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Being Heard:
A Classical Grounded Theory
Exploring the Experiences of Bedside Nurses Working in Children's Hospitals with Established Shared Governance Models

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by

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Dedication

This work is dedicated to all the nurses at Driscoll Children's Hospital –

for your continued support, enthusiasm, and the hard work that you do each day giving selflessly to provide care to the special infants and children in South Texas.

Your hard work and dedication is

what encouraged me to pursue my research. I am so grateful for all that you do.

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To my Father: Patrick Hugo Severance (1927-1976) -

Thank you for encouraging me to become a nurse.

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My best friend. Thank you for your love and support.

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You have taught me so much. I carry you with me each day.

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Being Heard:

A Classical Grounded Theory

Exploring the Experiences of Bedside Nurses Working in Children's Hospitals with Established Shared Governance Models

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This Classical Grounded Theory (CGT) study explored the experiences of bedside nurses working in children's hospitals where shared governance (SG) has been in place for at least four years. Shared governance is a professional practice model that has been offered as a way to improve nurse satisfaction, decrease nursing turnover, and increase nurse retention by including bedside nurses in the decision making processes affecting patient care, their practice environment, and the governance structure within their hospitals (Burnhope & Edmonstone, 2003; Linnen, 2014).

The goal of a CGT study is to explore social processes and develop theory grounded in actual data (Glaser, 1998). Analysis of study data resulted in identification of the substantive theory, *Being Heard*, the nurses' main concern. Nurses resolve their main concern, *being heard*, by a process of *voicing* consisting of three phases: *willingness*,

engaging, and assessing. Nurses first must be willing to offer their voice, then they can engage by participating in governance processes within the hospital system followed by assessing whether their voice has been heard by observing how their input was received and what happened to their input; the outcomes of their assessment will affect whether they will be willing to participate in the future. The substantive theory, *Being Heard,* describes the dynamic, interactive relationships between bedside nurses and hospital management and emphasizes the impact of presence and time in the relationships between bedside nurses and hospital management.

Hospitals that truly hear nurses, invite their input, and respond, are able to tap into an important source of information that can improve patient outcomes, enhance nurse retention, and improve the hospital's financial status. The substantive theory, *Being Heard,* suggest that hospitals where nurses are not heard deprive themselves of important information, they demonstrate lack of respect and trust for their nursing staff; ultimately their financial status will be impacted by nursing dissatisfaction and nurse turnover, which can affect patient satisfaction and outcomes.

The substantive theory, *Being Heard,* that emerged from this CGT study reflect the experiences of bedside nurses who practice in a SG environment and can inform healthcare administrators, nursing directors, and managers who are utilizing, or plan to implement, a SG model.

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List of Abbreviations

UTMB	University of Texas Medical Branch
GSBS	Graduate School of Biomedical Science
IRB	Institutional Review Board
SG	Shared Governance
IPNG	Index of Professional Nursing Governance
CGT	Classical Grounded Theory
CCM	Constant Comparative Method
ACL	Amplifying Causal Loop
EBP	Evidence Based Practice
IM	Immediate Manager
CEO	Chief Executive Officer
CNO	Chief Nursing Officer
RN	Registered Nurse
BSN	Bachelors of Science
MSN	Masters of Science of Nursing
ANCC	American Nursing Credentialing Center

Chapter One Introduction

INTRODUCTION

This dissertation presents the findings of a Classical Grounded Theory study that was conducted to explore the experiences of bedside nurses working in children's hospitals with an established shared governance model. Chapter One presents the background of the study, the study problem, the research question and aim of the study, and describes the study significance. Chapter One continues with a discussion of the study methodology and concludes with the delimitations of the study.

THE BACKGROUND OF THE STUDY

The increasing complexity of the healthcare environment has created many challenges for the nursing profession. A key element for organizing the delivery of healthcare is through nursing practice models that provide structure and context. Many health care organizations have adopted and implemented a shared governance model in order to develop such an environment that will support and empower nursing practice (Barden, Quinn, Donahue, & Fitzpatrick, 2011; Green & Jordan, 2004; Moore & Hutchinson, 2007; Relf, 1995). Shared governance (SG) is a management and leadership system that empowers all staff (Scott & Caress, 2005). Healthcare professionals and workers in a SG system are encouraged to work together to develop a multidisciplinary plan of care (O'May & Buchan, 1999). Power and control is shifted from the decisions of management to front line nursing staff (Anderson, 2011; Hess, 1996; Moore & Hutchinson, 2007; Latta & Davis-Kirsch, 2011). Shared governance is expected to encourage creativity, promotes interpersonal relationships, increases ownership, and

provides a sense of worth, yet there is a notable gap in the literature to determine what the bedside nurse actually experiences practicing in a SG environment.

Nurse retention and patient satisfaction are enhanced when nurses are satisfied with their environment and their work (Kowalik & Yoder, 2010; Lashinger & Leiter, 2006; Stumpf, 2001). An effective practice environment directly impacts the quality of nursing care and patient outcomes (Relf, 1995; Moore & Hutchinson, 2007). Exploring what the bedside nurse actually experiences while practicing in a SG environment will contribute to a broader understanding of how SG models impact nursing practice.

STUDY PROBLEM

Healthcare funding and increased complexity within hospital systems is creating many challenges for the nursing profession today. Health care organizations are merging creating even larger and more complex systems. Economic restraints are imminent; and hospital systems work to cut costs. The increase in acuity and decreased length of stay has significantly influenced nursing practice (Barden et al., 2011; Relf, 1995;Tiffin, 2012; Upenieks, 2002). Bedside nurses practicing in hospital environments care for sicker patients, and bedside nurses have heavier patient loads. In spite of this, both nursing and ancillary support staff is being reduced (Barden et al., 2011). All these changes in the healthcare environment may cause decision making about nursing practice in individual hospitals to be consolidated into management and administration. Nurses at the point of service may find themselves in their opinions being left out of the decision making process and the decisions that are made might become a source of contention and frustration (Barden et al., 2011; Wilson, 2013); nurses who are frustrated are more likely to seek a different position. Nursing turnover has implications for patient satisfaction and

outcomes and affects the hospital's financial situation (Start, Wright, Murphy, McIntosh, & Catrambone, 2013; Walter, Brown, & Sullivan, 2014; Wilson, 2013).

Shared governance has been touted as an approach that will improve satisfaction of nurses by bringing nurses into decision-making processes. A SG model within an institution is expected to encourage creativity and interpersonal relationships among the personnel, foster ownership, and promote a sense of worth among hospital employees. Research has focused on nurses' understanding of a SG model (Kennerly, 1996), nurses' commitment to a SG model (Frith & Montgomery, 2006), and nurses' perceived empowerment working in a SG culture (Hess, 2011; Overcash & Petty, 2012; Rheingans, 2012). Most of the research has been limited to a period within two years of implementation of SG (O'May & Buchan, 1999). Prior to the present study, no research has explored the actual experiences of bedside nurses working in a shared governance environment; nor has the research examined bedside nurses' experiences in hospitals where SG has been in place for more than four years. Do bedside nurses actually experience some of the benefits that are supposed to be offered by SG? Can hospitals maintain a SG environment for more than two or three years? From the perspective of the bedside nurse, what makes SG work or what keeps it from working?

RESEARCH QUESTION AND AIM OF STUDY

The research question that guided this study was: "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?" The aim of the research study was to gain understanding of what it is like for bedside nurses who are working in children's hospitals with established shared governance models, and to gain understanding of

bedside nurses' perspectives as to what is going on (Glaser, 2013) in hospitals where SG continues to be the organizational model after a minimum of four years.

SIGNIFICANCE

There is a gap in the literature as to whether the benefits SG is supposed to provide to nursing actually occur. While some research has focused on nurses' perceptions of a SG model (Kennerly, 1996; Ludemann & Brown, 1998; Prince, 1997; Richards, Ragland, Zehler, Dotson, Berube, Tygart & Gibson, 1999) there is limited research that addresses what bedside nurses actually experience when they practice in a SG environment. Knowing that nurses understand and are satisfied with SG is not the same as knowing what they experience while working in a hospital where SG has been the organizational model for more than four years.

The present research study is significant because the study findings will contribute to a broader understanding of how SG models impact the bedside nurses and their nursing practice. The research study is significant because it is the first step in understanding the experiences of bedside nurses as they practice in a hospital system that promotes SG. Exploring the experiences of bedside nurses provided direct insight to how the bedside nurses' practice is affected utilizing an established SG model and captured nurses' perspectives on what is involved when nurses interact within a shared governance system.

OVERVIEW OF THE RESEARCH METHODOLOGY

Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) (CGT) was used to explore the experiences of bedside nurses practicing in children's hospitals with a shared governance model in place for at least four years. Classical

Grounded Theory is an inductive process used to explore aspects of social processes at work in people's lives and to develop theory grounded in actual data (Glaser, 1998). Glaser (1998) states that CGT asks the question "what is really going on?"(p.12) with the participants related to the phenomenon of interest. Grounded theory is a rigorous method whose overall aim is to identify themes, patterns, and processes, and to understand how a group of people define, via their social interactions, their reality (Chen & Boore, 2009), leading to development of a theory "grounded" in the data (Glaser, 1978, 1992, 1998, 2012). Classical Grounded Theory is unique in that it provides more than meaning, understanding, and description of a phenomenon; it creates theory (Glaser 1978, 1992, 1998, 2012).

All study procedures were approved by the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB). Study data collection utilized online synchronous interviews. Eighteen bedside nurses from children's hospitals in Texas with an established SG model in place participated in the research study. Study data consisted of demographic data, data from the interviews and the researcher's memos.

Data collection and data analysis in a Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) are ongoing and iterative processes. Data analysis began with the collection of the first set of data and analysis of that data informed subsequent data analysis. The data was analyzed utilizing coding procedures described by Holton and Glaser (2012) and the constant comparison method (CCM), whereby data is collected and analyzed at the same time and each item of data is compared to all other items of data (Glaser, 1992). The ultimate goal of data analysis was to generate a

substantive theory that described what was going on with the bedside nurses who participated in the study.

THE STUDY DELIMITATIONS

This study was limited to bedside nurses who practice in children's hospitals in Texas where an established shared governance model had been in place for more than four years.

SUMMARY OF CHAPTER ONE

Chapter One has introduced the research study. The Chapter provided an overview of the background of the study, the research problem, and identified the research question and aim of the study. Chapter one continued with a discussion of the study methodology and concluded with the delimitations of the study.

PLAN FOR REMAINING CHAPTERS

Chapter Two will provide a review of the literature. Chapter Three will describe the application of Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to answer the research question: "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?" Chapter Four will discuss the study findings, including the substantive theory that emerged from the data. Chapter Five will provide the discussion, implications, and conclusions of the study.

Chapter Two Review of Literature

Chapter Two is the review of literature for this Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) (CGT) study that explored the experiences of bedside nurses who work in children's hospitals where shared governance (SG) has been in place for a minimum of four years. Glaser warns CGT researchers to avoid reading the literature prior to conducting the study because, unlike deductive research where the literature review is conducted prior to the study in order to provide a framework for the study, CGT is an inductive process. Thus, in order to prevent bias and preconceptions (Glaser, 2013), Glaser prefers that review of the literature related to a CGT study be done near the end of the research process to support and develop the theory (Glaser, 1978, 1998). The goal for the CGT researcher is to explore "what is really going on" (Glaser, 2013, p. 11), so the researcher must remain open to what is going on in the data in order to conduct the research with an open mind, clear of any preconceived notions. Glaser warns, "preconceived questions, problems, and codes all block emergent coding and block classical GT" (Glaser, 2013, p. 14): "first do the grounded theory and then weave in the literature as per the grounded theory model (1998, p. 73).

Nevertheless, the traditional dissertation process requires a literature review prior to conducting the research study. Therefore, the researcher reviewed the literature prior to defending the study proposal; once the research proposal had been approved by the dissertation committee and the Institutional Review Board, the researcher ceased reading literature related to the research topic and returned to the literature as the substantive theory emerged from the data (Glaser, 1998).

Chapter Two provides a literature review pertaining to the topic of the experiences of nurses working in hospitals with shared governance (SG). The review begins with discussions of the meaning and implications of SG; a discussion of the historical roots of SG is followed by a description of theoretical underpinnings related to SG, instruments that have been developed to measure SG, the effects of SG on nursing staff, and barriers to SG. The Chapter concludes with a discussion of the gaps of the literature that support the need for this Classical Grounded Theory study (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014).

THE CONCEPT OF SHARED GOVERNANCE

There is no single definition of SG in the literature. Nevertheless, it is possible to glean from the literature a set of core assumptions, values, and principles pertaining to SG that can provide a logical framework for understanding the concept of SG (Gavin, Wakefield, & Wroe, 1999). SG idealizes a partnership between hospital management and nursing staff. SG is a decentralized approach to nursing management that seeks to give nurses control over their practice; it does not promote the traditional hierarchical management approach, rather it promotes a management style in which nursing staff members are more involved in making decisions (Hess, 2004). Managers in a SG model serve a facilitative, rather than a controlling role. SG is a structural model because it is non-hierarchical; it also is a process model because it addresses power and decision making within the organization (Anderson, 2011; O'May & Buchan, 1999; Howell, Frederick, Clinger & Leftridge, 2001; Porter-O' Grady, 2003). SG is a "decentralized approach" (O'May & Buchan, p. 281) increasing nurses' influence and control over their practice; empowering them, and producing in them a sense of responsibility and

accountability (Anderson). Porter-O'Grady defines SG as "an organizational strategy that employs the attributes of partnership, equity, accountability and ownership between the worker and the workplace" (p.251). SG can improve communication among nurses, their managers, and other members of the healthcare team. It can create a positive work environment and enhance nursing practice by giving nurses control over their practice (Barden et al., 2011; Howell et al., 2001). "SG is about having a voice, being informed, heard, and included in the decision making process" (Moore & Hutchinson, 2007, p. 564). Thus, one of the goals of a SG model is increased job satisfaction by nursing staff and thereby enhancing recruitment and retention of nurses (Kowalik & Yoder, 2010).

Shared governance also affects the quality of patient care and patient outcomes. A stable and committed nursing staff is associated with better patient outcomes (Kowalik & Yoder; 2010, Laschinger & Leiter, 2006; Moore & Hutchinson, 2007).

