CLINICAL NURSES PERCEPTIONS ON SHARED GOVERNANCE APPLICATION AT THE NATIONAL CENTER FOR CANCER CARE AND RESEARCH

by

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Title: Clinical Nurses Perceptions on Shared governance application at the National Center for Cancer Care and Research

Abstract

Aim: Organizational restructuring and reform in the health care system have led to uncertainty and susceptibility among clinical nurses and their work environment. As a result, a negative effect on the nurse's role in decision making and delivery of patient care has been created. If nurses at the National Center for Cancer care and Research (NCCCR) have the ability to influence decisions that affect them the result will be more positive outcomes for patients, for the organization, and for the nurses themselves.

Methods: This study confirms the importance of shared governance and its positive effects on nurse recruitment and retention, nurse satisfaction, and optimal patient outcomes. The study investigated the internal and external factors that affect clinical nurses’ (CN) professional practices. The descriptive study design using the Hess Index of professional Nursing governance addressed to CNs in addition to the questionnaire including seven open ended questions generated quantitative and qualitative responses on the nurses’ perceptions of shared
governance at the NCCCR. Section I of the survey included demographic information about the CNs. Section II included 86 questions addressing six subscales, (I- Professional control, II- Organizational influence, III-Organizational recognition, IV-Facilitating structures, V- Liaison and VI- Alignment. These questions were rated on 5 point Likert scale.

**Results:** A sample of 200 CNs was invited to participate in the study. 105 CNs responded to this study (52.5%). The overall mean scores for each of the six subscales, which range between 1.9092 and 2.1484, indicate that CNs generally perceive that their work environments are controlled by nursing management/administration only, or primarily nursing management/administration with some staff nurse input. The qualitative responses revealed internal and external factors. The themes representing the internal factors include influencing decision making, quality of care, professionalism and satisfaction. Themes relevant to the external factors include organizational influences and work environment (management and administration) and organizational influence, and collaboration (collegial support).

**Conclusion:** The results of this study provide stakeholder’s with insights about the impact that shared governance practices have on CNs in their work environment hence they will be more understanding and aware about the need for implementing such practices. Consequently, the CNs’ professionalism and ability to provide quality patient care will be affected.
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CHAPTER I
INTRODUCTION

Organizational restructuring and reform in the health care system have led to uncertainty and susceptibility among clinical nurses within their work environment. As a result a negative effect on the nurse's role in the decision making and delivery of patient care was created (Green and Jordan, 2004). Generally at the National Center for Cancer Care and Research (NCCCR) in Qatar, clinical nurses are accountable to practice according to the standards identified by the Hamad Medical Corporation (HMC) and the policies and procedures of the HMC as well as those set by the NCCCR. Nurses are also accountable to practice according to the expectations and demands of the patient and family members.

If nurses have the ability to influence the decision making, pertaining to their practice, positive outcomes related to patients, the clinical nurses themselves, as well as to the organization as a whole will arise (Greco, Spence Laschinger, & Wong, 2006).

A. Statement of the problem

Nurses at the NCCCR reported lack of understanding about shared governance structure and processes; they complained about having no input into nursing practice decisions and were not even being empowered, based on anecdotal evidence. The trend was moving towards getting the nurses involved with the decisions, but not empowered to share and have inputs in the decision making. Magnet force nine, "Autonomy", implies
that as professionals', clinical nurses should be anticipated to have autonomy and responsibility over their own practice, which should be based on their knowledge, competence and expertise, through their participation in decision making at all levels even at the bed side (American Nursing Credentialing Center, ANCC, 2005a). According to magnet requirements, the nurse is expected to practice autonomously, consistent with professional standards. Independent judgment is expected within the context of interdisciplinary and multidisciplinary approaches to patient care (ANCC, 2005a). One of the testimonials presented at the ANCC was provided by the chief nursing officer of the North Hills Hospital, Jane McCurley in which she states:"The difference in the strength of our nursing department is palpable. Pride and camaraderie were apparent as we strengthened nurse autonomy and other criteria for designation. Our retention rates improved and staff nurse participation increased significantly as nurses realized the importance of their voice in decision making. Each nurse received a Pathway to Excellence pin to wear with dignity and honor"(ANCC, 2005a).

Different studies illustrated that clinical nurses experience a limited role in the decision making and shared governance process at the unit level, management and administration(Canadian Health Services Research Foundation [CHSRF, 2006a];Havens &Vasey, 2005;Nedd, 2006;Tourangeau,Coghlan, Shamian, & Evans, 2005). Nurses believe participating in the decision making and having control over practice is the responsibility of a professional nurse. Given that responsibility in addition to the fact that functioning independently is an aspect of autonomy, it is crucial to understand clinical nurses' perception on shared governance and the participation in the decision making. Shared governance within nursing is related to many positive outcomes such as
improving recruitment and retention of nurses, greater staff satisfaction rates, and empowered nursing work force. (Hess, 2004; Nedd, 2006; and Tourangeau et al., 2005).

What is crucial to shared governance flow is the creation of structures that permit staff to meaningfully contribute to the organizational corporate agenda through a process of decision making. Contrary to this a centralized authoritarian decision making has negative effects on nurses' perceptions of shared governance. There are several structures around the world for shared governance but commonly adopted are the models that comprise committees known as councils of elected or appointed staff members representing single or multiple disciplines. Empowering staff is a great challenge requiring effective planning preparation and commitment. NCCCR is in the process of establishing the process of shared governance under an effective leadership, multidisciplinary team work, a suitable framework and the examination of its structure and culture.

This research examines the perception of clinical nurses toward shared governance. The results of this study might be used as basis for the foundation of a unit based shared governance council in addition to determining the projected challenges of implementation.

**Purpose of the study**

The purpose of this study is to identify the perceptions that clinical nurses at the National Center for Cancer Care and Research have regarding shared governance including who has control over their practice. This study will provide readers with a description of what shared governance means to clinical nurses in this institution.
B. Significance and relevance

Due to the current trends and the future predictions of nursing shortage stakeholders are stressing on the provision of high quality patient care in a quality of work environment. This study will provide nurses at the NCCCR with the opportunity to share their perceptions of participation in the decision making within their organization, their profession and when providing patient care. Stakeholders' awareness of these perceptions may lead to strategies that strengthen the nurses' role in the decision making and shared governance structure. This will support the retention as well as the recruitment of the nurses. For a successful change toward decentralizing the decision making process it is important to study nurses' perception on shared governance. Also this study will help identifying criteria's that may foster shared governance application in other units. This application will consequently lead to the formation of a shared governance structure therefore meeting one of the requirements needed in the journey toward magnet recognition later on.

C. Definition of terms

- Shared governance: Shared governance is an organizational framework where Clinical nurses can utilize strategies that can both facilitate empowerment and manage their practice with much greater authority. Shared governance strategies include those that foster partnership, equity, accountability, promote job satisfaction, and encourage the Clinical Nurses to be involved in the decision
making processes from the bedside to an administration level towards establishing control over nursing practice (Anthony, 2004)

− Autonomy: Professional autonomy means having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base. The autonomy in nursing practice includes: the authority of total patient care, the power to make decisions in a relationship with the patient, and the freedom to make clinical judgments, choices and actions (Skar, 2010).

− Clinical Nurse: A registered nurse practicing nursing in a clinical area where patient care is provided according to the standard of practice and care inherent at the Hamad Medical Corporation and the National center for Cancer Care and Research.

D. Research Question

How can clinical nurses at the National Center for Cancer Care and Research be assisted to introduce a shared governance model?

Related questions:

− How is shared governance perceived by the clinical nurses at the Center before the introduction of the shared governance council?

− What are the internal and external forces that might affect the implementation of a shared governance structure? (Force field analysis)

− What are the best evidence-based strategies for enhancing the helping forces identified in the Force Field analysis?
− What are the best evidence-based strategies overcoming the hindering forces identified in the Force Field analysis?

− What are the roles of managers, leaders, and front line nurses (staff nurses and charge nurses) in implementing shared governance?

− What recommendations about the introduction of shared governance can be made to managers and leaders at the Center? How was shared governance perceived by the clinical nurses at the NCCCR hospital?
CHAPTER II
BACKGROUND

A. Literature review

"Shared governance elevates nurses from employees just doing jobs to professionals sharing in health care decision making with other stakeholders", says Dr. Tim O'Grady after he explained that shared governance represented a paradigm shift for nurses at St. Joseph’s Hospital of Atlanta and other hospitals that followed in its footsteps (Hughes, 2004).

Shared governance is defined by Porter O' Grady (2003a) as "structural model through which nurses can express and manage their practice with a higher level of professional autonomy" (p.251). In shared governance professional workers realize greater independence and are granted the power of autonomy for responsible decision making and greater efficiency therefore replacing the centralized decision making of a bureaucratic environment (Anthony, 2004). Porter o' Grady maintained that the majority of institutions that have attained magnet status used shared governance as their structural model to improve the professional nursing practice. Once implemented shared governance reduced costs and had a positive impact on the environment and on the nurses' job satisfaction (Anthony, 2004).

For shared governance to allow for nurses empowerment and for cost effective service delivery, decision making should be made at the point of service. This means the management structure should be decentralized. In order to make that happen there are
four principles that must occur at the point of service like the patients units for example: employee partnership, equity, accountability and ownership (Porter O' Grady, 2005).

Partnership implies that each member has key role in fulfilling the mission and the purpose of the organization and he/she is critical to the healthcare system effectiveness (Porter O' Grady, 2005).

Equity means that each member is essential to provide effective and safe care (Porter O' Grady, 2005).

Accountability means the willingness of each member to invest in decision making and express ownership in those decisions (Porter O' Grady, 2005).

Ownership includes the recognition and acceptance of the importance of every one's work and the fact that an organization success is related to how well individual staff member perform their jobs (Porter O' Grady, 2005).

Green and Jordan, (2004) described Shared governance as a way to maintain nursing job satisfaction, quality care and fiscal viability (p.2). This is related to the concept of workplace empowerment and organizational commitment as aligned by the notion that shared governance is a framework that relies on strategies that empower clinical nurses in an environment that respects and encourages individual professional accountability.

Empowerment of registered nurses through professional practice models including the shared governance model is considered crucial for the improvement of quality of care, containing costs, and retaining staff (Barden, 2009). One study aimed at
determining the relationship between perceptions of governance and empowerment among nurses working in an acute hospital setting, in a large tertiary care hospital in Queens New York using the Kanter's structural theory of empowerment. The total number of participants was 158 out of 348 nurses working in the study site facility where a shared governance model was placed for at least six months to one year. Participants completed two surveys, the index of professional nursing governance and the conditions of work effectiveness II questionnaire. A significant relationship ($r=0.34$, $p<0.0001$) was noted between perceptions of shared governance and empowerment. This indicated that as shared governance progressed, so did empowerment, noting that at the early stage of implementation, nurses perceived themselves as moderately empowered. Shared Governance provided a vital communication and decision making infrastructure. (Barden, Griffin, Donahue, and Fitzpatrick, 2011)

As a practical example of the shared governance model, staff led councils have many positive effects on the nurses' satisfaction, the quality of care and nursing leadership. The study of Brody, Barnes, Ruble, and Sakowski examined the effects of participation in staff nurse led practice councils on nurse job satisfaction and professional development. A three stage evaluation was conducted with nurses, managers, and executives participating in or involved with Evidence based Practice (EBP) councils tasked with improving patient outcomes at six community hospitals in a single non-profit hospital system in Northern California. As outcomes five themes were emerged: empowerment, meaningfulness, leadership growth, exposure to quality improvement, and vision. They concluded that staff-led councils have the potential to improve quality of
care, job satisfaction, vision and leadership provided that managers and executives are sufficiently prepared to work with and support the councils (2012).

Considering the impact of shared governance on patient outcomes, Rheingans conducted a study aimed at describing the nursing environment at a community non-profit Magnet hospital and examining the relationship between shared governance and caring on both nursing and patient outcomes. Out of 31 nursing units at Sarasota Memorial Hospital (SMH), one hundred forty survey packets were returned. The Index of Professional Nursing Governance was used and the overall level of shared governance was 182 (range: 86-430). This level places the hospital in a lower range of shared governance. The Shared governance scores were statistically significantly different according to work status, hospital unit/department, council participation, and professional certification; caring was significantly different by unit; safety climate varied significantly by unit; and job satisfaction was noted to differs significantly by unit, council participation, type of nurse, position of nurse, and professional certification. Regression analyses demonstrated significant contribution of specific shared governance subscales (goals and practice) and caring subscales (comforting and clinical) in predicting multiple job satisfaction and overall safety climate. Due to the limitation by number of units within this hospital system, statistical significance was not achieved when regressing shared governance and caring onto patient outcomes at the unit level; however large R2 values were noted with multiple indicators, including fall rates (.699), fall with injury rates (.788), pressure ulcer incidence (.423), medication management (.560), and identification errors (.403). The shared governance score validates that SMH is making
progress in shared governance. Self-assessed caring scores indicated that nurses’ perceptions are consistent with the chosen SMH nursing theory of Watson’s Theory of Caring. Shared governance and job satisfaction both improved with council participation (Rheingans, 2012).

Magnet requires that hospitals have structures and processes in place to ensure nurses participate in shared decision making. Shared Governance was found to be the most common method of meeting those criteria (ANCC, 2005a). Shared governance is necessary to cultivate a professional practice environment for nurses. Without it, organizations lack an innovative, effective way to minimize nurse turnover, improve clinical decision-making, and support the autonomous environment necessary to meet the expectations of the ANCC Magnet Recognition Program (Swihart, 2006). Hess designed a study to compare perceptions of Registered Nurses employed in Magnet hospitals, in-process Magnet hospitals (i.e., hospitals seeking Magnet recognition), and non-Magnet hospitals using data from the 2010 National Survey of Registered Nurses (NSRN). The NSRN measures nurses’ perceptions about their profession, workplace environment, and professional relationships and it is administered biennially. A self-administered mail survey to a national sample of 1,500 RNs was used of whom 518 indicated their magnet status and were analyzed. Results indicated that nurses employed in all three groups (Magnet, in-process, and non-Magnet hospitals) were uniformly satisfied with being a nurse; although significantly more Magnet and in-process nurses would recommend nursing as a career than would non-Magnet RNs. Magnet nurses were found to have higher opportunities to influence decisions about workplace organization and
participation in shared governance and employer-paid continuing education, and relationships with advanced practice nurses and nursing faculty than did non-Magnet nurses and in process Magnet nurses (Hess, DesRoches, Donelan, Norman, Buerhaus, 2011)

Workplace empowerment using shared governance structures and strategies affect nurses’ empowerment, and create positive work behaviors and attitudes. This link was noted by many researchers; Wagner et al. conducted a systematic review examining the relationship between structural empowerment which is the organization’s ability to offer access to information, resources, support and opportunity in the workenvironment and psychological empowerment for registered nurses (2010). A significant association between structural empowerment and psychological empowerment for registered nurses was revealed by ten papers representing six studies. The creation of an environment that provides structural empowerment is an important organizational strategy that contributes to nurses' psychological empowerment and ultimately leads to positive work behaviors and attitudes. Critical structural components of an empowered workplace can contribute to a healthy, productive and innovative nursing workforce with increased job satisfaction and retention (Wagner, Cummings, Smith, Olson, Anderson, and Warren, 2010).

