The Effect of a Shared Governance Model on Healthy Work Environment

Among Perioperative Nurses

By

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SHARED GOVERNANCE MODEL

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Abstract

To achieve safe patient care, effective communication among health care team members is needed. Lack of communication is the leading cause of sentinel events in the perioperative setting. Communication between members of the perioperative team — the surgeon, anesthesiologist, circulating nurse, and scrub nurse or technologist affects team collaboration and patient safety.

Communication has been identified as one of the key elements needed to accomplish team collaboration and a healthy work environment. In addition, the following five variables contribute to a healthy work environment: team collaboration, decision making, sufficient staffing, staff recognition, and authentic leadership.

The purpose of this study was to evaluate the effect of a unit-based professional practice council on the perioperative work environment. The aim was to assess communication and team collaboration before and after the implementation of a professional practice council among nurses working in the perioperative setting. A pre and posttest were distributed to a sample of operating room and recovery room nurses. Pre-implementation and post-implementation results were discussed using a t-test however could not be compared due to the variance in sample size and population. A Mann Whitney U test was used to compare pre and post implementation data. A total of 54 nurses completed a pre-implementation packet and a total of 10 nurses completed a post-implementation packet. The mean number of years of experience for the pre data collection group was 20 years, and the post data collection group mean years of experience were 11.5 years. Given the years of experience, job satisfaction, and nurse-assessed quality of care it would appear the pre implementation group had a higher job satisfaction score than the post implementation group. Themes of management support, quality

teamwork and effective communication were identified. Variables of communication, team collaboration, decision making, sufficient staffing, staff recognition, and authentic leadership must be present in order to create healthy work environment.

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SHARED GOVERNANCE MODEL

CHAPTER ONE

Introduction

Safe patient care requires effective communication between health care team members. In 2005 the American Association of Critical Care Nurses (AACN) identified communication as one of the key elements needed to accomplish team collaboration and a healthy work environment. Five other variables were also found to contribute to a healthy work environment: team collaboration, decision making, sufficient staffing, staff recognition, and authentic leadership (Schmalenberg & Kramer, 2008). Lack of communication is the leading cause of 80% of sentinel events in the operating room (Gillespie, Chaboyer & Lizzio, 2008). When operating rooms (ORs) and postoperative recovery units were studied nationwide, they scored lowest out of 15 different types of units in a variety of hospital care settings for experiencing a healthy work environment (Schmalenberg &Kramer, 2008).

Background

Members of the perioperative team most often include a surgeon, anesthesiologist, circulating nurse, and scrub nurse or technologist (Undre, Sevdalis, Healey, Darzi & Vincent, 2006). The Association of Perioperative Registered Nurses (AORN) requires that there be one circulating nurse and one scrub technologist or scrub nurse per procedure and that nursing or support staff be added depending on the complexity of the case and diagnosis of the patient (Conner, Blanchard, Burlingame, Chard, Denhom, Giarrizzo-Wilson, Maxwell-Downing, Mitchell, Ogg & Petersen, 2009).

The perioperative work environment is organized in a way that uses time and space efficiently. Time is allotted in blocks that are needed by the surgeon to complete a surgical case (Richardson-Tench, 2008). The blocks are divided into morning and afternoon sessions, and the

surgeon selects a time session that best fits his or her schedule. Nurses and technicians are assigned to a specific surgical procedural list that is regulated by hourly blocks. The time nurses and surgical technologists arrive for work is regulated by the start of the blocked surgical sessions. The instrumentation scrub technologist or nurse (scrub person) and circulating nurse (circulator) are also assigned to each surgical list. The knowledge of surgical procedures and appropriate equipment that these individuals possess has been found to be determinants of surgery outcomes (Fortunato, 2000).

Perioperative team members are isolated from other hospital unit staff not only by space but by dress (Richardson-Tench 2008). Because the surgery environment must be a sterile field all perioperative staff must wear hospital laundered scrubs, surgical caps, eye protection, and masks; additionally, personnel who scrub to perform procedures are required to complete a surgical hand scrub (Conner, et al., 2009). Following the hand scrub, the surgical scrub team must don sterile gowns and gloves.

Once surgery begins, it is the job of the circulator and the scrub person to anticipate and meet the surgeon's needs in order to help increase the quality and number of surgeries the surgeon is able to perform in a given block of time. The circulator is responsible for retrieving any unsterile supplies and delivering them to the sterile field, and the scrub person is responsible for attending to the surgeon (Richardson-Tench, 2008). An effective scrub nurse or technologist has the procedural expertise that enables him or her to provide the surgeon with needed instrumentation before it is requested. Thus, when a surgical technologist is requested by name for a procedure it is considered a high honor in the operating room and signifies a skilled and proficient scrub person.

The literature expresses the importance of clear communication between members of the perioperative team in collaborative pairs. For example, because of the way their roles interact, communication between the surgeon and the anesthesiologist, whose role is to sustain the patient's life during surgery, is perhaps more important during the procedure than communication between the anesthesiologist and scrub technologist; however, no relationship is more important, to the team overall; the teamwork model is based on collaboration, not hierarchy (Undre et al., 2006).

Timmons and Tanner (2005) published a benchmark study that discusses the hierarchy between the surgeon and the circulating nurse. This hierarchy was brought about by the nurse's "emotional labor" to keep the surgeon satisfied while maintaining a light and jovial atmosphere within the operating room. Although a hierarchical relationship was found between the nurse and the surgeon, none was reported between the surgeon and the scrub person. The researchers suggested this was due to the scrub person's required expertise in instrumentation during surgery. Of note was that the research sample was predominantly female nurses and male technologists.

For a team to provide safe patient care, staff must collaborate in a non-punitive environment characterized by strong, effective communication based on trust and respect (Forsythe, 2007). Effective communication was defined as precise instructions from one health care worker to another, clear communication between surgeon and anesthesiologist, and knowledge of what is needed for procedures as they occur on a surgical list (Undre et al., 2006). According to Undre et al. (2006), perioperative professionals also listed the following as components of effective teamwork: quality communication, non-punitive and meaningful feedback, and high levels of clinical expertise held by team members.

Research has demonstrated that nurses can sometimes be so consumed with technical aspects that the role of patient advocacy was sometimes forgotten (Silén-Lipponen, Tossavainen, Turunen & Smith, 2004). Silén-Lipponen et al. (2004) further identified the inner conflict that nurses may face between advocating for the patient and being tasked with technical skills required to complete patient care. The number of tasks required to complete care and the speed at which care is required can often be overwhelming to the nurse and hence threaten patient safety.

The degree to which an individual enjoys his or her work is defined as *job satisfaction* (McCloskey & McCain, 1987). A study by Schmalenberg and Kramer (2008) revealed that out of 206 different nursing units, perioperative and recovery room nurses held the lowest overall scores for job satisfaction (mean 6.39) compared to the National Magnet Hospital Profile (NMHP; mean 7.77, *p*=.04).

If a team communicates well and possesses a high level of expertise, safe, excellent patient care is an expected outcome (Alfredsdottir & Bjornsdottir, 2008). Patient outcomes are also based on perioperative safety, physiologic responses, and behavioral responses of the patient and family (Conner et al., 2009).

Significance of the Problem

Teamwork quality has been shown to affect how safely patient care is executed (Nadzam, 2009). As a key component of teamwork (Undre et al., 2006), factors that threaten clear communication between team members—including competent nursing care and the pressure to complete surgical procedures in a timely manner and keep productivity high—also threaten patient safety in the OR (Alfredsdottir & Bjornsdottir, 2008; Gillespie & Hamlin, 2009).

According to the AACN (2005), effective nursing communication includes not only interactions between team members but also includes patient advocacy through participating in

building evidence-based policies to guide care. The literature also indicates that effective nurse communication includes having and proficiently using technology knowledge to complement patient care. Breakdowns in communication can lead to decreased job satisfaction, a decreased perception of the quality of patient care, and it can help contribute to an unhealthy work environment; these outcomes have been found in the literature at a higher incidence in the OR compared to other nursing units (Schmalenberg & Kramer, 2008).

Problem Statement

Communication breakdowns affect a team's ability to not only work together but also to attain job satisfaction and deliver safe patient care. Lack of communication has been linked to the incidence of sentinel events in the operating room (Gillespie et al., 2008), and research suggests that patient care outcomes are linked with the tensions and behaviors caused by communication breakdowns between perioperative team members (Coe & Gould, 2008).

In a study on trends of disagreement and aggression between team members in 69 different ORs, half of the respondents surveyed (227 nurses [58%], 38 surgeons [9.7%], 56 anesthesiologists [14.32%], and 70 operating room professionals [17.9%]) reported experiencing aggressive behavior from the surgeon (Coe & Gould, 2008). The researchers used focus groups and a questionnaire to collect data. The focus groups defined *disagreement* as a conflict between two team members that could not be immediately resolved and *aggression* as yelling, malicious talk, bullying, rude behavior, refusal to speak, or purposely ignoring other team members. The questionnaire revealed that 69% of disagreements were between the nurse and surgeon and 52% of disagreements were between the circulating nurse and scrub person. The main sources of disagreement were cases running over their booked time (n=331), availability of surgical blocked time (n=351), availability of the equipment needed to complete cases (n=350), availability of

operating room staff to complete cases (*n*=346), changes in the order of the list of cases (n=336), and availability of the surgeon to do the case (n=323). Approaches reported to cope with aggressive behavior included discussing the problem with a colleague (54.8%), confronting the problem and seeking resolution (52.7%), avoiding confrontation (36.6%), and involving a manager in the problem (24.7%). Only one-fifth of participants expressed they felt the team always practiced patient-centered care (20.4%, *n*=79). In contrast, fewer nurses and physicians believed they had a shared vision of patient focused care (15.9%, *n*=35, *p*<0.008). The group who reported not sharing a common goal of patient care also reported a higher perception of aggression within the OR environment.