HISTORY OF SHARED GOVERNANCE

Swihart (2011), who has explored the historical roots of SG, says SG has broad representation within a number of independent, and sometimes interrelated, disciplines. She comments, "The concepts of shared governance are not new. . .philosophy, education, religion, politics, business and management, and healthcare have all benefited from a variety of SG models implemented in many diverse and creative ways across generations and cultures"(p.5). Swihart believes the principles of SG can be traced back as far as Socrates, who used concepts resembling those of SG to develop his philosophy of education, known as The Socratic Method, which facilitates autonomous learning. The United States government was built on the concept of SG. Lincoln's famous quote "of the people, by the people and for the people" (*The Gettysburg Address, 1863)* reiterates the

principles presented in the *Declaration of Independence* and *Preamble to the US Constitution* supporting the belief that citizens are a part of and play a role in the decision-making processed at state and federal levels (Swihart).

Shared governance emerged from the human resource era of organizational theories and comes from a wide ranging set of perspectives that include "organizational, management, and sociological theories" (Anthony, 2004, p. 2). The business community adopted the SG model in an effort to support positive outcomes by moving from a hierarchical top-down approach to a point of service outward (Swihart, 2011; O'May & Buchan, 1999). O'May & Buchan comment that elements of SG are reflected in research and subsequent applications developed by leading business and management experts. They cite Herzberg (1968) and McGregor (1960) who posited that an organization's most important asset is the organization's employees; Deming (1986), who discovered through his work in the Japanese industry that team building, emphasis on quality, and valuing team members enhances productivity; and Kanter (1977, 1993) who asserts that organizations are more effective and productive when they provide environments that support their personnel by giving them access to information and other important resources. The work of each of these individuals provides valuable insight into the SG concept that an organization's success derives not from its administration but from involvement and commitment of "at the point of service (or care)" (O'May & Buchan, 1999, p. 282).

SG in nursing practice began in the 70s and 80s as a way to deal with nursing shortages and fiscal austerity. Although the popularity of SG grew during that period, its popularity quickly diminished once the nursing shortage and fiscal austerity eased

(Bradnt & Sullivan, 2012). SG re-emerged in the early years of the second millennium as a way to improve the quality of patient care and patient outcomes since SG concepts lend themselves to utilization of evidence-based practice (EBP) (Bradnt & Sullivan; Painter, Reid, & Fuss, 2013).

Additional impetus for hospitals to move to a SG model arose from the Magnet Designation movement. Magnet Designation, developed by the American Nursing Credentialing Center (ANCC), is "an organizational credential awarded to exceptional healthcare organizations that meet ANCC standards for quality patient care, nursing excellence, and innovations in professional nursing practice" (ANCC, 2014). In order for hospitals to be eligible to apply and obtain Magnet designation; the organization must be able to support and sustain a formal empowering structure where nurses are involved in the governance and decision making processes of their practice (Hess, 2011; Overcash & Petty, 2012; Rheingans, 2012).

Increased healthcare costs and increased emphasis on quality and patient outcomes has intensified attention on shared governance to empower point of care staff and to create a collaborative workforce between the nursing staff and administration (Start et al., 2013; Rundquist & Givens, 2013; Walter et al., 2014; Wilson, 2012). Farrelly (2013) says, "Organizations now need to learn that the nurse at the front line of the service is crucial to the success associated with changing the environment of care" (p. 1037). Healthcare organizations are realizing that bedside nursing staff must be involved in organizational decision making in order to promote good patient outcomes. Painter et al., (2013) empowered their front line staff to work collaboratively to make changes in their work environment in order to improve patient outcomes by using evidence based

practice. EBP committees were developed so that front line nursing staff, in collaboration with their directors and managers, were able to improve their patient care and outcomes. Walter et al., (2014) used SG to engage nurses in EBP. Walter et. al comment, "Without SG, nurses may feel unable to pursue EBP principles because results may not readily be accepted or adopted" (p. 14).

Historically, SG has been utilized as a way to deal with nursing shortages, increased patient acuity, increased workloads, and dissatisfaction and turnover among nursing staff. The second millennium has seen healthcare organizations turning to SG to improve patient outcomes and the organization's financial situation. Each of these trends has helped to "define the practice of nursing within the organization" (Gray, 2013, p.16).

FRAMEWORK

There are no extant theories addressing SG, although organizational and management theories have been used to provide a framework to study the concepts of SG. The literature consistently describes empowerment as the main focus, or dominant characteristic of a SG system. Several researchers have used Kanter's (1977, 1993) Theory of Organizational Empowerment to examine nurse empowerment in organizations (Laschinger & Wong, 1999). Kanter's theory asserts that employees in any organization, healthcare or otherwise, are more involved and committed when the organization has created an empowering environment (Nedd, 2006). Kanter's theory claims that "individuals with access to information, support, resources, and opportunities to learn and grow in their work setting are empowered and are able to accomplish organizational goals" (as cited by Laschinger and Wong, p.308). The theory posits that successful implementation of empowerment depends on managers at all levels

relinquishing control in order to foster a work environment that promotes empowerment and accountability. Managers, whose primary emphasis is on accumulation of power, restricting flow of communication, and creating layers of bureaucracy guarded by institutional gate keepers, create barriers to SG.

Path-Goal Theory (Evans, 1970; House, 1971) also is utilized as a framework by SG researchers. Path-Goal Theory suggests that a leader must determine what leadership style will best meet employees' needs. The leader paves the way, providing a path for the employee that will support, guide, and direct the employees so they can accomplish their goals as well as the goals of the organization. Path-Goal Theory provides a framework for examining the underlying relationships between leadership behaviors and outcome variables. Kennerly (1996) suggests a cyclical interaction between the behaviors of the leader and the responses of the employees. For example, leaders who do not create a supportive environment for employees can create uncertainty, dissatisfaction, lack of organizational commitment, and job turnover among employees.

Likert's (Likert & Likert, 1976) Management Style Theory was developed to assess employees' perceptions of management within the organization. Likert's Management Style Theory describes the relationships, involvement, and roles between management and subordinates and identifies four leadership styles: 1) Exploitative Authoritative, 2) Benevolent Authoritative, 3) Consultative, and 4) Participative. "Likert's studies confirmed that the departments or units employing management practices [using Exploitative Authoritative or Benevolent Authoritative practices] were the least productive, and the departments or units employing [Consultative or Participative] management practices. . . were the most productive"

(http://managementstudyguide.com/likerts-management-system.htm nd, "Likert's Management System" para. 1).

Employees' perceptions of their relationships with the organization can affect the success or failure of the organization's attempts to meet its goals. Each of these theories, Kanter's (1977, 1993) Theory of Organizational Behavior, Path Goal Theory of Leadership (Evans, 1970; House 1971), and Likert's (Likert & Likert, 1976) Management Style Theory, originally were developed by the business world to address employee/leader relationships. The theories support the importance of a collaborative and participative management approach and have lent themselves to research addressing nursing staffs' perceptions of management in a SG environment.

MEASURING SHARED GOVERNANCE

Various instruments have been developed to measure the concept of shared governance. Hess's (1998) 86-item Index of Professional Nursing Governance (IPNG) is the only instrument that can be applied across all types of healthcare organizations and can measure the degree to which professional nursing participates in hospital governance. Hess began development of the IPNG with a careful review of the literature surrounding topics related to professionalism of nurses within healthcare organizations where he identified six themes that were central to the concept of SG. These themes are: 1) professional control, 2) organizational influence, 3) organizational recognition, 4) facilitating structures, 5) liaison, and 6) alignment" (p. 4). Hess identified sub-categories within each theme. The IPNG asks respondents to classify each theme and sub-category according to whether decisions are made: by nursing management/administration only, primarily by nursing management/administration with some staff nurse input, equally

shared by staff nurses and nursing management/administration, primarily by staff nurses with some nursing management/administration, or only by staff nurses; items where decisions are made only by staff nurses are ranked the highest and items made by nursing management/administration only are ranked the lowest. The scores on the IPNG are aggregated and higher scores reflect established shared governance whereas lower scores reflect traditional governance. The psychometric properties of the IPNG were tested utilizing 1,162 registered nurses from 10 hospitals. The IPNG was found to be reliable (Cronbach α .87-.91) and valid (0.95 Popham average congruency procedure). The IPNG is a well-accepted and reliable instrument for measuring the distribution of professional nursing governance within hospitals (Anderson, 2011; Hess, 1998; Overcash & Petty, 2012). Hess's IPNG is useful for measuring the degree to which SG is functioning within a healthcare organization. Therefore it can be used repeatedly to assess change in the SG model within a given institution.

Healthcare organizations increasingly are utilizing Hess's (1998) IPNG to evaluate whether their current SG models are working. Healthcare organization also are using the IPNG to determine whether changes they make in their SG structure support a true SG model (Clavelle, Porter-O'Grady, & Drenkard, 2013; Mouro, Tashjian, Bachir, Al-Ruzzeih, & Hess., 2013; Wilson, 2013; Walter et al., 2014). Anderson (2011) suggests using the IPNG to confirm that a hospital truly is practicing SG before trying to correlate SG to patient outcomes.

Other instruments have been developed to measure elements within the SG model. Pruett (1989) used Likert's Theory (Likert & Likert, 1976) as a framework to develop a survey to assess committee composition and activities as well as characteristics

of the nursing staff and management. Pruett's instrument was not tested for reliability or validity (Hess, 1998). Havens developed an instrument to measure the influence nursing staff has on nursing practice and nursing department involvement with SG. Neither Pruett's nor Havens's instruments were intended to measure the ongoing effects of SG (Hess).

Hitchens, Capuano, Bokovoy, & Houser (2005) developed an instrument to measure the progress of their hospital's SG professional practice model (PPM). The authors describe the instrument as "a 5-point Likert scale to assess 15 aspects associated with each of the key components of the hospital's PPM" (p.22); the 15 aspects were not identified in the article. Cronbach's alpha, Guttman split-half statistic, and test re-test correlation coefficient confirmed the reliability of the instrument and content validity analysis, face validity and concurrent validity confirmed the validity of the assessment. The authors wanted evidence that nurses perceived involvement in decisions and control over their practice. In addition to development of an instrument to measure the elements of each unit's PPM, the study findings revealed elements of the PPM that were more accepted than others; moreover, some elements of the PPM were viewed differently by nursing staff and by management. The hospital posts outcomes of each nursing unit's PPM on the nursing unit where it is utilized for discussion and ongoing development of each unit's PPM.

EFFECTS OF SHARED GOVERNANCE ON NURSING STAFF

The literature review identified several quantitative studies and one qualitative study that explored the responses of nursing staff members to implementation of SG. Most of the quantitative studies used a pre and post-implementation design. For example,

Ludemann and Brown (1989) compared nurses' perceptions of their work environment post implementation of SG to the nurses' recollections of the work environment prior to implementation of SG. The researchers conducted exploratory surveys at one and one-half years post-implementation when they asked nurses to describe their current feelings about working in a SG environment; they also collected data addressing the nurses' recollections of the pre-SG work environment. The data collection at 24 months post-implementation addressed nurses' responses to their current work environment. The study findings revealed that nursing staff members perceived the work environment more positively after the introduction of SG. The authors comment, "Nursing staff perceived themselves as working in an environment that gives them greater influence, autonomy, and freedom and job satisfaction was increased" (p. 54).

Kennerly (1996) conducted a quasi-experimental study utilizing Path Goal Theory of Leadership (Evans, 1970; House, 1971) to assess the effects of SG on nurses' and non-nurses' perceptions of their work and their work environment. Kennerly utilized a survey approach to gather from nurses and non-nurses at six months and 18 months after initiating SG. A control group of nurses and non-nurses from units not participating in SG was established and surveyed at the same time intervals. In addition to demographic data, Kennerly used an instrument in which she had combined several other instruments to collect data reflecting characteristics of nursing staff members and managers. The researcher surveyed 115 eligible participants (41.3% of the total nursing staff of the institution) prior to the implementation of SG to establish base line data. Six months after implementation of SG, 150 participants (58% of nursing staff on SG units, 55% on no-SG units [NSG]) were surveyed; then at 18 months 133 participants (57% SG and 52% NSG)

were surveyed again. Although the study findings revealed little difference in the perceptions of nurses and non-nurses of the work environment, with or without SG, the findings suggest that SG may offer a useful framework for teambuilding.

Richards et al. (1999) implemented a shared governance council model as a way to "reduce, eliminate, and consolidate nursing committees, enhance communication and increase the decision-making abilities and opportunities of staff members" (p. 1). The research study explored the perceptions of the nursing staff after implementation of the SG council model to assess the impact on the hospital's culture. The researchers conducted interviews and administered questionnaires to nursing staff members at 6 months and two years post-implementation. The study findings revealed that nursing staff perceived the change as very positive at 6 months but the nurses thought 6 months was too early to determine the true effects of SG. The staff nurses continued to have positive perceptions about SG after two years; the nurses saw improvement in communication and perceived they had more input in making decisions about their practice. Nevertheless, the staff nurses perceived very little change in the hospital's culture between the two periods. This last finding may have been impacted by the hospital's reduction in the number of their inpatient beds and the talk about merging with another hospital.

Ott and Ross (2014) conducted a qualitative research study exploring the lived experiences of nurse managers and staff nurses. Ott and Ross's study is the only study identified in the literature that used a qualitative approach to explore the experiences of nurses related to SG, although they do not define the specific study methodology they used. The researchers conducted interviews developed from their literature review. They interviewed nurse managers individually and staff nurses in pairs. The study findings led

the researchers to believe the nurse manager has a great deal of influence on the success of a SG model. The researchers advise nurse managers to partner with staff nurses, providing support and guidance to empower each nurse. The researchers believe the nurse manager must transform him or herself and become a facilitator; they believe SG must be a collaborative effort between nurse managers and their nursing staff.

Jones et al. (1993) conducted a pre/post implementation SG study that demonstrated the effects of SG on the work environment. They evaluated 29 patient care units over a three year time period post-implementation of SG. Their study found that there was a significant improvement in the management's decision-making style in the second year. Job satisfaction improved in all three years and organization job satisfaction and anticipated turnover improved during the second and third years. There was no improvement in group cohesion or job stress. Staff perceptions were more favorable of the SG process post-implementation than they were prior to implementation.

Prince et al. (1997) conducted a pre/post implementation study on a Mother/Baby-Gyn unit where a shared governance council was implemented. A Likert-type survey tool was used that assessed "staff perceptions reflecting work empowerment opportunity, teamwork, and related levels of satisfaction" (p. 3) pre-implementation and at one year post-implementation. Prior to implementation of SG the survey results showed that the nurses felt well informed, were satisfied, and contributed in committee meetings. Post implementation, the study results showed a slight improvement in communication; however nurses felt they did not always receive the necessary information they needed to do their work. The nurse manager was instrumental in providing information to the nursing staff but often times the nurse manager did not know until the last minute what

needed to be conveyed. And job satisfaction was decreased. It is of concern that during the time of the study there was "reorganization of the unit, leadership transition, and tightening of the nursing budget" (p. 8) which may have influenced the participants responses. Turnover rates remained unchanged, 84% of the staff felt they were able to help improve their unit, and there was a 20% increase in the number of staff who believed unit councils added value.