In a mixed methods study by Karmer et al. (2008), shared governance strategies including council structure, shared leadership and collaborative governance formed the mostly cited answers by nurse interviewees to the question: “What enables you to have control over your practice?” About 3,000 staff nurses completed the Essentials of Magnetism (EOM), an instrument that measures control over nursing practice (CNP), one
of the eight staff nurse-identified essential attributes of a productive work environment. Strategic sampling was used to identify 101 high CNP-scoring clinical units in 8 high-EOM scoring magnet hospitals. Interviews for 446 staff nurses, managers, and physicians on these high-scoring units, chief nursing officers, chief operating officers, and representatives from other professional departments were done; observations for all participants were made of all unit/departmental/hospital council and interdisciplinary meetings were held during a 4 to 6 day site visit. A constant comparative analysis of interviews and observations and an analysis of quantitative measure were used to identify structures and components of viable shared governance structures that enabled Control over Nursing Practice. It was noted that all eight hospitals had such structures, all followed the councilor model, and all had a combination of unit and central councils. During interviews nurses’ enthusiasm, pride, and respect when describing effective outcomes obtained through shared decision-making were significantly evident as well as for the recognition of shared governance structure and activities by nurses, physicians and other professional. The authors concluded that Shared Governance structures are effective in enabling nurses to Control Nursing practice through having input and making decisions regarding issues of importance to nurses, patients, and the organization. They admit that the viability of Shared Governance is expedited when such structures provide access to power, are characterized by wide participation, and are recognized as effective in achieving important outcomes as a result of shared decision making. Pride in outcomes will be manifested through such achievements. The shared governance (SG) provides the opportunity to nurture and develop excellent professional practice from within the organization and instituting a SG structure that will effectively enable CNP is a journey,
not a simple event requiring a culture change, time, and commitment (Kramer, Schmalenberg, Maguire, Brewer, Burke, Chmielewski, Cox, Kishner, Krugman, Meeks-Sjostrom, and Wald, 2008)

Shared governance was the only retention intervention that made a statistically significant difference in job satisfaction and no other retention strategy directly affected nurses' intention to stay in their jobs in a study by Ellenbecker et al who interviewed 123 New England agencies. The implementation of multiple recruitment and retention strategies was reported by most of the agencies. The effects of employer retention strategy on nurses' intent to stay were the indirect result of its effects on job satisfaction as suggested by the results of the regression. (Ellenbecker, Samia, Cushman, and Porell, 2007).

The need to provide the new generation of nurses with shared governance strategies is crucial for their empowerment and job satisfaction. This was noted by Wilson et al. who conducted a study exploring generational differences in job satisfaction. The Ontario Nurse Survey collected data from 6,541 Registered Nurses. Participants were categorized as Baby Boomer, Generation X, or Generation Y based on birth year.

In overall job satisfaction and five specific satisfaction components, Baby Boomers were significantly more satisfied than Generations X and Y.

The authors concluded that job satisfaction needs to be improved for younger generations of nurses. Nursing Management Strategies to improve job satisfaction for younger generations of nurses may include creating a shared governance framework.
where nurses are empowered to make decisions. (Wilson, Squires, Widger, Cranley, Tourangeau, 2008).

A two-phase comparative study explored the relationships between nursing unit environment (shared governance, traditional governance, specialized inpatient care unit) with measures of registered nurse occupational stress and occupation-related outcomes in a hospital with a reputation for excellent nursing care. Data from 69 staff nurses in one of the three different patient care areas were analyzed. A sample of nurses working in each of the units also were interviewed about common work stressors encountered, coping mechanisms used to deal with work stress, decision-making, and sources of work support. It was found that there were no significant differences among the three types of nursing unit governance structure on occupational stress, methods of coping with occupational stress, job control, and self-efficacy. But considerable differences were found related to the amount of supervisor support, coworker support, unit efficacy, turnover, absenteeism, and job satisfaction. Nurses working in the shared governance and specialty units had significantly more job satisfaction, perceived coworker support, and unit efficacy than RNs working in the traditional governance unit (Hall, 2004).

Chinese researchers Lee, Yang, Lee, and Wu (2000) used a quasi-experimental design to study nurses’ perceptions and the effects of implementing a unit based shared governance (UBSG) structure in a 150 bed Taiwanese community hospital. Their results indicated that nurses involved in UBSG group (n = 29) had higher perceptions of professional control over nursing practice than the control group (n = 24) that were not involved in the implementation of UBSG. These findings conclude a UBSG environment
facilitated nurses' involvement in governance activities, decision-making and professional practice. The content validity of the IPNG (Chinese version) was 0.89. Cronbach's alpha was established (0.98) with test-retest reliability at 0.74. Vincent (1999) describes correlation as a numerical coefficient that indicates the extent to which two variables are related or associated and is always between +1.00 and -1.00. (p88).

As noted in the above review, a shared governance work environment has many effects on nurses' performance, job satisfaction and perceived leadership than do a traditional bureaucratic environment.

B. Force field analyses: Internal and external factors

Clinical nurses’ perception of shared governance is based on the concept of who has control over nursing practice. The outcomes of shared governance can be examined in relation to the organization as a whole, the work climate or environment and the nurses’ satisfaction. The control over practice concept includes internal and external factors affecting shared governance outcomes. The internal factors are related to clinical nurses’ (CN) professionalism, satisfaction, and quality of care, including the effect that control over nursing practice has on autonomy and empowerment. The external factors include health care restructuring, organizational influences, and work environment models, such as shared governance and Magnet hospitals, and nursing leadership. The internal and external factors are interrelated and can be synergistic in how they affect control over nursing practice (Anthony, 2004).

Internal factors
The internal factors include:

- Professionalism relates to the CNs’ exhibiting competent and skilful behavior driven by nursing core values in alignment with their profession. This includes participation in decision making in all areas affecting patient care including policies/procedures, collegial relations and professional development.

- Satisfaction examines how Nurses feel about their work (recruitment/retention, intent to leave, organizational commitment, job stress, health, safety, security, supportive management, and opportunities for leadership)

- Quality patient care which is strongly related to staffing ratios/mixes, flow, patient placement, education of nurses, specialization and access to resources

- Empowerment which is obtained through building trust in CNs, communication, information sharing and increased employee involvement.

- Professional Practice Models are based on the fact that CNs are involved in deciding the activities, responsibilities, and credentials CNs must have to practice and provide safe patient care which also includes organizational support and collaboration

- Autonomy entails the CNs’ participation in decision making at all levels.

External factors

The external factors include:

- Work Environment Models are the Workplace features that Influence autonomy and professional practice; for example Magnet hospital designation
- Organizational Influences are Organizational attributes that are supportive and foster CN decision making, collaboration, and autonomy like the retention recruitment strategies, the budget cutoffs…

- Nursing Leadership is essential in fostering autonomy, professional accountability, and control over nursing practice


C. Conceptual framework

Based on the literature, there are six aspects that comprise shared governance and will be the framework used for this study. The index of professional nursing governance (IPNG) measures six dimensions of shared governance. These dimensions are directly derived from the professional, organizational, and nursing literature and are identified as subscales of IPNG which include professional control, organizational influence, organizational recognition, facilitating structures, liaison, and alignment.

1. Professional Control

This dimension examines who has control over professional practice. Elements of professional practice include what nurses can do at the bedside, developing standards of care, assessing and providing for professional educational and development, incorporating research into nursing care, and determining methods of nursing care
Hess (2004) suggests that “to control practice, nurses must have influence over themselves as a professional group” (p. 37). He proposes CNs who have the opportunity to be a part of decision making that influences policy facilitate more control over nursing practice, fostering a positive professional practice environment. Once CNs identify themselves as a professional group and take control over the organizational operational definition of nursing (what nurses need) they can reach their full potential of responsibility to maintain standards of practice thus ensuring safe practice with positive patient outcomes.

2. **Organizational Influence**

Organizational influence, as described by Hess (1998), addresses the question of “who has influence over the information and resources that support professional work” (p. 37). This dimension looks at access to information and resources for professional practice including daily patient assignment, consulting of nursing services outside of the unit and outside of nursing, flow of patients, and procuring supplies for nursing care.

3. **Organizational Recognition**

Hess (1998) defines organizational recognition as “who is empowered with formal authority by the organization” (p. 37). This dimension examines who controls practice and influences resources in the workplace including daily patient care assignment, controlling the flow of admissions and discharges, a more formal mechanism for consulting support services, and determining staffing levels. The recognition and value received from an organization that is consistent and committed to supporting the professional development of nurses is an important element in the CNs’ job satisfaction.
4. **Facilitating Structures**

Hess (1998) indicated that facilitating structures address the question of “who determines and participates in structures that provide a vehicle for making governance decisions in the organization” (p.37). Within other words who participates on committees that decide strategic planning and budgets for the organization, nursing department, and unit. Recognition of the facilitating structures such as leadership, ancillary staff, scope of CN work, and interdisciplinary practices assists in identifying the structural dimensions of a professional practice environment. As Hess suggests, power and control need to be distributed in an effort to reconcile conflict between professional groups. He also identifies the necessity of legitimizing the CNs’ professional practice by extending their authority to include areas otherwise controlled by the administration. This formal type of authority provides CNs an equal voice among different facilitating structures, groups, committees, and organizational structures. CNs commitment to participate in decision making regarding issues such as practice, management, quality, and education establishes meaning for control of practice, resulting in better patient outcomes.

5. **Liaison**

Liaison depicts “who has access to information necessary for controlling practice and influencing the allocation of organizational resources” (Hess, 1998). This dimension focuses on which group has access to the information and resources that support the professional practice environment of the CN.

6. **Alignment**
As identified by Hess (1998) alignment represents “who has the ability to promote, negotiate, and manage conflict and goals within the organization” (p.37). Hess depicts that conflict within the organizational structure needs a formalized grievance framework to be followed. This dimension entails who in the organization has the power to negotiate conflict. There is a plethora of governing bodies that regulate the CNs’ practice environment. Regulatory bodies, labor affiliations, quality assurance committees, and hospital policy and standards guide the CNs’ practice environment. Ultimately, responsibility and accountability are based on the CNs’ knowledge and ability to provide safe patient care. When the ability to provide safe patient care is jeopardized, conflict arises. The ability to manage conflict and goals within the organization has been left to upper management.
CHAPTER III

Methodology

This chapter describes the procedure used to study the perceptions that CNs have regarding shared governance within NCCCR. The design, setting, sample, ethical considerations, instrument, and procedures are discussed.

A. Design

A mixed method design study was used to investigate the perception of clinical nurses as well as the perceptions of the nurse managers/administratorstoward shared governance. This research design provided information in favor for both qualitative and quantitative research.

B. Setting

The National Center for Cancer Care and research previously known as AL Amal Hospital is a 67 bed oncology/hematology hospital the first of its kind to provide first class medical treatment for cancer patients in the State of Qatar.

The hospital is situated in the Rumaillah complex, and spreads across a surface area of about 14000 m2. It is a governmental facility that is part of Hamad Medical Corporation and offers a range of services for oncology/hematology patients aged 15
years and above. This includes diagnosis, planning treatment and evaluation. However Radiation Oncology is available for patients of all ages. All NCCCR services are provided in close coordination with psychological rehabilitation and palliative care support. The hospital offers extensive care and a pleasant atmosphere for the patients. It strives to combine cutting edge technology and medical excellence to make sure that Oncology/Hematology patients receive the absolute best in cancer care.

The NCCCR treats and cares for patients according to the latest medical standards. NCCCR staff provides passionate care and believes that building a trusting patient health care provider partnership is central to providing the best possible care. Therefore all patients are encouraged to take an active part in their recovery. Staff at the NCCCR are committed to a comprehensive cancer care through innovation leading edge technology and advanced research with the use of highest standards in both diagnosis and treatment of all cancer forms.

C. Sample

The sample included clinical nurses for the quantitative survey and nurse managers/administrators for the qualitative interview.

1. Inclusion Criteria

All present clinical Nurses from the NCCCR were invited to participate in this survey regarding their perceptions of shared governance, a total of 200 clinical nurses. The criteria for inclusion in the sample included being a registered nurse practicing
clinical nursing at the NCCCR. Excluded were the nurse managers and those in senior nursing administration. This latter population was invited to answer a set of questions other than the IPGN survey.

2. Sample size

Out of the 200 nurses surveyed, 105 returned completed questionnaire. Thus the response rate was 52.5%.

D. Ethical consideration

The distributed surveys included a cover letter identifying the researcher is a graduate student inviting the clinical nurses to participate in the study in addition to what the survey entails or what is it about. The letter explained also that the participation is strictly voluntary and has no risks to participants (Appendix C), and that the survey does not entail any information that would compromise the participants' confidentiality and anonymity was assured by avoiding inclusion of identifying data. To maintain confidentiality during the research, the collected data was stored with me till the end of the research. After having completed the study the surveys were kept with Mrs. Hammoud AEDN of the NCCCR.

Concerning interview with the nurse managers/ administrators, a full explanation of the whole study was provided to each candidate and a consent form for participating, taping, and quoting (Appendix D) was obtained before the beginning of each interview. The letter entailed that participation is strictly voluntary and that confidentiality will be
maintained in all published and written data analysis resulting from the study; Participant have the right to refuse participation or to withdraw their consent or discontinue participation at any time without penalty; Also they have the right of not answering or skipping any question if they prefer to. It was also mentioned that all data shared with other investigators will be aggregated data and have no identifiers that could be linked to their personal responses. Recorded tapes were kept in a locked office and only the investigator and co-investigators were entitled to use them in this study. All the tapes will be destroyed after 3 years of completing the study. The interview tapes will not be shared with collaborators.

