

Shared governance as vertical alignment of nursing group power and nurse practice council effectiveness

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Aims

Nurse empowerment has been associated with employee engagement, job satisfaction, and patient outcomes (Woodruff 2008; Aiken et al. 2002; Laschinger et al. 2001; Coile 2001). Empowerment is the central concept of nursing shared governance, and is reflected in several of the Forces of Magnetism in the American Nurses Association's Magnet Hospital Recognition program (Laschinger et al. 2003). Nurse empowerment results from the power of the nursing department and from the exercise of power by nurses in their local units. Several instruments exist for measuring nurses' power, including the Sieloff-King Assessment of Group Power: SKAGPO (Sieloff 1995). Meanwhile, shared governance—the experience of empowerment and the means of achieving empowerment—may not be directly measurable. Nurse Practice Councils (NPCs), however, appear to be the definitive means of approaching shared governance. NPCs enable the practice of power. This study draws on data from two previous studies to develop and validate an instrument for measuring the effectiveness of NPCs (Joseph et al. 2006; Joseph et al. 2008). An initial theoretical framework for better studying shared governance is presented, and the implications of this framework are discussed.

Background

Many conditions and factors impact an organization's or department's ability to shape nursing practice (Roberts & Vasquez 2004). Power is one essential characteristic of social, and consequently organizational, contexts and individual behavior.

Understanding the exercise of power—empowerment—requires an understanding of the way power operates within social contexts (Bradbury-Jones et al. 2008). Previous research has established links between organizational climate, culture, design and structure for exercising power for nursing shared governance (Agyris 2004; Porter-O'Grady 2003).

Kanter (1977) defined power as the ability to mobilize resources (human and materials) to get things done. Kanter argued that organizational context and human behavior are both essential variables in the workplace and that both require feedback loops for diagnosis and improvement. Subsequently, Sieloff (1995), using King's conceptual system (1981), defined group power as the capacity of a group to achieve its goals. Power, therefore, is a major contributor to organizational effectiveness. Sieloff hypothesized, moreover, that the ability of nursing departments to use power depends upon attributes such as environmental forces, position, resources, roles, power perspective, power competency, and communication competency. The mere sharing of power resources and opportunities to express one's autonomy vertically—up and down levels of an organization—can enhance work effectiveness (Laschinger et al. 2003;

Upenieks 2003; Sieloff 2004; Kramer et al 2008). Indeed, there is a substantial body of research suggesting that “empowerment should be viewed as a multiple-level process and can be considered both an effective and efficient approach to employee motivation and performance” (Seibert et al 2004).

Mathews et al (2006) hypothesized that chief nurse executives (CNEs) must ensure that nurse managers have the appropriate power in the organization to allow them to create work environments that foster increased access to the resources necessary to achieve organizational goals. Empowerment of nurses, in other words, happens through a vertical alignment of the power of the CNE and the nursing department with the exercise of power by nurse leaders at all levels in their respective work environments, all within an organizational context.

Although not previously described in just this way, the term “nursing shared governance” has been used to discuss this vertically aligned exercise of power by nurses. Hess (1998) offers a more traditional, organizational governance definition of shared governance as the processes and structures of authority over decision-making. Hess’ 88-item, Index of Professional Nursing Governance (IPNG) measures six dimensions: control over nursing personnel; access to information; resources supporting practice; participation; control over practice; and goals and conflict resolution. IPNG showed strong reliability, including subscale alphas of .87 to .91 and an overall alpha of .97 in a sample of 816 nurses from seven hospitals. However, the

IPNG has not been widely used. This may, in part, be due to the challenges of widely conducting a lengthy survey in a clinical setting as well as the IPNG's focus on a traditional conception of governance. Another reason for the lack of use of IPNG may be the difficulty of measuring shared governance directly in the absence of a more complete expression of shared governance as it operates at multiple levels within organizations.

Recently, nurse scholars have sometimes defined shared governance as "structures." Kramer et al (2008) conducted a notable, large-scale, multisite study that adopted this view. Operationalizing shared governance in this way offers conceptual simplicity and permits the grouping of a large number of different structures or experiences as exemplars of shared governance. However, it also results in treating these structures, as the end, in themselves, of shared governance. For Kramer et al (2008) shared governance ends up being equivalent to councils, severing the means-end connection between methods of approaching shared governance and the goal of shared governance. This perspective restricts one from seeing approaches to shared governance that are something other than a structure. It also makes it hard to conceive methods for judging which structures are more effective means of achieving the end of shared governance. That is, unless shared governance as a goal is reconnected to the means of achieving shared governance, and the effectiveness of the means or "structures" themselves can be measured.

