Two participants were unable to attend the scheduled Session Three so an alternate session was provided later the same day, allowing for their completion of Session Three and the project.

The nursing managers completed course evaluations at the end of each session as well as an overall training program evaluation (See Appendix H for Course Evaluation Surveys). In addition, after completion of the training program, an email was sent to the participants with the post-test SGNMS.

Data Analysis

The first level of data analysis planned for this project was descriptive statistics; to assist with summarizing the data, and describe the data (Polit, 2010). The descriptive statistics may include percentages, means and frequencies for demographic information requested at the end of the survey. The Course Evaluation results were collated for each session and as an overall program evaluation, also utilizing descriptive statistics (percentages).

The results from the pre-test and post-test of the SGNMS were analyzed using dependent groups t-test to determine differences for individuals and in aggregate. The SGNMS instrument had three subscales with three questions in each to measure the perceptions, knowledge and commitment to shared governance. These subscales were analyzed using dependent groups t-test to understand any change pre/post intervention.

Protection of Human Rights

This capstone evidence-based practice project met the Regis University Institutional review board (IRB) criteria as an exempt study. This project involved the use of educational tests and survey procedures. The information obtained was not recorded in such a manner that human subjects could be identified, directly or through identifiers linked to the subjects; and no disclosure of the human subjects responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation (Regis University Human Subjects Review Board, 2013).

The population of study was nurse managers that do not qualify as a vulnerable population. None of the nurse managers had a direct reporting relationship to the capstone project director. Participation in the project was voluntary and there was no threat to the nurse manager's position at the organization for not participating. Participation in the project posed minimal risk to the nurse managers. Confidentiality and anonymity was maintained as individual responses on the survey were not identified. The electronic survey system randomly assigned an identification number for each participant to link the pre-test and post-test SGNMS results. The capstone project director only saw pre-test and post-test data in aggregate and with group t-tests; individual responses cannot be identified. The SGNMS results were stored on a confidential computer of the project director. Only the project director had access to log into the computer.

The computer was hosted by a secure server through the pediatric hospital. Survey results were shared in aggregate for the entire survey, each subscale of the survey. No individual survey data was identifiable. Data will be stored for a period of four years on the project director's secure computer. Results from the survey were shared with hospital administration in order to develop further management development training and/or advance shared governance at this large pediatric hospital. The project director intends to submit this capstone project for publication and presentation at local and national conferences.

Instrumentation

There were two instruments utilized in this project: the Shared Governance Nursing Manager Survey (SGNMS) and the Course Evaluation. The SGNMS was modified from the Shared Governance Survey while the Course Evaluation was a project director-developed instrument based on Knowles Adult Learner Theory.

SGNMS was based on the Shared Governance Survey (Frith & Montgomery, 2006) which was published as part of an article in the Journal Nursing Administration Quarterly titled: *Perceptions, Knowledge and Commitment of Clinical Staff to Shared Governance*. Frith and Montgomery adapted the survey from the original Shared Governance Survey from Minors, White and Porter-O'Grady (1996) and created a 39-question tool. Frith and Montgomery reported an alpha coefficient of .95 for the original Shared Governance Survey with internal consistency for the survey sub-scales; knowledge (0.70), commitment (0.68) and perception of shared governance (0.74).

For this capstone project, the original Shared Governance Survey was adapted to focus on the population of nurse managers, and not clinical nurses as published. Permission to adapt the

survey for the population of nurse managers for this project was received from Dr. Tim Porter O'Grady, author on the 1996 Minors et al. study. (See Appendix I for Permission Email and Appendix J for the Shared Governance Nursing Manager Survey). Content validity for the SGNMS survey was established through six content experts at the pediatric hospital. None of the six reported any stress or harm with taking the survey. The length of time to take the survey on paper was ten to fifteen minutes. The content experts suggested two significant changes to the survey questions: 1) rearrange the order of the questions for improved flow and 2) change the wording of questions written in a negative tone. To keep the survey instrument as close to the original as possible, these extensive suggestions for changes were not incorporated into the SGNMS.

Demographics were added to the SGNMS to collect participant-level data on the following: 1) years worked as a registered nurse, 2) years worked as the manager in their current department, 3) highest degree in nursing, 4) current certification(s). The Course Evaluation instrument was created by the project director to gain feedback from the nursing managers after each of the three educational sessions on whether the educational objectives were clearly identified, if the objectives were met and if the project director was knowledgeable about the content. The nursing managers completed an overall course evaluation that included questions: 1) the objectives of the training program were clearly stated, 2) the objectives of the training program were met, 3) the training program stimulated my thinking about shared governance, 4) I benefited from this training program, 5) my practice will change as a result of this training program. (See Appendix H for the Course Evaluation Surveys).