Ethical approval for the study from the Hamad Medical Corporation Medical Research Center and the American University of Beirut Institutional Review Board were obtained on March 27, 2013 and April 10, 2013 consecutively.

E. Instrument

The instrument used for the quantitative survey was the Index of professional nursing governance (IPNG) survey (Appendix E). In addition, nurse managers and administrators’ inputs toward shared governance were solicited through an interview.

1. Methods of measurement

2. Quantitative

The "Index of Professional Nursing Governance" developed by Hess (2004) was used to assess nursing perceptions toward shared governance. The IPNG includes two sections: Section one consists of 11 questions that provide demographic information about the respondents. Two additional questions (Appendix F) pertaining to the country
of birth and the current grade were added to the pertinent questions. The demographics questions included sex, age, basic nursing educational preparation, highest educational degree, employment status, number of years as a practicing nurse, title of present position, type of nursing unit working on, number of years worked in this institution, and any specialty certifications.

Section two of the IPNG tool contains 86 questions rated on a 5 point Likert scale regarding how the CNs perceive control over nursing practice.

The Likert scale contains the following response possibilities: 5 = staff nurses only; 4 = primarily staff nurses with some nursing management/administration input; 3 = equally shared by staff nurses and nursing management/administration; 2 = primarily nursing management/administration with some staff nurse input; 1 = nursing management/administration only.

Subscale I: Professional control (who has control over professional practice in the organization), includes 13 questions that ask for perceptions on who has control over activities such as promoting opportunities and discipline. Subscale II: Organizational influence (who participates in governance activities within the organization), contains 14 questions that ask about perceptions on who has influence on issues such as staffing, equipment, and resources. Subscale III, Organizational recognition (who controls nursing personnel and related structures), involves 22 questions that address who has official authority in developing policies, standards of practice, and evaluations. Subscale IV: Facilitating structures (who determines and participates in governance decisions within the organization), consists of 10 questions regarding who is likely to participate in
committees affecting nursing issues at the unit and administration level. Subscale V: Liaison (who influences the resources that support professional practice), consists of 15 questions asking for perceptions of who has access to information and resources. Subscale VI: Alignment (who sets and negotiates conflict within the organization), accounts for 12 questions related to who is involved in issues around conflict and determining unit and hospital wide policies and procedures). Descriptive statistics, such as averages and percentages, are used to synthesize and describe data obtained from the above subscales. Loiselle, Profetto-McGrath, Polit, & Tatano-Beck (2007) define internal consistency of an instrument as reliability to the extent that all its subparts measure the same characteristic. (p. 319). The validity of the IPNG was noted in the study by Howel, Frederick, Olinger, Leftridge, Bell, Hess, et al. (2001) where it was used to measure nurses’ perceptions of governance facility wide. (p. 189). The IPNG was found to have content validity of 0.95 using Pop ham’s average congruency procedure. The internal consistency was demonstrated (alphas: 0.87 to 0.91) and the test retest reliability was 0.77.

3. Qualitative

A narrative description from the respondents provides more meaning and much deeper understanding of the phenomena under study. The obtained qualitative data add richness to the quantitative data results as it is suggested by Loiselle et al (2007). This qualitative part includes seven open ended questions addressed to the nurse managers’/administrators. The questions were as follows: 1. What does shared governance mean to you? 2. Do you feel you have enough shared governance practices in your work environment? 3. What are the internal factors that might affect the
implementation of shared governance at your area? 4. What are the external factors that might affect the implementation of shared governance at your area? 5. What do you think might positively drive the implementation of a shared governance model at your area? 6. Which strategies would you use in order to overcome the hindering forces toward the implementation of a shared governance model? 7. What is your role as a leader/manager/administrator in implementing a shared governance model? The interviewee comments were collected and divided in categories and themes. According to Bernard, thematic analyses move beyond counting explicit words or phrases and focus on identifying and describing both implicit and explicit ideas within the data, that is, themes. It is still the most useful in capturing the complexities of meaning within a textual data set and the most commonly used method of analysis in qualitative research (2010). The identified themes were aligned with the internal and external factors already identified in Chapter Two.

Themes relevant to the internal factors include CN professionalism, satisfaction, and quality of care, empowerment, and autonomy. The external factors are identified as health care restructuring, organizational influences, work environment models (shared governance and magnet hospital environment), and nursing leadership. The identified themes from this section provided an expansion to the quantitative data.

F. Procedure

The following information pertains to the approval of the research study. After filling the Research Proposal Form of Hamad Medical Corporation with the attached files
including the research proposal, the biographies of all investigators participating in the study, the CITI completion certificates of all investigators, the quality assurance including the signatures of all investigators, the consent form and the survey form and the flyer addressed to clinical nurses (Appendix A), documents were presented to Hamad Medical Corporation (HMC) Medical Research Center for review on March 6, 2013. The ethical approval for the study from Hamad Medical Corporation Medical Research Center was obtained on March 27, 2013 and the study (reference #13158/13: Clinical nurses perceptions on shared governance application at the National Center for Cancer Care and Research) was classified as “Exempt” according to the policies and regulations for research at HMC (Appendix G). On March 28 an amendment file including flyer for recruiting nurse managers/administrators (Appendix B), consent form addressed to the nurse managers/administrators, tape consent addressed to nurse managers/administrators, the questions that are going to be addressed to nurse managers/administrators during interviews, the protocol for recruiting nurse managers/administrators, and the waiver of informed consent requested by the research center were sent to the HMC Medical Research center for review. On March 31, 2013 approval for the amended file reference #13158/13 was obtained (Appendix H).

On Monday April 4, 2013, the application for Exemption from IRB Review from the American University of Beirut with the required documents (research proposal, Certificate of Research Approval from HMC, the flyers addressed to nurses and nurse managers/administrators, consent forms addressed to clinical nurses and nurse managers/administrators, questions addressed to nurse managers/administrators, study
transfer agreement form) was submitted to AUB Institutional Review Board for review. The approval for the study was obtained from the AUB IRB on April 10, 2013.

After obtaining the approvals the implementation of the study took place. All surveys were distributed to clinical nurses by me with the envelopes and the consent forms. Flyers were hanged on all unit boards. Also I sent invitations to 12 nurse managers/administrators. Calls were made to assure on participation and dates and time were set for all interviews. Ten nurse managers/administrators responded and showed interest in participating in the study. Two nurse managers/administrators apologized for not being able to participate as they were on leave.

Several visits to all clinical areas were done to remind all clinical nurses to participate in the study. Surveys in sealed envelopes were then collected from the boxes placed in each area for analysis.

Interviews with nurse managers and nurse administrators were performed according to the time and date set by each interviewee. During each interview participation and tape and quotation consent forms were obtained from each interviewee after having been provided with a full explanation of the study and obtaining a waiver of informed consent. All tapes were collected for analysis. Three participants refused to tape their inputs therefore notes about their responses were taken for more accuracy while quoting.

G. Data Analysis
The Statistical Package for Social Sciences (SPSS) Version 17.0 was used to analyze the IPGN descriptive data. Section one of the IPNG tool included the demographic information. A frequency table showing response rate results distribution over the units was obtained. Frequencies for gender differences were calculated. A frequency table provided explored the range of age in years of CN respondents. A pie graph was used to display the distribution of CNs related to their country of birth.

Nursing education was described using basic nursing education, highest level of nursing education, and certification and frequencies for each category calculated. The overall results were illustrated using a pie chart. Number of years in the present position and number of years in this institution were examined by frequencies and demonstrated in a line graph reflecting percentage in years.

For section two of the IPNG tool, the statistical significance was set at 0.05 with a confidence interval of 95%. The mean, standard deviation, and frequencies were calculated for each question. The mean, standard deviation, and Cronbach's alpha of each of the six subscales in section two (professional control, organizational influence, organizational recognition, facilitating structures, liaison, and alignment) were also calculated.

Section three of the survey consisted of seven open-ended questions focusing on a more personal perception of the managers/administrators professional practice environment in relation to shared governance. The respondents’ comments were transcribed according to the question. Responses were then categorized into internal and external factors that were
identified in Chapter Two. The responses were then explored for themes according to the internal and external factors.
CHAPTER IV

RESULTS

A. Response rate

The overall response rate was 52.5% (n=105) from a sample of 200 clinical nurses (Excluding nurses on annual leave). The final sample indicated that the higher response rates were received from clinical nurses in Day Care unit and the Palliative unit, table 4.1.

<table>
<thead>
<tr>
<th></th>
<th>Number of present clinical nurses</th>
<th>Number of Distributed surveys</th>
<th>Number of Returned surveys</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care</td>
<td>29</td>
<td>29</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>83.3</td>
</tr>
<tr>
<td>OPD</td>
<td>17</td>
<td>17</td>
<td>11</td>
<td>64.7</td>
</tr>
<tr>
<td>Ward 1</td>
<td>54</td>
<td>54</td>
<td>16</td>
<td>29.6</td>
</tr>
<tr>
<td>Ward 2</td>
<td>50</td>
<td>50</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Day care</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>Palliative</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>Total number of nurses</td>
<td>200</td>
<td>200</td>
<td>105</td>
<td>52.5</td>
</tr>
</tbody>
</table>

B. Demographics

The results in this study indicate that the overall NCCCR workforce is predominated by females (n=98 females, 93.3% versus n=7 male nurses, 6.7%
respectively). The higher distribution of men lies in the palliative care unit and it is about 30% of the male population.

The largest number of clinical nurses respondents (n=34) were between 26-30 years. Fourteen percent (n=14) about 41 years of age and above. A young generation of clinical nurses is dominating NCCCR.

**Table 4.2 Range of Age in Years of CN Respondents (N= 105)**

<table>
<thead>
<tr>
<th>Age groups of respondents</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>20-25 years</td>
<td>7</td>
<td>6.6</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>26-30 years</td>
<td>34</td>
<td>32.1</td>
<td>41.8</td>
</tr>
<tr>
<td></td>
<td>31-35 years</td>
<td>22</td>
<td>20.8</td>
<td>64.3</td>
</tr>
<tr>
<td></td>
<td>36-40 years</td>
<td>20</td>
<td>18.9</td>
<td>84.7</td>
</tr>
<tr>
<td></td>
<td>41 years and above</td>
<td>14</td>
<td>13.2</td>
<td>99.0</td>
</tr>
<tr>
<td></td>
<td>45.00</td>
<td>1</td>
<td>.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>92.5</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>177.00</td>
<td>7</td>
<td>6.6</td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>1</td>
<td>.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>7.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>106</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 4.1 illustrates the nationality of the CN participants. The highest percentage of the CNs at the NCCCR were Indians (n=64, 62.7%). In addition there were 23.5% from Philippines (n=24), 4.9% from Jordan (n=5), 2.9 from Egypt (n=3), 2.9% from Qatar (n=3), 2.9% from Tunisia (n=3).

**Figure 4.1 Cultural distribution of CNs at the NCCCR (n=102)**
About 51.4% of the clinical nurses’ respondents (n=54) indicated their basic nursing education was a nursing diploma and 48.6% (n=51) reported they had a baccalaureate degree as their basic nursing education.

About 51.4% of respondents (n = 54) indicated their highest educational degree was a diploma while 43.8% (n = 46) recorded having a baccalaureate degree in nursing. Four individuals listed having a master’s degree in nursing and one had a non-nursing master’s degree. The pie chart, Figure 4.2, provides an overview of the highest educational degree of CNs in this study in NCCCR.
In this study 38.5% (n=40) of the participants identified receiving a specialty certification.

CN respondents documented their present position in one of the following two categories: staff nurse (Grade 108) or charge nurse (Grade 109). About 90.5% (n=95) were staff nurses and 9.5% (n=10) indicated they are now in charge positions.

In this study the highest range of years of clinical nurses in their present position was from 6-10 years (n=50). Clinical Nurses with less than 5 years in present position represented 46.7% (n=49) of the sample.
Forty nine percent of the CN respondents \((n = 105)\) reported the number of years in their current institution to be less than 5 years; 50\% listed 6 to 10 years range of years in NCCCR. In addition 54 \% reported having a less than 5 years in their present position and 49 \% have a 6 to 10 range of years in present position. Figure 4.3 depicts the CNs. range in years in present position and institution.

![Figure 4.3 CNs in NCCCR Range in Years in Present Position and Institution.](image)

All clinical nurses working at the NCCCR reported having a full-time employment.

**C. Section II: IPNG Subscales regarding Shared Governance**

Section two of the IPNG survey tool consists of 86 statements organized into six subscales regarding control over professional nursing practice and shared governance.
The Likert scale for each statement had the following response possibilities regarding who has control over nursing practice: 5 = staff nurses only; 4 = primarily staff nurses with some nursing management/administration input; 3 = equally shared by staff nurses and nursing management/administration; 2 = primarily nursing management/administration with some staff nurse input; 1 = nursing management/administration only. Participants in this study were asked to rank each statement using the 5 point Likert scale; Mean scores were calculated for each statement and each subscale.

D. Summary of Results of IPGN subscales

The overall mean scores for each of the six subscales, ranged between 1.9092 and 2.1484, indicating that CNs generally perceive that their work environments are controlled by nursing management/administration only (1), or primarily nursing management/administration with some staff nurse input (2). An overview of the minimum and maximum score, mean, standard deviation and variance for each of the six subscales is provided in Table 4.10.

Findings of Subscale I, professional control, indicate CNs in this study do not perceive they have professional control over their work environment negatively affecting their control over practice as table 4.3 illustrates.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>M</th>
<th>SD</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>105</td>
<td>1</td>
<td>5</td>
<td>1.9092</td>
<td>0.72363</td>
<td>0.524</td>
</tr>
</tbody>
</table>
Control.

The results for Subscale II, organizational influence, suggest that CN respondents perceive limited ability to influence and access information in activities within this subscale, limiting their control over practice (Table 4.4).

| Table 4.4 Subscale II: Organizational Influence. |
|----------------|----------------|----------------|---------|---------|----------------|
|                | N              | Minimum Score  | Maximum Score | M       | SD       | Variance       |
| Organizational influence | 104            | 1              | 5             | 2.1484  | 0.83416  | 0.696          |

CNs in NCCCR perceive limited formal authority to control practice in these areas within Subscale III negatively affecting control over practice as identified in table 4.5.

| Table 4.5 Subscale III: Organizational Recognition. |
|----------------|----------------|----------------|---------|---------|----------------|
|                | N              | Minimum Score  | Maximum Score | M       | SD       | Variance       |
| Organizational Recognition | 105            | 1              | 5             | 2.0887  | 0.98134  | 0.963          |

The results for the facilitating structures subscale show that although some of the questions in this Subscale indicated that CNs experience some shared participation in certain activities, overall they perceive this area is controlled by primarily nursing management/administration (2). Table 4.6 shows that CNs perceive limited participation and control over practice inactivities within this Subscale.

| Table 4.6 Subscale IV: Facilitating Structures. |
|----------------|----------------|---------|---------|---------|----------------|
|                | N              | Minimum | Maximum | M       | SD       | Variance       |

39
Results of the liaison subscale indicate that CNs perceive they have limited access to information in these areas, limiting their control over practice, Table 4.7.

