The Implementation of a Nursing Practice Council

by

Kathleen Terry Desautels

A Practicum Project submitted to the Faculty of Graduate Studies of

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Abstract

Nursing Practice Councils were implemented in facilities within the Winnipeg Regional Health Authority in response to the recommendations from *The report of the Manitoba pediatric cardiac surgery inquest: An inquiry into the twelve deaths at the Winnipeg Health Sciences Centre in 1994* (Sinclair, 2000). This practicum project sought to define the Nursing Practice Council, to define the characteristics of a Nursing Practice Council, to explore the reasons for establishing a Nursing Practice Council, to determine the process required for establishing a Nursing Practice Council, to understand how Nursing Practice Councils are used and valued by nursing administration, and to implement a Nursing Practice Council at the Grace Hospital. Prior to the implementation of the new Nursing Practice Council, information was gathered through interviews with Chief Nursing Officers who had functioning Nursing Practice Councils and through the completion of a concept analysis. The theoretical inquiry in the form of the concept analysis combined with the experiential information of the Chief Nursing Officers, provided the basis for the implementation of the new Nursing Practice Council.

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Chapter One

Description of the problem

For many years, nurses in acute care organizations have practiced in hierarchal environments where the responsibility for decision-making occurs far from where nursing care is performed. In such hierarchical environments, ownership for problems and subsequent solutions rests solely with administration. As a result, organizational communication flows in a vertical direction, with information flowing from top to bottom. There are many disadvantages to an organization characterized by this vertical nature. For instance, higher costs for the provision of health care may result when frontline staff are not provided with the opportunities to participate in the decision making that may influence cost containment or reduction. As well, a restrictive environment may negatively affect both professional development and staff satisfaction. New organizational governing forms must be introduced to bridge the differences between the traditional bureaucratic models with centralized decision-making and professional practice models with independent authority for decision-making (Anthony, 2004).

The adoption of a professional governance framework in health care organizations may provide opportunities for staff empowerment through the promotion of accountability, ownership, and decision-making. Shared governance is an example of one professional governance model that has been used in health care settings. "Shared governance is a decentralized, participatory structure that fosters team work by allowing registered nurses a more active role in developing and implementing systems designed to achieve patient care outcomes and develop nursing practice" (Leary, Legg, & Riley, 1998,

p. 37).

The successful implementation of a shared governance model requires a distinct process, as well as an establishment of fundamental structures. Essential to the process of achieving a shared governance model is the establishment of partnerships between frontline practicing nurses and administration. One of the structures integral to the attainment of these partnerships is the Nursing Practice Council. In fact, the implementation of the Nursing Practice Council is essential to the process of operationalizing a shared governance model (Anderson, 1992; Porter-O'Grady, 1995; Alvarado, Bobin-Cummings & Godard, 2000).

The establishment of Nursing Practice Councils in the province of Manitoba occurred as a result of recommendations from *The report of the Manitoba pediatric cardiac surgery inquest: An inquiry into twelve deaths at the Winnipeg Health Sciences Centre in 1994* (Sinclair, 2000). As a result of what is commonly referred to as the Sinclair (2000) report, the Health Sciences Centre was charged with the responsibility of establishing a Nursing Practice Council. The recommendations for the establishment of the Nursing Practice Council from Sinclair (2000) were clear.

> It is recommended that: The HSC (Health Sciences Centre) restructure its nursing Council to allow nurses to select its membership and to give it responsibility for nursing issues within the hospital. The Nursing Council should have representation on the hospital's governing body and be responsible for monitoring, evaluating, and making recommendations pertaining to the nursing profession within the hospital and for nursing care. The Council should also serve as a vehicle through which nurses could report incidents, issues, and concerns

without risk of professional reprisal (p. 478).

In response to these recommendations, the Health Sciences Centre, as well as other facilities within the Winnipeg region, set out to establish Nursing Practice Councils. As one of the facilities within the Winnipeg Regional Health Authority, the Grace Hospital was poised to implement a Nursing Practice Council. The implementation of the Nursing Practice Council in this acute care community hospital became the objective of this practicum project. The goals of the project were to:

1. Define the Nursing Practice Council through the completion of a concept analysis.
2. Implement a Nursing Practice Council with the Chief Nursing Officer at a community hospital.
3. Explore the reasons for establishing a Nursing Practice Council.
4. Examine the process required for establishing a Nursing Practice Council.
5. Define the characteristics of the Nursing Practice Council through the completion of a literature search and through interviews with senior nursing leaders.
6. Understand how the Nursing Practice Council is used and is valued by nursing administration.
7. Understand how the Nursing Practice Council fits with the facility management, program management and with the concept of shared governance.
8. Identify the strengths and limitations of the Nursing Practice Council.

Summary

The recommendations from the Sinclair (2000) report provided the impetus for the implementation of Nursing Practice Councils in facilities within the Winnipeg Regional Health Authority (WRHA). The Grace Hospital was one of the last of the acute

care facilities within the WRHA to implement its Nursing Practice Council. Since there were functioning Nursing Practice Councils within the WRHA, opportunities existed to learn from the experiences of the Chief Nursing Officers who were associated with the hospitals. The experiential information from the Chief Nursing Officers combined with the results of the theoretical inquiry of a concept analysis, provided the basis for the implementation of a Nursing Practice Council. The purpose of this practicum is to identify the characteristics of a Nursing Practice Council, to determine how Nursing Practice Councils are used by various leaders and facilities within the WRHA, and to implement a Nursing Practice Council at the Grace Hospital.

Chapter 2

Concept Analysis

In preparation for the implementation of the Nursing Practice Council at the Grace Hospital, knowledge of the characteristics of a Practice Council was required. Unfortunately, a search of the literature revealed little on Practice Council, as well as Nursing Practice Council. This lack of information necessitated an alternate approach to ascertain the essential components comprising a Nursing Practice Council. The method chosen to uncover this information was through the process of concept analysis.

The goal of embarking on a concept analysis is to capture the true essence of the concept of Nursing Practice Council. "This essence typically is presented as a set of conditions that are both necessary and sufficient to delineate the domain and the boundaries of the concept" (Rodgers, 2000, p. 77). Rodgers' evolutionary approach to concept analysis was chosen for this examination of Nursing Practice Council. This analysis involved moving through five steps of a six-step process that included identification of the concept, identification and selection of appropriate realm, identification of attributes and contextual basis, analysis of data, and identification of an exemplar of concept. The sixth and final step of examining the implications for further development will be addressed in the conclusion of this document.

Identification of the concept

The concept of interest in this analysis is Nursing Practice Council. Several different names have been used to describe the entity known as the Nursing Practice Council, including committee, council, congress, and board. Through the process of completing the concept analysis, these terms will be examined for their relevance to the

concept.

Setting and sample

According to Rodgers (2000), the setting refers to the time period to be examined and the sample refers to the literature to be examined. Contributions from early researchers in the field of nursing, as well as current nursing literature will be included. The sample will include literature that is available, relevant, and pertinent to the understanding of Nursing Practice Council.

Data Collection: Attributes of the concept

This concept analysis began with an individual examination of each of the words that comprise the concept. It should be noted that the major focus of this particular exploration of the concept was placed on the relationship between practice and council. The examination of Nursing as part of the concept as a whole was addressed only in sufficient detail as to identify council ownership.

Nursing can be defined as the profession of a nurse, as well as the duties or tasks of a nurse (Merriam-Webster Online Dictionary, American Heritage Dictionary of the English Language, 2000). According to the Canadian Nurses Association (CNA), "nursing is a growing profession offering an astonishing range of choices and opportunities" (becoming a registered nurse, para 1). In Canada in 2005, there were 251,675 Registered Nurses employed in nursing (CNA, 2006, p. 2). Nursing also can be defined by the educational program from which a nurse graduates, as well as by the licensing body that grants the license to practice. There are three different licensing bodies and three distinct designations identifying nurses in Canada, the Registered Nurse (RN), the Licensed Practical Nurse (LPN), and the Registered Psychiatric Nurse (RPN).

> Registered nurses make up Canada's largest single group of health care professionals and practice in all clinical areas in every province and territory. RNs have the broadest scope of practice of all of the three regulated groups, and work in a variety of generalist, specialist, and advanced practice roles (Villanueve, M. & MacDonald, J., 2006, p. 26).

The range of responsibilities of the profession is useful in defining nursing. The range of nursing responsibilities also is referred to as the scope of practice. The scope of practice statement from the College of Nurses of Ontario (2005) states that

> The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventative, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function (p. 3).

Benner and Benner (1999) add to our understanding of nursing by describing it as being "centrally concerned with making astute judgements, skilfully performing and timing nursing and medical interventions, engaging in caring relationships with patients and working with other health team members" (p. 18). In summary, nursing can be described as a profession that has a range of responsibilities and skills used in the care of patients in a variety of settings. The exploration of the word practice clarifies the extent of the professional responsibilities.

Practice was the next word examined in the process of describing the Nursing Practice Council. Practice can be defined as "the exercise or pursuit of an occupation or profession" or the "business of a professional person" (Dicitionary.reference.com, practice, para 6-7). The description of practice includes "the performance of services that

are considered to require an appropriate license" (Merriam-Webster's Dictionary of Law, 1996, practice, para.3). In Manitoba, the College of Registered Nurses (CRNM) holds the legislated authority through the Registered Nurses Act (2001) to license Registered Nurses. The Registered Nurses Act of Manitoba (2001) indicates, "the practice of nursing is the application of nursing knowledge, skill, and judgement to promote, maintain, and restore health, prevent illness, and alleviate suffering (College of Registered Nurses of Manitoba, 1999, part 2, para. 1). Another view of practice can be obtained from the standards of practice established by professional nursing associations. Dean-Baar (1993) describes standards of clinical nursing practice "as authoritative statements that describe the performances that are common to the profession" (p. 35). According to Porter-O'Grady and Finnigan (1984), standards are statements used to define the performance expectations of a profession (p. 87). In summary, a practice refers to the work of a licensed professional carried out according to established standards.

The appreciation of the meaning of Council is vital to the understanding of concept of the Nursing Practice Council as a whole. The process of this exploration of council begins with a consideration of the synonyms. This examination of the words that have the same meaning or nearly the same meaning will provide an appreciation of the extensiveness of what could be involved with council. The synonyms for council according to Dictionary.reference.com include such words as "assembly, meeting, congress, diet, parliament, convention, convocation, and synod" (council, para. 7). These synonyms provide an indication that the work of a council might involve anything from the most basic of information sharing in an assembly, to more complex activities such as the decision-making that occurs to pass legislation.

To further delineate the uniqueness of council, words with similar pronunciation and spelling also were examined. The word counsel has the potential for being mistaken for council due to similarities in spelling and enunciation. Counsel and counsellor pertain chiefly to advice and guidance given to another and to a person (such as a lawyer or camp counsellor) who provides it (Dictionary.reference.com. council, para. 7 The American Heritage Book of English Usage, 1996, 3 word choice, council/counsel/consul). Although the pronunciation of council and counsel are the same, their meanings are significantly different. Council and counsel are not to be used interchangeably. (American Heritage Book of English Usage, 1996, 3.word choice, council/counsel/consul). It is significant within the realm of counsel and counselling that the issue of problem resolution is not addressed.

The word committee is another common word frequently used interchangeably with council. However, committee and council also represent distinct entities with different functions. Porter-O'Grady & Wilson (1995) believe that a committee's function is to serve in an advisory capacity to decision makers, whereas the council is the decision maker. These authors further describe a committee as being a structure that is directed by management to complete a prescribed assignment. An indication that management has influence on the agenda of a committee is illustrated by the references to delegation in the definitions. A committee is a "body of persons delegated to consider, investigate, take action on, or report on some matter" (Merriam-Webster Online Dictionary (2004), committee, para. 2a). Another dictionary refers to the work of the committee as being delegated, and includes the expectation that a committee produces a report (American Heritage Dictionary of the English Language, 2000, committee, para.1). The reporting

function indicates a passive nature that characterizes the work in which committees are engaged. The work of a committee, according to Porter-O'Grady and Wilson, tends to be focused on tasks and processes. This observation by Porter-O'Grady and Wilson on the work of the committee is supported by the description from other sources such as the Encarta World Dictionary (2006) in which committee is defined as a "group chosen to do task: a group of people appointed or chosen to perform a function on behalf of a larger group" (committee, para 1).

The use of the term committee can be seen in situations where a group functions within a traditional bureaucratic organization, where tasks have been delegated. In such situations, the committee's sole purpose lies in the provision of advice and guidance communicated through a written report and presented to an administrative body for decision-making. A committee's mandate does not include having authority for decision-making. Generally, a committee is struck as a temporary structure that is dissolved once its assigned work has been completed (Porter-O'Grady & Wilson, 1995, p. 161).