Indeed, Porter-O'Grady (2001, 2003) is not merely being imprecise when he explicitly rejects over-specification of nursing shared governance, describing it as **any approach** to empowerment *and* the **structures** to support empowerment. This perspective has led Porter-O'Grady to argue specifically against attempting to measure shared governance. He maintains that as an idea or goal that may be approached through many different possible methods shared governance may not be directly measurable. He further argues that precisely measuring shared governance—the goal—could even work counter to the idea of shared governance by limiting variety and innovation in the approaches taken toward shared governance. Shared governance, in short, is the end—empowerment—accomplished with structures and/or processes that support empowerment and through any method that advances empowerment.

Anthony (2004) reviews the theoretical antecedents of shared governance and observes certain commonalities: autonomy/empowerment, accountability, and participative, group-based decision making for patient care and the practice environment. It is this latter concept of participative, group-based decision making that most concerns us here. Kramer et al (2008) differentiated between unit-level and department or organization-level councils, which they label, respectively and perhaps revealing a conceptual bias, as “silo” and “integrated” shared governance. Similarly, O'May and Buchan (1999) identified NPCs as a definitive expression of shared

governance, a constant for approaching the goal of shared governance. Opening the door to multiple—but definable—expressions of this constant feature of shared governance, they further observe that prior research finds NPCs operating at four levels in hospitals: the nursing unit; the department; the executive level (coordinating activities of lower-level councils); and system-wide (where all nursing staff participate through cabinets). In short, nursing practice councils and the mechanisms for empowering them, at one level in the organization or another, may be taken as an observable and specifiable constant of shared nursing governance.

Within this study, shared governance is defined as a supportive nursing group power and the concomitant exercise of power by nursing work units—vertically aligned empowerment. But while shared governance is resistant to measurement due to the unlimited variety of ways it might be accomplished, the definitive means or structure for actualizing shared governance—Nursing Practice Councils—might be assessed quantitatively. This study sets the stage for assessing whether the measurement of NPC effectiveness—as the means of empowerment—can usefully reflect the vertical alignment of the exercise of power with the context of power of the nursing department.

In summary, the philosophy underlying this study is that the actualization of power as a characteristic of the socio-organizational context is a necessary condition for shared governance. Nursing, that is, must have power as a group within the

organization to achieve shared governance. But this context of power alone is not a sufficient condition for shared governance. Also requisite is for nurses working together at the unit level to have an effective means of exercising power. The definitive means of exercising power in the shared governance literature is the nursing practice council. Hence, shared governance is a product of nursing group power in alignment with the unit-level exercise of power. We submit, therefore, that understanding—and indexing the level of—shared governance requires measures of group power and of nursing practice council effectiveness. A recent large-scale study of more excellent units in more excellent magnet hospitals concludes strikingly near this study's beginning: "The viability of shared governance is expedited when [it provides] access to power...wide participation...and [is] recognized as effective in achieving important outcomes as a result of shared decision-making" (Kramer et al 2008).

In particular, this study aims to fill the gap in the literature for an index of the exercise of power at the unit level by describing the development and initial validation of the Nursing Practice Council Effectiveness Scale (NPCes). A framework for better studying shared governance as a multilevel is then presented and briefly examined in light of the vertical alignment of the exercise of power at the unit level with the power of the nursing department, as defined by Sieloff and King (1995), within the larger organizational context. This paper concludes with implications and limitations.

Method and Results: Development of a Survey Indexing the Effectiveness of Nursing Practice Councils

The development and initial validation of NPCes occurred over the course of two studies conducted in a seven-hospital system with over 4,000 nurses and 2,000 beds. This process included steps assessing content, face, internal reliability, predictive, convergent and discriminant validity. Each step is described in order for conceptual clarity so methods and results are presented for each step, rather than in separate sections.

