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Improving Nurse Engagement through Unit Practice Councils

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Abstract

Problem: According to the Advisory Board (2014), nurses are the least engaged group of healthcare employees. Healthcare organizations with a high percentage of disengaged nurses have increased nurse turnover rates and decreased patient satisfaction and safety scores (Kutney-Lee et al., 2016). Shared governance, in the form of unit practice councils (UPCs), is an underutilized model healthcare organizations can implement to increase nurse engagement.

Context: The UPC is an example of shared governance to engage and empower nurses to affect changes that impact their practice. This a multi-site health system with 21 medical centers in Northern California. This system would like to obtain the American Nurses Credentialing Center (ANCC) Magnet® recognition designation, which is based on nursing shared governance. Implementation of a shared governance model, such as a UPC, fulfills the requirement of exemplary professional practice under the Magnet® designation. Unit practice council is a structure that improves nurse engagement.

Intervention: The purpose of this project was to increase nurse engagement through the standardized implementation and evaluation of UPCs at two hospitals and seven nursing units within the macro-system of 21 Northern California hospitals. The intervention was a standardized toolkit that assists the staff nurse and nurse manager in co-leading the implementation of a UPC.

Measures: The primary outcome of interest was the improvement of nurse engagement on the Practice Environment Scale (PES) of the Nursing Work Index (NWI) pre- and post-implementation of the UPC. Data were analyzed for improvements in nurse participation in hospital affairs. The nurse and nurse manager, as co-leads of the UPC, were surveyed using the PES pre- and post-intervention of the UPC.

Results: Using a 4-point Likert scale, the manager and nurse participants reported greater than 10% improvement in engagement in the three areas of the PES of the NWI after implementing a UPC. Staff nurses' opportunities to participate in policy decisions increased 57%, opportunities to serve on hospital and nursing committees increased 29%, and nursing administrator consultations with staff on daily problems increased 29%. The nurse managers surveyed, reported an increase in opportunities for staff nurses to participate in policy decisions by 40%, staff nurses having the opportunity to serve on hospital and committees by 120%, and nursing administrators consulting with staff on daily problems by 20%.

Conclusions: Implementation of UPCs is a deliberate strategy taken by hospitals to improve nurse engagement, nursing practice, and patient outcomes.

Keywords: unit practice council, unit-based council, shared governance, engagement

Introduction

Problem Description

The Advisory Board (2014) estimates 33% of nurses surveyed across North America (*n* = 180,384) constituted the least engaged of all healthcare employees in their workplace. A highly engaged nursing workforce has a positive impact on nursing practice, as evidenced by improved outcomes, including lower staff turnover, increased job satisfaction, and lower burnout rates (Brooks Carthon et al., 2019). Engaged employees are individuals inspired to do their best work, are motivated to help the organization succeed, and are willing to exceed patient care service expectations (Advisory Board, 2014). Nurses are trained to practice at the highest level of their licensure, and because they are close to the patient, they can be the first to identify opportunities to impact patient care outcomes and drive change and improvement from the frontline. Engaged nurses feel empowered to speak up and advocate for improvements in patient care (The Advisory Board, 2014). In the complex, fast-paced, high-quality healthcare system, engaging frontline nurses is imperative, and healthcare organizations are exploring shared governance models to facilitate this (Advisory Board, 2014). The exemplary professional practice domain of the ANCC Magnet® Recognition Program emphasizes the importance of supporting and promoting nurse autonomy through shared governance decision-making.

The Magnet® Recognition Program designates organizations worldwide where nursing leaders successfully align their strategic nursing goals to improve patient outcomes. The Magnet® Recognition Program provides a roadmap to nursing excellence, which benefits an organization (ANCC, 2019). The benefits of Magnet® designation are improved patient outcomes, highly engaged staff, and a financially sustainable business. This health system is on a multi-year journey to ensure a culture of excellence, which will result in Magnet® designation

for all their medical centers. Most nursing units at the hospitals in northern California have not implemented unit practice councils (UPCs). The UPC was implemented in the Maternal Child Health nursing units in two hospitals and seven nursing units. The engagement and empowerment of nurses to have input in their professional practice is critical to the hospital leaders to improve nursing and patient outcomes as part of the Magnet® designation journey. The UPC provides the structure for nurses to have authority and accountability and to work collaboratively with the nurse manager to implement changes that impact their nursing practice. Although there are many existing committees on each nursing unit at the hospitals, there is not a venue for nurses to co-lead a committee, such as a UPC, where the nurses have professional equity, autonomy, and accountability (Ballard, 2010) for their nursing practice and can make evidence-based changes. Implementation of a shared governance model, such as a UPC, is required for Magnet® recognition. The leaders in the hospital system are interested in meeting the requirements of the American Nurses Credentialing Center (ANCC) Magnet® Recognition Program. The benefits of implementing a professional practice model, such as shared governance, include promoting nurse autonomy and influencing organizational decision-making, which results in positive outcomes for the staff, the patients, and the organization.

Available Knowledge

PICOT

A literature search was completed to evaluate the evidence for improving nurse engagement by implementing UPCs. Melnyk, Gallagher-Ford, and Fineout-Overholt's (2017) template formats were used to design the participant, intervention, comparison, outcomes, and time (PICOT) question to guide the literature search. The PICOT question for this project: Within the Maternal Child Health units (labor and delivery, mother-baby unit, neonatal intensive

care unit, and pediatrics), would utilizing a shared governance toolkit for implementing a unit practice council, compared to not having a toolkit, increase nurse engagement by the third quarter 2020?

Literature Search

The terms used for the literature search were *shared governance, unit practice councils, unit-based council, nurse engagement, professional practice model,* and *ANCC Magnet® Recognition Program*. Databases utilized for this search were Cumulative Index to Nursing and Allied Health Licensure (CINAHL), PubMed, Joana Briggs, and OVID. These databases were selected for their evidence-based articles and emphasis on nursing-related topics. Inclusion criteria consisted of journals written in the English language, evidence-based, and published within the last five years. Exclusion criteria rejected articles with no relevance to nursing outcomes or nurse engagement, were not in the English language, or were older than five years. An exception was made to include two articles that provided primary source information older than five years, where the primary source information was valuable and could not be found in more recent articles. The total yield from these search criteria resulted in 133 articles. The search for *shared governance* and *implementation* was conducted to narrow the search, which resulted in 29 articles. These articles were then reviewed for those most relevant to nursing outcomes and nurse engagement resulted in 12 articles.

The Johns Hopkins Research and Evidence Appraisal Tool (Dang & Dearholt, 2018) was used to analyze the level and quality of evidence of each journal article. The strength of evidence of the articles chosen were Level III-A/B. The Fineout-Overholt evaluation table (Melnyk et al., 2017) was then utilized to document the literature articles in a concise and easy to read format. The resulting table outlines the article's purpose, conceptual framework (as applicable), research

design, sample and setting, significant variables studied, data analysis, study findings, and the level and quality of the journal articles (see Appendix A). The literature review was narrowed to the top five articles chosen for the most relevance and best evidence related to UPCs. The articles were selected for the nursing practice and impact on patient care outcomes as they relate to quality, patient safety, and improved nurse engagement. The following review of the evidence demonstrates the impact shared governance has on nurse engagement.

Literature Review

An integrated literature review demonstrates the benefits of shared governance. Kutney-Lee et al. (2016) conducted a qualitative study to examine nurse engagement in hospitals with a shared governance model. The authors utilized the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data, which measures patients' perceptions of their hospital experience. Out of the hospitals surveyed (N = 425) the hospitals with an ANCC Magnet® designation and a shared governance model (n = 46), 22% of nurses described themselves as *moderately engaged*, 78% described themselves as *highly engaged*, and 0% responded as *somewhat engaged* or *least engaged* (Kutney-Lee et al., 2016). The results are impressive; 100% of nurses employed at ANCC Magnet® Recognition Program facilities report feeling engaged. Hospitals with a shared governance model had higher HCAHPS scores, with 68% of patients were more likely to recommend hospitals with the most engaged nurses than patients at hospitals without shared governance (Kutney-Lee et al., 2016). The least engaged nurses (43%) reported a higher percentage of job dissatisfaction compared to the highly engaged nurses (13%). Regarding nurses' quality of work, the least engaged nurses reported a higher percentage of fair or poor quality of care (33%), compared to highly engaged nurses (8%), who reported a lower percentage of fair or poor quality of care (Kutney-Lee et al., 2016). The study

results show ~~h~~ospitals that provide a shared governance model, such as a unit-based council, have more highly engaged nurses, who are most likely to improve quality of care and are satisfied with their jobs.

A qualitative study by Cox Sullivan et al. (2017) studied the nurse manager's perspective in implementing shared governance. The qualitative study took place at the Central Arkansas Veterans Health Administrative (VA) facility in Little Rock, Arkansas. Ten managers were interviewed to explore nurses' motivation to participate in shared governance and to elicit recommendations for success regarding the implementation and outcomes of nursing shared governance. Under the category of motivation, the study measured whether the staff was motivated to improve their work quality and whether the managers were motivated to remove roadblocks to enhance project success for staff nurses. Nursing participation in UPCs was associated with improvements in catheter-associated urinary tract infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and hospital-acquired pressure ulcers. The study recommended that managers coach and observe nurses to promote nurse autonomy in problem-solving instead of providing them with fixed solutions. The role of the manager should be to support the nurses in their practice by facilitating autonomous decision-making in shared governance meetings (Cox Sullivan et al., 2017).

One study reviewed the difference between nurses' and nurse managers' perceptions of shared governance activities and nurse engagement. The qualitative research design by Wilson, Gabel Speroni, Jones, and Daniel (2014), studied the participant nurses (n = 129) and managers (n = 15). Wilson et al. indicated that to support nurses' involvement in shared governance and to improve nurse engagement; nurse managers need to focus on four key elements:

1. Support the nurses' participation in shared governance activities

2. Ensure nurses work as a team
3. Ensure there is no disruption to patient care during the time nurses participate in shared governance activities
4. Ensure nurses are paid for their time, including UPC meetings

In 2019, Brooks Carthon et al. examined the relationship between the level of engagement, staffing, and assessment of patient safety among nurses working in a hospital setting. Their research was a secondary analysis of linked cross-sectional data, reviewing data from 26,960 survey responses involving 599 hospitals in four states. The independent variables examined were staffing and engagement. The dependent variables were a patient safety grade of favorable (A/excellent or B/good) or unfavorable (C/acceptable, D/poor, or F/failing), which was based on seven indicators of the patient safety climate survey. The seven safety climate items focus on nursing-specific safety related to patient care. The seven survey items are:

1. Methods to prevent errors from occurring are not discussed.
2. Actions of administrators do not show that patient safety is a top priority.
3. Staff is not given feedback about changes implemented based on incident reports.
4. Meaningful information about patients is lost during shift change.
5. Things fall through the cracks during patient transfer.
6. Staff does not feel free to question the decisions of those in authority.
7. Staff feel mistakes are held against them (Brooks Carthon et al., 2019).

A limitation of the study was that Brooks Carthon et al. (2019) did not address the phrasing of the negative format of the survey items and the impact on the results. Thirty-two percent of nurses gave their hospital a poor or failing patient safety grade. In 25% of hospitals, nurses fell in the least engaged on only somewhat engaged categories. Each additional patient

per nurse was associated with an increase in the odds of a hospital receiving an unfavorable patient safety grade by a factor of 1.06, an increase of 6%. For each unit increase in nurse engagement, the odds of a hospital receiving an unfavorable patient safety grade decreased by a factor of 0.71 or 29%. The results of the nurse engagement survey demonstrated that nurses are somewhat to most engaged when provided with opportunities to participate in committees. The survey findings also suggested that the least engaged nurses are not offered opportunities to participate. As nurse engagement increased, the odds of a hospital receiving an unfavorable patient safety grade decreased by 29%. Engaged nurses were 35% less likely to report a failure of administrators prioritizing patient safety. More engaged nurses were 26% more likely to provide feedback about changes based on incident reports, 24% were more likely to discuss error prevention strategies, and 21% felt free to question authority. Highly engaged nurses were less likely to report that mistakes were held against them (19%), relevant information was lost during shift change (13%), or things fell through the cracks (12%) (Brooks Carthon et al., 2019). The study findings support nurse participation in UPCs as an effective way to improve nurse engagement and to improve quality of care and patient safety.