One of the similarities between the words council and committee is that each is used to describe a group of individuals who have been assembled for a particular purpose. In addition, both council and committee can be described as a structure. Council also is similar to committee in that a group of individuals are gathered for the purpose of discussion and provision of advice. However, the notion that a council merely represents a meeting struck for the purpose of consultation, advice, deliberation, or discussion is misleading. One of the characteristics of council is that it has been created in a purposeful manner. The evidence of purposeful manner is found in the American Heritage Dictionary of the English Language (2006), where council and councillor are referred to

as "a deliberative assembly (such as a city council or student council), its work and its membership" (council, usage note). Another unique feature of a council is in the method that council members are attained. Council is comprised of "a body of people elected or appointed" (Dictionary.com, The Webster Online Dictionary, 2003). The Merriam-Webster Online Dictionary (2004) further delineates a council as "a usually administrative body, an executive body whose members are equal in power and authority, a governing body of delegates from local units of a federation" (council, para. 3). There also is a link identified between the council structure and leadership within the religious community (Encyclopaedia Britannica, 2007; American Heritage Dictionary, 2004; Dicitionary.com, 2003). Council is defined as "a meeting of bishops and other leaders to consider and rule on questions of doctrine, administration, discipline and other matters" (Encyclopedia Britannica, 2007, council, para. 1).

The foregoing definitions describe council as an assembly of individuals who are either elected or appointed to serve. Additionally, council is seen to function as a governing body that is distinguished by delegates who are representative of all departments within an organization. By virtue of council membership, each member is afforded equal power and authority. There is also a distinctly deliberate manner in the way in which the council has been structured which makes it stand out from other groups, such as committees. The business of the council is dependent on the type of organization in which it exists, and could include aspects of administration, legislation, as well as an advisory capacity. In some settings, exemplified by the church, the business of the council involves both policy development and its attendant deliberation. Although power and authority of the council have not been directly addressed by the definitions, the power of

the council is alluded to in such important outcomes described as legislation, doctrine, discipline. "The expectation is that the council will see to it that the work related to the exercise of its authority will be carried out and will result in desired outcomes" (Porter-O'Grady & Wilson, 1995, p.162). The council should be accountable for decision-making, and should not require approval from another individual or body. "A requirement of approval would eliminate the functional and decisional value of the council" (Porter-O'Grady& Wilson, 1995, p.162). The characteristics of an ideal council would include the authority and accountability to make decisions about the issues that are brought to the table. Although any group can strike a professional practice council, the Nursing Practice Council is specific to serve the unique requirements of the nursing profession.

Summary of the Attributes of the concept

The attributes or the characteristics of the Nursing Practice Council were determined through the examination of the three words that comprise the concept. Firstly, nursing can be understood as being a licensed profession, relying on professional standards to guide the practice or the performance of approved nursing services by its members. Within an organization, the practice of nursing may be demonstrated by a range of positions within a variety of settings. The composition of the membership of the Nursing Practice Council should reflect this organizational diversity.

The council should be structured with a deliberate framework. Within this framework, the provision of advice and guidance may be included. However, the primary function of the Nursing Practice Council is to make decisions for the resolution of nursing practice issues. By definition, a Nursing Practice Council should have the power and the authority to undertake necessary actions to deal with whatever practice related issues are

brought to the council. The process of management review or approval of decisions that are made at the council should not exist. The authority and responsibility for decision-making should rest with the council. Activities such as policy development and/or the approval of policies are potential areas for council involvement. Unlike a committee whose mandate may be narrow and whose lifespan is limited, the work of the council is ongoing.

The Nursing Practice Council can be defined as an assembly of nurses, deliberately brought together for the purpose of solving issues specific to nursing practice. The council should belong to the group that it serves, in this case nurses, and should influence how nursing is practiced in their organization.

Data Collection: Contextual Basis of the Concept

"The focus in exploring the contextual aspects of the concept [Nursing Practice Council] is to understand the situations in which the concept is used, the use of the concept in those varying situations, and its use by people with potentially diverse perspectives" (Rodgers, 2000, p. 91).

One of the oldest references indicating the existence of a Nursing Practice Council came from Phillips (1976). In this early description of a group that functioned in a psychiatric institute in Toronto, the term Committee was used. This Committee was characterized as a participative management tool used to enhance the efficiency of a nursing department (Phillips). Each nursing area in the facility, as well as each category of nursing staff had representation. Management was minimally represented by the day supervisor and by the coordinator of staff development. The director of nursing was an ex-officio member. Links were created between the Nursing Practice Committee and

other nursing committees in the facility, such as those concerned with research, audit, education, and management. Some of the work done by this early Committee included examining the functions of the inpatient nursing staff, determining the objectives and philosophy of the nursing department, preparing job descriptions, developing evaluation tools for performance appraisals, and developing policies. Phillips indicates that the purpose of the Committee was to look at the practice of nursing. However, there was no indication that issues affecting the ability of nursing staff to provide care were addressed by this Committee.

Foley (2000) provides a different view of a structure she also refers to as a committee. The focus of this article was on how nurses can be involved in controlling their practice. This Nursing Practice Committee was portrayed as having a strong connection to the collective bargaining process. It is the belief of this author that the collective bargaining contract was an important tool in assisting professional nurses to make decisions affecting working conditions and quality of patient care. "Regularly scheduled meetings with nursing and hospital administrators can provide a forum for the discussion of professional issues in a safe atmosphere. Many potential contract conflicts can be prevented by discussion before contract talks begin or grievances arise" (p. 383). Examples of nursing concerns that would be brought to this Nursing Practice Committee included, staffing ratios, patient acuity, patient classification systems, training, and use of auxiliary staff. The description and operation of this committee serve to focus on the work life issues of nursing rather than the professional practice issues. Foley identifies a connection between shared governance and the Nursing Practice Committee. However, she asserts that this connection results in a negative outcome. "It is necessary to avoid a

legal finding that the nurses, who are part of a shared governance model, have become so involved in the governance activities of the facility that they are no longer eligible for representation by a bargaining agent" (p. 384). Missing in the description of this Committee is the composition and characteristics of the membership.

Alvarado, Boblin-Cummings, and Goddard (2000) describe the development of a Nursing Practice Committee following the merger of two hospitals and four physical sites into one large corporation. The creation of their Nursing Practice Committee occurred as a result of the reorganization of health care delivery and the adoption of a new governance structure that included the establishment of a Professional Advisory Committee representing 25 disciplines. Each of these individual disciplines subsequently created their own professional committee. The focus of this article was the process by which the Nursing Practice Committee was developed. Areas reviewed included the composition of the membership, the mandate, the structure of the committee, and the principles of the committee. In the process of implementing the Nursing Practice Committee, staff nurses from the four physical sites were recruited, a result which was seen as successful in achieving strong representation. Membership included the chief of professional practice, 15 staff nurses, four educators, and two faculty members from McMaster University School of Nursing (p. 31). The stated mandate of this Committee was to develop a discipline specific committee that would promote nursing participation and empower nursing staff (p. 31). Although a good description of the process of implementation of the Committee was provided, information regarding the types of issues discussed at the Committee level was not included. The hierarchy in the reporting structure of this Committee was described. Within the hierarchy, the Nursing Practice

Committee reported to a Professional Advisory Committee which reported to the Chief of Professional Practice who reported to the Chief Executive Officer. It was not described how decisions were made in this reporting structure. However, the evaluation of the process and outcomes of designing a nursing committee structure generated a positive account.

Sorenson (2002) described how the Practice Council functioned in hospitals in the province of British Columbia. She identified two main purposes of Nursing Practice Councils. Firstly, she stated that the Nursing Practice Councils provided nurses with a means of attaining self-governance. In addition, she identified that Councils were a benefit to staff "by providing a forum for vocalizing and discussing issues from different viewpoints" (Sorenson, p. 16). This author indicated a relationship between the professional association and the hospital council. Although this Council was hospital based, strong membership representation came from nurses at the hospital who were also workplace representatives of the professional nursing association, the Registered Nurses Association of British Columbia. Standards of nursing practice were central to the discussion and used in the resolution of issues brought to Council.

The focus of the article by Homsted (2003) provided a description of the purpose of a professional practice council and examples of projects that could be addressed by the council.

> A Professional Practice Council provides a formal structure for all levels of nursing staff to work together for the advancement of professional nursing practice across the facility, to develop leadership among the nursing staff to work to improve the quality of work life of nurses across the facility. Being involved in

> a Professional Practice Council offers nurses the opportunity to be more fully informed, get involved, be a role model and have a voice in addressing nursing issues in your facility. (p. 6)

Homsted recommended that either a hospital wide council or a unit-based council could be implemented depending on where the interest for a council lay in the facility. She envisioned that the implementation of a hospital wide council would include nursing representatives from each clinical area, as well as from nursing management and nursing administration. Examples of the projects that Homsted envisioned the Council undertaking, included: accessibility and standardization of equipment, professional development of nursing staff, documentation issues, and review of policy and procedure. This author did not provide any suggestion of a framework within which the Council functioned. Information on the membership of the Council was not included in the article.

The work of Timothy Porter O'Grady (1992, 2001, 2004) alone, and in collaboration with others (Porter-O'Grady & Finnigan,1984; Porter-O'Grady, Hawkins, & Parker,1997; Wilson & Porter-O'Grady,1999) provided extensive information about the Nursing Practice Council. The descriptions of the Nursing Practice Council were always presented within the context of a shared governance model. To this end, Porter-O'Grady & Finnigan (1984) and Porter-O'Grady (1992) provide guidelines on the implementation of shared governance, including how the Nursing Practice Council fits into this model. Three fundamental statements are made about the relationship between the Nursing Practice Council and the organization that has embraced shared governance.

1.The clinical professional nurse has a responsibility for all clinical nursing activity.

2. The clinical professional nurse shall define, delineate, approve, and evaluate the acceptable basis for clinical practice within the institution.

3. The process and responsibility for managing practice is not to transfer to some dissociated second level individual or group traditionally recognized within a management context. (Porter-O'Grady, Finnigan, 1984, p. 89)

Included in the guidelines set out by Porter-O'Grady and Finnigan (1984) are those relating to how the membership is chosen for the Nursing Practice Council. These authors believe that when choosing the composition of the membership, practicing nursing staff should be given first consideration. Furthermore, Porter-O'Grady and Finnigan define practicing nursing staff as those nurses whose main responsibility lies in the provision of direct care (p.89). According to these authors, the majority of the seats at Council should be held by frontline practicing nurses. Representation from other nurses, such as coordinators and managers, should be the minority of the membership. As well, the chair always should be selected from among the frontline practicing members (Porter-O'Grady, 1992, p. 44). Limiting the selection of the chair from the ranks of frontline practicing nurses allows frontline nurses to have representation at appropriate administrative levels. Porter-O'Grady and Finnigan also delineate a number of functions they believe the Nursing Practice Council performs. One of the most noteworthy functions of the Council includes, the "determination and resolution of all conflicts, controversies, and issues related to the appropriate delivery of clinical nursing care" (p. 89). Therefore, the Nursing Practice Council and the practicing nurses who make up the majority of the Council have the responsibility and authority to make decisions on all matters surrounding the standards of nursing practice within a facility.

Leary, Legg, and Riley (1998) describe the approach their facility took during their adoption of a shared governance model of care. During the evolution to shared governance, a central Nursing Practice Council with four subsidiary committees was established. Membership on the central Nursing Practice Council included a representative from each ward and department in the hospital, as well as from nursing executive. A representative from the central nursing practice council was included in the membership of each of the four subsidiary committees of nursing standards, quality improvement and research, resource management, and nursing executive. The chairperson of the central Nursing Practice Council was elected by the membership. According to Leary et al., shared governance was introduced to promote increased autonomy and increased accountability for nurses over their practice. The authors state that they encountered some difficulties during the first 12 months of implementation. However, they neglect to describe the difficulties. In order to overcome the complications, they chose to expand the shared governance model into every department and unit in the facility.

> Nearly three years on, shared governance is integrated into the organisational structure of the hospital, has gained acceptance by the governing board and hospital management, and has accelerated the confidence and growth of individual nursing staff and the nursing division as a whole. (Leary et al., p. 39)

These authors also recommended that, for shared governance to be successful, it was essential that the entire organization embrace the model.

Evan, Aubry, Hawkins, Curley, and Porter-O'Grady (1995) refer to the implementation of a Nursing Practice Council as being one of the steps in the

restructuring process their hospital took towards implementing a shared governance model. They describe the Nursing Practice Council as initially being created for dialogue and decisions affecting nursing care. However, as the facility moved forward with shared governance, the Nursing Practice Council evolved into a Patient Care Council.

> The leadership of the nursing practice council, nursing administration, and clinical leadership from other disciplines began to conceptualize a patient care council whose accountability it would be to make decisions about patient care, quality, and work issues related to the delivery of patient based services. (p. 20)

With the evolution of the Nursing Practice Council into the Patient Care Council, the membership also evolved to include other disciplines in addition to nursing who were involved with patient care. All service areas at the facility had representation. The majority of the members were staff members, with administration having minimal representation. Furthermore, there were links created between the Patient Care Council and the other councils in the facility (operations, governance, physicians). Accountability for decisions related to patient care delivery was the responsibility of the Patient Care Council. The Operations Council that existed in this model functioned to ensure that the decisions made by the other Councils were supported and carried out. In this example of shared governance, the Chairs of all the Councils, including the Chair of the Patient Care Council, were also members of the Operations Council.

Foster (1993) identifies the Nursing Practice Council as an important structure which is at the centre of any shared governance system. Generally, the formation of the Nursing Practice Council was envisioned as one of the first steps towards implementing a governance model. According to Foster, the membership on the Council should be

composed of staff nurses, a manager, and a nursing administrator.