Timeframe

Permission to complete the capstone project at this large pediatric hospital was received from the CNO (See Appendix K for the Letter of Permission). Presentation of the capstone proposal occurred on November 12, 2013 with the Regis faculty accepting the proposal. The pediatric hospital required an internal approval through the Organizational Research Risk and Quality Improvement Review Panel (ORRQIRP). The ORRQIRP application was submitted on December 16, 2013 and approval received January 24, 2014. (See Appendix L for the ORRQRIP Approval Letter). CITI Training was completed in November 2012 in order to submit this capstone proposal to the Regis IRB. (See Appendix M – CITI Training Certificate). The Regis IRB application was submitted on February 10, 2014 and approval was received on February 13, 2014. (See Appendix N for Regis IRB Approval Letter). The introductory letter and electronic SGNMS pre-test were sent to the nurse managers on February 22, 2014. The intervention phase of this project occurred over three months (March, April and May). At the conclusion of the educational sessions, the SGNMS post-test and course evaluation were completed. Data analysis for this capstone project occurred in June 2014.

Budget and Resources

The economic climate of healthcare requires thorough planning for any initiative. Zaccagnini and White (2011) proposed that administrators and stakeholders must understand the both the direct and indirect costs of a project before deciding to proceed. Adhering to the budget is the responsibility of the project director.

Table 2

Budget

Item	Estimated Cost (per session)	Total Cost
DNP capstone project director preparation time	$325.00	$975.00
DNP capstone project director time – educational sessions	$130.00	$390.00
*Nurse manager participant time in educational sessions (2 hours each)	$100.00	$300.00
*11 nurse manager participants	$1,100.00	$3,300.00
*Handouts	$25.00	$75.00
Refreshments 3 sessions, estimate of 25 people	$15.00 per session	$45.00
Food 3 sessions, estimate of 25 people	$75 per session	$225.00
*in-kind donations provided by pediatric hospital		**$5,010.00**

Project Findings and Results

Objective 1

The first objective of this capstone project was to develop a shared governance management development training program by January 31, 2014. To complete the content of the management development training program, the literature was reviewed once more to solicit the evidence for each of the three educational sessions in the training program. The three components of the training program were completed via Power Point prior to each educational session. Each Power Point was approved by Regis University faculty prior to the educational session. Handouts were made from the Power Point slides and provided to each participant. This objective was met; however not all three sessions were completed by January 31, 2014. Each session was prepared in the two weeks prior to the session.

Objective 2

The second objective was to conduct three educational sessions for the nurse managers on shared governance with participants completing a pre-test/post-test SGNMS in spring 2014. The three educational sessions were scheduled on March 13, 2014, April 10, 2014 and May 8, 2014. All 11 participants were present for the March 13th Session One. Two participants were unable to participate in Session Two on April 10th, so a make-up session was provided on April 30th, prior to the scheduled Session Three. On May 8th, two sessions were offered as two nurse manager participants had mandatory hospital training to attend during the regularly scheduled Session Three. Providing the afternoon session allowed the managers to participate in both the mandatory hospital training and Session Three of the Nurse Manager Shared Governance Training Program. All 11 nurse managers did attend all three educational sessions to complete the manager development training program.

Challenges with the electronic survey tool were found immediately upon sending the pre-test SGNMS to the eligible participants. Through verbal and email exchanges, nurse managers said they completed the electronic SGNMS, but data was not visible in the survey system. One nurse manager said she opened the link to receive a message that she had already taken the survey, when in fact she had not yet taken the survey. Another issue was that two surveys had the same participant identification number, making it impossible to match pre-test/post-test results for those two participants. The project director consulted an expert on the electronic survey tool who was unable to explain why these errors were occurring. The expert was able to move the entire survey and pre-test data into another version of the electronic survey tool. The survey tool at the pediatric hospital was an older version and perhaps that contributed to the issues. After moving the survey, to ensure the ability to match pre-test/post-test SGNMS, the project director

asked two participants to retake the survey tool (those with the same identifier). Other participants who had not yet taken the survey were able to do so in the new survey system without incident. The post-test SGNMS was sent without experiencing the same issues. All 11 participants completed the pre-test SGNMS, manager training program, course evaluations and post-test SGNMS.

Objective 3

The third objective for this capstone project was to analyze the SGNMS pre-test/post-test results and course evaluations to make recommendations for future manager development training by June 2014. The results from the pre-test and post-test of the SGNMS were analyzed using dependent groups t-test to determine differences for the entire sample, before and after the educational intervention. The SGNMS instrument has three subscales with three questions in each to measure the perceptions, knowledge and commitment to shared governance. These subscales were analyzed using dependent groups t-test to understand any change pre/post intervention. The dependent group t-test is the appropriate test for this project because it is the same group of people, measured at two different points in time (pre-test and post-test) (Polit, 2012).