<table>
<thead>
<tr>
<th>Subscale V: Liaison.</th>
<th>$N$</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>$M$</th>
<th>$SD$</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison</td>
<td>105</td>
<td>1.00</td>
<td>5.00</td>
<td>2.0654</td>
<td>0.78854</td>
<td>0.622</td>
</tr>
</tbody>
</table>

CNs perceived limited ability to participate in these activities, negatively affecting their control over practice, Table 4.8.

<table>
<thead>
<tr>
<th>Subscale IV: Alignment</th>
<th>$N$</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
<th>$M$</th>
<th>$SD$</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment</td>
<td>105</td>
<td>1.00</td>
<td>5.00</td>
<td>1.9373</td>
<td>0.90477</td>
<td>0.819</td>
</tr>
</tbody>
</table>

An overview of the minimum and maximum score, mean, standard deviation and variance for each of the six subscales is provided in Table 4.9.

<table>
<thead>
<tr>
<th>Table 4.9: CNs in NCCCR Index of Professional Nursing Governance Subscale Scores.</th>
<th>$N$</th>
<th>Minimum score</th>
<th>Maximum score</th>
<th>$M$</th>
<th>$SD$</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Control</td>
<td>105</td>
<td>1.00</td>
<td>5.00</td>
<td>1.9092</td>
<td>0.72363</td>
<td>0.524</td>
</tr>
<tr>
<td>Organizational</td>
<td>104</td>
<td>1.00</td>
<td>5.00</td>
<td>2.1484</td>
<td>0.83416</td>
<td>0.696</td>
</tr>
</tbody>
</table>
Influence

Organizational Recognition

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>105</th>
<th>2.0887</th>
<th>0.98134</th>
<th>0.963</th>
</tr>
</thead>
</table>

Facilitating Structures

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>104</th>
<th>2.1231</th>
<th>0.98575</th>
<th>0.972</th>
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</table>

Liaison

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>105</th>
<th>2.0654</th>
<th>0.78854</th>
<th>0.622</th>
</tr>
</thead>
</table>

Alignment

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>105</th>
<th>1.9373</th>
<th>0.90477</th>
<th>0.819</th>
</tr>
</thead>
</table>

*p<0.5

Subscale I: Professional Control

Subscale I, Professional Control was found to have the lowest mean score of all subscales (n=105, M=1.9). Table 4.10 provides an overview of means from each statement in this subscale, from highest to lowest mean.

Table 4.10 Subscale I Professional Control Highest to Lowest Mean.

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Determining what activities nurses can do at the bedside</td>
<td>105</td>
<td>2.5143</td>
</tr>
<tr>
<td>13 Determining methods of nursing care delivery (e.g. primary, team, case management)</td>
<td>105</td>
<td>2.2381</td>
</tr>
<tr>
<td>12 Incorporating research ideas into nursing care</td>
<td>105</td>
<td>2.1810</td>
</tr>
<tr>
<td>11 Selecting products used in nursing areas</td>
<td>105</td>
<td>2.1619</td>
</tr>
<tr>
<td>2 Developing and evaluating patient care standards and quality assurance/improvement activities</td>
<td>105</td>
<td>2.1048</td>
</tr>
<tr>
<td>5 Determining activities of ancillary nursing personnel (aids, unit clerks, etc.)</td>
<td>105</td>
<td>2.0381</td>
</tr>
</tbody>
</table>
Results from this subscale indicate CNs in NCCCR (n = 105) perceive that areas such as personnel, nursing activities, standards and protocols, professional education, nurse performance and disciplinary action, selecting products, incorporating research and determining the model of nursing care delivery are controlled by nursing management/administration only (1) or primarily nursing management/administration with some staff nurse input (2).

Question one (n = 105, M = 2.5143) pertains to who controls and determines what activities nurses can do at the bedside had the highest mean however only four nurses (3.8%) of all CN respondents ranked staff nurses only have control over what activities nurses can do at the bedside. The majority of CN respondents (49%) listed nursing management/administration only and primarily nursing management/administration with some staff nurse input control what activities nurses can do at the bedside. For question thirteen (n = 105, M = 2.2381) 30 CNs chose nursing management/administration with some staff nurse input, 31 CNs chose nursing management/administration only and only
three CNs chose staff nurses only control determining methods of nursing care delivery (primary, team, or case management). For question 12 (n = 105, M = 2.1810) 31 CNs chose nursing management/administration only, 30 CNs responded that primarily nursing management/administration with some staff nurse input control incorporating research ideas into nursing care, while only 4 CNs chose primarily staff nurses with some nursing management/administration input, control this activity and only 1 CN chose staff nurses only.

The overall results of this subscale indicate that CNs perceive a limited role for themselves in professional control relevant to control over professional activities in this area. Cronbach’s alpha was calculated to be 0.915 for this subscale.

![Figure 4.5 CNs in NCCCR Frequency Subscale 1 Professional Control (n = 105).](image)

1- Nursing management/administration only.
2- Primarily nursing management/administration with some staff nurse input.
3- Equally shared by staff nurses and nursing management/administration.
4- Primarily staff nurses with some nursing management/administration input.

5- Staff nurses only.

Subscale II Organizational influence

Subscale II (n = 104, M = 2.1484), has the highest mean between the subscales.

Table 4.11 illustrates the mean result from each question from highest to lowest.

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Making daily patient care assignments for nursing personnel</td>
<td>105</td>
<td>2.8000</td>
</tr>
<tr>
<td>14 Determining how many and what level of nursing staff is needed for routine patient care</td>
<td>105</td>
<td>2.6476</td>
</tr>
<tr>
<td>17 Monitoring and procuring supplies for nursing care and support functions.</td>
<td>105</td>
<td>2.5619</td>
</tr>
<tr>
<td>15 Adjusting staffing levels to meet fluctuations in patient census and acuity.</td>
<td>105</td>
<td>2.5143</td>
</tr>
<tr>
<td>18 Regulating the flow of patient admissions, transfers, and discharges.</td>
<td>105</td>
<td>2.5143</td>
</tr>
<tr>
<td>22 Consulting hospital services outside of nursing (e.g. dietary, social service, pharmacy, human resources, and finance).</td>
<td>105</td>
<td>2.1429</td>
</tr>
<tr>
<td>24 Determining cost effective measures such as patient placement and referrals (e.g. placement of ventilator dependent patients, early discharge of patients to home health care).</td>
<td>105</td>
<td>2.1048</td>
</tr>
<tr>
<td>21 Consulting nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).</td>
<td>105</td>
<td>2.0476</td>
</tr>
<tr>
<td>19 Formulating annual unit budgets for personnel, supplies, equipment and education.</td>
<td>105</td>
<td>1.9905</td>
</tr>
<tr>
<td>23 Making recommendations concerning other departments’ resources.</td>
<td>105</td>
<td>1.8952</td>
</tr>
<tr>
<td>25 Recommending new hospital services or specialties (e.g. gerontology, mental health, birthing centers).</td>
<td>104</td>
<td>1.8365</td>
</tr>
<tr>
<td>20 Recommending nursing salaries, raises and benefits.</td>
<td>105</td>
<td>1.7619</td>
</tr>
<tr>
<td>26 Creating new clinical positions.</td>
<td>105</td>
<td>1.6667</td>
</tr>
<tr>
<td>27 Creating new administrative or support positions.</td>
<td>105</td>
<td>1.6095</td>
</tr>
</tbody>
</table>
Figure 4.6 presents the frequencies of Subscale II, organizational influence, indicating that CNs (n = 151, M = 2.1) in NCCCR perceive low influence and have access to some information in certain activities within this subscale.

Question (27) Creating new administrative or support positions, has the lowest mean (n=105, M=1.6095). Sixty nine percent of clinical nurses ranked Nursing management/administration only. The highest mean refers to question (16) Making daily patient care assignments for nursing personnel (n=105, M=2.8) where 19 CNs listed and Nursing management/administration only and 14 CNs listed staff nurses only. CNs indicated they perceive a limited role in the influence and access to information within the dimensions of subscale II, organizational influence, negatively affecting control over practice. Cronbach's alpha was calculated at 0.914 for this subscale.
Table 4.12 illustrates the statements from subscale III, directed at which group in the CNs perspective has formal authority in several activities, from highest to lowest mean score. The data in this subscale has a mean score (M = 2.0887) indicating that overall, CNs perceived limited formal authority in most activities in this subscale. They perceive formal authority in the workplace -- control over practice and influencing resources is controlled by primarily nursing management/administration with some staff nurse input and seems slightly moving toward equally shared by staff nurses and nursing
management/administration. Question (40) Procedures for determining daily patient care assignments has the highest mean (n=105, M=2.8381); 30 CNs listed Nursing management/administration only, 23 CNs listed Primarily nursing management/administration with some staff nurse input, and 25 CNs listed Staff nurses only. Question (33) Written guidelines for disciplining nursing personnel, has the lowest mean (n=105, M=1.6476) 70 CNs listed Nursing management/administration only, 16 CNs listed Primarily nursing management/administration with some staff nurse input, and 6 CNs listed Staff nurses only.

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 Procedures for determining daily patient care assignments</td>
<td>105</td>
<td>2.8381</td>
</tr>
<tr>
<td>41 Daily methods for monitoring and obtaining supplies for nursing care and support Functions</td>
<td>105</td>
<td>2.8286</td>
</tr>
<tr>
<td>42 Procedures for controlling the flow of patient admissions, transfers, and discharges</td>
<td>105</td>
<td>2.7333</td>
</tr>
<tr>
<td>39 Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity</td>
<td>105</td>
<td>2.7238</td>
</tr>
<tr>
<td>38 Acuity and patient classification system for determining how many and what level of nursing staff is needed for routine patient care</td>
<td>105</td>
<td>2.4762</td>
</tr>
<tr>
<td>46 Formal mechanisms for consulting and enlisting the support of hospital services outside of nursing (e.g. dietary, social service, pharmacy, physical therapy)</td>
<td>105</td>
<td>2.2857</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Value</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>49</td>
<td>Access to office equipment (phones, personal computers, copy machines)</td>
<td>105</td>
</tr>
<tr>
<td>45</td>
<td>Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical)</td>
<td>105</td>
</tr>
<tr>
<td>28</td>
<td>Written policies and procedures that state what nurses can do in direct patient care</td>
<td>105</td>
</tr>
<tr>
<td>37</td>
<td>Procedures for generating schedules for RNs and other nursing staff</td>
<td>105</td>
</tr>
<tr>
<td>43</td>
<td>Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education</td>
<td>105</td>
</tr>
<tr>
<td>47</td>
<td>Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass)</td>
<td>105</td>
</tr>
<tr>
<td>32</td>
<td>Organizational charts that show job titles and who reports to whom</td>
<td>105</td>
</tr>
<tr>
<td>31</td>
<td>Written process for evaluating nursing personnel (performance appraisals)</td>
<td>105</td>
</tr>
<tr>
<td>29</td>
<td>Written patient care standards and quality assurance/improvement programs</td>
<td>105</td>
</tr>
<tr>
<td>48</td>
<td>Location of office space</td>
<td>105</td>
</tr>
<tr>
<td>34</td>
<td>Annual requirements for continuing in services</td>
<td>105</td>
</tr>
<tr>
<td>36</td>
<td>Policies regulating promotion of nursing personnel to management and leadership Positions</td>
<td>105</td>
</tr>
<tr>
<td>30</td>
<td>Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises</td>
<td>105</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>35</td>
<td>Procedures for hiring and transferring nursing personnel</td>
<td>105</td>
</tr>
<tr>
<td>44</td>
<td>Procedures for adjusting nursing salaries, raises and benefits</td>
<td>105</td>
</tr>
<tr>
<td>33</td>
<td>Written guidelines for disciplining nursing personnel</td>
<td>105</td>
</tr>
</tbody>
</table>

Figure 4.7 illustrates the frequency distribution of the subscale III statements.

**Figure 4.7 CNs in NCCCR Frequency Subscale III Organizational Recognition (n = 105).**

- 1- Nursing management/administration only.
- 2- Primarily nursing management/administration with some staff nurse input.
- 3- Equally shared by staff nurses and nursing management/administration.
- 4- Primarily staff nurses with some nursing management/administration input.
- 5- Staff nurses only.

**Subscale IV: Facilitating Structures**
Subscale IV, facilitating structures (n = 104) with an overall mean of (2.1231) deals with who participates in committee structures and a number of activities affecting nursing issues at the unit and administration level. Question (50) Participation in unit committees for clinical practice has the highest mean (n=104, M=2.6442); 46 CNs listed Equally shared by staff nurses and nursing management/administration, 17 CNs listed Nursing management/administration only and 27 CNs listed Primarily nursing management/administration with some staff nurse input. Table 4.13 provides an overview of the mean scores for each statement from highest to lowest.

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in unit committees for clinical practice</td>
<td>104</td>
<td>2.6442</td>
</tr>
<tr>
<td>Participation in nursing departmental committees for clinical practices</td>
<td>104</td>
<td>2.4712</td>
</tr>
<tr>
<td>Participation in the multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice</td>
<td>104</td>
<td>2.3558</td>
</tr>
<tr>
<td>Participation in unit committees for administrative matters such as staffing, scheduling and budgeting</td>
<td>105</td>
<td>2.1238</td>
</tr>
<tr>
<td>Forming new unit committees</td>
<td>104</td>
<td>2.0577</td>
</tr>
<tr>
<td>Forming new nursing departmental committees</td>
<td>105</td>
<td>2.0571</td>
</tr>
<tr>
<td>Forming new multidisciplinary professional committees</td>
<td>104</td>
<td>2.000</td>
</tr>
<tr>
<td>Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting</td>
<td>105</td>
<td>1.9238</td>
</tr>
<tr>
<td>Participation in the hospital administration committees for matters such as</td>
<td>105</td>
<td>1.8286</td>
</tr>
</tbody>
</table>
The overall results suggest that most CNs perceive little or no control in the facilitating structures including committees that require participation in activities affecting nursing issues at the unit and administration level. Cronbach’s alpha was calculated at 0.954 for this subscale. Figure 4.8 illustrates the frequency distribution of the statements of this subscale.