The "voyage" to shared governance, according to Anderson (1992) began with the Nursing Council serving as the implementation committee for this model of care (p. 65). Initially, staff nurses were chosen for the positions of chairperson and chair-elect for this 26-member council. In subsequent years, nurses with at least one year's employment at the hospital would submit their names to be entered in a lottery to be drawn for membership. Each member on the Council was expected to serve a two year term with one fourth of the members changing every six months. Membership on the Council included a wide representation of nurses from each level of the "clinical ladder," as well as 13 staff nurses (p. 66). This membership configuration had 50% of the 26-member council represented by staff nurses. The work of the Council included enhancing the professional role of the nurse. In the process of fulfilling this objective, the Council developed a new dress code. Future work of the Council included the development of Council by-laws and a shared governance model. The authors believed that, through the progress made in implementing a shared governance model, individual nurses as well as the profession of nursing was empowered.

DeSantis and DiTolvo (1999) describe a connection between shared governance and their Professional Nursing Care Advisory Board. This article describes the completion of a project that was directed by a Professional Nursing Care Advisory Board. The board members liased with both staff and management to achieve common goals. Open communication between administration and the board members was featured as an important function of the group. The board consisted of ten members elected from each clinical area by their peers. The board members served for18 months. In addition to the

ten elected members, there were ten alternates, as well as a Clinical Nurse Specialist who served as a facilitator.

The move to a professional practice model has been connected to the objective of achieving Magnet status, a prestigious award of recognition from the American Nurses Credentialing Centre. Professional practice models are an expectation of the Magnet program, with shared governance a frequent choice (Drenkard, 2005; Steibinder, 2005; Taylor, 2005; Johnson, Billingsley, May, Costa, & Hanson, 2004; Force, 2004). An integral part of establishing a professional practice model such as shared governance, includes the implementation of either a supporting council or a congress structure. Mathews & Lankshear (2003) believe that the essential element of any professional practice structure is the presence of a council. Drenkard (2005) identifies the use of a Nursing Practice Congress as a key element within the congressional method of shared governance that exists in her facility. The process of attaining Magnet designation leads to the adoption of an organizational model of shared governance and the complementary councillor or congressional structures to support it.

Upenieks and Abelew (2006) believe that the expectations of the Magnet program played a significant role in guiding the reorganization of their nursing department from "a hierarchical ownership to a shared governance partnership" (p. 249). Stolzenberger's (2003) organization identified an increasing dissatisfaction with the nursing department's traditional committee structure at the same time as they were investigating the Magnet program. In Stolzenberger's (2003) organization, the Magnet standards promoted staff nurse participation in departmental governance and subsequently, guided the organization to create a Nursing Practice Council. "The vast majority of the hospitals that have

achieved Magnet status use shared governance as their structural model for sustaining professional nursing practice. Indeed, most of these hospitals wouldn't have obtained, nor sustained their magnet status without it" (Porter-O'Grady, 2004, para. 1).

Analysis of Data

Through the analysis of the data collected on the background and the characteristics of the Nursing Practice Council, the true essence of this concept can now be determined. One of the most important characteristics of the Nursing Practice Council is that it is owned by frontline practicing nurses. These front line practicing nurses can be described as licensed members of a professional association, who practice in a particular health care organization. As members of a licensed profession, nurses rely on standards to guide their performance or practice. These standards of practice for nurses also should guide the way in which the Council operates to solve practice issues. The Nursing Practice Council should exist as a structure in the framework of an organization. The Nursing Practice Council and its members should have the authority to make decisions relevant to nursing care that are independent of administrative or management approval.

The examination of the contextual basis of the concept provided information on where and how a Nursing Practice Council functions. Organizations that have implemented Nursing Practice Councils are primarily hospital organizations within Canada (Alvarado et al., 2000; Sorenson, 2000; Legg et al., 1998; Phillips, 1976), the United States (Drenkard, 2005; Homsted, 2003; Stolzenberger, 2003; DeSantis & DiTolvo, 1999) and the United Kingdom (Doherty, 2000). There was no evidence of Nursing Practice Councils functioning in other settings such as clinics or community agencies. Where Nursing Practice Councils were found in hospitals, most were acute care

facilities (Taylor, 2005; Stolzenberger, 2003; Homsted, 2003; Alvarado et al., 2000; Sorenson, 2000; DeSantis & DiTolvo, 1999; Legg et al., 1998). One example existed of a practice committee functioning in a psychiatric facility (Phillips, 1976).

Several different names were used to denote a Nursing Practice Council, including committee, council, congress, and board. Committee was used by Phillips (1976); Alvarado et al.(2000); and Foley (2000), whereas council was used by Homsted (2003); Stolzenberger (2003); Evan et al. (1995); Porter O'Grady (1992, 2001, 2004); Porter-O'Grady & Finnigan (1984); Porter-O'Grady, Hawkins, & Parker (1997); and Wilson & Porter-O'Grady (1999). The term board also was identified as being used in conjunction with this structure (DeSantis & DiTolvo, 1999). Nursing Practice Congress was selected by Drenkard (2005). There was no correlation between the dates of the articles and the choice of the name for the group. Of note were Stolzenberger's (2003) actions in changing the name from committee to council, which points toward the significance attached to the name of the group. During the process of meeting the criteria for Magnet status, Stolzenberger (2003) related that both the name, as well as the focus of the Nursing Practice Committee was changed to Nursing Practice Council. Although the name the group is known by should be reflective of its importance, there does not appear to be a specific reason for choosing the name for the group other than personal preference.

A connection was found between the implementation of the Nursing Practice Council and the adoption of a shared governance model (Disantis & DiTolvo, 1999; Leary et al., 1998; Evan et al., 1995; Foster, 1993; Anderson, 1992). The Nursing Practice Council was seen as one of the steps in the process of embracing shared governance. In

some situations, it was the first step in the process (Anderson, 1992; Foster, 1993; Evan et al., 1995). In other circumstances, the Nursing Practice Council was implemented after other pieces of a shared governance structure were in place. The effort to achieve Magnet status repeatedly drove the implementation of a professional practice model and subsequently, a Nursing Practice Council (Drenkard, 2005; Steibinder, 2005; Taylor, 2005; Johnson et al., 2004; Force, 2004). There were also situations in which there was no connection between shared governance and the Nursing Practice Council (Phillips, 1976; Sorenson, 2002).

The purpose of the Nursing Practice Council was identified as providing a forum for the discussion and resolution of those professional practice issues that were unique to nurses in their organization. Within the shared governance implementation manual, Porter-O'Grady (1992) indicated that the function of the Nursing Practice Council was "to define and control issues related to clinical practice" (p. 41). According to Alvarado et al., (2000); Sorenson, (2000); and Homsted, (2003), the Nursing Practice Council provides a means for nurses to voice and resolve their professional concerns. Porter-O"Grady and Finnigan (1984) believed the role of the council rested in the "determination and resolution of all conflicts, controversies, issues related to the appropriate delivery of clinical care" (p. 89). Homsted (2003) expanded on the purpose of the council, as she described a formal structure for all levels of nursing staff to work together for the advancement of professional practice and promotion of leadership across the facility. Evan et al., (1995) also identified the Nursing Practice Council as having a role in the promotion of professional development of nurses.

According to Porter-O'Grady (1992), the power to make key decisions rests

within the role of the Nursing Practice Council (p.41). The promotion of decision making by nurses at all levels of the organization, was seen as one of the principle functions of the council (Force, 2004; Alvarado et al., 2000; Evan et al., 1995). Incorporated within the responsibility for decision making on practice issues was the ability to act on those solutions without management approval. As a result of having the authority and accountability for nursing practice, nurses should become more empowered. Anderson (1992) and Force (2004) identified empowerment as an outcome of the implementation of shared governance, including a Nursing Practice Council. Porter-O'Grady (2001) also identified shared governance as fostering the empowerment of nurses. In relation to the Nursing Practice Council, empowerment was seen as a positive outcome according to Sorenson (2002), and a negative outcome according to Foley (2000).

There was agreement in the literature that the majority of the membership of the Nursing Practice Council should come from the ranks of frontline practicing nurses. It was also suggested that each clinical area be represented by a practicing nurse (Phillip, 1976; Porter-O'Grady, 1992; DeSantis et al., 1999; Homsted, 2003). Frontline practicing nurses also should hold the majority of the seats at Nursing Practice Council (Porter-O'Grady & Finnigan, 1984; Alvarado et al., 2000) and management should have minimal representation (Phillips, 1976; Porter-O'Grady, 1992). In fact Porter-O'Grady (1992), recommended that management be represented on Council by one manager and one administrator. However, lacking in the literature were guidelines on how to achieve the objective of the desired membership composition.

Links between the Nursing Practice Council and other nursing organizations were revealed. Foley (2000) believed that the Nursing Practice Council should have a

relationship with the labour union. According to Foley (2000), the purpose of the Nursing Practice Council was to serve as a forum for the resolution of issues pertaining to the collective agreement. In contrast, Sorenson (2000) believed that the purpose of the Nursing Practice Council was for the examination and resolution of professional practice issues as indicated by the standards of the professional association. There was a link to the academic world with the addition of faculty membership on the Nursing Practice Council described by Alvaredo et al (2000).

Through this examination and analysis of the data, a clearer understanding of the Nursing Practice Council has been achieved. The next step in understanding of this concept is derived from an example of the process of implementing a Nursing Practice Council.

Exemplar of the Concept

"The purpose of identifying an exemplar is to "...illustrate the characteristics of the concept in relevant contexts, and as a result enhance the clarity and effective application of the concept of interest" (Rodgers, 2002, p. 96). In the course of determining the characteristics of a Nursing Practice Council, the search for information consistently ended within the tenets of shared governance. Repeatedly, the structure known as the Nursing Practice Council was found entrenched in the literature on the shared governance framework. As a result, this exemplar will examine how the implementation of a Nursing Practice Council fits within the framework of a shared governance model. The guidelines from Porter-O'Grady's (2001) work on shared governance implementation will form the basis for the example.

Porter-O'Grady (2001) described the implementation of shared governance as a

journey that takes place in three stages. Stage one involves formulating the changes necessary for the organization and the people to move to the shared governance model. In stage two, the structures needed to support the shared governance framework are created. Finally, the process of maintaining shared governance is outlined in stage three.

Stage one involves the creation of changes to both the individuals and the system (Porter-O'Grady, 2001). Any organization contemplating a move to shared governance must consider how the environment and the people of the organization should be prepared to transform their operating method. The mangers and leaders of the organization are vital to the success of this stage. It is through the management structure that the decision to embrace this model occurs. In the initial phases of the project, the momentum is in the control of the managers. In this stage, it is important that all of the preliminary preparations be made before proceeding to the next steps. "Failure to address underlying issues in the first stage of change means either revisiting them later or undermining the subsequent stages dooming them to failure in the long term" (p. 472).

The focus of this preparatory stage involves clearly defining the meaning of shared governance for each individual in the organization. "To ensure lasting change a slow evolutionary approach to implementing shared governance is necessary requiring persistence and determination" (Doherty et al., 2000, p. 78). It is particularly important during this preparatory stage that everyone in the organization, from staff nurses to managers, have a similar understanding of what shared governance entails. Gavin et al., (1999) believe that if shared governance does not mean the same thing to everyone involved, the "ramifications for successful implementation will be profound" (p. 194). Caramanica (2004) stated that until all the managers in her facility had accepted the

organizational changes implicit in shared governance, staff were unable to exercise legitimate authority for nursing service (para 7, line 13).

The second stage in the move to shared governance (Porter-O'Grady, 2001) involves undertaking the structural changes to support the new behaviours. In this phase, structures and principles needed to support shared governance are implemented. Organizations that implement shared governance typically create new organizational structures, such as councils. An important structural changes occurring in this stage is the establishment of a framework of inter-related councils. It is crucial during this stage that individuals learn the principles involved to effectively create and maintain the council structure. The Nursing Practice Council in particular, is viewed as being an important structure that is at the centre of any shared governance system (Foster, 1993, p. 92).

The Nursing Practice Council is often one of the first councils set up in the process of implementing a governance model. However, as Brooks (2004) indicates, creating the structure of the councils is the easy part of implementing shared governance (para.2). A greater challenge lies in ensuring that the individuals involved in the process learn the principles involved to effectively create the council structure. This second stage, according to Porter-O'Grady (1992), involves the affirmation of critical power shifts and authority reconfiguration. Gavin et al., (1999) state that "implicit in shared governance is the transfer of control from supervisory and middle management to front line staff" (p.196). With a transfer of control, frontline staff will need to be prepared to manage their new responsibilities. Designing learning activities to address such needs as decision making, team building, partnership, ownership, empowerment, and accountability will be required.

The operationalization of the shared governance model can be accomplished by using one of three frameworks, an administrative model, a congressional model, or a councillor model. The councillor model was identified as the most common model of shared governance in use (Porter-O'Grady, 1992; O' May & Buchan, 1999; Hess, 2004). Although not implicitly declared as such, the councillor model was described as being the framework for the implementation of shared governance (Taylor, 2005; Stolzenberger, 2003; Homsted, 2003; Alvarado et al., 2000; Sorenson, 2000; DeSantis & DiTolvo, 1999; Legg et al., 1998; Evan et al., 1995; Anderson, 1992).