Data Set and Coding. The data was downloaded from the electronic survey tool (Redcap) into Excel. The electronic survey tool is limited in its ability to sort and organize data within the software, so downloading to Excel was necessary. Once in Excel, the data was cleaned and labels attached to each column. The electronic survey tool assigned participant numbers in order to match the pre-test and post-test results. In Excel, columns were organized to place the

pre-test and post-test results for each question next to each other. Columns were labeled by question number for the 38 Likert-scale questions on the SGNMS(1pre, 1post, 2pre, 2post etc).

The first three demographic questions were labeled 39, 40 and 41. A new column was added (certYN) to indicate whether the participant was certified, based on the identification of their specific certification in the demographic section of the survey tool and yes was assigned to number one and no was assigned to number two. For the small sample, it was determined that presence of certification was more important than type of certification. For the demographic questions 'years as an RN' and 'years as the nurse manager', numbers were assigned to responses as follows:

1 = less than one year

2 = 2 – 5 years

3 = 6 – 10 years

4 = 11 – 15 years

5 = 16 – 20 years

6 = 21 – 25 years

7 = 26+ years

Highest nursing degree was coded as follows:

1 = diploma degree

2 = associate's degree

3 = bachelor's degree

4 = master's degree

5 = doctoral degree

Once the data set was clean and labeled, it was uploaded into SPSS for analysis.

Software Package. The statistical software package being utilized for this capstone project is IBM SPSS Statistics 22. SPSS is a full service analytical software program. Included in the software are descriptive statistics, bivariate statistics and prediction (IBM, 2014). SPSS was chosen because it is the commonly used analytical software in this author's work place and school.

Effect Size. Effect size is not an appropriate calculation for this data given a dependent group t-test was performed.

Description of the Sample. The total available sample was 38 nurse managers and 11 nurse managers completed the training program, yielding a 29% participation rate. Shortly after sending the invitation to participate to all 38 eligible nurse managers, one manager left the organization, one was promoted to an interim director position and two declined to participate due to upcoming maternity leaves, leaving a total possible sample of 34 (32% participation). One nurse manager did complete the pre-test with the intent to participate, but was unable to attend the educational sessions so the pre-test data was excluded from analysis. Descriptive statistics were completed on four demographic questions and the course evaluations.

Demographics. The sample of 11 nurse managers was analyzed and revealed that no managers had less than 11 years of nursing experience. Over 63% of the sample fell in the 11 years to 20 years of nursing experience and approximately 37% had more than 20 years nursing experience. Table 1 and Figure 2 contain the highest nursing degree analysis.

Table 3

Years as RN

	Frequency	Percent	Cumulative Percent
11-15 years	4	36.4	36.4
16-20 years	3	27.3	63.6
21-25 years	2	18.2	81.8
26+ years	2	18.2	100.0
Total	11	100.0	

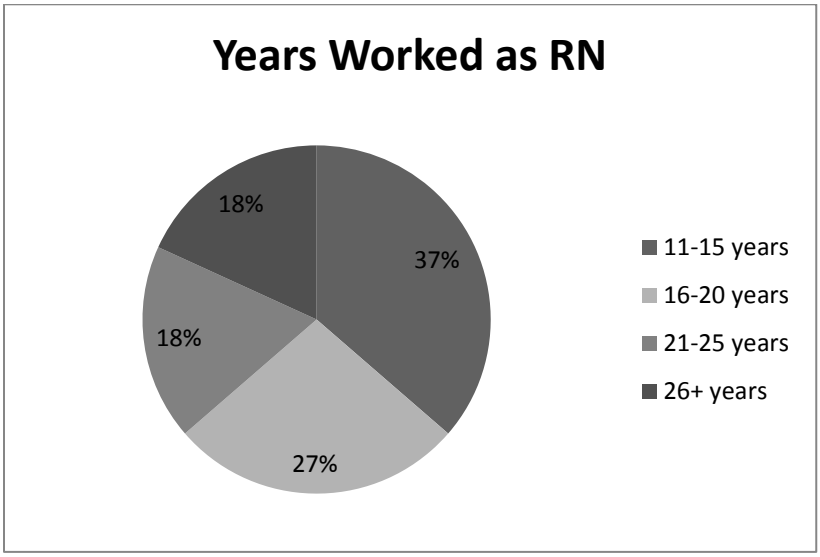

Figure 2 – Years worked as RN

Nearly 82% of the sample had fewer than five years' experience as the nursing manager in their current department with 9% (one person) in the six to ten year range and 9% (one person) in the 11 to 15 year range. Table 2 and Figure 3 contain the analysis.