The characteristics of shared governance and the relationship with nursing practice environments in organizations with the ANCC Magnet® designation is studied by Clavelle et al. (2013). They conducted a qualitative study of 95 chief nursing officers (CNO) and leaders of facilities with the ANCC Magnet® designation using the Index of Professional Nursing Governance (IPNG) and the Nursing Work Index-Revised (NWI-R). The IPNG is an 86-item instrument that measures the perceptions of governance in six scales: control over personnel, access to information, resources in support of the practice, participation, control over practice, and goals and conflict resolution (Clavelle et al., 2013). Five of the six scales are within the

shared governance range (access to information, resources supporting practice, participation, goals and conflict resolution, and control over practice). The leaders perceived the top characteristic of shared governance to be nurse autonomy, which is described as nurses having decision-making authority for patient care. The evidence demonstrates a positive relationship between shared governance and a nursing practice environment that is consistent with the ANCC Magnet® Recognition Program (Clavelle et al., 2013). This evidence reaffirms that nurses engaged in shared governance are active participants in improving their professional practice.

Practice Environment Scale-Nurse Work Index (PES-NWI)

In the early 1980s, a nurse survey, the Nursing Work Index (NWI), was developed from research on hospitals that were successful in retaining staff nurses (Lake, 2002). Lake (2002) conducted research to develop the practice environment scale (PES) from the NWI. The objectives of the study were first, to develop a parsimonious and psychometrical scale and second, to provide a reference for Magnet® hospitals from which the NWI was developed (Lake, 2002). The PES-NWI consists of nine items which exhibited high reliability at the individual and hospital level. The individual-level internal consistency was high (α=.83). The reliability of the hospital-level measure was robust, with an average interitem correlation of .64 (Lake, 2002).

The study supports the PES-NWI was higher for nurses in Magnet® hospitals compared to nonmagnet hospitals ($p<.001$). A higher score indicates agreement, a value above 2.5 indicates agreement and a value below 2.5 indicates disagreement (Lake, 2002). Nurses working in Magnet® hospitals (n = 1,610) reported a value of 2.76 compared to nurses working in a nonmagnet hospital reported a value of 2.44 (Lake, 2002).

Summary

Nurse engagement has been defined as the inclusion of nurses in organizational decision-making, inter-professional collaboration, and opportunities for professional development (Brooks Carthon et al., 2019). Nurses' participation in advisory boards, unit councils, and hospital committees promote engagement. Organizations that foster employee engagement outperform their counterparts in job satisfaction, retention, profitability, and performance (Kutney-Lee et al., 2016). The benefits of nurse engagement are documented in the literature as decreased nurse turnover, decreased nurse burnout, and increased job satisfaction. Staff nurses are the ideal professionals to make decisions about nursing practice since they are the closest to the patient and the delivery of care. An optimal method to improve nurse engagement, as documented in the literature, is through the implementation of UPCs. The literature review demonstrated the benefits of shared governance to improve nurse engagement, which ultimately results in improved patient outcomes.

Rationale

Avedis Donabedian, a physician and educator, created the Donabedian model in 1966, a conceptual model that provides a framework for evaluating the quality of healthcare. Healthcare organizations have used the classic Donabedian model to assess various aspects of the organization, such as appropriate staffing, pay, and professional involvement in decision-making to achieve better patient care outcomes (Upenieks & Abelew, 2006). The model has three components: structure, process, and outcome (see Appendix B). The Donabedian framework was used to develop the toolkit and UPC. The structure, process, and outcomes from the Donabedian model was utilized in the development of the toolkit.

Structure

The Donabedian structural assessment looks at the attributes of the settings in which patient care occurs. Examples of structural measures include materials, resources, human resources, organizational structures, and methods (Donabedian, 1988). Shared governance is an excellent example of a structural measure. Using the structural measure of the Donabedian model, the project evaluates the number of staff members participating in shared governance, the qualifications of staff involved, and the frequency of the meetings (Upenieks & Abelew, 2006).

Process

The second component of the Donabedian (1988) model is a process, which is defined as the actual work in giving and receiving patient care, including the patient's activities in seeking care. The process measure analyzes the care that patients receive in a hospital. By applying Donabedian's framework to implementing a shared governance model, the project evaluates the professional nurse model used for delivering care, interpersonal management of patient care, and continuity of care to measure the process (Upenieks & Abelew, 2006).

Outcome

The final component of the Donabedian (1988) model is the outcome, which addresses the effects of care on the health status of patients and populations. This measure also includes improvement in the patient's knowledge and satisfaction with the care provided in the hospital. According to the Donabedian model, an essential aspect of implementing the shared governance model is the measurement of data. Examples of outcome measures used in implementing this project are nurse engagement using the Practice Environment Scale (PES) of the Nursing Work Index (NWI) and pre- and post-intervention survey data of the nurses on the UPC.

The three components of the Donabedian (1988) model are dependent and interconnected. An organization with a good structure is likely to have a good process, and if it

has a good process, it is expected to have good outcomes. Using the Donabedian model, if shared governance is in place, the organization will have the structure to build processes and drive results. Shared governance empowers nurses to increase their accountability, equity, and ownership of organizational and operational decisions (Upenieks & Abelew, 2006). The Donabedian model provides a framework to improve nurse engagement through shared governance, specifically through UPCs.

Specific Aims

The aim of this project was to create and implement a shared governance toolkit to improve nurse engagement on the Practice Environment Scale (PES) of the Nursing Work Index (NWI) for the nurse and nurse manager, co-leading a UPC in the Maternal Child Health units. The PES-NWI is a valid and reliable instrument that measures participation in hospital affairs and is endorsed by the National Quality Forum (Press Ganey Associates, 2016).

The aim of this project was: In the Maternal Child Health units, the PES-NWI will increase 10% from pre- to post-intervention through the implementation of UPCs based on using a standardized toolkit by the end of the third quarter 2020. The process measure was the toolkit, and the expected improvement was an increase in the PES-NWI.

Methods

Context

The objective of this project was to develop and implement a toolkit for the nurse and the manager to co-lead the UPC for their Maternal Child Health unit. The toolkit assisted the co-leads and members of the UPC to implement, lead, and sustain the UPC.

Key Stakeholders

The key stakeholders were the team members who have a strong interest or concern with the project. The first group of key stakeholders was the sponsors who removed barriers to implementation. The sponsors were the regional Maternal Child Health director, the participating hospitals' Chief Nurse Executives, and the Maternal Child Health Directors from the participating hospitals. The champions were the team members that led the UPCs, the nurse manager, and the nurse co-lead. The staff nurses participating in the UPC are critical to the success of the UPC and are also key stakeholders. The DNP student was the project manager and was an essential key stakeholder who assisted and supported the rollout in the nursing units. The key stakeholders were invested in implementing UPCs for the nursing units in the Maternal Child Health service line in two separate hospitals.

The chief nurse executives of the participating hospitals were supportive and invested in this project. In consultation with the regional maternal child health director the decision was made to work directly with the nurses. The project does not violate the union contract; hence, a meeting with the union in advance was not required. As with existing quality improvement projects, the nurse managers and service directors worked directly with the nurses.

All Maternal Child Health Directors were engaged to participate in the implementation of UPC and the utilization of the toolkit. Initially, there was considerable interest; however,

because of the COVID-19 pandemic, many of the leaders had to reprioritize initiatives. As a result, two hospitals and seven nursing units participated in the implementation. Of the participating hospitals, the implementation was successful, and the engagement of the co-leads improved.

Intervention

Toolkit

The intervention was the development and implementation of a standardized toolkit to support the co-leads (nurse manager and staff nurse) to implement a UPC. The toolkit is a comprehensive document that has all the components of implementing a UPC. The toolkit has a table of contents that has different sections broken down.

The toolkit started with an introduction. The introduction explained the background, the definition of shared governance, and unit practice council. As teams form and co-leads implement UPC, it is essential to understand the purpose of shared governance. The benefit of unit practice council from the literature is described in the toolkit. The benefits for the staff nurse co-chair is explained.

The toolkit defines a team composition that outlines the number of members, time commitment, term limit, and membership. This section of the toolkit was derived from Donabedian's conceptual framework. The framework describes the structure, process, and outcomes.

The toolkit consisted of meeting tools, such as agenda planning, running a meeting, leading a discussion, reaching consensus, and managing conflict. Examples from the Institute for Healthcare Improvement (IHI) on process improvement, such as plan, do, study, act, and aim statement are included (IHI, 2020). A list of successful implementation projects is included in the

toolkit. The toolkit has the coaching tools to support managers in helping nurses understand the intent of the UPC. Valuable documents, such as sample electronic mails, introductory electronic mail, and end of each meeting summary, are included. Sample documents, such as questionnaires for participants, sample electronic mail, and flyers for announcements for the co-leads are provided so that the co-leads do not have to create their own documents. Preparation in advance of implementation was imperative because UPC implementation took time and commitment. The toolkit is included in the appendix (see Appendix P).

Processes

Before initiating the UPC, a formal training session was scheduled with the manager to review the importance of guiding and supporting the team rather than leading. According to Ballard (2010), managers need to be prepared in advance of implementation. There is value in spending quality time with the manager to review the manager's role. The training for the manager focused on the manager as a coach to mentor instead of managing a group of nurses. The managers had a steep transition to make going from leading to supporting.

An explanation of the role of the staff nurse and how it differs from the manager's position was a crucial element in the implementation of the UPC. The staff nurse, as the co-lead, was educated to focus on shared governance and not self-governance. One of the barriers to successful implementation is that some nurses want to discuss their personal agendas instead of focusing on shared governance and evidence-based practices (Ballard, 2010). Meeting tools, such as agenda planning, PDSA (plan, do study, act), aim statements, taking minutes, building consensus, and project planning, were reviewed with the co-leads before implementation. The Institute of Healthcare Improvement (IHI) Model of Improvement tools was included in the toolkit. Institute of Healthcare Improvement is based on W. Edwards Deming's work on quality

improvement. The IHI model also promotes the Plan-Do-Study-Act (PDSA). The PDSA quality improvement framework was chosen for the small rapid-cycle tests of changes (see Appendix C).

Topics Appropriate for the UPC

After the meeting with the manager, a meeting took place with the staff nurse and manager together to review the toolkit, set expectations for the staff nurse and manager, and answer questions. The purpose and the benefits of a UPC were presented to ensure a shared understanding. Since many nurses and managers have not worked in a hospital with ANCC Magnet® designation, it was essential to review examples of appropriate topics for the UPC.

The implementation of UPCs took place with nurses who are members of an organized labor union association. There were some elements that the nurses and managers needed to be aware of that do not qualify as UPC topics. Topics related to the union contract pay, schedules, and staffing are non-negotiable and are not appropriate for discussion at the UPC. It was important for the co-leads to know how to redirect those conversations in the event they came up. The training included the talking points on guiding conversations with staff. A list of examples for UPC projects was provided to the manager and nurse co-leads. Emphasis was placed on the importance of the shared governance model, particularly on nurse autonomy, equity, accountability, and the impact nurses have on improving their professional nursing practice (Clavelle et al., 2013).

Gap Analysis

A gap analysis was completed in preparation for the performance of the intervention (see Appendix D). At the time of the gap analysis, many nursing units within Maternal Child Health did not have UPCs, and there was no forum for nurse engagement in decision-making. At this multi-level system, nurses attend meetings but do not co-lead committees, and there are no

resources to show them how to co-lead a UPC. The intention of the UPC model specifies that the nurse will co-lead with their manager. The evidence suggests that managers and nurses will come together in purpose and with discipline to improve nursing practice and nurse engagement (Ballard, 2010).

The hospitals in this system are data-driven organizations, but the gap analysis shows that there are little data for the organization that tracks nurse engagement. The literature indicates that nurses are the least engaged group of healthcare workers, and their lack of engagement can lead to problems with turnover and patient care outcomes (Advisory Board, 2014).

Gantt Chart

The project timeline is described in a Gantt chart (see Appendix E). The timeline and the plan for the project were completed with collaboration from the University and the Maternal Child Health nursing directors at the northern California hospitals. Maternal Child Health nursing units in two separate hospitals implemented UPCs. The nurse and nurse manager, as co-leads, completed a pre-intervention survey. The toolkit was created in January 2020 and implemented in the second quarter of 2020. The post-survey was completed three months from the start of implementation.