In the councillor model of shared governance, a coordinating council guides the work of the supporting councils (Porter-O'Grady, 1992; Westrope, Vaughn, Bott, & Taunton, 1995; Hardt, 1996; Leary et al., 1998; Doherty & Hope, 2000; Force, 2004). The number and type of supporting councils established depends on the functional areas of professional practice that exists in each individual organization. It is within the framework of the councillor model that the Nursing Practice Council functions as one of the supporting councils. Other supporting councils could include a management council, an education council, a quality council, or others at the discretion of the coordinating council. In many circumstances, the organizational adoption of a shared governance framework begins with the establishment of a Nursing Practice Council. "This reflected the notion that change must begin with the largest group closest to the point of service. If change does not happen there, it does not matter where else it takes place" (Wilson & Porter-O'Grady, 1999, p. 165).

The final stage of the implementation of the shared governance model involves the maintenance of all of the principles, processes, and structures that were established in

stage two. The preservation of shared governance and the councillor structures, such as the Nursing Practice Council, requires ongoing commitment by all of the stakeholders from management to staff. The nurses in the organization will benefit from shared governance in their ability to have control of their practice and share in the decisions that affect work life throughout the organization (Caramanica, 2004, para. 12, line 22).

The purpose of identifying an exemplar is to "... illustrate the characteristics of the concept in relevant contexts and as a result enhance the clarity and effective application of the concept of interest" (Rodgers, 2002, p. 9). The effective functioning of the entity known as the Nursing Practice Council occurs when the implementation takes place within well-planned organizational endeavour.

This exemplar clearly demonstrates that the Nursing Practice Council exists as one of the structures in the framework of a shared governance model. For that reason, the implementation of a Nursing Practice Council should occur in a systematic approach within the auspices of a shared governance model. The role for the management of an organization is to initiate the movement towards a shared governance approach. At the same time, it is essential that management transfers the authority and decision-making responsibilities to the staff that make up the majority of the membership.

Summary

Rodgers' (2000) evolutionary approach to concept analysis was used to examine the concept, Nursing Practice Council. This analysis involved working through a five step process starting with the identification of the concept. An exploration of the setting and sample addressed the source of the research that would be explored in the analysis. Through the examination of relevant contributions in the literature from the field of

nursing, the attributes of the concept were determined. The Nursing Practice Council was identified as an assembly of nurses deliberately brought together for the purpose of solving nursing practice issues. One of the most important attributes of the Nursing Practice Council was identified as the power and authority to make decisions regarding nursing practice issues. The data collection and analysis enhanced the information on the Nursing Practice Council with additional evidence confirming ownership of the Council by frontline practicing nurses. Through the process of data collection, a connection between the Nursing Practice Council and shared governance was revealed. Literature on the achievement of Magnet status within hospital organizations also demonstrated the implementation of a shared governance model and subsequently, a Nursing Practice Council. An exploration of an exemplar of the concept further consolidated the belief that the Nursing Practice Council should be a part of a professional practice model, such as shared governance. This evidence verifies the belief that the Nursing Practice Council should exist as one structure in a framework of a shared governance model.

Chapter 3

Methodology

Three approaches were taken during this practicum project to expand the existing knowledge base of the structure and functioning of the Nursing Practice Council. The significance of what is meant by a Practice Council was determined thorough the completion of a concept analysis using Rodgers (2000) evolutionary approach (see Chapter 2). To further expand on the available information on the structure and function of Nursing Practice Councils, five Chief Nursing Officers (CNOs) who had implemented a Nursing Practice Council and who represented different facilities within the WRHA were interviewed. Prior to conducting the interviews with the CNOs, approval was sought and received from the University of Manitoba Education/Nursing Research Ethics Board (see Appendix A). The information from the concept analysis and the interviews with the CNOs assisted in the third activity, the planning and subsequent implementation of a new Nursing Practice Council in a community hospital.

Interviews were conducted with five CNOs from within the WRHA. These CNOs were recruited with the assistance of the CNO from the Grace hospital with whom the student was collaborating. A letter from the Grace Hospital CNO together with a letter of introduction from the student was sent to six CNOs within the WRHA. The student subsequently contacted the five CNOs who agreed to participate to arrange an interview. The goal of the interviews was to discover what value the Nursing Practice Council provided to the CNO and to their facility. It was expected that the interviews would provide valuable information pertaining to the process of implementation, as well as the ongoing operation of the individual councils. A list of 15 interview questions (see

Appendix B), as well as the consent form (see Appendix C) for the interview were sent to the CNOs prior to the scheduled interview date. Each of the interviews was approximately 1 hour in length and were held between November 2003 and January 2004. The data obtained from interviewing the five nursing leaders was compared to the four desired attributes for the operation of a Nursing Practice Council as identified by Sinclair (2000). The first expectation was that nurses in an organization be allowed to select the membership of the Nursing Practice Council. In addition, the nurses who served on the Nursing Practice Council were to be charged with the responsibility for nursing issues within the hospital. Also included in the mandate of the Council, according to Sinclair, was the responsibility for monitoring, evaluating, and making recommendations pertaining to the nursing profession within the hospital, and for nursing care. Finally, the Nursing Practice Council was to have representation from its membership on the hospital's governing body (p. 478).

At the same time as the interviews were taking place, preparations for the implementation of the council at the Grace Hospital began. These preparations included a number of planning sessions between the student and the CNO at the Grace Hospital. One of the first tasks accomplished during these meetings was a draft proposal for the Terms of Reference. Using the Terms of Reference from established Nursing Practice Councils within the WRHA as a guideline, the Terms of Reference and membership profile for the new council were drafted. In creating the Terms of Reference and membership structure for the Grace Hospital Nursing Practice Council, the unique culture and structure of the organization were taken into account.

In planning for the Nursing Practice Council, there was mutual agreement

between the student and the CNO, that the majority of the members serving on the Council should be frontline nurses representing their nursing area. It was believed that having frontline nurses in the majority of the members on the Council, would increase the likelihood of having their voices heard on practice issues. As well, it was hoped that, as a group, the nurses would feel more comfortable expressing themselves in a setting where the membership was predominantly their professional peers. The implementation plan included having one nursing representative from each of the 11 nursing areas. Also to be included in the membership was an educator, the infection control practitioner, and the local nursing union president. There would be limited representation from nursing management on the council. In addition to the CNO, three Council members would represent nursing management. In total, the Nursing Practice Council would have a membership of 18. The CNO would initially serve as Nursing Practice Council Chair, with the view of having a Council member take on the position once the Council was fully functional.

It became apparent during the planning for the Nursing Practice Council, that a climate of trust and transparency with the local nurse's union at the facility had to be maintained. During the initial stages of implementation, the CNO fielded some inquiries from the nursing union concerning the role of the Nursing Practice Council. In particular, there were some questions about how this new council and the existing labour management council (Nursing Advisory Council) were different. A decision was therefore made to provide a seat on the Nursing Practice Council to the local president of the labour union representing the nurses.

Although the initial intent was to have the nursing units elect their representatives,

there was not sufficient interest on any of the individual nursing units to effect this plan. Therefore, the first group of representatives for the Nursing Practice Council were appointed from those nurses who volunteered. An unexpected benefit occurred however, when more than one nurse from a unit showed an interest in participating on the Council. When this occurred, both nurses were accepted and a system of having alternates was created. As a result, if one nurse was unable to attend a meeting, there was another individual who could represent the area.

The next step in the implementation was to seek approval from the Nursing Administration team on the proposal for establishing the Nursing Practice Council, including the Terms of Reference and membership structure. Within this group, the approval of the Nursing Unit Managers was particularly important in ensuring that the implementation was successful. These Managers were integral to the process as they would be responsible for encouraging their staff nurses to represent their areas on the Nursing Practice Council. They also were expected to provide behind the scenes commitment and support necessary to ensure that members would have the time away from demanding nursing units to attend the monthly meetings.

The explanatory meeting regarding the implementation of the Nursing Practice Council was successful and resulted in the acceptance of the plan by the members of the nursing administration. The announcement for the launching of the Nursing Practice Council at the Grace Hospital subsequently was distributed to all the nursing units. Attached to the written notice was a poster advising nursing staff of the upcoming meeting and requesting interested individuals to discuss their interest with their manager or the CNO (see Appendix D). Names of nurses who agreed to serve on the Nursing

Practice Council were then submitted from the unit manager to the CNO. A letter of welcome was sent to those nurses chosen for the Nursing Practice Council from the CNO (see Appendix E). Included with the letter was Sorensen's (2002) article describing a Nursing Practice Council. This short two-page article was chosen to provide some background information on the functioning of a Nursing Practice Council in preparation for the first meeting.

The CNO and the student decided that an orientation session would be useful to familiarize the membership with the operations of a Nursing Practice Council. A four-hour orientation session was planned. Each nurse in attendance for the orientation was granted four hours of paid time whether or not she was previously scheduled to worked on the orientation day. If the orientation happened to fall on a regularly scheduled working day for the member, a replacement nurse was obtained. The session started at 1230 with lunch provided by the CNO. The provision of paid time, in addition lunch at the orientation, conveyed the importance of the Nursing Practice Council to the nurses.

The student and the CNO determined the agenda for the first meeting, as well as the content of the orientation session (see Appendix F).The orientation session was prepared and presented by the student. The orientation session commenced with a description of the Sinclair (2000) report. This brief account of Sinclair's report was intended to assist the members of the Nursing Practice Council understand the reasons behind the formation of the Council. The focus was placed on reviewing the particular recommendations from the report that related to the implementation of a Nursing Practice Council. Following the review of the recommendations, a description of the characteristics of a Nursing Practice Council was provided. In particular, what constituted

a nursing practice issue was discussed. A systematic approach to determine which issues could be brought to Council was provided to ensure that members were clear on what constituted appropriate nursing practice issues. Guidelines from the Registered Nurses Association of British Columbia (1986) and Kucy's (1986) article on resolving professional practice issues according to the Registered Nurses Association of Nova Scotia were used to formulate an approach to determine situations which constitute a professional practice issue. Unfortunately, the CRNM did not have a guideline of this nature to refer to. Finally, a case study on the identification and the process of resolving a practice issue was used to promote discussion and to apply the principles that were presented.

The first meeting of the Grace Hospital Nursing Practice Council was held on February 3, 2004 with 17 of 18 members in attendance. During this first meeting, the Terms of Reference were accepted and a schedule of monthly meetings was decided. It was determined that the meetings would be held monthly for 90 minutes. Members coming to the meeting on their days off would be financially reimbursed for attending. The CNO's administrative assistant would send out the agenda two weeks prior to the meeting. It was expected that members would submit their agenda items to the CNO's administrative assistant well in advance of the next meeting. Administrative support would be provided for transcribing and distributing the council minutes. This administrative support would allow all council members to be able to concentrate on the issues brought forward for discussion.

Summary

The methodology for this practicum project involved the use of three approaches to

expand the existing knowledge base of the structure and functioning of the Nursing Practice Council. This chapter focused on the planning required for the implementation of the Nursing Practice Council at the Grace Hospital.

Chapter 4

Interviews with Chief Nursing Officers

The implementation of the Nursing Practice Council at the Grace Hospital occurred following the establishment of other Practice Councils in facilities within the Winnipeg Regional Health Authority. Given that there was experience in implementation within the WRHA, Chief Nursing Officers from health care organizations with existing and functioning Nursing Practice Councils were approached for information. The information that was obtained from the interviews with these CNOs was used in the implementation and development of the Nursing Practice Council at the Grace Hospital. At the time of interviews (Fall, 2003), the Nursing Practice Councils in the five facilities examined had been in place for 2 to 6 years. The facility whose practice council had been in place the longest had changed the iteration of the council at least three times during the 6 year period. However, in four of the five facilities, the establishment of a Nursing Practice Council was a relatively recent event occurring within 2 years.

The implementation of Nursing Practice Councils in the WRHA was a result of *The report of the Manitoba pediatric cardiac surgery inquest: an inquiry into twelve deaths at the Winnipeg Health Sciences Centre in 1994* (Sinclair, 2000). This report, commonly referred to as the Sinclair Report, was cited as the primary reason for establishing a Nursing Practice Council in four facilities, as well as at the Grace Hospital. One CNO stated that the establishment of the council was

> *...directly related to the pediatric inquest and the fact that it was clear through that whole process that nurses' voices were not heard in the right places at the right time around the right things.*

The Sinclair Report was not cited as the reason for the establishment of the Nursing Practice Council in one organization. According to the CNO in this hospital, the implementation of the Nursing Practice Council coincided with a movement from a model of centralized nursing services to a program management model. The predecessor to the Nursing Practice Council was described by this CNO as

> *...an integrated nursing practice committee composed of four standing committees, policy and procedure, education, research, and professional development. I think the old committee was much more management focused, administrative focused, and this one is more broad based.*

During the discussion with the CNOs concerning the development of their Practice Councils, another Council and its relation to the Nursing Practice Council was mentioned. The Nursing Advisory Council exists at all five facilities represented by the CNOs as well as at the Grace Hospital. The Nursing Advisory Council provides the opportunity for the labour union representing nurses, and nursing management to meet and discuss issues related to the collective agreement. This council's business is limited by the parameters of the collective agreement and may address such issues as overtime, staffing levels, and unsafe workloads. The Nursing Advisory Council would not be the appropriate forum for addressing such issues as standards of care and professional practice. Sinclair (2000) believed that, prior to the dissolution of the Nursing Advisory Committee at Winnipeg's Health Sciences Centre in June 1994, this committee "had significant status and authority within the hospital over the regulation of the nursing profession" (p. 91). This statement gives rise to some uncertainty as to whether Sinclair's recommendations were based on the belief that the Nursing Advisory Committee and the

Nursing Practice Council were essentially the same entity.

