NURSES SURVEY RESPONSES ABOUT KNOWLEDGE OF NURSE PRACTICE COUNCILS AT ST. PAUL’S HOSPITAL

by

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ABSTRACT

This electronic survey study was designed to examine the perceptions, knowledge and commitment of nursing staff regarding shared governance (Nurse Practice Council) at St. Paul’s Hospital (SPH). A cross-sectional survey design was used in this study. The study was conducted in the summer of 2010 at St. Paul’s Hospital, a tertiary hospital in Vancouver, B.C. A 114 nurses participated in the survey who were eligible and agreed to participate in the study. An electronic standardized SG survey was used to collect data for this study. The survey used Likert-like questions to measure the nurses’ perception, knowledge and commitment to the Nurse Practice Council (NPC). Additionally a small number of open-ended questions were used to verify the data from the Likert-like responses. Descriptive statistics were used to measure the level of perception, knowledge and commitment of nurses toward the Nurse Practice Council. Finally content analysis was employed to analyze the nurses’ responses to the open-ended questions.

The SG study findings suggest: (1) Staff at SPH supports NPC and has a positive perception of NPC; (2) Staff members do not have enough knowledge about the NPC; and (3) Staff is not sure if administration at SPH is committed to the work of the NPC. The findings also indicate that staff believes the NPC has the potential to make a difference by increasing frontline nurse staff involvement, through education and awareness. Additionally leaders require education in order to increase administrative support and indirectly improve frontline attendance.

Results of the one-way ANOVA showed that knowledge of NPC was statistically significant and varied according to practice area. However, no significant results were identified when examining perceptions and commitment according to practice area.
In considering the literature that suggests perceptions, knowledge and commitment are essential in the implementation and sustainment of SG, it is surprising that the only significant result was knowledge. These findings indicated that more work is required to improve nurses’ perceptions of NPC, moreover improving the commitment level of staff to SG and the NPC.
PREFACE

This research was approved by the Providence Health Care Research Ethics Board.

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CHAPTER 1: INTRODUCTION

Background

Today’s healthcare system is complex and unpredictable. Safe, effective care delivery requires high standards of nursing professionalism and engagement.

“The nurse as a member of a profession assumes responsibility for the quality of nursing care for patients/clients […]. As a professional, the nurse aspires to improve the discipline of nursing and its contribution to society through participation in professional activities […] and the need for life-long learning and continual growth toward expert practice” (Simms, 1991, p.39).

Nurse researchers (Aiken et al., 2002; Porter O’Grady, 2003) have shown that certain professional practice models or frameworks enhance nurse professionalism. In my thesis I focused on one particular professional practice model, the Shared Governance (SG) model that is associated with positive nurse outcomes including: increased job satisfaction, organizational commitment, retention, enhanced professional autonomy and staff-leader participatory decision-making (Edmonstone, 1998; Horstman et al., 1994; Laschinger & Havens, 1996; Westrope et al., 1995; Daugherty & Hart, 1993).

Shared governance is an organizational framework that decentralizes formal authority and power, giving nurses control over decisions related to their professional practice and their practice environments (Geoghegan & Farrington, 1995). The SG model originated from business and management studies that examined how to enhance employee involvement in organizational decision-making. Geoghegan and Farrington emphasized that organizational excellence begins at the grassroots level, instead of from the top down in traditional hierarchal models. Nurse leaders (e.g., Porter O’Grady, 1995) adapted a generic employee-management participatory decision-making
model for the nursing profession based on the premise that: “the success of any system is dependent on the investment, commitment and ownership of the stakeholders who are located closest to the point of care” (O'May & Buchan, 1999, p. 282).

Nursing SG was first established in the late 1970s and early 1980s when there was a nursing shortage across both Canada and the United States (U.S.) (Christmas, 1976; Cleland, 1978). Researchers (Kramer & Schmalenberg, 2003) discovered that certain hospitals were having more success than other hospitals at recruiting and retaining nurses within the U.S., while little focus was on Canada. The American Academy of Nursing conducted research to identify what nurses found satisfying about their practice and practice environments (Havens & Aiken, 1999). The American Academy of Nursing Fellows nominated 165 hospitals that had reputations for successfully attracting and retaining nurses and delivering high-quality nursing care (Havens & Aiken). Ultimately the Academy designated 41 hospitals as magnet hospitals\(^1\) because of their high nurse satisfaction, low job turnover, and low nurse vacancy rates (Havens & Aiken). These hospitals all shared a set of core organizational values, namely: the nurse executive is a formal member of the highest decision-making body in the hospital, nursing services are organized in a flat organizational structure rather than a pyramid structure, and decision-making is decentralized to the unit level giving nurses on each unit as much discretion as possible (Havens & Aiken). All of these attributes

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\(^1\) Magnet status is an award given by the American Nurses’ Credentialing Center (ANCC), an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing. A Magnet hospital is stated to be one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution. Magnet status is also said to indicate nursing involvement in data collection and decision-making in patient care delivery. The idea is that Magnet nursing leaders value staff nurses, involve them in shaping research-based nursing practice, and encourage and reward them for advancing in nursing practice. Magnet hospitals are supposed to have open communication between nurses and other members of the health care team, and an appropriate personnel mix to attain the best patient outcomes and staff work environment (Havens & Aiken, 1999).
have a striking resemblance to recommendations made by the Institute of Medicine and
the National Commission of Nursing that nurses be more involved in decision-making
about: patient care, working conditions and hospital governance (Havens & Aiken). SG
came about as a means of giving nurses more control over practice (Kramer &
Schmalenberg) and was linked with all magnet hospitals in the U.S.

Control over nursing practice (C/NP) is defined as: “shared or unit-based
decision-making related to an environment in which administrators use a participative
management style” (Kramer et al., 2009, p. 3). As control over practice is a central factor
in magnet hospitals, SG became a way to formally implement nurse’s control over their
nursing practice (Kramer & Schmalenberg, 2003). The magnet research, in particular,
has demonstrated many professional nursing benefits arising from SG implementation
(Havens & Aiken, 1999). Although SG is associated with many positive nurse outcomes,
most SG research has taken place in the U.S. Little research has taken place in Canada
to determine the benefits and challenges associated with SG implementation.

The Research Problem

This study took place in one healthcare institution, St. Paul’s Hospital (SPH) in
Vancouver, British Columbia (B.C.), Canada. St. Paul’s Hospital adopted a SG model to
enhance professional nursing practice. Although this model has been in place since the
early 1990’s no formal research has been conducted to determine the successes and
challenges associated with this model from the perspective of the SPH nurses.

Research Questions

The purpose of this study is to better understand SPH nurses’ knowledge,
perception and commitment towards their SG model. The specific questions that guided
my research study were: (a) What are the perceptions, knowledge, and commitment of
nursing staff regarding SG at SPH? (b) What have nursing staff heard about the Nursing Practice Council (NPC) at SPH?

**Description of Shared Governance at St. Paul’s Hospital**

There are many SG models reported in the literature, which I describe in detail in chapter two (Scott & Caress, 2005; O’May & Buchan, 1999; Hess, 2004). St. Paul’s Hospital most closely resembles the councilor model (refer to Appendix A). The councilor model consists of different councils within the organization such as: the Management Council, Practice Council, Quality Council and Education Council. These councils have specific roles and responsibilities related to nursing practice, and a Nursing Coordinating Council facilitates collaboration on shared issues. The Nursing Coordinating Council makes final decisions related to patient-care and other healthcare related issues. The councilor model has been described as an excellent way to empower staff and enhance participatory decision-making related to patient care and nursing practice (Westrope, 1995).

St. Paul’s Hospital has a Nurse Practice Council (NPC), a Nurse Educator forum, and a Quality Improvement (QI) Committee. The Nurse Practice Council is modeled after the SG councilor model reported in the literature. The senior nursing leadership team piloted SG by beginning with the practice council. At SPH, the senior leadership team\(^2\) makes final decisions related to nursing professional practice, and the decisions are based upon input from the Nurse Educator forum, the NPC and the QI committee. The NPC meets once a month with an average of 15 to 20 frontline staff nurses representing a variety of clinical areas. Membership in the council is voluntary and

\(^2\) The Senior Leadership Team (SLT) at St. Paul’s Hospital is comprised of the CEO, Vice Presidents and the Chief Nursing Officer.
regular wages are provided for all nurses who attend. Most clinical areas nominate a nurse to act as their representative and to attend the NPC meetings. The NPC is led by the chair that is a frontline staff nurse and co-chaired by the Director of Nursing and Professional Practice for the organization. The chair has a two-year term that is voluntary. Members of the council can volunteer to be the chair. An election is held within the council to finalize who will lead the council for the two-year term. It is the responsibility of the chair to set the agenda for each month, review and distribute the minutes to other members. The council discusses topics that are of interest to the frontline staff; facilitates Nursing Week events; and provides feedback to other areas of the organization about policy development relevant to nursing. Staff nurses who attend the NPC provide input related to patient-care, workload issues and other pertinent topics. There is no formal method of disseminating information discussed at the council meetings to other frontline staff. Some nurses who attend the council meetings take information to their respective units and discuss the meeting topics, but not all members do this. The NPC encourages frontline staff that attends council meetings to discuss items of interest with their colleagues on their units as a way of gaining a wider appreciation for the NPC and its role in nurse decision-making at SPH.

**My Interest in Shared Governance**

As a keen yet novice researcher, I learned about SG while taking an administrative leadership course at the University of British Columbia (UBC) and participated in a course that analyzed different attributes of leadership and the contexts surrounding frontline nurses' work environment. The course built on my experiences and understanding of governance and encouraged me to explore its complexities. In practice, I have actively been involved in the NPC at SPH since becoming a Registered
Nurse (RN) and in the past year have taken on the role as chair of the NPC. After spending a few years working in the acute care setting as an RN, my interest in SG was further sparked from the perspective of a frontline staff member. I developed awareness about the inconsistencies in decision-making related to patient-care and nursing practice that the frontline staff faced, having little say in the processes.

**Research Assumptions**

As a nurse on a busy acute care unit, I know that many of my nursing peers are concerned about workload and quality of care provision. Some of my colleagues talk about leaving the nursing profession. As chair of the NPC at SPH, I am frustrated by the lack of staff attendance and participation, although the literature states that SG is associated with positive nurse outcomes such as improved job satisfaction and retention. My assumption is that SG at SPH should be providing a formal avenue for nurses to voice their concerns and actively engage in problem solving with their peers and leaders. I want to explore nurses’ knowledge, perceptions and commitment to SG at SPH to determine how we can revise or refine this new model to have a positive influence on nursing professional practice.

**Overview of Methods and Analyses**

My study population included all the nurses (Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses) at SPH. The inclusion criteria included all employed, unionized nurses among all the SPH practice areas. After obtaining ethics approval from the UBC Behavioral Ethics Board and the Providence Health Authority Institutional Review Board, I electronically distributed a survey via the intranet to all SPH nurses with a working e-mail address. The survey is based upon a standardized SG survey (Frith & Montgomery, 2006) that measures nurses’ knowledge, perception and
commitment to SG within their respective healthcare organizations. In addition to 39 Likert-like questions, I have included two open-ended questions specific to SPH nurses. I analyzed the Likert-like questions using descriptive statistics, and I employed content analysis (Neuendorf, 2002; Graneheim & Lundman, 2004) to analyze the nurses’ responses to the open-ended questions.

**Organization of Thesis**

In this first chapter, I provided a definition and background of SG, the topic of my thesis. I have identified my research problem and stated the research questions associated with my study. I also provided a brief description of SG at SPH, my interest in SG as a nurse and researcher, and an overview of methods and analytic techniques.

In chapter two I provide a critical evaluation of the literature of SG and related concepts such as participatory decision-making, autonomy, C/NP and nurse empowerment. In the second chapter I focus on SG processes, for instance: participatory decision-making; SG structures and models, for example the councilor model; and research exploring the benefits and challenges associated with SG.

Chapter Three, the Research Design and Methods chapter, includes a detailed description of the research approach and rationale, the ethical issues, the participants, study procedures, data collection instruments (e.g., survey tool), data analysis of both the Likert-like questions and open-ended questions, and include a section to discuss how I ensure the rigor of my work. Chapter four, the Results chapter, provides the findings from the Likert-like questions along with the statistical presentation of the results. Results from the open-ended questions are provided with verbatim quotes from the open-ended responses to support the categories and sub-categories I have assigned to the nurses’ responses. This chapter concludes with a discussion on study
limitations.

Chapter five, the Findings chapter, discusses my research findings in greater detail and my interpretations of the findings. In this chapter I elaborate on all the results provided in chapter four and explain how the current SPH cultural context affects some of the results. This chapter also discusses the implications and makes further recommendations. The recommendations are aimed at how SPH can utilize this research and move forward in their SG endeavors. The thesis concludes with recommendations for future research.
CHAPTER 2: LITERATURE REVIEW

Introduction

I undertook a critical evaluation of the literature to learn more about shared governance (SG) and its importance to nurses. The first section of this review includes a definition of SG and concepts closely related to SG, such as: control over nursing practice (C/NP), nurse autonomy and nurse empowerment. The second section provides a review of SG models, and the third section focuses on research evidence that supports the importance of SG. The final section summarizes the strengths and weaknesses associated with the SG nursing research literature.

I completed the literature review using the databases: PubMed, CINAHL, and Google Scholar. Key words used to identify literature for the shared governance section included; nursing, shared governance, self-governance, shared-leadership, autonomy, retention, decision-making, practice environment, working conditions, councils and evaluation. Key words used to identify practice councils included; nursing, councils, involvement, shared governance, nurse development, satisfaction, autonomy, retention, encouragement, leadership and working conditions. Key words used to identify literature for the participatory decision-making section included; nursing, involvement, job satisfaction, engagement, retention, and Canada. The focus of the literature review was original research in peer-reviewed journals, but I also included the grey literature, such as editorials.
Shared Governance

Definition

Shared governance is an alternative approach to the traditional management structure or practice in which nurses have limited formal governance, authority or control over practice environment matters (Scott & Caress, 2005; Hess, 1994). Shared governance is an organizational structure and process that gives nurses’ control over practice issues and extends their influence to administrative areas previously controlled by management (Hess). Doherty and Hope (2000) believe that the philosophy of shared governance is related to a decentralized style of management that creates an empowered work environment for nurses.