Work Breakdown Structure

The work breakdown structure (WBS) provides a visual display of the project rollout that gives the team an overview of the project to support communication and alignment. The project's main tasks included designing the plan, identifying key stakeholders, determining the budget, implementing the project, and evaluating the effectiveness of the WBS (see Appendix F). Donabedian's model of structure, process, and outcomes served as a framework for creating shared governance and was used as a guide for the WBS.

The initial branch of the WBS is the UPC planning process. It is crucial to identify the plan before starting a project to ensure that everyone has the same level of understanding. The PICOT question guided the literature search, which provided evidence-based what on the project design. The literature review was completed to gather evidenced-based best practices and used for implementation of the toolkit. The assessment of the current state for UPCs was the next step of the project. The development of the aim statement, toolkit, timeframe for implementation, evaluation of the UPC, and sustainability plan have all been included in the project.

The next branch of the WBS was the development of the key stakeholder list. Identifying the key stakeholders in project planning is vital in ensuring the success of the project. The key stakeholders are members of the team invested in ensuring the success of the project. The sponsors of UPCs are at the top of the key stakeholder list. The sponsors can remove barriers as they arise and are vested in ensuring success. The champions, nursing directors, and key stakeholders who are close to the frontline staff encourage others to support the project. The manager and the staff nurse, as co-leads, are the team members that worked with the frontline staff to support the implementation of the project. Finally, the frontline staff nurses comprise the team involved with the performance of the UPC and experience implementation, which is the most rewarding step of the project.

The budget (to be discussed) has a branch of the WBS of its own because it is an important aspect of a successful project rollout. The organization requires all projects to have a budget planned and approved before the implementation of any project.

The implementation branch of the WBS begins with planning meetings. The toolkit has a solid plan to follow, which is a key to successful implementation. The literature supports meeting with the manager before the implementation to review the manager role (Ballard, 2010). The

next step was to meet with the manager and the staff nurse co-leads together to ensure each co-lead understood their position, the principles of shared governance, and the elements of the toolkit before implementation. The actual implementation of the UPC was full of excitement and anticipation, as the team worked hard for that day. The final step was the debriefing to identify the areas of success and opportunities for improvement.

Another critical component of the WBS was to evaluate the efficacy of the UPC in increasing nursing engagement. The co-leads' nurse engagement was assessed based on the evidence-based tool, the PES-NWI. The results from the pre-intervention and post-intervention were analyzed. The final step of the evaluation process was to share the results throughout the organization.

SWOT Analysis

A strengths, weaknesses, opportunities, and threats (SWOT) analysis was completed to assess the attributes in support of the project, areas to focus on, and opportunities for change (see Appendix G). A significant strength of the implementation of the UPC was the support from the chief nursing executive (see Appendix H). Additional organizational strengths included the existing nursing and manager partnership, implementation of evidence-based practices, strategic goal for shared governance implementation, system process improvement, desire for increased communication, and focus on patient satisfaction. The organizational weaknesses noted in the analysis included the lack of a formalized process, length of the time to formulate a UPC, size of the unit, the culture of the team, silo point of view, potential future nursing shortage due to an aging workforce, and organizational focus on ways to do more with less.

An analysis of opportunities and threats from the environment outside the organization were also included in the analysis. The opportunities found during the SWOT analysis were

designation in the ANCC Magnet® Recognition Program, an increase in patient satisfaction scores, improved nurse engagement, improved clinical outcomes, decreased harm to the patient, and decreased nurse turnover. The scope of this project focused on improving engagement. Due to the time constraints and confounding factors, such as work stoppage and COVID-19 pandemic this project did not focus on measuring nurse turnover. Identification of the threats found during the SWOT analysis included factors that negatively affect the organization's performance, such as threats to the organization's reputation, funding for UPCs, and nursing availability.

Responsibility and Communication Plan

The responsibility and communication plan for this project is outlined in a matrix (see Appendix I). In-person meetings with the DNP student's chief nursing executives took place to provide a project plan and timeline. Presentation with the Maternal Child Health directors took place monthly to provide updates on the project and UPC implementation. Communication with co-leads was very important to the success of this project, so monthly meetings, with presentations and training, took place with the nurse and manager co-leads before and during implementation. Engaging the frontline staff was imperative and fundamental to the core of UPC communication. The monthly meetings included ongoing training for the frontline staff once implementation initiated. One week before each UPC meeting, the -DNP student met with the co-leads to review the agenda, review the status of the UPC, and provide feedback. The co-leads were receptive and appreciative of the mentorship.

Budget

Funding for UPCs was identified through a proposed budget, which provided oversight to the key stakeholders of the cost and resources required for the project. The budget was approved before the implementation of the project. The project manager performed frequent checks of the

budget during the project to ensure the team stayed within the budget. The budget for this project was calculated at $89,430, which included the cost of the toolkit, the training cost for the co-leads, meeting time, mentorship, meetings, and supplies (see Appendix J). Included in the budget were the costs of the two hospitals implementing UPCs. Each team consisted of a nurse and manager co-lead. The budget was designed with three participating nurses, one from each shift. Of the two hospitals participating, one was a large hospital, and the other was a small hospital. The large hospital had 20 participants (four nursing units), which included four managers, four nurse co-leads, and 12 staff nurses, one from each shift participating. The smaller hospital had 13 participants (three nursing units), which included one manager who oversaw all three nursing units, three nurse co-leads, and nine nurses participating. There was a total of 33 participants from the two hospitals. The Maternal Child Health directors were invited to attend and participated when able based on their schedule.

Cost Avoidance/Benefit Analysis

The budget was designed with an implementation strategy to introduce and spread the UPC toolkit. The cost avoidance was calculated for the total revenue. The literature documented that the cost of nurse turnover is estimated at $88,000 per nurse (Kovner, Brewer, Fatehi, & Jun, 2014). The projection is to retain one nurse for each nursing unit with a UPC. The calculation for cost avoidance is $88,000 per nurse times seven nurses. The total cost of the project implementation is $375,590, with the cost of the project manager included in the budget (see Appendix K). As a result of improved nurse engagement, the anticipation is that there will be savings from nurse retention, with the cost avoidance of $616,000 at the end of the first year. This amount was calculated against the cost of nurse turnover compared to the total cost for UPC implementation.

Study of the Interventions

The intervention of the toolkit was implemented at two medical centers within seven nursing units. The DNP student led the kick-off meeting with the Maternal Child Health director, nurse manager co-lead, staff nurse co-lead, and staff nurses participating in the UPC. The agenda was prepared in advance by the DNP student. A PowerPoint presentation explained and described shared governance and UPCs to ensure each team member had the same level of understanding of the purpose of a UPC. The council structure, attendance, and commitment were also included in the review. The DNP student was a UPC subject matter expert, and this kept the team engaged through project planning, brainstorming project ideas, voting, and selecting projects. Education was performed on the Institute of Healthcare Improvement's Model of Improvement, PDSA cycles, and developing aim statements. At the end of the kick-off meeting, the team understood shared governance, UPC, and project management tools; they had plans for data collection and had identified one or two projects. The DNP student led the first meeting, took minutes, and created the data collection tools. After the first UPC meeting, the team had projects identified, an aim statement initiated, and the planning phase of PDSA began.

The co-leads led the subsequent meetings. The DNP student met with the co-leads one week before the scheduled meeting date and time to review the agenda, analyze the data collected, and plan for the next meeting. The UPC team worked on the PDSA plans for their projects. The nurse co-lead and manager were able to lead the UPC due to the resources and materials provided in the toolkit.

Measures

The PES-NWI was utilized to analyze this project (see Appendix L). The primary independent variable was the intervention, which was the development and implementation of

the toolkit. The dependent variable was nurse engagement. The PES-NWI is a valid and reliable instrument endorsed by the National Quality Forum (Press Ganey, 2016). The nine statements from the PES under *nurse participation in hospital affairs*. This section from Press Ganey was chosen from the literature on nursing engagement (Lake, 2002). The statements are:

- Career development/clinical ladder opportunity,
- Opportunity for staff nurses to participate in policy decisions,
- A chief nursing officer who is highly visible and accessible to staff,
- A chief nursing officer equal in power and authority to other top-level hospital executives,
- Opportunities for advancement,
- An administration that listens and responds to employee concerns,
- Staff nurses are involved in the internal governance of the hospital,
- Staff nurses have the opportunity to serve on hospital and nursing committees, and
- Nursing administrators consult with staff on daily problems and procedures (Press Ganey, 2016).

The responses to the statements indicate the level of engagement (1 = *least engaged*, 2 = *somewhat engaged*, 3 – *moderately engaged*, and 4 = *most engaged*).

Of the nine statements, the focus to assess nurse engagement was on three statements. Due to the COVID-19 pandemic and time constraints, focus on three statements were chosen based on the studies from Brooks Carthon et al., (2019) and Kutney-Lee et al., (2016) The three questions to assess nurse engagement from nurse participation in hospitals affairs are:

1. Opportunity for staff nurses to participate in policy decisions,
2. Staff nurses are involved in the internal governance of the hospital (e.g., practice and

policy committees), and

3. Staff nurses have the opportunity to serve on hospital and nursing committees.

Analysis

The quantitative analysis was conducted on the PES-NWI to compare nurse engagement pre- and post-intervention implementation of the UPC. The results were imported into an Excel spreadsheet for ease of analysis, and the results were analyzed to compare the pre- and post-intervention results. Descriptive statistics were utilized to analyze the data, including the mean and percentage variance (see Appendix M). The co-leads pre-and post-intervention data were analyzed for qualitative data to review nurse engagement from least engaged to most engaged. The survey results indicate an improvement in engagement for the co-leads from pre-intervention to post-intervention of the toolkit and UPC.

Ethical Considerations

On August 10, 2019, the University of San Francisco's DNP department determined that this project met the guidelines for an evidence-based change in practice project outlined in the DNP project checklist and was approved as non-research. There were no identifiable issues or conflicts of interest noted for this project. The project was a quality improvement project that did not require an Institutional Review Board (IRB) approval for implementation. Approval as a quality improvement project exempt from IRB approval was completed through the USF School of Nursing and Health Professionals (see Appendix N). The Northern California Hospital's Research, Compliance, and IRB Administration reviewed the project and determined the project did not meet the regulatory definition of involving human subjects, which would require IRB approval (see Appendix O).

University of San Francisco produced the 2028 planning document to reflect the core values of the University (USF, 2016). The key element is the Jesuit Catholic tradition of academic excellence, diversity, San Francisco location, and education from a global perspective. The document explains that the Jesuit tradition is committed to the pursuit of excellence and challenges students to be thoughtful and to ask essential questions of ultimate meaning and purpose (USF, 2016). The approach that used to implement the UPCs is consistent with the Jesuit tradition of being thoughtful and finding answers to questions in the evidence before design and implementation. Unit practice councils promote the advancement of nursing practice by reviewing and implementing nursing research and evidence, which is consistent with the Jesuit tradition of the pursuit of excellence.

The American Nurses Association (ANA, 2015) Code of Ethics Provision 4 states, "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care" (p. 16). In this project implementation, the nurse acts as a co-leader by actively participating and engaging in practice changes for nurses. In alignment with the ANA code, the nurse will participate in committees and decision-making that contribute to enhancing nursing practice. In alignment with Provision 1.5 Relationships with Colleagues and Others, a culture of respect, specifically psychological safety, was promoted in the handling of the data collection. The identity of the employee completing the survey was protected, and the survey results did not identify the employees completing the survey.

Results

The scope of this project was the implementation of the UPC using a standardized toolkit in the Maternal Child Health units to improve nurse engagement. The literature supports the use

of standardized tools, such as a toolkit, to implement the components of UPCs that follow evidence-based recommendations. Ballard (2010) recommended the development of a toolkit to support the successful implementation of UPCs and to increase engagement in the workforce. The toolkit helped the nursing units with the training, development, and education to successfully implement UPCs and improvement in nursing engagement.

The intervention of the toolkit (see Appendix P) guided the team with resources and material. The kick-off meeting (see Appendix Q) incorporated the agenda, review of membership, PowerPoint presentation of shared governance and UPCs, and PDSA plan for project rollout. Project management tools for voting and consensus-building were utilized.