Of interest was the concern expressed by nurses at some of the facilities that the Nursing Practice Council might take over the responsibilities currently held by the Nursing Advisory Council. According to one CNO, nursing staff initially perceived that the Nursing Advisory Council and the Nursing Practice Council had similar purposes.

> *There's been quite a bit of criticism about Nursing Practice Council usurping the role of Nursing Advisory Council and I of course see them as different mandates.*

Another CNO confirmed the nursing staff concerns.

> *They [staff] were very concerned about this particular council in relation to Nursing Advisory Council, in relation to their collective agreement, and it took us a while to get over that hump of what not to come and complain about.*

One CNO was quite clear in her understanding of the differences between the two groups.

> *The Nursing Advisory Council has its focus on individual issues of a Registered Nurse whereas the Nursing Practice Council functions to assess the common good of nursing as a discipline within the organization and how we work together collectively.*

It was evident that practicing nurses were confused about the differences between the functions of these two councils whereas the CNOs were not at all confused.

There were differences between the five facilities as to how the labour union and the Nursing Practice Council related to each other. In four of the facilities, the section in the Terms of Reference listing the membership of the Nursing Practice Council did not identify a specific member from the labour union representing nurses in the organization.

Only one facility included specific labour union representation on the membership list of the Practice Council. One CNO received much criticism about the Nursing Practice Council usurping the role of the Nursing Advisory Committee. Her belief was that the mandates of the two Councils were quite different. Another CNO stated that the labour union was not invited to Council membership. The majority of the frontline practicing nurses from these facilities belong to a collective bargaining unit. Therefore, if the majority of the membership of the Nursing Practice Council were comprised of frontline staff, then the local nursing union would have sizeable representation regardless of having a designated seat. However, it is uncertain whether a nurse who is both a member of the Nursing Practice Council and the labour union would be cognisant of whose interests s/he is representing when s/he attends Nursing Practice Council, the labour union or the nursing unit. Therefore, it was recommended that a designated labour union representative be on the Nursing Practice Council so as to leave the nursing unit representative free to concentrate on practice issues.

Another group identified by the CNOs as potentially having a relationship with the Nursing Practice Council was the College of Registered Nurses of Manitoba (CRNM). One CNO acknowledged the absence of a formal connection between the Nursing Practice Council and the College of Registered Nurses of Manitoba. This CNO thought that there was a

natural fit for practice standards and code of ethics.

There should be a formal connection between the CRNM and the Nursing Practice Council. The CRNM standards of practice should be used by the members of the Nursing Practice Council in determining the appropriateness of practice issues presented at the

Council. All members of the Nursing Practice Council are members of their professional association. Therefore, it must be determined how a link could be established between the professional association and the individual Nursing Practice Councils.

The objectives of the existing Nursing Practice Councils were summarized through the interviews with the CNOs. Additional information on these objectives was ascertained through an examination of the Terms of Reference from the five corresponding councils. It was unanimously expressed by all five of the CNOs that the main objective of the Nursing Practice Council was to provide a voice for front line nurses. Some of the other objectives of the Nursing Practice Council expressed by the CNOs included:

to share information and discuss nursing related issues;

to provide a preferred direction for patient care and services related to the profession and to practice;

to provide a forum for the clinical nurse representing their respective units.

to help people see outside the walls of their own program;

to provide leadership for clinical practice in nursing at the hospital;

to express concerns about other disciplines that impact nursing.

These preceding objectives describe a Council established more for the provision of advice and guidance than for solving practice issues. There are no action nor decision making statements cited in these stated objectives. The sole action statement related by the CNOs was regarding the approval of nursing policy and procedure by Nursing Practice Council.

An examination of the written Terms of Reference for the Nursing Practice

Councils of the five facilities, provided additional information on the objectives of the Nursing Practice Councils. The verbs that were used in the objectives included: serving, promoting, assessing, and describing. Again, these written objectives did not contain evidence of any action statements. In particular, there was a noticeable absence of any reference to direct decision making by the Nursing Practice Council. It also was notable that in comparing the written Term of Reference for these five Councils, the phrasing was similar and in some instance identical. The similarities evident in the wording, as well as the content would suggest that the Terms of Reference for all of the facilities had the same beginning. The similarities in the Terms of Reference of the facilities represented by the CNOs also is helpful in explaining the corresponding resemblance in the structure and operation of the five Councils.

None of the CNOs interviewed had structured the Nursing Practice Council in their facility according to a conceptual framework. However, two of the five Chief Nursing Officers saw the establishment of a practice model, as the next step in the evolution of their Nursing Practice Council. The primary focus of the Nursing Practice Council in the beginning stages was identified by the CNOs as listening to what the clinical practice nurses had to say about their practice. However, as the Council matured, it was acknowledged that the establishment of a practice model for the nurses within the facility was essential work for the Council to undertake. Of note was the fact that the two Nursing Practice Councils that were in existence for the longest period of time were the ones that identified the desire to explore the development of a practice model for nursing. After approximately 2 years of operation, these two Nursing Practice Councils had advanced to the point where they were able to tackle more complex issues including, the

development of a model.

The interviews with the CNOs revealed two methods employed to recruit members for the Council. Members were appointed or elected by their peers. Alternatively, some facilities left the decision for the process of membership identity to the clinical area. In one facility, representatives were chosen randomly and sent to the Council meeting if they happened to be at work on the meeting day. Unfortunately, this manner of participation had the potential of having a different individual attend each month. Overall, Nursing Practice Council membership in all of the facilities consisted of nurses from a variety of areas who represented a variety of nursing positions.

The membership on the Nursing Practice Council was comprised primarily of nurses representing individual nursing units. In four of the five facilities, one member on council represented one nursing unit. However, one facility determined their membership on the basis of programs (medicine, surgery, critical care, etc). In this case, two clinical practice nurses, two clinical resource nurses and a nurse who was on the program team, represented each program on Council. With this method, where membership was determined through program alliance, it is conceivable that, while the program may be well represented, an individual nursing unit may not be. Communication of information to and from the Council may also be a challenge with this approach.

In one facility, the Nursing Practice Council membership also included those groups of nurses who might be distanced from interacting with nursing colleagues or the CNO because of the type of position and reporting structure in the organization. For instance, nurses who were employed by a department within the facility other than nursing, such as Medicine or Human Resources, had a seat on Council. Therefore, the

opportunity was provided for these nurses to communicate with the CNO and other nurses, and discuss issues that may not be appreciated by their non-nurse colleagues or manager. By structuring the composition of the membership in this way, this particular CNO ensured that all nurses in the organization were linked through their membership in the Nursing Practice Council.

In each of the organizations, there was a core group of positions represented at the Nursing Practice Council, which included the Chief Nursing Officer, unit nurses, first line leader/manager, Nursing Director, Nursing Educator, President of the local Nursing Union, Infection Control Nurse, and the Facility Patient Care Manager. Other positions that were included at some facilities were: Associate Director of Care, Risk and Quality Manager, Research and Evaluation, Chair of Allied Health Council, Chairs of other nursing committees, Central Support Services, Utilization Manager, Nurse Clinician, Occupational Health and Safety Nurse, Home Care, and an LPN. Although the core group of individuals at each facility was similar, differences were seen in the actual number of nurses representing each category. One facility included all of the clinical managers and directors in the membership of the Council, while another large facility included a total of 33 representatives from the nursing units alone. The CNO who had the largest Council membership was cognisant that the size of council had the potential to make decision making prohibitive

The membership total for the Nursing Practice Council also was unique to each organization with numbers ranging from 20 to 78. The percentage of frontline nurse on the council ranged from 35% to 75% (see Appendix H). Although the total membership at one facility numbered 78, the average number of members who actually attended the

council meetings was estimated by the CNO to be between 20 and 25. It was not determined during the interviews with CNOs at other facilities whether there was a correlation between the total number of Council members and their attendance.

In some facilities the members of the Nursing Practice Council were financially compensated to attend the monthly meetings. Other facilities provided replacement staff to facilitate the attendance of nurses who were working on the day of the meeting. Some facilities were organized to have both a designated individual, as well as an alternate who could attend the Nursing Practice Council meeting in the absence of the designated member.

In all of the facilities the Nursing Practice Council reported and was responsible to the Chief Nursing Officer. As well, the majority of the Councils were chaired initially by the CNO. However, imbedded in the Terms of Reference of all of the Nursing Practice Councils was a plan to replace the CNO as chair after 6 to12 months of operation. There were different approaches taken by the facilities in determining who would replace the CNO as Chair. In many facilities a system of co-chairing the Council was established using the CNO and a unit nurse, or the Associate Director of Care and a unit nurse or a Manager and a unit nurse. In two facilities a CNO appointed Manager or a CNO appointed Clinical Nurse Specialist followed the CNO as Chair of the Council. It is evident that the CNO as well as nursing management have considerable influence in the Nursing Practice Council through their input in selection of the Chair. It is particularly problematic that a Nursing Practice Council owned by practicing nurses has this level of managerial influence.

Meetings of the Nursing Practice Council were held monthly in all the facilities.

There were no meetings held during July and August. The length of the meetings was dependant on the facility with a range of 1 to 3 hours. According to the Terms of Reference for the facilities, members expected to serve on the Nursing Practice Council for either a two year or a three year term.

Issues were identified and brought to Nursing Practice Council for discussion by a variety of methods that were contingent on how the Council was structured. Examples of how issues were identified included: chart audits, issues identified at Program Council, or by individual nurses who spoke directly to their Nursing Practice Council representative or to the Co- chairs.

The accepted practice employed for addressing issues at a Nursing Practice Council meeting required Council representatives to submit issues as agenda items prior to the next meeting to a central source either a secretary, co chair, or chair. A specified time prior to the meeting, usually 1 to 2 weeks was established as the deadline for submission of agenda items. One CNO identified that representatives were permitted to raise issues at meeting of the Council.

Issues which were considered appropriate to be brought to the Nursing Practice Council according to one CNO

> *...are the ones that are assessing the common good of nursing as a discipline within the organization and how we work collectively.*

As well, issues were identified as those that met the following criteria: i) exist across the organization, and ii) nursing related or impacting nursing. Other CNOs did not offer comment on criteria established to determine the appropriateness of issues considered by the Nursing Practice Council. The CNOs identified that it was the responsibility of the

unit representatives to provide feedback to their respective units about the resolution of the issues discussed.

The evolution of the Nursing Practice Council in some facilities included the establishment of a reporting mechanism from clinical committees. Prior to the implementation of the Nursing Practice Council, confusion existed within some organizations as to where some committees reported. Those committees were described by the CNOs as

> *floating out there but impacting nursing* or as *mavericks who reported nowhere.*

The solution for one CNO was to create a reporting relationship from these disconnected committees to the Nursing Practice Council. Committees that were seen as appropriate to report to the Nursing Practice Council were those whose work had the potential to cross all nursing units and programs in the organization. According to one CNO, if the committee had a relationship to nursing and was practice based, it was deemed appropriate to have a formal connection to the Nursing Practice Council. An example of the committees whose jurisdiction subsequently came under the Nursing Practice Council were: wound care, pain management, and peripherally inserted central catheters.

A link from the committees to the Nursing Practice Council also was created to allow frontline nurses input into such matters that affected professional practice such as policies and procedures. One CNO stated that the Procedure Committee, consisting of educators who worked in isolation, had a significant impact on nursing as a whole. This Procedures Committee was responsible for the development and revision of procedures that were to be adopted by nursing. Prior to the establishment of the Nursing Practice

Council, their recommendations were taken directly to Administration for approval. Following the establishment of the Nursing Practice Council, approval for recommendations from the Procedures Committee was required from Nursing Practice Council prior to submission to Administration. At another facility, all procedures were reviewed by the Nursing Practice Council prior to being put into practice. A contradictory opinion regarding the importance of the Nursing Practice Council and the review of procedures was conveyed by another CNO. She identified that a significant amount of time was spent at Nursing Practice Council examining the details of a nursing procedure.

> *We're trying very hard as a Council to move out of that because we want to spend more time working on the professional practice issues and how we can make a difference in the organization and make a difference in terms of care delivery as a discipline.*

The solution at this facility was to hire a permanent chair for the Policy and Procedure committee. It was not determined during the interview what the reporting mechanism was for this committee to the Nursing Practice Council.

Sinclair (2000) recommended that the Nursing Practice Council have responsibility for nursing practice issues within a facility. However, the CNOs indicated that, although decisions could be made at Nursing Practice Council, they required additional approval from administration. For example, two CNOs reported that all nursing policies required approval by the facility's Leadership Council prior to being put in effect. Leadership Council was identified as the senior executive at the facility. It was not the mandate of Leadership Council to examine the content of policy, but to assess its financial impact, fit with regional policies, political issues, or need for an educational

plan. Additionally, policies might be required to go to the Medical Council for information. Although the lack of responsibility for decision making was only alluded to within the operation of the Nursing Practice Councils within the WRHA, one facility clearly stated in the Terms of Reference that the Nursing Practice Council is

...not charged with decision making authority.