Table 4 Years as manager in current department

	Frequency	Percent	Cumulative Percent
Less than 1	3	27.3	27.3
2-5 yrs	6	54.5	81.8
6-10 yrs	1	9.1	90.9
11-15 yrs	1	9.1	100.0
Total	11	100.0	

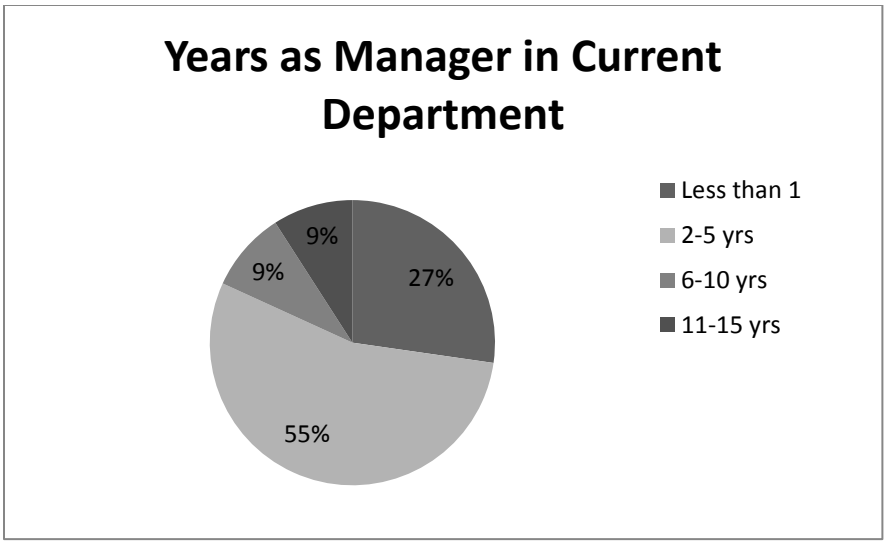

Figure 3 – Years as manager in current department

The sample had 54.5% bachelors of nursing (BSN) preparation and 45.5% masters of nursing preparation (MSN) and 73% of the sample were certified. Tables 3 and 4 and Figures 4 and 5 contain the analysis.

Table 5

Highest Nursing Degree

	Frequency	**Percent**	**Cumulative Percent**
BSN	6	54.5	54.5
MSN	5	45.5	100.0
Total	11	100.0	

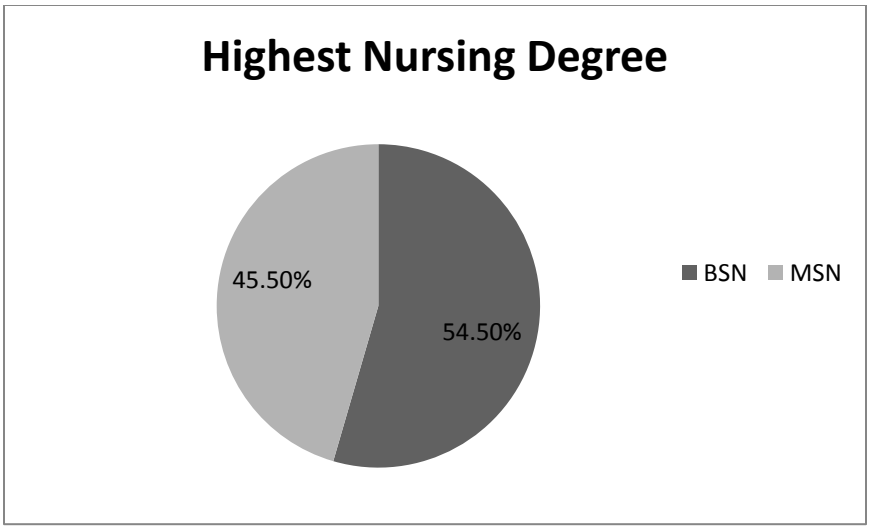

Figure 4 – Highest nursing degree

Table 6

Certification

	Frequency	Percent	Cumulative Percent
Yes	8	72.7	72.7
No	3	27.3	100.0
Total	11	100.0	

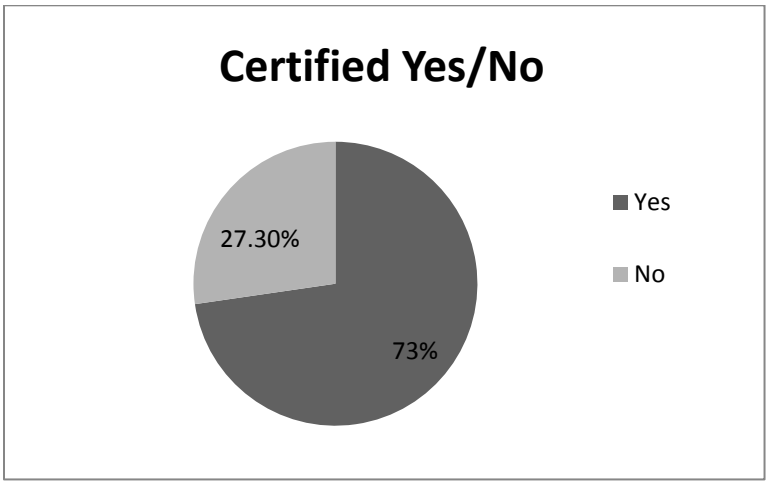

Figure 5 – Certification

Course Evaluations. The course evaluations were overwhelmingly positive for the three individual sessions as well as the overall course evaluation. The individual sessions evaluated