The primary outcome of the project was an improvement in nurse engagement based on the NDNQI RN survey with the PES, which was completed as a pre- and post-intervention survey. The participants reported an improvement in the level of engagement in the three focused categories after implementing the UPC. Improvements in three areas under nurse participation in hospitals affairs were:

- Opportunity for staff nurses to participate in policy decisions.
- Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).
- Staff nurses can serve on hospital and nursing committees (Press Ganey, 2016).

Baseline and post-intervention data collection from the nurse and nurse manager co-leads was conducted on the PES-NWI to evaluate nurse engagement. The level of engagement improved for the staff nurses and nurse managers in the three categories after implementing UPC and utilizing the toolkit. The co-leads completed a survey pre-intervention and post-intervention using a 4-point Likert scale. The goal was to increase nurse engagement by 10%.

For opportunities to participate in policy decisions, staff nurses showed a 57% increase from 2.4 to 3.4, opportunities to serve on hospital committees staff nurses showed an improvement by 29% from 3.4 to 3.7 and staff nurses' opportunities to participate in policy decisions increased by 29% from 3.4 to 3.7. The nurse managers surveyed, reported an increase in opportunities for staff nurses to participate in policy decisions by 40% an increase from 3.2 to 3.6. The level of engagement related to involvement in internal governance improved by 120% for the nurse managers from 2.6 to 3.8. Engagement improved related to staff nurses having the opportunity to serve on hospital and nursing committees by 20% for nurse managers from 3.4 to 3.6.

The balancing measure of the existing situation was that the staff nurse and manager structure existed before starting the project. The seven nursing units had experienced nurse managers that were excited, embraced and cheer leaded the implementation of who were open to UPCs. The staff nurses chosen as co-chairs were the nurses on the unit who were respected, subject matter experts, and expressed an interest in improving their nursing unit. The balancing measure before implementation was the impetus to implement shared governance to fulfill the ANCC Magnet® Recognition Program.

The DNP student observed an increase in staff engagement and satisfaction after the implementation of UPC. The nurses stated they were happy they could finally work on projects to improve nursing practice and patient care. An unintended consequence of the project was the improved relationship between the DNP student and the nurses and nurse managers. As a result of this project, staff nurses in a union environment worked closely with the DNP student, a nursing director. The relationship broke down the silos and improved the trust between management and nurses.

There were some modifications made during this project due to unanticipated delays that took place. There was a potential of a union work stoppage. All normal operations were placed on hold while the organization planned and prepared for a work stoppage.

There was a delay in implementing the UPC due to the COVID-19 pandemic . All efforts focused on protecting our patients and staff from spreading the pandemic.. The original plan was to implement the UPC in person. Due to the COVID-19 pandemic and the strict guidelines around social distancing, the DNP student utilized resources and changed the in-person meetings to virtual meetings by leveraging technology. Two additional hospitals expressed interest in rolling out the UPC. The hospitals were not able to start implementation until August 2020 due to the COVID-19 pandemic. An unintended benefit from virtual meetings was the cost elimination of food and drinks planned in the original budget. Originally, the meetings were to be held in person, with the plan to provide food and water for the participants; however, due to the COVID-19 pandemic, the meetings were held virtually, which resulted in eliminating the cost of food and drinks.

One nursing department, through UPC, improved the education patients receive related to blood sugar monitoring for pregnant patients on labetalol. One UPC chose their first project to create a one-page handout for patient education on newborn blood sugar monitoring. Another UPC improved the HCAHPS quiet at night for their unit utilizing the PDSA cycle implemented by the UPC.

Discussion

Summary

The project's aim was to improve nurse engagement through the implementation of the UPC by implementing the toolkit created by the DNP student. The level of engagement improved for the staff nurses and nurse managers in the three categories after implementing the UPC. For the staff nurses, an increase of 57% for opportunities to participate in policy decisions was realized, with an increase of 40% in the same measure for the nurse managers. The level of engagement related to involvement in internal governance improved for staff nurses by 29% and for nurse managers by 120%. Staff nurse and nurse manager engagement improved related to staff nurses having the opportunity to serve on hospital and nursing committees by 29% for staff nurses and 20% for nurse managers. The staff nurses described satisfaction in completing projects that relate to nursing practice. The co-leads articulated the benefits of learning the process improvement of project management, such as aim statements and PDSAs.

The most significant contribution to the successful change was the time allotted to implement the UPC. The toolkit created by the DNP student recommended a 4-hour meeting time each month. The key stakeholders were committed to the success of the UPC and supported the structured time. The relationship between the manager and nurse improved as a result of UPC implementation. The new possibility of an improved relationship between manager and nurses emerged as the team worked closely together.

An essential component of the project was the importance of a structured toolkit to implement UPCs. The process improvement tools from the IHI supported the co-leads to lead projects through data analysis. As the co-leads became more comfortable with leading meetings and using project management tools, they could take on more projects.

The findings of the project will be shared with the regional Maternal Child Health director peer group, the regional Magnet® Recognition Program committee, and the regional chief nurse executive. The toolkit has been shared with the regional Magnet® Recognition Program committee and a plan to implement in all the hospitals and nursing units is under consideration.

Interpretation

The project's results are consistent with research findings of improved nurse engagement from implementing a UPC (Brooks Carthon et al., 2019; Cox Sullivan et al., 2017; Kutney-Lee et al., 2016). Meeting with the manager and staff nurse co-leads before the execution was imperative, as suggested by Ballard (2010).

Shared governance, such as a UPC, is a non-hierarchical structure to enable the profession of nursing to come together in purpose and discipline (Clavelle et al., 2013). Nurse engagement improved as a result of the implementation of the UPC. Also, the trust and relationship became stronger between the manager and the staff nurse. There was a breakdown of silos and an enhanced relationship. The project outcomes were consistent with anticipated outcomes. The cost of implementing UPCs was related to meeting time for the team, with the cost of food eliminated as a result of virtual meetings. The benefits of UPCs, the direction towards Magnet® Recognition Program designation, nurse engagement, and strengthened relationship between nurse and manager.

The leaders of this organization are invested in the UPC outcomes. The project supports the Donabedian conceptual framework. Additional resources can be added to the toolkit and utilized for sustainability. As the members of the UPC work together, they will take on new

projects as they finish out existing projects. Membership for UPC is a two-year commitment, with 50% of the team continuing with the committee.

Limitations

Time commitment by the staff nurses and manager was a significant factor that contributed to the success of the project. The commitment to the success of a UPC by the leaders was substantial. The time commitment of the DNP student to support seven departments to implement UPC was a considerable undertaking. The Magnet® Recognition Program committee will determine the implementation for the remaining hospitals and nursing units. The toolkit has been provided to the Magnet® Recognition Program committee. The one-to-one mentorship before the kick-off meeting and the continued consultation before the monthly meetings led to the success of the project. The toolkit is structured in design and implementation, which yields to standardization among the nursing units and hospitals.

A possible barrier to this project was the staff nurses' schedules. Due to staffing conflicts, some staff nurses had challenges in attending the meetings. A mitigation strategy identified and implemented is that the staff nurse co-lead sent an electronic mail with the meeting minutes and action items. Another mitigation strategy the nurses developed on their own to meet on their day off to avoid staffing conflicts. Another barrier to this project was pre-scheduled vacation conflicts with the meeting date and time. Initially, the UPC committees set up standard meeting dates and times for the same time each month. For example, the team scheduled UPC meetings on the second Tuesday of the month. An identified solution was to set the next month's meeting at the start of each session. This solution allowed the team to be flexible with their schedule and avoided staffing conflicts.

Conclusions

This project evaluated nurse engagement pre- and post-intervention of UPC based on a standardized toolkit. The PES-NWI was utilized to assess quantitative data to analyze how nurse engagement was affected by the project. The nursing director will report out to the chief nursing executive responsible for ensuring the ongoing success and for removing obstacles. The intentional development of staff nurse and manager co-leads are anticipated to yield positive results of improved quality of care, increased satisfaction, and staff engagement. A skillful and confident leader can support the team to participate in performance improvement activities and empower staff to lead a performance improvement project utilizing the performance improvement tools. One of the more long-term effects of ensuring the sustainability of the project is the leadership structure and support of UPCs. An organization needs to invest in UPCs to engage staff, improve patient outcomes, and achieve and maintain the Magnet® Recognition Program designation.

Other Information

Funding

This project was supported by the local chief nursing executive, the regional Maternal Child Health director, and the regional chief nursing executive. The DNP student's time and creation of the toolkit were funded and supported by the chief nursing executive. Their local departments and local hospitals invested the staff nurse and manager time and pay. The funding of this project is heightened by the organizational decision for the Magnet® Recognition Program designation.

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Appendix A

Evaluation Table

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
Brooks Carthon, J. M., Hatfield, L., Plover, C., Dierkes, A., Davis, L., Hedgeland, T., … Aiken, L. H. (2019). Association of nurse engagement and nurse staffing on patient safety. *Journal of Nursing Care Quality, 34*(1), 40-46. doi:10.1099/NCQ.000000000000034								
Examined the relationship between the level of engagement, staffing, assessments of patient safety, and the number of nurses working in hospital settings	Donabedian's conceptual model	**Design:** Qualitative **Method:** Secondary analysis of linked cross-sectional data	**Sample:** 26,960 survey responses **Setting:** 599 hospitals 4 states	**Independent variable 1:** Staffing **Independent variable 2:** Engagement **Dependent variable:** Patient safety grade and seven indicators	Survey data	Frequency distributions, measures of central tendency, and bivariate correlations Logistic regression model to determine the association of nurse engagement and nurse staffing Statistical analysis 2-tailed	32% of nurses gave their hospital a poor or failing patient safety grade. In 25% of hospitals, nurses fell in the least engaged or only somewhat engaged categories. Each additional patient per nurse was associated with an increase in the odds of a hospital	**Rating:** Level III-A **Worth to Practice**: Improve nursing outcomes through unit practice councils **Strengths:** Authors utilized the PES-NWI to assess nurse engagement. **Weaknesses:** Secondary analysis **Feasibility:** Ease of applying findings to the

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
							receiving an unfavorable patient safety grade by a factor of 1.06 (95% CI, 1.03–1.10), an increase of 6%. For each unit increase in nurse engagement, the odds of a hospital receiving an unfavorable patient safety grade decreased by a factor of 0.71 (95% CI, 0.68-0.75), 29%.	project **Conclusions:** Interventions to improve nurse engagement and adequate staffing serve as strategies to improve patient safety. **Recommendations**: Include findings into project for PES-NWI tool and findings
Clavelle, J. T., Porter-O'Grady, T., & Drenkard, K. (2013). Structural empowerment and the nursing practice environment in Magnet®® organizations. *Journal of Nursing Administration, 43*(11), 566-573. doi:10.1097/01.NNA.0000434512.81997.3f								
Described characteris-tics of shared	Kanter's theory of structural	**Design:** Qualitative, correlational	**Sample**:95 CNOs and 107 nursing	Index of Processional Nursing	Survey through Survey	Descriptive statistics	NWI-R ranged from total scores on the	**Rating:** Level III-A

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
governance and its relationship with nursing practice environments in ANCC Magnet® Recognition Program	determinanats	design **Method:** Surveys of Magnet® CNO and leaders using the Index of Processional Nursing Governance (IPNG) and the Nursing Work Index-Revised (NWI-R)	practice chairs (NPCs) **Setting**: 344 organiza-tions in the US holding ANCC Magnet® designation as of June 1, 2012	Governance (IPNG) (86-item instrument) measures perceptions of governance in six scales utilizing: - Control over personnel - Access to information - Resources supporting practice - Participa-tion - Control over practice - Goals and conflict resolution NWI-R character-	Monkey	*t*-tests, $\chi 2$, ANOVA Pearson's correlation Statistical Package for the Social Sciences (SPSS)	nurse work index-revised ranged from 1.35 to 1.48, with a significant, positive correlation between total IPNG score and total NWI-R score (r = 0.416, $p <$ .001).	**Worth to Practice**: Nurses engaged in shared governance are active participants in their own nursing professional practice **Strengths:** Studied CNO on their perception of shared governance **Weaknesses:** Staff nurses were not surveyed on their feedback of shared governance **Feasibility:** Study utilized a Nursing work index-revised