Figure 4.8 CNs in NCCCR Frequency Subscale IV Facilitating Structures (n = 105).

- 1- Nursing management/administration only.
- 2- Primarily nursing management/administration with some staff nurse input.
- 3- Equally shared by staff nurses and nursing management/administration.
- 4- Primarily staff nurses with some nursing management/administration input.
- 5- Staff nurses only.
Subscale V: Liaison

Subscale V, liaison (n = 105, M = 2.0654), focuses on which group has access to information regarding activities that determine allocation of organizational resources that control practice such as quality assurance of nursing practice, professional accountability, unit budget and expenses, hospital finances, unit and departmental goals, strategic planning, results of satisfaction surveys, physician/nurse satisfaction with collaborative practice, nurse satisfaction, statistics of nurse turnover and nurse ratios, management and physician opinion of nursing services, and access to up-to-date nursing resources.

Question (69) Nurses’ satisfaction with their general practice has the highest mean (n=105, M=2.4571); 21 CNs listed Staff nurses only, 39 CNs listed Nursing management/administration only, and 25 CNs listed Primarily nursing management/administration with some staff nurse input. The results indicate that CNs perceive on average that nursing management/administration only have access to information in these areas. Question (63) has the lowest mean (n=105, M=1.4571) Hospital’s financial status; 79 CNs listed Nursing management/administration only, 9 CNs listed Primarily nursing management/administration with some staff nurse input, and only one CN listed Staff nurses only. Table 4.14 provides the mean scores for questions in this subscale indicating that CNs perceive more access to information regarding satisfaction with general clinical than in other areas.

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>105</td>
<td>2.4571</td>
</tr>
</tbody>
</table>
Figure 4.9 demonstrates the frequency results from subscale V. In general CNs perceive a limited access to information relevant to the subscale of liaison concerning the activities that enable control over nursing practice and influence of organizational resources. Cornbrash’s alpha for this subscale was calculated at 0.923.
1- Nursing management/administration only.
2- Primarily nursing management/administration with some staff nurse input.
3- Equally shared by staff nurses and nursing management/administration.
4- Primarily staff nurses with some nursing management/administration input.
5- Staff nurses only.

**Subscale VI: Alignment**

Subscale VI, (n= 105, M =1.9373), deals with the alignment or the abilities of various groups to participate in setting goals and negotiating the resolution of conflict at various levels in the organization and has the lowest mean between all scales. Table 4.15 illustrates the results of this subscale ranging from the highest mean to the lowest. The highest mean in this subscale refers to question (75) Negotiate solutions to conflicts among professional nurses (n=105, M=2.2286). Twenty eight CNs listed Nursing management/administration only, and 43 CNs listed primarily nursing management/administration with some staff nurse input. Question (83) Formulate the
mission, philosophy, goals, and objectives of the hospital has the lowest mean between the statements in this subscale 83 CNs listed Nursing management/administration, 25 CNs listed Primarily nursing management/administration with some staff nurse input and 6 CNs listed Staff nurses only.

<table>
<thead>
<tr>
<th>Question</th>
<th>Count</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>75</strong> Negotiate solutions to conflicts among professional nurses</td>
<td>105</td>
<td>2.2286</td>
</tr>
<tr>
<td><strong>81</strong> Write the goals and objectives of the nursing unit</td>
<td>105</td>
<td>2.1714</td>
</tr>
<tr>
<td><strong>76</strong> Negotiate solutions to conflicts between professional nurses and physicians</td>
<td>105</td>
<td>2.1619</td>
</tr>
<tr>
<td><strong>77</strong> Negotiate solutions to conflicts between nurses and nursing management</td>
<td>105</td>
<td>2.0857</td>
</tr>
<tr>
<td><strong>78</strong> Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc.)</td>
<td>105</td>
<td>2.0762</td>
</tr>
<tr>
<td><strong>84</strong> Write unit policies and procedures</td>
<td>105</td>
<td>1.9048</td>
</tr>
<tr>
<td><strong>85</strong> Determine nursing departmental policies and procedures</td>
<td>105</td>
<td>1.8857</td>
</tr>
<tr>
<td><strong>79</strong> Negotiate solutions to conflicts between professional nurses and hospital and hospital Administration</td>
<td>105</td>
<td>1.8667</td>
</tr>
<tr>
<td><strong>80</strong> Create a formal grievance procedure</td>
<td>105</td>
<td>1.7524</td>
</tr>
<tr>
<td><strong>82</strong> Write the philosophy, goals and objectives of the nursing department</td>
<td>105</td>
<td>1.7429</td>
</tr>
<tr>
<td><strong>86</strong> Determine hospital-wide policies and procedures</td>
<td>105</td>
<td>1.7048</td>
</tr>
<tr>
<td><strong>83</strong> Formulate the mission, philosophy, goals, and objectives of the hospital</td>
<td>105</td>
<td>1.6667</td>
</tr>
</tbody>
</table>

Figure 4.10 illustrated the frequency of the statements of the Alignment subscale. Cronbach's alpha for this subscale was 0.958.
E. Narrative responses

The qualitative part of the survey included seven open ended questions. A more personal view from the side of nurse managers/administrators was highlighted in this section. Common themes were identified according to internal and external factors. Statements related to each theme are discussed as follows

1- What does shared governance mean to you?
The themes related to internal factors included CNs ability to influence in the decision making, quality of care and collaboration.

- **Influence in decision making:**
  - “Sharing the decisions, governance, ownership; everything that goes with management and leadership”
  - “Shared governance is to include more and more representation in the decision making”
  - “Sharing decision making, and not delegating the role to one staff”
  - “Shared governance mean to me that staff can participate effectively in the decision making according to the organizational policies and procedures”
  - “Having shared decision making, providing more empowerment to nurses through emphasizing their inputs in the decision making process”
  - “Having inputs regarding nursing practice, being involved in the decision making”
  - “Compile decision making”

- **Quality of care**
  “Nurses have the autonomy and power to decide whatever the best quality of care of patient should be provided based on EBP”
  - “Quality of care should be evaluated by nurses with the assistance and support of leadership”
  - “To participate in any decision related to patient care, patient satisfaction”
• Collaboration
  - “Sit together CNs and management team to come up with decisions related to patient care and improvement”
  - “Having everybody sitting around the table in order to decide on all issues related to patient care and organization performance and patient safety”
  - “Essential to any hospital, decision should be made collaboratively with all health care providers”

The themes related to external factors include the work environment (management and administration) and organizational influence and collaboration.

• Work environment (management and administration) and organizational influence

  - “Shared governance is a delicate balance between facility and staff participation in planning and decision making on one hand and administrative accountability on the other hand”
  - “Having the right and the support to share in the organizational related to decision making”
• Collaboration:
  - “Work in collaboration with the stake holders”
  - “Working in collaboration with the management team in order to provide better quality of patient Care”
  - “Partnership in decision making”

2- Do you feel you have enough shared governance practices in your work environment?

The responses to this question were distributed as follows:

* 50 % of nurse managers/administrators felt they have shared governance at their work environment.
* 20% of nurse managers/administrators felt they have shared governance at their work place sometimes
* 30% of nurse managers/administrators felt they do not have shared governance at their work environment.

3-What are the internal factors that might affect the implementation of shared governance at your area?

The themes related to internal factors include the influence in shared decision making and quality of care:

• Influence in decision making
  – “Lack of an adequate communication channels”
  – “The centralized decision making”
– “Inability to share in the decision making”

- Quality of care
  - “Nursing capabilities and knowledge”
  - “Having employees with a low range of educational level practicing within the institution”
  - “Busy shifts and workloads”
  - “Having multicultural setting with different mentalities and beliefs”
  - “Having a multinational setting which is a multi school environment”
  - “Instability of positions meaning there is a lot of positions exchanges taking place at all time”

4- What are the external factors that might affect the implementation of shared governance at your area?

The themes related to external factors include the Work environment (management and administration) and organizational influence, and collaboration:

- Work environment (management and administration) and organizational influence
  - “Continuous change in the leadership personnel”
  - “Micromanagement and leadership based on old theories, not on transformational leadership”
  - “Most leaders are not playing the influencing role, they are not empowering staff to be part of the decision making”
- “Lack of transparency from the leader’s side”
- “Weakness of higher levels of management”
- The system itself has a lot of deficiencies in empowering nurses and implementing shared governance.
- The system and the structure of the organization as a whole
- The vision of the corporate
- Centralization and imposed organizational decisions
- Interference from stakeholders and imposed decisions and practices

• Collaboration
  - “Physician dominated environment, nurses do not have a say, with no support for other health care providers to have inputs”
  - “Imposed decision making from stake holders”
  - “Nurses versus physicians conflicts”

5- What do you think might positively drive the implementation of a shared governance model at your area?

The themes related to internal factors include influence in shared decision and quality of care:

• Influence in decision making
  - “Every person should be valued for his input”
− “Involve CNs in the decision making at all levels”

• Quality of care
− “Starting with myself, changing my attitudes and act as role model”
− “Hiring more experienced personnel and placing staff at the right position”
− “Having a well documented set of principles and guidelines”

The themes related to external factors include work environment and organizational influence, and collaboration

• Work environment (management and administration) and organizational influence
− “The organizational structure should be reviewed and modified”
− “Creating a supportive and an empowering atmosphere”
− “Strong support from superiors”
− “Support from all stakeholders”
− “Motivating staff to move toward shared governance practices”
− “Having more transparency from the side of the leaders”

• Collaboration
− “Involve CNs in the strategic planning”
− “Collaborating and creating a team work for better implementation of shared governance”
6- Which strategies would you use in order to overcome the hindering forces toward the implementation of a shared governance model?

The themes related to internal factors include influence in the decision making, quality of care and satisfaction:

- **Influence in decision making**
  - “Seeking inputs from all nurses”
  - “Create better channels of communication”
  - “Empowering the decision of the front line nurses”
  - “Involve CNs in patient care in all issues related to patient care organizational performance and patient safety”
  - “Staff input must be heard valued and acted upon”

- **Quality of care**
  - “Provide more education about shared governance”
  - “Identify the criteria of putting the right person in the right place”
  - “Perform a choc change”
  - “Encourage evidence based practices”
  - “Enhance Critical thinking and leadership skills through educational workshops and sessions”
  - “Report unacceptable behaviors and attitudes”
  - “Create improvement plans and projects”
  - “Adequate nurse to patient ratio”
  - “More education and implementation of evidence based practices”
• Satisfaction
  - “Maintaining job satisfaction therefore high quality of patient care”

The themes related to external factors include work environment (management and administration) and organizational influence and collaboration

• Work environment (management and administration) and organizational influence
  - “Having the authority to lead”
  - “Seeking for top management support”
  - “Encourage the implementation of unit councils”
  - “Create a non blaming environment”

• Collaboration
  - “Creating a partnership between the organization and the individual nurse”,
  - “More collaboration with top level management”

7-What is your role as a leader/manager/administrator in implementing a shared governance model?

The themes related to internal factors include influence in decision making, quality of care and professionalism

• Influence in decision making
- “Encourage sharing decision making”
- “Involve CNs in all decisions”

• Quality of care
  - “Monitor and supervise all educational activities”
  - “Responsible for delivering high quality of educational standards”
  - “Encourage in service sessions”
  - “Encourage continuing education”
  - “Enhance the effectiveness of nursing education”

• Professionalism
  - “Act as role model”
  - “Once I have the documented guidelines and protocols I will adhere to implement shared governance and be responsible and committed to deploy it among my employees”
  - “To find the barriers for implementing a shared governance model in collaboration with CNs then set action plans and put a time frame to implement these plans”

• The themes related to external factors include work environment (management and administration) and organizational influence, and collaboration
• Work environment (management and administration) and organizational influence
  - “Being more transparent as leader”
  - “Motivating staff and empowering them to practice according to shared governance principles”

• Collaboration
  - “Gain the input of nurses, consider them as partners”
  - “Encourage staff to participate positively in the critical thinking and decision making and to consider their inputs”
  - “Support my subordinates and emphasize their inputs”
  - “Support from superiors”

F. Summary of Results

A greater number of CN respondents indicated their basic nursing education was a nursing diploma which was about 51.4 % of the clinical nurses’ respondents and 48.6% reported they had a baccalaureate degree as their basic nursing education. About 51.4 % of respondents indicated their highest educational degree was a diploma while 43.8% recorded having a baccalaureate degree in nursing. And only four individuals listed having a master’s degree in nursing and one had a non-nursing master’s degree. In this
study 38.5 % of the participants identified receiving a specialty certification. All the CNs listed working as full-time.

The quantitative data from the IPNG subscales, Professional control (M = 1.9092); Organizational influence (M = 2.1484); Organizational recognition (M = 2.0887); Facilitating structures (M = 2.1231); Liaison (M = 2.0654); Alignment (M = 1.9373), provided information that indicates CNs perceive limited shared governance in several areas within each subscale. The overall results indicate that governance is perceived to be held mainly by nursing management/administration with some staff nurse input and by nursing management/administration.

The qualitative responses revealed internal and external factors previously outlined in Chapter 2. The themes representing the internal factors include influencing in the decision making, quality of care, Professionalism and Satisfaction. Themes relevant to the external factors include, organizational influences and work environment (management and administration), and collaboration (collegial support). The lack of influence and support in decision making affecting patient care issues in addition to the lack of collaboration are clearly evident and provider richness to the statistical findings. The next chapter presents a discussion of the methodological issues, the conceptual framework, and the research findings. The limitations of the study are provided and recommendations are made for stakeholders and additional research.
The six subscales (professional control, Organizational influence, Organizational recognition, Liaison and Alignment) provide us with information related to specific areas of the shared governance concept. But when taken together, the overall scores resulting from these subscales reveal who is exerting more influence over their professional practice environment and decisions within the organization.

A. Methodology

1. Response rate

The overall response rate was about 52.5%. The total number of the CNs is about 279. The number of distributed surveys was 200 having a huge number of CNs on leave or transferred to other hospitals; 105 CNs responded by returning the filled surveys. The response rate might be considered as average to low if we consider the total population of the CNs (N=279). This is due to the high tendency of displacing the CNs. On the other hand, it maybe that some CNs are not responding due to the feelings of disinterest and disengagement in surveys. In order to get higher responses nurses must feel that their feedback is valuable and acted on in a way that demonstrates their voice is heard.