Content validity refers to whether an index or survey measures all essential aspects of the concept under study. Content validity was initially established by a multidisciplinary research team that included three nurse researchers and a social science methodologist. Content validity was based on extracting recommended attributes of nursing practice councils or theorized consequences of shared governance, as found in peer-reviewed journal articles published between 1990-2006. With the goal of a brief survey that would be easily used in the practice setting, the team derived a list of essential components of shared governance or nursing practice councils, and systematically discussed whether any essential components were missing. By consensus, nine attributes or consequences of NPCs were identified as essential elements of NPC effectiveness (see Table 1).

Face validity reflects a judgment about whether a way of testing or measuring a concept appears likely to actually do so. The nine components of NPC effectiveness were drafted as survey items. The team reviewed the wording of the draft survey items for precision and clarity. Based on a second review of the consistently mentioned concepts in the literature, as well as their understanding of shared governance, the research team agreed by consensus that the nine-item survey appeared to be face valid as a brief, easily used, measure of the effectiveness of NPCs. These content and face validity steps resulted in a 9-item, nine-point, self-report scale (Nursing Practice Council effectiveness scale, NPCes).

The NPCes has been used in two studies (Study1 N = 119; Study2 N = 248), providing data for the assessment of internal reliability. As described below, these studies also provided data for initial assessments of the predictive, concurrent, convergent and discriminant validity of the NPCes.

Internal Reliability refers to the degree of internal consistency of the items making up an index. That is, while validity tests help define the construct that a set of items is indexing, internal reliability assesses whether the items of an instrument perform together as an index. Internal reliability of the NPCes was assessed using data from two studies. Study1 and Study2 results are reported separately where indicated below. Otherwise, the results from the combined data are used. Table 2 below summarizes certain study and sample characteristics.

NPCes results were assessed for sampling adequacy for each study and for the combined data set (N = 263). For the combined data, the Kaiser-Meyer-Olkin Measure of sampling adequacy = .907,¹ which is well over the generally accepted minimum of .50. Bartlett's Test of Sphericity rejected the null hypothesis that the responses to the instrument represent an identity matrix (Chi-square = 1949.4, 36 df). These results indicated that factor analysis was appropriate for examining the internal associations among items of the NPCes.

Factor analysis and scale reliability results for each item and the total scale of the NPCes are summarized in Table 3. Exploratory principal axis factor analysis using varimax rotation was applied to the individual studies and to the combined data. Missing values were deleted pairwise. Study2 resulted in a single-factor solution accounting for 66.11% of total variance. Study1 results generated a two factor solution with factor1 accounting for 34.9% and factor2 contributing 26.0%, a total of 60.9% of total variance. Factor2 of Study1 was composed of the three items about whether NPCes were *improving* patient care, patient safety or nurse-physician communication. The existence of a second factor in Study1 may be a consequence of the early stage of implementation of the NPCes at the time of that study, whereas Study2 occurred 18 months after Study1. In Study1, after principal axis extraction and prior to rotation, all

¹ KMO for Study1 = .869, for Study2 = .900.

items loaded $> .5$ on the first extracted factor and, in scale analyses, the lowest inter-item correlation = .469.

It is possible that aspects of procedure produced these differences in factor structure. Data from Study2 were collected online while Study1 data were collected in one-on-one interviews. It is possible that interviews may have introduced some systematic bias into these three items on improvements resulting from NPCs. In addition, for Study2, the items were randomly ordered for each participant, reducing the likelihood of an order bias in the survey. Study2 also had a substantially larger sample, which should produce more stable factor analysis results. Given the above, it is not surprising that factor analysis for the Combined studies revealed a single factor. This solution accounted for 62.8% of the total variance.

Scale and item analyses were similarly conducted for each study and for the combined sample. Table 3 shows that Cronbach's α for the total scale = Study1, Study2 =, and 0.935 (Combined), meaning that NPCes exhibited excellent internal consistency. Item analysis found that deleting the item on Management Support would improve NPCes performance by .0027. However, the inter-item correlation of .564 shows this item correlates with the total of the scores of the other items beyond the usual standard of .3. The research team determined that deletion of the Management Support item was not warranted given the slight gain in overall internal reliability of the scale, particularly since leadership support is essential to NPC success.

Taken together, the above results suggest that the 9-item NPCes provides a strong index of the construct of interest: the effectiveness of Nursing Practice Councils. In addition, NPCes' internal structure may be sensitive to systematic variations in NPC effectiveness, NPC maturity, or procedural biases.