Frith and Montgomery (2006) compared nursing staff members' responses to implementation of SG. The authors developed their 39-item Likert-type Shared Governance survey based on the work of Minors, White, & Porter-O'Grady,(1996). Nursing staff members (RNs, LPNs, and care technicians) responded to the survey just prior to implementation of SG and at one year post implementation. The goal of the longitudinal study was to assess the nursing staff's perception, knowledge, and commitment to SG. The study revealed a decrease in perception and knowledge of SG between the pre-implementation and post-implementation period even though commitment to SG increased. Study findings also demonstrated that implementation of SG is time-consuming but effective and commitment from all levels of the organization is needed. The findings also revealed that staff apathy, insufficient time to implement SG, role ambiguity, and communication are barriers to successful implementation.

O'May and Buchan (1999) conducted a literature review in which they analyzed 48 articles that "described or evaluated implementation of SG" (p. 281). The authors concluded that studies evaluating the effects of SG should be longitudinal and should assess characteristics of nursing staff utilizing psychometrically sound instruments and incorporating repeated measures before during and after implementation. They also

discovered that most of the evaluations of the effects of SG occur within one to two years of implementing SG, making it difficult to assess the long term effects of shared governance. Implementation of SG requires careful planning and all stakeholders must have a clear understanding of SG and their own role in the implementation processes. While the decision to implement a SG model typically is initiated at the administrative level, successful implementation of SG is determined by how well staff members accept and adopt the model. O'May and Buchan conclude that "SG is not a panacea, a stand-alone, one-dose fix, which will inherently cure all the issues it has been employed to address. . .it requires continual support, adjustment and evaluation" (p. 297).

Most of the research studies exploring the effects of SG on nursing staff occurred in the late 90s and early 2000s. Authors in the 2000s have begun to describe hospitals' efforts to enhance existing SG models by implementing unit- and hospital-wide councils as a way to increase bedside nurses' involvement in the decision making processes within their practice environment (Duncan & Hunt, 2011; McDowell, Williams, Kautz, Madden, Heilig, & Thompson, 2010; Styer, 2007). Start et al. (2013) recommend that organizations implementing or revising their current SG model "make an effort to involve all key stakeholders starting from the early steps of the process to promote successful adaptation to the organizational change" (p. 14).

Dunbar, Park, Berger-Wesley, Cameron, Lorenz, Mayes, and Ashby (2007) describe how one hospital worked to reshape and reinvigorate the practice of SG within their organization. Surveys had revealed deterioration of SG practices in the institution: the relationships between nursing staff and administration, nurses' perceptions of their own autonomy, their potential for career advancement, and their ability to make decisions

about practice issues and affect unit management all were shown to be at lower levels than earlier in the hospital's history with SG. The CNO implemented a transition team and hired a consultant to assist in assessment, development, education, and implementation of the new SG process that occurred over a 2-year period. The authors stress that SG is "an ongoing process that will require continued commitment, vigilance, and flexibility. . .maintenance planning is vital in determining the final impact of SG" (p. 183). They also concluded that a transition team is critical to the successful implementation of SG and a very valuable resource when making changes in how SG is perceived within the institution and how SG functions.

Hospitals in 2000s continue to pursue Magnet designation. Magnet Designation in 2000s has expanded the concept of SG to include SG as a way to create a culture of service excellence and to support bedside nurses in the decision making processes of their practice (Moore & Hutchinson, 2007; Force, 2004; Latta & Davis-Kirsch, 2011; Watters, 2009).

Shared governance can increase nurse satisfaction and professional autonomy, improve patient care outcomes, and improve the hospital's financial status through cost savings (Porter-O' Grady, 1994; Swihart, 2011). SG may offer a framework for team functioning and team building; it may enhance perceptions of the work environment, although different studies have had different findings.

The research studies that have explored the effects of SG on nursing staff have limited themselves to examining the effects or experiences of nurses up to 24 months after implementation of SG in the hospital. The studies tend to focus on comparison of the nurses' experiences before SG to their experiences after its implementation. Therefore

the studies' emphasis seems to be on examining the transition and early implementation phases in the history of SG in a given institution. To date, no studies have explored nurses' experiences in established SG environments. Research studies have focused on nurses in acute care adult hospitals. To date, no studies have explored the experiences of nurses in children's hospitals that have a SG model.

BARRIERS TO SHARED GOVERNANCE

Despite the advantages of SG, several authors question its effectiveness and the degree to which it is actually practiced (Porter-O'Grady, 1994; Gavin et al. 1999; Hess, 1994). An impediment to SG is that it replaces the traditional hierarchical form of hospital governance and requires empowerment of nurses and enhancement of their leadership skills and knowledge (Williamson, 2005). "Implementation requires a shift away from traditional hierarchical, centrally controlled management styles (Bina, Tippetts, & Specht, 2014). Healthcare institutions may claim to have a SG system but continue to maintain a hierarchical structure which contradicts SG concepts: the organization says one thing but does another and nurses are not always included in key decisions about their practice and practice environment (Ballard, 2010; Clavelle, et al., 2013; Galvin et al., 1999; Gray, 2013; Porter-O'Grady, 2001; Williamson, 2005).

SG can be challenging to implement and requires ongoing evaluation and assessment in order to survive (Ballard, 2010; Burnhope & Edmonstone, 2003; Dunbar et al., 2007; Frith & Montgomery, 2006; O'May & Buchan, 1999; Porter-O'Grady, 1994; Gray, 2013). Gray states: "Integrating SG can be arduous and time consuming" (p. 17), which becomes a barrier to successful implementation of a SG model. Some members of the nursing leadership team may fear losing control, while members of the hospital's

administrative team can be concerned about increased costs as nurses dedicate additional hours above and beyond their normal work week to attend SG meetings and functions. Although SG might be easy to describe, it often is difficult to implement, disseminate, and enculturate. The complex interactions that occur at the level of the nursing unit, the hospital, or the hospital system influence either the success or failure of shared governance. Success of SG models depends on leadership support, role redefinition, delineation of decision-making roles and processes, identifying and publicizing communication plans and on-going education of all participants in the SG process (Ballard, 2010).

Many of the studies regarding SG lack rigor both in the research methods that have been used as well as the data analysis procedures (O'May & Buchan, 1999). SG is a complex concept; it is defined in a variety of ways and implementation may coincide with other nursing management innovations; implementation of a SG model is hard to evaluate (O'May & Buchan; Gavin et al., 1999). The ability to effectively measure the effects of SG has been challenging since few tools have been developed measuring governance. Martin (1995) suggests that studies should be longitudinal and utilize psychometrically sound instruments to assess characteristics of the nursing staff before, during, and after implementation. Jones et al. (1993) say the effects of SG on the hospital system "may not be observed for one to two years or more post implementation" (p. 212). Therefore, O'May and Buchan advise researchers to consider Havens's suggestion to conduct long-term evaluations of SG effects over a five year period.

GAPS IN LITERATURE

There are no extant theories addressing the experiences of nurses working in hospitals with shared governance models. Research to date has focused on pre and post implementation comparisons to determine the effects of SG on the experiences of nurses. The research has been limited to examining the first one to two years after implementation of a SG model. Moreover, research on the effects of SG on nurses' experiences has tended to be limited to adult acute care hospitals. The present study will fill several gaps in the literature. Utilization of Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to explore the experiences of bedside nurses in children's hospitals where SG had been in place for a minimum of four years led to development of a substantive theory reflecting the concerns and experiences of bedside nurses who work in children's hospitals where shared governance has been in place for a minimum of four years.

SUMMARY OF CHAPTER TWO

Chapter Two has provided a discussion of the literature pertaining to the topic of the experiences of nurses working in hospitals with shared governance (SG). The Chapter has included a discussion of the concept of shared governance and its historical roots, theoretical frameworks related to SG, instruments that have been developed to measure SG, research exploring the effects of SG on nursing staff, and barriers to SG. Finally, Chapter Two has identified the gaps in the literature that support the need for this Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) study exploring the experiences of bedside nurses who work in children's hospitals with established SG.

PLAN FOR REMAINING CHAPTERS

Chapter Three will describe the application of Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to answer the research question: "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?" Chapter Four will discuss the study findings including the substantive theory that emerged from the data. Chapter Five will provide the discussion, implications, and conclusions of the study.

Chapter Three Methods

Chapter Three describes the application of Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) (CGT) to the research question, "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?" The Chapter begins with a discussion of Classical Grounded Theory and its appropriateness for the research study. Chapter Three provides a description of the study website, where recruitment of study participants and data collection occurred; and a discussion of the study sampling and recruitment procedures, as well as participant inclusion criteria. The Chapter continues with a description of the study data collection procedures, data management, and data analysis processes. The data analysis section begins with a description of CGT data analysis procedures followed by a discussion of the data analysis processes used in the study. Next, Glaser's (1978, 1998) criteria for trustworthiness that were utilized to assure rigor throughout the study, are described. The Chapter ends with a discussion of ethical issues related to the study.

Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) (CGT) was used to explore the experiences of bedside nurses practicing in children's hospitals with a shared governance model in place for at least four years. Classical Grounded Theory is an inductive process used to explore aspects of social processes at work in people's lives and to develop theory grounded in actual data (Glaser, 1998). Glaser (1998) states that CGT asks the question "what is really going on?" (p.12). Grounded theory is a rigorous method utilizing the constant comparison method (CCM) for data analysis (Glaser, 1978), whereby data is collected and analyzed at the same time

and each item of data is compared to all other items of data (Glaser, 1978, 1998, 1992). The overall aim of CGT is to identify themes, patterns, and processes and to understand how a group of people define, via their social interactions, their reality (Chen & Boore, 2009), leading to development of a theory "grounded" in the data (Glaser, 1978, 1992, 1998, & 2012). Classical Grounded Theory is unique in that it provides more than meaning, understanding, and description of a phenomenon; it creates theory (Glaser 1978, 1992, 1998, & 2012).

There are no extant theories addressing shared governance. Moreover, there has been very little research regarding the experiences of nurses who work in children's hospitals with established SG models. This study explored the experiences of nurses practicing at the bedside in children's hospitals with established shared governance models using CGT methodology (Glaser 1978, 1992, 1998, 2005, 2012, 2013, 2014). Analysis of the data utilizing the CGT technique of constant comparison resulted in emergence of the substantive theory, *Being Heard*.

THE STUDY WEBSITE

A study website was created to recruit bedside nurses to the study and from which to conduct the research (www.bedsidenurseexperiences.weebly.com). Clicking on the link to the study website brought up the study home page (Appendix A). The study home page provided the following information: what the study was about, who could participate, what was involved, and when the study would take place. The study website home page provided direct links to access additional information about the research study: "more information," "requirements," and "how to participate." The "study purpose" link from the home page brought up a brief description of the purpose of the

study (see Appendix B). The "participation requirements" link brought up a list of the study inclusion criteria (Appendix C). The "downloads" link (Appendix D) brought up a list of links to each of the following: study consent form (Appendix E), the research flyer (Appendix F), the demographic data form (Appendix G), and two links with information about creating a Gmail account. The link to the recruitment flyer (same as Appendix F) contained the researcher's email and phone number; it invited bedside nurses to explore the study website and to contact the researcher either by email, phone, or text if interested in participating in the research study. Clicking on "chat" or "participate" took the user to a password log (Appendix H); each participant was given her/his individual password by the researcher prior to their interview. The study website web master removed all participant information, including demographic data and interview data prior to the researcher conducting a subsequent interview.

STUDY SAMPLING, RECRUITMENT, AND PARTICIPANT INCLUSION CRITERIA

The study used purposive, snowball, and theoretical sampling. Purposive sampling selects informants based on their "first-hand experience with a culture, social process or phenomenon of interest" (Streubert & Carpenter, 2011, p. 28). Snowball sampling is a form of purposive sampling where participants in the study are asked to refer other people who might be able to participate (Streubert & Carpenter). Theoretical sampling reflects the concurrent processes of collecting, coding, and analyzing data in order to generate theory, allowing the researcher to determine where and what data to collect next to support the development of the emerging theory (Glaser, 1978, 1992, 1998).

All study procedures were submitted to the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB) for approval (see Appendix I for IRB approval letter and Appendix E for study consent form). UTMB IRB approval allowed the researcher to begin recruitment of bedside nurses to participate in the study. The participant recruitment strategy delineated in the initial research protocol was that the researcher would email Chief Nursing Officers [CNOs] working in children's hospitals within the United States where a SG model had been in place for greater than four years to seek permission to recruit their bedside nurses (Appendix J). The researcher followed up with a second email or phone call to the CNOs to answer questions and provide information about the study. Several CNOs agreed to help with the recruitment process. The researcher and the CNOs worked together to determine the most appropriate strategy for distributing recruitment flyers to their staff nurses. The strategy agreed to by the CNOs and researcher was that the researcher would email the recruitment flyer to the CNOs who then would disseminate the flyer among their bedside nurses. The proposed recruitment strategy yielded no study participants, so the researcher submitted a proposed amendment to the participant recruitment procedures to the UTMB IRB to use peer networking for participant recruitment. Approval of the amendment by the UTMB IRB (Appendix K) allowed the researcher to reach out to her peers who had contacts in children's hospitals in Texas where SG had been in place for greater than four years. The researcher's peers disseminated the study flyer via email to bedside nurses in four children's hospitals in Texas with an established shared governance model. The IRB-approved amendment to the study protocol also included offering a twenty-dollar gift card to study participants. The initial dissemination of the study flyer by the researcher's

peers resulted in the researcher being contacted by five bedside nurses who met the study inclusion criteria and agreed to participate in the study. Utilizing snowball sampling, the researcher requested that those five bedside nurses inform their colleagues about the research study. The ultimate study sample consisted of 18 bedside nurses (participant demographic data will be discussed below).

Participants in the study were bedside nurses who:

- worked in children's hospitals that had SG in place for at least four years
- were able to speak, read, and write in English
- had access to a computer
- possessed skills required to participate in online data collection

There were no exclusionary criteria related to sex, age, race, or gender.