whether the objectives were clearly stated, objectives were met and the facilitator was knowledgeable about the topic. All three sessions were in the 91-100% for "strongly agree" on the evaluation questions. The overall course evaluation asked additional questions related to the program stimulating thinking about shared governance, whether the participant benefited from the training program and whether their practice would change as a result of the training program. All questions ranged in the 91-100% for "strongly agree". (See Appendix O for Summary of Course Evaluations).

Individual comments were also positive and included:

- Really good energy and facilitation for sharing of ideas. Ideas were thoughtful and presented clearly.
- Thank you, this was helpful for me as a new manager.
- Great information that I can/will apply to my practice.
- Great time for discussions and real situations.
- It's good to get to mentor/coach their decision making but not make the decisions.
- I would love to have my new leaders go through this course.
- Good program – should be included in new clinical manager orientation.

Cronbach's Alpha. The 38-questions in the original tool were analyzed for reliability in SPSS utilizing Cronbach's alpha (α) and were found to have high (excellent) reliability with $\alpha = .951$.

Dependent Group T-test. To evaluate the effectiveness of the nursing manager training program and answer the PICO question, each participant completed a pre-test and post-test using the Shared Governance Nursing Manager Survey. (See Appendix J – Shared Governance

Nursing Manager Survey). Through use of a dependent group t-test (paired sample t-tests) in SPSS, the entire sample was analyzed to understand whether a change occurred in the knowledge, perceptions and commitment to shared governance.

The analysis indicates that for the entire sample 23 of the 38 questions (60.5%) demonstrated a statistically significant change from pre-test to post-test based on a pValue of $\leq$ 0.05. See Table 7 for the full sample analysis.

Table 7

Paired Samples Test – Full Sample

	Pre Mean	Post Mean	Paired Differences					t	df	Sig. (2-tailed)
			Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
						Lower	Upper			
Question 1	**Shared governance allows staff participation in decisions that affect clinical practice.**									
1pre - 1post	4.45	4.82	-.3636	.5045	.1521	-.7026	-.0247	-2.390	10	**.038**
Question 2	**Shared governance changes the way we relate to each other at work.**									
2pre - 2post	3.91	4.64	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
Question 3	Since shared governance, staff are making more decisions affecting their own practice.									
3pre - 3post	3.82	4.55	-.7273	1.1909	.3591	-1.5273	.0728	-2.025	10	.070
Question 4	Management and staff are partners in patient care.									
4pre - 4post	4.64	4.64	.0000	.6325	.1907	-.4249	.4249	.000	10	1.000
Question 5	Empowerment means everyone is able to use authority already present in their role.									
5pre - 5post	3.82	4.45	-.6364	1.0269	.3096	-1.3263	.0535	-2.055	10	.067

Question 6	**We have enough time for shared governance.**									
6pre - 6post	3.27	4.18	-.9091	.8312	.2506	-1.4675	-.3507	-3.627	10	**.005**
Question 7	**Shared governance is a good use of our time and energy.**									
7pre - 7post	3.91	4.64	-.7273	.6467	.1950	-1.1617	-.2928	-3.730	10	**.004**
Question 8	**Administration is firmly committed to shared governance.**									
8pre - 8post	3.91	4.45	-.5455	.6876	.2073	-1.0074	-.0836	-2.631	10	**.025**
Question 9	**We accomplish more now than before we had shared governance.**									
9pre - 9post	2.91	4.45	-1.5455	1.0357	.3123	-2.2413	-.8496	-4.949	10	**.001**
Question 10	**I have the necessary skills to make shared governance successful.**									
10pre - 10post	3.55	4.36	-.8182	.6030	.1818	-1.2233	-.4131	-4.500	10	**.001**
Question 11	Nurse/staff retention has improved.									
11pre - 11post	2.82	3.45	-.6364	1.5015	.4527	-1.6451	.3724	-1.406	10	.190
Question 12	Physician relationships have improved.									
12pre - 12post	2.64	3.09	-.4545	1.8091	.5455	-1.6699	.7608	-.833	10	.424
Question 13	My department is kept better informed about what's going on.									
13pre - 13post	3.36	3.73	-.3636	1.5015	.4527	-1.3724	.6451	-.803	10	.441
Question 14	**Shared governance is NOT an extra burden.**									
14pre - 14post	3.73	4.27	-.5455	.6876	.2073	-1.0074	-.0836	-2.631	10	**.025**
Question 15	**Problems and solutions are discussed openly in our department.**									
15pre - 15post	3.82	4.36	-.5455	.6876	.2073	-1.0074	-.0836	-2.631	10	**.025**
Question 16	**Good ideas from everyone are heard and responded to.**									
16pre - 16post	3.73	4.27	-.5455	.5222	.1575	-.8963	-.1946	-3.464	10	**.006**

