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Using a Shared Governance Structure to Evaluate the Implementation of a New Model of Care: The Shared Experience of a Performance Improvement Committee

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Abstract

Sustaining change in the behaviors and habits of experienced practicing nurses can be frustrating and daunting, even when changes are based on evidence. Partnering with an active shared governance structure to communicate change and elicit feedback is an established method to foster partnership, equity, accountability and ownership. Few recent exemplars in the literature link shared governance, change management and evidence-based practice to transitions in care models. This article describes an innovative staff-driven approach used by nurses in a shared governance performance improvement committee to use evidence based practice in determining the best methods to evaluate the implementation of a new model of care.

The National Institutes of Health (NIH) Clinical Center (CC) is a 240-bed research hospital and ambulatory care center supporting the clinical research programs of the 27 NIH institutes and centers. In 2007, nursing at the CC launched a national effort, in collaboration with colleagues across the country, to define and describe the emerging practice specialty of clinical research nursing (CRN). This practice development agenda became the strategic focus for the nursing organization as nurses with substantial experience in clinical research as well as those new to the practice specialty began the rewarding process of uncovering, documenting and standardizing the elements that make their practice unique. The cornerstone of CRN is the provision and coordination of nursing care for participants in clinical research studies (1). A strategic plan and team structure engaging all leadership in nursing and nursing shared governance, called Clinical Research Nursing 2010 (CRN₂₀₁₀), was established, and groups worked for 4 years to create and validate concept documents, communicate through nursing management and advanced practice nursing structures, and

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discuss them with staff shared governance (SG) leaders (2). Nursing leadership then turned from the application of the specialty of CRN to the process of planning, delivering, coordinating and evaluating care provided to research participants in the CC. After discussions involving all areas of practice, a recommitment was made by leadership and staff to the principles and accountability embodied in the concept of primary nursing (3). Four roles at the clinical unit level were defined; primary clinical research nurse (PCRN) (accountable for planning, providing and coordinating care for an individual research participant); and protocol coordinator (PC) (accountable for the implementation of a clinical study in a particular area and coordination of the medical and protocol driven requirements of a group of research participants; assigned clinical research nurse (ACRN) (the nurse caring for the participant other than the PCRN); and the clinical research technician (CRT) (Table 1) (4). Standards of care were outlined to serve as a guide to the CRN detailing the ethical, compassionate, collaborative and informed care delivered to each research participant (Table 2).

Shared Governance and Evidence Based Practice at the NIH Clinical Center

Nursing SG, implemented in 1992, has undergone several updates and revisions, based on internal staff input, benchmarking with colleagues in academic medical centers and periodic review of new evidence. The SG structure includes the nursing practice council (NPC), with representatives from each nursing unit, and each nursing role in the department (e.g. managers, clinical specialists, etc.) as well as nurses from other departments including perioperative medicine or interventional radiology who do not report through nursing. The chief nurse officer (CNO) is an ex-officio member. The NPC operates through subcommittees representing the areas of practice identified as important for staff representation. These include the clinical practice committee (CPC), the performance improvement committee (PIC), and the nursing information systems committee (NIS). Recently, the committee structure was expanded to include the nursing research participant education committee (NRPC) and the recognition and retention committee (R&R). All SG committees have representation from each clinical area, and are led by a chair and co-chair elected from the staff. Shared governance works under the guidance of bylaws that are reviewed and revised each year by the NPC and administratively approved by the CNO. Each committee has a senior executive sponsor who assures resources are provided for committee, provides policy input for the committee's work, and provides mentorship and support to the chair and co-chair. A cornerstone of SG at the CC is the *nursing practice council request (NCPR)*, a communication initiated by a nurse and forwarded to the chair of NPC. Requests are brought forward for discussion at monthly NPC meetings, the nurse initiating the NCPR presents to colleagues and answers questions. The NCPR is assigned to a SG committee. Figure 1 outlines progress of a staff nurse NCPR from inception and presentation to NPC, subsequent review by the appropriate committee, return to the NPC for final vote and implementation of practice change. As noted in Figure 1, the SG structure is fluid, as practice changes occur, the plan, do, study, act (PDSA) (5) cycle continues the evaluative process sustaining transformation and guiding future practice changes.