The bedside nurses who were interested in participating in the research study contacted the researcher either by phone, text, or email to volunteer for the study. The researcher responded back to each of the participants using the same modality the nurse had used to contact the researcher. The following is the message the researcher sent:

> "Thank you so much for volunteering to participate in my research study. The interview is conducted online using either a Gmail chat or the study website chat room. There are 3 parts to the interview: the study consent, demographic data collection, and the interview questions. I am forwarding the information to the study website as well as the consent and demographic form for your convenience. Please send me an email or text if you are interested in participating in the study. I am offering a $20 gift card to either Target or Starbucks." (the researcher's phone number and website link address were included in the message)

The nurse responded back to the researcher indicating her/his intent to participate in the study. The researcher confirmed that the nurses who agreed to participate were bedside nurses working in a children's hospital with an established shared governance model, had access to a computer and the internet, and were able to participate in an online interview. If the nurse met the study inclusionary criteria and s/he agreed to participate in

the research study, an interview date and time convenient to the nurse and the researcher was scheduled. The bedside nurses were encouraged to select a date and time that was convenient for them when they would have few interruptions and could have privacy for the interview. The researcher asked the bedside nurses to visit the study website and to read both the study consent form and the demographic data questionnaire prior to the interview. The bedside nurses could email the completed study consent and demographic information to the researcher if they chose. Most study participants opted to wait until the interview when the researcher discussed the study and obtained consent to participate. The researcher confirmed the best method for communication for each bedside nurse so that the researcher could send a reminder for the interview and the nurse could contact the researcher with any additional questions or concerns.

The researcher assessed the comfort level of each of the participants about participating in an interview online using either a G-mail chat or the study website chat room. The majority of the participants (17 of the 18) stated they had previous experience and felt comfortable being interviewed online. The researcher coached the remaining participant on using the study website chat room and conducted a trial run that helped the participant feel more at ease with the process.

DATA COLLECTION PROCEDURES

Data for the study consisted of demographic data, interview data, and the researcher's memos and notes. Data for the study was collected using online semi-structured typed synchronous interviews within either a G-mail chat or the study website chat room according to the preferences of the study participants. Online semi-structured interviews are flexible and allow the use of open-ended questions and the opportunity for

storytelling (Nilsen, 2013; Streubert & Carpenter, 2011). Scott (2011) comments that online interviewing "lends itself very well to the research method [GT] and. . .the theoretical fit is good" (p. 87). Online data collection also allows access to participants across different regions. It affords a level of privacy and confidentiality; and a written transcript of the data is immediately available (Kazmer & Xie, 2008; Nilsen, 2013; Opdenaker, 2006). Utilizing a chat room to conduct online interviews can be a dynamic process as the researcher is able to gather many details during the course of the conversation.

Scott (2011) provides several cautions to grounded theorists who are contemplating using online interviewing. First, the researcher should understand his or her own capabilities and preferences in relation to conducting the interview (p. 89). Second, the interviewer should take pains to help the interviewee feel safe and comfortable. Scott refers to Glaser's (1998) recommendation that if the interviewee is comfortable, the environment will "instill a spill" (p. 111). The interviewer should be sure the interviewee has the appropriate hard and software to participate in the interview; moreover, the researcher should be sure the interviewee has the requisite skills to participate in the interview.

The bedside nurses agreeing to participate in the research were given several options for online participation. The bedside nurses could choose to participate anonymously by using a pseudonym to establish a new Gmail account for the interview process, or they could participate anonymously through the study website by choosing a website icon. If the bedside nurse already had a personal Gmail account the nurse could choose to use that account for the study interview. The researcher reminded nurses who

opted to use their personal Gmail accounts that such accounts do not ensure anonymity, although their data would be kept confidential. Moreover, those who opted to receive the gift card would have to share their mailing address with the researcher. While all of the participants were assured that their identity and identifying information would remain confidential, one bedside nurse chose to participate in the study anonymously from a group email account which shielded her identifying information; that nurse did not want a gift card.

Data collection began when the bedside nurse and researcher logged onto either the Gmail chat or the study site chat room at the agreed-upon time. The researcher acknowledged the bedside nurse by typing "hello" and waited for the participant to respond. The researcher asked each bedside nurse how s/he was doing and if s/he was ready to proceed. The nurse's response allowed the researcher to begin the description of the research study and answer any questions the nurse might have. The researcher discussed the study consent form, including how the study data would be used and stored, the participant's ability to withdraw at any time, and how the participant's confidentiality would be protected. The researcher then asked the bedside nurse if s/he had any additional questions about the study; when the potential bedside nurse's questions were answered, the researcher asked whether the bedside nurse had reviewed the study consent form. Once the nurse confirmed that s/he had read the consent form, the researcher asked the nurse to indicate her/his willingness to consent to participate in the study to indicate by typing "I agree" or "I disagree." The researcher encouraged the bedside nurse to print a copy of the study consent for her/his own records. The nurse typing "I agree" allowed the researcher to begin data collection.

Data collection began with demographic data collection (same as Appendix G). The researcher posted sections of the demographic data and allowed the participant to respond before posting the next section. The first demographic data section addressed age and gender; section 2 addressed race/ethnicity; section 3 addressed education; and section 4 addressed the participant's nursing experiences. Three of the participants emailed the data collection form to the researcher prior to the interview. The researcher acknowledged that she had received their demographic data and asked if they had any questions regarding the demographic information.

The interview phase of data collection utilized semi-structured interview questions developed for the study (Appendix M). Glaser (personal communication, 2013) recommends beginning the interview with very broad questions. Scott (2011) reminds CGT researchers that the method is exploratory so participants should be allowed to discuss whatever they wish in relation to the phenomenon of interest, the researcher should allow participants' responses to guide subsequent questions.

The researcher began the interview by asking, "Can you tell me about your experiences working in a children's hospital?" The bedside nurses' responses lead to the formulation of subsequent questions, such as: "What do you mean by. . .?" "Can you give me an example?" In some cases, the researcher posed questions that were more specific to shared governance: "Can you tell me what it is like working in a SG environment?" "Do you hear the term SG talked about in your hospital?" The researcher conducted the interview by posting each interview question and allowing the participant time to respond before posting the next question or any probes. Scott (2011) comments that conducting an interview using a chat room can be difficult because it is hard to tell when the chat

partner has finished typing her/his response and the current thread can be interrupted if one starts to type too soon. If this researcher was unsure whether the bedside nurse had completed typing a response, the researcher typed a comment such as, "Have you completed your response?" Periodically, the researcher checked to see if the participant was becoming fatigued by typing such things as, "Is it ok to continue?" Near the end of the interview, the researcher asked the participant if s/he had any further questions or comments regarding the research topic. At the conclusion of the interview, the researcher informed the bedside nurse that s/he could email, text, or phone the researcher with any additional thoughts and/or questions prior to the study's completion. The researcher also confirmed the bedside nurse's willingness to be contacted in the event that the researcher had any further questions. The researcher offered each participant a one-time gift of a twenty dollar (US) gift card to either Starbucks or Target as a token of appreciation for their participation in the research study and obtained the participant's mailing information. The researcher sent the gift card and a thank you note to the participant within ten days of the conclusion of the interview.

Each of the eighteen bedside nurses who participated in the study was interviewed once. The total time the researcher and participants were in the chat room for the interview ranged in length from 60 – 90 minutes and averaged 87 minutes. However, several of the nurses left the interview for a few minutes to attend to other matters such as a crying baby, to remove an item from the oven, or to say goodbye to guests.

The final data elements included in the research study were the researcher's notes and memos. The researcher used her notes to record such things as her observations and

notes to herself about the data collection and data analysis processes. The researcher's memos are discussed below in the data analysis section.

DATA MANAGEMENT

Study data collection utilized online synchronous typed interviews that occurred in real time on both the researcher's and bedside nurse's computer, therefore, a transcript of the entire interaction was available immediately (Kazmer & Xie, 2008). The researcher asked the bedside nurse to not share any of her/his recorded transcript with other potential participants. The transcript was downloaded from the study website onto the researcher's password-protected computer and the web master removed the transcription from the study website. All study data was password protected and secured on the researcher's computer and a back-up external drive. An original copy of each transcript was saved intact. A second copy of the transcript was made and any information that could be linked to describe the participant was removed and an identifying code assigned. The first interview was coded as P1, the second interview P2 the third interview P3 and so on. The de-identified coded transcripts were used for data analysis. All transcripts along with any additional data and the researcher's notes were kept under lock and key in the researcher's home or office. All information related to the study will be destroyed once the research is complete and all reports are written.

DATA ANALYSIS

Data collection and data analysis in a Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) are ongoing and iterative processes. Data analysis begins with the collection of the first set of data and analysis of that data informs subsequent data analysis. For example, analysis of one set of data helps to determine

what questions to ask during the next data collection session. The data is analyzed utilizing the constant comparison method (CCM) to "generate theory through systematic and explicit coding and analytic procedure" (Holton & Glaser, 2012, p. 28).The following sections will discuss data analysis techniques utilized CGT research, including theoretical sampling, coding, theoretical saturation, and memos.

THEORETICAL SAMPLING

Theoretical sampling is core to Classical Grounded Theory. Theoretical sampling continually guides the process of coding, collecting and analyzing the data. "It is the 'where next' in collecting data, the 'for what' according to the codes and the 'why from' the analysis in memos" (Glaser, 1998, p. 157). Theoretical sampling is an ongoing fluid process where codes are elicited from the raw data utilizing the constant comparison method. Data identified by theoretical sampling are coded theoretically to elaborate and hone the emerging theory (Glaser, 1978). Codes continue to be theoretically developed as they and their properties are compared to other codes. Once saturation occurs and no new codes or properties can be identified; theoretical sampling for that code ceases; however, theoretical sampling continues throughout the process to further develop the emerging theory (Glaser, 1978).

Coding

Classical Grounded Theory consists of substantive coding and theoretical coding (Glaser, 1998). "Substantive codes conceptualize the empirical substance of the area of research. Theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory" (Glaser, 1978, p. 55). Substantive coding is the process of breaking the data apart, fracturing the data into pieces that can be

analyzed and "raised to a conceptual level" (Glaser, 1978, p. 56) and theoretical coding "weaves the fractured story back together again" (p.72) so the theory can describe and explain the phenomenon of interest.

Substantive coding has 2 phases: open coding and selective coding. The researcher begins coding a set of data with open coding, analyzing the data line by line asking questions such as "What is this data a study of?" "What categories does this indicate?" and "What is actually happening in the data?" (Glaser, 1978, p. 57). Open coding also involves identifying clusters of coded data that appear to fit together forming categories. Data collection and analysis continues, leading to the emergence of one category that seems to organize or be central to all the other categories. Additional data collection, analysis, and coding led to the formulation of tentative relationships among the categories and identification of the central, or core category. Emergence of the core category allowed the researcher to begin coding selectively. Selective coding is the process of coding the data as it relates to the core category and patterns among the categories.

Theoretical coding can be described as a "final stage" (Evans, 2013, para 16) in coding the data when conducting classical grounded theory. "Theoretical codes provide the models for theory generation and emerge during coding, memoing, and especially in sorting" (Glaser, 1998, p. 163). TCs can be either implicit or explicit; they are a dimension of the core concept and their purpose is to integrate the substantive theory (Glaser, 2005).

Theoretical Saturation

Theoretical saturation occurs when the substantive theory is complete with "concepts that have fit, work, have relevance and are saturated" (Glaser, 1978, p. 125). Theoretical saturation implies theoretical coverage as far as the study can take the analyst" (Glaser, p. 125), thus, the researcher is no longer able to glean additional information related to the problem, the main concern of the participants. The emerging categories and their properties have saturated; no new categories or properties are revealed in the data.

Memos

Memoing is the heart of Grounded Theory research, the main process that allows the researcher complete freedom to generate ideas and thoughts while analyzing, coding, and constantly comparing the data that eventually lead to written theory. **"**Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (Glaser, 1978, p. 83). Memoing is an ongoing fluid process that begins when the data is first coded and continues through to the very end of the study. As the researcher collects and codes the data, she will stop to memo so that her ideas and thoughts will not be forgotten and can be referred back to. The four basic goals in memoing are to theoretically develop *ideas* (codes), with complete *freedom* into a memo *fund*, which is highly *sortible*" (Glaser, 1978, p. 83).

Data Analysis Process

The data analysis process in the present study implemented and utilized the CGT analytic elements discussed above. The following description will, by necessity, describe

the process as though it was linear. Nevertheless, it is important to keep in mind that CGT data analysis is an iterative process.

Data analysis began with the first interview utilizing open coding and constantly comparing the participant's responses line by line, incident to incident, to identify patterns and differences within the data. Memos were used to record the researcher's ideas, questions, and hunches related to the data. Data items that resembled other data items were clustered together then labeled with a code to reflect what was going on in each cluster.

The second bedside nurse was interviewed and data from the second interview was analyzed; the clusters, or categories, of data that emerged were compared to those in interview one. Holton and Glaser (2012) advise CGT researchers to code "for as many categories as fit [while allowing for the emergence of new categories as well as determining whether] new incidents fit into existing categories" (p. 278), constantly comparing new data with itself as well as with other data. The process continued throughout data analysis.

Open coding resulted in identification of nine clusters, or categories, of data and their properties (Glaser, 1998). These clusters were: 1) having a voice/input, 2) working collaboratively, 3) providing quality care, 4) management, 5) support, 6) affecting change, 7) cost, 8) angst, and 9) being a part. Analysis of the data using constant comparison continued, leading to identification of the bedside nurses' "main concern" (Holton & Glaser, 2012, p. 29), which was *being heard*. Identification of the bedside nurses' main concern, *being heard*, allowed the researcher to move to selective coding.

Selective coding, as well as memoing, reorganized and delimited the clusters of data. Selective coding and memoing also led to recognition of the relationship among the clusters of data. Glaser (1978) calls such relationships "theoretical codes" (p. 72), commenting that "theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory. [Theoretical codes] weave the fractured story back together again" (p. 72). It became apparent that the bedside nurses were utilizing a process, conceptualized as *voicing*, to resolve their main concern.

Voicing was identified as the theoretical code in the data and consisted of a feedback loop in which the outcome of the process feeds back into the next iteration of the process. Glaser (2005) labels such a theoretical code an "amplifying causal loop" (p. 9) (ACL). Glaser describes an ACL: "As consequences become continually causes and causes continually consequences, one sees either worsening or improving progressions or escalating severity. Causal looping amplifies in either direction: positive or negative" (p. 9).

Identification of the theoretical code, *voicing*, generated additional memoing that led the researcher to theoretically sample additional data as well as existing data in order to test the theoretical code and to refine and saturate the existing categories. Although the categories of the theory appeared to be saturated when the researcher had interviewed 12 bedside nurses, six additional nurses were interviewed because they were eager to participate in the study. The data provided by the six additional nurses confirmed and enhanced the substantive theory that had emerged.