The shared governance structure represents an administrative model that includes a partnership between nursing administration and the frontline clinical staff (Porter-O'Grady, 1995). Shared governance is often misunderstood as ‘giving power to employees’, which sounds like a one-way process. Instead, nurses are expected to be active participants, aware of the principles associated with SG (O'May & Buchan, 1999). It is essential that all participants involved in SG understand that everyone is a key stakeholder (O'May & Buchan). The core principles of SG are: (1) clinical staff are accountable partners in the delivery of quality, safe nursing care; and (2) the organization must grant frontline nurses formal authority to make practice environment decisions (Frith & Montgomery, 2006). These guiding principles help promote collective responsibility and accountability for practice, moving away from the traditional hierarchical management style. Nurses participate in important practice decisions, and leaders have a facilitative role, rather than controlling one (Geoghegan & Farrington, 1995).
Related Shared Governance Concepts

Control Over Nursing Practice

Kramer and Schmalenberg (2003) conducted a qualitative study by interviewing 279 staff nurses in 14 U.S. Magnet hospitals. The purpose of their study was to: (a) determine what Control Over Nursing Practice (C/NP) means to staff nurses; (b) attempt empirical quantification of C/NP; and (c) ascertain relationships between the categorical rankings of C/NP, nurses’ rankings of job satisfaction, and their perceptions of quality of care on their units. Interview data were simultaneously analyzed and coded using constant comparative analysis (Kramer & Schmalenberg).

The interviewed nurses described C/NP as more than “enactment, control, or decision-making [… but as] autonomy. C/NP means working with other nurses to have a say in broader issues affecting nurses, nursing and patient care” (Kramer & Schmalenberg, 2003, p.441). The C/NP function was found to be made up of a myriad of activities that the researchers organized into clinical, managerial, environmental and cultural domains (Kramer & Schmalenberg). No one domain was determined to be more important than another, nor were any particular outcomes more meaningful. Of the 14 magnet hospitals that took part in this study, 13 were found to have a significant relationship between C/NP rankings and nurse job satisfaction (Kramer & Schmalenberg). The authors concluded that C/NP is an important component of the magnet hospital environment. Shortcomings of this research included its cross-sectional nature (e.g., more longitudinal research is needed to understand complex processes, such as C/NP), and the results cannot be generalized to all hospitals due to the magnet status of those that participated, setting them apart.
Participatory Decision-Making

Parsons (2004) studied the effectiveness of participatory decision-making. She used a participatory action research approach to initially engage management and staff in identifying practice environment problems and working together towards solutions. The group of staff included executives and managers serving as visionaries for a positive future, championing change, coaching individual staff and planning teams and providing staff support for planned change and ensuring follow-through on the process and implementation. After an initial training period, management and staff formalized a participatory decision-making structure and process, meeting regularly to address practice environment interventions. Outcomes of this intervention included increased staff engagement in problem-solving, more positive workplace perceptions, improved teamwork, and staff reports of feeling empowered and having more control over their work environment (Parsons; Parsons, Cornett, Sewell & Wilson, 2004).

In another study carried out in 2006, the emergency department (ED) at Northeast Methodist Hospital in San Antonio, Texas set out to describe the planning, implementation and sustainability of team behavioral norms to create a healthy workplace (Parsons, Batres & Golightly-Jenkins, 2006). The ED department consisted of 28 beds and staffed consisted of 61 full-time RNs, technicians, unit secretaries and physician assistants. As the staff prepared for a major expansion and transition into a new facility they visualized through mind mapping the department’s desired future. Priorities were determined and specific action plans for these priorities were developed and presented to all participants. On staff acceptance of the action plan, the staff team began implementation. A comparison between one year post-implementation and pre-implementation revealed a statistically significant increase of 6% in the percentage of
staff that rated their job satisfaction as very satisfied and strongly satisfied (Parsons, Batres & Golightly-Jenkins). Participatory decision-making demonstrated that after implementation, there were increases in staff job satisfaction, nurse retention rates, and managers stated that operational processes were more streamlined for them (Parsons, Batres & Golightly-Jenkins).

**Autonomy**

Nurse autonomy is important at two levels: clinical autonomy or nurses’ autonomy over practice-related decisions at the bedside, and autonomy over practice, which is often used interchangeably with C/NP (Kramer et al., 2009). In this thesis, autonomy will refer to C/NP. Autonomy is a desired state in the workplace obtained over time. Structures and processes, such as SG, are necessary for nurses to have autonomy over practice or C/NP (Kramer et al.). Laschinger and Havens (1996) also found that an increased level of education leads to higher autonomy among nurses. Increased autonomy is associated with nurses who have higher levels of organizational commitment, lower levels of burnout and increased participation in their organization’s decision-making processes (Laschinger & Havens).

**Structural Empowerment**

Kanter’s (1993) conceptual framework of structural empowerment has been extensively studied by Canadian nurse researchers. Laschinger, a researcher from the University of Western Ontario, has extensively studied different aspects of nurse empowerment. In Kanter’s framework, structural empowerment occurs when organizations and their leaders provide staff with access to information, resources, opportunities to learn and grow, and supports, such as mentors and role models. This framework includes power as a structural determinant that directly affects organizational
behaviors and attitudes (Kanter). Power is related to access to empowerment structures. Formal power comes from job title and authority, and informal power is obtained through peer networks, alliances and the social groups within the workplace.

Laschinger and Havens (1996) carried out a study that focused on Kanter’s framework and examined the relationship between staff nurses’ perceptions of work empowerment and the degree of C/NP. More than 200 nurses in western Ontario were surveyed via mail using standardized assessment tools, such as: the Conditions of Work Effectiveness Questionnaire (CWEQ) and the Control over Nursing Practice (C/NP) Questionnaire (Gerber, 1990). The CWEQ measures perceptions of access to sources of work empowerment as described by Kanter: 1) information, 2) support, 3) resources, and 4) opportunity. These four subscales combined provide an overall measure of perceived work empowerment (Laschinger & Havens). The C/NP Questionnaire measures nurses’ work autonomy or control over issues within the nurses’ scope of practice.

Nurse participants perceived themselves to be moderately empowered: access to resources scored the lowest among types of empowerment structures. Perceived work empowerment was strongly related to perceptions of C/NP, supporting Kanter’s (1993) assertion that access to organizational empowerment structures enables staff to have more control over their work environment. Of interest is that nurses in this study perceived most of their power to come through informal power sources, versus formal power sources as described above. Shared governance may be considered a type of formal power and research is needed to determine if SG is an important way to raise nurses’ perceptions of access to power. Laschinger and Havens (1996) also found that
access to empowerment structures was significantly positively correlated with work satisfaction and perceived work effectiveness.

The research related to C/NP, participatory decision-making, autonomy and structural empowerment supports the close relationships between these concepts and improved nursing outcomes. In the following section I discuss the SG models and structures required for successful implementation and sustainment.

**Shared Governance Models**

Although there are a variety of SG models four types are most frequently cited in the literature: unit-based, congressional, councilor and administrative (Scott & Caress, 2005; O’May & Buchan, 1999; Hess, 2004). The unit-based model is focused on establishing participatory decision-making at the unit level. An organization may have multiple unit models present, all operating separately. A weakness is the lack of connection between these unit-based decision-making models and organizational decision-making at higher levels, such as departmental or executive levels.

The congressional model focuses on a central congress: all nursing staff are considered members, and they may voluntarily attend congressional decision-making sessions. Nurse representatives are elected to serve on a central cabinet, and there may be sub-committees or task forces working on a variety of nursing practice issues. The third model, the councilor model, is one of the most popular models. There are a variety of organization-wide councils, such as education, quality improvement, and practice. There is a coordinating council that oversees and coordinates council activities and has final, decision-making authority. Staff nurses are generally elected to serve on these councils, and they are expected to actively engage in making decisions that have relevance to quality of care delivery in the practice environment. The fourth model, the
administrative model, is very similar, although there is an administrative or executive-level council that has a final say in making decisions, adding a layer of bureaucracy between council work and final decision-making (Yanko, Hardt & Bradstock, 1995). In many organizations, SG begins as unit-based councils (Hess, 2004; Porter-O'Grady, 1995). Although this model tends to isolate nurses' decisions from other organizational levels, it has been shown to gradually ease staff into a wider organizational implementation of SG leading to increased staff involvement and sustainability of the SG model (O'May & Buchan, 1999).

Of note is that SG gained prominence within healthcare organizations in the 1990s. Over the last decade, restructuring and organizational shifts to program management models have eroded nurses' formal and informal C/NP (Kramer & Schmalenberg, 2003). Recently, there has been a resurgence in SG: this may be due to the predicted nursing shortage and the desire to implement organizational structures and processes, such as SG and participatory decision-making, that will enhance job satisfaction, organizational commitment and retention (Scott & Caress, 2005). Additionally the SG model can also pave the way for inter-professionalism and teamwork. Shared governance has focused primarily on nurse decision-making, but the framework can be applicable for inter-professional decision-making (Scott & Caress). O'May and Buchan (1999) believe that, “as a response to the escalating problems of pricing and management constraints, co-operative and democratic teamwork would offer one way of attempting to reduce costs and increase cohesiveness and autonomy” (p. 283).
Leadership

Within the SG literature, leadership has been identified as an important factor ensuring successful SG implementation. Laschinger & Leiter (2006) tested a model, The Nursing Worklife Model that was first developed by Lake in 2002. The five worklife factors are: (1) effective nursing leadership, (2) staff participation in organizational affairs, (3) adequate staffing for quality care, (4) support for nursing model of patient care, and (5) effective nurse/physician relationships. The researchers sought to determine what work life factors most influenced nurse burnout and nurses’ perceptions of patient safety. The study population consisted of all Registered Nurses in Ontario and Alberta. These researchers found that nursing leadership was the driving force in the model. Nurse leaders, for example, were responsible for promoting positive RN/physician relationships; nurse leaders advocated for adequate staffing and safety and quality initiatives; and nurse leaders ensured that nurses had a voice in clinical decision-making (e.g., nursing model of care) and organizational decision-making (e.g., SG). This study also showed that leaders serve as a buffer against nurse burnout, such as emotional exhaustion and depersonalization, and in practice environments associated with effective leaders, nurses reported perceptions of better patient safety outcomes. The researchers cited the cross-sectional design as a shortcoming, urging other researchers to conduct similar, longitudinal research. Despite this design shortcoming, this study demonstrated the importance of effective leadership and established significant associations between leaders, positive work environments and professional practice models, such as SG, that result in less nurse burnout and improved patient safety (Laschinger & Leiter).
Culture

It is impossible to pinpoint an exact start and finish date of the bureaucratic structure that has governed nursing for so many years. Graves (1971) defined bureaucracy as a “system with a hierarchal structure of authority, a clear-cut division of labor and a formal system of rules and regulations to govern official decisions and actions” (p.491). History gives us a great example of the bureaucratic model in the form of the Daughters of Charity from the 17th century. Although these women were well educated, they were taught to obey what they were told (Nelson, 1999). The ethos of the Daughters of Charity was to say little and do much, which is a fundamental tenet of the bureaucratic system.

With the passing of time and shifting political ideologies resulted in Florence Nightingale’s rise during the 19th Century. Nightingale brought about a cultural shift whereby, nurses played an increasingly larger role in the provision of healthcare. Important changes such as having nurses report to more senior nurses and not only to physicians were evidence of this shift during this time period (McPherson, 2005). This helped to build more autonomy among nurses and aided in the process of nurses feeling empowered within their workplace. The current healthcare climate is based on business management models that threaten to erode the progress nursing have made towards having a voice within the organization (Rodney et al., 2009). Nurses have to deal with increased workloads, lower staffing levels, and deskilling of the nursing workforce. This is a time when nurses and nurse leadership need to promote a strong nursing culture of professionalism and an advanced skill set. SG may be the means to accomplish this goal.
Shared governance requires relationships, decisions, structures and processes to be changed permanently at every level within the system (Porter-O’Grady, 2001). Shared governance is not something that can be implemented overnight (Scott & Caress, 2005). It requires widespread commitment and strong leadership as well as a great deal of consideration and planning (Scott & Caress). SG is “an ongoing and fluid process that requires continual assessment and revaluation to be flexible and adaptive to the environment” (O’May & Buchan, 1999, p. 281). Researchers (Scott & Caress) illustrated the importance of adapting the culture within an organization to become one where staff are encouraged to be proactive and interactive at least a year prior to the implementation of a shared governance structure. Some organizations choose to start small with “unit-based” councils: to promote participatory decision making at the grassroots level before expanding throughout other levels of the organization.

Scott and Caress (2005) laid out the process that they used to effectively implement an SG culture within their healthcare organization in the UK. They began by building up what they termed as a network of key people who were identified as potential supporters for SG implementation. A steering committee of these key people was established, and the committee sent out an invitational/informational letter to all staff, soliciting their interest in SG. Clinical staff volunteers formed a SG working committee. This committee developed a vision statement, overall goals and objectives, and selected a unit council structure to move SG forward. In their case study of one organization’s journey towards an SG culture, Scott and Caress stated that the most important factor was clinical staff engagement or “shared leadership.” “Shared leadership focuses on empowering employees to act autonomously, be decisive at the point of service and create a shared vision aligned with organizational goals” (Scott &
Caress, p.9). In order for this to happen, staff has to be prepared for their roles and responsibilities, which can be done through education seminars and other activities. Staff also has to be educated in order to raise awareness of SG, have an understanding of the overall aims, objectives, and identify any potential concerns (Scott & Caress). 

**Benefits of Shared Governance**

The research shows that SG has numerous benefits. Shared governance improves staff nurses’ sense of empowerment, job autonomy as well as job authority, accountability and responsibility (Erikson et al., 2003; George, 1997; Kovner et al., 1993; Laschinger & Havens, 1996; Motz & Lewis, 1994; Westrope et al., 1995). Studies also suggest that SG positively impacts employee opinions and job satisfaction (Thrasher et al., 1992; Jones et al., 1993; Daugherty & Hart, 1993; George; Hastings, 1995; Reif, 1995). A significant amount of research also shows SG increases nurses’ perceptions of professional growth and promotional opportunities, as well as opportunities to increase leadership competencies (Edmonstone, 1998). Studies suggest that SG improves staff reactions to change there is an increased focus on the patient, and administrators have increased respect for clinical staff (Minnen et al., 1993; Daugherty & Hart). Some other potential benefits include increased ownership over nursing practice and a sense of worth; increased morale, motivation, staff contribution; encouragement of creativity and promotion of interpersonal relationships (Geoghegan & Farrington, 1995). Improved communication, (Brodbeck, 1992) increased sense of cohesiveness, teamwork and collegiality (Brodbeck; Skubak et al., 1994; Ireson & McGillis, 1998) were other attributes that were found to be associated with the implementation of SG. Finally SG has been shown to increase efficiency of care delivered (Ireson & McGillis), and staff and leaders
acquire proactive approach to quality improvement and safety initiatives through SG council work (Horstman et al., 1994).