In 2003, nursing at the CC embraced the concept of using systematic review and evaluation of evidence to inform practice standards and practice changes (6). Evidence based practice

(EBP) was introduced to SG by engaging the CPC in the process of reviewing and evaluating evidence when considering changes to practice documents such as nursing procedures or standards of practice. Committee members were taught strategies for searching the literature, collecting and assessing evidence, and summarizing findings in a table of evidence. Nurses were supported and encouraged in making informed decisions that include assessment of feasibility in the practice environment as well as consideration of interdisciplinary colleague acceptance and current practice. EBP is now fully embedded in the nursing organizational culture and structure and is an accepted step in considering practice changes (TABLE 3).

Using Evidence to Find Best Practices for Program Evaluation

When nursing leaders at the CC developed a plan to implement a new model of care (MOC), the incorporation of staff nurse participation through SG was a natural strategy. Partnership with staff leaders and SG provided a well-documented best practice to implement change and foster an environment conducive to professional growth (7–14). Adhering to the process outlined in Figure 1, the CNO used the standard NCPR asking NPC to create a plan to support the implementation. Each branch of the SG had a specified charge; CPC was asked to validate the model as feasible for implementation in each of the clinical practice areas represented in SG; NIS was asked to propose requirements for clinical documentation to support the change, and PIC was challenged to develop a strategic plan to evaluate the implementation of the MOC. EBP was utilized to evaluate best methods for initial and ongoing evaluation as well as those to assess long term outcomes. The approach involved the same steps used to consider the evidence in support of a clinical practice change (15) (Table 3), and was applied to consideration of existing evidence for the best way to evaluate an organizational change in the model of nursing care.

Finding the Evidence

A search of the literature was conducted by nurses on the PIC subcommittee to review methods utilized by organizations to assess and capture change relating to implementing models of care, including primary nursing. The question guiding the search was: "What are the best methods to evaluate the implementation of a new model of care within a hospital nursing environment?" The search included the following electronic databases: Health and Psychosocial Instruments (HAPI), Pub Med, *Cumulative Index to Nursing and Allied Health Literature* (CINAHL), Web of Science and Scopus. Subcommittee members organized the literature review into a table of evidence including: citation, level/type of evidence, strengths/limitations and analysis/synthesis (See Table, Supplemental Digital Content 1, <http://links.lww.com/JONA/A247>).

Themes from the Evidence

Themes included the importance of identification and consideration of primary stakeholders, the need for education of stakeholders (pre-implementation through post-implementation), and the timing of evaluation (baseline, immediately post-implementation and ongoing). Stakeholders affected by a change in model of care include patients, nursing staff and the physicians (16). Undergoing a transitional change in MOC has a significant impact on the

primary stakeholders and the organization and the method of evaluation should target outcomes that affect each stakeholder (17). Education was identified as integral to successful implementation and sustained practice change (16,18,19). Timing was identified as an important theme for evaluation. A unit may most effectively capture progress and growth in implementing the model by introducing the change and conducting repeated assessments (16). Specht (20) recommended using multiple assessments over time, as well as training all staff in methods of assessment and data collection.