The substantive theory that emerged during data analysis focused on the bedside nurses' main concern, *being heard*. The bedside nurses resolved their main concern

utilizing a process of *voicing*, an amplifying causal loop, consisting of three phases: *being willing, engaging, and assessing*. Chapter Four will provide a detailed discussion of the theory and its elements.

TRUSTWORTHINESS

Trustworthiness is the term used when referring to the credibility or plausibility of a qualitative study's procedures and findings. Trustworthiness in qualitative research is comparable to validity and reliability in quantitative research. Glaser (1978, 1998) cites four criteria to support the trustworthiness of a Classical Grounded Theory study (Glaser, 1978, 1998, 2005, 2012, 2013, 2014). These criteria are: 1) fit, 2) work, 3) relevance, and 4) modifiability:

Fit: The categories and the theory must not be forced into preconceived conceptualizations (Glaser 1978; 1998).The findings of the present study "fit" because the categories and their relationship with each other arose from the data itself. Peer review and debriefing throughout all phases of the study assured that neither researcher bias nor preconceptions would find their way into the process.

Work: "Work" is the ability of a grounded theory to explain, predict, and interpret what is happening (Glaser, 1978). Work is accomplished by systematically analyzing the data reflecting a variety of social variables, distilling from the evidence the core issues, and validating the grounded theory. The theory that emerged in the present study works because it can explain, predict, and interpret the bedside nurses' experiences and responses to working in a shared governance environment. The categories of a theory must first fit then work and have relevance as it pertains to the research (Glaser, 1978, 1998).

Relevance: Relevance reflects the degree to which the theory "grabs" (Glaser 1978, p.95) the essential evidence and pulls it together. Relevance is achieved when the core problems and processes emerge through data collection and analysis. Without relevance, the research is not important; the CGT is relevant when it reflects the main concerns of those involved (Glaser, 1978, 1998).The theory that emerged clearly reflects the bedside nurses' main concern, *being heard*, and the processes they utilized to resolve their main concern.

Modifiability: Theories can be altered as new information arises. Modifiability occurs with constant comparison of the emerging theory to the new data. The theory must not force the data, but be modified as it is constantly compared to new data. Theory is ever-changing as new data emerges. The theory that emerged in the present study lends itself to modifiability because it has the potential to be applied in new situations or to be modified as new data emerge.

ETHICAL CONSIDERATIONS

The risks associated with this study were minimal. The potential risks to the participants were loss of confidentiality and interview fatigue. Information describing the privacy and confidentiality risks to the study participants was disclosed prior to data collection as a part of the subject consent process.

Data was obtained utilizing synchronous online interviews. The internet provides little privacy or confidentiality even though many internet users feel that there is no threat (Frankel, 1999). Discussions of the risks related to the use of the internet were revealed in the informed consent process. Participants were offered the option to participate in the study using a Gmail account and a fictitious name, or they could use their current email

address with the understanding that a personal email address forfeited anonymity. Instructions for establishing a Gmail account using a pseudonym to insure confidentiality was provided on the online study website.

Participants were encouraged to schedule the interview at a time and location where they would have privacy and there would be minimal risks of interruptions. The researcher conducted the interviews from her personal computer either in her own home or at her office with the door closed and signage posted to prevent interruptions. Confidentiality was assured by removing identifying material from the interview transcripts and each transcript was assigned a code number. The code was the only identifier applied to the demographic data and transcripts that was used for the data analysis. The researcher used a password-protected laptop computer, external hard drive, and a USB flash drive for data storage. These items were secured in a locked cabinet in the researcher's home. The consent forms and codebooks containing the names and code numbers of the participants were secured in a locked file cabinet in the researcher's home and kept separate from all other materials related to the study, which was stored in a different file and location. The pseudonym and code number were the only identifier applied to the word-processed electronic files containing the interview transcripts.

The risk of participant fatigue during the interview process was an additional risk. The researcher assessed whether the participant was becoming fatigued during the interview process by periodically asking if the participant was ok to continue or if s/he needed to take a break. Participants were assured they could withdraw from the study at any time and without adverse consequences. None of the interviews lasted longer than 90 minutes.

Summary of Chapter Three

Chapter Three has described the application of Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013) to the research question, "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?" The Chapter has described the study website, participant sampling and recruitment procedures, participant inclusion criteria, data collection, management, and analysis; criteria utilized to assure rigor in the study procedures and the ethical issues related to the study.

Plan for Remaining Chapters

Chapter Four will provide a detailed discussion of this Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) study that explores the experiences of bedside nurses working in children's hospitals with established shared governance models. The Chapter will provide a description of the demographic data related to the study participants and the substantive theory, *Being Heard*, that emerged from the data, including the elements of the theory.

Chapter Five will present the discussion of the study findings and the substantive theory. Chapter Five also will discuss the substantive theory in relation to the extant literature, the implications of the study, as well as the study strengths and limitations.

Chapter Four Findings

Chapter Four provides a discussion of the findings of this Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) study that explored the research question, "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?" The Chapter begins with a description of the study participants, followed by a discussion of the substantive theory that emerged from the study data.

Study Participant Demographics

A total of 18 bedside nurses from children's hospitals in Texas where a shared governance model had been in place for greater than four years participated in the research study. Table 4.1, below, summarizes the demographic data. The bedside nurses ranged in age from 26 to 53 years old with a mean age of 32. The nurses had been in nursing practice from 2 months to 26 years, with an average of 7.8 years. Fourteen of the nurses identified themselves as Caucasian, 1 as Hispanic, 1 as Hispanic-white, 1 as Asian and 1 did not report. Three of the participants were male and 15 were female. Two of the nurses had graduated from Associate Degree Nursing (AND) programs, one from a diploma program; fourteen were Bachelor of Science Nurses (BSN) and one was Master's of Nursing (MSN) prepared.

Table 4.1

Demographic Data

Age	Gender	Race	Education	Total years nursing experience	Ever worked in inst that is not SG	Total years in current institution
3 (26-28)	**15 Female**	**14 (Caucasian)**	**14 (BSN)**	**3 (< 1 yr)**	**6 (non SG)**	**3 (less 1 yr)**
8 (30-33)	**3 Male**	**1 (Hispanic)**	**2 (ADN)**	**5 (1-4.11)**	**3 (not sure)**	**8 (1-4.11)**
3 (41-49)		**1(Hispanic/white)**	**1 Diploma**	**6 (5-10)**	**9 (no)**	**6 (5-10)**
1 (52)		**1 (Asian)**	**1 (MSN)**	**2 (9.5)**		**1 (22yr)**
3 (NR)		**1 (NR)**		**2 20-(22 yr)**		

The purpose of this Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) study is to explore the experiences of bedside nurses who practice in children's hospital where shared governance (SG) has been in place for at least four years. The specific aim for this study is to provide a better understanding of how SG models impact the bedside nurses. The research question being addressed is: "What are the experiences of bedside nurses working in a children's hospital where a shared governance model has been in place for at least four years?"

Constant comparison of the data led to the emergence of the main concern of the bedside nurses and the substantive theory, *Being Heard*. The nurses resolve (Glaser, 1978) their main concern through the process of *voicing*. *Voicing* is a process consisting of three phases, *willingness, engaging, and assessing,* in which the outcome of the third phase, *assessing,* impacts the next iteration of the process. Glaser (2005) labels such a process an "amplifying causal loop" (p 9) (ACL). Glaser describes an ACL: "As consequences become continually causes and causes continually consequences, one sees

either worsening or improving progressions or escalating severity. . . Causal looping amplifies in either direction: positive or negative" (p. 9).

The following sections will describe the study findings beginning with an overview of why *being heard* is important to the bedside nurses, followed by a discussion of the ACL *voicing* and the phases the nurses use in the process of *voicing* in order to *be heard*: *being willing, engaging, and assessing.* These descriptions will lead to the discussion of the substantive theory that emerged from the study findings, *Being Heard*.

BEING HEARD

Being heard is the main concern of the bedside nurses who work in an established shared governance hospital environment. The bedside nurses are responsible for providing direct care to their patients, so they have the most complete understanding of their patient's needs and the impact of their work environment as it relates to their patients' care. The bedside nurses are in an excellent position to know what will work for their patients and their unit, but in order to make their knowledge known, their voices must *be heard*.

Several bedside nurses describe why it is important for their voices to *be heard*: "When something good or bad happens, it is much easier for the bedside nurses to *voice* what the positives and negatives are rather than an outsider guessing and implementing changes based off of paper or what they heard" (participant 3, line 82). "I think it is really important the bedside nurses' voices are heard because oftentimes we are the only people that recognize a problem exists" (participant 6, line 77), "The care to the patient is given by the bedside nurse, not the upper level managers. Therefore, we often know what processes are doable, or will even make sense to implement" (participant 11, line152),

"As a bedside nurse I know what is happening everyday on my unit and although I may not know the research that the administrators may have, I know whether or not it is feasible" (participant 7, line 75), "I know our managers would not have known what to do without the involvement of the bedside nurses" (participant 2, line 35).

The bedside nurses work most closely with patients, on the "frontline" of the care environment. The nurses' comments reflect the reality that the nurses' primary focus is within the patient care environment in the nursing unit. They have a unique and wholistic perspective about what needs to be done to enhance and improve patient care and their working environment. *Voicing* is the process bedside nurses use in order to *be heard*.

VOICING

Voicing is a feedback process consisting of three phases: *being willing, engaging and assessing*. The entry point of the ACL, *voicing*, is *being willing*. The bedside nurses must *be willing* to offer their voice; when they are not *willing* to offer their voice, the entire process comes to a standstill. If, however, the nurses are *willing* to *voice*, the process progresses to *engaging*, the second phase in the process of *voicing*. The bedside nurses *engage* in various venues where they can *voice*, such as serving on committees, participating in patient rounds, communicating through emails, and face-to-face talks with their peers, managers and members of the healthcare team.

Willingness and *engaging* lead to *assessing*, the third phase in the process of *voicing*. *Being willing* and *engaging* do not guarantee that the bedside nurses' voices will *be heard*, so the nurses observe what happens to the information they have offered. The nurses' *assessing* whether their voice has been heard will affect the nurses' decisions

about what they will do in the future when the need to *voice* arises. *Voicing* reflects the nurses' movement into the healthcare environment beyond their nursing units.

Willingness

Willingness is essential for the process of *voicing.* The bedside nurses must *be willing* to articulate their thoughts, ideas, and concerns. The *willingness* to *voice* is the nurses' choice. Various factors affect whether the bedside nurses are *willing* to offer their voice. These factors include their relationships with their peers in their nursing units; their relationships with their managers; and their desire to provide quality care to their patients. The bedside nurses' personal history, their peers' experiences, the nurses' previous experiences, and their personal needs are additional factors that influence their *willingness* to *voice*. The factors that affect the bedside nurses' *willingness* to *voice* are described in the following sections.

Relationships with Nursing Peers

The bedside nurses are more *willing* to *voice* when they feel they *belong* within the nursing team on their unit and feel *supported* by the other nurses in their unit. *Belonging* means they feel a part of the group; they feel included; they have a closeness or bond with their peers; they have a sense of mutuality and loyalty with the group; and they share common goals with others in their nursing units. One of the bedside nurses states that her favorite thing about where she works is: "my co-workers and the close little family that we are" (participant 3, line 91). Another nurse states, "I feel a part of the process" (participant 3, line 95). Another refers to her unit as home: "I have been there for so many years that it feels like home and somewhat like a family (participant 11, line 5).

Being willing is affected by the degree to which the bedside nurses feel supported by their peers. The nurses frequently cite examples from their day-to-day lives to illustrate their feeling supported by their nursing colleagues. “We are always there to help out our pod mates, if one person isn't busy and someone next to them is we always step in and do what we can to catch each other” (participant 3, line 7). “I love it…everyone around me is helpful” (participant 2, line 5), “I get tons of support” (participant 2, line 9), “when doing a bedside procedure everyone always jumps in to help” (participant 3, line 15). “I like [that] I can count on my co-workers to help me if I need it” (participant 6, line 2). “If a bedside procedure or code takes place, everyone always jumps in to help and be of assistance” (participant 3, line 14). Bedside nurses who have a sense of belonging and support with their peers on their nursing unit feel more secure and confident; they have a sense of security and mutuality with their peers that empowers each member of the group.

The empowerment derived from the relationships with their nursing peers helps the bedside nurses to be more *willing* to *voice* their ideas and concerns.

Relationships with Management

The bedside nurses’ *willingness* to *voice* is affected by the relationship they have with their management team. (The term, manager, is used to refer to all levels of supervision within the nursing units and the institution as a whole. The term, immediate manager [IM] is used to refer to the bedside nurses’ immediate supervisors. IMs may be team leaders, clinical coordinators, or charge nurses). The bedside nurses express how important it is for them when their IMs show concern for them, when they actively listen, when they provide support, demonstrate a caring attitude, and feel safe with management.

When the bedside nurses have a good working relationship with their IM, they are more *willing* to *voice* their ideas and concerns. “Our management’s presence on the floor throughout the day, constantly reminding us they are in this with us, is a huge plus” (participant 8, line 4). “Charge nurses and managers come around with open ears,” (participant 3, line 25). “They ask how my day is going” (participant 2, line13). “Our manager always hears our complaints and tries to help us out” (participant 6, line 88). The managers also help the bedside nurses feel safe by supporting the nurses: “Our manager has our back” (participant 14, line 47).

The nurses respect and appreciate managers who are willing to work side by side with them; an IM who is working with the bedside nurse is better able to relate to the realities of the nurses’ lives and to support them. One nurse tells how her IM works on the unit once a week: “They keep up their skills, understand what patients and staff are talking about, just have a better understanding of the overall daily picture” (participant 5, line 99). The bedside nurses report that their IMs keep them in the loop by informing them of changes within the organization or policies affecting their work. “The managers go to all of the same meetings [as we do]. We listen most of the time about new things happening, or new policies, or changes in any way” (participant 2, line 58), “She's very good about taking notes on what we say and then talking to whoever she needs to about resolving the issues. She will usually send a follow up e-mail out to let us know what answers she has found” (participant 11, line 87). “When we do our surveys it is our manager that reviews it with us and says what she is going to do to improve the areas that are low and asks for suggestions etc.(participant 18, line 38).The ongoing presence of the IMs and their day-to-day interactions with the bedside nurses creates a relationship

characterized by mutual knowing, rapport, comfort, and trust. The bedside nurses' *willingness* to *voice* is enhanced when they know their IM "has their back."