It is evidenced by these processes and this statement that the Nursing Practice Council does not have the ability to have final decision making authority for nursing issues within their respective facilities.

One CNO indicated that the occurrence of a critical incident, such as the one that prompted *The report of the Manitoba pediatric cardiac surgery inquest: An inquiry into twelve deaths at the Winnipeg Health Sciences Centre in 1994* and subsequently, the Sinclair Report (2000), would probably not have been brought to Nursing Practice Council. This CNO indicated that, if such an incident occurred, it would be categorized as a critical clinical occurrence under the Winnipeg Regional Health Authority policy. Once declared a critical clinical occurrence, the executive of the facility would become involved and they would respond to it. The occurrence would then likely be reported to the Nursing Advisory Council for input and discussion regarding continuing nursing involvement. The Nursing Practice Council would receive information on the resolution of such an issue during their monthly meetings. There was no indication from the other four CNOs as to what arrangements their organization would employ in response to such an occurrence.

The communication of the information regarding Nursing Practice Council activities was seen as important by all of the CNOs. Transcription and distribution of the

minutes from the Nursing Practice Council meetings were a priority following each meeting. Typically, minutes were posted on all the nursing units. One CNO described the minutes as being

> *...widely distributed and open to everyone in the organization and are available everywhere.*

The timely distribution of the minutes was done in an effort to provide each Council representative an opportunity to discuss the issues with their colleagues while the topics were fresh in their minds. As well as soliciting feedback from their colleagues, representatives also were expected to use the minutes as an opportunity to solicit other practice issues to place on the agenda. All of the CNOs clearly articulated that the members of the Council were responsible for going back to their respective areas to speak to their colleagues about the issues discussed at the Nursing Practice Council meetings.

All of the CNOs interviewed affirmed that the Nursing Practice Council served a useful purpose in their facility. The Nursing Practice Council was seen as a place where professional development and professional practice could be fostered. Activities associated with professional development included the responsibility for approval of policies and procedures and dialoguing with colleagues on evidenced based practice. The Nursing Practice Council also was seen as a place where the professional development of staff was promoted with the result that

> *...nurses are confident and articulate about the skills and contributions that they make to the team.*

The most striking reason described by the CNOs as the value of the Council was as a means of connecting them with their frontline nurses to hear the issues that affect nursing

practice. As well as having an opportunity to meet with frontline nurses, the Nursing Practice Council provided an opportunity for the CNO to share information with nurses. Other notable values that the CNOs saw the Council providing was the chance for nurses to meet and dialogue with other nurses. The promotion of discipline identity was also seen as an objective of the Nursing Practice Council.

> *In the environment of program management and the absence of a designated department of nursing, the Nursing Practice Council has now become the hub where nurses come together. This is more meaningful because it is the group that has the authority for bringing the voice to nursing and nursing issues.*

The CNOs expressed a variety of concerns with regards to what they saw as weaknesses in their Nursing Practice Council. One concern identified was the inadequate length of time for the scheduled meetings. A 1 hour meeting was viewed as not long enough by two CNOs. However, another CNO viewed a 3 hour meeting as inadequate to complete the work of the Council. The length of time for meetings may be dependent on individual facility requirements.

The impression from all five CNOs was that there was still a considerable amount of work to be done for the Council to be as effective as they would like it to be. One CNO said:

> *We're still at a very infancy stage of nurses understanding it, believing it, and living it.*

Another CNO had concerns that the inconsistency in attendance and participation at Nursing Practice Council indicated a lack of understanding in the value of the Council.

> *I think the major weakness is the variability and I don't know if it's understanding*

of their responsibility, but there is great variability in the representatives and their consistency in coming to meetings, in their willingness to speak up, and in their communication back to their colleagues. Where that happens it works well. Where it doesn't happen it's no different than it was prior to having the committee.

On the topic of ownership of the Council, one CNO stated that

...membership needs to own and direct the work of the Council.

Another CNOs also believed that the nurses, through the Nursing Practice Council, owned their practice.

There was no formal evaluation of what makes a particular Nursing Practice Council effective in any of the facilities examined. There were anecdotal accounts from the CNOs as to what they saw as indicators of successes. Success was viewed by one CNO as meeting the priorities identified at Nursing Practice Council and capturing those using chart and process audits. Another CNO recalled the satisfaction she witnessed as nurses successfully worked thorough and changed a procedure to improve patient care. There was a belief stated by one CNO that the effectiveness of the Council's operating structure was demonstrated to the staff through the communication of the resolution of an issue which had been brought to Council.

They saw that we were doing something about it and that's what they need.

According to one CNO a more effective and trusting relationship between frontline staff and management was achieved through the structure of the Nursing Practice Council. There exists a need for further research to determine the effectiveness of the Nursing Practice Council, both actual and perceived, from frontline nursing staff as

well as from nursing management.

One of the anticipated outcomes of the establishment of Nursing Practice Councils was that nurses would feel empowered in their work. Evaluation of change in behaviours related to the implementation of the Nursing Practice Council was not explored in any of the facilities. Again, there was only anecdotal evidence of changes that had occurred that might be linked to a sense of empowerment. One CNO believed that she had seen a change in how members of the Nursing Practice Council had developed their leadership skills, as well in their demonstration of a greater willingness to speak at Council meetings. In addition, this CNO believed that members demonstrated an increased confidence level in the manner with which they made presentations at Nursing Practice Council. Overall, this particular CNO believed she had seen positive personal growth in the membership. It would be useful to research whether a link exists between empowerment and the Nursing Practice Council.

One of the recommendations from Sinclair (2000) was that "the Nursing Council should have representation on the hospital's governing body..." (p. 478). The interviews with the CNOs revealed different reporting structures in each of their facilities. At the time that the interviews took place, a board of directors existed in three organizations. The remaining two facilities participated on a board of directors at the regional level. Where a facility had a board of directors, the CNO attended the board meetings and submitted reports that were then presented by the Chief Executive Officer. However, within all facilities, both nursing and the Nursing Practice Council were represented by the CNO at their facility's Executive Committee which consisted of the senior executive managers of the facility. Although one CNO described herself as a voice at the board

level for nursing, she also acknowledged that information from Nursing Practice Council was not a standard part of her regular report to the board. Another CNO identified herself as the link from nursing to the board in the event that a practice issue of any magnitude occurred. A third CNO indicated that she was responsible to the board for nursing practice in the facility. In summary, where a board of directors existed, the CNO served as the representative for nurses. In most instances, however, only select information was provided to the board by the CNO. The CNO represents nursing at the executive level at the facility.

Summary

This chapter provided the results of the interviews with five Chief Nursing Officers (CNOs) representing different facilities within the WRHA with an operational Nursing Practice Council. The Nursing Practice Councils, functioning under the guidance of the five CNOs, were in place for 2 to 6 years. The information gathered during the interviews with these five CNOs was instrumental in planning the implementation of the Nursing Practice Council at the Grace Hospital.

Chapter 5:

Discussion

Three varied but complementary approaches were taken during this practicum project to gain an understanding of the structure and function of a Nursing Practice Council. The first approach involved the completion of a concept analysis. During the process of completing this concept analysis, a scarcity of literature on Nursing Practice Councils was discovered. A wider search of the literature uncovered evidence that the Nursing Practice Council was a structure firmly embedded within a model of shared governance. On completion of the concept analysis, a definition of the Nursing Practice Council, capturing the essence of what the Council should be, was created. With a description of the Nursing Practice Council completed from a theoretical perspective, an examination of the practical application of the concept was undertaken. The information gained from the experiences of CNOs in the WRHA with existing Nursing Practice Councils was the second undertaking in this search for information. This course of inquiry provided a view of the Nursing Practice Council from both an operational and practical perspective. Ultimately, the theoretical perspective gained from the concept analysis, combined with the factual application from the CNOs, were instrumental in completing the final task in this project, the planning and subsequent implementation of a Nursing Practice Council in a community hospital, as described in Chapter 3. The objective of this chapter is to review the eight goals of the practicum project and describe how they were met.

To define the Nursing Practice Council through the completion of a concept analysis.

The Nursing Practice Council was defined as an assembly of nurses deliberately

brought together for the purpose of solving issues specific to the practice of nursing. The Council should belong to the group that it serves and should influence the work that they do in the organization.

To implement a Nursing Practice Council with the Chief Nursing Officer at a community hospital.

This goal was achieved in February 2004, when the first meeting of the Grace Hospital Nursing Practice Council was held. As in the other WRHA facilities, the implementation of the Nursing Practice Council at the Grace Hospital occurred as a result of the recommendations from Sinclair (2000). The process for establishing this Practice Council at the Grace Hospital was straightforward. Two important elements to the project were already in place that contributed to a smooth process of implementation. Direction for the need to implement the Nursing Practice Council came from the Winnipeg Regional Health Authority. In addition, there was support for the project from the Grace Hospital CNO. Initial planning through to implementation occurred over a 3 month time period. Research on existing Nursing Practice Councils occurred simultaneously over this three-month time frame. The use of Terms of Reference from other facilities were used in formulating the Terms of Reference for the new Council at the Grace Hospital. The orientation program for Council membership allowed for the process of engagement of the members.

To explore the reasons for establishing a Nursing Practice Council.

The implementation of Nursing Practice Councils within the WRHA occurred in four out of five of the facilities involved in this study because of the recommendations of the Sinclair Report (2000). Although one facility had an existing Nursing Practice

Council, this Council subsequently underwent reorganization because of the Sinclair Report (2000). Under the jurisdiction of the CNOs, each of the five facilities initiated a Nursing Practice Council taking into account their own unique operating structure and organizational culture. Although none of the facilities employed a specific framework in the implementation of their Practice Council, two CNOs indicated that they were moving towards the development of a nursing practice model. A movement to the development of a professional practice framework occurred after at least 2 years of operation of a Nursing Practice Council. This development may be connected to the ability of the Nursing Practice Council to undertake and address increasingly complex issues.

Another reason for the implementation of a Nursing Practice Council was related to the adoption of an organizational framework such as shared governance (DiSantis & DiTolvo, 1999; Leary et al., 1998; Evan et al., 1995; Foster, 1993; Anderson, 1992). In some situations, the implementation of a Nursing Practice Council was the first step in the process (Anderson, 1992; Foster, 1993; Evan et al., 1995). In other circumstances, it was implemented after other pieces of a shared governance structure were in place. The effort to achieve Magnet status also drove the implementation of a professional practice model and subsequently, a Nursing Practice Council (Drenkard, 2005; Steibinder, 2005; Taylor, 2005; Johnson et al., 2004; Force, 2004).

Examine the process required for establishing a Nursing Practice Council.

A significant amount of preparation was required to implement a Nursing Practice Council. The experience of the five CNOs, as well as this practicum project, attests to this. The first step in the process for establishing a Nursing Practice Council required a decision from senior administration. Particulars such as the membership roster, selection

of the chair, and scheduling of meetings were decided upon early in the process of planning for implementation of the Council. However, the compelling challenge associated with the Nursing Practice Council did not lie solely within these details. The greater challenge rests with the operationalization of the Council. There are key operational functions that need to be attended to for the Nursing Practice Council to fulfill its purpose. The most important operational function is to establish a governance model. The Nursing Practice Council should provide practicing nurses with the responsibility for identifying nursing practice issues, as well as the necessary authority and decision-making ability to resolve them. It also should include the establishment of a reporting mechanism (who reports to the Council and who does the Council report to), the process of decision-making, and the flow of information both to and from the Council. There should be a plan in place on how to maintain the operation of the Council once it has been implemented.

Define the characteristics of the Nursing Practice Council through the completion of a literature search and through interviews with senior nursing leaders.

A defining characteristic of the individual Nursing Practice Councils identified in the literature and through the interviews with the CNOs was in the composition of the membership. Membership descriptions included both the number and the position held, as well as the number of managers in relation to the numbers of practicing nurses. Membership selection and expected length of term also were studied. The number of members and positions represented at each Nursing Practice Council were related to the needs and requirements of each facility. The interviews with the CNOs revealed that the size of the facility was a major factor in determining the number of Council members, as well as which positions were represented. Larger facilities with many nursing units had a

larger number of Council members. Porter-O'Grady (1992) recommended that a Nursing Practice Council should have no more than 10 to 14 members. Similarly, Hardt et al., (1996) specified that a Council should have fewer than 15 members. In the five facilities examined in the WRHA, membership rosters ranged from a low of 20 to a high of 78. At the Grace Hospital, the total membership numbered 18.

As well as having a manageable number of Council members, it was recommended that at least 70% of the members of the Nursing Practice Council should be the frontline practicing nurses (Porter-O'Grady, 1992). The data collected from the interviews with the CNOs demonstrated that only two facilities had 70% of members who were frontline practicing nurses. The Grace Hospital, at 66%, was one of the facilities that had less than the suggested percentage of frontline practicing nurses as members of the Nursing Practice Council. This statistic was disappointing, particularly when a deliberate effort was made to promote representation by frontline practicing nurses.