The above demonstrates that NPCes provides a strongly internally consistent face- and content-valid index of nursing practice council effectiveness. Initial evidence on the predictive, concurrent, discriminant and convergent validity of NPCes is presented in Table 4. For each type of validity, the table indicates whether the source is Study1, Study2 or the Combined results, the latter being preferred when available due to the larger number of observations.

Predictive validity assesses an instrument's ability to predict an independent construct that it should theoretically be able to predict. Empowerment has previously been associated with job satisfaction in many studies (Manojlovich 2005). As shown in Table 4, NPCes operates as would be theorized, exhibiting a significant positive correlation with satisfaction in a relatively small sample.

Concurrent validity is demonstrated when an instrument can distinguish between two different groups. Educational level categories were (1) diploma or associate's degree (NPCes mean = 57.96, SD = 16.08), (2) bachelor's degree (NPCes mean = 56.16, SD = 15.39), (3) master's or doctorate degree (NPCes mean = 54.94, SD = 17.04). There is a tendency for nurses with lower levels of education to rate their NPC higher —

suggesting perhaps the importance of NPCs as a means of empowerment for those who do not possess more traditional means like positional authority—but this tendency is not statistically significant. Since this sample's ratings of NPC effectiveness do not vary substantially by level of education, comparing education-level groupings does not provide evidence of concurrent validity for NPCes.

Position categories were (1) Non-manager nurse (NPCes mean = 64.05, SD = 10.74), (2) assistant nurse manager (NPCes mean = 50.01, SD = 17.87), (3) nurse manager (NPCes mean = 59.58, SD = 13.39), and (4) department director or chief nursing officer (NPCes mean = 55.69, SD = 15.43). Comparisons on ratings of NPC effectiveness between these groups is much more pronounced than the comparisons between educational levels. It is noteworthy that, with nurses who are not in management positions giving much higher ratings for the effectiveness of their NPC, the pattern again is for those with fewer traditional power assets to value their NPC more highly. Here, evidence of concurrent validity for NPCes is found as the resulting Kendall's tau-b of -.226 is significant ($p < .001$).

Convergent validity is in evidence for an instrument when data show it to be strongly and positively associated with other methods of measuring a similar concept. In Study1, workplace structural empowerment was measured using the Conditions of Work Effectiveness Questionnaire-II: CWEQ-II (Laschinger & Wong 1999; Laschinger et al. 2001) was incorporated in the interview. CWEQ-II consists of 19 items that measure

aspects of empowerment structure, as well as a 3-item measure of staff nurses' perceptions of concept of formal power and a 4-item measure of staff perceptions of informal power. In Study2, nursing group power was measured using the Sieloff-King Assessment of Group Power in the Organization (Sieloff, 1995). This 36-item instrument is theorized to have nine subscales: Chief Nurse Executive's Power Competency, Communication Competency, Controlling the Effects of Environmental Forces, Goals/Outcome Competency, Position, Power Capacity, Power Perspective, Resources, Role. The overall scale is labeled Power Actualized, reflecting Sieloff's adoption of King's theory that the nursing group's ability to actualize power in the organization is based on different kinds of power assets and competencies.

As shown in Table 4, NPCes correlated strongly and positively with both CWEQ-II ($r = .736, p < .001$) and SKAGPO's Power Actualized ($r = .505, p < .001$). Of the 10 measures used as evidence of the criterion-related validity of NPCes, NPCes had the strongest correlations with these two theoretically congruent measures. This finding provides compelling evidence of NPCes' validity as a measure of nurse empowerment, at least in institutions where nursing practice councils are operating.

Discriminant validity assesses an instrument's lack of association with other measures for which no association should be expected. An aspect of Study2 was the use of Saucier's (1994) 40-item Mini-Marker of the five commonly accepted dimensions of personality: extroversion/introversion, agreeableness/disagreeableness,

conscientiousness/lack of concern, emotional stability/neuroticism, and intellectual openness/closed mindedness. As the main aim of Study2 was to examine associations between organizational culture, power and personality (Joseph et al 2008), the research team had no particular theory about which of the five personality dimensions would be more likely to associate with nurses' ratings of their nursing practice councils. It is, however, clear that an instrument that associates strongly – positively or negatively – with all or most of these personality characteristics may be unable to disentangle what it is purported to be measuring from people's personalities. In addition, an instrument exhibiting very strong associations with all or most of the personality dimensions may be imbued with biased cultural understandings that align with ideas about "positive" or "negative" persons or personalities. Personality inventories, like Saucier's, are not intending this social desirability bias. They are intended to provide a means of describing the dimensions of personality from one end to the other. But an instrument on, say, nurse power that is consciously or unconsciously imbued consistently with culturally derived ideas about "preferred behavior" or powerful persons or roles might too often and too strongly correlate with multiple dimensions of personality.