Question 17	**Most of the staff really wants shared governance to work.**									
17pre - 17post	3.55	4.36	-.8182	.8739	.2635	-1.4053	-.2311	-3.105	10	**.011**
Question 18	**CHCO administration sincerely wants shared governance to work.**									
18pre - 18post	3.82	4.55	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
Question 19	**Staff are supported in projects they initiate.**									
19pre - 19post	3.73	4.36	-.6364	.5045	.1521	-.9753	-.2974	-4.183	10	**.002**
Question 20	I encourage staff to participate in decision-making.									
20pre - 20post	4.36	4.73	-.3636	.6742	.2033	-.8166	.0893	-1.789	10	.104
Question 21	I believe in shared governance.									
21pre - 21post	4.55	4.73	-.1818	.6030	.1818	-.5869	.2233	-1.000	10	.341
Question 22	I believe staff can competently govern their own activities.									
22pre - 22post	3.64	3.91	-.2727	.6467	.1950	-.7072	.1617	-1.399	10	.192
Question 23	**I have the skills and information I need to support shared governance.**									
23pre - 23post	3.09	4.27	-1.1818	.8739	.2635	-1.7689	-.5947	-4.485	10	**.001**
Question 24	**Shared governance challenges me to grow as a professional.**									
24pre - 24post	3.91	4.64	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
Question 25	I want to participate in a leadership role in shared governance.									
25pre - 25post	3.73	4.09	-.3636	.9244	.2787	-.9847	.2574	-1.305	10	.221
Question 26	Shared governance is NOT just a fad.									
26pre - 26post	4.09	4.55	-.4545	1.0357	.3123	-1.1504	.2413	-1.456	10	.176
Question 27	**The staff participates in shared governance activities.**									
27pre - 27post	3.91	4.55	-.5455	.5222	.1575	-.8963	-.1946	-3.464	10	**.006**

Question 28	**I believe shared governance increases the professionalism of the staff.**									
28pre - 28post	3.91	4.64	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
Question 29	**My supervisor encourages staff involvement in shared governance activities.**									
29pre - 29post	4.00	4.55	-.5455	.5222	.1575	-.8963	-.1946	-3.464	10	**.006**
Question 30	The staff is excited to be involved in making patient care / practice decisions.									
30pre - 30post	3.82	4.27	-.4545	.6876	.2073	-.9164	.0074	-2.193	10	.053
Question 31	**Shared governance is a system of management that allows staff participation.**									
31pre - 31post	3.91	4.55	-.6364	.5045	.1521	-.9753	-.2974	-4.183	10	**.002**
Question 32	**Shared governance is a key element in what keeps me working here.**									
32pre - 32post	2.82	3.73	-.9091	1.1362	.3426	-1.6724	-.1458	-2.654	10	**.024**
Question 33	We have more responsibility and authority to solve problems than before.									
33pre - 33post	3.55	4.18	-.6364	1.5667	.4724	-1.6889	.4162	-1.347	10	.208
Question 34	**We have access to the information and communication we need.**									
34pre - 34post	3.64	4.09	-.4545	.5222	.1575	-.8054	-.1037	-2.887	10	**.016**
Question 35	We understand roles/responsibilities in shared governance.									
35pre - 35post	3.55	3.91	-.3636	1.2060	.3636	-1.1739	.4466	-1.000	10	.341
Question 36	Management at CHCO really wants an empowered staff.									
36pre - 36post	4.45	4.64	-.1818	.4045	.1220	-.4536	.0899	-1.491	10	.167
Question 37	**Most patient care decisions are made at the bedside.**									
37pre - 37post	3.55	4.09	-.5455	.5222	.1575	-.8963	-.1946	-3.464	10	**.006**
Question 38	**Staff will support / let shared governance work here.**									
38pre - 38post	3.45	4.09	-.6364	.9244	.2787	-1.2574	-.0153	-2.283	10	**.046**

The Shared Governance Survey from Minors, White and Porter-O'Grady (1996) was adapted by Frith and Montgomery (2006). Frith and Montgomery reported the use of three sub-scales in the survey tool that measured perceptions, knowledge and commitment. Each of these three sub-scales is measured by three different questions from the survey tool. (See Appendix J – Shared Governance Nursing Manager Survey).

Perceptions. The perception sub-scale is measured by questions 21, 28 and 32. The dependent group t-test analysis revealed that two of the three questions were statistically significant (question 28, p = .024 and question 32, p = .024). Question 21 was not significant at p = .341. Question 21 had a pre-test mean of 4.55 and post-test mean of 4.73 indicating a high level of agreement among the sample for "I believe in shared governance." The Cronbach's alpha on the perceptions sub-scale revealed good reliability with α = .743.