Council members were chosen using one of two methods. Members were either elected or appointed. An innovative idea regarding membership selection came from open meetings held with the staff nurses in Anderson's (1992) facility. The solution was to hold a lottery in which names were drawn from those nurses who wanted to serve on the Council and were employed in nursing at the facility for at least 1 year. However, what may be more important in deciding which method to use in choosing membership is that the Council uses a method that best fits with both the philosophy of the Council and culture of the organization. A consideration for the method chosen is the recognition that the efficiency and continuity at the Nursing Practice Council meetings may be influenced by having the same members or their alternates regularly attend, rather than selecting

different unit representatives each month.

Length of term for Council members was another identifying characteristic of the Nursing Practice Council. The length of term was indicated in the Terms of Reference for four of five facilities. Of the facilities identifying length of term for the Council, the majority indicated a term of 2 years, while one facility implemented a 3 year term. Establishing tenure is an important issue in setting up the Terms of Reference. "Groups with unlimited tenure and the ability to renew membership as an unlimited opportunity creates an elitism that does not encourage staff empowerment or even creativity" (Porter-O'Grady, 1992, p. 44). Members at the newly implemented Nursing Practice Council at the Grace Hospital were asked to serve a minimum of two years.

The selection of the chair for the Nursing Practice Council of the Council was another universal step in the implementation process. Four of the five CNOs interviewed reported that they served as chair when the Nursing Practice Council was first established. Over the course of time, the CNO was replaced as chair. There was no indication as to what set of circumstances might have triggered this change in the chair at the individual Councils. However, the maturation of the Council and its membership may have played a role in the timing of this event. The method of selecting the new chair, as well as the position held by the chair, varied from facility to facility. Similar to what occurred at other facilities, the CNO at the Grace Hospital initially served as the chairperson with the expectation that another Council member assume the chair within the first year of operation. Porter-O'Grady (1992) believed that the chair must always be selected from among practicing staff nurses. When the opportunity for chairing the Council is provided to staff nurses, trust is built, leadership is promoted, and decision-making ability is

fostered (Anderson, 1992; Porter-O'Grady).

There were connections identified between the Nursing Practice Council and two other nursing organizations. These organizations were the collective bargaining unit and the professional organization (CRNM). Differences were found among the five facilities regarding how the labour union and the Nursing Practice Council interacted. In four facilities the membership roster for the Nursing Practice Council did not identify a specific member from the labour union; two facilities (including the Grace Hospital) identified a specific labour union representation on the membership list of their Practice Council. It may be constructive to have a seat designated specifically for a member of the nurses' collective bargaining unit at the Nursing Practice Council. This action serves to provide transparency for the work done within the Nursing Practice Council with the labour union. According to Crocker, Kirkpatrick, and Lentenbrink (1992), the shared governance structure, which includes the Nursing Practice Council, should be sanctioned by the collective bargaining agreement between the union and the hospital. Porter-O'Grady (2004) recognized that "while collective bargaining is not traditionally seen as shared governance activity, it certainly falls within the context of shared decision making" (para.7).

There was concern about the relationship between the Nursing Advisory Council and the Nursing Practice Council at the facilities represented by the CNOs. The Nursing Advisory Council and Nursing Practice Council are two distinct groups that deal with different aspects of the work life of nurses and they co-exist within the facilities in the WRHA. A Nursing Advisory Council is specifically designed for union members and management to discuss collective bargaining issues. However, the successful growth and

maturation of the Nursing Practice Council involves the understanding that the Nursing Practice Council's mandate is not to take the place of, or to function as a forum for those issues that come under the jurisdiction of the collective bargaining agreement. "The committees created to accomplish shared governance should consider professional issues only and should not deal with issues concerning grievances, labour disputes, wages, rates of pay, or other terms and conditions of employment" (Crocker et al., 1992, p. 254). One CNO defined nursing practice issues as

> *...those that are assessing the common good of nursing as a discipline within the organization and how we work collectively.*

However, ensuring that a transparent relationship exists between the bargaining unit and the Nursing Practice Council ensures that the work of the Nursing Practice Council can be accomplished without opposition from the members it serves.

The other Nursing organization that has a relationship with the Nursing Practice Council is the professional association. Currently, there is not a formal alliance with any of the individual Nursing Practice Councils and the CRNM. The standards of practice for nursing care are established by the provincial professional associations, such as the CRNM. Since these standards for nursing practice are established by the professional nursing association and ideally should be used by the Nursing Practice Council, an effort needs to be made to create a connection between these organizations.

At the time that Sinclair was writing his report in 1994, a board of directors was in place in each individual facility within the WRHA, including the Health Sciences Centre. One of the recommendations from Sinclair (2000), as well as Porter-O'Grady and Finnigan (1984), included a provision for representation from the Nursing Practice

Council on the hospital's governing body. At the present time, the CNOs who were interviewed, as well as the CNO at the Grace Hospital, represented nursing at the governing body. Frontline practicing nurses do not have a seat at the facility's decision making table as was recommended by Sinclair.

In addition to the lack of representation by practicing nurses on a governing body, the current Council structure does not provide the Nursing Practice Council with the authority to act on decisions made on nursing practice issues. "Approval of staff council decisions by administration or other management groups is not required" (Porter-O'Grady, 1992, p. 97). "Each council has final decision making authority for their area of accountability" (Hardt et al., 1996, table 1, p. 301). However, in the current Nursing Practice Councils recommendations must go to another level. It does not appear that Sinclair's (2000) vision, that having the Nursing Practice Council at each facility deal with critical occurrences which negatively impact nursing practice, has transpired. The interviews with the CNOs confirm that the Nursing Practice Council does not have a role in the resolution of critical nursing practice issues. Instead of being an integral part in the process, the Nursing Practice Council's role in these situations is reduced to receiving information after the fact.

Understand how the Nursing Practice Council is used and valued by nursing administration.

All of the CNOs interviewed believed that the Nursing Practice Council was a valuable asset to nursing administration. They saw the function of the Nursing Practice Council as providing an opportunity for them in their role as CNO to meet and dialogue with nurses. Other values that they indicated included:

provide a voice for frontline nurses.

share information and discuss nursing issues.

provide direction for patient care and services.

provide a forum for clinical nurses representing their units.

provide leadership for clinical practice in nursing at the hospital.

help people see outside the walls of their own program.

express concerns about other disciplines that impact nursing.

The CNOs also believed that, through participation in the Nursing Practice Council, nurses were provided with the chance to be more responsible for their practice. At least one of the CNOs identified that, through the Nursing Practice Council, nursing staff were provided with the opportunity to own their practice. However, this same CNO also recognized that these nurses might not realize the full extent of their ownership.

The Nursing Practice Council has control of it all. I don't think they know that yet, they don't quite get it.

It would be interesting to know from the practicing nurse's perspective, what they believe ownership of their practice entails. It would also be interesting to know how frontline practicing nurses view the role of the Nursing Practice Council.

Understand how the Nursing Practice Council fits with facility management, program management and with shared governance.

At the present time, the Nursing Practice Councils within the WRHA have little impact on the management of the facility in which they are located. The Nursing Practice Council must make recommendations and seek approval from another level in their organization prior to effecting decisions. However, in a shared governance framework,

the Nursing Practice Council would function differently. The Nursing Practice Council would be one of several councils that would have input into a Central Coordinating Council and subsequently, the facility management.

The Nursing Practice Council could be a valuable asset to an organization with program management. The operation of the Nursing Practice Council can cross programs and practice settings to bring nurses together to discuss and resolve issues that are unique to nursing. One CNO stated that

> *...in the environment of program management and the absence of a designated department of nursing, the Nursing Practice Council has now become the hub where nurses come together. This is more meaningful because it is the group that has the authority for bringing the voice to nursing and nursing issues.*

The Nursing Practice Council is an integral component of the framework of shared governance. There is evidence from the CNOs from the WRHA, as well as from the literature reviewed, that the Nursing Practice Council exists as a stand-alone structure (Sorenson, 2002; Foley, 2000) in some organizations. Other authors introduce the idea that the Nursing Practice Council could be a part of a larger functioning system (Phillips, 1976; Evan et al; 1995; Homsted, 2003). However, it is through the literature on shared governance that the Nursing Practice Council can be viewed as being part of a larger framework. Overwhelmingly, the reason identified for the implementation of the Nursing Practice Council was related to the adoption of a governance model for nursing care (Porter-O'Grady, 1992; Westrope et al., 1995; DeSantis & DiTolvo, 1999; Alvarado et al., 2000; Sorenson, 2002; Stolzenberger, 2003). The adoption of a shared governance model also was instrumental in the implementation of the Nursing Practice Council

during the process of attaining Magnet status (Upeniks et al., 2006; Porter-O'Grady, 2004; Force, 2004).

Identify the strengths and limitations of the Nursing Practice Council.

There is evidence from the interviews with the CNOs, as well as from the literature, that the Nursing Practice Council exists as a stand-alone structure (Sorenson, 2002; Foley, 2000) in some organizations. In these instances, the effectiveness of the Nursing Practice Council will be limited in the absence of connections to other Councils or committees.

The size of the membership also will have an effect on the ability of the Nursing Practice Council to perform the prescribed responsibilities. "Large councils (more than 15 members) may become cumbersome to manage because effective decision making is difficult in larger groups" (Porter-O'Grady, 1992, p. 98). As well as restricting the decision making ability, large Councils may pose a financial hardship on the organization. Each meeting may be costly if nurses are either being paid to attend or if replacement staff are provided and have to be paid. All of the Nursing Practice Councils, including the Grace Hospital Council, had memberships larger than suggested in the literature. One CNO, with a Nursing Practice Council numbering 33 members, identified that it was a challenge to keep the work of such a large group flowing in an organized and effective manner.

Barriers that prevent nurses from attending Nursing Practice Council meeting will negatively impact the functioning of the Council. Members may fail to attend Council meetings because of inability to leave the nursing unit or in the absence of financial remuneration. Caramanica (2004) identified the difficulty of having staff members

scheduled away from their department and relieved of their assignments to attend Council meetings as one of three barriers related to implementing shared governance. One strategy identified to encourage attendance at monthly meetings was to have both a designated member, as well as an alternate member representing each area. With this approach, it is possible that either the member or the alternate is able to attend in spite of the inherent challenges of shift work. Other potential solutions to improving attendance included providing salary reimbursement for those members who attended the meeting on their off days and/or paying for a replacement if the member was scheduled to work the day of the meeting. Porter-O'Grady (1992) recommended that meetings of the Nursing Practice Councils should be considered as paid time, whether staff are already present at work or are coming in on their off time (p. 44). The Nursing Practice Council in one Magnet facility also supported compensation for Council participation during scheduled time off, as well as during working hours to allow participation at Council meetings (Stolzenberger, 2003, p. 527). During the interviews with the CNOs, it was revealed that the facility with the largest membership roster had an average meeting attendance of less than one third. Coincidentally, this particular facility also did not financially compensate members for attendance. By providing paid time to attend the Nursing Practice Council meetings, a subtle, but strong message, is conveyed to nursing staff about the importance of the Council and its work. Finally, the process for effecting the decisions made at the Nursing Practice Council with the requirement for either administrative review or approval is a limitation of the Council.

One of the strengths of the Nursing Practice Council is the composition of its membership. Although, the number of managers who are members of the Council may

inhibit the work of the Council, the number of practicing nurses on Council may actually promotes its effectiveness. The recommended size of Council is 10 to 14 members with 70% of those members composed of practicing nurses (Porter-O'Grady, 1992).

The strength of the Nursing Practice Council lies in the ability of the membership to effect decisions on practice issues. The optimal functioning of the Nursing Practice Council also would occur when it is one part of an organizational framework. It has the potential to provide a setting where connections to other individuals and committees within the organization could occur. The Nursing Practice Council also provides a place for the CNO to hear the concerns of frontline practicing nurses. However, the primary function of the Nursing Practice Council lies within its authority to make decisions and take appropriate action to solve nursing practice issues.

Summary

This chapter reviewed the results of the completion of the 8 practicum objectives. Information from the concept analysis, the interviews with the CNOs, as well as the implementation of the Nursing Practice Council at the Grace Hospital were used to achieve the objectives.

Chapter 6

Conclusion

This examination of the implementation of the Nursing Practice Councils within the WRHA has determined that the primary influence for their establishment was because of the recommendations from the Sinclair report (2000). Similarities were identified in both the content and constitution of the Terms of Reference employed by all the Councils. The CNOs suggested similar beginnings. The outcome of using similar Terms of Reference within the five facilities, as well as the Grace Hospital, was that all of the Nursing Practice Councils operated in a similar manner. There were, however, subtle differences evident in the functioning of each of the six Nursing Practice Councils. These differences became evident over the length of time each Council was in operation and might be related to the experience gained and adaptations made to the unique requirements of each organization. These differences in operation also may be due to each organization's distinct culture. In addition, the length of time that the Council was in operation seemed to be connected to the likelihood that the Council would become more highly developed. For example, the two Nursing Practice Councils that had been in operation the longest were the ones that were working towards the development of a professional practice model.