The bedside nurses' interactions with managers beyond the level of their immediate manager are more sporadic. Some of the nurses work in hospitals where there is a management level between the IM and the CNO, which herein is referred to as the manager. The bedside nurses' relationships with their managers are more formal and somewhat wary. ". . .open communication [is a good idea], but the managers are still the boss. The staff nurses still watch carefully what they do when the managers are around. When the managers are not there the staff is more relaxed" (participant 9, line 56).

Bedside nurses' interactions with the Chief Nursing Officer (CNO) are rare. Nevertheless, the nurses' sense of comfort is enhanced when their CNO takes time to visit with the bedside nurses to assess their needs, the work they are doing, and to recognize their accomplishments: "I love feeling safe approaching management and even upper administration personnel" (participant 8, line 145). "Our CNO comes by during the dayshift and asks the nurses how things are going and if people have any suggestions; she seems very open to input from bedside nurses" (participant 16, line 48). "We have 'coffee talks' with our CNO monthly and this is an opportunity for nurses to meet and hear the latest nursing news of our institution and provide our feedback regarding these issues. We are also able to bring any issues/concerns to the table, present plans for suggested changes, and can become more involved and join a unit or facility committee to ensure implementation is successful" (participant 8, line 58). "The CNO is very present and makes an effort to feel the pulse of the hospital" (participant 15, line 42). "The CNO came by our unit once to congratulate us on 324 days without a central line infection, and

she did stop and talk to each nurse" (participant 6, line 58).The CNOs appear committed to building and sustaining a relationship with the bedside nurses. This helps the CNO seem less remote and more accessible, it communicates support and encouragement; more important, it communicates that the CNO values and respects the bedside nurses. The CNO's relationships with the bedside nurses foster the bedside nurses' *willingness* to *voice*.

The bedside nurses rarely mention administrators beyond the CNO level. One nurse comments: "I have never seen the CEO" (participant 16, line 51). The bedside nurses seem not to know how to respond when the CEO attempts to connect with them: "The CEO tries to reach out, but I do not feel he has much to do with [us]" (participant 15, line 44). "The CEO walks around a lot and is very friendly and always says hi to the staff, but we don't really talk with him" (participant 6, line 61).The CEO's intermittent appearances do not provide an adequate basis for the bedside nurses to be able to establish a relationship with the CEO.

PROVIDING QUALITY CARE

Providing quality care to promote good patient outcomes is a main focus for the bedside nurses. They want to provide the best care possible and they want to make a difference. "Everything the nurses want . . . is for the betterment of their patients" (participant 2, line 77). "We always discuss current practices, how we are doing with our 'quality initiatives' . . . as well as patient satisfaction" (participant 6, line 45). "As a bedside nurse I have a voice, a way of expressing concerns and also bettering the department in which I work" (participant 4, line 8). The bedside nurses believe their shared governance (SG) model supports the bedside nurses to have a voice: "I feel as a

member of SG you can express various needs, retiming acuities for patient ratios, patient outcomes etc." (participant 5, line 89). The bedside nurses are more willing to use their voice when they know they have the opportunity to offer their ideas and solutions that can make a difference in the care they provide to their patients.

PERSONAL HISTORY

The bedside nurses' personal history can affect their *willingness* to *voice*. Nurses may have held positions where they did not feel valued or supported. Such a history can make them reluctant to be *willing* to offer their voice. Several bedside nurses describe working in other non-shared governance institutions where their judgment was not valued and their input was not sought nor included in the development of their policies and procedures. "The policies and procedures are rigid and do not allow for nurses to use their judgment or to have input in how nursing care is delivered" (participant 1, line 23), and "institutions will ask nurses for their input but then they do not incorporate that input" (participant 1, line 34). One nurse describes how she was not allowed to have a voice in the decision making processes. "Hospitals I've worked in before bedside nurses did not have a voice in the decision making process and often decisions were just passed down from management" (participant 7, line 3). These experiences make it more difficult for the bedside nurses to *be willing* to offer their voice.

PEERS' EXPERIENCES

The bedside nurses' *willingness* to offer their voice can be influenced by the experiences of their peers. Their peers' description of their own experiences as well as their peers' opinions can either positively or negatively affect the bedside nurses' *willingness* to *voice*. One of the bedside nurses described what she had heard and how it

affected her thinking: “I have heard stories of people getting run off because they voiced their opinion too much. . . I do think that when people are part of a committee they need to be careful with what they say…” (participant 3 line 67). Others have described how the more seasoned nurses seem to have a poor outlook: “I often hear seasoned nurses say they started out trying to become [involved], but nothing ever changed so they stopped caring” (participant 5, line 124). Although their peers’ opinions and experiences may discourage the bedside nurses’ *willingness* to *voice*, the bedside nurses may be encouraged to offer their voice when they see positive outcomes from their peers’ experiences. The bedside nurses observe when their peers interact with the system. The bedside nurses are more *willing* to offer their voice when the outcomes of their peers’ interactions with the system have positive results; they are less *willing* to offer their voice when their peers’ experiences with the system have negative results.

Personal Needs

The bedside nurses also may *be willing* to *voice* to meet personal needs. For example, some of the bedside nurses receive evaluation or compensation credit for their involvement in committees. “We get credit for coming to meetings which help our yearly evaluations and salary raises” (participant 16, line 84). Others may be *willing* to *voice* when they need to make a change in their work environment. “ When there was conflict between different shifts (night & day) about use/care of the refrigerator, [we] asked our ER manager for recommendations and she facilitated getting a second fridge” (participant 4, line 71).

The bedside nurses may *be willing* to *voice* about issues related to their work and holiday schedules. One bedside nurse describes a situation where bedside nurses

did not believe they had input into the scheduling process on their unit. Several of the bedside nurses expressed their dissatisfaction with the arrangement leading to the development of a committee of bedside nurses to work with the team leader to improve the scheduling process. **"**[The] scheduling committee [will improve the] fairness of the holiday schedule. My hope is that this committee will be able to work more closely with this team leader" (participant 4, line 124). Another nurse describes a similar experience. The bedside nurses were unhappy with the scheduling process as well as how changes in policies and procedures were being implemented. The bedside nurses input resulted in bedside nurses' becoming actively involved in unit activities. "[Our] committee meets once a month to talk about the issues going on our floor from policies and procedures to holidays and schedules. Anyone can come and voice their concerns. We talk about how we think our floor needs to be run" (participant 16, line 20).

When an unpopular decision has been made that personally affects the bedside nurses, they are often more *willing* to offer their voice rather than endure the consequences. One bedside nurse shared how the staff on their skin care committee, composed entirely of bedside nurses, thought the committee could be more effective with support from a skin care specialist. "The staff nurses on that committee said we needed more upper level input, so CNSs were added to the committee. The whole scope of this committee is changing because the staff nurses on the committee requested it. Now the skin care reps will get more education time (workshops) and then have project time to implement the ideas i.e. time to teach the staff" (participant 9, line 85).

Bedside nurses may be *willing* to offer their voice when decisions have been made or processes put in place that impact their work environment or interfere with their personal life.

Outcomes of Their Assessing

The outcomes of the bedside nurses' *assessing* their interactions with the system will affect their *willingness* to participate in future opportunities for them to *voice*. The process of *assessing* and its impact on the nurses' *willingness* to *voice* will be described in more detail in subsequent sections of this discussion.

Willingness Summary

Willingness is an affective experience that culminates in the nurses' choice as whether to take advantage of opportunities to *voice*. *Willingness* is enhanced by positive supportive relationships with peers and IMs within the nurses' home unit. *Willingness* is enhanced by CNOs who make themselves known and communicate respect for nurses. Physical proximity and time affect the development of the relationships bedside nurses have with their nursing peers and their immediate mangers as well as the CNO; these relationships have a powerful influence on the bedside nurses' *willingness* to *voice.*

Willingness is strongly driven by the bedside nurses' desire to provide quality care to their patients. *Willingness* is affected by the nurses' personal history and their observations of their peers' experiences as well as their own personal needs. Bedside nurses' *willingness* to *voice* also is affected by their own forays into *voicing* in order to *be heard*.

The bedside nurses' *willingness* to *voice* would be impaired by poor relationships within their nursing units. Although none of the bedside nurses report poor relationships

with their nurse peers, their IMs, and their CNOs, they all talk about the importance of good relationships within their unit contributing to their *willingness* to *voice*. Negative outcomes of their own or their peers' experiences attempting to interact within the system also will impact bedside nurses' *willingness* to interact. In a sense, each nurse's attempt to *voice* with the system is observed, as is the outcome, by every nurse within their home unit, affecting each nurse's *willingness* to *voice*.

The nurses are driven by the desire to provide quality care to their patients. The issue is whether nurses feel empowered to *voice* about the things they know will enhance patient care. It can be difficult for nurses to *be willing* to *voice* to take care of their own personal needs.

Willingness is the first and most crucial aspect of *voicing*. Unwillingness to *voice* deprives the healthcare system of valuable information that may improve patient care and the bottom line. Bedside nurses who are *willing* to *voice* then proceed to the next phase of *voicing*, which is *engaging*.

Engaging

The second phase in the process of *voicing* is *engaging*. Bedside nurses who are *willing* to offer their voice are more likely to move forward to *engaging*. *Engaging* occurs when bedside nurses step forward to have a *voice* and provide input. Bedside nurses *engage* by offering their ideas; they *engage* by participating in the decision-making processes and providing feedback related to the care of their patients, their work environment, and their practice. There are various venues in which bedside nurses have opportunities to *engage*. Bedside nurses also must weigh the potential costs of *engaging*.

VENUES

Bedside nurses *engage* by participating in various venues where they are able to provide input related to the care of their patients and their work environment. They *engage* by participating in unit-based and hospital committees and councils; they speak up during patient rounds. They *engage* by assisting with the development of policies and procedures. They communicate their ideas through surveys, emails, suggestion boxes, and face-to-face interactions with peers, managers, and other members of the healthcare team. *Engaging* more often occurs during interactions with their nursing peers, sometimes with their CNO, and, on occasion, during face-to-face interactions with upper administration.

Hospitals usually schedule some meetings that all nurses are required to attend. "We have quarterly staff meetings that we are required to attend" (participant 6, line 44). Other meetings are encouraged but not required. "You don't have to attend any if you don't want to, but nurses are encouraged to come and give their input" (participant 16, line 84).Whether the meeting is required or the bedside nurse has opted to attend, the nurse's physical presence at the meeting does not mean the nurse will *engage* in the interaction. *Engaging* is a decision that is made by each of the bedside nurses.

COSTS

Engaging requires giving of oneself; it requires commitment. Bedside nurses may have to use their personal time going above and beyond their normal schedule and coming in on their days off to attend meetings. Although giving up personal time may cause some dissatisfaction, the ability to *engage* to make a difference is worth the effort:

"I don't like that it takes up a lot of my time to be on the committees, but I love that we can make changes as bedside nurses" (participant 10, line 72).

Engaging also can entail risks. The bedside nurse who engages offers her ideas, opinions, suggestions, and observations. Once offered, such products are subject to judgment; that judgment is linked back to the bedside nurse. The bedside nurse will enter the third phase of *voicing, assessing,* to evaluate the outcome of her *engaging*.

Engaging Summary

Engaging is the active, observable, overt phase of *voicing*. *Engaging* reflects bedside nurses' activities as they involve themselves in the operations and business of the healthcare system. *Engaging* provides opportunities for bedside nurses to share their perspective with the system, to *voice* and *be heard*. *Engaging* also allows the healthcare system to avail itself of valuable information. The bedside nurse who *engages* with the system may have to sacrifice her/his own time in order to *engage*. Moreover the nurse takes a risk by *engaging*; the nurse determines the outcome of *engaging* during the third phase of *voicing, assessing*. Whether the bedside nurse *engages* with the healthcare system will be determined by the other phases of *voicing, willingness,* and *assessing*.

Assessing

Assessing occurs when the bedside nurses evaluate whether their voice is *being heard*. They observe what happens with their input: Did their input lead to change? Were their ideas taken into consideration as decisions were made? Did their input affect the quality of care provided to their patients? *Assessing* also gives the nurse information about her/his standing in the organization: Did the organization welcome the nurse's

input? If so, how did the organization respond to the nurse's input, and by implication, to the nurse as the source?

From the bedside nurses' standpoint, there are several potential responses by the system to the nurses' *engaging*. 1) The bedside nurses may discern that their input was received positively. 2) The bedside nurses may discover that their input was received negatively. 3) They may find that their input was received but could not be acted on. 4) There may be no response or an unclear response to their input. 5) Finally, they may learn their input is not sought so they had no opportunity to *engage*.

The bedside nurses' *assessment* may reveal their input has been utilized and their thoughts and ideas have helped to make a difference. "When a new [strategy dealing with bloodstream infections] was rolled out, it was quite labor intensive. Over the course of time, they have listened to the bedside nurses and it has been streamlined significantly" (participant 11, line 142). The bedside nurses are more willing to support change when that change is a result of what the nurses had to offer: "It is easier to be compliant with change. . .many nurses of different experience and expertise, as well as other team members from the facility have all had valuable input and the result, even if a compromise, is some way for everyone involved to provide the highest quality care available" (participant 8, line 96).

There are times when the bedside nurses provide information that is rejected by the system. A bedside nurse described an event that occurred on her unit. The manager (level above the IM) wanted the nurses to document patient monitoring data in two separate locations in the patient's chart. The bedside nurses shared their opinion that double documentation was unnecessary and time consuming. The bedside nurses were

frustrated when the manager responded by requiring the nurses to comply "management wants more, bedside nurses don't have time to do more" (participant 3, line 57). The manager's response implied that the nurses' feedback was not important.

Bedside nurses also may learn their input has been considered but the system provides an explanation as to why their ideas cannot be implemented. "Concerns are sometimes heard and maybe cannot always be acted on…..managements' hands are tied too sometimes" (participant 3, line 62), "They always hear [us] and try to help us out, and they always tell us a reason if it is something that cannot currently be changed" (participant 6, line 88). Even though their input cannot be implemented, the system's response indicates the nurses were heard and the nurses are more accepting and understanding.

Occasionally bedside nurses may offer input and not be able to discern a response. For example, one bedside nurse commented that her manager tends not to respond to nurses' messages. The bedside nurses are unsure how to interpret the manager's lack of response and were left with a sense of futility about communicating with the manager. The system's response might be ambiguous: "They might say [they will do] it on the outside but do something different behind closed doors (participant 3, line 65). "Above [the CNO level] I'm not confident we have as much say as they would like us to think we have" (participant 18, line 67). "I believe most staff feel they have a say but it will not affect the outcome" (participant 4, line 89). Ambiguous or no response by the system or managers can cause the nurses to become frustrated and distrustful.