2. Conceptual Framework
The conceptual framework used for this study was based on Hess’s understanding of control over nursing practice and shared governance as articulated in the IPNG survey tool. The conceptual framework provided a structure that was effective in maintaining the continuity between the description of the study tool and subsequent discussion of the results of this study that was supported by the relevant literature. The IPNG survey tool captured pertinent information about the CNs.

3. IPGN demographics

The results in this study indicate that the overall NCCCR workforce is predominated by females (93.3%). According to the latest statistics, male nurses represent just a small fraction of the nursing workforce in the United States (American Society of Registered Nurses ASN, 2012). About 51.4% of the clinical nurses’ respondents indicated their basic nursing education was a nursing diploma and 48.6% reported they had a baccalaureate degree as their basic nursing education. About 51.4% of respondents indicated their highest educational degree was a diploma while 43.8% recorded having a baccalaureate degree in nursing. Four individuals listed having a master’s degree in nursing and one had a non-nursing master’s degree. In her study, Peirce (2010) states that the number of nurses is not as important to the provision of care as the quality of nurses produced. Pragmatically, nursing education should prepare the workforce. Idealistically, nursing education should prepare an educated constituency who can improve patient care. Realistically, the profession of nursing needs it all, an adequate number of nurses prepared at the baccalaureate level, who can improve patient care (Pierce, 2010). In this study 38.5% of the participants identified receiving a specialty certification.
should recommend and stress on CNs to obtain more educational offering and
development. Continuing education should be supported. This will prompt more nurses to
seek for further education. The largest number of clinical nurses respondents (n=34)
were between 26-30 years. Fourteen percent were about 41 years of age and above. A
young generation of clinical nurses is dominating NCCCR. By 2012, the average age of
the RN population in the United States is 46.8 years (Nursing Statistics, 2012). This
reveals that NCCCR is having a young generation of nurses suggesting more energetic
population with more capabilities. The highest percentage of the CNs at the NCCCR was
Indians (62.7%). There were 23.5% from Philippines, 4.9% from Jordan, 2.9 from Egypt,
2.9% from Qatar, and 2.9% from Tunisia. The highest percentages of Nurses in Qatar are
coming from different nationalities. This distribution reflects that of other health centers
in Qatar. Local nurses are forming the lowest percentage of all. Many efforts are working
toward attracting Qatari citizens to choose nursing as a profession in the aim of
increasing local nursing care providers.

B. Discussion of IPNG results

The dimensions of shared governance are examined using the six subscales of the
IPGN. Means of less than” 3” on the 5 point Likert scale indicated that CNs perceived
that nursing management/administration had more control over their practice than they.
For each subscale Cronbach’s alpha was calculated to be greater than 0.75.

**Subscale I: Professional control**
Professional Control was found to have the lowest mean score of all subscales (n=105, M=1.9092). Results from this subscale indicate CNs in NCCCR (n = 105) perceive that areas such as personnel, nursing activities, standards and protocols, professional education, nurse performance and disciplinary action, selecting products, incorporating research and determining the model of nursing care delivery are controlled by nursing management/administration only or primarily nursing management/administration with some staff nurse input. NCCCR should look for strategies to involve CNs in the decision making processes. Similar results were found by Lee et al. (2000); the IPNG analysis showed same results to this subscale (M=1.7). Howell et al. (2001) provided similar results to this study indicating nurse management/administration dominates the activities in this subscale with little to no input from clinical nurses. It is important that stakeholders, executives, managers and administrators recognize the issues that CNs at the NCCCR have regarding the initiatives toward the quality of their workplace in each area of their practices. The recognition of these opinions and concerns of CNs will provoke efforts to address these concerns hence increasing CNs control over their practice in addition to improving their morale and their satisfaction that consequently lead to promoting the patient’s quality of care.

**Narrative responses related to professional control:**

The first question of the open-ended questions in the qualitative section of this study asked Nurse managers/administrators to describe. What does shared governance mean to you? Their responses indicated that being supported, encouraged, and having influence in decision making positively affects their control over nursing practice. They described how participating in decision making would have a positive impact on their
professional practice environment including areas such as best practice, research, integrating new practices/policies, nursing standards, and practice issues. One of the respondents defined shared governance as “Sharing the decisions, governance, ownership; everything that goes with management and leadership”, and “Having everybody sitting around the table in order to decide on all issues related to patient care and organization performance and patient safety”. Kramer and Schmalenberg (2003) provided the same qualitative results; they defined control over nursing as participating in the decision making at all levels.

Quantitative results indicated that CNs do not perceive that they are involved in the decision making even though they emphasized its importance and the need to implement it; These responses are congruent with the qualitative Ones. Further research regarding CNs perceptions of their involvement and decision making in these areas emphasizing control over nursing practice specific to areas affecting patient care is suggested. Studies including focus groups are also suggested. Such studies will provide CNs at the NCCCR with the opportunity to describe their control over nursing practice. A pre and post-implementation study of a professional practice model that would contribute to the CNs’ ability to identify, describe, and compare their experiences regarding control over nursing practice should be performed.

**Subscale II: Organizational influence**

Subscale II, organizational influence, identifies who influences and has access to information supporting professional work relevant to a number of nursing activities. Subscale II has a mean of 2.1484, which is the highest mean between the
subscales. CNs in NCCCR perceive slightly more opportunity to influence and have access to some information in certain activities within this subscale. Yet CNs perceive nursing management/administration only and primarily nursing management/administration with some staff input influence and have access to information in most dimensions in this subscale. Similar results were indicated by Lee et al. (2000) after analyzing IPNG data of subscale II preceding the implementation of a unit-based shared governance model. Howell et al. (2001) also reported results from subscale II indicating management/administration with some staff input controlling the activities in this subscale. Tourangeau et al. (2005), Spence Laschinger (2004) and Ulrich, Buerhaus, Donelan, Norman, & Dittus (2005) indicated that the lack of ability for nurses to influence and have access to information that concerns resources like adequate staffing to meet patients’ demands, acuity distributions, and decision making at all levels influences nurses’ satisfaction in a negative way.

**Narrative responses related to organizational influence**

Answers to question (5) “what do you think might positively drive the implementation of a shared governance model at your area?” and question (6) “which strategies would you use in order to overcome the hindering forces toward the implementation of a shared governance model?” indicated that having access to decision making and activities that affect direct patient care and promote a professional practice environment are the most important factors in significantly changing the CNs’ control over nursing practice. Statements such as: “Seeking inputs from all nurses”, “Create better channels of communication”, “Empowering the decision of the front line nurses”,...
“Involve CNs in patient care in all issues related to patient care organizational performance and patient safety” and “Staff input must be heard valued and acted upon” stress on the need of CNs to have access to decision making and activities affecting patient care and professional environment. These results are similar to the ones presented by Tourangeau at al. (2005), Spence Laschinger (2004) and Ulrich et al. (2005). Congruency between quantitative and qualitative results in this subscale is well noted as CNs perceived that management/ administration have control over the activities within this subscale with little to no CNs inputs.

Health care organizations should be committed to work towards recognizing and valuing CNs’ inputs in areas that directly affect patient care. In order to enhance communication and recognize the value of each CN managers/administrators should be encouraged to survey CNs regarding input into decision making at all levels including patient, unit and organization. Such surveys will provide results that can be used in setting goals for facilitating CN input in decision making.

**Subscale III: Organizational Recognition**

Subscale III, organizational recognition (M=2.0887), examines who in the organization has formal authority, influence over the information and resources that support professional work relevant to nursing personnel, control over practice, and influencing resources. CNs in NCCCR perceive limited formal authority to control practice in these areas within Subscale III negatively affecting control over practice. CNs perceive formal authority in the workplace, control over practice and influencing resources is controlled by primarily nursing management/administration with some staff nurse input and seems slightly moving toward equally shared by staff nurses and nursing
management/administration. Lee et al. (2000) presented results of the IPNG analysis related to this subscale which are a little bit higher than the overall mean of the subscales results in this study. Howell et al. (2001) also provided results inclined toward nurse management/administration having control over practice with some clinical nurses input on few areas in this subscale.

**Narrative responses related to organizational recognition:**

Answers to question (3) what are the internal factors that might affect the implementation of shared governance at your area?, and to question 4 what are the external factors that might affect the implementation of shared governance at your area?, resulted in a set of answers addressing the lack of transparency and support from the superiors side. Such statements are as follows: “Most leaders are not playing the influencing role, they are not empowering staff to be part of the decision making”, “Lack of transparency from the leader’s side”, “Weakness of higher levels of management”, “The system itself has a lot of deficiencies in empowering nurses and implementing shared governance”. Results of this subscale are similar to the results indicated by Greco et al. (2006), Spence Laschinger (2004) and Ulrich et al. (2005) indicating that CNs are not provided with the adequate opportunities to influence in the decisions related to work place, the organization and the patient care. As advocated by CHSRF (2006b), staffing plans must be developed at the organization and unit levels in consultation with front-line nurses CNs expertise, an element of professionalism, might be further acknowledged by organizational structures and the public stakeholder. The overall job satisfaction and recruitment/retention of CNs are crucial and actually affected by the fact of recognizing the importance of CNs having decision making opportunities within the organization. As a
consequence the value of this will be their obvious dedication to provide a high quality patient care.

**Subscale IV: Facilitating Structures**

Subscale IV, facilitating structures, is identifying who participates in committee structures and activities affecting nursing issues from the unit to the administrative level (M=.2.1231). Overall, CNs perceive that greater participation lies with nursing management/administration only and primarily nursing management/administration with some staff input controlling the nursing issues within this subscale, at the unit and administrative level. The overall results suggest that most CNs perceive little or no control in the facilitating structures including committees that require participation in activities affecting nursing issues at the unit and administration level. Similar results were presented by Lee et al. (2000) and Tourangeau et al. (2005).

**Narrative responses related to facilitating structures**

Several statements provided by nurse managers revealed that CNs are lacking for support and empowerment; they also mentioned that the system as a whole have many deficiencies as well as the organizational structure. Such statements are: “The system itself has a lot of deficiencies in empowering nurses and implementing shared governance”, “The system and the structure of the organization as a whole”, “The organizational structure should be reviewed and modified” etc.…

Responses to question (2) Do you feel you have enough shared governance practices in your work environment? were distributed as follows: 50 % of nurse managers/administrators felt they have shared governance at their work environment,
20% of nurse managers/administrators felt they have shared governance at their work place sometimes and 30% of nurse managers/administrators felt they do not have shared governance at their work environment. Clarifications about whether these distributions applied to the patient, unit, or organizational level should be investigated. The study by Manojlovich (2005) on structural empowerment indicated that nurses continue to experience a lack of participation in the decision making at the organizational level in their work place which consequently affects CNs professional practice as well as their job satisfaction. Clinical nurses in this study perceive limited control over nursing practice when participating in activities in this subscale. A special concern is the lack of control that CNs perceive about participating in multidisciplinary professionalism and staff scheduling. The implementation of professional practice environments which recognizes CN involvement in decision making at all levels and interdisciplinary collaborative practice, will provide positive outcomes for the CNs and the organization as a whole.

**Subscale V: Liaison**

Subscale V, liaison, focuses on which group has access to information regarding activities that determine allocation of organizational resources that control and support professional practice. Subscale V, liaison had a mean of 2.0654. Lee et al. (2000) indicated same results of this IPNG subscale (M=2.0).

**Narrative responses related to Liaison:**

One of the respondents focused on the lack of resources necessary to maintain standards of practice through answering question (7) what is your role as a leader/manager/administrator in implementing a shared governance model? He said: “Once I have the documented guidelines and protocols I will adhere to implement shared
governance and be responsible and committed to deploy it among my employees. This comment is similar to the reported findings of Spence Laschinger, Sabiston, Finegan, & Shamian (2001) where nurses indicated the lack of resources that support the work environment which lead to a decrease in the quality of patient care.

CNs perceive their control over nursing practice is limited in this subscale which is specific to accessing information that controls and supports professional practice. Administrators must focus on implementing professional practice environments that support CNs and positively affect CNs recruitment and retention. It is through understanding nursing issues and nursing work environments that emphasize quality patient care that organizations will positively contribute to the CNs’ control over nursing practice, satisfaction, and recruitment/retention. Administrators must work hard toward increasing CNs access to information including use of email, open forums to stimulate discussion, periodic staff surveys and visible nursing leadership.

**Subscale VI: Alignment**

Subscale VI, (M =1.9373), deals with the alignment or the abilities of various groups to participate in setting goals and negotiating the resolution of conflict at various levels in the organization and has the lowest mean between all scales. The overall results from this subscale indicates that CNs perceive that nursing management/administration only and primarily nursing management administration with some staff nurse input have the foremost ability to be involved in these activities. Similar results were presented by Lee et al. (2000) analysis of this subscale results (M=2.0).

Conflict negotiation continues to be a process that requires effort from all disciplines. Green and Jordan (2004) suggest that nurse empowerment within the work
environment is enhanced by engaging nurses in decision making, work redesign and conflict resolution. They also suggest that although the concept of collaboration is embedded in conflict resolution, typically nurses have limited skills in this area. CNs need knowledge and practice regarding conflict negotiation strategies in preparation for ongoing collaboration, affecting their ability to advocate for and provide quality patient care. A multidisciplinary collaborative approach should be used when multiple perspectives are being suggested by different team members and all parties in the decision making process should be respected.

**Narrative responses related to Alignment:**

CNs admitted that promoting collaboration, a theme in the narrative responses, is perceived as something that requires more improvement. They stated: “Creating a partnership between the organization and the individual nurse”, “More collaboration with top level management” and “Physician dominated environment, nurses do not have a say, with no support for other health care providers to have inputs”. All healthcare disciplines must share a common goal, which is the best quality of patient care. This vision must be embraced by leadership support and empowerment. Therefore collaboration is a must in order to establish an environment of mutual respect, trust and professional recognition which eventually affects quality patient care. Improving nurse-physician relationships is highly recommended. Organizations should look for strategies that facilitate collaborative practice. A committed and collaborative approach will provide organizations, CNs and the patient with positive results.
C. Discussion of Themes from Qualitative Data

1- What does shared governance mean to you?

The themes related to internal factors included CNs ability to influence in the decision making, quality of care and collaboration. All CNs commented on the importance of being involved or having influence in decision making as well as having inputs in the organizational policies and procedures. The second theme related to quality involved ensuring high quality of patient care and being valued as CNs. Concerning collaboration managers stressed on the need of having a collaborative decision making approach.