In order to develop a culture of safety, health care teams need to communicate in an environment free of intimidation and avoidance (Forsythe, 2007). The most important focus in the creation of a culture of safety is to maintain a patient focus. Forsythe (2007) suggests that the culture of safety is encouraged by members increasing their ability to build partnerships, building trust, having respect for one another, and collaborating with each other. All of these factors work together to help health care professionals deliver safe patient care.

Purpose Statement

The purpose of this study was to evaluate the effectiveness of a shared decision making model designed to increase communication, quality of care, and job satisfaction for team members of a perioperative unit. The specific aims were (a) to assess communication and team collaboration before and after implementation and (b) to assess the perceptions of quality of care and job satisfaction before and after implementation of a professional practice council among OR and recovery room nurses in a perioperative unit.

CHAPTER TWO

Review of Literature

A healthy work environment has been defined by the AACN as one that promotes job satisfaction and excellent patient care (Shirey, 2006a). Variables of the healthy work environment include communication, team collaboration (AACN, 2005), and job satisfaction (Schmalenberg & Kramer, 2008). In the perioperative setting, a healthy work environment is defined as "safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of all the members of the perioperative team" (AORN, 2009, p. 1).

Members of the perioperative team include the surgeon, anesthesiologist, circulating nurse, and scrub nurse or technologist (Undre et al., 2006). Communication between these members impacts the work environment through its effect on team collaboration and patient safety (Forsythe, 2007). Yet, in a study by Schmalenberg and Kramer (2008), perioperative nurses were reported to have the lowest job satisfaction and healthy work environment out of 15 different units studied.

The purpose of this study was to assess communication, team collaboration, and perceptions of patient safety and job satisfaction before and after the implementation of a shared decision-making model among operating room nurses and recovery room nurses working in the perioperative setting.

Databases used for the literature review were CINAHL, EBSCO, Pub Med, Cochrane Database, Health Source: Nursing Academic Edition, Health Source Consumer Edition, and Health Technology Assessments. Keywords used for the literature search were *operating room*, *nurse*, *social support*, *perioperative nurses*, *healthy work environment*, *nurse-physician*, *relationship*, *team-work*, *team collaboration*, *safety*, *work place stress*, *social support*,

leadership, *nurse manager*, *morale*, *job satisfaction*, *nursing practice*, *staffing*, *meaningful recognition*, *decision making*, and *team interaction*. In 2005 the AACN defined *healthy work environment* as one with effective communication, team collaboration, effective decision making, authentic leadership, job satisfaction, and meaningful recognition. These components were found to work collaboratively in establishing a healthy work environment that results in positive patient safety and quality of care outcomes (Schmalenberg & Kramer, 2008).

Communication and Team Collaboration

Nurses should be as skilled in communication as they are in clinical procedures and knowledge (AACN, 2005). Nurses who are skilled in communication are self-aware, respectful, open, trusting, able to inquire, solve conflict, and negotiate with other team members. They are also adept in patient advocacy and active listening (AORN, 2009). In the operating room, a nurse is part of a team that includes the surgeon, scrub technologist, the anesthesiologist, and other health care practitioners (Catchpole, Mishra, Handa, and McCulloch, 2008). Nurses must actively utilize their communication skills in the pursuit of team collaboration in order to achieve a healthy work environment (Ulrich et al., 2007) this means honing the ability to resolve disputes between team members, and between patient and family members if necessary, in order to achieve optimum patient care.

Silén-Lipponen et al. (2004) studied three different cohorts of nursing students who were acclimating to operating rooms in Finland, the United States and England. Acclimation to the OR environment, including acceptance into the OR team, was observed to occur in three progressive stages: understanding the makeup of the perioperative team, gaining membership to the team, and getting a technical orientation to the team (Silén -Lipponene et al., 2004).

When interviewed about their acclimation experiences, students observed that the OR environment was separate from the rest of the hospital and seemed to consist not only of teams by profession (e.g., anesthesia or nursing teams), but it also consisted of the team within the theatre looking after the patient. Students reported that the OR culture was punitive when making errors and that their acceptance as members of the team was strongly linked to finding an experienced, supportive mentor with an encouraging and positive attitude. This mentor's support and positivity motivated students to engage in learning and hence become part of the team. In contrast, students' team membership was hindered by overbearing and substitute mentors.

Once students gained technical orientation to team work, they were able to make observations about how the nurse interacted with other team members and how safe decisions were made in the context of patient care. Students noted that they became more aware of their nurse preceptor's delicate balancing of technical and social skills, timing and precision of actions, strictness as an effective teaching technique, lack or abundance of interaction skills, and of the preceptor's contribution to an atmosphere that was sometimes sullen and restrictive to change in practice. They also observed that the team worked well together but sometimes forgot to prioritize patient-focused care.

The quality of communication between perioperative team members has a significant impact on patient care and team collaboration. In a study conducted to assess the quality of relationships between members of the OR team, participant interviews revealed a distinct difference of opinion held by each group of professionals as to whether members worked as one team or in multiple teams ($p=<0.05$; Undre et al., 2006); 67% of nurses felt that the perioperative team worked as a single unit, but only 33% of scrub personnel and none of the anesthesiologists or surgeons agreed with that assessment. Instead, the majority of scrub technologists, surgeons,

and anesthesiologists believed that multiple specialized teams performed the work of the perioperative team.

Mishra, Catchpole, and McCulloch (2009) developed a tool that measures teamwork in the operating room. The research revealed a correlation between prevalence of adverse events and quality of teamwork and communication (Mishra, et al., 2009).

Undre et al., 2006 analyzed data using a mixed model analysis of variance (ANOVA). The analysis yielded an effect of pairs (F 7,133= 64.92, $p=< 0.001$) such that the quality of communication between the scrub technologist and anesthesiologist, the scrub nurse and circulating nurse, and the surgeon and scrub nurse was perceived to be better than that of the communication between the surgeon and scrub technologist, the anesthesiologist and scrub nurse, and the scrub nurse and scrub technologist. Furthermore, the analysis revealed (F 21,133= 2.92, $p=<0.001$) that the quality of communication between an anesthesiologist and surgeon, and between a scrub nurse and scrub technologist was perceived to be lower than the overall quality of communication between other pairs. These results did not factor in the importance of the communication between those pairs. The importance rating of communication between the surgeon and the anesthesiologist surpassed the quality rating of that same pair (F 7,140= 5371, $p=<0.001$).

In addition, 75% of professionals interviewed endorsed a collaborative versus hierarchical approach to teamwork (Undre et al., 2006) when sharing their belief that in the most ideal OR team structure the anesthesiologist and surgical and nursing team members share a portion of the responsibility of care.

Research revealed that an absence of response to nurse inquiries and the nurse's repeated soft-spoken requests reinforced the tension and hierarchy between the circulating nurse and

surgical team members (Gardezi, Lingard, Espin,Whyte, Orser & Baker, 2009). Researchers in

the United Kingdom conducted private interviews with a sample of 14 nurses and 3 operating

room technologists over a nine-month time period that revealed the phenomena of the "hostess

role" (p. 85) or the nurse's unspoken obligation to "keep the surgeon happy" or "not do anything

to upset the surgeon" in the course of a work day. Rather, the goal of the nurse was to keep the

atmosphere of the operating room theatre jovial and the mood light (Timmons & Tanner, 2005).

Surgical technologists were not expected to fulfill the hostess role as were the circulating nurses

in this study. The sample included 15 female subjects and 2 male subjects, which may suggest

gender played a factor in the findings. Although this study is cited as a benchmark in many other

research papers, it was a qualitative study and therefore had a low level of evidential

significance. The scrub technologist may also hold a hierarchical role over the circulating nurse

in the OR because of the required expertise in technology and skill that is developed by working

directly alongside the surgeon (Richardson-Tench, 2008).

One study tested the effect of nurse-physician communication on job satisfaction for

nurses in the ambulatory care setting (Wilkinson & Hite, 2001). The authors concluded there was

not a statistically significant relationship ($p= 0.286$) between the nurse-physician relationship

and nurses' job satisfaction. Although the authors indicated that job satisfaction and nurse-

physician communication were important predictors of healthy work environment, this

hypothesis has not been tested in the OR.

Patient Safety

According to the American Nurses Association's (ANA) nursing code of ethics, the nurse

must strive to protect health, safety and rights of the patient (2005). The AORN also embraces

safety with a patient-centric safety culture as part of its guidance statement for practice (Conner

et al., 2009). The culture of safety is made up of five subcultures: reporting, flexibility, learning, wariness, and justice.

Creating a culture of safety requires equality among members of the health care team (Forsythe, 2007). Other variables that strongly foster a culture of safety within the perioperative environment include trust, respect, and collaborative relationships between team members. This can only be accomplished in an atmosphere where all members have a voice and communication is free of intimidation and avoidance.

Research has defined the following as important elements of protecting patient safety: team expertise, specific skills training for cases, and years of experience in perioperative nursing (Alfredsdottir & Bjornsdottir, 2008). Factors that threaten safety within in the operating room were increased speed of task, lack of control of circumstances (defined as trying to complete too many tasks at once), decreased staffing, and unclear role expectations (Alfredsdottir & Bjornsdottir, 2008). Researchers have noted a juxtaposition between increased productivity and patient safety, in that the demand for productivity limits time for continuing education and training nurses with the expertise skills needed to provide competent care (Alfredsdottir & Bjornsdottir, 2008; Gillespie & Hamlin, 2009).

Nurses must be patient advocates and have the ability to make decisions and voice concerns about patient safety as they arise. For Lindh, Severinsson, and Berg (2009), this is better accomplished as nurses develop three moral strengths: the courage to act on their convictions of what is best for the patient, an ability to develop a relationship with the patient that allows nurses to advocate their preferences in patient care, and the flexibility to do what is right in an emergency situation or unexpected event. In order to foster moral strength, effective managerial support is needed.