Assessing the Impact on Key Stakeholders

Impact on Patients—Multiple strategies to evaluate patient perceptions of care delivery changes were identified during the review. Evaluators may create and pilot surveys (21) or modify surveys previously used and adapted for their specific needs (20). Measures such as Likert scales, which collect data using graduated responses, are more sensitive, and therefore more useful for demonstrating change (22). Rapkin (22) developed structured interviews evaluating patient satisfaction using a Likert scale to evaluate 9 areas of care to assess aspects of patient health care experiences. Robinson (23) discussed patient satisfaction indicators; respect, courtesy, competency, efficiency, patient involvement in decision making, time for care, availability and access. Cropley (24) utilized a structured survey to perform a retrospective study evaluating the effect of relationship-based care on patient satisfaction, length of stay and readmission rates. Tonges (25) utilized a structured survey to examine overall satisfaction, satisfaction with nurse, concern for privacy, pain control, response to calls and presence of a hospital-acquired infection were outcomes influencing patient satisfaction. Seek (26) used case presentations to identify qualities of nursing care such as knowledge of system and patient advocacy which positively impacted patient satisfaction. Shebini (27) found that “knowing the nurse caring for you” improves patient satisfaction. Carabetta(18), found that primary nursing improved patient satisfaction and that the patient felt cared for. Fernandez (17) reported that evaluating outcomes for patients contributed to overall patient satisfaction including; medication errors; adverse intravenous outcomes; pain scores; quality of patient care; pressure areas; infection rates; length of stay; readmission; and quality of care. One study demonstrated a reduced length of stay was related to the addition of a case manager role (28). In summary, the effect of changes in the care delivery model on the patient experience and patient outcomes has been a priority for evaluation but has been evaluated using multiple indicators. An assessment of a best practice MOC should therefore incorporate assessment of how the change affects patient level outcomes.

Impact on Nurses—Improved nurse satisfaction was identified as an important indicator of success when evaluating the impact of MOC changes (20, 21, 29–31). When assessing nursing satisfaction, qualitative indicators such as narratives (19), and open-ended interviews (20), researchers were able to describe meaningful changes from the perspective of nursing staff. Fernandez (17) reported indicators identified to evaluate nurse satisfaction including; interprofessional communication; professional development; support from senior staff; role clarity/confusion; nurse documentation; job satisfaction; nurse absenteeism; and nurse attrition. Winsett (32) conducted a survey asking “what does nursing mean to you?” and monitored nurse turnover to assess nurse satisfaction with relationship-based care.

Benner (33) suggests case studies and exemplars as a reliable method for teaching, relating satisfaction, critiquing one's work and sharing knowledge. When discussing outcomes management, Kinnaird and Dingman (34) reported that nurses report high satisfaction from the work itself when they see they have made a difference and their work is valued. They further describe collecting stories as an early indicator of change in the nursing culture (34). Donoghue (31) reported support and resources as valuable contributors to nurse satisfaction. Several authors identified empowerment, collaborative relationships and increased knowledge as possible outcomes for nurses and job satisfaction (22, 30, 31, 35).

Impact on Physicians—Studies evaluating physician or medical team satisfaction with MOC were extremely limited in the literature. In a seminal study, Fogelsson (36) reported a single qualitative study utilizing a questionnaire to identify physician perceptions of the most important primary nursing activities (developing care plans; planning discharge arrangements; teaching patients and families; and providing continuity of care) and collaborative activities of the medical team (communication). The lack of evidence of the evaluation of physician perceptions was intriguing to committee members who continued to identify physician colleagues as critical to the success of a MOC change and also key stakeholders in the process.

Performance Improvement Committee-Unit-Based Case Presentations

After reviewing the evidence the committee recognized the need to evaluate how the MOC was being implemented throughout the various practice areas, as part of the pre-implementation assessment. This evaluation was needed to determine the extent of change that new MOC would require and identify new areas for evaluation. The CC environment includes in-patient units, as well as out-patient clinics and day hospitals. The protocol requirements and disease processes of research participants vary from healthy volunteers to acutely ill patients with chronic illness. Case studies provide a methodology to share knowledge and describe patients and clinical situations in a memorable narrative (37) that could be applicable to the diverse clinical practices environments in the CC. It was agreed that using case studies created/provided by a nurse in a specific care environment would provide a method to capture early changes during the initial introduction and implementation process of the new MOC.

During monthly committee meetings PIC members shared unit-based case studies, providing a narrative description of the research participant and their care. Members participated in enthusiastic discussions regarding primary nursing and the MOC implementation; passion and commitment inherent in relationship-based care became evident, highlighting common threads of CRN care in the varying clinical environments. Case presentations consistently captured the individual compassion and attention to care for research participants integral to the standards of care (Table 2). The committee includes case study assessment as a key element in its recommendation for ongoing evaluation of the MOC.