**Challenges Associated with Shared Governance**

Shared governance requires thoughtful planning, strong leadership and commitment from all nursing staff. SG also requires a great deal of time from all those involved. Management and clinical staff must commit to attending meetings and participating in projects, and this may be a particular issue for unionized staff who are expected to do this on their own time (Scott & Caress, 2005). Another limitation frequently cited in the literature was the difficulty organizations face with disseminating SG information to all staff within the organization (Scott & Caress; Burnhope & Edmonstone, 2003; Richards et al., 1999). The success of SG often depends on what is discussed within council meetings, and how council information is shared throughout the organization. If relevant information is not thoroughly disseminated to all staff, the sense of collective identity and commitment to SG wanes: staff begins to feel that nothing is getting done or they lose faith in the SG model (Scott & Caress).

Another concern associated with the SG model is cost: cost-effectiveness studies are lacking with respect to SG. Some researchers (Hess, 2004) suggest that there may be no net financial benefits to organizations. Costs to consider are the initial implementation and training of staff and release time and coverage for staff participation in council work (Hess). An assumption is that increased nurse retention will offset SG costs to the organization, but there is no research that clearly demonstrates how an organization will receive financial benefits from SG implementation. The major driver in the U.S. for SG implementation is magnet accreditation: Shared governance is a requirement for magnet certification (ANCC, 2010). Although Canada does not have the
option to obtain magnet certification (ANCC), the vast amount of research that has come from the U.S. is stimulating Canadian healthcare organizations. The organizations want to explore if they too can successfully implement and sustain SG and obtain the same benefits that so many hospitals in the U.S. have seen.

Other research suggests that there are significant difficulties associated with motivating staff to participate in SG (Daugherty & Hart, 1993), and nurses are often concerned about the time commitments associated with SG council work, particularly when they are faced with lots of job stressors, such as increased workloads (Prince, 1997). Before beginning on the journey of SG it is very important for organizations to consider whether critical factors are in place to implement SG, particularly strong leadership, organizational supports and a culture conducive to SG (Hess, 2004).

The next chapter will describe the research methods, including the sample population, study site and survey tool. Analytic techniques, such as qualitative content analysis and descriptive statistical analyses with Likert-like questions will be described in detail.
CHAPTER 3: RESEARCH DESIGN AND METHODS

Research Approach and Rationale

This was a cross-sectional descriptive electronic survey study conducted at an urban, tertiary care hospital in Vancouver, British Columbia to determine staff nurses’ knowledge, perception and commitment to shared governance (SG). The SG model at the study site, St. Paul’s Hospital (SPH), has been in existence since the 1990s. This was the first formalized study to determine nurses’ perceptions of this SG model. The aim of the survey was for nurses to be able to share information that will aid in the development of more robust practice councils at SPH. A survey format was used to provide staff nurses with a confidential way to express their views about SG, and this method was selected because surveys are an efficient way to collect information on large sample populations (Polit & Beck, 2008). I was able to survey a sample of the entire staff nurse population at SPH, and the selected electronic survey format permitted me to easily collate a large amount of data. The electronic distribution method was more cost-effective and convenient than paper survey distribution and collection.

Ethical Issues

Ethical approval was received from the University of British Columbia (UBC) Behavioral Ethics Board and the Providence Health Authority Institutional Review Board. An online survey with cover letter was distributed to all participants. The cover letter (refer to Appendix B) explained the study purpose and provided details about participant rights. The cover letter also provided investigator and ethics committee contact details, details about the potential to win an incentive and information about the online database (i.e., SurveyMonkey, 1999) that hosted and stored the survey data. Completion of the survey was voluntary. Participants had three weeks to complete the survey, which
allowed them time to read the cover letter and consider it first before completing the survey. All those who began the survey were made aware of their ability to withdraw from the survey at any time without any consequence.

I did not have access to the entire sample population e-mail list: An administrative secretary was responsible for sending out the cover letter and electronic survey link to participants. Once completed surveys were returned electronically, I removed the attached e-mail addresses and created a password-protected list in Excel. I was the only person who had access to this participant list, and the purpose of this list was to determine which participants would be recipients of the incentives.

This was a self-funded study and the institutional and university ethics committees considered a limited number of small incentives appropriate. The total and individual incentive amounts were discussed and approved by members of my graduate thesis committee. The total self-funded incentive amount was $200 and each individual incentive amount was set at $20. A total of ten Chapters cards were given out. To decrease the chance of personal bias, I used every 10th participant e-mail address from the Excel list of returned electronic surveys.

Survey data and e-mail addresses will be kept in a password-protected Excel database on my personal computer and I will delete electronic data five years from the end of the study. I am storing hard copies of data in a locked storage file, and these hard copies will be kept for five years according to ethics protocol and shredded at the end of that time.
Assumptions and Biases

Given my professional and personal commitment to SG at SPH, I am aware that I may have had influence over some peers’ decision to complete the survey. I am also aware of potential biases influencing my analysis of the data. To minimize these biases, I sent out the surveys via the administrative secretary, and I removed any personal identifiers from the electronic surveys. I worked closely with members of my thesis committee to ensure that I was aware of any other biases that influence my interpretation of the data.

Participants

To obtain the most representative sample of nurse responses for this survey study, I originally intended to sample the entire staff nurse population at SPH (Polit & Beck, 2008). The inclusion criteria for this study included nursing professionals with active employment at SPH. These criteria were chosen because all types of nurses participate in the SPH nursing practice council (NPC). Nursing types include: Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Registered Psychiatric Nurses (RPNs). My target population, the entire staff nurse population at SPH, consists of 1700 nurses with approximately 1460 RNs, 162 LPNs and 78 RPNs. Only 294 staff nurses had active SPH e-mail accounts on file with the nursing department’s administrative secretary. The accessible study population, therefore, totaled 294 staff nurses: 252 RNs, 28 LPNs and 14 RPNs. Based on the proportion of RNs, LPNs and RPNs in the sample population, representation of nursing types in this population was similar or representative of the proportion of nursing types in the target population (Polit & Beck). The actual study sample consisted of 114 nurses who returned their completed electronic surveys. A description of the actual study sample is presented in chapter four.
Study Procedures

Once ethical approval was obtained, posters (refer to Appendix C) were displayed around SPH a week before the survey study e-mail was sent-out. For instance posters were displayed in approved locations such as in the elevators, on announcement boards and on walls in high-traffic areas. An electronic version of the poster was also placed in the electronic daily newsletter that is sent out through SPH e-mails. The SPH nursing director’s administrative secretary sent out the survey study e-mail with the survey link and cover letter attached. This minimized my direct contact with participants. Return of the e-mail survey signified participant consent. Return occurred automatically through SurveyMonkey (1999), and I imported this information directly into an Excel database for research analysis. Reminder e-mails were sent out through the nursing director’s administrative secretary at weekly intervals until study close at three weeks from the original survey study e-mail.

Data Collection Instruments

The survey tool for this study contains a demographic section, a 39-item Likert-like section and two open-ended questions pertaining to nurses’ preferences with respect to SG. Appendix D contains the survey tool for this study. Each of the Likert-like questions is rated on a 1 to 5 scale where: (1) strongly agree, (2) agree, (3) disagree, or (4) strongly disagree, and (5) don’t know.

This study’s survey tool was modified and validated by Frith and Montgomery (2006) based on an original tool by Minors, White and Porter-O’Grady (1996). The original tool is no longer in print. Frith and Montgomery stated that Minors et al. established content validity and construct validity with confirmatory factor analysis. Confirmatory factor analyses conducted by Minors et al. on the original survey identified
three distinct categories with high internal consistency: knowledge (0.70), commitment (0.66) and perception (0.80) (Minors et al.). Perceptions are defined as individuals’ beliefs about SG; knowledge is defined as awareness of the structure and process of SG; and commitment is defined as individuals’ affective commitment or emotional attachment to the importance of SG (Frith & Montgomery).

Frith and Montgomery (2006) modified the original tool by adding two open-ended questions to the original tool. They determined face and content validity by reviewing the SG nursing literature and obtaining feedback on the survey questions from a task force of nurse leaders with knowledge of SG models. Although their validation process is not explicitly described in the article, Frith and Montgomery concluded that the survey questions captured the importance of knowledge, perception and commitment to SG.

Frith and Montgomery (2006) conducted confirmatory factor analyses on a survey administered to 2000 clinical staff. The breakdown of clinical staff composition is not reported in the article: The clinical staff was employed at a healthcare organization in the U.S. with an SG model. Internal consistency for the three categories was similar to the original results from Minors et al. (1996): knowledge (0.70), commitment (0.68) and perception (0.74). The alpha coefficient was 0.95 indicating a highly reliable tool.

For this study, I added two demographic questions about job title and area of practice to determine whether my sample population was representative of the target population or entire nursing population at SPH. I modified the language for the Likert-like questions on the Frith and Montgomery survey tool (2006) by changing “shared governance” to “nursing practice council.” At SPH, we have been using “nursing practice council” to signify our organization’s version of the SG model and staff are not familiar with the term “shared governance.” I also modified the Frith and Montgomery open-
ended questions to use the “nursing practice council” language. One question was asked to ascertain SPH nurses’ level of awareness with respect to the NPC. Since participation is voluntary and attendees are encouraged to share NPC information with their peers, I wanted to determine whether this is an effective way for raising nurses’ awareness of NPC at SPH. A second question was included to provide participants with an opportunity to address any issues related to NPC that they felt were not addressed by the Likert-like questions. I determined face and content validity of my modified survey and open-ended questions by reviewing the questions with my thesis committee. Reliability testing is the degree to which an experiment or evaluation gives consistent results each time it is employed (Polit & Beck, 2008). Reliability testing of this survey tool with my study population was beyond the scope of my thesis.

Data Analysis

Demographics

Actual numbers or frequencies and percentages of RNs, LPNs and RPNs were tabulated using the Excel database (Huck & Cormier, 1996). Because I did not have an actual breakdown of numbers of RNs, LPNs and RPNs from specific practice areas, I determined practice area representation by looking at frequencies of all nursing type participants (i.e., RNs, LPNs, RPNs) with respect to areas of practice.

Likert-Like Questions

The 39 Likert-like questions on the survey tool were used to answer the first research question: “What are the perception, knowledge and commitment of nursing staff regarding SG at SPH”? To analyze the nursing participants’ responses, I used descriptive statistics (Polit & Beck, 2008). Frequencies were used to determine how many participants responded with a “1”, “2”, “3”, “4” or “5” to each of the Likert-like
questions. Because the “5” response on the scale represents “Don’t Know,” and therefore can not be considered a part of the interval scale this response was eliminated from further calculations. An assumption is that we could treat the 1-4 scale as an interval-level scale (personal communication, Dr. Craig Phillips, October 14, 2010). Means and standard deviations were calculated for participants’ responses to the 39 Likert-like questions based on a 1-4 scale. To determine whether there were differences in participants’ responses to the three categories (i.e., knowledge, perception, and commitment), I conducted a one-way between groups Analysis of Variance (ANOVA) on the means for the three categories. I chose to use an ANOVA test because this test examines whether the means of several groups are equal or not (Polit & Beck). ANOVAs are useful in comparing three or more means, and in this case I compared five different means.

**Open-ended Questions**

Content analysis was used to analyze the nurses’ responses to the two open-ended questions. These questions were: “What are the most common comments that you hear from colleagues about Nursing Practice Council at St. Paul’s Hospital” and “Please share with me any additional views or information that you believe are relevant to improving the Nursing Practice Council at St. Paul’s Hospital”. Qualitative content analysis is the examination of the content of narrative data to identify major themes and patterns among the data (Graneheim & Lundman, 2004). This process involves fracturing the data into smaller units, coding and naming the units according to the content they represent and then grouping the coded data based on shared themes (Graneheim & Lundman). I used a deductive content analysis approach (Graneheim & Lundman, 2004) and coded responses under three main categories (Knowledge,
Perceptions, Commitment) to correspond with the three-sub scales on the SG survey. After reading through the question responses several times, I created sub-categories for each of the three main categories. For the Perceptions category, my pre-determined sub-categories were Positive Perceptions of SG, Negative Perceptions and Misperceptions of SG. For the Knowledge category, my pre-determined sub-categories were Lack of SG knowledge and SG knowledge evidence. For the Commitment category, my pre-determined sub-categories were Commitment to SG and Lack of Commitment. I was prepared to create additional sub-categories as needed. To code the data, I looked for exact phrases and words (meaning units) that were unique from one another and coded each meaning unit under the appropriate sub-category and corresponding main category. I also selected representative thematic quotations from the nurses’ responses for each of the sub-categories. The researcher Neuendorf (2002) states that it is important to understand the quantitative underlay that is connected to content analysis, which involves doing a frequency count or counting of either word units, phrases or themes depending on the researcher’s intent to capture literal (i.e., exact words) versus latent (i.e., implied meanings of words) meaning in the data.

**Research Rigor**

In quantitative research, the terms validity and reliability refer to the data collection instrument’s ability to measure what they are supposed to measure (validity) in a consistent fashion (reliability). As described within the Data Collection Tools section, initial development and subsequent pilot work with the SG tool (Frith & Montgomery, 2006; Minors et al., 1996) demonstrated that this is a valid, reliable tool. I ensured content validity for the modifications I made by consulting with my thesis committee.
In qualitative research, validity refers to “the extent to which the research findings represent reality” (Morse & Field, 1995, p. 244). In this study, I have used quotations to enrich the data findings and provide opportunities for others to check my thematic interpretations against exact nurse quotations. Morse and Field define qualitative reliability as “the measure of the extent to which random variation may have influenced the stability and consistency of the results” (p. 243). When establishing reliability it is imperative to think about the precision of the information gathered from the study participants and the consistency with which the research is collected (Dempsey & Dempsey, 2000). In this study every participant who completed the survey was given the same information, was permitted to take as long as they wanted to and could take the survey when it was most convenient for them. Another way to ensure reliability is to provide as much background about the questions and administration techniques as possible so that others may “go to the same or similar setting and obtain similar responses” (Dempsey & Dempsey, p. 135). I have provided detailed information about the tool and data collection procedure to enhance replicability.