Effective Decision Making

Decision making was defined as the nurse's commitment to being involved in developing policy changes and implementing those changes to affect positive patient care outcomes (Ulrich et al., 2007). The nurse involved in effective decision making also advocates for patient care and is accountable for his or her professional practice (AORN, 2009). Executing professional and competent decisions requires an element of trust within a perioperative team to be effective (Gillespie & Hamlin, 2009).

Gillespie and Hamlin (2005) reviewed the literature to define competence in the perioperative nurse. Gillespie and Hamlin (2005) included nurse managers, staff nurses and surgeons who worked in the perioperative setting. In summary, the sample identified competence was defined by six components: practical knowledge, aesthetic knowledge, communication, teamwork, clinical co-ordination, and leadership. Practical knowledge is the ability to anticipate patient needs based on past experience and clinical expertise (Chard, 2000; Sigurdsson, 2001; Bull & FitzGerald, 2006). Aesthetic knowledge expanded beyond the technical role of the nurse to incorporate roles of patient advocacy and patient caregiver (Gillespie & Hamlin, 2009; Richardson-Tench, 2007; Sigurdsson, 2001). In deciding what is best for the patient, the OR nurse may be conflicted in making the accurate decision based on the juxtaposition of practical and aesthetic knowledge. Decision making can also be impacted by personal and work environment stress (Fox, 2003).

Authentic Leadership

A healthy work environment and effective teamwork cannot exist without a supportive leader (Cox, 2001; AACN, 2005). Authentic leaders understand their function, practice reputable values, lead with compassion, establish lasting relationships, and are self-disciplined and

consistent in their approach (Shirey, 2006b). They are able to be true to their core values and identity in practice. The more these leaders are true to their values, the more authentic they become.

Nurse leaders are often selected and hired on the basis of excellent patient care and consistent positive patient outcomes because it is assumed that the ways a nurse manages patient care will translate into how they will manage a nursing unit (Laurent, 2000). Although positive patient outcomes are the ultimate goal of excellent nursing, further training is needed to become a skilled nurse manager (Schmalenberg & Kramer, 2009).

Schmalenberg and Kramer (2009) identified ten attributes of an excellent nurse manager as reported by staff nurses, managers, and physicians. These attributes were included the ability of the nurse manager to act as the peace keeper in the nurse-physician relationship and in relationships with other units in the hospital. It was also found that an excellent manager was able to match expected workload with sufficient staffing and represent their staff's opinions and concerns in meetings with other departments. Managers who were available for staff to voice their concerns in privacy and confidence and who practiced the values held by the organization were held in high esteem. The researchers concluded that nurse managers should promote teamwork and encourage staff to take advantage of continuing educational opportunities. The nurse manager's ability to provide the equipment needed to deliver safe patient care was found to be important, as was the manager's ability to provide staff with specific examples of needed improvement or of work excellence (Schmalenberg & Kramer, 2009).

Transformational Leadership and Meaningful Recognition

In order to achieve a healthy work environment, the nurse manager must share a common purpose or end goal with his or her staff (Day, Minichiello &Madison, 2007). Furthermore, by

consulting nurses before implementing a decision the manager recognizes staff members' input

as a meaningful part of determining excellent patient care and fosters further team collaboration

(Day et al., 2007). This type of leadership was defined as *transformational leadership* (Nielsen,

Yarker, Randall & Munir, 2009). According Nielsen, Randall, and Munir (2009)

transformational leadership has a direct impact on employees' self-efficacy and overall well-

being. Self-efficacy is employees' assurance in their own ability to complete a task while being

able to handle stressors of the environment around them (Nielsen et al., 2009). When a team of

health care professionals has this ability, it is called *team-efficacy* (Nielsen et al., 2009).

Meaningful recognition could be a public acknowledgement of a staff member's

excellence in patient care. In one study done with neonatal intensive care unit nurses, managers

recognized staff members for going above and beyond their roles. Research revealed a decrease

in nurse turnover as a result (Rikli, et al., 2006). Clevenger (2008) discussed a recognition

program implemented for preceptors with the hope of increasing job retention of OR nursing

staff. The author claimed the program affirmed preceptors in their roles and improved morale in

the nursing unit, but no formal research was conducted to support these statements. Further

research of how a leader's meaningful recognition of staff is needed to be able to implement

successful findings.

Appropriate Staffing

Part of developing healthy work environment requires managers to consider the

appropriate number of personnel needed to staff a unit. Staff nurses also need to possess the skill

set necessary to complete the tasks required to produce positive patient care outcomes

(Schmalenberg & Kramer, 2009). The AACN (2005) describes appropriate staffing as the

partnering of patient care demands with nursing skill and capability. Further, AORN standards

suggest that sufficient staffing decisions are made possible by the nurse manager's adequate planning and consideration of the skill mix and number of employees needed and of budgeting and scheduling allowances (Conner et al., 2009).

Although every institution is clinically unique, general principles can be applied to calculate staffing of perioperative care areas. During surgery, the AORN requires that there is one circulating nurse and one scrub technologist or scrub nurse per procedure; additional nursing or support staff may be needed depending on case complexity and patient diagnoses. Having the tools available to estimate staffing needs is very helpful to a nurse manager. Research has shown that by utilizing OR systems data or anesthesia billing information, a nurse manager is able to make an accurate estimate of staffing needs of the second shift (3pm to 11pm) in the OR (Dexter & Epstein, 2003). Accurate staffing was seen to lead to a decrease in overall cost to the department and ineffective work production.

A survey of teaching and community operating room directors in the United States found a 10% vacancy rate for RNs and 8% vacancy rate for surgical technologists (STs; Saver, 2008). The survey was distributed to 312 hospitals throughout the United States. Scores were compared and discussed. The staffing ratio of RN to ST was 62:38 in 2008 and had remained consistent since 1996. Overall, RN vacancies in the OR had decreased from 4.1 to 3.3; however, the overall number of ST vacancies rose from 1.5 in 2007 to 2.1 in 2008. The average turnover rate for RNs was 7% while the average ST turnover rate was 5%. In general, the use of travel or contract staff decreased from 32% in 2007 to 22% in 2008. As a result of vacancies, shortages, and turnovers, the amount of overtime hospitals utilized increased. Given the data, the author surveyed how many hospitals would hire new graduate nurses to help bridge the staffing gap and found that 70% of teaching hospitals hire new graduate nurses in comparison to 55% of community

hospitals. Collectively, 14% of hospitals would not hire new graduate nurses or nurses without previous OR experience.

Given the staffing shortage and the challenges of meeting patient care needs, skill diversity and expertise must also be considered. Skill diversity and expertise affect how well a surgical department is staffed. In England, the inability to provide surgeons with multi-skilled staff was a predictor of case cancellations (Lloyd, 2008). When hiring staff with a limited skill mix, orientation materials help to strengthen staff skill mix and therefore further enhance quality of care.

Quality of Care

Conner et al. (2009) stated the goal of perioperative nursing practice was to help patients and their families attain a level of health equivalent to or exceeding pre-surgery levels. Quality of care was defined by patient outcomes based on perioperative safety, physiologic response, and behavioral responses of patients and families. Examples of perioperative safety include patient freedom from signs and symptoms of injury or infection, correct medication administration, adequate tissue perfusion, adequate fluid and electrolyte balance, and efficient cardiopulmonary perfusion during perioperative care (Conner et al., 2009). In addition, during the postoperative phase patients will display sufficient pain control and returned neurological function. Patients and family members will also be given the tools to understand postoperative care, rehabilitation and possible complications that may occur.

In a study of new staff nurses, quality of care had a positive relationship to excellent orientation, mentoring, and opportunities for continued education once orientation had been completed (Boswell, Lowry, & Wilhoit, 2004). The authors conducted a study of 67 nurses from 8 hospitals in a 12-month period. The research instrument used was a series of 17 questions

identified from a literature search as being important to new hire nurses and nurse managers.

Continuing education was rated as "very important" by the majority of nurses interviewed

(n=40). Forty-two percent of participants stated they were comfortable engaging in nurse-

physician relations and 58% indicated they were not. In addition, 27 participants felt comfortable

communicating with physicians only if they knew the outcome of the communication could be

predicted. The authors concluded that confidence was a factor in initiating nurse-physician

communication. Eleven nurses who were uncomfortable communicating with physicians avoided

calling the medical doctor when it was indicated; suggesting that quality of care may be

threatened when new nurses are too intimidated to initiate nurse-physician communication.

Soderhamn and Idvall (2003) perceived threats to quality of care in the operating room to

include communication with physicians and fear of inflicting accidental harm to a patient. The

ability of the nurse to communicate a patient's needs has an effect on perceptions of the nurse's

quality of care. Research found that the ability of a perioperative nurse to convey the patient's

postoperative pain assessment and intervene with pain medication had a positive relationship

with the nurse's perception of quality of care (Soderhamn & Idvall, 2003). Likewise, the

strongest variables of quality care that patients perceived were pain management and temperature

(Leinonen, Leino-Kilpi, Stahlber, & Lertola, 2001). Patients expressed that their nursing care

could be improved by allowing patients more initiative, giving them more encouragement, and

providing them with more educational activities. Patients also expressed the need for increased

opportunities to ask questions about their care. Some patients commented that they had very little

influence in decisions about their care. This indicates that the nurse's ability to advocate for the

patient plays an important role in quality of care.

Job Satisfaction

Job satisfaction has many key elements in the arena of nursing. Job satisfaction was defined as the degree to which employee enjoys his or her work (McCloskey & McCain, 1987). There are several intrinsic and extrinsic components of job satisfaction (Healy & McKay, 2000; Taris & Feij, 2001); some intrinsic components were employees' value of self-expression, job variety, and autonomy, and extrinsic components include aspects that are naturally conducive to work such as wages and opportunities for promotion.