Organizational Resources for Outcome Evaluation

The NIS worked with the nurse informaticists within the Department of Clinical Research Informatics to produce a user friendly method of communicating valuable participant care

information between healthcare teams and the inpatient and outpatient environments. National Database of Nursing Quality Indicators® (NDNQI) (38), as well as nurse job satisfaction and nurse practice environment scale surveys were conducted, with greater than 85% nurse participation in 2010 and 86% in 2012. Results were reviewed and utilized to generate unit based performance improvement projects, and the content of this data set reflected several indicators identified in the literature. Inpatient satisfaction is tracked using a survey mailed to patients after discharge. The CC's automated occurrence reporting system is utilized to track positive reports and occurrences that indicate best practices or problematic trends initiating follow-up for potential change in the new MOC. The patient care representative provided anecdotal information regarding patient feedback. Indicators from all sources were considered and prioritized in order of occurrence. With the additional information provided by the existing CC resources, the next step would be to combine the information from all sources and utilize the cumulative feedback from PIC members to capture key indicators and methods to evaluate the CC environment (See Table, Supplemental Digital Content 2, <http://links.lww.com/JONA/A248>).

Using Staff Expertise to Identify Additional Potential Indicators

Individual PIC members discussed the implementation of the MOC with their nurse manager and obtained feedback from their peers. The committee, comprised of nursing staff from all practice areas, utilized a nominal group technique to develop indicator lists and stakeholder statements incorporating key concepts from the dimensions of practice and the standards of care. Each member was asked to write 3 statements from the perspective of key stakeholders (nurse, research participant and medical team) describing the impact of the MOC. Posters were placed around the room to indicate the 5 dimensions of practice within the domain of CRN (2). Each statement was placed into the appropriate dimension and further grouped by stakeholder. Individual standards of care were incorporated into each survey group ensuring consideration of each standard. Indicators obtained from the literature review and the PIC discussions were then combined with other institutional indicators. The subcommittee utilized these indicators to develop 3 stakeholder surveys using a Likert scale. The surveys would then be utilized to evaluate the implementation of the MOC throughout the CC. As nurses are responsible for implementing the MOC, they were identified as the priority stakeholders for the initial evaluation process.

Determining the Best Method for Evaluation

The committee summarized its work assessing the best evaluative practices from the literature, assessing the potential use of existing organizational data as ongoing measures for evaluation, and incorporating staff nurse expertise in the form of proposed indicators reflecting the unique clinical research environment of the CC. A proposal for evaluating the new MOC was presented to the CNO, approved, and returned to NPC. The proposal was approved and an action plan was initiated, following approval by NPC. While each individual nursing unit (in-patient and ambulatory care) is responsible for implementing the MOC, the PIC members provide support of the ongoing evaluation process. Thus, the evaluation of the implementation of the CRN2010 MOC has evolved through the process; a

request to NPC, evidence-based evaluation by PIC with full participation of the CRN staff, and a revised proposal presented to nursing leadership for final approval.

Lessons Learned

The experience of determining the best method to evaluate the implementation of a new MOC in a hospital nursing environment and providing the ground work for the evaluative process was new and exciting for members of the PIC. Collaboration among leadership, SG, and global representation from all practice areas led to a cohesive partnership enabling the entire nursing staff to have a voice as the work progressed. Eliciting concerns and considerations of peers through the PIC committee representatives was invaluable in the development of a process impacting the nursing department. Expert resources were brought in to facilitate the education and integration of EBP in the evaluation process; this step was essential and provided support and guidance as well as educational knowledge. Partnerships between PIC, the subcommittee and leadership facilitated incorporation of multilevel perspectives, while combining knowledge and experience. Commitment of members was crucial as they performed the work of the subcommittee in addition to ongoing commitments to patient care. Excellent communication skills among team members allowed much of the work to be completed verbally and on-line, maintaining information flow and minimizing face-to-face meeting time. Having a flexible time line allowed for assimilation of new information and facilitated communication to the committee members and leadership. As projected target points were achieved, the subcommittee met with nursing leadership to update progress and validate that work aligned with the goals of the nursing executive team. As the evaluation of the implementation of the new CRN MOC is set in motion, PIC will move forward confident in the knowledge that the evaluation methods being used are based on the best practices found in the literature. The evaluative process has been endorsed by the CRN's as well as nursing leadership; and the charge set by the CNO through SG has been met.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Shared governance structure provides the best method to implement change and foster an environment conducive to professional growth, encouraging staff involvement from inception through improved practice. The ensuing **plan, do, study, act** (PDSA) (5) is necessary to influence sustained change and continual practice growth and development.