To further ensure research rigor, I used triangulation to strengthen conclusions I have drawn from the study data. Triangulation refers to the use of more than one method to draw conclusions (Creswell, 1994). I used deductive reasoning as a means to determine whether participants’ responses to the two open-ended questions corresponded to their responses to the three categories on the survey tool (i.e., knowledge, perception and commitment). By using statistical findings from Likert-like questions and frequency counts from open-ended questions, I was able to strengthen my conclusions with respect to how the majority of nurses responded to questions about
SG. Triangulation was also conducted by validating my findings with my thesis chair’s interpretation of the data.
CHAPTER 4: RESULTS

This chapter provides the findings from a validated tool, the Shared Governance (SG) survey (Frith & Montgomery, 2006). The survey includes a demographic section, 39 Likert-like questions and two open-ended questions. The language was modified from “shared governance” to “nurse practice council” to suit the specific practice context. The tool was originally validated for a U.S. nursing population. For this study, survey face and content validity were based upon my review of the SG literature, a discussion with my thesis committee and the St. Paul’s Hospital (SPH) SG Steering Committee. I determined survey tool reliability by calculating the internal consistency for the three categories and the overall tool. Internal consistency for the survey varied between the three categories: perceptions (0.87), knowledge (1.0), and commitment (1.0). The alpha coefficient for the entire survey was 0.89, which indicates a highly reliable tool.

Demographics

The accessible study population totaled 294 nurses including 252 RNs (86%), 28 LPNs (9%) and 14 RPNs (5%). The study sample of 114 nurses consisted of 92 RNs (81%), 13 LPNs (11%) and 9 RPNs (8%) for a response rate of 39%. Frequency and percentage comparisons between the accessible study population and the study sample are provided in Table 1. In Table 2 the frequencies and percentages are presented for the study sample according to practice areas.
Table 1.

**Accessible Study Population and Study Sample Population**

<table>
<thead>
<tr>
<th>Designation</th>
<th>Accessible Study Population* n (%)</th>
<th>Study Sample Population** n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>252 (86%)</td>
<td>92 (81%)</td>
</tr>
<tr>
<td>LPN</td>
<td>28 (9%)</td>
<td>13 (11%)</td>
</tr>
<tr>
<td>RPN</td>
<td>14 (5%)</td>
<td>9 (8%)</td>
</tr>
</tbody>
</table>

Note. *N=294.  
**N=114

Table 2.

**Frequencies and Percentages According to Practice Areas**

N=114

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Frequency and Percentage n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medicine/Surgery</td>
<td>49 (43%)</td>
</tr>
<tr>
<td>Critical Care 2</td>
<td>18 (16%)</td>
</tr>
<tr>
<td>Cardiac</td>
<td>21 (18%)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>10 (9%)</td>
</tr>
<tr>
<td>Other (Includes Outpatient Clinics) 3</td>
<td>15 (14%)</td>
</tr>
</tbody>
</table>

2 Specialty areas include the Emergency department, inpatient Dialysis department, Maternity/Neonatal Intensive Care (NICU), Intensive Care Unit (ICU).
3 Other areas include the IV Therapy team, Infection Prevention and Control team and Generalist Educators. Clinics include the Heart Function Clinic and the Chronic Pain Clinic.
Descriptive Statistical Results

The Likert-like questions asked participants to rate their responses as: (1) strongly agree, (2) agree, (3) disagree, (4) strongly disagree, and (5) don’t know (refer to Appendix D & Appendix F). Participant data was entered into an Excel database where Table 3 was created to summarize frequencies and percentages of participants who responded to questions within each sub-scale as either “1,” “2,” “3,” “4” or “5”.

Percentages presented in Table 3 are based on the number of responses divided by 114 (study sample) and multiplied by 100. For example, if 26 nurses answered with #1 for question one, the percentage was calculated as 23%.
<table>
<thead>
<tr>
<th>Category</th>
<th>Questions/ Items</th>
<th>“Strongly Agree” n (%)</th>
<th>“Agree” n (%)</th>
<th>“Disagree” n (%)</th>
<th>“Strongly Disagree” n (%)</th>
<th>“Don’t know” n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions</td>
<td>NPC allows staff participation in decisions that affect clinical practice.</td>
<td>10 (9)</td>
<td>48 (42)</td>
<td>9 (8)</td>
<td>3 (3)</td>
<td>24 (21)</td>
</tr>
<tr>
<td></td>
<td>NPC changes the way we relate to each other at work.</td>
<td>5 (4)</td>
<td>41 (36)</td>
<td>14 (12)</td>
<td>2 (2)</td>
<td>32 (28)</td>
</tr>
<tr>
<td></td>
<td>Since NPC, staff are making more decisions that affect their own practice.</td>
<td>5 (4)</td>
<td>31 (27)</td>
<td>20 (18)</td>
<td>4 (4)</td>
<td>34 (30)</td>
</tr>
<tr>
<td></td>
<td>We have enough time for NPC.</td>
<td>6 (5)</td>
<td>22 (19)</td>
<td>33 (29)</td>
<td>11 (10)</td>
<td>22 (19)</td>
</tr>
<tr>
<td></td>
<td>Nurse/staff retention has improved because of NPC.</td>
<td>0 (0)</td>
<td>9 (8)</td>
<td>30 (26)</td>
<td>8 (7)</td>
<td>44 (39)</td>
</tr>
<tr>
<td></td>
<td>NPC challenges me to grow as a professional.</td>
<td>12 (11)</td>
<td>41 (36)</td>
<td>13 (11)</td>
<td>3 (3)</td>
<td>22 (19)</td>
</tr>
<tr>
<td></td>
<td>I believe NPC increases the professionalism of the staff.</td>
<td>17 (15)</td>
<td>45 (39)</td>
<td>10 (9)</td>
<td>1 (0.001)</td>
<td>18 (16)</td>
</tr>
<tr>
<td></td>
<td>NPC is a key element in what keeps me working here.</td>
<td>1 (0.001)</td>
<td>16 (14)</td>
<td>47 (41)</td>
<td>12 (11)</td>
<td>13 (11)</td>
</tr>
<tr>
<td>Knowledge Questions/ Items</td>
<td>“Strongly Agree” n (%)</td>
<td>“Agree” n (%)</td>
<td>“Disagree” n (%)</td>
<td>“Strongly Disagree” n (%)</td>
<td>“Don’t know” n (%)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
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<td>------------------</td>
<td>--------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>5. Empowerment means everyone is able to use authority already present in their role.</td>
<td>13 (11)</td>
<td>58 (51)</td>
<td>11 (10)</td>
<td>1 (0.001)</td>
<td>11 (10)</td>
<td></td>
</tr>
<tr>
<td>10. We accomplish more now than before we had NPC.</td>
<td>4 (4)</td>
<td>29 (15)</td>
<td>11 (10)</td>
<td>4 (4)</td>
<td>46 (40)</td>
<td></td>
</tr>
<tr>
<td>14. My department is kept better informed about what’s going on because of the NPC.</td>
<td>6 (5)</td>
<td>30 (29)</td>
<td>25 (22)</td>
<td>9 (8)</td>
<td>21 (18)</td>
<td></td>
</tr>
<tr>
<td>16. Problems and solutions are discussed openly in NPC.</td>
<td>15 (13)</td>
<td>35 (31)</td>
<td>6 (5)</td>
<td>1 (0.001)</td>
<td>34 (30)</td>
<td></td>
</tr>
<tr>
<td>17. Good ideas from everyone are heard and responded to in NPC.</td>
<td>14 (12)</td>
<td>33 (29)</td>
<td>7 (6)</td>
<td>1 (0.001)</td>
<td>36 (32)</td>
<td></td>
</tr>
<tr>
<td>20. Staff is supported in projects they initiate through NPC.</td>
<td>6 (5)</td>
<td>33 (29)</td>
<td>9 (8)</td>
<td>2 (2)</td>
<td>41 (36)</td>
<td></td>
</tr>
<tr>
<td>23. I believe staff can completely govern their own activities through NPC.</td>
<td>9 (8)</td>
<td>45 (39)</td>
<td>15 (13)</td>
<td>4 (4)</td>
<td>18 (16)</td>
<td></td>
</tr>
<tr>
<td>24. I have the skills and information I need to support NPC.</td>
<td>9 (8)</td>
<td>40 (35)</td>
<td>20 (18)</td>
<td>9 (8)</td>
<td>13 (11)</td>
<td></td>
</tr>
<tr>
<td>28. The staff participates in NPC activities</td>
<td>4 (4)</td>
<td>41 (36)</td>
<td>17 (15)</td>
<td>8 (7)</td>
<td>21 (18)</td>
<td></td>
</tr>
<tr>
<td>31. The staff is excited to be involved in making patient care/practice decisions through the NPC.</td>
<td>2 (2)</td>
<td>39 (34)</td>
<td>22 (19)</td>
<td>5 (4)</td>
<td>21 (18)</td>
<td></td>
</tr>
<tr>
<td>32. NPC is a system of management that allows staff participation.</td>
<td>9 (8)</td>
<td>48 (42)</td>
<td>5 (4)</td>
<td>3 (3)</td>
<td>24 (21)</td>
<td></td>
</tr>
<tr>
<td>34. NPC gives staff more responsibility and authority to solve problems than staff had before NPC</td>
<td>2 (2)</td>
<td>32 (28)</td>
<td>19 (17)</td>
<td>1 (0.001)</td>
<td>35 (31)</td>
<td></td>
</tr>
<tr>
<td>35. NPC gives staff access to the information and communication nurses need.</td>
<td>9 (8)</td>
<td>36 (32)</td>
<td>13 (11)</td>
<td>2 (2)</td>
<td>29 (25)</td>
<td></td>
</tr>
<tr>
<td>36. We understand roles/responsibilities of members in NPC.</td>
<td>5 (4)</td>
<td>34 (30)</td>
<td>28 (25)</td>
<td>10 (9)</td>
<td>12 (11)</td>
<td></td>
</tr>
<tr>
<td>38. Most patient care decisions are made at the bedside.</td>
<td>8 (7)</td>
<td>43 (38)</td>
<td>26 (23)</td>
<td>6 (5)</td>
<td>6 (5)</td>
<td></td>
</tr>
<tr>
<td>Commitment</td>
<td>Questions/ Items</td>
<td>&quot;Strongly Agree&quot; 1 n (%)</td>
<td>&quot;Agree&quot; 2 n (%)</td>
<td>&quot;Disagree&quot; 3 n (%)</td>
<td>&quot;Strongly Disagree&quot; 4 n (%)</td>
<td>&quot;Don't know&quot; 5 n (%)</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------</td>
<td>---------------------</td>
<td>---------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>4.</td>
<td>Management and staff are partners in patient care.</td>
<td>14 (12)</td>
<td>44 (39)</td>
<td>20 (18)</td>
<td>10 (9)</td>
<td>6 (5)</td>
</tr>
<tr>
<td>7.</td>
<td>NPC is a good use of our time and energy.</td>
<td>14 (12)</td>
<td>50 (44)</td>
<td>4 (4)</td>
<td>1 (0.001)</td>
<td>25 (22)</td>
</tr>
<tr>
<td>8.</td>
<td>Administration is firmly committed to NPC.</td>
<td>7 (6)</td>
<td>37 (32)</td>
<td>16 (14)</td>
<td>5 (4)</td>
<td>29 (25)</td>
</tr>
<tr>
<td>9.</td>
<td>My manager helps make NPC work.</td>
<td>4 (4)</td>
<td>23 (20)</td>
<td>25 (2)</td>
<td>11 (10)</td>
<td>31 (27)</td>
</tr>
<tr>
<td>11.</td>
<td>My manager has the necessary skills to make NPC successful.</td>
<td>3 (3)</td>
<td>35 (31)</td>
<td>17 (15)</td>
<td>6 (5)</td>
<td>30 (26)</td>
</tr>
<tr>
<td>13.</td>
<td>Physician relationships have improved because of NPC.</td>
<td>1 (0.001)</td>
<td>10 (9)</td>
<td>32 (28)</td>
<td>8 (7)</td>
<td>40 (35)</td>
</tr>
<tr>
<td>15.</td>
<td>NPC is NOT an extra burden.</td>
<td>15 (13)</td>
<td>41 (36)</td>
<td>7 (6)</td>
<td>1 (0.001)</td>
<td>27 (24)</td>
</tr>
<tr>
<td>18.</td>
<td>Most of the staff really wants NPC to work.</td>
<td>11 (10)</td>
<td>39 (34)</td>
<td>7 (6)</td>
<td>1 (0.001)</td>
<td>33 (29)</td>
</tr>
<tr>
<td>19.</td>
<td>SPH administration sincerely wants NPC to work.</td>
<td>8 (7)</td>
<td>35 (31)</td>
<td>3 (3)</td>
<td>2 (2)</td>
<td>43 (38)</td>
</tr>
<tr>
<td>21.</td>
<td>My manager encourages staff to participate in NPC decision-making.</td>
<td>5 (4)</td>
<td>32 (28)</td>
<td>25 (22)</td>
<td>13 (11)</td>
<td>16 (19)</td>
</tr>
<tr>
<td>22.</td>
<td>I believe in NPC.</td>
<td>24 (21)</td>
<td>45 (39)</td>
<td>3 (3)</td>
<td>2 (2)</td>
<td>17 (15)</td>
</tr>
<tr>
<td>26.</td>
<td>I want to participate in a leadership role in NPC.</td>
<td>5 (4)</td>
<td>33 (29)</td>
<td>22 (19)</td>
<td>2 (2)</td>
<td>29 (25)</td>
</tr>
<tr>
<td>27.</td>
<td>NPC is NOT just a fad.</td>
<td>17 (15)</td>
<td>50 (44)</td>
<td>4 (4)</td>
<td>0 (0)</td>
<td>20 (18)</td>
</tr>
<tr>
<td>30.</td>
<td>My manager supports/encourages staff involvement in NPC.</td>
<td>9 (8)</td>
<td>29 (25)</td>
<td>23 (20)</td>
<td>9 (8)</td>
<td>21 (18)</td>
</tr>
<tr>
<td>37.</td>
<td>Management really wants an empowered staff.</td>
<td>9 (8)</td>
<td>34 (30)</td>
<td>20 (18)</td>
<td>10 (9)</td>
<td>16 (14)</td>
</tr>
<tr>
<td>39.</td>
<td>Staff will support NPC at SPH.</td>
<td>7 (6)</td>
<td>54 (47)</td>
<td>4 (4)</td>
<td>1 (0.001)</td>
<td>23 (20)</td>
</tr>
</tbody>
</table>
Inferential Statistical Findings