There are also times when the bedside nurses' *assessments* reveal they have been excluded from a decision making process related to their practice. This outcome causes

contention and frustration: “SG is not always followed like it should be so it gets frustrating” (participant 9, line 96). A bedside nurse described an event where a change was implemented requiring the bedside nurses to reposition their patient’s pulse-ox every four hours rather than their current practice of every 12. The bedside nurses’ thoughts had not been solicited so they resented the change in practice and it was not easily accepted: “This makes the staff nurses feel like they are being treated like children [especially when] the nurses feel the change is stupid. . .if it was brought up and discussed in the [council] meeting first, then it would have rolled out in a more positive way” (participant 9, line 69, 78).

Nurses will watch to see whether their input is solicited regarding decisions being made that affect patient care and nursing practice. Nurses will watch to see what happens to the input they have offered to the system. The outcomes of the bedside nurses’ *assessment* of the system’s response to their input reveals important information about the degree to which the system values them as individuals and as members of the nursing team. Bedside nurses respond enthusiastically when their input receives positive responses: “I have become more of a patient advocate and have a voice that my area of work counts on and wants to hear” (participant 5, line 84). A history of bedside nurses attempting to provide input to the system and the system responding negatively or not at all will affect the individual nurse; it also will have effects beyond the individual bedside nurse because nurses share their experiences with each other: “When my co-workers hear that I am going to a unit based council meeting (UBC) or Nursing Practice council (NPC) they tell me things will never change and I am just a newbie with big ambitions” (participant 5, line 54). Although this nurse chose to interact with the system, her

comment reflects the disengagement of the other nurses and the potential effects of their disillusionment on other, newer, nurses.

ASSESSING SUMMARY

Assessing is the process bedside nurses use to determine what happened when they voiced to provide input to the system. Bedside nurses will observe and gather data then make decisions that will influence whether and how they will interact with the system in the future. The outcome of the nurses' *assessing* reveals whether they were *heard.* The system's responsiveness to the nurse indicates whether the nurse was *heard.* Although the nurses' preference would be that the system liked and implemented their input, the nurses were satisfied as long as they received feedback about what happened with the information they offered; any response confirmed that their voice was *heard*. When there is a lack of response by the system to the nurses' input, or when the system does not invite the nurses' input, there is a greater risk of damaging the nurses' trust and confidence in the system. The bedside nurse's *assessing* reveals whether the system is "walking the talk" of shared governance. *Assessing* also reveals the degree to which bedside nurses can trust the system and management-level people who represent the system. The outcome of an individual nurse's *assessing* will influence that nurse; it also will influence the nurse's peers. The outcome of *assessing* will affect the *willingne*ss of that nurse, and potentially the nurse's peers, to *voice* and *engage* with the system in the future.

SUBSTANTIVE THEORY: BEING HEARD

Being Heard is the substantive theory that emerged in this study that explored the experiences of bedside nurses working in children's hospitals with an established shared

governance model. The bedside nurses' primary focus is at their patients' bedside, placing them in a position where they have important information that can impact patient care, the nursing unit, and potentially the hospital at large. *Voicing* is the process the bedside nurses utilize to *be heard*; *voicing* consists of three successive interactive phases: *being willing, engaging*, and *assessing*.

Being willing is driven largely by the bedside nurses' commitment to their patients. *Being willing* is influenced by the nurses' interactions and relationships with their peers, management personnel, members of the healthcare team, their personal experiences and work history, as well as their observations of their peers' experiences. *Being willing* is an internal process in which the nurses weigh the importance of *being heard* against their confidence and sense of security or safety in their own situation.

Engaging, the second phase in *voicing* is the active observable phase of *voicing*. *Engaging* occurs when the bedside nurse who wants to *be heard* steps forward to *voice*, offering information to the system. Bedside nurses *engage* by participating in activities such as committees, patient rounds, and interactions that occur beyond the patient's bedside and the nursing unit. *Engaging* often entails costs to the bedside nurses because they may need to give up their personal time to *engage*. *Engaging* also may entail risk because the nurses do not always know how their contributions will be received.

Assessing, the third phase in *voicing*, occurs when the bedside nurses gather data to determine whether their voices were *heard*. Knowing that they were *heard* is their main concern. The outcome of the bedside nurses' *assessing* will affect future iterations of *voicing*.

The bedside nurses know they are *heard* when they receive feedback; feedback nurtures an ongoing dialogue between the bedside nurses and the hospital system and communicates respect. When the nurses are able to determine that their voices were *heard*, they may be more *willing* to continue to offer their voice and *engage* in the various venues to do so. The bedside nurses want their voices to *be heard*; they feel valued and empowered when what they have to say is acknowledged. Even when what they have to say is rejected, acknowledgement of their input lets the nurses know their voice has been *heard*. If the system does not respond, when the bedside nurses' input has been excluded or ignored, or when their input has not been solicited, they may lose their desire to *be willing* to *engage* and to offer their voice. The nurses may decide to continue to offer their voice, pause and continue to *assess*, or withdraw all together.

It is important for the bedside nurses' voices to *be heard*. The voices of the nurses can affect the care of their patients but also can affect the healthcare system as a whole. The healthcare system also affects the ability of the nurses to offer their voice. Bedside nurses feel valued and included when their voices have *been heard* in the decisions that affect their patient care and work environment. They feel a sense of empowerment that can impact their job satisfaction and retention.

The substantive theory, *Being Heard*, reflects the impact of presence and time in the relationships between bedside nurses and hospital management. The bedside nurses' primary focus has to do with the care they deliver to their patients. Part of the goal of shared governance is to move bedside nurses' focus so that instead if limiting their attention to their patients, the nurses are willing and able to be more involved in the hospital system. While the hospital system may decide to espouse a shared governance

model and provide technology or create committees to foster bedside nurses' *being heard*, other elements have to be in place.

A crucial element in the substantive theory of *Being Heard* is the individual nurse's relationships with others. The substantive theory reflects the spreading cumulative impact of nurses' desire to *be heard* and individual nurse's forays into interactions with the hospital system beyond the nursing unit. Other nurses are aware when one of their nurse colleagues participates in the hospital system beyond the nursing unit; they observe what the other nurse does and the outcomes of her/his efforts. Each iteration of an individual nurse's *voicing* provides information to that nurse and her/his colleagues that ultimately will determine the general "tone" or "culture" within the hospital system: Does the hospital system value and respect nurses and nursing? Does the hospital understand and support the concept of nurses' involvement in the governance of the system? Nurses who believe they and nursing are heard, respected, trusted, and feel welcome at the table are more likely to respond with enthusiasm, involvement, and commitment to the system. When nurses do not believe they are heard, they do not feel respected or trusted, nor do they feel welcome at the table. Such nurses are more likely to respond with disappointment, detachment, and apathy. Hospitals that truly hear nurses, invite their input, and respond, are able to tap into an important source of information that may improve patient outcomes, enhance nurse retention, and improve the hospital financial status. Hospitals where nurses are not heard or invited to the table deprive themselves of important information, they demonstrate lack of respect and trust for their nursing staff; ultimately their financial status will be impacted by nursing dissatisfaction and nurse turnover which can affect patient satisfaction and outcomes.

SUMMARY OF CHAPTER FOUR

Chapter Four has presented the findings of this Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) study that explored the experiences of bedside nurses working in children's hospitals with established shared governance models. A description of the study participants was followed by a discussion of the substantive theory, *Being Heard,* that emerged from interviews conducted with 18 bedside nurses.

PLAN FOR REMAINING CHAPTER

Chapter Five will provide the discussion, implications, and conclusions of the study. Chapter Five also will describe the study's strengths and limitations and suggestions for future research.

Chapter Five Discussion

INTRODUCTION

The research study used Classical Grounded Theory (Glaser, 1978, 1992, 1998, 2005, 2012, 2013, 2014) to explore the experiences of bedside nurses working in a children's hospital with an established shared governance model. Chapter Five reviews the research problem and question and provides an overview of the methodology used to answer the research question. Chapter Five then discusses the substantive theory that emerged from the study findings and compares the study findings to the extant literature. Chapter Five continues with a discussion of the implications of the theory, the study significance, strengths and limitations. Finally Chapter Five discusses recommendations for future research and the study conclusions.

STATEMENT OF PROBLEM

Hospitals and healthcare systems constantly are faced with problems related to recruiting and retaining nurses. There may be insufficient numbers of nurses available to staff their facilities; or, once nurses have been recruited to the hospital, the nurses change jobs to work elsewhere. Moreover, as healthcare organizations restructure in order to reduce costs, improve care, and increase operational efficiencies, they are forced to do more with less and maintain or improve patient outcomes (Swihart, 2011); nurses must care for sicker patients and do so with fewer resources. The American Association of Critical Care Nurses (AACN) blames the high numbers of nursing vacancies and nursing turnover on "unsupportive practice environments, long work hours, an aging workforce, and excessive physical and

psychological demands" (as cited in Bina, Tippetts, & Specht, 2014, p. 441). Linnen (2014) comments, "Many nurses leave their positions because of negative experiences with heavy or unrealistic workloads and due to feeling unheard and under-valued if not worse" (p. 46).

Shared governance (SG) has been offered as a way to overcome nursing shortages and nursing turnover by enhancing nursing practice within institutions utilizing a shared governance model. Shared governance is a professional practice model that empowers nurses by acknowledging the key position of bedside nurses within the hospital environment (Swihart, 2011) by making them part of the decision making processes related to their practice and work environment. Shared governance increases nurse satisfaction, retention and improves patient care and outcomes (Havens & Vasey, 2003; Kear, Duncan, Fansler, & Hunt, 2012). Although the research has focused on the benefits of a shared governance model, research has been limited to measuring or evaluating SG, assessing outcomes in terms of patient wellbeing, and nurse satisfaction and retention, most research has explored the effects of shared governance within the first two years of implementation. Prior to the present study, no research has examined the experiences of bedside nurses working in children's hospitals with shared governance models nor has research explored the experiences of nurses working in hospitals where shared governance has been in practice for four or more years. Moreover, prior to the present study, there were no extant theories describing the experience of SG from the standpoint of the bedside nurse.

REVIEW OF METHODOLOGY

Classical Grounded Theory (Glaser, 1978, 1998, 2005, 2012, 2013) (CGT) was selected as the research method because it led to "a theoretical explanation of how problems are managed" (McCallin, Nathaniel, & Andrews in Martin & Gynnild, 2011, p. 74) and helped the researcher find out "what is really going on" (Glaser, 1998, p. 12) with bedside nurses working in a shared governance environment. CGT provides a systematic guide for the researcher, beginning with formulation of the research questions and continuing through data collection and analysis, to identification of the core category and explication of the substantive theory. "CGT is a revolving-step method that starts the researcher from being "a 'know nothing' to becoming an expert. . .in a substantive area" (Glaser,1998, p. 13). The researcher in the present study used CGT to explore the experiences of bedside nurses in a shared governance environment to identify the bedside nurses' main concern and the substantive theory, *Being Heard,* that was grounded in the data and explained the nurses' experiences. Glaser (1998) comments that the focus of CGT must be on what is relevant to the people experiencing the phenomenon of interest. "It is their main concern and their continual processing of it that is the focus of grounded theory" (p. 116).

Participants for the study were recruited and interviewed using an online study website created for the research study (www.bedsidenurseexperiences.weebly.com). Eighteen bedside nurses who were working in children's hospitals in Texas where shared governance had been in place for a minimum of four years were interviewed for the study. Study data was collected within

the website using online synchronous typed interactions that allowed a transcript of the subject consent process and all data to be available in real time. Study data consisted of demographic data, interview data, and the researcher's memos. Data analysis utilized the processes described by Glaser (1978, 1998, 1992, 2005, 2012, 2013, 2014). Classical Grounded Theory (CGT) data analysis is an iterative process using systematic coding procedures and the constant comparative method (CCM). Data analysis in this CGT study began with line-by-line coding of the first data set answering questions such as, "what's going on here?" (Glaser, 1998, p. 12). Coding led to identification of clusters of data that appeared to fit together forming categories. Collection of additional data and continuing analysis of data lead to identification of one category that appeared to organize, or be central to, all other categories; this category, called the core category, described the participants' "main concern" (Glaser, 2013). The core category and the bedside nurses' main concern in the present study was *being heard*. Data analysis also led to formulation of tentative relationships among the categories. Identification of the core category and relationships among the categories allowed the researcher to begin coding selectively related to the core category and patterns among the categories. Throughout all aspects of data collection and analysis, the researcher used a process of memoing to record such things as ideas, questions, and suggestions for continued data collection; these memos became part of the study data. Early in data analysis, the researcher's memos identified a process consisting of a temporal relationship among the categories: some categories preceded others; in addition, the outcome of the process fed back into subsequent iterations of the process. Selective coding and the researcher's memoing process led to the need to collect additional data for the purposes of theoretical sampling in order to test

the core category, subcategories, and the explanatory relationship among the categories. Analysis of the data from the interviews with the last six nurses confirmed the core category, *being heard*; the temporal sequence and boundaries of the subcategories; and the feedback nature of the relationship among the subcategories. Interviews with the last six nurses provided data that saturated (Glaser, 1978) the elements of the theory that had emerged from the data. The substantive theory, *Being Heard*, that emerged from the data was a process of *voicing* by which the nurses sought to be *heard*. *Voicing* consisted of three phases: *being willing*, *engaging*, and *assessing* in which the outcome of *assessing* affected future iterations of *voicing*.

STUDY FINDINGS: THE SUBSTANTIVE THEORY, "BEING HEARD"

Data analysis using Classical Ground Theory methodology led to identification of the core category and the substantive theory, *Being Heard*, the main concern of the bedside nurses. Bedside nurses have important information that can impact patient care and they want to *be heard* in order to share that information. Bedside nurses resolve their main concern, *being heard* by a process of *voicing* which consists of three phases: *willingness*, *engaging,* and *assessing.*

Nurses first must be *willing* to *voice*; being *willing* arises from the sense that it is safe and acceptable for nurses to participate in the system. Nurses who are *willing* to *voice* may choose to *engage* within the system by participating in governance-related activities, such as serving on committees, participation in council meetings, and providing input into the development of policies and procedures. *Assessing* occurs when nurses observe the system's response to their input. *Voicing* is a feedback process in which each phase leads to the next with the outcome of the process looping back,

affecting future iterations of the process; moreover, one nurse's *voicing* attempts are observed by other nurses. Over time, the outcomes of repeated iterations of the *voicing* process result in a trend that tells nurses whether nursing participation in the hospital's governance process is respected and valued. It is crucial that the system respond to nursing input; the system might not agree or accept the input from nursing, but it is necessary for the system to respond because it indicates that the nursing input has been *heard*. Hospital systems that do not respond to nursing input, or systems that do not invite nursing to participate in decision making about a given issue, are indicating that they do not respect or value nursing. Such systems risk alienating and discouraging their nurses; they place themselves at higher risk for nursing turnover. Systems that are receptive and responsive to nursing input will empower nurses and enhance nurse satisfaction and retention. Such systems will profit from the information that is available from nurses who truly participate in the governance of the hospital system.