On the other hand, one or more of these dimensions of personality might reasonably be associated with a measure of empowerment. This research team found no research on nurse power and personality and, therefore, had no theoretical basis upon which to expect one result or another. For this reason, all five dimensions of

personality were correlated with NPCes scores to assess the discriminant validity of NPCes. The team assumed that some personality measures might be associated with NPCes scores but that there should not be very strong associations across all or most personality dimensions.

Three of the five personality dimensions had modest but statistically significant correlations with NPCes (Table 4). In particular, agreeableness, extroversion and intellectual openness correlated with NPCes scores, whereas emotional stability and conscientiousness did not. These findings offer initial support for the discriminant validity of NPCes.

It is intriguing to note, meanwhile, that, in retrospect, it seems quite reasonable that more agreeable and extroverted nurses would more highly value the collaborative, group effort that comprises the socio-behavioral definition of a nursing practice council. Moreover, it also seems, again in retrospect, perfectly unsurprising that individuals with higher scores on the intellectual openness dimension of personality would score their NPC higher. In terms of nursing practice improvement, NPCs serve to organize and oversee the identification of opportunities for improving practice in the local unit, on the basis of evidence and knowledge development. Among the jobs of NPCs, in other words, is that of actualizing a culture of inquiry through evidence gathering, research and, in general, the expression of intellectual curiosity and openness to change.

To summarize these results, the NPCes appears to be well designed to fill the gap of an index of the exercise of nurse power at the unit level through nursing practice councils. NPCes has strong internal reliability. It was developed based on research-team reviews for content and face validity. Assessments of how NPCes performs relative to other measured constructs offer initial evidence that it has appropriate predictive, concurrent, congruent and discriminant validity as an operationalization of the effectiveness of nursing practice councils and nurse empowerment at the unit level.

Conclusions: Group Power, Unit Power and Shared Governance

It is argued here that shared governance might best be understood in terms of the vertical alignment of (a) the power of the nursing group, with (b) the exercise of power at the unit level, and (c) within the overall organizational context. This theoretical framework is illustrated in Figure 1. Beginning the examination of this incipient theory depended upon the existence of an index of the exercise of power at the unit level. Thus, the development, psychometric performance, and validity of the Nursing Practice Council effectiveness scale (NPCes) had to occur first, and this was described above.

The framework shown in Figure 1 reflects the recurring awareness in the literatures on power and shared governance that empowerment occurs due to different kinds of inputs from different levels or roles in an organization. Theoretically then,

SKAGPO (Sieloff 1995) and NPCes work together as expressions of different levels of the vertical alignment of nurse power within an organization. Consequently, the framework offers SKAPGO and NPCes as operationalizations of shared governance. They are expected to complement each other as, respectively, measures of supportive nursing group power led by the chief nurse executive and the exercise of power at the unit level, led often perhaps by a nursing practice council chair. Additional research may improve these operationalizations.

From a theory development standpoint, the most important issue at hand is whether this framework can help advance understanding about when, how and why shared governance works. This framework does permit the specification of assumptions about how and why shared governance works, and will be more fully described elsewhere. For the purposes of clarifying this framework, the following are four tentatively offered examples of assumptions communicated by this framework that could be tested in future studies.

1. Shared governance will be in greater evidence where nursing group power is high and where the exercise of power at the unit level is also high.
2. Shared governance will be approached more quickly and effectively where there is a good vertical fit between the methods used for nursing group power and the methods practiced by nursing practice councils.

3. Shared governance will be in greater evidence in organizational communications but less evident among nurses on the floor where nursing group power is high but the exercise of power at the unit level is low.
4. Shared governance will produce inconsistent outcomes but high nurse satisfaction where nursing group power is low but the exercise of power at the unit level is high.