Analysis of variance (ANOVA) is useful to compare three or more means (Polit & Beck, 2008). Table 4 presents means and standard deviations for each practice area according to the main categories. A one-way ANOVA was used to test for differences between nurses from different practice areas with respect to the three survey categories. The five practice areas are: Medicine/Surgery, Cardiac, Critical Care, Psychiatry and Other (e.g., outpatient clinics). Knowledge of NPC differed significantly across the five different practice areas, $F(4,70) = 3.517, p = .011$. Tukey post-hoc comparisons of the five different practice areas indicate that the Medicine-Surgery areas ($M = 2.33, 95\% \text{ CI } [1.26, 3.40]$) and Other areas ($M = 2.36, 95\% \text{ CI } [1.17, 3.51]$) have significantly greater knowledge than Critical Care ($M = 2.17, 95\% \text{ CI } [1.30, 3.00]$), Cardiac ($M = 2.14, 95\% \text{ CI } [1.08, 3.18]$) and Psychiatry ($M = 2.12, 95\% \text{ CI } [1.30, 2.86$), $p = .05$. Comparisons between the Perceptions category ($M = 2.38, 95\% \text{ CI } [1.26, 3.50]$) and the Commitment category ($M = 2.19, 95\% \text{ CI } [1.22, 3.26]$) and the five practice areas were not statistically significant at $p < .05$. 
<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Perceptions Means (SD)</th>
<th>Knowledge Means (SD)</th>
<th>Commitment Means (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine/Surgery</td>
<td>2.48 (0.74)</td>
<td>2.33 (0.77)</td>
<td>2.31 (0.81)</td>
</tr>
<tr>
<td>Cardiac</td>
<td>2.19 (0.79)</td>
<td>2.14 (0.76)</td>
<td>2.11 (0.80)</td>
</tr>
<tr>
<td>Critical Care</td>
<td>2.34 (0.73)</td>
<td>2.17 (0.61)</td>
<td>2.15 (0.63)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2.43 (0.86)</td>
<td>2.12 (0.56)</td>
<td>2.05 (0.73)</td>
</tr>
<tr>
<td>Other</td>
<td>2.43 (0.90)</td>
<td>2.36 (0.84)</td>
<td>2.35 (0.88)</td>
</tr>
<tr>
<td>F(p) values</td>
<td>0.40 (0.81)</td>
<td>3.52 (0.01)</td>
<td>1.75 (0.15)</td>
</tr>
</tbody>
</table>

Note. p<.05
Content Analysis Findings

Research Question 1: What are the most common comments that you hear from colleagues about Nursing Practice Council at St. Paul’s Hospital?

For question 1, there were 114 unique meaning units: one meaning unit per response. I used all the pre-determined sub-categories except those sub-categories for the Perception category. For this category, I did not use the Negative Perceptions of Misperceptions sub-categories: no meaning units fit these sub-categories. I did not need to create additional sub-categories or main categories for the meaning units corresponding to the first question.

After coding the 114 responses, I obtained frequency counts along with percentages for each sub-category per main category by dividing the number of sub-category meaning units by the total number of responses per category and multiplying by 100. Refer to Appendix E for the entire breakdown of all responses in sub-scales and categories. Table 5 is the frequency count table for the sub-categories per category (Knowledge, Perceptions, Commitment) for question one. Direct quotations are provided following Table 5 to explain what each meaning unit represents according to each sub-category.
Table 5.

*Frequency Count for Each Sub-Category per Major Category*

N=114

<table>
<thead>
<tr>
<th>Perceptions</th>
<th>Knowledge</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Positive Perceptions</td>
<td>Knowledge Evidence of SG</td>
<td>Commitment to SG</td>
</tr>
<tr>
<td>12 (10%)</td>
<td>10 (9%)</td>
<td>7 (6%)</td>
</tr>
<tr>
<td>Lack of Knowledge</td>
<td>65 (57%)</td>
<td>Lack of Commitment</td>
</tr>
<tr>
<td>65 (57%)</td>
<td></td>
<td>20 (18%)</td>
</tr>
</tbody>
</table>
Perceptions Category

Positive Perceptions

Some examples of positive perceptions are: “It [NPC] is rewarding and relates to the issues we encounter on the unit on a daily basis”. Another person referred to NPC as, “[…] the tester and idea providers”. Other responses included, “Empowering”, “Good for you for going. Do you think it helps?” and, “Those involved speak with commitment and enthusiasm”. “NPC supports nurses in dealing with common problems. It supports nurses to be professionals in their workplace. No other committee could do this”.

Knowledge Category

Knowledge Evidence of SG

Responses included such statements as, “A good forum for people to know what is going on in the hospital” or, “Good place to communicate, Nursing concerns are heard and discussed”. Other participants stated that, “It’s a venue where nurses’ can discuss improvements in practice on the units” and others are, “Glad to have a voice in shaping nursing practice”. Some of the other positive responses include, “It is a forum that lets nurses from all areas help decide on issues before they reach the units” and it is, “Very informative. Helps nurses understand that we [nurses] are all struggling with similar issues”.

Lack of Knowledge

The majority of responses in this sub-category all said the same thing; “I have never heard of it [NPC] before”. The responses ranged from “Haven’t heard very much” to, “Do not discuss, largely unaware of what is going on in the NPC meetings”. One staff member even said, “I have never heard anyone talk about this council at work. A UBC nursing student mentioned it to me once”.

Other responses that specifically asked, “What is it”. These responses had more interest in what NPC is. Such responses were, “What is it” or, “What is the Nursing Practice Council? Who makes up the NPC” or, “Don’t really know what it is and does” or, “What is it? What purpose does it really do?” and finally, “What is it? What do you do there? When is it?” Two comments specifically said, “What is it? What purpose does it really do? Just another meeting for leaders to go to!” and, “I don’t think most nurses know about nursing practice council. I believe most decisions about nursing care are actually mandated by management and on the physician level”. Other responses included, “Need more information”. Another participant wrote, “I don’t know anything about NPC? What is the mission statement of this council? How are they kept accountable to nurses and their needs?” Another participant wrote, “Unfortunately I don’t have enough information regarding NPC and their work”.

**Commitment Category**

**Commitment to SG**

One participate simply wrote, “I want to go”. Another participant wrote, “Would like to participate, but can not attend as no replacement is available. I think that staff have to be better educated as to what NPC could and should be and that NPC’s success depends on the participation and commitment”. Another participant stated, “Wish I could be covered on the unit to go to NPC”.

**Lack of Commitment**

The most common response from participants when asked what their colleagues say about nursing practice council is that they do not have enough time to attend the council meetings. For example participants said, “The units are usually too busy, or not enough staff; to attend meetings”; another person said, “[NPC] requires a time
commitment—not always available for a four hour meeting”; or “Too hard to attend consistently when working shift work”. One comment was more negative than the others stating, “Too much time for too little to show for—insular group”. This did not fit with the other comments, though it did fit with the sub-theme of not having enough time to commit to the council. One participant wrote that, “The time to fully participate is a challenge…it is more than just attending a meeting, there is additional work that is done outside of the meeting to ensure the work is truly meaningful and effective”.

Other comments said such things as, “A select few of the nursing staff make the time to participate. I believe that most clinical decisions are driven by individual staff at the bedside. I am unsure how much of the decisions made at NPC actually are implemented at bedside”. Or another comment stated, “There are a lot of forums and I am not sure how they are all connected”. One participant said, “The most common comment I have heard recently from my colleagues regarding the NPC is that while ‘Good ideas’ may arise from the council, the current fiscal situation in the hospital determines the value of any initiatives (not the benefit to the patient)”. Another comment that was brought forth from a participant indicated the disconnect that exists between certain clinical areas and the council. This participant said,

“Working in the community, we are somewhat detached from SPH. In the Renal program I feel we should become MORE involved in the NPC. I would like to see more leaders from the program attend the CNL and NPC meetings. This might help in the communication within the Renal program, and make us all aware of what the other units in the Renal program and hospital are doing”.
Research Question 2: Please share with me any additional views or information that you believe are relevant to improving the Nurse Practice Council at St. Paul’s Hospital.

This question was optional for participants to answer. Of the 114 participants, there were 50 responses, totaling 44% of the sample population. Refer to Appendix E for a complete breakdown on responses. For the Perceptions category, my pre-determined sub-categories were Positive Perceptions of SG, Negative Perceptions or Misperceptions of SG. For the Knowledge category, my pre-determined sub-categories were Lack of SG Knowledge and SG Knowledge Evidence. For the Commitment category, my pre-determined sub-categories were Commitment to SG and Lack of Commitment. I was prepared, however, to create additional sub-categories, depending on participants' responses. After coding the 50 responses to question 2 I only used the Positive Perception sub-category for the Perceptions main category: For the Knowledge category, I did not use the pre-determined sub-categories. Instead, I created a new sub-category titled, Increasing Staff Knowledge. I did not use the pre-determined sub-categories for the Commitment category. I needed to create two new sub-categories titled, Administrative Commitment and Staff Commitment. I obtained frequency counts for each of the sub-categories corresponding to the three main categories. Table 6 contains the frequency counts by sub-category for the three main categories.
Table 6.  
*Frequency Count for Each Sub-Category Under the Three Main Categories*

N= 50

<table>
<thead>
<tr>
<th>Perceptions n (%)</th>
<th>Knowledge n (%)</th>
<th>Commitment n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Perceptions of SG 10 (20%)</td>
<td>Increasing Staff Knowledge 27 (54%)</td>
<td>Administrative Commitment 8 (16%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff Commitment 5 (10%)</td>
</tr>
</tbody>
</table>
Perceptions Category

Positive Perceptions of SG

Of the responses four were simple and stated, “I feel it is working well” or, “Keep it going” and, “I think the NPC meetings are run very well. Meeting agendas are appropriately followed. We have speakers that are from various areas talking about implementation of new things. Nothing comes to mind at this time”. One participant wrote, “I like that NPC financially supports nursing education as there is not enough funding available from other sources”. Two responses had specific comments, the first said, “As a person who actually sits on the council I think we should be given identifier vests or something to show that we are on the council and people can approach us for questions/concerns [and it] promotes professionalism/knowledge/awareness”. Another comment by a participant said, “Would be appreciated if NPC members were asked for their input prior to decisions being made. Sometimes it feels like NPC is just another check that management has to go through to move ahead on things, i.e. Geriatrics program changes and cutting ICU outreach”.

Knowledge Category

Increasing Staff Knowledge

This sub-category had the majority of responses for open-ended question two. Participants had suggestions such as, “Recruit more champions to chat it [NPC] up more” and, “Better communication, follow-ups with non-NPC members”. Other responses included, “NPC needs to do a better job of communicating their work. Emails of minutes only go to select staff. You need to advertise [NPC] work in a more widely
circulated venue such as the communication flyer or the d’Vine⁴. Another participant said, “I believe it would help if NPC participants would do an awareness campaign to disseminate information on the purpose and mandates of the council. I think that the needs of the NPC would be better met if participation was promoted”.

Other responses included, “All nursing areas should have representation. Those that are on NPC need to bring the information back and share this at staff meetings” and, “Better integration with practice leaders (Clinical Nurse Specialist, Nurse Practitioner, practice leaders)” is needed. There were six responses all directed at expanding the coverage of the different nursing areas. One participant wrote, “I think it would be beneficial to have a practice council on each unit that fed up to the NPC”. Another person wrote, “Needs to be more visible and inclusive ensuring participation of nurses from ALL units”. The other responses were similar to these, focusing on encouraging more participation from different units. Two responses were very specific with their suggestions. One participant said, “Wish there was more of an attempt to include the Mental Health Program nurses. There remains a strong division between RNs and RPNs, therefore there is not a lot of broader learning or discussions about the emotional impact that occurs”. The other participant suggested to, “Have the RN Network⁵ join the group”.

There were a number of responses, all aimed at providing small examples of what the NPC needs to do to further develop and expand. For instance one participant

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⁴ The d’Vine Providence newsletter is published six times a year online and across all Providence Health Care sites. Catering to staff, physicians, researchers, volunteers, patients and visitors. The d’Vine includes regular features on PHC people, research and initiatives.

⁵ The Registered Nurses Network of BC (RN Network) serves as a coalition created to coordinate strategic planning and action toward the establishment of a permanent professional association mechanism for nursing in BC. It serves as a temporary voice for articulating a nursing perspective on matters of public policy or concern outside of the mandate of existing organizations until such time as a more permanent mechanism for professional nursing policy involvement emerges.
wrote, “I think it would be helpful if more staff knew what NPC is all about. I rarely hear very much information about it”. There were a few other responses that focused on creating more awareness of NPC. The responses included, “More awareness”, “More awareness, and maybe [an] easily [accessible] meeting room closer to the clinical area” and, “Should be more advertised”. All of these are simple tips, but come from frontline staff that implies that if these were implemented, attendance and involvement in the council would improve. Other comments highlighted the need for more information about the council. For instance various responses stated, “More information on what it [NPC] is and its intentions and possibilities for involvement” and, “I would like to be better informed about the council in general”. The final set of responses in the knowledge sub-scale provided some very tangible and simple solutions. For example one participant wrote, “I don’t know anything about you guys [council members]. If you can approach each nurse in a more personal/casual way, I think it would make a difference” and, “Could we get minutes of the meetings?” and, “Ensuring that nurses know what work the NPC does and how that impacts their work environment”.

Commitment Category

Administrative Support

Responses included, “Management should really encourage participation from their staff members. The staff should be able to inform the rest of the nurses during staff meetings of what was discussed” and as simple as, “More support by Management, i.e. Operations Leaders, Clinical Nurse Leaders”. Other participants said such things as, “Operations Leaders and Clinical Nurse Leaders need to make more of an effort to ensure that staff from all areas are given a regular opportunity to attend NPC. Staff also need to hear regularly what NPC is doing and what is happening to concerns brought
forth” and, “NPC has to be supported by all levels of administration”. Some responses were multi-faceted and said such things as, “I think that for NPC to actively affect change then management needs to listen to nursing staff more. If nursing staff [are] burnt out due to workload issues then cutting staff on day shifts and cutting beds for older adults is not a solution”. Another participant wrote, “I think the NPC needs to be more visible and become [more of] a presence and the nurse leaders on the floor need to encourage their staff to participate and make it possible for them to do so, not just by [staff] coming in on their day off, if they happen to have one that day”.