Research revealed a model of resilience as an important factor to job satisfaction in the OR (Gillespie et al., 2007). Resilience, or the ability to adapt in the midst of adversity (Tusaie & Dyer, 2004); values of hope and self-efficacy, coping, control, and competence were highly valued in the ability to maintain resilience in and among operating room nurses (Gillespie et al., 2007). The authors found that these values had a significant impact on job satisfaction in the operating room. Conversely, research showed a negative relationship between job stress and job satisfaction (Grant, Donaldson & Larsen, 2006). Furthermore, nurses who were satisfied in their jobs were less likely to leave their places of employment (Mrayyan, 2005).

In one study, nurses 26 years of age and younger experienced increased job satisfaction with the increase of shared governance in decision making, self- scheduling or job share opportunities, and management support to attend continuing education and career development classes (Wilson, Squires, Widger, Cranley & Tourangeau, 2008). Schmalenberg and Kramer (2008) studied job satisfaction in a sample of 2,990 staff nurses working in 206 clinical units of 8 different magnet hospitals nationwide. Perioperative and recovery nurses had the lowest scores for overall job satisfaction of all the clinical groups studied, with a mean score of 6.39 out of 10. The National Magnet Hospital Profile (NMHP) mean was 6.58. In contrast, the highest scores for

overall job satisfaction belonged to nurses in outpatient care (mean 7.77) and neonatal intensive

care (mean 7.73, $p = .04$). Based on these results, the authors concluded that perioperative and

recovery room nurses were least satisfied in their jobs out all the areas surveyed.

Other research has explored ways to increase job satisfaction in the operating room. One

author found that perioperative nurses had an increase in sense of job satisfaction with the

implementation of computer charting and technology (McHugh, 2004). The computer program

helped nurses save time by tracking patient status (preoperative, intraoperative, or postoperative)

in the perioperative system. Knowledge of patients' progression through the system allowed

nurses more time to deliver patient care and increased overall job satisfaction and quality of care.

By examining the literature relevant to healthy work environment themes of

communication, team collaboration, decision making, authentic leadership, meaningful

recognition and appropriate staffing were defined. In addition, aspects of patient safety were also

examined. These seven components were reviewed as they pertain to the OR work environment.

Research findings suggest that there is a relationship between teamwork and professional

interactions that may impact the work environment and nurses' perceptions of patient outcomes

and job satisfaction in the perioperative work setting. Further study is needed to determine how

healthy environment and patient care outcomes can be improved in perioperative care.

Theoretical Framework

The AACN synergy model for patient care was used to examine the findings of this

study. Synergy is the end product of pairing patient care needs with nursing care competence

(Kaplow & Reed, 2008). This model was used as a framework to promote healthy work

environment in the OR and to encourage growth of effective communication and teamwork in

other facilities as well (Stanton, 2008). The synergy model was defined by patient characteristics

and nursing competencies. In 1995, the AACN defined eight patient attributes and eight nursing competencies as they apply to the synergy model: resiliency, vulnerability, stability, complexity, resource availability, participation in care, participation in decision making, and predictability. The competencies the nurse needed to ascertain included clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry, and facilitation of learning (Hardin & Kaplow, 2005). According to Hardin and Kaplow (2005), all patients have different characteristics and strengths; however, the eight characteristics of this model are possessed by all patients and need to be continually assessed by the nurse along with the patient's individual capabilities in order to deliver optimum care.

Three application principles also need to be considered when implementing the AACN cynergy Model for Patient Care. First, the patient is a being composed of spirit, body, and soul that must be considered in whole when advocating for the patient and planning care. Secondly, the patient has a community and a family that continues to provide a context for the nurse-patient relationship throughout the care process (Kaplow & Reed, 2008). Finally, nurses can be described by a number of dynamic characteristics, and these characteristics continue to develop and define who the nurse is in the process of care (Hardin & Kaplow, 2005).

In the perioperative clinical setting the nurse is the advocate for safe patient care. Once the patient is anesthetized this factor becomes of utmost importance because the patient is unable to verbalize their preferences and concerns during surgery.

CHAPTER THREE

Methods

The purpose of this study was to evaluate the effectiveness of implementing a shared governance model. The specific aims were to (a) assess communication and team collaboration before and after implementation of the shared governance model and (b) assess the job satisfaction and perception of patient safety care among operating room and recovery room nurses in the perioperative environment. The research questions were (a) What are the effects of a shared governance model upon team communication and collaboration in the operating room and recovery room setting? and (b) Is there an improvement in perception of quality of care and job satisfaction after implementation of shared governance model?

It was hypothesized that the implementation of a shared governance model would improve team communication and collaboration. The hypothesis was tested with the implementation of five shared governance councils in a surgical services department at a metropolitan pediatric hospital.

Design

A quasi-experimental pre- and post-test design was used to test the efficacy of the shared governance model (Haag-Heitman & George, 2010) when applied to Surgical Services. A packet containing demographic data and an Essentials of Magnetism Tool II (EOM II) was distributed to operating room and recovery room nurses prior to formation of the shared governance councils in order to obtain baseline data. Council membership included a staff chairperson and co-chairperson, RNs and other operating room support staff, one nurse manager, and one nurse educator.

Each council met monthly for four months to discuss problems in practice and research evidence-based solutions. A theoretical framework to govern practice was identified and incorporated into the councils' conduct ground rules. Evidence-based practices, principles, and theoretical frameworks determined changes purposed to perioperative practice. All members had equal opportunity to contribute to the group, and confidentiality was established as a ground rule to ensure members could contribute and share freely within their groups. Post-test questionnaires were distributed to all operating room and recovery room staff nurses after the councils had met for four months.

Sample and Setting

The study was conducted at a 700-bed metropolitan pediatric hospital with 16 operating rooms. The hospital performs approximately 20,000 surgical procedures annually, including cardiovascular and thoracic, craniofacial, dental, general surgery, urology, neurology, ophthalmology, oral and maxillofacial, orthopedics, otolaryngology, plastics, and liver and kidney transplant procedures. There were approximately 60 operating room nurses, 77 recovery room nurses, 30 surgical scrub technologists, 35 surgeons, and 30 anesthesiologists working in the operating room being studied.

A convenience, non-probability sampling method was used in this study. The eligibility criteria were (a) male or female staff nurses who (b) worked in the operating room, recovery room, or pre-operative area; (c) no float staff were used in this study. All staff nurses, nurse managers, nurse supervisors, and nurse educators were invited to participate in the study. The approximate sample size of the study was 140 with a correlation coefficient of 0.25, an alpha of 0.05, and a power of 0.80.

Instruments

The study packet included a demographic data form, a Single Global Job Satisfaction question, a single question assessing Nurse-Assessed Quality of Care, and an Essentials of Magnetism II tool (EOM II). The EOM II measures variables of a healthy work environment (clinically competent colleagues, nurse-physician relationships, decision making, and supportive nursing leadership), and uses seven subscales to measures what the AACN defines as a healthy work environment (Schmalenberg & Kramer, 2008). In addition two subscales were used to measure job satisfaction and nurse-assessed quality of care. Demographic information collected for this study was participant age, gender, professional title, years of experience, certifications, regular number of hours worked, shift worked, and educational preparation.

EOM II. The 58-item, seven-subscale EOM II was based on Donabedian's conceptual paradigm and on grounded theories for each of the eight essentials of a magnetic work environment (Schmalenberg, 2007). Each question is rated on a four-point Likert scale with the response options for most items ranging from "strongly agree" to "strongly disagree." For items relating to nurse-physician interaction the Likert scale ranges from "true for most physicians, most of the time" to "not true for any physicians." The internal consistency reliability for the EOM II subscales ranged from 0.88 to1.00 with a median of 0.92 (Schmalenberg, 2007).

Job satisfaction and perceived quality of care. The Single Global Job Satisfaction and the Nurse-Assessed Quality of Care (QC) were used to measure participants' satisfaction with their current jobs and their perceptions of the quality of patient care provided on their units. Responses on both tools were measured on a Likert scale of 0 to 10; the Single Global Job Satisfaction tool scores ranged from 0 ("it's terrible") to 10 ("I love it"), and the QC scores ranged from 0 ("dangerously low") to 10 ("very high quality of care"). The Cronbach's alpha for

the Global Job Satisfaction and QC ranged from 0.80 to 0.90 with a median of 0.88

(Schmalenberg, 2007).

Procedure

      A quasi- experimental pre- and post-study was used to test the efficacy of forming a

professional practice council in a perioperative setting. Staff was notified via staff meetings,

email, and flyers of the opportunity to be a part of the shared governance councils. Participation

was completely voluntary. Staff interested in joining a council contacted the unit nurse educator.

While members were being selected for the councils, packets including an introductory letter

with waiver for consent statement, the demographic data form, and the EOM II questionnaire

(see Appendices B-D) were distributed to all operating room, recovery room, and nursing

leadership staff who worked in the perioperative unit. Participants were given one month to

complete the packets; when complete, they were asked to return the packets to a locked

collection box located on the unit.

      Individual responses to the demographic form and study questionnaire were not coded to

protect the confidentiality of the participants; however, returned packets were kept in a secure

and locked area inaccessible to anyone not directly involved in the study's data collection or

analysis, and individual responses were aggregated with other staff responses and reported in the

aggregate form so that no personal identifying information was reported. Finally, the principle

investigator destroyed all completed packets at the end of the study.

      Five shared governance councils were formed after completion of the pre-test, developed

in accordance with Haag-Heitman and George's shared governance model (2010). The five

shared governance councils were an OR Clinical Practice Council, a PACU Clinical Practice

Council, a Surgical Services Professional Development Council, a Surgical Services Quality

Council, and a Coordinating Council.

Development of the councils presented an opportunity to study the effects of shared

governance on healthy work environment. Council members were recruited through two kickoff

meetings held by the director of surgical services and the OR educator. If interested in joining a

council, staff would contact the director of surgical services, and interested members were

emailed with council meeting times and locations. Participation was completely voluntary.