In the real world, of course, both levels of nursing power (the group's power to shape and support authority over decision-making and the effectiveness of the nurses to exercise power at the unit level) occur within a larger organizational context. It is well beyond the scope of this article to unpack "organizational context." But the organizational context seems to be, generally, an area of weakness in this area of study. The larger context within which nurses create and exercise power deserves much empirical study if shared governance is to advance. The organization-level context within which nurses gain, maintain or lose power includes factors as divergent as patient population characteristics, the organization's financial resources, organizational culture, leadership styles and personalities, even regulatory constraints and rules governing payments, and the historically prevailing "medical model" of medical decision making in health care in general. This team's reading of the literature suggests that few of these contextual factors have been incorporated into theories and studies on shared governance.

Here, the focus is on the intraorganizational context of nurses. That is, nurse power across levels of the organization. In particular, this paper begins to specify ways of studying the importance of vertical alignment between the power of the nursing department, led by nurse managers and executives, and the expression of power by nurses working on the floor in their respective work units.

Limitations and Implications

This study has several important limitations. The two studies used to evaluate the NPCes were conducted in the same seven-hospital system. Additional analyses with NPCes at other sites are needed more firmly establish its utility as an index of nursing council practice effectiveness. These analyses should be organized to include assessments of specific aspects of reliability and validity. In particular, follow-up studies should be designed with a conceptual framework for shared governance in mind, and include assessments of theoretically derived convergent validity. That is, if the NPCes is a strong index of the effectiveness of nursing practice councils, what other evidence can best be used to assess the interaction of NPCes with SKAGPO and/or to index shared governance in other ways.

This study did not conduct a thorough examination of the internal reliability or validity of SKAGPO, the suggested complementary measure. SKAGPO has been extensively used and tested previously. However, the suggestion here that SKAGPO

and NPCes may be powerful complements in understanding shared governance raises questions about how they interact with each other. As this study focused on the development of the NPCes and introduced a framework for understanding shared governance as the vertical alignment of nursing power in the organization, it raised important questions that it did not answer. The psychometric and practical interaction of these two instruments merits additional attention.

However much value the theoretical framework presented here may offer it requires work. It fills a gap in operationalizing the leadership contributed by nurses “in the trenches” and, consequently, demands a more realistic, multilevel view of how power operates in organizations. One of the strong values of SKAGPO is its theoretical breadth, including subscales that seem capable of helping to disentangle these levels, particularly in conjunction with measures specifically designed to observe the exercise of power by non-research, 12-hour shift nurses in action at the unit level.

It also offers the promise of mending the split between means and ends with which the literature on shared governance continues to struggle. If the field cannot formally operationalize how to approach the goal of shared governance, the state of the evidence on shared governance and how best to achieve it will remain largely anecdotal or case based. But this value of the framework presented in Figure 1 is now a promise. It is preliminary and needs study as well as further development. It does not, for

example, yet offer skeletal elements of “organizational context” on which to being layering substance.

Overall, these results contribute to the knowledge related to shaping work environments in ways that may improve decision-making. Specifically, this study suggests specific diagnostic tools to understand two levels for actualized power, one at the group or departmental level and one at the unit level. Departments of nursing, depending perhaps on their stage in the journey toward shared governance, have the option of determining which diagnostic level is most needful of examination and redesign. Nurse leaders may choose to use diagnostics at the group level to communicate challenges and to negotiate their power capacity with the wider organization in order to actualize power for shared goals. Meanwhile diagnostic reports at the unit level may provide nursing leadership with the insight on what they can do to support nurse practice councils and nurses seeking empowerment at the unit level.

Actualizing power by levels of nursing leadership should be approached utilizing both direct leadership and indirect leadership (Bass & Avolio, 1995). Direct leadership requires interaction with immediate followers, as when the chief nursing officer discusses nursing issues with the other senior staff of a hospital. Indirect leadership can be filtered through intermediaries to exercise power, as when nursing leadership designs ways to promote a culture of inquiry by offering training to

managers on the use of motivational language or offering training to nurses with patient care duties in the competencies of evidence-based practice. Both approaches to leadership serve to enhance the confidence and power perspective of the nursing group and unit level group.

The chief nurse executive, in particular, must ensure that the wider organization recognizes the contribution of nursing. This visibility will contribute to the power capacity and perception of power by the department of nursing and unit level nurses. In addition, the chief nurse executive must ensure that all levels of nursing leadership have the power competency, communication competency, power capacity, and resources to exercise power. Nurse leaders, in this way, build the supportive basis of power that can contribute to nurse practice councils' effectiveness. In the reverse direction, nurse practice councils must be coached with facilitation skills, problem solving skills, and be able to consistently see and come to trust this management support.