**Staff Commitment**

There were five responses that fit into the sub-category of Staff Commitment. One respondent said, “It is difficult to attend the meetings-I know many people are involved, but it would be nice to have different times once and a while to allow some others to go”. Another person said, “More involvement, show outcomes of the meetings and what has been changed because of the NPC”. A couple of the other responses involved staff involvement but were more abstract. For instance, “I think that staff empowerment and nursing involvement in quality improvement and clinical decision making should be done at the unit, program and organization level, not in isolation”. One other participant wrote, “NPC should be more present and reach out to all the staff for a better understanding of their goals”.
Limitations

It is important to consider the various limitations associated with this study. Although the Frith and Montgomery (2006) survey tool had previously been validated as stated in chapter three, there were some obstacles encountered when surveying and analyzing the data. This particular survey has never been used in Canada before, therefore not all questions fit well with the Canadian Healthcare system. In addition the language used in the original tool is different and can skew the meaning to Canadian nurses. The “5” response could not be treated as an item on an interval-level scale due to its non-numerical natures. This influenced the statistical analyses conducted on survey data. Additionally the total nurse population at St. Paul’s Hospital was unreachable. I was only able to survey those nurses with work e-mail addresses that were accessible to the nurse administrative secretary.
CHAPTER 5: FINDINGS

This chapter organizes my interpretations of the data findings from chapter four according to the study’s key research questions. As noted earlier, I used triangulation to compare the descriptive statistical findings from the 39 Likert-like questions and compared those findings to the content analysis findings from the two open-ended questions according to the three pre-determined categories. By utilizing data triangulation to compare multiple data sources I was able to validate my conclusions (Polit & Beck, 2008). Additionally I discussed the implications for St. Paul’s Hospital and highlight recommendations for future research based on the findings from this study.

Interpretation of Findings for Question 1

Research Question 1: What are the perceptions, knowledge and commitment of nursing staff regarding SG at SPH?

Perceptions

Within the Perceptions category, none of the scale items (i.e., “1,” “2,” “3,” “4,” “5”) received the majority of responses. The number of respondents with “1” responses or “Strongly Agree” was generally less than 15% of the total responses for the Perception category questions. The majority of nurse respondents, therefore, did not indicate strong agreement with any of the questions. There were four questions that received over 35% of “2” or “Agree” responses. These items were: NPC allows staff participation in decisions that affect clinical practice; NPC changes the way we relate to each other at work; NPC challenges me to grow as a professional; and I believe NPC increases the professionalism of the staff. Nurses’ responses to the Likert-like questions indicated that the greatest proportion of respondents either agreed or indicated “Don’t know” to all the Perception questions except two items where the majority of responses were
“Disagree”. These items were: *We have enough time for NPC; and NPC is a key element in what keeps me working here.* These two items and related findings may indicate that NPC does not play a vital role and therefore it could be assumed staff are not making the time to participate in the council meetings and therefore NPC is not a key element in maintaining their employment at SPH.

Based on the descriptive statistical findings in the perceptions category, questions one and two are associated with what NPC can lead to or offer to staff members. The questions were: *NPC allows staff participation in decisions that affect clinical practice, and NPC changes the way we relate to each other at work.* The majority of responses for these answers were “agree” and could be assumed to be positive, likewise the open-ended responses coded into the positive perceptions sub-category support this. For instance responses included “Empowering” and “It is rewarding and related to issues that we encounter on the unit on a daily basis”. Content analysis of the open-ended questions supported nurses’ more favorable perceptions of SG at SPH. The only comments related to nurses’ SG perceptions were positive ones: there were no negative comments or comments reflecting misperceptions of SG at SPH. The ANOVA results from the SG survey demonstrated non-significant differences among the nursing practice areas with respect to perceptions category responses.

As discussed previously in chapter two, control over nursing practice (C/NP) as discussed by Kramer and Schmalenberg (2003) is described as more than “enactment, control, or decision-making […but as] autonomy. C/NP means working with other nurses to have a say in broader issues affecting nurses, nursing and patient care” (p.441). Previous research has highlighted that there is a significant relationship between control over nursing practice rankings and nurse job satisfaction (Kramer & Schmalenberg).
Likewise participatory decision-making has been found, after implementation, to increase job satisfaction among staff, increase nurse retention rates, and managers have stated that operational processes are more streamlined (Parsons, Batres & Golightly-Jenkins, 2006). This perceived involvement that was found at SPH in the decision-making process could lead to increased engagement among frontline staff at SPH and ultimately impact nurse job satisfaction.

**Knowledge**

Within the Knowledge category, the majority of nurse responses were answered as “2” or “Agree”. The number of respondents with “1” responses or “Strongly Agree” was generally less than 13% of the total responses for the knowledge category questions. The majority of nurse respondents, therefore, did not indicate strong agreement with any of the questions. There were three questions that received over 40% of “2” or “Agree” responses. These items were: *Empowerment means everyone is able to use authority already present in their role;* I believe staff can completely govern their own activities through NPC; and *NPC is a system of management that allows staff participation.* These three items have key foundational values rooted in SG leading me to believe SPH has the potential to successfully develop and sustain SG (NPC).

Nurses’ responses to the Likert-like questions indicated that the majority of respondents either agreed or indicated, “Don’t know” to all the Knowledge items. There were four items that received over 30% of “5” or “Don’t know” responses. These questions were: *We accomplish more now than before we had NPC; Good ideas from everyone are heard and responded to in NPC; Staff are supported in projects they initiate through NPC; and NPC gives staff more responsibility and authority to solve problems than staff had before NPC.* These items that received the majority of
responses as “Don’t know” may be due to the lack of knowledge that staff have about what NPC does, who the members are or even how to find out about more information. This thought was also supported by the open-ended responses. When asked what participants hear their colleagues saying about NPC, 57% of responses answered with, “What is it”.

Content analyses of the open-ended questions supported this lack of nurses’ knowledge of NPC at SPH. The majority of comments related to nurses’ SG knowledge was related to a lack of knowledge. A small number of comments supported the interpretation that staff nurses have a limited knowledge of what the NPC does at SPH. Other open-ended responses focused on what could be done to improve nurse’s knowledge of NPC. For instance suggestions included, “Should be more advertisement” and “Approach each nurse in a more personal/casual way [to discuss what the council does]”. It is obvious from the large amount of responses related to communication that this is a problem that may pose a perfect jumping off point to increase awareness through improving the methods of communication to staff about NPC. It is imperative that the NPC share both their successes and the topics that are currently being worked through with the rest of the frontline staff at SPH. This will help to increase and promote awareness for what the council is doing.

The ANOVA results of knowledge varied by practice area and results were found to be statistically significant. Acute care nurses in Medical-Surgical areas for instance, had greater knowledge of SG than nurses in Cardiac, Critical Care and Psychiatry. This may be because of the large number of nurses employed in those areas and therefore more flexibility to attend the NPC meetings. Additionally Other areas were found to have statistically significant more knowledge than the Cardiac, Critical Care and Psychiatry
areas. This may be because the term Other covers a variety of areas, which include the Outpatient Clinics and the generalist Nurse Educators. These individuals generally have more awareness of NPC, and some have come to speak to the council on protocols to be implemented within SPH. Additionally these areas have difficulty getting coverage to attend the council meetings because they are specialized areas and therefore only specially trained nurses can work in these areas.

SG can only be successful if staff feels that they are empowered within their roles in the workplace (Frith & Montgomery, 2006). Empowerment occurs when organizations and their leaders provide staff with access to information, resources, opportunities to learn and grow, and supports such as mentors and role models (Kanter, 1993). Over 51% of responses in the knowledge category indicate that staff agreed with this key foundational point of SG. Additionally, power is included with empowerment as a structural determinant that directly affects organizational behaviors and attitudes (Kanter). Power is related to access to empowerment structures. The survey results indicated that 38% of responses “agree” most patient care decisions are made at the bedside at SPH. This indicates that staff is empowered in their roles and therefore have power to make decisions within their workplace. Therefore SPH has the foundation to further implement SG structures because staff perceived themselves as being empowered.

Commitment

Within the Commitment category, the majority of nurse responses were answered as “2” or “Agree”. The number of respondents with “1” responses or “Strongly Agree” was generally less than 15% of the total responses for the commitment category questions. The majority of nurse respondents, therefore, did not indicate strong
agreement with any of the questions. There were four questions that received over 40% of “2” or “Agree” responses. These items were: *NPC is a good use of our time and energy; I believe in NPC; NPC is NOT just a fad;* and *Staff will support NPC at SPH.* These items lead me to view the Commitment category responses as positive. I believe these items and responses can provide leadership with evidence that staff believe NPC is a useful forum and therefore they should ensure adequate resources are allotted for the council to operate. Nurses’ responses to the Likert-like questions indicated that the greatest proportion of respondents either agreed or indicated, “Don’t know” to all the Commitment questions. There were two items that scored greater than 35% for “5” or “Don’t Know”. These items were: *Physician relationships have improved because of NPC;* and *SPH administration sincerely wants NPC to work.*

Content analyses of the open-ended questions results supported the point that staff nurses at NPC were unclear if administration wanted NPC to work. For instance 38% responded with “Don’t Know” to the item: *SPH Administration sincerely wants NPC to work.* Additionally 16% open-ended responses were also related to the lack of administrative support. Such responses included: “Management should really encourage participation from their staff members. The staff should be able to inform the rest of the nurses during staff meetings of what was discussed”. The ANOVA results from the SG survey related to the Commitment category varied by practice area, though they were not statistically significantly.

This leads to the conclusion that there is a separation between staff who feel administration is supportive of NPC, and those who do not. Despite this headwind of a lack of perceived leadership support, nurses are generally in favor of NPC. This provides an opportunity to increase engagement and momentum with the concept of SG
through leadership buy-in, although there is a disconnect among staff at SPH and their views of management. Of those who participated in the survey, 39% believe Management and staff at SPH are partners in patient care. However, when it comes to whether management specifically supports the NPC staff do not believe it. Management could potentially attain a more favorable view from frontline staff if they were deemed to support the NPC. Results from the Employee Engagement Survey at Providence Health Care (St. Paul’s Hospital) indicated that although there is a meaningful improvement in terms of overall employee engagement, the target of being within the 50th percentile was not met (Providence Health Care, 2010). In 2007 the grand mean was 3.48 and in 2009 it rose to 3.62 (Providence Health Care). This indicates that there was improvement but the target of 3.98 (50th percentile) was not met (Providence Health Care). These levels of engagement could be tied to levels of commitment and SPH administration may choose to focus on improving employee engagement rates, before focusing on SG at SPH.

The 47% of nurses at SPH that support NPC, led me to believe that these staff members support and look for autonomy in the workplace. Autonomy is a desired state in the workplace that is obtained over time and therefore requires commitment (Kramer et al., 2009). Structures and processes, such as SG, are necessary for nurses to have autonomy over practice or as stated above, control over nursing practice. It was Laschinger and Havens (1996) that found an increased level of education leads to higher autonomy among nurses. Increased autonomy is associated with nurses who have higher levels of organizational commitment, lower levels of burnout and increased participation in their organization’s decision-making processes (Laschinger & Havens).
Interpretation of Findings for Question 2

Research Question 2: What have nursing staff heard about NPC at SPH?

Based on the open-ended responses I determined the main points that nurses have heard about NPC at SPH. Staff members have heard about the positive benefit to having a forum to discuss pertinent issues. For instance in SPH a common issue that had been on the NPC agenda for many months was the issue of the laundry bins. In January 2010 the laundry bins changed from being large bins to small disposable bag bins. The change came about with little warning and many staff members were greatly impacted by this change. In the early months of 2010 staff brought forth the issue during a roundtable discussion at NPC, but as time progressed it was determined that this topic required greater emphasis. Measures were taken to allot time on the agenda and certain members were delegated to contact Occupational Health & Safety (OH&S), housekeeping and each member was asked to perform informal audits in their workplace. The audits looked at how often in a 12-hour shift nurses were spending time emptying the new small-size laundry bag bins. The following month the audits were presented and through discussion with OH&S it was determined that the small-size bag bins were brought in as a means of preventing back injuries. Unfortunately the workload was not being evenly dispersed. The duty of emptying the laundry bag bins was to be shared between housekeeping and nursing, but instead housekeeping was not fulfilling their duty. On average nurses were having to empty bins 12 times per shift. That is equal to once every hour. This was valuable time that could be spent with patients. The Director of Nursing Practice brought this information forward to her next meeting with housekeeping, and from that meeting roles and responsibilities were clarified. Further education was brought about to inform other staff that the duty was to be shared
between nursing and housekeeping. Based on what council members have said at meetings in late 2010, the workload has since improved. This perception of having a forum to discuss issues and draw out solutions would be the greatest driver of SG at SPH. This is why it is important for staff to be made aware of the work that the NPC does and has done within SPH.

Many participants simply said they have heard other staff members asking; “What is it” or that the staff “Have never heard of it”. Currently there is no formalized structure for disseminating information to staff about NPC meetings. The minutes are typed up and made available on the intranet but staff is generally unaware of how to locate the minutes or that they even exist. The bigger issue is that staff does not know the council exists. There needs to be more of a formalized structure in place to disseminate information and for staff to know who they can speak to when they have a question about the council or when they want to know what is currently being discussed at the council meetings.

Staff at SPH has also heard nurses discuss who should be included/involved in the NPC. For instance one nurse heard how it would be beneficial to include more nurses from the Mental Health Program, which would aid in reducing the divide between RPNs and RNs. SPH has an excellent Mental Health Program that provides inpatient and outpatient mental health services to adults and seniors. General Psychiatry is the largest service within the Mental Health Program, providing care through community, outpatient, inpatient and consultation services. Such programs include: Eating Disorders, Chronic Pain Management, Reproductive Psychiatry, Refractory Psychosis and Geriatric Psychiatry. Due to the Mental Health Program being so large, it is important that the nurses working in the Mental Health Program feel that they are part of
the larger organization. In addition the Mental Health Program makes up such a large part of the organization and touches so many areas that they need to be included in larger discussions to improve patient care and nursing practice.