The themes related to external factors included the work environment (management and administration) and organizational influence, and collaboration. Managers/administrators indicated the need for administration accountability in enhancing nurses’ participation in the decision making. They mentioned that CNs should have the right to share their inputs and should be supported by the administration. Another point provided by respondents is the need for collaboration with stakeholders and act as partnership in the decision making in order to have positive patient outcomes.

2- Do you feel you have enough shared governance practices in your work environment?

The responses to this question were distributed as follows:

Fifty percent of nurse managers/administrators felt they have shared governance at their work environment, twenty percent of nurse managers/administrators felt they have shared governance at their work place sometimes and thirty of nurse
managers/administrators felt they do not have shared governance at their work environment. Results of this question indicate that half of the interviewees reported having felt enough shared governance practice in their work environment. But the fact of having a number of managers/administrators contrasting that, suggests a lack of shared governance perception in the work field. The study of Ulriche et al. (2005) presented similar results as nurses did not feel that they have adequate opportunities to influence in the decision making at the organizational workplace level or/and the patient level.

3-What are the internal factors that might affect the implementation of shared governance at your area?

   The themes related to internal factors include the influence in shared decision making and quality of care. Respondents indicated they are unable to properly share in the decision making. They also highlighted that the lack of adequate communication channels might be a factor affecting shared governance implementation. The second team defined by respondents was related to quality of care including the fact of facing resistance to change. They also indicated the need for more education and more staff qualifications. The multicultural setting was also highlighted by respondents.

4- What are the external factors that might affect the implementation of shared governance at your area?

   The themes related to external factors included the Work environment (management and administration) and organizational influence and collaboration. Respondents mentioned the micromanagement and centralized decision making in
addition to deficiencies in the system and the organizational structure affecting the
application of shared governance processes. They also emphasized the physician
dominated environment and the conflicts arising between nurses-physicians. The study
done by Spence Lachinger, Almost, & Tuer-Hodes (2003) confirmed that a supportive
management structure enables the CNs to have control over their practice hence
positively affecting the quality of patient care

5- What do you think might positively drive the implementation of a shared governance
model at your area?

The themes related to internal factors include influence in shared decision and
quality of care. Respondents highlighted the need for more involvement in the decision
making in addition to providing staff with more understanding about shared governance.
They also requested for a set of guidelines to be followed for proper application of the
concept. Themes related to external factors included work environment and
organizational influence, and collaboration. Respondents identified the need for more
supportive atmosphere which works toward motivating CNs and providing them with
more transparency. Also they proposed a structural review. Concerning collaboration,
voices were raised about the need for collaboration and involvement in the strategic
planning. Spencer Lachinger et al. (2003) suggested that nurses have strong interest in
collaborating with other disciplines in order to promote a team approach for patient care.

6- Which strategies would you use in order to overcome the hindering forces toward the
implementation of a shared governance model?
The themes related to internal factors include influence in the decision making, quality of care and satisfaction. Respondents listed empowering and valuing CNs and seeking their inputs are suggested strategies to overcome hindering forces, adding to that the creation of better communication channels. As quality related concerns adequate staffing ratios, more education and evidence based practices were strategies provided by managers/administrators. Concerning satisfaction some respondents indicated the importance of maintaining high satisfaction rate therefore high quality of patient care. Themes related to external factors include work environment (management and administration) and organizational influence, and collaboration. Strategies suggested included the need to encourage unit councils’ implementation, seeking for top management support and creating a non blaming environment. As well as the need for more collaboration with top level management’

7. What is your role as a leader/manager/administrator in implementing a shared governance model?

The themes related to internal factors include influence in decision making, quality of care and professionalism. As leaders, respondents admitted the need to encourage CNs in sharing decision making. Also most of the respondents indicated the need to monitor and supervise all educational activities, encourage in service sessions and encourage continuing education. Regarding professionalism some of the leaders expressed their willingness to being committed and responsible for deploying shared governance concepts when provided with the available resources. Themes related to external factors included work environment (management and administration) and organizational influence, and collaboration. Respondents showed their tendency for being more
transparent as leader, in addition to their direction toward motivating staff and empowering them to practice according to shared governance principles. Supporting staff, gaining their inputs, and consider them as partners are implications presented by respondents are related to the collaboration theme. A supportive and collaborative work culture can be evidenced through nurses’ influence in the decision making hence enhancing professionalism, satisfaction and specialty control over nursing practice as reported by Cameron, Armstrong- Stassen, Bergeron, & Out, 2004, Spence Laschinger et al., 2001, and Tourangeau et al. 2005)

D. LIMITATIONS

- The low response rate decreases the ability to generalize the quantitative results. But qualitative results have provided rich narrative themes and transferability of these themes might be practical.
- The questionnaire used and the interviews done increase the chances of narrative subjectivity when categorizing responses into themes.
- The study was confined to describing the perceptions of CNs and nurse managers. No managers, physicians or members of other professional groups were surveyed or interviewed.
- The questionnaire used was not designed for use in a multi-national healthcare organization and does not take account of the different preparation of nurses recruited from different countries.
E. RECOMMENDATIONS

- Professional Practice Model:

Even though the clinical nurses were somewhat involved in developing the NCCCR professional practice model, they seemed unaware of what this model entails and reluctant in appreciating the value of its presence. The key elements of the professional practice environment should be emphasized in this model including professionalism, scope of practice and standards of practice. The organization must disseminate to all nurses the importance of this model, which is based on providing high quality of care based on partnership and collaboration and the role it plays in bringing significance to their daily work. The main goal of all health care organizations is to provide and maintain a high quality of patient care. Clinical nurses must “act as change agents” to encourage health care organizations to adopt leadership and professional practice environments that sustain standards of practice as indicated by Gullo and Gestle (2004).

- Continuing education and professional development

A learning needs assessment should be performed by the management team regarding the educational needs of clinical nurses at the NCCCR. Suggestions considered as supportive and encouraging to clinical nurses might include: stressing the needs identified by the nurses themselves, paid education days, replacements for education days, managerial and financial support for conferences attendance, and access to available resources such as journals, evidence based articles…etc
• Management and organizational Support

Nursing management and administration should provide support and guidance to Clinical nurses in adopting a model of professional practice that recognizes and supports CN participation in decision making. The creation of a professional environment is associated with the recruitment and retention on the CNs in addition to the patient’s safety and quality of care.

• Collaboration

NCCCR should explore internal initiatives that foster communication and collaboration between nursing management/administration and interdisciplinary health care providers. Collaboration in deed has a positive impact on CN satisfaction, recruitment/retention and safe patient care.

• Involvement in decision making

Forming unit based shared councils is suggested; The purpose of these Councils is to provide a structure in which empowered clinical nurses can have autonomy in practice, decision making ability related to both clinical and professional practice decisions in addition to collaboration hence ensuring a high level of professional performance by all nurses.

F. FUTURE RESEARCH
1- Focus groups inclusion to discuss shared governance and control over nursing practice in various areas. Challenges that CNs face will be acknowledged, addressed and interventions will follow.

2- Pre and post implementation study of a professional practice model to determine any significant changes related to the CNs' control over nursing practice.

3- Research regarding the ongoing changes in health care restructuring and the impact on CNs

4- Replication of this study using the IPNG tool and applying it to all Hamad Medical Corporation institutions hospitals to provide further information regarding CN perceptions of Shared governance plus comparing results in between hospitals.

**G. CONCLUSION**

Organizational restructuring and reform in the health care system have led to uncertainty and susceptibility among clinical nurses within their work environment. Negative effects relevant to nurse's role in the decision making and delivery of patient care have emerged. Nursing judgments which are like indictors of shared governance prevalence would affect patient care and safety. This study investigated the CNs involvement in decision making under a broad perspective related to shared governance through a descriptive survey design. Shared governance was explored using the internal factors related to the CNs’ influence regarding professionalism, satisfaction, quality of care, autonomy, and empowerment and the external factors which are more distant to the
CNs’ influence including health care restructuring, organizational influences, work environment models, and nursing leadership. Results indicated that clinical nurses have limited influence and or participation in decision making from the patient, unit, and administrative levels. This in fact might negatively affect CN satisfaction, retention/recruitment, organizational culture, and patient outcomes. In summary, CNs perceive that control over their nursing practice is held primarily by nursing management/administration with some staff input. The results of this study provide stakeholders with insights about the impact that shared governance practices have on CNs in their work environment hence they will be more understanding and aware about the need for implementing such practices. Consequently, the CNs’ professionalism and ability to provide quality patient care will be affected.
REFERENCES


Barden, A. (2009). Shared Governance and Empowerment in Registered Nurses Working in a Hospital Setting. Doctoral thesis, Frances Payne Bolton School of Nursing Case Western University; Cleveland, OH


APPENDICES

Appendix A: Flyer for Clinical Nurses

Dear RNs,

You, as clinical nurses at the NCCCR, have an essential role in nurturing quality professional practice environment for your professional practice, colleagues and the care of your patients. You are invited to participate in a survey about clinical nurses perceptions shared governance application at the National Center for Cancer Care and Research (NCCCR). Participation is voluntary and anonymous.

Completing the survey will take no more than 20 minutes of your time.

To participate, or for more information, please contact: LayalDiba: lid01@aub.edu.lb 0097433132813
Appendix B: Flyer for nurse managers/ administrators
Dear Nurse Managers/Administrators,

You as nurse managers and nurse administrators are the main change agent. You have a vital role in creating a climate that is actively supportive of shared decision making.

You are invited to participate in the study about clinical nurses perceptions shared governance application at the National Center for Cancer Care and Research (NCCCR). Participation is voluntary and anonymous.

Participation entails taking part in a 30-minute interview.

To participate, or for more information, please contact:

LayalDiba: lid01@aub.edu.lb
0097433132813
Appendix C: Consent form for Clinical nurses

CONSENT FORM – CLINICAL NURSES

Clinical Nurses perceptions on shared governance application at the National Center for Cancer Care and Research

Principal Investigator: Dr. Michael Clinton, Professor
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Co-Investigator: Mr. Michael Harkous, DON Education, National Center for Cancer Care and Research
Contact information: E-mail address: mharkous@hmc.org.qa
Telephone: (+974) 4439 7800/ 7801/ 7802, ext: 7939

Student Investigator: Ms. Layal Diba, Registered Nurse, MSN student at the American University of Beirut School of Nursing
Contact information: E-mail address: lid01@aub.edu.lb
Telephone: 0097433132813

My name is Layal Diba, MSN student from the American University of Beirut. As part of the requirement for completing the Masters in Nursing Science program, I am conducting a research study about clinical nurses’ perceptions of the implementation of a shared governance model at NCCCR, including the driving and the hindering forces. The study will offer an insight into a perspective that clinical nurses at the NCCCR have about shared governance. Your input as nurses is needed for better understanding of the driving as well as the inhibiting factors affecting the introduction of a shared governance model in addition to getting more approaches into the best practices and recommendations required for the proper application of a shared governance model. Before we begin, I would like to take a few minutes to explain why I am inviting you to participate and what will be done with the information you provide. You will be asked to complete an anonymous survey. I am doing this study as part of my studies at AUB. I will be recruiting 110 RNs as well as interviewing 10 nurse managers and 3 nurse administrators, and will be using the
information as the basis for my thesis. I may also use this information in articles that might be published, as well as in academic presentations. Your individual privacy and confidentiality of the information you provide will be maintained in all published and written data analysis resulting from the study. Please note that your participation is completely anonymous. You will not be asked to provide your name or any identifying information about yourself.

Your participation should take approximately 20 minutes. Please understand your participation is entirely on a voluntary basis and you have the right to withdraw your consent or discontinue participation at any time without penalty. There are no foreseeable risks associated with participation in this study. No questions of sensitive nature will be asked. There are no direct benefits to you resulting from this study and you will not receive any reimbursements for your participation. You have the right to refuse participation in this study. Your refusal to participate will not result in any penalties or loss of benefits to which you are otherwise entitled. Your present and future relationship with the American University of Beirut will not be affected in any way.

If at any time and for any reason, you would prefer not to answer any questions, please feel free to skip those questions. If at any time you would like to stop participating, please do. You will not be penalized for deciding to stop participation at any time.

The approved methodology of recruitment in this study is via flyers. The site for conducting this study is NCCCR, and this consent form is applicable only to this site. You can keep the copy of this consent with you, for your records. Please note that this study is not related in any way to your workplace and refusing to participate will not involve any penalties or repercussions on your job or employability. No one would be able to link your answers to your identity. Please drop the completed survey in the box in the designated area in on your floor. Make sure the two envelopes provided are sealed properly, so that your anonymity is protected. Completion and return of the survey, will be taken as confirmation of your voluntary participation in the study.

Please note that this study has been approved by the American University of Beirut’s Institutional Review Board.
If you have any questions, you may contact me at lid01@aub.edu.lb or 0097433132813. If you have questions about your rights as a participant in this research, you can contact the IRB Social and Behavioral Sciences Office at AUB: 01-350000, ext 5445 or irb@aub.edu.lb

If you are interested in participating in this study, please proceed to complete the survey.

Thank you!
Appendix D: Consent form for nurse managers/administrators

CONSENT FORM – NURSE MANAGERS AND ADMINISTRATORS

Clinical Nurses perceptions on shared governance application at the National Center for Cancer Care and Research

Principal Investigator: Dr. Michael Clinton, Professor
Address: Rafic Hariri School of Nursing
American University of Beirut
Contact information: E-mail address: mc42@aub.edu.lb
Telephone: 01-350000, ext 5956

Co-Investigator: Ms. RajaaHammoud, AEDN, administration, at the National Center for Cancer Care and Research
Contact information: E-mail address: rhammoud@hmc.org.qa
Telephone: (+974) 44397803/4, ext: 7803/7804

Co-Investigator: Mr. MickealHarkous, DON education, at the National Center for Cancer Care and Research
Contact information: E-mail address: mharkous@hmc.org.qa
Telephone: (+974) 4439 7800/ 7801/ 7802, ext: 7939

Student Investigator: Ms. LayalDiba, Registered Nurse, MSN student at the American University of Beirut School of Nursing
Contact information: E-mail address: lid01@aub.edu.lb
Telephone: 0097433132813

My name is LayalDiba, MSN student from the American University of Beirut. As part of the requirement for completing the Masters in Nursing Science program, I am conducting a research study about clinical nurses’ perceptions of the implementation of a shared governance model at NCCCR, including the driving and the hindering forces. The study will offer an insight into a perspective that clinical nurses at the NCCCR have about shared governance. Your inputs as nurse managers and nurse administrators are needed for better understanding of the driving as well as the inhibiting factors affecting the introduction of a shared governance model in addition to getting more approaches into the best practices and recommendations required for the proper application of a shared governance model. I will be interviewing 10 nurse managers and three nurse administrators.