Understanding a department's nursing group power is a commitment toward establishing healthy work environments, where job satisfaction, employee engagement, and positive patient outcomes are experienced. How power is exercised vertically is a reflection of the organizational culture and its leadership. Nurse leaders must continue to strategize and provide venues to ensure the development of nursing confidence for

control of nursing practice, collaboration, and opportunities for inquiry to impact practice.

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Conflict of interest

The authors have no potential conflicts of interest associated with this study. Neither the authors nor their families have received any special financial or other tangible benefit, including patent ownership, stock ownership, consultancies, or fees, in conjunction with the study.

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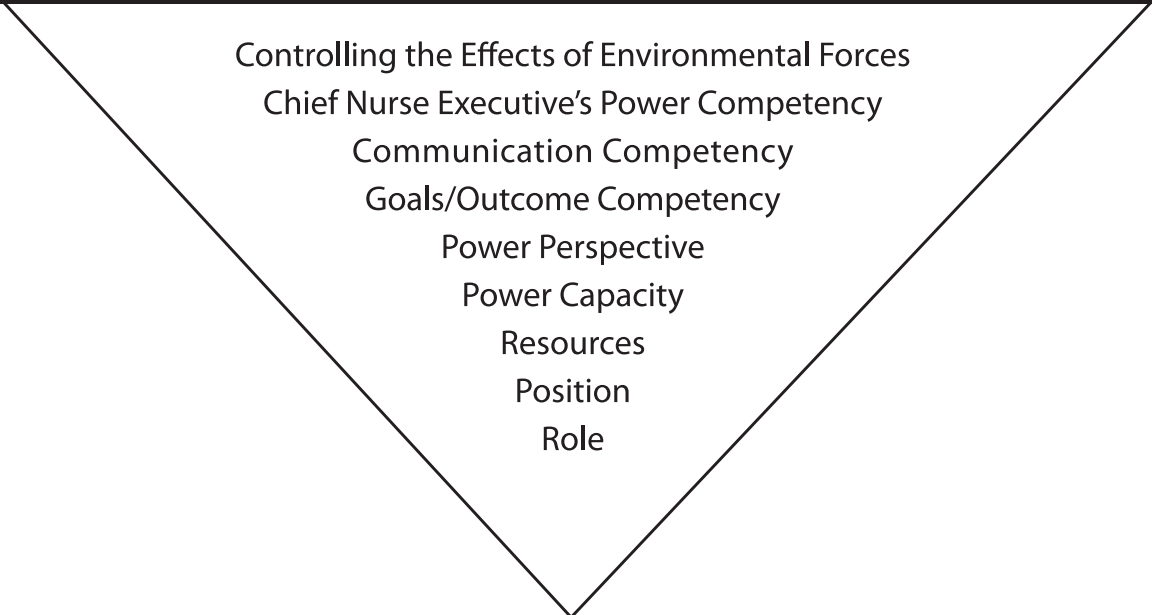
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Group Power within the Organization

(SKAGPO, Sieloff & King)



Controlling the Effects of Environmental Forces
Chief Nurse Executive's Power Competency
Communication Competency
Goals/Outcome Competency
Power Perspective
Power Capacity
Resources
Position
Role


Leadership Power Actualized
CONTEXT OF NURSE POWER



Nursing Shared Governance

PRACTICE OF NURSE POWER

Unit Power Exercised



Empowers Nurses
Operates Skillfully
Improves Patient Care
Improves Patient Safety
Receives Management Support
Examines Nursing Practice Issues
Results in Nursing Practice Changes
Improves Professional Respect for Nursing
Leads the Organization on Nursing Practice Issues

Nursing Practice Council Effectiveness

(NPCes)

Table 1: Elements of the Nurse Practice Council Effectiveness Scale (NPCes)

Attributes of Effective NPCs	Desired Results of Shared Governance
1. Skillful: operates effectively as a committee and as an engine of evidence-based studies	5. Empower nursing and nurses
2. Useful: focuses on examining practice issues	6. Improve patient care
3. Effective: results in changes in practice	7. Improve patient safety
4. Supported by Management: the NPC operates under circumstances that are favorable to its effectiveness	8. Lead the organization on nursing practice issues
	9. Improve professional respect and communication, including with physicians