**Implications and Recommendations**

The findings from both research questions have led to the final conclusions and recommendations. The three main points that came out of the SG survey results were: (1) Staff at SPH have a positive perception of NPC, but (2) Staff do not have enough knowledge about the NPC, and (3) Staff are not sure if administration is committed to the work of the NPC. These three points will help to further guide the discussion of the implications and recommendations. The four areas that I chose to focus, based on these three main points from the SG survey are: (1) Practice, (2) Education, (3) Leadership, and (4) Research.

**Practice**

There is a significant amount of research that demonstrates how SG increases nurses’ perceptions of professional growth and promotional opportunities, as well as opportunities to increase leadership competencies (Edmonstone, 1998). Studies also suggest that SG improves staff reactions to change and that there is an increased focus on the patient (Minnen et al., 1993). Other potential benefits of SG include; increased ownership over nursing practice; increased morale, motivation, staff contribution; encouragement of creativity, promotion of interpersonal relationships; improved communication, increased sense of cohesiveness, teamwork and collegiality (Geoghegan & Farrington, 1995; Brodbeck, 1992). Finally SG has been shown to increase efficiency and quality of care delivered (Ireson & McGillis, 1998).
Based on the findings from the SG survey at SPH and the number of positive responses, participants appear to support the idea and the foundational ideology of NPC and generally want to become further involved. Furthermore the concept of advocacy seems to resonate with the participants. Overall the responses were very positive and show that NPC, and by extension, shared governance, at the most basic level is successful at SPH. The research undertaken indicates that the Nursing Practice Council at St. Paul's is a well respected vehicle through which participatory decision-making can be effected. The council is the proverbial ‘low hanging fruit’ where frontline staff can come and be heard and affect change. Further expansion of representation on the council will only serve to have more of an impact. The larger the NPC group to draw from the more potential for change within the organization. This is because the more nurses who attend the council the better the opportunity to disseminate information to other frontline staff members. This would encourage other staff members to become involved with the council if staff hear about topics that pertain to them and hold their interest. In addition staff would feel that they are backed by a council that functions in their best interest. It is imperative that the NPC represent all areas of practice and represent as many different views as possible, and therefore increasing attendance is of utmost importance. The Nursing Practice Council at St. Paul’s Hospital has the potential to make a difference, particularly with 47% of nurse respondents indicating agreement with statements such as, “NPC allows staff participation in decisions that affect clinical practice”. It is from this vantage point that the council can evoke change within the hospital. It is at this juncture that NPC requires more advertising, various methods of informing staff about the council and support from leadership. These topics will be discussed in the following sections.
Education

Education is an important aspect of a nurse’s ongoing growth. The College of Registered Nurses of British Columbia (CRNBC) require nurses to demonstrate ways in which they are maintaining their practice, and what they do to update their skills on an annual basis. It is my opinion that this is the most important component in order for SG implementation to be effective and sustained. The findings from the SG survey displayed the large number of staff members who have a lack of awareness about the NPC’s role and mandate. A large number of staff, at 57%, provided open-ended responses that were coded as “Lack of Knowledge”. Through increased education and advertising, combined with an increase in attendance the council would offer a larger platform to affect change. In order that staff at SPH further understands how the NPC is working for them it is imperative that the council show them some of their ‘wins’. For example, in early 2010 management made the decision to move from large laundry bins to small laundry bins to aid in the reduction of infectious disease control and prevent back injuries (refer to section 5.2.1 Perceptions).

It is this type of example of the NPC positively affecting change for nurses that needs to be disseminated to other frontline staff members. Clearly, there are not enough success stories circulating within the hospital. Success breed’s success, and positive results will increase the potential for change for the NPC. It is not only the change that is important, but also the feeling among frontline staff that they can affect this change. When nurses feel they are more likely to have an impact on something they are much more likely to be involved. There are many steps that NPC can take to increase this awareness. For instance posting minutes from monthly council meetings on the intranet and sending email updates about what topics will be discussed at council meetings.
Additionally the council should work to increase social networking by using Facebook, online blogs and online chats to increase knowledge and discussion of the council. The NPC should also use Nursing Week events to create a larger presence. For instance the BBQ that is held mid-Nursing Week should have all NPC members present, along with the leaders who support the council to circulate and raise the level of awareness. All these strategies would go a long way towards improving the number of people that NPC is able reach.

Another way to ensure staff learns about the NPC is to educate new hires at orientation. By incorporating a short session into orientation this ensures new staff understand that SPH supports and encourages participation in the council. Additionally as a part of the orientation new hires could shadow a practice council meeting. This would encourage participation and help to further disseminate what the council does to other staff. Another way that could be utilized to disseminate information to staff from council meetings would be to hold Nursing Grand Rounds. This would be a forum that could be held twice a month, where staff members (anyone) could bring their lunch and listen to a presentation of work the NPC is doing. This would open up more opportunities for discussion and allow for more staff to be involved and share their opinions. It is important to realize that while there is a general lack of knowledge about the council, there is also a significant amount of goodwill that can be built upon to improve efficiency of change.
Leadership

In SG literature, leadership is an important factor ensuring the successful implementation (Laschinger & Leiter, 2006). The literature also states that through SG administrators have an increased respect for clinical staff and leadership competencies are improved (Daugherty & Hart, 1993; Edmonstone, 1998). The SG survey at SPH indicated that 38% of staff is unsure if administration supports the work of NPC. If staff perceived administrative support to be stronger, this would foster increased staff commitment. Staff must be made aware from their leader, that they can receive coverage in order to be able to attend NPC meetings. Additionally nurse leaders must advocate for adequate staffing. This coverage must not place an undue burden on the remaining staff on the ward so that there is pressure to not attend the meetings. Perhaps an option would be for the Clinical Nurse Leaders to provide coverage for the frontline staff allowing them to attend meetings for the 4-hour period. Studies indicate that time allotted for professional development and increased engagement increases job satisfaction and retention (Parsons, Batres & Golightly-Jenkins, 2006). Utilizing this research as a means to substantiate nurse involvement in the NPC would help to provide concrete evidence. I believe at SPH this would be our first jumping off point. To educate leadership and get their buy-in will help to increase attendance at the council meetings, leaders could encourage their staff to bring back the information that is discussed at council meetings, and staff will feel encouraged by their leaders to attend and to be actively involved.
Research

Further research needs to be undertaken to understand what barriers are standing in the way of leaders engaging in and accepting the idea of SG. Conversely we also need to understand what facilitators would encourage the process in our healthcare system. Additionally more research is required within the Canadian context to better understand how the Canadian Healthcare system can benefit from SG, as the vast majority of research has been focused on the U.S. Where there is more research surrounding SG in the U.S., that healthcare system also has implemented SG at more healthcare facilities than Canada and we must understand why this is the case. More specifically research must be carried out within the context of SPH to better understand how staff would be best educated and supported. Additionally research could be done at SPH focusing on developing the idea of Nursing Grand Rounds and learning what would need to be in place to make this possible. It is imperative that we learn whether this method would be useful and successful in educating staff about NPC.
Conclusion

Reflecting back on the original research, the study findings and my interpretation of these findings, I believe that there are three main points to make from the following two research questions that underpin the entire study. (1) What are the perceptions, knowledge, and commitment of nursing staff regarding SG at SPH? And (2) What have nursing staff heard about NPC at SPH? I found, based on the findings discussed in chapter four, and by use of triangulation, three main points were made: (1) Staff at SPH support NPC and have a positive perception of NPC; (2) Staff do not have enough knowledge about the NPC; and (3) Staff are not sure if administration is committed to the work of NPC. The survey responses support both the current state of Nursing Practice Council as well as an evolved more prevalent form where nurses have more input into the decision-making process. This study indicates that the NPC has the potential to make a difference through increasing frontline staff nurse involvement by education and awareness. By educating staff on what the role of the council members is and what the council works at will lead to increased attendance. Additionally leaders must also be educated to increase administrative support and indirectly improve frontline attendance. Research shows that there is an asymmetry of information regarding NPC and that an awareness campaign could have positive effects on the growth of the council. Overall this research provides a jumping off point for further research on shared governance structures.
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magnetism at multiple levels: a healthy workplace intervention, part II – An


APPENDICES

Appendix A: Shared Governance Model

FIGURE 1.

Shared Governance-Councilor Model

Westrope (1995)
Appendix B: Consent Form

Nurses Survey Responses about Knowledge of Nurse Practice Council at St. Paul’s Hospital.

Principal Investigator: Maura MacPhee, RN, PhD  
UBC School of Nursing

Co-Investigator: Kelly Lee, RN  
UBC School of Nursing

Shared Governance is a nursing management innovation that allows nurses more control over decision-making, while extending influence to administrative areas previously controlled by management. Currently St. Paul’s Hospital is implementing shared governance by establishing a nurse practice council for nurses to share their practice-related thoughts and concerns. No research has been done at St. Paul’s to learn more about nurses’ perceptions of practice councils.

You are being asked to participate in this survey because you are a nurse at St. Paul’s Hospital. The purpose of this study is to learn more about Shared Governance, specifically practice councils at St. Paul’s Hospital. We would like to invite you to participate in a survey to find out what you think about practice councils at St. Paul’s. This information will help us make improvements to our nursing practice council.

This survey is part of Kelly Lee’s thesis work at the University of British Columbia School of Nursing. She is currently the Chair of the Nursing Practice Council at St. Paul’s, and is invested in improving the practice council model to best meet the needs of St. Paul’s nurses.

The survey should take you less than 15 minutes to complete. The survey will ask you questions about your knowledge and thoughts about the St. Paul’s nurse practice council. The survey will not ask you to include your name, although there will be a few demographic questions such as how long you have been a nurse at St. Paul’s. Completion and return of the survey will signify your willingness to participate in the study. There are no known risks associated with participating in the survey. There is no direct benefit for participating in this study. You may have the possibility of receiving a $20 Chapters gift certificate. Kelly Lee will deliver the gift certificates to the ten recipients within 2 weeks of the random draw. Potential benefits include enhancement of the current nurse practice council.
This online survey company is hosted by a web survey company located in the United States of America (USA) and as such is subject to U.S.A. laws, in particular, the U.S.A. Patriot Act, which allows authorities access to the records of internet service providers. This survey or questionnaire does not ask for personal identifiers or any information that may be used to identify you. The web survey company servers record incoming IP addresses of the computer that you use to access the survey but no connection is made between your data and your computer’s IP address. If you choose to participate in the survey, you understand that your response to the survey questions will be stored and accessed in the USA. The security and privacy policy for the web survey company can be found at the following link: http://www.surveymonkey.com/Monkey_Privacy.aspx.

Kelly Lee will code the survey answers using an Excel database on a password-protected computer. There will be no personal identifiers entered into this database. Kelly will be sharing analyses of the data with her thesis advisor and thesis committee. After 5 years, per standard research protocol, the electronic computer database of recording will be erased, and any hard copies of notes will be shredded for disposal.

Findings and a summary of this study will be written up and will be available to all nurses and nurse leaders at St. Paul’s Hospital, though no personal or individual identifiers will be used.

Please feel free to contact Dr. Maura MacPhee, Principal Investigator, if you have any questions about the research study.

If you have any concerns about your treatment as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604 822-8598 or the Chair of the UBC-PHC Research Ethics Board at 604-682-2344 ext. 63496.
Calling All Nurses...

We want to hear what you think about the Nursing Practice Council at St. Paul’s Hospital. Please complete a quick Online Survey---

You’ll be getting an e-mail with a survey link...soon!

An honorarium may be provided for participating

Any questions???
Contact Kelly Lee
Appendix D: Survey

Nurses Survey Responses about Knowledge of Nurse Practice Council at St. Paul’s Hospital.

A Masters student, Kelly Lee, from the University of British Columbia School of Nursing is conducting a survey study on practice councils. Kelly Lee is also Chair of St. Paul’s Hospital Nurse Practice Council. The purpose of this survey is to find out what nurses at St. Paul’s Hospital know about practice councils. The following survey questions are taken from a Shared Governance survey created by Frith and Montgomery (2006). There are a few demographic questions for you to complete at the beginning of the survey, and there is one question to complete with additional comment space at the end of the survey. Please DO NOT write your name on the survey. Thank you so much for your time and consideration.

DEMOGRAPHICS

1. What is your job title? Please tick one

| Registered Nurse (RN) | Registered Psychiatric Nurse (RPN) | Licensed Practical Nurse (LPN) |

2. How long have you been a nurse? ________

3. How long have you worked as a nurse at St. Paul’s Hospital? ________

4. What unit do you primarily work on? ________

PRACTICE COUNCIL SURVEY
(Adapted from Frith and Montgomery (2006)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t know</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

NPC = The Nursing Practice Council at St. Paul’s Hospital (SPH)

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<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>1</td>
<td>NPC allows staff participation in decisions that affect clinical practice.</td>
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<td>2</td>
<td>NPC changes the way we relate to each other at work.</td>
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<td>3</td>
<td>Since NPC, staff is making more decisions that affect their own practice.</td>
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<td>4</td>
<td>Management and staff are partners in patient care.</td>
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<tr>
<td>5</td>
<td>Empowerment means everyone is able to use authority already present in their role.</td>
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<tr>
<td>Question</td>
<td>1</td>
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<td>6  We have enough time for NPC.</td>
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<td>7  NPC is a good use of our time and energy.</td>
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<tr>
<td>8  Administration is firmly committed to NPC.</td>
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<td>9  My manager helps make NPC work.</td>
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<tr>
<td>10 We accomplish more now than before we had NPC.</td>
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<tr>
<td>11 My manager has the necessary skills to make NPC successful.</td>
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<tr>
<td>12 Nurse/staff retention has improved because of NPC.</td>
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<tr>
<td>13 Physician relationships have improved because of NPC.</td>
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<tr>
<td>14 My department is kept better informed about what’s going on because of the NPC.</td>
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<tr>
<td>15 NPC is NOT an extra burden.</td>
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<tr>
<td>16 Problems and solutions are discussed openly in NPC.</td>
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<tr>
<td>17 Good ideas from everyone are heard and responded to in NPC</td>
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<tr>
<td>18 Most of the staff really wants NPC to work.</td>
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<td>19 SPH administration sincerely wants NPC to work.</td>
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<tr>
<td>20 Staff is supported in projects they initiate through NPC.</td>
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<tr>
<td>21 My manager encourages staff to participate in NPC decision-making.</td>
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<td>22 I believe in NPC.</td>
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<td>23 I believe staff can competently govern their own activities through NPC.</td>
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<td>24 I have the skills and information I need to support NPC.</td>
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<td>25 NPC challenges me to grow as a professional.</td>
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<td>26 I want to participate in a leadership role in NPC.</td>
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<td>27 NPC is NOT just a fad.</td>
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<tr>
<td>28 The staff participates in NPC activities.</td>
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Please answer the following question:
1. What are the most common comments that you hear from colleagues about Nursing Practice Council at St. Paul’s Hospital?