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
				istics of the nursing professional practice environment in four subscales: - Autonomy - Control over practice - Nurse-physician relationship - Organiza-tional support				tool based on Likert scale that assessed autonomy, control over practice, RN-MD relationship, and organizational support **Conclusions:** The positive relationship between shared governance and the nursing practice environment in Magnet® organizations. **Recommendations**: This article reaffirms that nurses engaged in shared governance are

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
								active participants in improving their professional practice
Cox Sullivan, S., Norris, M. R., Brown, L. M., & Scott, K. J. (2017). Nurse manager perspective of staff participation in unit-level shared governance. *Journal of Nursing Management 25*(8), 624-631. doi:10.1111/jonm.12500								
Examined the nurse manager's perspective surrounding the implementation of unit-level shared governance in one VA facility in central Arkansas	None	**Design**: Qualitative **Method:** Convenience sampling; face-to-face semi-structured interviews	**Sample**: Ten nurse managers; **Setting:** Central Arkansas Veterans Administrative Facility Little Rock, Arkansas	Demographic data collected for descriptive statistics. Interview data analyzed using content analysis and constant comparison.	Face to Face Interview. Open ended questions	Two experienced researchers reviewed the codes and definitions for dependibility	Global themes: - Motivation - Demotivation - Recommendations for success - Outcomes Nurses became energized through creating processes to improve quality or streamline required effort to accomplish their work. -Demotivation:	**Rating:** Level III-A **Worth to Practice**: Role of the nurse manager in shared governance **Strengths:** face-to-face interview with nurse managers **Weaknesses:** Small sample size of 10. **Feasibility:** Role of nurse manager to support nurses

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
							staff became discouraged when projects did not accomplish the desired results - Recommend-ations for success: education and understanding of unit-level shared governance. -Outcomes: improvement of quality and patient safety indicators	**Conclusions:** Shared governance may be associated with increased nurse empowerment, self-management, engagement, and satisfaction. **Recommendations**: Utilize findings into the project
Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., … Aiken, L. H. (2016). Nurse engagement in shared governance and patient and nurse outcomes. *Journal of Nursing Administration, 46*(11), 605-612. doi:10.1097/NNA.0000000000000412								
Examined the differences in nurse engagement in shared governance across	Kanter's theory of structural empowerment	Secondary analysis of linked cross-sectional data using nurse, hospital, and HCAHPS	**Sample:** 20,674 RNs **Setting:** 177 hospitals	Nurse measures: - Engage-ment in shared governance - Nurse job	HCAHPS data	$\chi 2$ (categorical variables) F tests & ANOVA (continuous variables)	42% (n = 177) were classified as having most engaged nurses, 36% (n =155) had moderately	**Rating:** Level III-A **Worth to Practice**: Nurses in Magnet® organizations

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
hospitals to determine the relationship between nurse engagement and patient		data		outcomes and quality of care. - Patient measures - Hospital measures		Logistic regression STATA	engaged nurses, 19% (*n*=80) somewhat engaged, and 3% (*n* = 13) were least engaged.	are moderately to highly engaged **Strengths:** Large sample size **Weaknesses:** Secondary analysis **Feasibility:** Improved patient outcomes as a result of shared governance **Conclusions:** A professional practice environment that incorporates shared governance may serve as a valuable intervention for organizations to promote

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
								optimal patient and nurse outcomes. **Recommendations**: Apply study findings to the toolkit for this project
Lake, E. T., (2002). Development of the practice environment scale of the nursing work index. *Research in Nursing and Health, 25,* 176-188. doi:10.1002/nur.10032								
Research conducted to develop the practice environment scale (PES) from the NWI. The objectives of the research were first, to develop a parsimonious and	N/A	**Design:** Qualitative **Method:** Voluntary participation; surveys	**Sample:** Two samples of hospital data. 11,636 nurses **Setting:** Magnet® hospitals (n = 1,610)	Survey	Construct Validity	Content validity assessed by three of four original magnet study researchers. SAS program Cronbach's alpha The PES-NWI consists of nine items which	The study supports the PES-NWI was higher for nurses in Magnet® hospitals compared to nonmagnet hospitals ($p<.001$).	**Rating:** Level III-A **Worth to Practice**: Reliable and valid tool to assess nurse engagement **Strengths:** This study has been cited in other literature articles related to shared governance for the work the

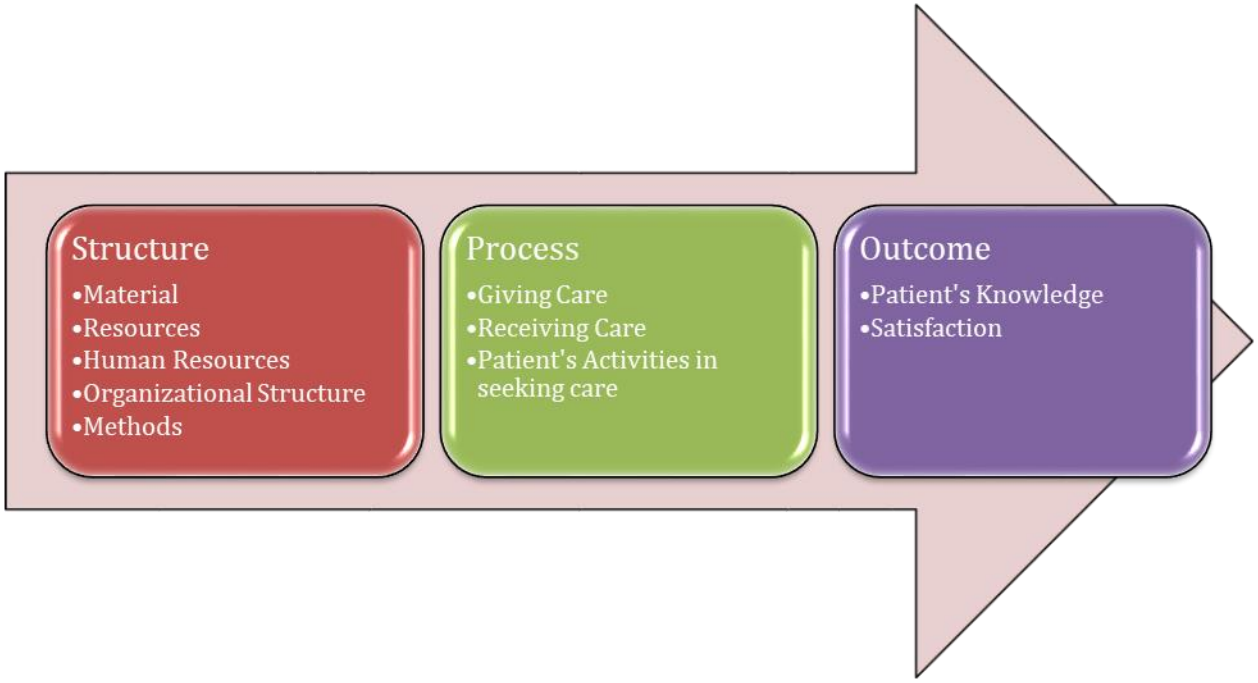
Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
psychometrical scale and second, to provide reference for Magnet® hospitals from which the NWI was developed						exhibited high reliability at the individual and hospital level. The individual-level internal consistency was high (α=.83). The reliability of the hospital-level measure was robust, with average interitem correlation of .64. A higher score indicates agreement, a value above 2.5 indicates agreement and a value below 2.5 indicates disagreement		author conducted on the tool. **Weaknesses:** Study is from 2002. Another study has not been conducted to evaluate the tool **Feasibility:** Easy to use 9 question tool **Conclusions:** Nurses working in a Magnet® hospitals reported higher engagement than nurses working in a non-magnet hospital **Recommendations**: Utilize the reliable and valid tool, PES-NWI for the

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
								project.
Wilson, J., Gabel Speroni, K., Jones, R. A., & Daniel, M. G. (2014). Exploring how nurses and managers perceive shared governance. *Nursing*, *44*(7), 19-22 doi:10.1097/01.NURSE.0000450791.18473.52								
Explores differences between direct care nurses' and nurse managers' perceptions of factors affecting direct care nurses' participation in unit-based and general shared governance activities and nurse engagement	None	**Design:** Qualitative research design **Method:** Survey research study September – November 2011	**Sample:** 144 participants **Setting:** Shore Health System, a two-hospital, not for profit, Easton and Cambridge, MD	Nurses' perception of being supported by the unit manager. Nurses perception that the unit works as a team. Nurses feeling, they have time to participate in activities. Nurses believing, they will be paid for activities beyond	26-item research survey,	SAS Statistical analysis Frequency distribution Fisher exact tests Chi-square	79% reported some level of engagement.	**Rating:** Level III B **Worth to Practice**: Recommendations for the nurse manager to support the nurses **Strengths:** Large sample size **Weaknesses:** Protected time identified as a barrier **Feasibility:** Study surveyed nurse managers and staff nurses perception of unit-based and shared governance **Conclusions:**

Purpose of the Study	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Critical Appraisal Tool & Rating Worth to Practice/ Strengths & Weaknesses/ Feasibility/ Conclusions/ Recommendations
				scheduled shift.				Nurse managers and unit-based councils should evaluate nurses' perception of manager support, teamwork, lack of disruption to patient care. **Recommendations**: Incorporate findings and recommendations for nurse managers into the toolkit

Appendix B

Donabedian Framework



(Donabedian, 1988)

Appendix C

CQI/PDSA Plan

1. Reasons for Action	4. Gap Analysis	7. Completion Plan
Problem Statement/Business Case: This organization is on a multi-year journey towards Magnet® Recognition Program. This organization does not have UPC implemented in each nursing unit. What are we trying to accomplish? (SMART Goal): In the Maternal Child Health Units, the PES-NWI will increase 10% from pre- to post-intervention through the implementation of unit practice councils based on a standardized toolkit by the end of the third quarter 2020.	• Many nursing units do not have UPC. • Low staff engagement • Lack of nurse autonomy	▪ Implement UPC Projects ▪ Staff nurse and manager to co-lead independently ▪ Utilize PDSA process for project implementation ▪ Two Hospitals, seven nursing units
2. Current State	**5. Solution Approach**	**8. Confirmed State**
The Advisory Board Company (2014) estimates 33% of nurses surveyed across North America (n=180,384) constituted the least engaged of all healthcare employees in their workplace. The literature documents the cost of nurse turnover is estimated at $88,000 per nurse (Kovner, Brewer, Fatehi, & Jun, 2014).	• Implement Unit Practice Councils utilizing the toolkit • Mentor nurse managers and staff nurse co-leads	Increased staff engagement
3. Future State	**6. Rapid Experiments**	**9. Insights**
Outcome Measure: Increased nurse engagement Process Measures: Implement UPC Toolkit Balancing Measures: impetus to implement shared governance in order to fulfill the American Nurses Credentialing Center (ANCC) Magnet Recognition Program®	▪ Consultation meeting prior to go-live to draft plan ▪ Staff nurse and manager training ▪ Kick-off Meeting ▪ Implementation of UPC ▪ PDSA of projects ▪ Mentoring sessions before monthly meeting	+ Improved relationship between manager and staff nurses + Deference to expertise. Promote staff nurse autonomy, expertise, and collaboration Δ Educate team on the process improvement tools Spread/Sustain Plan: 1. Regional Magnet® Recognition Committee to assess and determine unit practice implementation spread

Appendix D

Gap Analysis

Item	Current State	Target State	Action Item
Implementation of unit-practice council	Lack of UPC in MCH nursing units	Implement UPC in seven MCH nursing units	Create plan for implementation
Data	Pre-intervention data for co-leads: 1. Opportunities to participate a. Nurse 2.9 b. Manager 3.2 2. Involved in internal governance a. Nurse 3.4 b. Manager 2.6 3. Opportunity to serve on committee a. Nurse 3.4 b. Manager 3.4	10% increase post-intervention	PES-NWI survey of co leads
Standard work	Lack of standardization and tools to support co-leads	Standard toolkit to support implementation of unit-practice councils	Develop toolkit for implementation of unit-practice councils Leadership development with the managers and nurses to develop co-lead roles