Before we begin, I would like to take a few minutes to explain why I am inviting you to participate and what will be done with the information you provide. You will be asked to participate in a short interview. Your participation entails answering questions about your
role in shared governance; factors that affect the implementation of shared governance etc. Please stop me at any time if you have questions about the study.

I am doing this study as part of my studies at AUB. I will be interviewing 10 nurse managers and 3 nurse administrators, and will use the information as the basis for my thesis. I may also use this information in articles that might be published, as well as in academic presentations. I will also share this data with co-investigators at the NCCCR. Your individual privacy and confidentiality of the information you provide will be maintained in all published and written data analysis resulting from the study. All data shared with other investigators are aggregated data and have no identifiers that could be linked to your personal responses.

Your participation should take approximately 30 minutes. Please understand your participation is entirely on a voluntary basis and you have the right to withdraw your consent or discontinue participation at any time without penalty. There are no foreseeable risks associated with participation in this study. No questions of sensitive nature will be asked. There are no direct benefits to you resulting from this study and you will not receive any reimbursements for your participation. You have the right to refuse participation in this study. Your refusal to participate will not result in any penalties or loss of benefits to which you are otherwise entitled. Your present and future relationship with the American University of Beirut will not be affected in any way.

If at any time and for any reason, you would prefer not to answer any questions, please feel free to skip those questions (in the interview you can say ‘skip this question’ or ‘pass’). If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether. You will not be penalized for deciding to stop participation at any time.

The approved methodology of recruitment in this study is via flyers. The site for conducting this study is NCCCR, and this consent form is applicable only to this site. You can keep the copy of this consent with you, for your records.

I would like to tape record this interview so as to make sure that I remember accurately all the information you provide. I will keep these tapes in a locked office and they will only be used by investigator and co-investigators in this study. All the tapes will be destroyed after 3 years of completing the study. The interview tapes will not be shared with my collaborators. You may still participate in the interview if you do not want to be taped.

Please note that this study has been approved by the American University of Beirut’s Institutional Review Board.

If you have any questions, you are free to ask them now. If you have questions later, you may contact me at lid01@aub.edu.lb or 0097433132813. If you have questions about your rights as a participant in this research, you can contact the IRB Social and Behavioral Sciences Office at AUB: 01-350000, ext 5445 or irb@aub.edu.lb
Are you interested in participating in this study?

If yes, please sign your name below.

Participant’s Signature:
Name: __________________________ Signature: __________________________
Date and Time: __________________________

Do you give your consent for the discussion to be tape-recorded?
If yes, please sign your name below.

Participant’s Signature:
Name: __________________________ Signature: __________________________
Date and Time: __________________________

Consent to Quote from Interview
I may wish to quote from this interview either in the presentations or articles resulting from this work. A made-up name will be used in order to protect your identity, unless you specifically request that you be identified by your true name.
Do you agree to allow me to quote from this interview?

Participant’s Signature:
Name: __________________________ Signature: __________________________
Date and Time: __________________________

Researcher’s Signature:
Name: __________________________ Signature: __________________________
Appendix E: Questions addressed to nurse managers and nurse administrators

Questions addressed to nurse managers and nurse administrators:

1. What does shared governance mean to you?
2. Do you feel you have enough shared governance practices in your work environment?
3. What are the internal factors that might affect the implementation of shared governance at your area?
4. What are the external factors that might affect the implementation of shared governance at your area?
5. What do you think might positively drive the implementation of a shared governance model at your area?
6. Which strategies would you use in order to overcome the hindering forces toward the implementation of a shared governance model?
7. What is your role as a leader/manager/administrator in implementing a shared governance model?

Appendix F: Ethical approval letter from HMC Medical Research Center
Ref. No: RC/31213/2013
Date: 27th March 2013

Ms. Layal Imad Diba
Research Nurse
School of Nursing
American University of Beirut

Dear Ms. Layal,

Subject – Ethical Approval for the Research proposal# 13158/13: “Clinical Nurses perceptions on shared governance application at the National Center for Cancer Care and Research”

The above Research Proposal submitted to the Medical Research Center has been reviewed and classified as ‘Exempt’. according to the rules and regulations for research at HMC.

On behalf of the Research Committee we inform you that the above Research Proposal meets with the ethical requirements of the Hamad Medical Corporation and approval is granted for one year from 27th March 2013.

This research study should be conducted in full accordance with all the applicable sections of the rules and regulations for research at HMC and you should notify the Research Committee immediately of any proposed changes that may affect the 'exempt' status of your research proposal. It is the Principal Investigator's responsibility to obtain review and continued approval of the proposal before the date of expiry of the ethical approval.

A study progress report should be submitted bi-annually and a final report at the study's completion.

We wish you all success and await the results in due course.

Yours sincerely,

[Signature]
Dr. Anum Sarah John
Coordinator, Research Committee

Co:
1. Prof. Michele Clinton, School of Nursing-AUB
2. Ms. Raja Hammoud, AEDN, Administration-NCCCR
3. Michele Harkous, DON, Education-NCCCR
4. Mr. Najib Khraisat Al Mannai, Executive Director Hospital, NCCCR
5. Medical Director, NCCCR
Appendix G: Ethical approval letter from HMC for the amended file request

Ref No: RC/37113/2013
Date: 1st April 2013

Ms. Layal Imad Diba
Research Nurse
School of Nursing
American University of Beirut

Dear Ms. Layal,

Subject – Ethical Approval for the Research proposal# 13158/13: “Clinical Nurses perceptions on shared governance application at the National Center for Cancer Care and Research”

Reference is made to your request dated 31st March 2013, for the amendment to the above mentioned protocol.

We would like to inform you that the Research Committee has reviewed, approved and stamped the Waiver of signed Informed consent form for above mentioned research protocol. This consent form will be valid from 1st April 2013 to 26th March 2014.

One copy of Waiver of Signed Informed Consent should be handed over to the participant and the second copy should be kept with Principal Investigator in the research records. No research participants may be involved in any research procedure after the expiration date of the ethical approval. Any modifications to the research protocol must be approved by the Research Committee, prior to implementation (this includes any change of investigator(s)). All recruitment materials and tools must be approved by the Research Committee, prior to being used.

We wish you all success and await the results in due course.

Yours sincerely,

Dr. El Rashied Zakaria
Vice Chairman, Research Committee

Cc:
1. Prof. Micheal Clinton, School of Nursing-AUB
2. Ms. Raja Hammoud, AEDN, Administration-NCCCR
3. Micheal Harkous, DON, Education-NCCCR
4. Mr. Naji Khamis Al Mannai, Executive Director Hospital, NCCCR
5. Medical Director, NCCCR
# Professional Nursing Governance

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

1. **Sex:** 
   - Male  
   - Female  
   - Age:  

2. **Please indicate your BASIC nursing educational preparation:** 
   - Nursing Diploma  
   - Associate Degree in Nursing  
   - Baccalaureate Degree in Nursing  

3. **Please indicate the HIGHEST educational degree that you have attained at this point in time:** 
   - Nursing Diploma  
   - Bachelor's Degree, Nursing  
   - Master's Degree, Nursing  
   - Doctorate, Nursing  
   - Master's Degree in Nursing, Specialty  

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

5. **Please specify the number of years that you have been practicing nursing:**  

6. **Please indicate the title of your present position:**  

7. **Please indicate the type of nursing unit that you work on:** 
   - Medical  
   - Surgical  
   - Critical Care  
   - Operating Room  
   - Recovery Room  
   - Emergency Room  
   - Clinic  
   - Other (please specify):  

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

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

10. **Have you received any specialty certifications from professional organizations?** 
   - Yes  
   - No  

11. **If YES, please specify the type of certification and year received:** 

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

1. Determining what activities nurses can do at the bedside.  
2. Developing and evaluating patient care standards and quality assurance/Improvement activities.  
3. Setting levels of qualifications for nursing positions.  
4. Evaluating (performance appraisal) nursing personnel.  
5. Determining activities of ancillary nursing personnel (aide, unit clerks, etc.).  
6. Conducting disciplinary actions of nursing personnel.  
7. Assessing and providing for the professional/educational development of the nursing staff.  
8. Making hiring decisions about RNs and their nursing staff.  
9. Promoting RNs and other nursing staff.  
10. Appointing nursing personnel to management and leadership positions.  
11. Selecting products used in nursing care.  
12. Incorporating research ideas into nursing care.  
13. Determining methods of nursing care delivery (e.g., primary, team, case management).  

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### Professional Nursing Governance

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

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

#### PART II

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<table>
<thead>
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<tbody>
<tr>
<td>14.</td>
<td>Determining how many and what level of nursing staff is needed for routine patient care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>Adjusting staffing levels to meet fluctuations in patient census and acuity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Making daily patient care assignments for nursing personnel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>17.</td>
<td>Monitoring and procuring supplies for nursing care and support functions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>Regulating the flow of patient admissions, transfers, and discharges.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>Formulating annual unit budgets for personnel, supplies, equipment and education.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>Recommending nursing salaries, raises and benefits.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>21.</td>
<td>Consulting nursing services outside of the unit (e.g., administration, psychiatric, medical-surgical).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>Consulting hospital services outside of nursing (e.g., dietary, social service, pharmacy, human resources, finance).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>Making recommendations concerning other departments’ resources.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>Determining cost effective measures such as patient placement and referrals (e.g., placement of ventilator-dependent patients, early discharge of patients to home health care).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>25.</td>
<td>Recommending new hospital services or specialties (e.g., gerontology, mental health, birth centers).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>26.</td>
<td>Creating new clinical positions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>Creating new administrative or support positions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>

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

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

#### PART III

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<tbody>
<tr>
<td>28.</td>
<td>Written policies and procedures that state what nurses can do in direct patient care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>Written patient care standards and quality assurance/improvement programs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>31.</td>
<td>Written process for evaluating nursing personnel (performance appraisal).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>Organizational charts that show job titles and who reports to whom.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>33.</td>
<td>Written guidelines for disciplining nursing personnel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>34.</td>
<td>Annual requirements for continuing inservices.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>35.</td>
<td>Procedures for hiring and transferring nursing personnel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>36.</td>
<td>Policies regulating promotion of nursing personnel to management and leadership positions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>37.</td>
<td>Procedures for generating schedules for RNs and other nursing staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>
PROFESSIONAL NURSING GOVERNANCE

38. Acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care. 1 2 3 4 5
39. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity. 1 2 3 4 5
40. Procedures for determining daily patient care assignments. 1 2 3 4 5
41. Daily methods for monitoring and obtaining supplies for nursing care and support functions. 1 2 3 4 5
42. Procedures for controlling the flow of patient admissions, transfers and discharges. 1 2 3 4 5
43. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education. 1 2 3 4 5
44. Procedures for adjusting nursing salaries, raises and benefits. 1 2 3 4 5
45. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. administration, pharmacy, medical-surgical). 1 2 3 4 5
46. Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g. dietary, social service, pharmacy, physical therapy). 1 2 3 4 5
47. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass). 1 2 3 4 5
48. Location of and access to office space. 1 2 3 4 5
49. Access to office equipment (e.g. phones, personal computers, copy machines). 1 2 3 4 5

In your hospital, please circle the group that PARTICIPATES in the following activities:
1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART IV

50. Participation in unit committees for clinical practice. 1 2 3 4 5
51. Participation in unit committees for administrative matters such as staffing, scheduling and budgeting. 1 2 3 4 5
52. Participation in nursing departmental committees for clinical practice. 1 2 3 4 5
53. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting. 1 2 3 4 5
54. Participation in multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice. 1 2 3 4 5
55. Participation in hospital administration committees for matters such as employee benefits and strategic planning. 1 2 3 4 5
56. Forming new unit committees. 1 2 3 4 5
57. Forming new nursing departmental committees. 1 2 3 4 5
58. Forming new multidisciplinary professional committees. 1 2 3 4 5
59. Forming new hospital administration committees. 1 2 3 4 5
### PROFESSIONAL NURSING GOVERNANCE

#### PART V

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Access to Information</th>
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</thead>
<tbody>
<tr>
<td>60.</td>
<td>The quality of hospital nursing practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>61.</td>
<td>Compliance of hospital nursing practice with requirements of surveying agencies (Joint Commission, state and federal government, professional groups).</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>62.</td>
<td>Unit's projected budget and actual expenses</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>63.</td>
<td>Hospital's financial status.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>64.</td>
<td>Unit and nursing departmental goals and objectives for this year.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>65.</td>
<td>Hospital's strategic plans for the next few years.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>66.</td>
<td>Results of patient satisfaction surveys.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>67.</td>
<td>Physician/nurse satisfaction with their collaborative practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>68.</td>
<td>Current hospital status of nurse turnover and vacancies</td>
<td>1 2 3 4 5</td>
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<tr>
<td>69.</td>
<td>Nurses' satisfaction with their general practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>70.</td>
<td>Nurses' satisfaction with their salaries and benefits.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>71.</td>
<td>Management’s opinion of bedside nursing practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>72.</td>
<td>Physicians’ opinion of bedside nursing practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>73.</td>
<td>Nursing peers' opinion of bedside nursing practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>74.</td>
<td>Access to resources concerning recent advances in nursing practice (e.g., journals and books, library).</td>
<td>1 2 3 4 5</td>
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#### PART VI

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Access to Information</th>
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</thead>
<tbody>
<tr>
<td>75.</td>
<td>Negotiate solutions to conflicts among professional nurses.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>76.</td>
<td>Negotiate solutions to conflicts between professional nurses and physicians.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>77.</td>
<td>Negotiate solutions to conflicts between professional nurses and other hospital services (respiratory, dietary, etc).</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>78.</td>
<td>Negotiate solutions to conflicts between professional nurses and nursing management.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>79.</td>
<td>Negotiate solutions to conflicts between professional nurses and hospital administration.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>80.</td>
<td>Create a formal grievance procedure.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>81.</td>
<td>Write the goals and objectives of a nursing unit.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>82.</td>
<td>Write the philosophy, goals and objectives of the nursing department.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>83.</td>
<td>Formulate the mission, philosophy, goals and objectives of the hospital.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>84.</td>
<td>Write unit policies and procedures.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>85.</td>
<td>Determine nursing departmental policies and procedures.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>86.</td>
<td>Determine hospital-wide policies and procedures.</td>
<td>1 2 3 4 5</td>
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