The characterization of a Nursing Practice Council completed through the concept analysis closely reflected the recommendations of Sinclair (2000) regarding the functioning of the Nursing Practice Council. Both the definition of the Practice Council and Sinclair's Report indicate that a Nursing Practice Council should have the responsibility for membership selection, ownership of nursing issues, and a voice on the

organization's governing body. The other recommendations from Sinclair such as the Nursing Practice Council's functions of monitoring, evaluating, and making recommendations pertaining to the nursing profession within the hospital, as well as report incidents, issues, and concerns without risk of professional reprisal, were not captured in the concept analysis

Since the establishment of the Nursing Practice Councils within the six facilities examined, some of Sinclair's (2000) recommendations have yet to be realized. One Sinclair's recommendations was that nurses have the opportunity to select the members for their Nursing Practice Council. However, in practice, selection of membership, as well as the position of Chair, were obtained primarily through managerial influence or appointment. Another recommendation was that practicing nurses have responsibility for nursing issues within the hospital. Unfortunately, this authority for nursing practice issues has yet to be undertaken by the Nursing Practice Councils. The interviews held with the CNOs indicated that all decisions made at Council level required approval of either the CNO or the governing body of the hospital prior to implementation. Incidents and issues of the magnitude that prompted the investigation and inquiry into the infant deaths and the recommendations from Sinclair would most likely be handled at an administrative level and then come back to the Nursing Practice Council for information. It is unclear what level of responsibility for nursing practice issues actually lies within each Nursing Practice Council. However, it is clear that the authority to act on controversial issues lies outside the mandate of the Nursing Practice Councils within the WRHA. In addition, practicing nurses continue to function without a seat at a governing body. The CNO remains the practicing nurses only link to the governing body, whether it is a board of

directors or an assembly of the facility's senior administrators.

A significant amount of preparation is required to implement a Nursing Practice Council. The experience of the five CNOs, as well as this practicum project, attests to this. Particulars such as the membership roster, selection of the chair, and scheduling of meetings require consideration early in the process of implementation. However, the compelling challenge associated with the Nursing Practice Council does not lie solely within these details. The greater challenge rests with the operationalization of the Council. There are key operational functions that need to be attended to for the Nursing Practice Council to fulfill its purpose. The most important operational function is to establish a governance model. The Nursing Practice Council should provide practicing nurses with the responsibility for identifying nursing practice issues, as well as the necessary authority and decision-making ability to resolve them. It also should include the establishment of a reporting mechanism (who reports to the Council and who does the Council report to), the process of decision-making, and the flow of information both to and from the Council.

The inability of the CNOs and the nurses in their organizations to meet the objectives set out by Sinclair (2000) can be related to the implementation method. At the present time, Nursing Practice Councils have been put into operation as solitary structures without a corresponding supportive framework. Examples exist in the literature that demonstrate the ability to implement a structure, such as a Nursing Practice Council without implementing a framework, such as shared governance (Sorenson, 2000; Foley, 2000). In addition, there is confirmation from the five Chief Nursing Officers that Nursing Practice Councils have been implemented without a framework, such as shared

governance. However, significant evidence exists that endorses the implementation of the Nursing Practice Council as part of a larger framework of shared governance (Porter-O'Grady, 1992; Westrope et al., 1995; DeSantis & Ditolvo,1999; Alvarado et al., 2000; Sorenson, 2002; Stolzenberger, 2003). The effectiveness of the Nursing Practice Council would be enhanced if it were part of a Councillor model of a shared governance framework connected to other supporting Councils and guided by a Coordinating Council. The Nursing Practice Council would then be an effective assembly, able to speak for the interests of the nurses in a facility through its elected representatives. A practicing nurse would be the chair of the Nursing Practice Council and represent nurses and the Nursing Practice Council at the Coordinating Council. This framework also promotes decision making at each Council level. This integrated structure would support nurses to own and be accountable for their practice. Sinclair's vision of having frontline nurses at a hospital's governing body would be fulfilled.

It will always be difficult for frontline nurses to have control over their practice when the necessary structures and processes are either nonexistent or not sufficiently developed to be effective. If nurses are to have meaningful input and control of their practice, the operationalization of the Nursing Practice Council needs to occur within a councillor model of a shared governance framework. Kramer and Schmalenberg (2003) indicate that the outcome of self governance is control of nursing practice.

There is no doubt that the shared governance framework and the Nursing Practice Councils should be tightly intertwined. In fact, the Nursing Practice Council is so entrenched in the tenets of shared governance, that its ability to function effectively is influenced by the strength of the relationship. Research is required on how best to

implement the Nursing Practice Council, in particular, the choice of the most effective order of implementation. One option is to implement a Nursing Practice Council with a future view of evolving that structure into a larger and more inclusive model, such as shared governance. Another alternative is to adopt an organizational model, such as shared governance, with the implementation of a Nursing Practice Council as one of the first steps in the process. Whichever method is chosen, it is essential that the implementation of a Nursing Practice Council occur as part of an integrated approach to achieving a shared governance model.

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Appendix A

Ethical Approval

UNIVERSITY OF MANITOBA

RESEARCH SERVICES & PROGRAMS
Office of the Vice-President (Research)

Winnipeg, MB R3T 5V6
Telephone: (204) 474-8418
Fax: (204) 261-0325
www.umanitoba.ca/research

APPROVAL CERTIFICATE

28 April 2004

TO: **Kathleen Terry Desautels** (Advisor J. Scanlan)
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research ~~Ethics Board~~ (ENREB)

Re: **Protocol #E2004:017**
"Implementation of a Nursing Practice Council"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix B

Interview Questions

1. **How long has the Nursing Practice Council been in place in your facility?**
2. **Why was the Nursing Practice Council established in your facility?**
3. **Did the Nursing Practice Council replace an existing committee in your facility?**
4. **What do you see as the main purpose of the council?**
5. **Was the council established with a specific conceptual framework in mind?**
6. **By what process are members obtained for the council ?**
7. **Could you describe the process of handling a practice issue from identification to resolution?**
8. **What is the mechanism for disseminating the Council decisions/ results to nurses in your facility?**
9. **What do you see as the strengths of the Practice Council?**
10. **Do you see any weaknesses in the Practice Council?**
11. **As Chief Nursing Officer, how would you describe the value of a Practice Council?**
12. **Have you evaluated the effectiveness of the Council? If so by what method has it been evaluated?**
13. **One of the outcomes of Nursing Practice Councils is that nurses feel empowered in their work. How has the Nursing Practice Council impacted your nurses is this regard?**
14. **Were there any barriers, organizational, personal, or others that needed to be changed in order to facilitate the work of the Council?**
15. **What is the relationship between the Nursing Practice Council and the governing body of your organization? Is the Council represented at the governing body? If so by whom?**

Consent for Interview with CNO

Research Project Title: Implementation of a Nursing Practice Council

Researcher: Kathleen Terry Desautels RN BN

I hereby agree to participate in this study of Nursing Practice Councils. Terry Desautels, a student from the Faculty of Nursing at the University of Manitoba, has informed me that the information obtained during my participation will be used by her in the completion of a practicum project as part of the requirements for the Masters of Nursing in Administration.

Terry Desautels may be contacted _____. Her practicum chairperson at the Faculty of Nursing at the University of Manitoba is Dr. Judith Scanlan who may be contacted at 474-8175.

This practicum project has received approval from the Education/Nursing Research Ethics Board at the University of Manitoba. Contact person is Margaret Bowman, Coordinator, Human Ethics who may be contacted at 474- 7122..

This practicum project involves the implementation of the Nursing Practice Council at the Grace General Hospital. The goals of this research study are to:

1 Understand what constitutes a Nursing Practice Council
2 To compare the similarities and differences in the functioning of nursing practice councils in the Winnipeg Region
3 To determine the value of the Nursing Practice Council

I understand that I will be interviewed by Terry Desautels.

I understand that I will be provided with a list of interview questions prior to the interview.

I understand that there will be one interview that will be approximately one hour in length.

The interview will be held at a time and a location that is mutually agreeable. The interview may be by phone if agreeable

The interview may be captured on a recording device if agreeable.

All of the information I provide will be kept confidential. My identity including my name, position and my affiliated institution will remain confidential. As a participant, I will be identified in the written report of the research by a letter or a number. As well, only the researcher and the practicum committee will have access to the contents of the interview.

I will receive no benefit from being in this study, although the sharing of information about the nursing practice council may further the understanding of the value of this council in my institution and in the nursing community as a whole.

There are no risks in the sharing of the information that I provide.

I understand that the results of the interview will be kept locked in a filing cabinet in the residence of the researcher. Access to this cabinet will be restricted to the researcher. The data will be kept for seven years after which it will be disposed of by shredding.

I will be provided with feedback on the research project in the form of summary of the research results if I request it.

I will be provided with a copy of this signed consent. My signature on this form indicates that I have understood to my satisfaction the information regarding participation in the research project and agree to participate. I am free to withdraw from the study at any time, and /or refrain from answering any questions I prefer to omit, without prejudice or consequence.

Signature of Participant_____

Printed name _____

Signature of Researcher_____

Date_____

I would like to receive a summary of the research results.

No ☐ Yes ☐

If yes, please indicate your mailing address below.

Name_____

Address_____

Appendix D

Wanted

Nurses who want to have a voice in how nursing is performed at the Grace Hospital to serve on the NURSING PRACTICE COUNCIL

What is it? A forum for nurses to discuss and propose solutions for nursing practice issues with the Vice-president of Patient Care.

Who is it? One representative and an alternate from each nursing area.

Why? To have a voice in how nursing is performed and practiced at the Grace Hospital.

When? Orientation session January 2004 followed by monthly meetings.

For more information or to apply for this exciting opportunity please contact your nurse manager or Wendy Woolley at local 2389

Appendix E

The Salvation Army Grace General Hospital
300 Booth Drive, Winnipeg, Manitoba
R3J 3M7
(204) 837-8311

January 19, 2004

Dear Nursing Practice Council Members:

Welcome to the membership of the Nursing Practice Council at the Grace General Hospital. Thank you for representing your colleagues. This is an exciting opportunity for you as a nurse to exchange ideas and find solutions to nursing practice challenges with colleagues throughout the facility. As Vice-President of Programs & Patient Care Services, the formation of this Council provides me with the opportunity to discuss nursing practice issues with you.

To familiarize you with the operations of the Nursing Practice Council, an orientation session has been organized for:

Date:	**TUESDAY, FEBRUARY 3RD**
Time:	**1200 to 1600 hours**
Location:	**Conference Room B**
	(Lunch will be provided.)

If you are scheduled to work on this day, please make the appropriate arrangements with your Nurse Manager so that you will be available. If you are not scheduled to work on this day, please notify your Nurse Manager as you will be paid at straight time for your attendance.

Enclosed is an article for you to read prior to the orientation session. This article will give you an understanding of the functions of a Nursing Practice Council.

I am looking forward to meeting with you and discussing the practice of nursing.

Sincerely,

Mrs. Wendy Woolley, RN, MN
Vice-President, Programs & Patient Care Services

WW/kl
Attachments

Appendix F

Orientation Agenda for the first meeting of the Nursing Practice Council at the Grace Hospital

1. Description of the *Report of the Manitoba Pediatric Cardiac Surgery Inquest. An Inquiry into twelve deaths at the Winnipeg Health Sciences in 1994.*
2. Overview of the recommendations of the Sinclair Report (2000) that led to implementation of Nursing Practice Councils throughout the WRHA.
3. Description of the characteristics of a Nursing Practice Council.
4. Discussion of the purpose of the Nursing practice Council.
5. Reasons why nurses should act on professional practice issues.
6. Explanation of nursing standards.
7. Process of denitrifying a practice issue through to its resolution.
8. Case study exercise of a practice issue.
9. Discussion.

Appendix G

Membership Numbers

Facility (1) 20 members, 15 unit representatives or 75% of total membership

Facility (2) 34 members, 12+ unit representatives or 35% of total membership

Facility (3) 22 members, 14 unit representatives or 63% of total membership

Facility (4) 78 members, 60+ unit representatives or 76% of total membership

Facility (5) 33 members, 17 (10 clinical nurses, 7 clinical resource nurses) or 51% of total membership.

Grace Hospital 18 members,(11 unit representatives) or 66% of total membership

Appendix H

Summary of the Terms of Reference for Nursing Practice Councils

To serve as a vehicle for the discussion of professional and supportive nursing issues and concerns. These issues may be related to nursing or interdisciplinary issues that impact nursing practice.

- To collaborate in multidisciplinary quality of care, risk management and service improvement initiatives.
- To assess the impact of proposed changes which may affect nursing, practice and make appropriate recommendations to the "Joint Management Council."
- To promote nursing practice in accordance with nursing standards: College of Registered Nurses of Manitoba, College of Registered Psychiatric Nurses of Manitoba, College of Licensed Practical Nurses of Manitoba.
- To set direction for nursing clinical practice, education and research.
- To develop processes for monitoring and evaluating nursing standards and Quality Improvement initiatives.
- To ensure Integrated Quality Systems monitoring and reporting by Program.
- To review and approve nursing policies and procedures.
- To ensure consistency in application of policies and procedures as they relate to nursing practice.
- To identify and support professional development activities for nurses.
- To promote the exploration of workload, information and documentation systems that facilitate and support nursing practice within the hospital.

- To ensure the application of evidence-based nursing practice.
- To facilitate communication between programs, patient care teams and support services within the hospital.
- To promote and facilitate the conduct and use of nursing research.
- To serve a s a conduit for practice changes.
- To serve as a forum for nurses to refer and resolve their professional concerns.
- Promoting recruitment and retention.