FIGURE 1.
NIH Clinical Center Shared Governance Workflow and Communication
^aDeming⁵

TABLE 1

Roles in the Care Delivery Model

Scope of Activity	Protocol Coordinator Role	Primary CRN Role	Assigned CRN Role	Clinical Research Tech Role
Focus of Work	Group of participants on a given protocol	Individual participant who requires continuity for care spanning more than one day or visit	Individual participant	Individual participant or unit tasks (i.e. setting up research bloods)
Time Frame	Duration of Protocol or long term program of care	Episode of Care (inpatient admission or one or more protocol related visits)	Shift	Shift
Assessment	Overall impact of protocol, level of nursing care required, clinical needs of patient population (group assessment)	Health status, needs and responses over an episode of care – presenting and as they evolve during participation (individual assessment).	Immediate presenting needs, follow-up based on prior caregiver report, new or emerging needs based on changes in therapy or health status	Immediate needs and responses to care; participant initiated requests or concerns
Planning	Plan and standards for specific protocol-based care and patient population-based care that become part of the protocol implementation plan.	General and specific goals and plan for episode of care (to be achieved by the end of the episode)	Priorities for care during shift, including delegation of appropriate activities. Review of existing plan; recommendations for changes based on shift-to-shift observations	Priorities for care during shift
Implementation	Education of staff; preparation of protocol specific forms and research participant educational materials; ongoing participation in research team coordination of care	Implementation of nursing plan of care, medical orders and protocol procedures, incorporating participant feedback and adjusting as indicated by participant response	Implementation of nursing plan of care, medical orders and protocol procedures	Implementation of delegated care per plan of care and protocol
Evaluation	Quality monitoring to assess consistency in implementation; assessment of patient feedback and need for change as protocol progresses; evaluation of participant outcomes assessing for trends and needs for changes in protocol implementation plan	Assessment of patient responses over entire episode, movement towards identified goals and effectiveness of protocol procedures with feedback to clinical research team and modification of plan as appropriate	Assessment of patient responses during shift with feedback to clinical team and recommendations for changes as appropriate	Monitoring of specific patient responses and reporting g to covering CRN

TABLE 2

Standards of Care

Clinical Research Nursing Standards of Care ^a	
1	Research participants can expect that information about their care and condition is discussed and communicated with confidentiality, and that care is being appropriately documented
2	Research participants can expect that nurses will communicate and collaborate effectively with members of the clinical research team to assure coordinated, high quality care
3	Research participants can expect that their care and treatment are consistent with the research protocol guiding their participation, and that valid data are being collected by the nursing staff
4	Research participants can expect to receive evidence-based nursing care consistent with the accepted professional standard related to their particular condition or therapy
5	Research participants can expect to know which nurse is accountable for their care and how to contact that person
6	Research participants can expect prompt assessment and appropriate response to changes in condition or untoward responses to research procedures
7	Research participants can expect that treatment and monitoring will be individualized to accommodate individual needs, to the extent allowed by the protocol, and that in <i>all cases</i> participant safety, comfort and well-being will be placed <i>above</i> research requirements
8	Research participants can expect to develop an understanding of their condition, research participation and treatment, and be able to manage self care as appropriate after discharge
9	Research participants can expect that while in the Clinical Center they will have a sense of being cared for as an individual and that they will receive prompt, courteous and individualized services from nurses and patient care staff
10	Research participants can expect to be involved with discussions and decisions about their plan of care and research participation

^a CRN 2010 Model of Care⁴

TABLE 3

CC Nursing Competency: Evidence-Based Practice Source: (15)

FIVE STEPS OF EVIDENCE-BASED PRACTICE	
1	Ask the PICO ^a question.
2	Access the best evidence.
3	Appraise and analyze the evidence.
4	Apply the evidence – make a practice change.