Table 8
Paired Samples Test – Perceptions Sub-scale

	Pre Mean	Post Mean	Paired Differences					t	df	Sig. (2-tailed)
			Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
						Lower	Upper			
21pre - 21post	4.55	4.73	-.1818	.6030	.1818	-.5869	.2233	-1.000	10	.341
28pre - 28post	3.91	4.64	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
32pre - 32post	2.82	3.73	-.9091	1.1362	.3426	-1.6724	-.1458	-2.654	10	**.024**

Knowledge. The knowledge sub-scale is measured by questions 1, 2 and 3. The dependent group t-test analysis revealed that two of the three questions were statistically

significant (question 1, p = .038 and question 2, p = .024). Question 3 was not significant at p= .070, which may be because the question is related to the structure of having shared governance, which was not changed during the timeframe of this project. The Cronbach's alpha on the knowledge sub-scale revealed poor reliability with α = .573.

Table 9

Paired Sample Test – Knowledge Sub-scale

	Pre Mean	Post Mean	Paired Differences					t	df	Sig. (2-tailed)
			Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
						Lower	Upper			
1pre - 1post	4.45	4.82	-.3636	.5045	.1521	-.7026	-.0247	-2.390	10	**.038**
2pre-2post	3.91	4.64	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
3pre-3post	3.82	4.55	-.7273	1.1909	.3591	-1.5273	.0728	-2.025	10	.070

Commitment. The commitment sub-scale is measured by questions 17, 18 and 26. The dependent group t-test analysis revealed that two of the three questions were statistically significant (question 17, p=.011 and question 18, p=.024). Question 26 was not significant at p=.176. This is likely due to the positive perception in pre-test and would not expect it to change significantly during the timeframe of this project. The Cronbach's alpha of the commitment sub-scale revealed acceptable reliability with α = .602.

Table 10

Paired Samples Test – Commitment Sub-scale

	Pre Mean	Post Mean	Paired Differences					t	df	Sig. (2-tailed)
			Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
						Lower	Upper			
17pre - 17post	3.55	4.36	-.8182	.8739	.2635	-1.4053	-.2311	-3.105	10	**.011**
18pre - 18post	3.82	4.55	-.7273	.9045	.2727	-1.3349	-.1196	-2.667	10	**.024**
26pre - 26post	4.09	4.55	-.4545	1.0357	.3123	-1.1504	.2413	-1.456	10	.176

ANOVA. An analysis of variance (ANOVA) was run in SPSS to understand if there was significant variation among the survey responses and each of the four demographic variables and the analysis revealed that none of the four demographic variables collected were statistically significant.

Interpretation of Results

PICO

Reflecting on the original PICO question, does a shared governance manager development training program increase the perceptions, knowledge and commitment to shared governance among a group of nurse managers at a large pediatric hospital? These results indicate that yes, overall this manager development training program on shared governance did increase the perceptions, knowledge and commitment of a group of nurse managers at a large pediatric hospital.

Session Objectives

The results indicate that the intervention was successful at improving the perceptions, knowledge and commitment of the 11 nurse managers in the sample. The three educational sessions that constituted the training program had different foci and did not aim to address all 38 questions on the SGNMS.

Session One. Session One provided the history and purpose behind shared governance, the themes found in the literature review, Kanter's Work Empowerment Theory, the vision for shared governance, connection to the professional practice model and current state of shared governance. Questions from the survey tool that connect to this content include questions: 1, 2, 4, 5, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 26, 28, 29, 30, 31, 34, 36, 37.

Session Two. Session Two focused on the roles and responsibilities of different parties included in shared governance, with a particulate focus on the nurse manager role. Also included were the types and ranges of decision-making that occurs in a clinical setting, techniques for decision-making, benefits of staff engagement in decision-making and barriers to that engagement. Survey questions connected to this session include: 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 20, 21, 23, 24, 26, 27, 28, 29, 31, 32, 33, 34, 35, 36, 38.

Session Three. Session Three focused on reviewing Session One and Session Two, case study discussions of real-life decisions and identification of one to two strategies to improve shared governance in their department. This session was application of learning and did not specifically address any additional survey questions.

Manager Development Training Program Objectives

The training program objectives were met as indicated by the change in pre-test / post-test perceptions, knowledge and commitment to shared governance and the course evaluations. Each participant generated strategies to improve shared governance in their department. Ideas included:

- Changing the meeting time to offer it to more staff
- Manager to be present at each meeting to coach / mentor
- Shared governance bulletin board with agendas, minutes, representatives names and which staff they are assigned to for communication
- Celebrate "wins" – decisions made by the shared governance group
- Using decision-making technique taught in training program
- Asking staff to offer input before providing their own
- Set clear expectations about decision-making
- Prevent the "dump and run" phenomenon by not allowing staff to "dump" their issues on the manager – refer to the shared governance group to discuss and resolve as necessary.