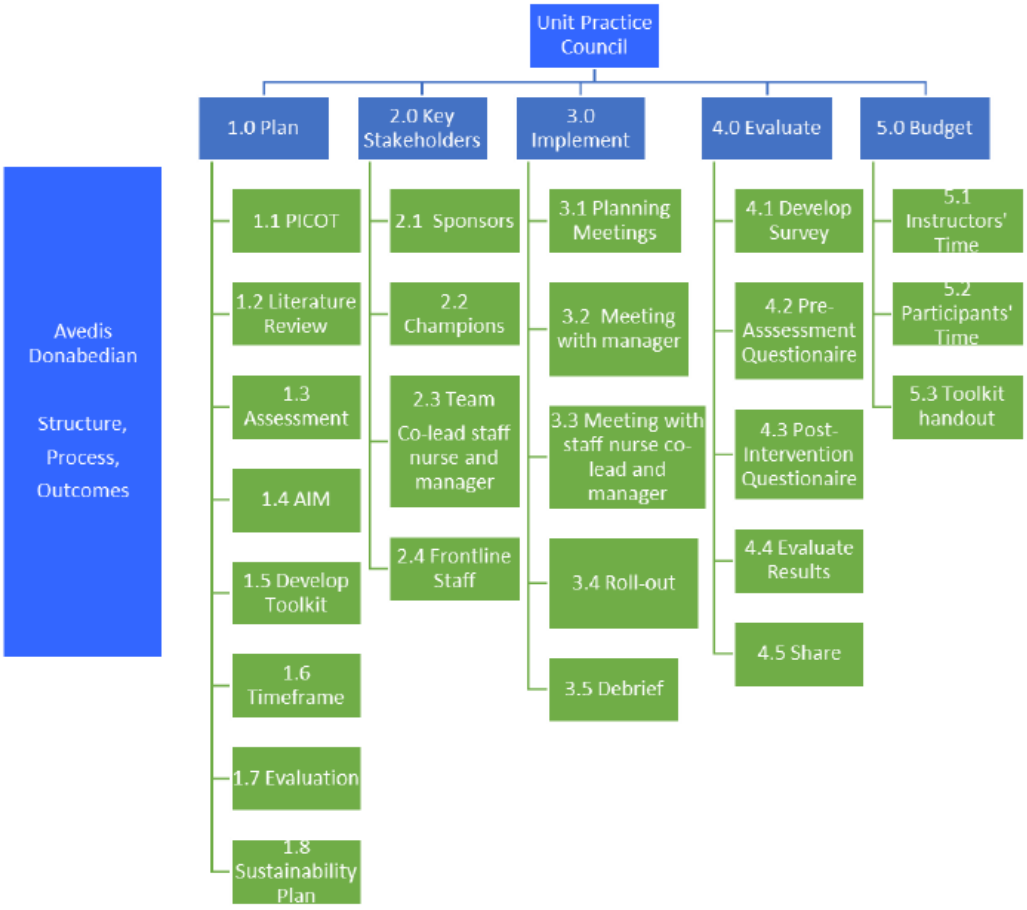
Appendix E

Gantt Chart

Deliverable	Responsible for Deliverable	2019												2020											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Semester 1: Spring 2019																									
Identify DNP projects of interest	Pavna Sloan																								
Literature review of potential DNP projects	Pavna Sloan																								
Literature review of evidence based pratice	Pavna Sloan																								
Discuss DNP project of interest with CNE (Bi-monthly)	Pavna Sloan																								
Semester 2: Summer 2019																									
Commit to project	Pavna Sloan																								
Meet with Key Stakeholders (Bi-monthly)	Pavna Sloan																								
Monthly updates at Peer Group Meeting	Pavna Sloan																								
Update CNE of DNP of project analysis (Bi-monthly)	Pavna Sloan																								
Complete Statement of Determination	Pavna Sloan																								
Complete IRB	Pavna Sloan																								
Semester 3: Fall 2019																									
Develop PICOT for DNP Project	Pavna Sloan																								
Develop Gantt Chart for DNP Project	Pavna Sloan																								
Develop Workbreakdwon Structure for DNP Project	Pavna Sloan																								
Develop SWOT for DNP Project	Pavna Sloan																								
Meet with Key Stakeholders (Bi-monthly)	Pavna Sloan																								
Monthly updates at Peer Group Meeting	Pavna Sloan																								
Monthly updates to CNE	Pavna Sloan																								
Observe Organizations with current Unit-Based Councils	Pavna Sloan																								
Semester 4: Spring 2020																									
Meet with Key Stakeholders (Bi-monthly)	Pavna Sloan																								
Monthly updates at Peer Group Meeting	Pavna Sloan																								
Monthly updates to CNE	Pavna Sloan																								
Pre-Survey Data Collection (Pre-Intervention)	Pavna Sloan																								
Collate Data Results	Pavna Sloan and Regional Practice Leader																								
Create Toolkit	Pavna Sloan and Regional Practice Leader																								
Implementation	Pavna Sloan and Regional Practice Leader																								
Semester 5: Summer 2020																									
Evaluation plan	Pavna Sloan and Regional Practice Leader																								
Post Survey	Pavna Sloan																								
Collate Post Survey Results	Pavna Sloan and Regional Practice Leader																								
Meet with Key Stakeholders (Bi-monthly)	Pavna Sloan																								
Monthly updates at Peer Group Meeting	Pavna Sloan																								
Monthly updates to CNE	Pavna Sloan																								
Semester 6: Fall 2020																									
Sustainablity Plan	MCH Directors																								
Meet with Key Stakeholders (Bi-monthly)	Pavna Sloan																								
Monthly updates at Peer Group Meeting	Pavna Sloan																								
Monthly updates to CNE	Pavna Sloan																								
Draft Final DNP Project Paper: October 15																									
DNP Final Presentation																									
Electronic Portfolio																									
Repository Submission																									
Final Presentation: December																									
Graduation: December																									

Appendix F

Work Breakdown Structure



Appendix G

SWOT Analysis

Strengths	Weaknesses
Nursing and Manager partnership Implementation of Evidence-Based Practice Strategic goal for system shared governance implementation System process improvement Increase communication Exceptional patient care	Lack of formalized process Time consuming Size of unit Culture of unit "Silo" point of view Aging workforce, potential future shortage Organizational focus on "do more with less"
Opportunities	**Threats**
Achieve Magnet Recognition Program® Increased patient satisfaction Improved nursing engagement Improved clinical outcomes Decreased harm to the patient Decreased nurse turnover	Reputation Funding Nurse availability

Appendix H

Letter of Support from Organization

KAISER PERMANENTE

July 29, 2019

Jodi Galli, MSN
Kaiser Foundation Hospital
Kaiser Walnut Creek Medical Center
1425 South Main Street
Walnut Creek, CA 94596

Re: Pavna Sloan

Pavna Sloan is in the EL-DNP Program at the University of San Francisco. I agree with Pavna completing her practicum hours at Kaiser Permanente Medical Center.

Sincerely,

Jodi Galli, MSN
Kaiser Walnut Creek Medical Center
Chief Nurse Executive

Appendix I

Responsibility/Communication Matrix

Deliverable	Audience	Communication Type	Description	Delivery Method	Frequency	Owner
Project plan and timeline	Chief Nursing Executive	Meeting	Discussion	In-person	Bi-monthly	P. Sloan
Project plan and timeline	MCH Directors	Presentation	Discussion	In-Person	Monthly	P. Sloan
Project Plan and timeline	DNP Committee Chair	Meetings	Discussion	Zoom	Bi-monthly	P. Sloan
Implementation Plan	Co-leads, nurse and manager	Meetings and Presentations	Training	In-Person	Monthly	P. Sloan
Unit Practice Council Implementation	UPC Team	Meetings and presentation	Training	In-Person or Virtual	Monthly	P. Sloan

Appendix J

Budget

Item	Description	Cost
Toolkit	Project Manager time to create toolkit	$100*6 hours* 5 months =$3,000
Training for co-leads, manager and nurse	4 hour Training 7 nursing units 5 managers 7 nurse co-leads	Project Manager ($100*4*7) = $2,800 Manager (co-lead) ($90*4*5) =$1,800 Nurse (co-lead) ($90*4*7) =$2,520 = $7,120
Kick-off Meeting	Hours per meeting: 4 Number of Teams: 7	Project manager: ($100*4) = $400 Manager and nurse co-lead: ($90*2*4) = $720 Staff nurses: ($90*3*4) = $1080 $2,200 * 7 teams = $15,400
Mentorship	Hours per meeting: 1 Number of Teams: 7 Number of months: 4	Project manager: ($100*1*7) = $700 Manager and nurse co-lead: ($90*2*1*7) = $1,260 = $1,960
Monthly Meetings	Number of months: 4 Hours per meeting: 4 Number of Teams: 7	Project manager: ($100*4*4) = $1,600 Manager and nurse co-lead: ($90*2*4*4) = $2,880 Staff nurses: ($90*3*4*4) = $4,320 $8,800 * 7 teams = $ 61,600
Supplies	Supplies for projects	$50 * 7 teams = $350
TOTAL Cost		$89,430

Appendix K

Cost/Benefit Analysis

Return on Investment: Benefits/Cost Ratio	$616,000/$375,590 = 1.64					
Cost Analysis: Cost/Participants	**$ 375,590/33 = $11,381**					
Cost Avoidance		**$ 616,000**	**$ 616,000**	**$ 616,000**	**$ 616,000**	**$ 2,464,000**
	Base	Year 1	Year 2	Year 3	Year 4	Total
RN Turnover	$ 88,000	$ -	$ -	$ -	$ -	$ 88,000
RN Orientation less non-prod hours	$ 15,120	$ -	$ -	$ -	$ -	$ 15,120
Nurse Co-Lead less non-prod hours	$ 20,160	$ 30,240	$ 30,240	$ 31,147	$ 31,147	$ 142,934
Manager Co-Lead less non-prod hours	$ 21,600	$ 21,600	$ 22,248	$ 22,248	$ 22,248	$ 109,944
Staff Nurse Participation less non-prod hours	$ 60,480	$ 90,720	$ 90,720	$ 93,442	$ 93,442	$ 428,804
Project Manager time for creating and developing a toolkit	$ 3,000					$ 3,000
Project Manager time for implementation	$ 22,400	$ 2,800				$ 25,200
Supplies	$ 2,800	$ 4,200	$ 4,200	$ 4,200	$ 4,200	$ 19,600

Appendix L

Pre- and Post-Intervention Data Collection Tool

Nurse Participation in Hospital Affairs	
Survey Items	Key: 1 = Least engaged, 2 = Somewhat engaged, 3 = Moderately engaged 4 = Most engaged
1. Career development/clinical ladder opportunity	
2. Opportunity for staff nurses to participate in policy decisions	
3. A chief nursing officer which is highly visible and accessible to staff,	
4. A chief nursing officer equal in power and authority to other top-level hospital executives	
5. Opportunities for advancement	
6. Administration that listens and responds to employee concerns	
7. Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees)	
8. Staff nurses have the opportunity to serve on hospital and nursing committees	
9. Nursing administrators consult with staff on daily problems and procedures	
Copyright © 2016 Press Ganey, 2016 NDNQI RN Survey with Practice Environment Scale Cited in: Lake, 2002; Brooks Carthon, et al., 2019; Kutney-Lee, et al., 2016	

Appendix M

Results

Survey Items	Key: 1 = Least Engaged 2 = Somewhat Engaged 3 = Moderately Engaged 4 = Most Engaged					
	Pre-Intervention Assessment, Mean (Manager)	Post-Intervention Assessment, Mean (Manager)	Variance	Pre-Intervention Assessment, Mean (Staff Nurse)	Post-Intervention Asessment, Mean (Staff Nurse)	Variance
1 Career development/clinical ladder opportunity	3.4	3.6	20%	3.1	3.3	14%
2. Opportunity for staff nurses to participate in policy decisions	3.2	3.6	40%	2.9	3.4	57%
3. A chief nursing officer which is highly visible and accessible to staff,	2.8	2.4	-40%	1.9	1.9	0%
4. A chief nursing officer equal in power and authority to other top-level hospital executives	3.2	2.4	-80%	2.6	2.3	-29%
5. Opportunities for advancement	2.8	4.0	120%	3.1	2.7	-43%
6. Administration that listens and responds to employee concerns	3.4	3	-40%	3.1	3.3	14%
7. Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees)	2.6	3.8	120%	3.4	3.7	29%
8. Staff nurses have the opportunity to serve on hospital and nursing committees	3.4	3.6	20%	3.4	3.7	29%
9. Nursing administrators consult with staff on daily problems and procedures	3.2	3.6	40%	2.9	3.1	29%

***blue shade indicates the three statements evaluated for engagement**

Appendix N

Signed Statement of Non-Research Determination Form

DNP Statement of Non-Research Determination Form

Student Name:___**Pavna Sloan**_____

Title of Project: Improve nurse engagement through unit practice council

Brief Description of Project: Kaiser Permanente Northern California Hospitals will implement unit practice councils for their maternal child health nursing units to improve nurse engagement by 10% from pre- to post-intervention. The intervention will be a toolkit to help co-leads, nurse and manager on tools to implement unit practice councils. The nurse co-lead will complete a survey pre- and post-intervention. Descriptive statistics will be collected on nursing units, size, beds, and average daily census.