Approximately 140 participants joined the shared governance councils. Each council

consisted of 7-15 staff members, 5-12 RNs, 2-3 surgical scrub technologists (for the OR and SS

Quality Improvement Councils only), 1 Chair, 1 co-Chair, 1 recorder, 1 management

sponsor/facilitator, and 1 educator. Surgical technologists were included in the council structure

because of essential role in the perioperative health care team. The OR clinical practice council

also included 1 sterile processing technologist. Each council met once a month and at the end of

each month all chairpersons and co-chairpersons attended a coordinating council meeting to

discuss the progress of their respective councils. Each council developed a charter from which

they governed the group's conduct. The councils used consensus decision making and

confidentiality was included as one of the ground rules. The framework of the Clinical Practice

Councils (CPC) for both OR and PACU was:

- Met to discuss problems that arose in practice,

- Research- and evidence-based approaches used to solve identified problems, and

- Implemented solutions based on a theoretical framework and supported researched

  methods.

The Surgical Services Professional Development Council (SSPDC) used a nurse-driven approach to address ways to help nurses develop professionally. Responsibilities included:

- Building a unit blog on the intranet of the hospital's website

- Submitting action plans and successes for publication in the hospital newsletter

- Addressing nursing concerns gleaned from annual surveys conducted to assess job satisfaction and develop a workplace culture of safety

- Planning and supporting nurses and health care week activities

The framework for the Surgical Services Quality Council (SSQC) was:

- Ensured and coordinated quality improvement activity efforts;

- Prepared staff for continued readiness for Joint Commission, California Health Department, California Children's Services (CCS), and Centers for Medical and Medicaid Services (CMS);

- Reviewed department audits to discuss the validity of evidence-based practice changes; and

- Discussed quality reports and incident reports that needed further follow up with education and professional practice development.

Each council had a chairperson, a co–chairperson, an education sponsor, and a management sponsor in addition to voting members. There was no limit on the number of members who could join a council. Membership was determined by personal interest and the topic of focus for each particular council. Each council met monthly to discuss problems that arose from nursing practice and used a research- and evidence-based approach to solve those problems. The councils made decisions with equal input from all members. They also developed a theoretical framework

from which they governed group conduct. Confidentiality was one of the ground rules of all shared governance council meetings.

After four months, a post-questionnaire packet was distributed to the same perioperative department. Some participants were different due to change of staff at meetings or new staff hires. One month was given for the collection of packets; after completion participants placed them in a locked mailbox located on the unit. The principle investigator collected the questionnaires and compiled the data for analysis.

Data Analysis

Descriptive statistics were utilized to calculate frequencies, percentage, means, medians, and standard deviations. An independent t-test was performed on the pre and post-data test groups. Comparison of the pre and post groups was made possible by utilizing a Mann Whitney U test. Analyses was performed using Statistical Package for the Social Sciences (SPSS) software version 16.0. For the purpose of this study, the significance level was set at $p < 0.05$.

CHAPTER FOUR

Results

The goal of this research study was to evaluate whether or not a shared decision making model affected healthy work environment in a perioperative unit. Communication, quality of care, and job satisfaction for team members of a perioperative unit were evaluated through a 58 question validated tool before and after the implementation of shared decision making councils. The specific aims were (a) to assess communication and team collaboration, and (b) to assess the perceptions of quality of care and job satisfaction among OR and recovery room nurses in a perioperative unit.

Description of Sample

A total of 54 nurses completed a pre-implementation packet and a total of 10 nurses completed a post-implementation packet. Table 1 and Table 2 show each sample's characteristics. The mean number of years of experience for the pre data collection group was 20 years, and the post data collection group mean years of experience was 11.5 years.

Organization Job Satisfaction and Nurse Assessed Quality of Patient Care

The descriptive data in tables one and two include values of Organizational Job Satisfaction and Nurse Assessed Quality of patient care on the unit. The mean for organizational job satisfaction in the pre implementation group was 5.75 and the mean for the post implementation group was 4.83 indicating reduced job satisfaction.

The nurse-assessed quality of patient care on the unit in the pre-implementation group had a mean of 6.92 indicating the post-implementation nurse assessed quality of patient care was less than the pre-implementation group. The post-implementation group had a mean of 5.9 for nurse-assessed quality of patient care on the unit. Given the years of experience, job satisfaction,

and nurse-assessed quality of care it would appear upon inspection that the pre group is more

satisfied than the post group.
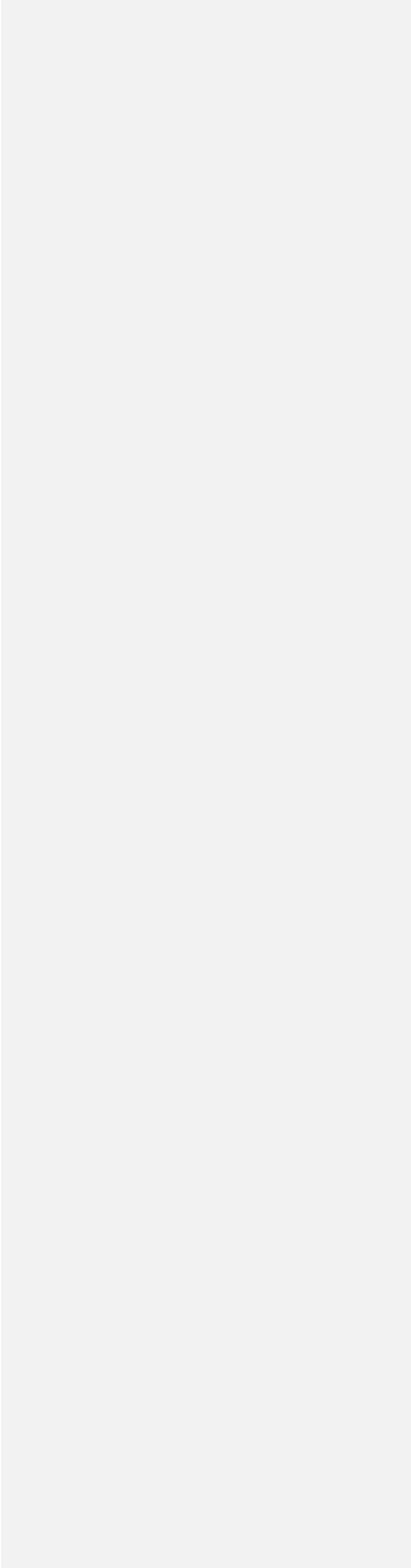
Table 1-Pre Implementation Group Demographics

Sample Characteristics (n=54)

Characteristics	Value
Age, mean (range) yr.	47 (45-50)
Gender	
Male	4
Female	50
Ethnicity	
Hispanic	2
Black (non-hispanic)	1
White (non-hispanic)	34
Asian/Pacific Islander	17
Department	
OR	25 (46)
PACU	29 (54)
Clinical Unit Experience, mean (range) y	9.5 (0.17-35)
Experience as an RN, mean (range) y	20 (1-46)
Shift worked	
10 hours	17 (32.7)
8 hours	25 (48.1)
12 hours	6 (11.5)
Days	51 (98)
Nights	1 (2)
Highest Earned Degree	
ADN	16 (30.8)
BSN	29 (59.2)
MSN	2 (3.8)
Organizational Job Satisfaction, mean (range)	5.75 (2-10)
Perceived Quality of Patient Care, mean (range)	6.92 (2-10)
Certifications	
CNOR	6 (11)
CAPA	6 (11)
Other	3 (5)

Note: Values are expressed as number (%) unless otherwise indicated. OR, Operating Room; PACU, Perioperative Anesthesia Care Unit; ADN, Associate Degree Nursing; BSN, Bachelor of Science in Nursing; MSN, Masters of Science in Nursing; CNOR, Certified Nurse Operating Room; CAPA, Certified Ambulatory Perianesthesia Nurse. Organizational job satisfaction possible range 1-10, 10= I love it. Perceived quality of patient care possible range 1-10, 10 = very high.

Table 2-Post Implementation Group Demographics

Sample Characteristics (n=10)

Characteristics	Value
Age, mean (range) yr.	41 (23-44)
Gender	
Male	0
Female	10
Ethnicity	
Hispanic	0
Black (non-hispanic)	0
White (non-hispanic)	3 (25)
Asian/Pacific Islander	7 (75)
Department	
Operating Room (OR)	5 (50)
PACU	5 (50)
Clinical Unit Experience, mean (range) y	6 (1.5-12)
Experience as an RN, mean (range) y	11.5 (4-22)
Shift worked	
Day 10 hours	6 (50)
Day 8 hours	6 (50)
Day Shift	10 (100)
Night Shift	0
Highest Earned Degree	
ADN	2 (20)
BSN	8 (80)
MSN	2 (20)
Organizational Job Satisfaction, mean (range)	4.8 (1-8)
Perceived Quality of Patient Care, mean (range)	5.9 (1-9)
Certifications	
CNOR	2 (20)
CAPA	3 (30)

Note: Values are expressed as number (%) unless otherwise indicated. OR, Operating Room; PACU, Perioperative Anesthesia Care Unit; ADN, Associate Degree Nursing; BSN, Bachelor of Science in Nursing; MSN, Masters of Science in Nursing; CNOR, Certified Nurse Operating Room; CAPA, Certified Ambulatory Perianesthesia Nurse. Organizational job satisfaction possible range 1-10, 10= I love it. Perceived quality of patient care possible range 1-10, 10 = very high.

SHARED GOVERNANCE MODEL   33

A pre and post questionnaire analysis was done. Due to the difference in sample size a pre and post group t-test was used to look at the data in each group but comparison was not possible. Questions reaching statistical significance were analyzed using a Mann Whitney U test to compare the groups.

Pre-Implementation Results

The following pre-implementation results were statistically significant; question four ($p=.046$) with PACU RNs answering true most of the time and sometimes, and question twelve ($p=.045$) where OR RNs answered this question disagree.