Please share with me any additional views or information that you believe are relevant to improving the Nurse Practice Council at St. Paul’s Hospital.

Thank You,
Kelly Lee
Appendix E: Breakdown of Categories & Sub-Categories

Nurses Survey Responses about Knowledge of Nurse Practice Council at St. Paul’s Hospital.

Open-Ended Questions:

Question 1/2: What are the most common comments that you hear from colleagues about Nursing Practice Council at St. Paul’s Hospital?

Perception Category:

A. Positive Perceptions Sub-Category

- it is rewarding and relates to the issues that we encounter [sic] on the unit on a daily basis
- Good for you for going. Do you think it helps?
- Those involved speak with commitment [sic] and enthusiasm
- NPC support nurses in dealing with their common problems, it support nurses to be real professionals in their work. No other committee could do this.
- they are the tester and idea providers
- Empowering

Knowledge Category:

A. Knowledge Evidence Sub-Category

- It’s a venue where nurses’ can discuss improvements on practice on the unit.
- Glad to have a voice in shaping nursing practice
- A good forum for people to know what is going on in the hospital.
- Very informative. Helps nurses understand that we are all struggling with similar issues,
- It is a forum that lets nurses from all areas help decide on issues before they reach the units.
- Good place to communicate Nursing concerns are heard and discussed.

B. Lack of Knowledge Sub-Category

- I don’t hear it discussed.
- I have never heard of it before
- haven’t heard much
- I have never heard anyone talk about this council at work. A UBC nursing student mentioned it to me once.
- I rarely [sic] if ever hear of NPC being discussed
- I do not hear much. I don't think people really know about it.
To be honest, it is not something that is talked about. Working in out patients, we are a little bit isolated from the rest of the hospital.

I hear very little about NPC and its influence on patient care. Mostly I hear about personal agendas
do not discuss, largely unaware of what is going on in the NPC meetings
Don’t really hear anything about this council.
Haven't heard very much
that they have never heard of it
I have never heard anyone comment on NPC
Not a lot of discussion about NPC in my unit, that I am aware of
Never heard any
That they don’t know very much about it.
What is it?
Not all staff aware of the role. Those that are can see the positives if action is taken.
Most staff is unaware of NPC and when they take place.
not sure what it really is about
From staff that attend NPC- great way to voice unit concerns. From colleagues that don't attend chances are they have not heard of it and don't say much
What is the Nursing Practice Council? Who makes up the NPC
"What's Nursing Practice Council?"
Don't really know what it is and does
What is it?
What is that?
that they do not know its purpose or what it is
What is it? What purpose does it really do? Just another meeting for leaders to go to!!
Most of them are unaware of its existence
I don't think most nurses know about nursing practice councils. I believe most decisions about nursing care are actually mandated by management and on the physican [sic] level
What is it? What do you do there? When is it?
need more information
What does the NCP do? That’s great that you are able to hear about what’s going on around the hospital.
Staff do not know enough about NPC and its role within the organization
I don't know anything about NPC? What is the mission statement of this council? How are they kept accountable to nurses and their needs?
not enough communication as to what goes on at NPC with non NPC members
Unfortunately I don't have enough information regarding NPC and their work.
They don't know what it is or who is on the council.
**Commitment Category:**

A. *Commitment to SG Sub-Category*

- I want to go
- They would like to participate, but cannot attend as no replacement is available. I think that staff need to be better educated as to what NPC could and should be and that NPC's success depends on their participation and commitment
- wish I could be covered on the unit to go to NPC

B. *Lack of Commitment Sub-Category*

- Does require a time commitment - not always available for a four-hour meeting.
- "The units are usually too busy, or not enough staff; to attend meetings"
- The time to fully participate is a challenge...it is more than just attending a meeting, there is additional work that is done outside of the meeting to ensure the work is truly meaningful and effective
- Too much time for too little to show for - Insular group
- too hard to attend consistently [sic] when working shift work
- Working in the community, we are somewhat detached [sic] from SPH. In the Renal program I feel we should become MORE involved in the NPC. I would like to see more leaders from the program attend CNL meetings, and NPC meetings. This might help in the communication within the renal program, and make us all aware of what the other units in the renal program are doing.
- The most common comment I have heard recently from my colleagues re the NPC is that while 'good ideas' may arise from the council, the current fiscal situation in the hospital determines the value of any initiatives (not the benefit to the patient)
- That they are not supported by their management to go and therefore [sic] do not attend. (If you are working there is no way to go to NPC) Many staff do not understand the role of the NPC
- A select few of the nursing staff make the time to participate. I believe that most clinical decisions are driven by individual staff at bedside. I am unsure how much of the decisions made at NPC actually are implemented at bedside.
- Staff sometimes feel that when they bring things up at NPC they get a reaction from others wondering whey they are bringing it up at NPC.
- There are a lot of forums and I am not sure how they are all connected. i.e. clinical [sic] resource mtg educator mtg etc.
Question 2/2: Please share with me any additional views or information that you believe are relevant to improving the Nurse Practice Council at St. Paul’s Hospital.

**Perceptions Category:**

A. *Positive Perceptions Sub-Category*

- Keep it going
- Would be appreciated if NPC members were asked for their input prior to decisions being made. Sometimes it feels like NPC is just another check that management has to go through to move ahead on things. E.g. geriatrics program changes, and cutting ICU outreach
- I think the NPC meetings are run very well. Meetings agendas are appropriately followed. We have speakers that are from various areas talking about implementation of new things. Nothing comes to mind at this time
- As a person who actually sits on the council I think we should be given identifier vests or something to show that we are on the council and people can approach us for questions/concerns...promotes professionalism/knowledge/awareness
- I fell it is working well
- I like that they financially support nursing education, as there is not always funding available from other sources.
- bigger profile
- don’t know
- Am not rally familiar with it, so would be unable to comment.
- Staff unable to attend

**Knowledge Category:**

A. *Increasing Staff Knowledge Sub-Category*

- Recruit more champions to chat it up more.
- better communication, follow ups with non NPC members
- I believe it would help if NPC participates would do an awareness campaign to disseminate info on the purpose and mandates of the council. I think that the needs of the NCP would be better met if pariticipation [sic] were promoted.
- NPC needs to do a better job of communicating their work. Emails of minutes only go to selected staff. You need to advertise your work in a more widely circulated venue such as the communication flyer or the D’Vine
- have the RN network join the group
- Encourage more participants from different units.
• All nursing areas should have representation. Those that are on nursing council need to bring the information back and share this at staff meetings.
• I believe more units that are not well represented need to experience the NPC.
• Needs to be more visible and inclusive ensuring participation of nurses from ALL units.
• Unit Practice Councils would allow for the involvement of more point of care nurses
• Wish there was more of an attempt to include the Mental Health Program nurses. There remains a strong division between RNs and RPNs therefore there is not a lot of broader learning or discussions about the emotional impact that occurs.
• Better integration with practice leaders (CNS, NP, practice leaders)
• using more people from the ward
• I think it would be beneficial to have a program council on each unit that fed up to the NPC
• I think it would be helpful if more staff know what NPC is all about. I rarely hear very much info about it.
• I don’t think enough people know about it and each dept should have 2 represents
• More communication so more people know what it is
• I don’t know anything about you guys. If you can approach each nurse in a more personal/casual way, I think it would make a difference.
• More awareness, and maybe a easily accessed meeting room closer to the clinical area
• Know next to nothing about NPC, the word needs to get out more
• I would like to be better informed about the council in general
• Could we get minutes of the meetings? Can anyone attend? Could they be more vocal? Can they help us?
• More info on what it is and its intentions and possibilities for involvement [sic]
• More awareness
• ensuring that nurses know what work the NPC does and how that impact their work environement [sic]
• Should be more advertised.

Commitment Category:

A. Administrative Support Sub-Category

• need more buy in from the OL for staff to attend
• I think the NPC needs to be more visible and become a presence and the nurse leaders on the floor need to encourage their staff to participate and make it possible for them to do so, not just by coming in on their day off, if they happen to have one that day.
• I think that for nursing practice council to actively affect change then management needs to listen to nursing staff more. If nursing staff is burning out due to workload issues then cutting staff on day shifts and beds for older adults is not a solution.
• more support by management i.e. operations leaders, CNL’s
• NPC has to be supported by all levels of administration and all hospital
communication/plans/processes need to be transparent which they currently are not
• I believe management needs to be more supportive of NPC and I think it needs to be '
  advertised' to staff so we know when and where it is.
• Management should really encourage participation from their staff members. the staff
  should be able to inform the rest of the nurses during staff meetings of what was
  discussed.
• Ops leaders and CNL's need to make much more effort to ensure that staff from all
  areas is given the regular opportunity to attend NPC. Staff also needs to hear
  regularly what NPC is doing and what is happening to concerns brought forth.

B. Staff Commitment Sub-Category

• I think that staff empowerment and nursing involvement in quality improvement and
  clinical decision making should be done at the unit, program and organizational level
  not in isolation.
• I believe that the NPC is a great idea, but there is a general sense of despair and
  feeling that all decisions are based on the bottom line, not what is the best plan for
  patient care. There is also a sense that huge decisions are being made that directly
  impact patient care (negatively), and that these decisions may be irreversible.
• It is difficult to attend the meetings-- I know many people are involved, but it would be
  nice to have different times once in a while to allow some of us to go.
• NPC should be more present and reach out to all the staff at SPH for better
  understanding of their goals.
• more involvement, show outcomes of our meetings and what has been changed
  because of our NPC
Appendix F: Bar Graphs of Results

Nurses Survey Responses about Knowledge of Nurse Practice Council at St. Paul’s Hospital.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPC allows staff participation in decisions that affect clinical practice.</td>
<td>10</td>
<td>48</td>
<td>9</td>
<td>3</td>
<td>24</td>
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<tr>
<td>NPC changes the way we relate to each other at work.</td>
<td>5</td>
<td>41</td>
<td>14</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>Since NPC, staff are making more decisions that affect their own practice.</td>
<td>5</td>
<td>31</td>
<td>20</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Management and staff are partners in patient care.</td>
<td>14</td>
<td>44</td>
<td>20</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Empowerment means everyone is able to use authority already present in their role.</td>
<td>13</td>
<td>58</td>
<td>11</td>
<td>1</td>
<td>11</td>
</tr>
</tbody>
</table>

Please rate your responses. NPC refers to the Nursing Practice Council at St. Paul’s Hospital.
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<table>
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<tr>
<th>Answer Options</th>
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<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My manager has the necessary skills to make NPC successful.</td>
<td>3</td>
<td>35</td>
<td>17</td>
<td>6</td>
<td>30</td>
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<tr>
<td>Nurse/staff retention has improved because of NPC.</td>
<td>0</td>
<td>9</td>
<td>30</td>
<td>8</td>
<td>44</td>
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<tr>
<td>Physician relationships have improved because of NPC.</td>
<td>1</td>
<td>10</td>
<td>32</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>My department is kept better informed about what’s going on because of the NPC.</td>
<td>6</td>
<td>30</td>
<td>25</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>NPC is NOT an extra burden.</td>
<td>15</td>
<td>41</td>
<td>7</td>
<td>1</td>
<td>27</td>
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</tbody>
</table>

![Chart showing responses to survey questions about NPC effectiveness and impact.](chart.png)

**Legend:**
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't know
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</tr>
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<tr>
<td>We have enough time for NPC.</td>
<td>6</td>
<td>22</td>
<td>33</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>NPC is a good use of our time and energy.</td>
<td>14</td>
<td>50</td>
<td>4</td>
<td>1</td>
<td>25</td>
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<tr>
<td>Administration is firmly committed to NPC.</td>
<td>7</td>
<td>37</td>
<td>16</td>
<td>5</td>
<td>29</td>
</tr>
<tr>
<td>My manager helps make NPC work.</td>
<td>4</td>
<td>23</td>
<td>25</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>We accomplish more now than before we had NPC.</td>
<td>4</td>
<td>29</td>
<td>11</td>
<td>4</td>
<td>46</td>
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<tbody>
<tr>
<td>Problems and solutions are discussed openly in NPC.</td>
<td>15</td>
<td>35</td>
<td>6</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Good ideas from everyone are heard and responded to in NPC.</td>
<td>14</td>
<td>33</td>
<td>7</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Most of the staff really wants NPC to work.</td>
<td>11</td>
<td>39</td>
<td>7</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>SPH administration sincerely wants NPC to work.</td>
<td>8</td>
<td>35</td>
<td>3</td>
<td>2</td>
<td>43</td>
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<tr>
<td>Staff are supported in projects they initiate through NPC.</td>
<td>6</td>
<td>33</td>
<td>9</td>
<td>2</td>
<td>41</td>
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<tr>
<td>Answer Options</td>
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<td>Disagree</td>
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<tr>
<td>My manager encourages staff to participate in NPC decision-making.</td>
<td>5</td>
<td>32</td>
<td>25</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>I believe in NPC.</td>
<td>24</td>
<td>45</td>
<td>3</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>I believe staff can competently govern their own activities</td>
<td>9</td>
<td>45</td>
<td>15</td>
<td>4</td>
<td>18</td>
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<td>I have the skills and information I need to support NPC.</td>
<td>9</td>
<td>40</td>
<td>20</td>
<td>9</td>
<td>13</td>
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<td>NPC challenges me to grow as a professional.</td>
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<td>I want to participate in a leadership role in NPC.</td>
<td>5</td>
<td>33</td>
<td>22</td>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>NPC is NOT just a fad.</td>
<td>17</td>
<td>50</td>
<td>4</td>
<td>0</td>
<td>20</td>
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<td>The staff participates in NPC activities.</td>
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<td>47</td>
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<td>34</td>
<td>28</td>
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<td>Management really wants an empowered staff.</td>
<td>9</td>
<td>34</td>
<td>20</td>
<td>10</td>
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<td>Most patient care decisions are made at the bedside.</td>
<td>8</td>
<td>43</td>
<td>26</td>
<td>6</td>
<td>6</td>
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<td>Staff will support NPC at SPH.</td>
<td>7</td>
<td>54</td>
<td>4</td>
<td>1</td>
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