A) Aim Statement: The Kaiser Permanente Northern California Hospitals, Maternal Child Health Nursing Units, will improve nurse engagement by 10% by implementing evidence-based unit practice councils by the third quarter of 2020.

B) Description of Intervention: The intervention is the toolkit to support the c-leads, nurse and manager to implement unit practice councils to increase nurse engagement.

C) How will this intervention change practice? The toolkit is an evidence-based practice to improve nursing practice and increase nurse engagement.

D) Outcome measurements: Increase nurse engagement by 10% from baseline to intervention. The survey will be collected pre-and post-intervention.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

✓ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	✓	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	✓	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	✓	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	✓	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	✓	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	✓	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	✓	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	✓	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	✓	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print):

_____Pavna Sloan _____

Signature of Student: _____ *Pavna Sloan* **_____DATE___8/10/19_____**

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print): Dr. Elena Capella

Signature of Supervising Faculty Member (Chair):

Elena Capella **DATE 08/10/19**

Appendix O

The Northern California Hospital's Research, Compliance, and IRB Administration

October 7, 2019

Subject: RDO KPNC 19 – 137 Pavna Sloan
Title: Improve Nurse Engagement through Unit-Practice Councils in MCH

Dear Ms. Sloan:

As a Research Determination Official (RDO) for the Kaiser Permanente Northern California region, I have reviewed the documents submitted for the above referenced project. The project does not meet the regulatory definition of research involving human subjects as noted here:

[X] Not Research

The activity does not meet the regulatory definition of research at 45 CFR 46.102(d):

Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

[ ] Not Human Subject

The activity does not meet the regulatory definition of human subjects at 45 CFR 46.102(f):

Human subject means a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information.

Therefore, the project is not required to be reviewed by a KP Institutional Review Board (IRB). This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. Also, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed.

Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Sincerely,

David C. Matesanz

Director
Research Compliance and IRB Administration
Financial Conflict of Interest Officer
Kaiser Permanente
NCAL Regional Compliance, Ethics, & Integrity Office
1800 Harrison St., 10th Floor, Oakland, CA 94612

Appendix P

Unit Practice Council Toolkit

UNIT PRACTICE COUNCIL TOOLKIT

Abstract

Guide on how to set up councils in NCAL Medical Centers

Pavna Sloan, DNP(c), MSN, RNC-OB, NEA-BC

KAISER PERMANENTE
PATIENT CARE SERVICES
NORTHERN CALIFORNIA

FOR MANAGEMENT USE ONLY – DO NOT DISTRIBUTE

MCH – Unit Practice Councils

Manager Playbook – 2020

Table of Contents

KAISER PERMANENTE
PATIENT CARE SERVICES
NORTHERN CALIFORNIA

FOR MANAGEMENT USE ONLY – DO NOT DISTRIBUTE

Introduction

Tim Porter-O'Grady and Sharon Finnegan first published on the topic of shared governance in 1984. Shared governance is a nursing practice model for professional practice based on the principles of partnership, equity, accountability, and ownership. It is a nonhierarchical structure for nursing, which enables the profession to come together in purpose and discipline. In the past thirty-five years, thousands of health care organizations have implemented shared governance.

Unit practice council (UPC) is a format for organizations to fulfill the shared governance model required by the ANCC Magnet Recognition Program®. This forum allows nurses to work collaboratively with their managers to improve nursing practice by implementing evidence-based practice. The UPC model provides a platform for issues to be resolved closest to the point of patient care and by the staff delivering the care. UPC places the responsibility, authority, and accountability for practice-related decisions in the hands of the individuals who will operationalize the decision.

As Kaiser Permanente Northern California prepares for the Magnet recognition journey for all medical centers, shared governance and established unit practice councils will be instrumental in engaging staff in meaningful and purposeful ways about the work they do.

Benefits of Unit Practice Councils

1. Increased staff engagement
2. Lower staff turnover
3. Increased job satisfaction
4. Lower staff burnout rates

Benefits for the Staff Nurse Co-Chair

1. Staff nurse has autonomy and is empowered to influence change in the unit
2. Staff nurse has a sense of ownership of the work in the unit
3. Staff nurse is the face and voice of change in the unit
4. Staff nurse creates the agenda based on knowledge of the unit's needs
5. Staff nurse acts as lead for the unit

Unit Practice Council Composition

Membership	1. Staff Nurse Co-Lead 2. Manager Co-Lead 3. One nurse per shift (If there are no applicants for a specific shift, other applicants will be selected) 4. Educator 5. Optional: Ancillary Staff (Unit Assistant or Techs), Assistant Nurse Manager 6. Optional: MD partner
Time Commitment	4 hours/month

Membership Selection	Membership is determined by the Management Team through an application process Members serve 2-year terms Current members can reapply for new terms on the Council 50% of existing council members to stay on team
Appointed Positions	Chair Secretary
Charter	Every Council must have a charter that outlines the • Purpose • Scope • Membership Application • Process • Oversight • Decision Making • Ground Rules

Meeting Tools

a. Template Agenda and Meeting Notes/Action Items
    a. Each meeting should have an agenda the staff nurse co-lead and manager co-lead agree on
    b. Each meeting should have notes and action items for each meeting
    c. Examples for agenda and meeting notes are located under Samples

b. Sample Project Tracker
    a. Project tracker is used to track projects and status
    b. Project tracker sample is located under Samples

c. Reaching consensus
    a. Consensus will be used for decision-making
    b. Chairs to lead the discussion
    c. Actively participate in decision-making
    d. "Let's try it" attitude
    e. Vote with thumbs up or thumbs down

AIM Statement

1. Measurable
2. Time-specific

Plan, Do, Study, Act (PDSA)

PDSA is an Institute of Healthcare Improvement (IHI) process for implementing change and performance improvement initiatives. Steps in the PDSA Cycle:

Step 1: Plan 1. Plan the test or observation, including a plan for collecting data. 2. State the objective of the test. 3. Make predictions about what will happen and why. 4. Develop a plan to test the change. (Who? What? When? Where? What data need to be collected?)	**Step 2: Do** 1. Try out the test on a small scale. 2. Carry out the test. 3. Document problems and unexpected observations. 4. Begin analysis of the data.
Step 3: Study 1. Set aside time to analyze the data and study the results. 2. Complete the analysis of the data. 3. Compare the data to your predictions. 4. Summarize and reflect on what was learned.	**Step 4: Act** 1. Refine the change, based on what was learned from the test. 2. Determine what modifications should be made. 3. Prepare a plan for the next test.

Project Management

Forming teams: Effective teams include members representing three different kinds of expertise within the organization: system leadership, technical expertise, and day-to-day leadership.

There may be one or more individuals on the team with each kind of expertise, or one individual may have expertise in more than one area, but all three areas should be represented in order to drive improvement successfully.

Expertise	Description	Role
Clinical Leader	Teams need someone with enough authority in the organization to test and implement a change that has been suggested and to deal with issues that arise.	The team's clinical leader understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.
Technical Expertise	A technical expert is someone who knows the subject intimately and who understands the processes of care.	Provide additional technical support by helping the team determine what to measure, assisting in design of simple, effective measurement tools, and

		providing guidance on collection, interpretation, and display of data.
Day-to-Day Leadership	A day-to-day leader is the driver of the project	Understands the details of the system, but also the various effects of making change(s) in the system.

Project Sponsor is the executive authority of the project. They provide resources and overcome barriers on behalf of the team and provide accountability for the team members.

The Sponsor is not a day-to-day participant in team meetings and testing but should review the team's progress on a regular basis.

Setting Aims: The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

Establishing Measures: Teams use quantitative measures to determine if a specific change actually leads to an improvement. Use a balanced set of measures for all improvement efforts: outcomes measures, process measures, and balancing measures.

Outcome Measures: How does the system impact the values of patients, their health and wellbeing? What are impacts on other stakeholders such as payers, employees, or the community?

Process Measures: Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

Balancing Measures (looking at a system from different directions/dimensions): Are changes designed to improve one part of the system causing new problems in other parts of the system?

Selecting changes: Ideas for change may come from those who work in the system or from the experience of others who have successfully improved.

Testing changes: The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change. Reasons to Test Changes:

- To increase your belief that the change will result in improvement.
- To decide which of several proposed changes will lead to the desired improvement.
- To evaluate how much improvement can be expected from the change.
- To decide whether the proposed change will work in the actual environment of interest.
- To decide which combinations of changes will have the desired effects on the important measures of quality.
- To evaluate costs, social impact, and side effects from a proposed change.
- To minimize resistance upon implementation

Implementing changes: Implementation is a permanent change to the way work is done and, as such, involves building the change into the organization. It may affect documentation, written policies, hiring, training, compensation, and aspects of the organization's infrastructure that are not heavily engaged in the testing phase. Implementation also requires the use of the PDSA cycle.

Spreading changes: Spread is the process of taking a successful implementation process from a pilot unit and replicating that change in other parts of the organization. During implementation, teams learn valuable lessons necessary for successful spread, including working with people to help them adopt and adapt a change. Spread efforts will benefit from the use of the PDSA cycle. Units adopting the change need to plan how best to adapt the change to their unit and to determine if the change resulted in the predicted improvement.

Unit Practice Council Project Examples

- Journey home
- Skin to skin
- No bathing
- breastfeeding
- Pain management
- Staff recognition
- Unit welcome binder
- MCH skills day
- Fetal Demise
- Throughput
- Late preterm infant core
- New patient white board
- Change in policies to match work-flow
- Change in Pyxis set up
- Education for staff
- Monthly education posters
- Surgical Site Infection roll out
- Cooling therapy
- Waste management
- Supply room revamped

Examples of projects that are not UPC

1. Contractual topics
2. Hiring, salary, staffing and scheduling
3. Regulatory requirements
4. Immediate safety concerns
5. Performance Management

Leadership Tools

https://www.mindtools.com/pages/main/newMN_LDR.htm

1. Manager to coach
    a. Listen
    b. Coach
    c. Guide the team instead of making the decisions
    d. Management support the meeting with their presence
    e. Remove barriers
    f. Collaborate
    g. Stamp of approval for projects
2. Nurse
    a. Self-governance to shared governance
    b. Keep the patient at the center
    c. Implement evidence-based practices

d. Listen to the team
e. Lead by example
f. Respect from colleagues
g. Earn trust
h. Mentoring

3. Change management
   a. Listening for intent
   b. Be curious
   c. Ask clarifying questions

Samples

Charter Template	Sample Charter.docx	
Ground Rules Template	UPC Ground Rules.docx	• *Be on time* • *Begin and end the meeting on time* • *"Be Present" i.e. actively engaged and prepared to participate* • *Place cell phones on silence* • *No backing up to catch up late members* • *Have a timekeeper, facilitator, and minute keeper* • *Purpose identified on the agenda* • *Provide agenda and assignment out prior to council meeting* • *Members must notify chair and nurse manager if unable to attend meeting* • *Council members will speak freely and will listen attentively to others* • *No interrupting each other* • *All comments should be phrased in a positive manner* • *Each council member get their say, not necessarily their way* • *Silence equals agreement* • *Once we agree, we will speak with one voice* • *Members must respect the confidentiality of the council* • *No sidebar conversations* • *No hidden agendas*

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Agenda Template	Project Name Mtg Agenda Example.doc	PROJECT NAME MEETING AGENDA DATE, TIME LOCATION: CALL IN:
Project Tracker Template	Tracking Log.xlsx	**Project Name Tracking Log** **Update DATE** **Open Items**

Objectives

- Objective 1
- Objective 2

Agenda

Time	Topic	Outcome	Lead	Materials
X:00 - X:00		▪ Outcome		
X:00 - X:00		▪ Outcome		
X:00 - X:00		▪ Outcome		
X:00 - X:00	Next Steps	▪ Recap ▪ Next Agenda Topics		

Action Items

#	Action	Owner	Due Date	Status
1				
2				
3				
4				

Decision Log

#	Decisions	Decision Makers	Decision Date	Next Steps
1				
2				
3				
4				
5				

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		# | Date Raised | Group | Topic | Issue 1 3 4 6
AIM Statement	IHITool_Aim_Statement_Worksheet.pdf	**Aim Statement Worksheet** An aim statement is the answer to the first question in the Model for Improvement, "What are we trying to accomplish?" Effective aim statements delineate clear, specific plans for the work ahead. Use the prompts below to write an effective aim statement. Then use the checklist to double-check your work.
Plan Do Study Act Template	QIToolkit_PDSAWorksheet.pdf	**Template: PDSA Worksheet** **Objective:** **1. Plan:** Plan the test, including a plan for collecting data. **Questions and predictions:** • **Who, what, where, when:** **Plan for collecting data:** **2. Do:** Run the test on a small scale. **Describe what happened. What data did you collect? What observations did you make?** **QI ESSENTIALS TOOLKIT:** PDSA Worksheet Institute for Healthcare Improvement · ihi.org **3. Study:** Analyze the results and compare them to your predictions. **Summarize and reflect on what you learned:** **4. Act:** Based on what you learned from the test, make a plan for your next step.