Post-Implementation Results

Due to the small sample size in the post-implementation group data does not support statistical significance due to a potential for type I error. The following items represent trends demonstrated in the data; question four where PACU RNs answered true some times ($p=.023$), question six PACU RNs answered true most of the time and sometimes ($p=.009$), and question 10 PACU RNs agree that the "organization provides financial assistance and /or paid time off for nurses to attend educational programs" ($p=.036$),

Pre and Post Implementation Results Compared

All findings need to be viewed in light of the fact that the sample size for the post implementation group was small. Table 3 represents the Mann Whitney U results of the EOM II comparison of the pre and post implementation groups.

Table 3
Pre and Post Implementation Comparison of EOM II

Question #/Topic	pre mean	post mean	Mann Whitney U	p value
8) The nurse manager supports continuing education				
	29.55	45.29	158.500	.0058
21) Nurses have input into creation of policies				
	30.08	43	186.000	.020
38) The nurse manager has "got our back"				
	29.43	45.79	192.500	.004
42) The nurse manager adequately staffs the unit				
	29.02	44.67	154.000	.004
56) Our organization anticipates change				
	29.32	44.68	146.500	.007

Note: Mean Values are expressed where the higher the value the more it trends towards "disagree", and the lower the value it trends towards "agree" for that group. Statistical significance is signified by $p=<.05$

CHAPTER FIVE

Discussion

Implications for Nursing

        The purpose of this study was to assess communication, team collaboration, and perceptions of patient safety and job satisfaction before and after the implementation of a shared decision-making model among operating room nurses and recovery room nurses working in the perioperative setting. According to Schmalenberg & Kramer, 2008 the following six variables were also found to contribute to a healthy work environment: communication, team collaboration, decision making, sufficient staffing, staff recognition, and authentic leadership. All six variables must be present in order to create a healthy work environment.

        The results for organizational job satisfaction scored lower after implementation (mean 4.83) of a shared governance council then before implementation (mean 5.75) suggesting a negative correlation between organizational job satisfaction and shared governance. The nurse-assessed quality of patient care on the unit in the pre-implementation group (mean 6.92) was higher than the post implementation group (mean 5.9) possibly indicating a negative correlation between nurse-assessed quality of patient care and the implementation of a shared governance council. The post implementation sample size was smaller (n=10) than the pre implementation group (n=54), therefore all findings for this study cannot be considered statistically significant and could not be generalized to a similar population without further research. It would appear based on these results that shared decision making had little effect on organizational job satisfaction and nurse-assessed quality of patient care, however other elements of healthy work environment must be present in order to create a healthy work environment and hence effect these two variables.

Wilson et al., 2008 found that an increase in nursing job satisfaction was associated with an increase of shared governance in decision making and management support to attend continuing education. For the purposes of this study the findings did not support this research. The results of the pre and post group comparison using a Mann Whitney U test revealed the pre group agreed (mean rank 29.55; Mann Whitney U= 158.500; p=.0058) the nurse manager supported staff attendance of continuing education whereas the post implementation group strongly disagreed (mean rank 45.29) suggesting the implementation of shared governance was correlated to decrease in nurses being able to attend continuing education and hence shared governance did not foster this element of healthy work environment. In addition the Organizational Job Satisfaction mean was lower in the post implementation group (4.83) than the pre-implementation group (5.75).

According to the AACN (2005), effective nursing communication includes not only interactions between team members but also includes patient advocacy through participating in building evidence-based policies to guide care. In the pre post comparison results, question 21 supported this finding (p = .020, Mann Whitney U= 186.000) revealing the post analysis group compared to the pre analysis group disagreed that staff had input into policy and procedures that governed nursing practice. These results suggests that more work would need to be done to incorporate bedside nurses into the decision making processes and hence contribute to creating a healthy work environment within this particular perioperative nursing unit.

Even though leadership was initially not a variable to be measured in this study, it is a component of healthy work environment. Findings revealed data relating to the variable of leadership.

Schmalenberg and Kramer (2009) identified ten attributes of an excellent nurse manager as reported by staff nurses, managers, and physicians. One of these ten attributes was the ability of the nurse manager to act as the peace keeper in the nurse-physician relationship and in relationships with other units in the hospital. Literature also suggested an excellent manager was able to represent their staff's opinions and concerns in meetings with other departments and were available for staff to voice their concerns in privacy and confidence, and the ability to match care workload to nursing skill as important attributes a nurse manager leading successfully. Question 38 in the pre and post implementation comparison revealed the post implementation group strongly disagreed the nurse manager represented the positions and interests of staff (mean rank= 44.13, p= .004, Mann Whitney U=172.500) bearing a statistically significant result that concurs with the literature. Question 42 also had a statistically significant result where nursing staff disagree (mean rank=44.67, p=.004, Mann Whitney U=154.000) the nurse management assures adequate numbers of competent staff are available to get the job done. Question 56 in the combined analysis suggests a lack of communication between the bedside nurses and nurse manager as the post implementation group disagreed (mean rank=44.68, p=.007, Mann Whitney U=146.500) with administration being able to anticipate changes and being able to communicate those changes with staff.

The results of this study indicate strong themes of leadership support, the importance of quality communication and team work are necessary in order to accomplish a healthy work environment which is consistent with the literature.

Study Limitations

This study has several limitations. The post implementation sample size was too small to consider the findings truly significant. A larger sample size would have been necessary to be able

to make the findings generally applicable to similar nursing populations. In addition the smaller sample size may also not be a true reflection of this department's greater population. Further research in multiple perioperative units may yield significantly stronger findings.

The pre implementation analysis was conducted five months after the councils had been launched. The delay in data collection was due to IRB approval and the needs of the unit took precedent as this would have been a project that was implemented regardless of the research being conducted. One month prior to the pre data collection the director of Surgical Services left the department and an interim director was appointed by senior hospital leadership. These contributing factors may have skewed the pre implementation results. A hiring freeze took place organization wide two months before the post data collection began. Post data collection was conducted one year and five months after the councils had formed. Variables beyond the study could have influenced the response of participants involved in the study.

Future Research

Healthy Work environment is comprised of following six elements; communication, team collaboration, decision making, sufficient staffing, staff recognition, and authentic leadership (Schmalenberg & Kramer, 2008). All elements must be present in order to create a healthy work environment. Future research in a perioperative setting could look at how to develop the team dynamic between the surgical technologist, nurse, surgeon and anesthesiologist and how their function effects healthy work environment. Mishra et al., 2009 developed a tool to measure team work and its effect on adverse outcomes in the operating room perhaps incorporating an assessment of team work would benefit in nurturing a healthy work environment in the perioperative setting seeing as the care of the patient is driven by team work and communication as the strongest variables of healthy work environment. Furthermore, a tool to study healthy

work environment that includes not only nurses but also other perioperative team members may indicate new findings which could be incorporated into creating a healthy work environment in a perioperative unit.

Although positive patient outcomes are the ultimate goal of excellent nursing, further training is needed to become a skilled nurse manager (Schmalenberg & Kramer, 2009). Further research and implementation of education for the nurse manager may impact the future of healthy work environment in not only perioperative care areas but in all nursing care areas as a whole. A larger sample size in future research would also contribute to the statistically significant outcomes that could be more liberally applied to perioperative nursing units as a whole.

Conclusion

Lack of communication is the leading cause of 80% of sentinel events in the perioperative setting (Gillespie, et al., 2008). Communication and teamwork are large components of being able to achieve a healthy work environment (Schalamenburg & Kramer, 2008). Authentic leadership and effective nurse leaders also contribute to healthy work environment outcomes (Schmalenberg & Kramer, 2009). In order to achieve healthy work environment elements of communication, team work, collaboration, decision making, sufficient staffing, staff recognition, and authentic leadership must be present. Future studies of how team work effects healthy work environment and leadership development for nurse managers may contribute to the overall health of the work environment in the perioperative environment. These elements also need to be present in order to successfully implement shared governance (Haag-Heitman, B., & George, V. (2010). Continued research is needed to determine if healthy work

environment and shared decision making impact quality of care and job satisfaction of future of

nursing job satisfaction and patient care outcomes.
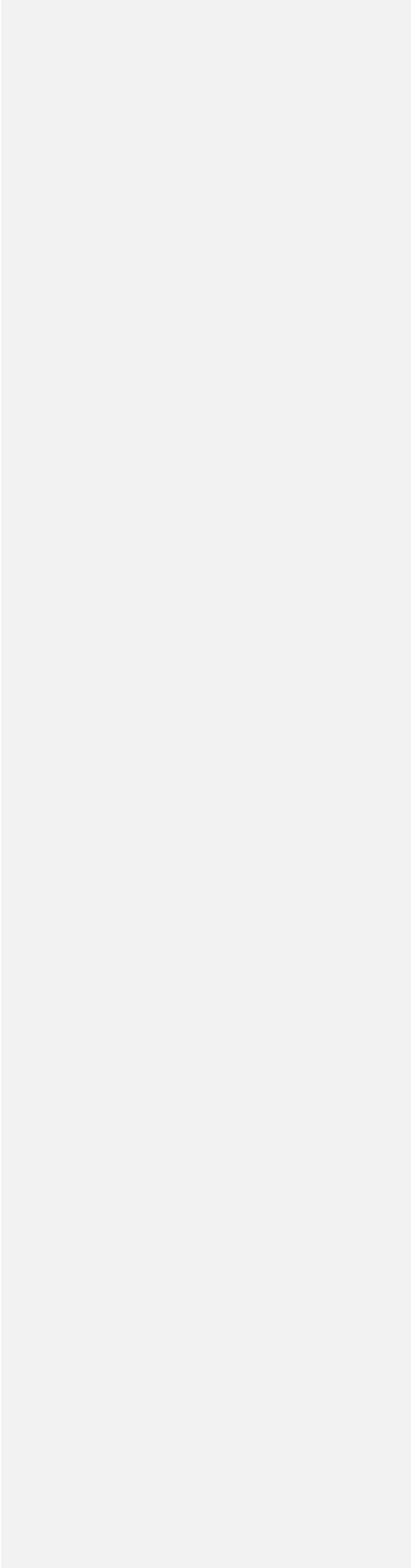
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Appendix A