Table 2: Focus and Sample Characteristics of Studies Using NPCes

	Study1	Study2
Focus	Evaluation of NPC implementation	Organizational context, nursing power and nurse manager personality
Data Collection	Apr-Jun 2006	Jan-Feb 2008
Collection Method	Interviews, on nursing unit	Online
Selection Method	Managers and NPC Chairs of 29 of 44 units with NPCs, and convenience sample of 3 members per NPC.	Three waves of invitations to population of all assistant nurse managers and above (N = 396). 248 responses = 62.6% response rate.
Effective Sample Composition	28 Nurse unit managers 91 Nurses, non-managers 24 NPC chairs 67 NPC members 119 Total	7 CNEs 27 Directors 38 Nurse unit managers 93 Assistant managers 83 Did not specify title 2 Refused to participate 250 Total

Table 3: NPCes psychometrics for Combined Studies, Study1, and Study2

	N	Mean	SD	Fctr ²	<i>r</i>	A ³
Supported by management	286	7.30	1.99	.570	.564	.938
Useful	286	6.76	2.04	.842	.806	.925
Contributing leadership	284	6.57	2.21	.838	.810	.924
Improving patient care	285	6.54	2.08	.860	.826	.923
Improving patient safety	285	6.47	2.25	.837	.800	.925
Conducted skillfully	285	6.24	2.17	.770	.749	.928
Effective	284	6.05	2.10	.830	.795	.925
Powerful	286	5.45	2.37	.818	.801	.924
Improving nurse-physician communication	281	5.40	2.51	.690	.669	.934
Combined Studies NPCes Scale Results	274	56.61	16.02	62.26%		.935
Supported by management	115	7.71	1.83	.547	.470	.896
Useful	117	7.47	1.60	.732	.745	.878
Contributing leadership	117	7.38	1.79	.713	.780	.873
Conducted skillfully	117	7.13	1.75	.607	.660	.882
Improving patient care	116	7.09	1.86	.805	.718	.877
Improving patient satisfaction	117	6.83	2.25	.903	.684	.880
Effective	115	6.58	1.84	.738	.664	.882
Powerful	116	6.26	2.01	.796	.797	.870
Improving physician nurse communication	115	5.70	2.55	.506	.496	.900
Study1 NPCes Scale Results	110	62.03	12.83	61.00%		.894
Supported by management	171	7.02	2.04	.574	.581	.948
Useful	169	6.27	2.16	.837	.807	.937
Improving patient satisfaction	168	6.21	2.22	.908	.872	.933
Improving patient care	169	6.17	2.15	.901	.865	.934
Contributing leadership	167	6.01	2.31	.821	.800	.937
Effective	169	5.69	2.19	.861	.834	.935
Conducted skillfully	168	5.63	2.22	.782	.756	.940
Improving physician nurse communication	166	5.19	2.48	.794	.769	.939
Powerful	170	4.91	2.45	.792	.781	.939
Study2 NPCes Scale Results	164	52.97	16.93	66.11%		.945

² For maximum clarity in examining item results across studies, Fctr shows loadings after rotation for Study1, but without rotation for Study2 and Combined since rotation is not possible for single factor solutions. For Scale Results, the Fctr column shows the percent of variance explained by NPCes.

© For item results, α is the estimated Cronbach's Alpha if the individual item were deleted. For Scale Results, α is Cronbach's Alpha for the NPCes scale.

Table 4: Initial criterion-related indicators of validity for NPCes

Type of validity	Source	Measure	n	r^4	p
Predictive	Study1	Job Satisfaction	104	.234	.017
Concurrent	Combined	Education level	241	-.062	.228
Concurrent	Combined	Position	235	-.226	.000
Convergent	Study1	Empowerment	105	.736	.000
Convergent	Study2	Group power	171	.505	.000
Discriminant	Study2	Extroversion	161	.239	.002
Discriminant	Study2	Agreeableness	161	.229	.003
Discriminant	Study2	Conscientiousness	161	.139	.079
Discriminant	Study2	Emotional stability	161	.114	.149
Discriminant	Study2	Intellectual Openness	161	.165	.037

⁴ For education level and position, the reported r is Kendall's tau-b for correlations with ordered variables. All other r are Pearson correlation coefficients.