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		Determine what modifications you should make — adapt, adopt, or abandon:
Staff Nurse Questionnaire	UPC Questionnaire.June 20	**Unit Practice Council Questionnaire** **Information** Name: Date: Time: Department: Shift: Thank you: Thank you for your interest in Unit Practice Council. In order to make sure this committee would be a good fit, please answer the following questions. **Questions** Question #1: Why are you interested in Unit Practice Council? Response: Question #2: What qualities do you bring to Unit Practice Council? Response: Question #3: What project ideas would you like to work on? Response: Question #4: What other committees are you on? Response: **Additional Notes** Please enter any additional information you would like us to know about you
Communication Template	E-mail Introduction.LD.docx	*I would like to introduce our brand new* XXXXX *Unit Practice Council. We are recruiting members for the UPC. If you are interested in representing our unit please sign up on the sheet in the* XXXX. *We are looking for one member from each shift.* *The Unit Practice Council improves nursing practice closest to the point of patient care by the nurses delivering the care. Basically,* XXXXX *nurses identifying issues, creating solutions and implementing actions to benefit our unit and patient care.*

		Our first unit practice council meeting has just concluded, and we are so excited to share our first project. *The first project is to improve* XXXX. *We chose this project so that we can improve communication, improve the health and safety of our patients, and transfer patients in a timely manner. We are collecting data, please complete a short survey available in the* XXXX. *The survey will be available from* XXXXXX. *We value your feedback!* *We are all looking forward to doing great things for our unit in the future! If there are any ideas or issues you feel need attention please feel free to bring them to the Unit Practice Council or a member of the UPC.*

Resources

1. Clinical Library
2. Hospital phone list

Appendix Q

Kick-Off Meeting Agenda and Slide Deck

DEPARTMENT UPC MEETING AGENDA

DATE, TIME
LOCATION:

Objectives
▪ Pavna to share UPC with Team Members ▪ 1 Nurse from each shift ▪ Charter ▪ Project to work on ▪ Future meeting dates and times

Agenda

Time	Topic	Outcome	Lead	Materials
11:00 – 11:30	Welcome	▪ Welcome team member ▪ Shared PPT on UPC	Pavna Sloan	
11:30 – 1:00	Project Ideas	▪ Discuss 1st project to work on ▪ Brainstorm ▪ Decide ▪ Next Steps	Team	
1:00 – 1:25		▪ Break		
1:25 – 2:50		▪ Future Meeting – Date/Time/Location ▪ 1st Project: PDSA ▪ Charter	Pavna	
2:50 – 3:00	Next Steps	▪ Recap ▪ Next Agenda Topics: ▪ Email from XXX	Pavna	

Next Steps: Post meeting

Description	Owner	Due Date
1. Send email to staff	XXX	
2. Form	XXX	
3. Add to DIS Board	XXX	

Action Items

#	Action	Owner	Due Date	Status
1	Charter	XXX	XXX	
2	Thank you Cards/Emails	All		

	Thank you to different disciplines that attend meetings			
3				
4				

Decision Log				
#	Decisions	Decision Makers	Decision Date	Next Steps
1	1st Project: Materials/Supplies	Team	XXX	
2	Meeting date/time	Team	XXX	
3				
4				
5				

Shared Governance

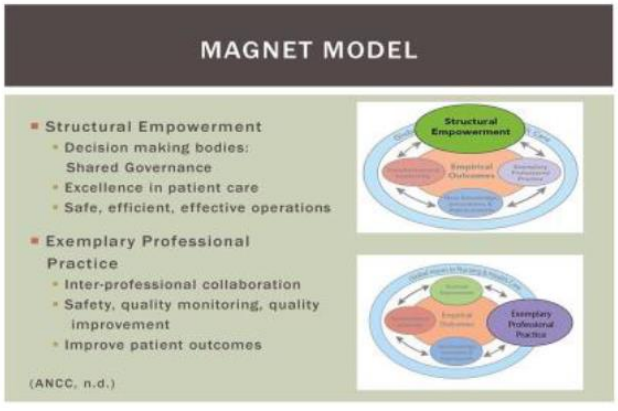
- Founded in the 1980s
- Tim Porter-O'Grady and Sharon Finnegan first published on the topic of shared governance in 1984
- Shared governance is a nursing practice model for professional practice based on the principles of partnership, equity, accountability, and ownership (Ballard, 2010)
- Shared governance is a nonhierarchical structure for nursing, which enables the profession to come together in purpose and discipline (Clavelle, Porter O'Grady, & Drenkard, 2013)
- In the past thirty-five years, thousands of health care organizations have implemented shared governance

ANCC Magnet Recognition Program®

- Unit practice council (UPC) is a format for organizations to fulfill the shared governance model required by the ANCC Magnet Recognition Program®
- Forum for nurses to work collaboratively with their managers to improve nursing practice by implementing evidence-based practice
- The UPC model provides a platform for issues to be resolved closest to the point of patient care and by the staff delivering the care

Why start a UPC? .....the benefits of UPC

- Increase staff engagement
- Increase empowerment
- Improved quality of care
- Improve patient satisfaction
- Increased nursing retention
- Increased job satisfaction
- Enhanced performance
- Deference to expertise
- Magnet Journey
- .... And much more



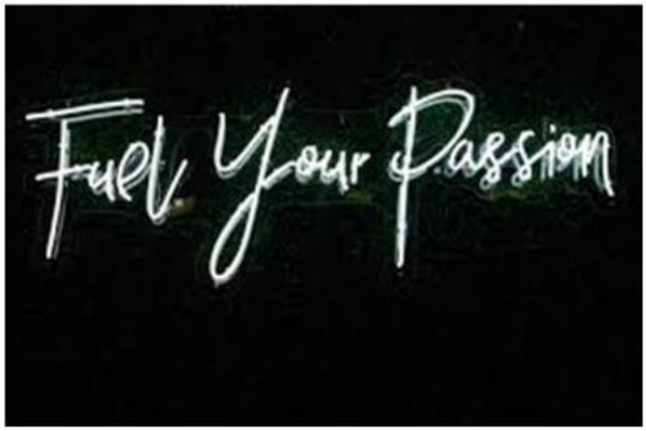
Verbatim comments from KP MCH Nurses on UPC

Purpose & Examples of UPC Projects

Evidenced-based nurse driven projects

Policies & Workflow

- Skin to skin
- Late preterm infant care
- Fetal demise
- Surgical site infection roll out
- Panda checklist
- Panda warmer drawers
- Room organization
- Miso job aide
- Skills Day Planning



Literature supporting UPC

- Organizations that provide nurses with the most significant opportunities to engage in shared governance, such as UPCs, have highly engaged nurses and better patient care outcomes

(Kutney-Lee et al., 2016; Cox Sullivan et al., 2017; Brooks Carthon et al., 2019)

- The studies support engaged nurses are more likely to ensure improved quality of care for their patients, improve patient satisfaction, increased nursing retention, increased job satisfaction, and enhanced performance

(Kutney-Lee et al., 2016)

Data (Kutney-Lee et al., 2016)

- In hospitals with an ANCC Magnet Recognition Program® and a shared governance model (n=46)
  - 22% of nurses described themselves as "moderately engaged,"
  - 78% described themselves as "highly engaged,"
  - 0% responded, "somewhat engaged" or "least engaged
- 100% of nurses employed at ANCC Magnet Recognition Program® facilities report feeling engaged—with zero nurses disengaged
- Hospitals with a shared governance model had higher HCAHPS scores
  - 68% patients most likely to recommend hospitals with the most engaged nurses
- Least engaged nurses reported a higher percentage of job dissatisfaction (43%) compared to highly engaged nurses (13%)

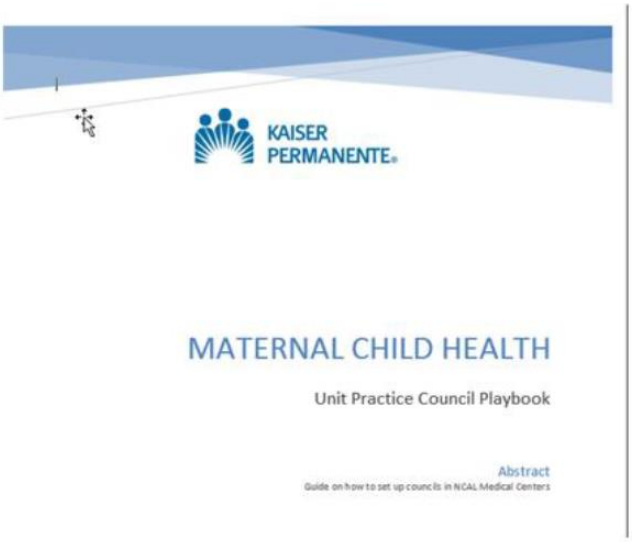
Data (Kutney-Lee et al., 2016)

- The study results show hospitals that provide a shared governance model, such as a unit-based council, have more highly engaged nurses, who are most likely to improve quality of care and are satisfied with their jobs

Toolkit

Toolkit to help manager and nurse to co-lead Unit Practice Council

- Charter
- Agenda
- Membership
- Smart Goal
- Meeting tools
- Coaching Tips
- PDSA tools



Council Structure

Co-Leads:

- Staff RN
- Manager

Participants

- 1 staff nurses from each shift
- ANM
- CNS/Educator

References

- Ballard, N. (2010). Factors associated with success and breakdown of shared governance. *Journal of Nursing Administration, 40*(10), 411–416. https://doi.org/10.1097/NNA.0b013e3181f2eb14
- Brooks Carthon, J.M., Hatfield, L., Plover, C., Dierkes, A., Davis, L., Hedgeland, T., & Aiken, L. H. (2019). Association of nurse engagement and nurse staffing on patient safety. *Journal of Nursing Care Quality, 34*(1), 40-46. https://doi.org/10.1099/NCQ.000000000000034
- Clavelle, J. T., Porter O'Grady, T., & Drenkard, K. (2013). Structural empowerment and the nursing practice environment in Magnet ® organizations. *Journal of Nursing Administration, 43*(11), 566-573. https://doi.org/10.1097/01.NNA.0000434512.81997

References

- Cox Sullivan, S., Norris, M. R., Brown, L. M., & Scott, K. J. (2017). Nurse manager perspective of staff participation in unit-level shared governance. *Journal of Nursing Management 25*(8), 624–631. https://doi.org/10.1111/jonm.12500

- Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., & Aiken, L. H. (2016). Nurse engagement in shared governance and patient and nurse outcomes. *Journal of Nursing Administration, 46*(11), 605–612. https://doi.org/10.1097/NNA.0000000000000412

Questions?