Approval Letter to Use EOM II Tool

Fwd: EOM tool and Nurse- Assessed Quality of Care (QC) tool
From:**Jocelyn Firth** (jfirth100@pointloma.edu)
Sent: February 22, 2010 8:31:07 PM
To: jocelynfirth@hotmail.com
    Attachments:
    EOMII (c) - 2007 With NAQC & OJS.doc (115.5 KB), EOMII(C) HSRA Conditions of Use - 2009.doc
    (83.5 KB)
---------- Forwarded message ----------
From: claudializ <claudializ@juno.com>
Date: Mon, Dec 7, 2009 at 12:06 PM
Subject: Re: EOM tool and Nurse- Assessed Quality of Care (QC) tool
to: jfirth100@pointloma.edu

Dear Ms. Firth,

Yes, you can utilize the EOMII for your master's thesis on healthy
work environments. The Nurse-Assessed Quality Care Scale is not
copyrighted by us. I don't believe anyone holds a copyright. Quite a
few studies have used some form of this single item indicator. I am
attaching the conditions of use for the EOM. The weighting and
scoring formulas are proprietary and we do not release them. We do
make changes to the costs for students. If your sample size is less
than 100, I can score them and send you a data base at no charge. The
reports are not included but I assume you need to do your own data
analysis. Comparative data for the EOMII is published in an article
in Nursing Research January 2008.

Claudia Schmalenberg

On Sat, 5 Dec 2009 15:25:40 -0800 Jocelyn Firth
<jfirth100@pointloma.edu> writes:

Hello Ms. Schmalenberg,
 I am an operating room nurse educator working on my thesis to
complete my MSN. My thesis is on healthy work environment in the
operating room. I am writing to ask permission to use 2 of your tools.
Essentials of Magnetism and Nurse-Assessed Quality of Care. My thesis
question is: how does implementing a professional practice council in
the operating room affect communication, team collaboration,
perceptions of patient safety and job satisfaction?
 I would very much like to use these 2 tools to conduct an
experimental pre and post assessment of the implementation of a
professional practice council.
 I look forward to your reply
Warm Regards
Jocelyn Firth

Appendix B

The Effect of Healthy work Environment over the Job Satisfaction and Perceived Quality of Care among Operating Room Nurses

Introductory Letter to Potential Staff Participants

Dear Participant,
You are being invited to participate in a research study called:
    The Effect of Shared Governance on Healthy Work Environment, Quality of Care and Job
                Satisfaction among Nurses Working in Perioperative Care
Below is a brief description of all that is entailed in being a participant. Please read carefully and
thank you for considering being a part of this research study.

Brief Description of the Research Study:
Jocelyn Firth, RN is conducting a research study to find out more about Shared Governance on
Healthy Work Environment, Quality of Care and Job Satisfaction among Nurses Working in
Perioperative Care. You have been asked to take part because your feedback is crucial to
determine if outcomes have been reached and whether or not Shared Governance made an
impact on obtaining and maintaining a Healthy Work Environment, in determining Quality of
Care and Job Satisfaction. The purpose of this study is to assess team collaboration, decision
making, staffing, staff recognition and authentic leadership which are all components that make
up a healthy work environment. The study will also determine perceptions of patient safety and
job satisfaction before and after the implementation of Shared Governance councils among
nurses working in the OR and PACU units.
What will happen? How long will the study last?
If you agree to be in this study, the following will happen to you:

Prior to the councils being established each nurse in Surgical Services (SS) will be given a
research packet containing the EOM II, a Job Satisfaction questionnaire and questionnaire
assessing Nurse-Assessed Quality of Care questionnaire and Demographic Data. The purpose of
the research study will be explained and a consent form will be completed if you wish to
participate in the study. If you choose not to participate in the study you may return your packet
at the end of the meeting. If you do not participate your employment status will not be affected in
any way. The packets will be distributed at department staff meetings and collected by the end
of the meeting. There will be a collection box at the back of the room where you may turn in
your packet. To maintain confidentiality the demographic data and study questionnaire responses
will be coded and you will be instructed not to put your name on the data collection forms.
Consents will be collected separated from the packet so it will not be known if you have agreed
to participate or not. All data and forms will be kept in a confidential lock box, available only to
the researcher. No personal identifying information will be reported. The individual responses to
the demographic form and study questionnaire will be in sealed envelopes. At the end of eight
months all surgical services nurses will be asked to complete a post intervention packet using the
same procedure outlined above. The individual responses will be aggregated with the responses
of other staff and reported only in the aggregate form. No personal identifying information will
be reported.

RISKS reasonably to be expected, and notice of unforeseeable risks. Participation in this study may involve some added risks or discomforts. These include:
The risk to you is minimal as the survey participation will be confidential and no emotional harm is expected. There may be minimal physical and time burdens of answering a 58-question survey. Time will be given in the staff meeting to fill out the questionnaire data. The study may involve risks that are currently unforeseeable. However, if any new risks become known in the future you will be informed of them.
Reasonable benefits to be expect.
There may or may not be any direct benefit to you from these procedures. The investigator, however, may learn more about Shared Governance and its effect on Healthy Work Environment, Job Satisfaction, and Perceptions of Patient Safety.

VOLUNTARY nature of participation and right to withdraw without penalty. Subjects must give consent without coercion or undue influence.
Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without jeopardy to your employment at this institution.

Extent to which CONFIDENTIALITY will be maintained.
Research records will be kept confidential to the extent allowed by law.
In order to protect your confidentiality this study is being conducted under a waiver of consent. This means that once you have completed this questionnaire packet you have given your consent to participate. There is not a formal consent because by doing so information could be linked back to individual participants.

Procedures for orderly termination of a subject's participation
You may be withdrawn from the study if you do not follow the instructions given you by the study personnel. If you decide that you no longer wish to continue in this study, you will be required to inform the principle investigator.

Plan to inform participants of new findings
You will be told if any important new information is found during the course of this study that may affect your wanting to continue.
Thank you for considering being involved with this research. If you have any further questions please contact, Jocelyn Firth at 858-966-8717 or contact the Director the RCHSD Institute for Research Board, Lori Murphy at (858) 966-4008.

Appendix C

Pre-Study Demographic Form

Directions: Please circle the appropriate number or fill in the blank. Your responses will be kept confidential.

1. What is your gender?
   a. Female
   b. Male

2. Please circle your age range.

   21-26   27-32   33-38   39-44   45-50   51-56   57-62   63-68   68-73

3. Which best describes your ethnic group?
   a. Hispanic
   b. Black (non-Hispanic)
   c. White (non-Hispanic)
   d. Asian/Pacific Islander
   e. Other_____

4. Which department/area do you work in?

   OR   PACU   Other

5. How many years have you been a nurse in this area? _____

6. How many years have you been a registered nurse (RN)? _____

7. What is your highest earned degree?

   a. Associate degree
   b. Diploma
   c. Baccalaureate (Nursing)
   d. Masters (Other field)
   e. PhD (Other field)

8. Do you currently hold certification in any specialty area?
   a. No
   b. Yes (what specialty?) _____

9. What best describes your present employment position? Please circle all that apply.
a. Full-Time Staff Nurse
b. Part Time Staff Nurse
c. Charge Nurse
d. Service Coordinator
e. Nursing Supervisor
f. Nursing Administration
g. Other_____

Appendix D

Post-Study Demographic Form

Directions: Please circle the appropriate number or fill in the blank. Your responses will be kept confidential.

1. What is your gender?
    a. Female
    b. Male

2. Please circle your age range.

    21-26   27-32   33-38   39-44   45-50   51-56   57-62   63-68   68-73

3. Which best describes your ethnic group?
    a. Hispanic
    b. Black (non-Hispanic)
    c. White (non-Hispanic)
    d. Asian/Pacific Islander
    e. Other_____

4. Which department/area do you work in?

    OR   PACU   Other

5. How many years have you been a nurse in this area? _____

6. How many years have you been a registered nurse (RN)? _____

7. What is your highest earned degree?

    a. Associate degree
    b. Diploma
    c. Baccalaureate (Nursing)
    d. Masters (Other field)
    e. PhD (Other field)

8. Do you currently hold certification in any specialty area?
    a. No
    b. Yes (what specialty?) _____

10. What best describes your present employment position? Please circle all that apply.
    a. Full-Time Staff Nurse
    b. Part Time Staff Nurse
    c. Charge Nurse
    d. Service Coordinator
    e. Nursing Supervisor
    f. Nursing Administration
    g. Other_____

9. Were you a member on one of the Shared Governance Councils?
    a. Yes

    b. No

Appendix E

Health Sciences Research
Nursing Administration and Research Consultation
ESSENTIALS OF MAGNETISMII (EOMII) ©

Please complete the following background information. Then indicate the extent to which each statement is operative in, or descriptive of the environment in which you are currently engaged in nursing practice.

 Information about Yourself and Your Work Environment

On what **clinical unit** do you usually work? Indicate **hospital unit number** (Ex. 6W) _____
and then the **kind of patients** on that unit (Ex. oncology) _____
What **shift** do you usually work? (Ex. 12 hour nights; 8 hour evenings) _____
 What is the total number of **years of RN work experience** you have had? _____
How long have you worked on the clinical unit on which you are currently working? _____
Circle your **highest level of nursing education**? ADN; Diploma; BSN; MS; Other_____

		True for most MDs, most of the time	True for some MDs, some of the time	True for 1 or 2 MDs on occasion	Not true for any MDs
1	Nurse-physician relationships on my unit are that of a 'student-teacher' with physicians willing to explain and teach the nurses.				
2	Nurse-physician relationships consist of willing cooperation based on *mutual* power, trust, and respect.				
3	Relationships between nurses and physicians are frustrating, hostile; may be characterized by 'power plays,' antagonism, or resentment.				
4	Relationships with MDs are that of 'student-teacher' with nurses influencing doctors in their prescribing of care for patients.				
5	Our nurse-physician relationships are rather formal, characterized mainly by nurses responding to physician's questions.				
6	Physicians treat the nurses on this unit as equals; they need our assessments and observations of the patient and we need their medical knowledge if together we are going to help the patient.				

		Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*
7	Other professionals indicate they value nurses pursuing their education, extending knowledge, and increasing competence				
8	Our nurse manager makes it possible for us to attend continuing education, outside courses and/or degree completion programs.				
9	In this organization, there are few rewards for pursuing one's education, such as promotion, salary increases, or recognition.				
10	This organization provides financial assistance and/or paid time off for nurses to attend educational programs.				
11	Nurses here fear 'getting into trouble' or 'taking big risks' if they make autonomous decisions.				
12	Autonomous nursing practice is facilitated here because nurses 'feel' or know that nurse managers will support them.				
13	Staff nurses must obtain orders or consent from an authority source before making independent or interdependent decisions.				
14	On this unit, nurses make independent decisions within the nursing sphere of practice and interdependent decisions in those spheres where nursing overlaps with other disciplines.				
15	Our evidence-based practice activities provide us with the knowledge base needed to make sound clinical decisions.				
16	This organization has many rules and regulations that prevent nurses from making independent or interdependent decisions.				
17	In this hospital, nurses have to do things that, in our professional judgment, are not in the best interests of the patient.				
18	Nurses are held accountable in a positive, constructive, learning way for the outcomes of autonomous nursing practice.				
19	There is a general understanding among nurses on this unit that nursing administration wants us to function autonomously.				
20	We have a Council or committee structure through which nurses on our unit and in this hospital control nursing practice.				
21	Staff nurses have input and make decisions with respect to *practice* issues and policies such as selection of equipment, how frequently to change IV line dressings, etc.				

22	Physicians, administrators, nurses and other professionals (ex. physical therapists) recognize that nursing in this hospital controls its own practice.				
23	Shared decision-making is more talk than action here; we may have input and can offer suggestions, but we don't make decisions.				
24	Representatives from other departments and disciplines such as transportation, pharmacy, respiratory therapy, participate in our shared decision-making activities on a regular basis.				
25	Nurses in this organization have input and make decisions related to *personnel* issues and policies that directly affect them such as floating, schedules, care delivery system.				
26	Nurses on my unit can describe decisions made and outcomes achieved as a result of the shared decision-making process.				
27	Nursing practice, policies, issues and standards are determined by nursing management, administration or people outside of nursing. Staff nurses do not have control.				
28	The nurses on my unit judge that, most of the time, we are adequately staffed to give *quality patient care*.				
29	We don't have enough competent and experienced nurses who 'know' the unit, patients and physicians to provide *safe* care.				
30	We modify our patient care delivery system (Ex. team, primary) on the basis of the number and the experience of RNs available.				
31	We work as a team on this unit. We need one another and need to work together if patients are to receive quality care.				
32	Our group cohesiveness enables us to give quality care with our current level of staffing.				
33	Our unit is not budgeted enough RNs positions for the acuity of our patients. This makes it very difficult to give quality patient care even when all budgeted positions are filled.				
34	Nurses on my unit demonstrate a proficient level of competent performance.				
		Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
35	Competent performances of nurses are recognized and rewarded both on this unit and in this organization.				
36	Continuing education toward a nursing degree is recognized as a way in which nurses can				

	increase their nursing competence.				
37	National certification is recognized as evidence of proficient clinical competence.				
38	Our nurse manager represents the positions and interests of the staff and of our unit to other departments and to administration; he/she "watches our back".				
39	If we need resources such as equipment or supplies, our nurse manager can make it happen				
40	Our nurse manager is diplomatic, fair and honest in resolving conflicts between nurses, physicians or other departments.				
41	Our nurse manager supports and encourages interdisciplinary— physicians, nurses, and other disciplines—planning and action.				
42	The nurse manager on our unit sees to it that we have adequate numbers of competent staff to get the job done.				
43	Our nurse manager cites specific examples, both positive and negative, when he/she provides us feedback.				
44	The NM of our unit promotes staff cohesion and is a positive force in getting us to work together.				
45	Our nurse manager is visible, available, approachable and 'safe' to talk to.				
46	Our nurse manager instills and "lives" the values of the organization regarding patient care. He/she "walks the talk".				
47	Our nurse manager fosters sound decision-making by asking for 'best practice' evidence for the decisions we are making				
48	This hospital is willing to try new things.				
49	Concern for the patient is paramount on my unit and in this hospital.				
50	Problems are solved by swift action; people are not afraid to take risks.				
51	People on my unit are enthusiastic about their work				
52	High performance and productivity are expected of everyone.				
53	We work together as a team, both within nursing and with medicine and other disciplines.				
54	Cost (money) is important, but quality patient care comes first in this organization.				
55	The contributions of all members of the staff				

	(RNs, nurse assistants, techs) are important and valued.				
56	Our administration anticipates organizational changes that need to be made because of changes in the health care system, and sees to it that we are out in front.				
57	This is a value driven organization. Values are known, understood, shared, and frequently talked about.				
58	We make a conscious effort to transmit our cultural values to in-coming nurses, physicians, techs and assistants.				

THE FOLLOWING TWO OUTCOME RATING SCALES ARE NOT A PART OF THE EOMII©
THEIR USE IS OPTIONAL, BUT WE WOULD APPRECIATE YOU COMPLETING THEM.

ORGANIZATIONAL JOB SATISFACTION

Rate how **satisfied** you are with the features of **your current nursing job** that are derived from organizational affiliation—factors such as competitive salary and benefits, retirement, workload, adequate parking, food availability and so on. (Circle any number on the scale)

0	1	2	3	4	**5**	6	7	8	9	**10**

It's terrible!   **I'm satisfied**   **I love it!**
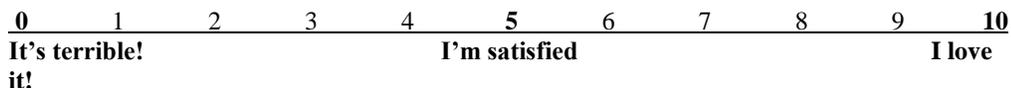
NURSE-ASSESSED QUALITY OF PATIENT CARE ON UNIT

Select a number that indicates the **usual quality of care provided to patients** on your unit?

0	1	2	3	4	**5**	6	7	8	9	**10**

Dangerously Low   **Safe, but not much more**   **Very high quality**
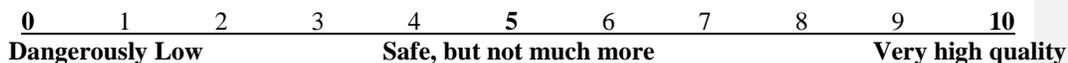
COMMENTS

(Please feel free to write-in any comments that you wish).

Appendix F

Rady Children's Hospital San Diego

Ready-to-Accrue Letter

Research Approval Notification

Research Administration
Email: research@rchsd.org

Date:	**06/22/11**
RCHSD project:	**2249 (12363 under old numbering system)**
Principal Investigator:	**Jocelyn Firth, RN**
Title:	**The Effect of Shared Governance over Health Work Environment, Quality of Care and Job Satisfaction Among Nurses Working in Perioperative Care**

The above-referenced project may now be activated at Rady Children's Hospital-San Diego. Please use the RCHSD project number in all internal communications and correspondence pertaining to this study. If the use of an informed consent for the project is applicable, please place the number on the consent.

This approval is valid for the duration of your Institutional Review Board (IRB) approval. If the IRB approval lapses or expires, this approval notification will no longer be valid.

As the principal investigator for this study, it is your responsibility to follow all applicable RCHSD policies and procedures and to notify us of any changes in the status of your project or in changes in your research plan that will affect resource utilization at RCHSD.

Sincerely,

Ed Quigley, PhD, MBA
Research Administration Officer
Rady Children's Hospital-San Diego

Appendix G

Ross Oakes Mueller <RossOakesMueller@pointloma.edu>
<div align="right">Fri, Sep 9, 2011 at 1:31 PM</div>

To: Jocelyn L Firth <jfirth100@pointloma.edu>, Jocelyn L Firth <jfirth100@pointloma.edu>
Cc: Jeanne Maiden <JeanneMaiden@pointloma.edu>, Jeanne Maiden <JeanneMaiden@pointloma.edu>

PLNU IRB
Expedited Review
908
Friday, September 9th, 2011
PI: Jocelyn Firth
Additional Investigators: Jeff Belcher, RN
Faculty Advisor: Jeanne Maiden, PhD
Title: The Effect of Shared Governance on Healthy Work Environment, Quality
of Care and Job Satisfaction Among Nurses Working in Perioperative Care.

The research proposal was reviewed and verified as an expedited review under category 7 and has been approved in accordance with PLNU's IRB and federal requirements pertaining to human subjects protections within the Federal Law 45 CFR 46.101 b. Your project will be subject to approval for one year from the September 9, 2011 date of approval. After completion of your study or by September 9, 2012, you must submit a summary of your project or a request for continuation to the IRB. If any changes to your study are planned or you require additional time to complete your project, please notify the IRB chair.

For questions related to this correspondence, please contact the IRB Chair, Ross A. Oakes Mueller, Ph.D., at the contact information below. To access the IRB to request a review for a modification or renewal of your protocol, or to access relevant policies and guidelines related to the involvement of human subjects in research, please visit the PLNU IRB web site.

Best wishes on your study,

Ross A. Oakes Mueller, Ph.D.
Associate Professor
Department of Psychology
IRB Chair

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619.849.2905
RossOakesMueller@pointloma.edu