Limitations, Recommendations, Implications for Change

Limitations

There are limitations to this evidence-based practice project. The small sample size makes it difficult to generalize this information beyond the participant group. The author intended to analyze individual differences pre-test / post-test; however there were not enough external variables to analyze. Nor were there enough subjects to trend the external variables. The sample group was a homogeneous group with all BSN and MS/MSN prepared nurse managers

and high percentage of the sample was certified. The large pediatric hospital in this capstone project is a Magnet facility and has expectations for BSN and higher education for all nurse leaders and specialty certification. The survey instrument is a possible limitation as it was not originally developed for use with nurse managers.

Recommendations

Based on the analysis of this evidence-based practice project, the shared governance nurse manager training program is beneficial to the nurse managers. The recommendation of this author is that the training program be offered to all new nurse managers within six months of hire into the manager role. The course evaluation feedback supports this recommendation. The feedback also suggested the program be offered to all new leaders. The content can easily be tailored for any nursing audience and could also be an optional course for staff nurses and other nursing leaders to attend. The host organization has staff in human resources that are dedicated to people development, so this author also recommends offering this course content to the organization as the benefits of shared governance reach beyond the nursing profession.

The course was taught in six hours but split into two hour sessions over three months time. The intent was to spread the learning over time while measuring the effectiveness pre / post. For future offerings of this program, it may be necessary to consolidate the program into one session of six hours, or perhaps reducing it to four hours. This would allow staff nurses to attend the program without accruing overtime (full-time nurses' work 12 hour shifts or 36 hours per week so a four hour program would put them at 40 hours). If the program were to remain split over three months, a recommendation from a participant should be incorporated to further the learning. The suggestion was to provide a homework assignment between the sessions to

keep the participant engaged over the time between sessions. The homework could include an article to review or case study to answer.

This author believes this is an original use of a shared governance measurement tool by applying it to nurse managers instead of staff nurses. The majority of measurement conducted and published thus far is focused on the staff level perceptions of shared governance and their involvement in decision-making. Future study should focus on nurse managers and their role in creating the engaging work environment and structure of shared governance. This study should also be replicated with a larger sample size and perhaps a multi-center study would provide greater insight into the external variables that may or may not affect the perceptions, knowledge and commitment to shared governance.

The use of this survey tool with nurse managers did have excellent reliability overall (α = .951); however it was less reliable on the three sub-scales. so further investigation to refine the questions specific to the nurse manager role is warranted. Nurse managers' have a critical role in developing, implementing, sustaining and evaluating shared governance so further study in this area would benefit the nursing profession.

Implications for Change

The implications of successful shared governance and achieving a high level of engagement from the staff nurses is evident in the literature review. Nursing managers are critical to the success of shared governance and promotion of an environment that engages nurses (Hess & Swihart, 2013; Lacey, Cox, Lorfing, Teasley, Carroll & Sexton, 2007; Stuenkel, Nguyen & Cohen, 2007; Stumpf, 2001). Organizations should invest in the education and

training of nurse managers in not only the purpose of shared governance, but practical applications and useful tools to make decisions.

Another implication for nursing practice is that engaged staff will provide autonomy and accountability for their practice (Barden, Griffin, Donahue & Fitzpatrick, 2011; Graham-Dickerson, Houser, Thomas, Casper, ErkenBrack, Wenzel & Siegrist, 2013; Kowalik & Yoder, 2010; Weston, 2008). Nurses practicing at the top of their licensure leads to improved patient outcomes (Golanowski, Beaudry, Kurz, Laffey and Hook, 2007; Houser, ErkenBrack, Handberry, Ricker & Stroup, 2012; Institute of Medicine, 2004; Kalisch, Curley & Stefanov, 2007; Profitt Newman, 2011; Stumpf, 2001).

Nursing satisfaction improves and burnout is reduced with engaging work environments (Fransson Sellgren, Ekvall, & Tomso, 2008; Houser, ErkenBrack, Handberry, Ricker and Stroup, 2012; Laschinger, Leiter, Day & Gilin, 2009; Moore & Hutchinson, 2007). Reducing turnover has a financial benefit for organizations considering the cost is estimated at $42,000 to $64,000 for turnover of one registered nurse (Buffington, Zwink, Fink, DeVine & Sanders, 2012).

Conclusions

The purpose of this evidence-based practice capstone project was to determine whether a manager development training program on shared governance could increase the perceptions, knowledge and commitment to shared governance at a large pediatric hospital. While this project had a small sample (11 nurse managers), positive change was found pre-test / post-test, indicating the perceptions, knowledge and commitment to shared governance can be improved through a management development training program.

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