Relationships are an important element in the substantive theory, *Being Heard*. The individual nurse's relationships with her/his nursing colleagues, her/his immediate manager, and the Chief Nursing Officer (CNO) will affect that nurse's *willingness* to *voice* in order to be *heard.* Nurses who feel supported by their colleagues and their managers are more *willing* to *engage* in the governance processes. The individual nurse's forays into *voicing* will be observed by her/his nursing colleagues so the outcome of one nurse's attempts to interact with the system will affect the *willingness* of his or her nursing colleagues to *engage* with the system. The immediate manager is an important position to facilitate or to hinder a nurse's *engagement* with the system; the immediate manager also may convey information the nurse will use to *assess* whether her/his input

was heard. The individual nurse's sense of comfort with the CNO also enhances the *willingness* of nursing staff members to *engage* in the processes within the system. The nurse-system relationship also is a factor in the substantive theory *Being Heard.*

COMPARISON TO EXTANT LITERATURE

Glaser (1978, 1992, 1998, 2005, 2013) advises the Classical Grounded Theory (CGT) researcher to avoid if at all possible delving into the extant literature prior to conducting a CGT study. Glaser's (2013) preference is that the CGT researcher first explore "what is really going on" (p. 11) with the people who participated in the study in order to conduct the research free of preconceptions. Once the GT theory has emerged from the study data, Glaser (1998) advises the CGT researcher to go to the literature and "weave" (p. 73) the literature into the theory. Prior to this research study there were no theories addressing the experiences of bedside nurses practicing in a children's hospital with established shared governance (SG) models.

The main goal of shared governance is to empower bedside nurses and to make them a part of the decision making processes related to their practice and practice environment by creating a non-hierarchical governance structure that balances power among management and the bedside nurses (Clavelle, et al., 2013). Porter-O'Grady (2003) says SG should reflect four principles: partnership, equity, accountability, and ownership.

Shared governance (SG) models impact hospital systems, nursing units, nurses, nursing practice, and the nursing practice environment. Some authors have explored the effects of SG related to nurse satisfaction (Brook, Olsen, Rieger-Kligys, & Mooney, 1995; Jones et al., 1993; Ludeman & Brown, 1989; Villardo, 1993; Zelauskas

& Howes, 1992, & Stumpf, 2001. Researchers have explored bedside nurses' perceptions of a SG model in order to determine the benefits of implementing a SG model (Brooks et al.; Frith & Montgomery, 2006; Hess, DesRoches, Donelan, Norman, & Buerhaus, 2011; Jones et al. 1993). Others have evaluated various implementation strategies to determine what does and does not work to identify barriers to successful implementation (Jones et al., Edwards et al., 1994; Prince, 1997; Westrope et al., 1995; Ireson & McGillis, 1998; Kennerly, 1996; Ludemann & Brown, 1989; & Richards et al., 1999). Other studies have utilized management theory to explore the impact SG has on the relationships between management and the bedside nursing staff (Kennerly, 1996; Jones et al.; Laschinger & Wong 1999; Ludemann & Brown). More recent studies have focused on how to revive existing SG structures in order to reinvigorate bedside nurses' involvement and thereby improve quality of care (Gray, 2013; Rundquist & Givens, 2013; Start et al., 2013; Walter, et al.; 2014; Wilson, 2012; Zuzelo, McGoldrick, Seminara, & Karbach, 2006).

The majority of the articles and research studies describe hospitals where SG had been implemented for two years or less, or was in the process of being implemented. Thus, the SG processes in the hospitals where the studies were conducted were relatively new or in developmental phases. While some of the more recent studies have focused on systems that have been practicing SG for an extended period of time; the focus of those studies was on reviving the current SG model in order to improve quality of care (Gray, 2013; Rundquist & Givens, 2013; Start et al., 2013; Walter, et al., 2014; Wilson, 2012).

The current study provides several significant additions to the extant literature. The study used Classical Grounded Theory to explore the experiences of bedside nurses in children's hospitals in Texas where SG was well established and for many years. With only one exception (Ott & Ross, 2014), research has not focused on the experiences of bedside nurses, rather it has focused on bedside nurses' opinions about shared governance. Moreover, this study focused on the experiences of nurses in children's hospitals where SG was not novel but was a fact of life. The substantive theory that emerged from the data supports some of the contentions of existing organizational theories. Each of the existing organizational theories, Kanter's Structural Theory of Organizational Empowerment (1977), Path-Goal Theory (Evans, 1970; House, 1971; Kennerly, 1996), addresses the balance of power between management personnel and service-level personnel. Each of these theories advocates reallocation of power from administration so it is shared with service level personnel so that service-level personnel are empowered and become more accountable within the organization. The theories believe leadership styles that support and inform employees will enhance organizational commitment of employees and decrease job turnover. The substantive theory, *Being Heard*, reflects the impact of leadership style on the satisfaction of employees; leaders who support and facilitate the efforts of employees to provide information to the system will enhance the flow of information that will improve the productivity of the organization, enrich and deepen trust and respect between themselves and their employees, and intensify employees' commitment to the organization. The study findings, like those of Kennerly (1996) and

Ludeman and Brown (1989) reveal that an empowering environment gives nurses sense of autonomy, enhances satisfaction, and facilitates team building.

Hess's (1998) Index of Professional Nursing Governance (IPNG) was developed to measure aspects of shared governance within an organization. Hess's instrument measures the degree to which nurses feel they have: "1) professional control, 2) organizational influence, 3) organizational recognition, 4) facilitating structures, 5) liaison, and 6) alignment" (p. 4) within the organization. The theory, *Being Heard*, echoes the importance of each of these elements.

Dunbar et al. (2007) describe the outcomes of a project undertaken by one hospital to reinvigorate shared governance within the organization. The authors conclude that SG requires "continue commitment, vigilance, and flexibility" (p. 183). Findings of the present study suggest that it is possible for hospitals to maintain a thriving SG culture, but maintaining a thriving SG culture requires long-term, unremitting nurturance. Empowering nurses doesn't last without reinforcement and attention.

IMPLICATIONS

This study has important implications for any organization that depends on its point-of-service employees to carry out the organization's mission and vision. Although the substantive theory, *Being Heard*, was grounded in data reflecting the experiences of bedside nurses working in children's hospitals with established shared governance models, the theory can inform organizations beyond children's hospitals and healthcare systems.

The substantive theory, *Being Heard*, is enacted through a process of *voicing*. The *voicing* process consists of three phases, *willingness*, *engaging*, and *assessing*.

Of the three phases, the second phase, *engaging*, is more overt and active. In many ways there are fewer implications of the *engaging* phase. *Engaging* requires systems and technological support, usually put in place by the organization, in order for the individual to participate. The individual first must *be willing* to participate; the individual has to make a choice based on his or her sense that it is safe and worthwhile to participate. *Being* willing to participate is heavily influenced by the individual's *assessment*, over time, of the outcome of his or her own and others' forays into *engaging* within the system.

Relationships are a core element in the substantive theory, *Being Heard*. Relationships play an integral role in the operations of any organization. The substantive theory describes relationships among employees, their colleagues, and management personnel and the impact on the functioning of the work environment. A sense of support and the camaraderie within the peer group and with managers can free employees to interact with the organization beyond their immediate work environment. Managers are in a position from which they either can inhibit or facilitate employees' interactions with the organization. Managers' beliefs about their roles and their goals for themselves are crucial in their interactions as gatekeepers between employees and the organization. Organizations that trust and respect their employees and provide systems that support flow of information from each direction can obtain information vital to the functioning and productivity of the organization.

STUDY SIGNIFICANCE

Findings of this Classical Grounded Theory study illuminate the experiences of bedside nurses who practice in a shared governance environment. Study findings provide important information to healthcare administrators, nursing directors and managers who are utilizing, or plan to implement, a shared governance model in their facility. The study findings and the substantive theory, *Being Heard*, describe the dynamic, interactive relationship between bedside nurses and hospital management and emphasizes the effects of time and a developing culture within the institution. Although the substantive theory, *Being Heard*, arose from data obtained from hospitals, the theory can inform other organizations such as academic institutions, social and religious institutions, and industry where information from people at the point of service can enhance the effectiveness and productivity of the organization.

STRENGTHS AND LIMITATIONS

Several strengths and limitations can be identified in this Classical Grounded Theory (CGT) study. Study strengths include utilization of CGT methodology, as well as recruiting participants and collecting data from the study website. CGT allowed the researcher to explore first-hand experiences and reflections of the bedside nurses and resulted in rich data. This is the first study that explored the experiences of bedside nurses working in an established shared governance environment and the study findings engendered the first substantive theory addressing those experiences. Moreover, the substantive theory has potential to be developed into a formal theory. The researcher's experiences conducting the study confirmed Glaser's (1998) statement, "Grounded theory empowers the researcher

with its high probability of real contribution to the field under study by discovering its prevalent problem" (p. 116).

The study sample could be viewed as a limitation of the study. The nurses who participated in the study were recruited from children's hospitals located in Texas. The nurses self-selected to participate in the study; thus, like many studies, the study results only reflect the opinions and the experiences of the nurses who wanted to share their stories. All of the nurses were eager and excited to share their experiences and several referred their peers to the study. The study was limited to bedside nurses; thus, the viewpoints of management and administrative personnel, as well as the viewpoints of individuals in ancillary departments, were not included.

Children's hospitals possess a unique culture. While this unique culture may be a strength of the study, it also may be a weakness since study findings only reflect children's hospitals. A further strength of the study was that it explored shared governance in hospitals where the model had been in place for an average of nine years. Therefore the study results revealed characteristics of long term, dynamic, and effective shared governance cultures.

SUGGESTIONS FOR FUTURE RESEARCH

Future research can be directed either toward developing the substantive theory, *Being Heard*, into a formal theory or toward exploring issues that have arisen in the present study. Future research could be undertaken in which an approach similar to the one utilized in this study could be applied to other healthcare environments that have a shared governance (SG) model, such as healthcare clinics, specialty hospitals, and adult hospitals.

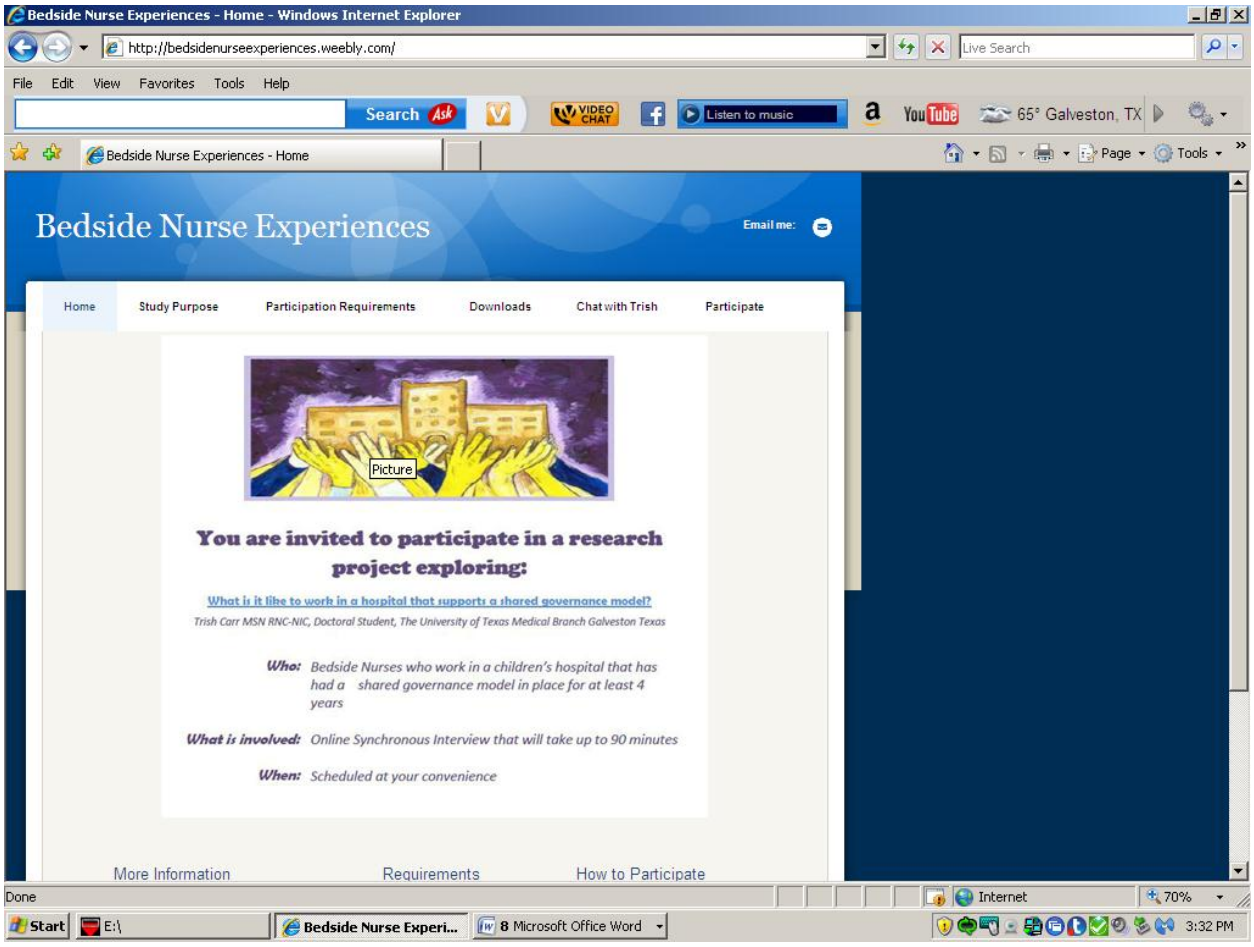
Such research should include states beyond the boundaries of Texas. A similar approach should be used to explore the experiences of personnel in the hospital such as managers, administrators, and personnel in ancillary departments. Future research could explore the roles and experiences of physicians practicing in hospitals with shared governance cultures.

Results of studies such as those suggested above potentially will contribute to development of the substantive theory, *Being Heard*, to the level of a formal theory. Further elaboration of the substantive theory could occur by exploring its utility in environments other than healthcare.

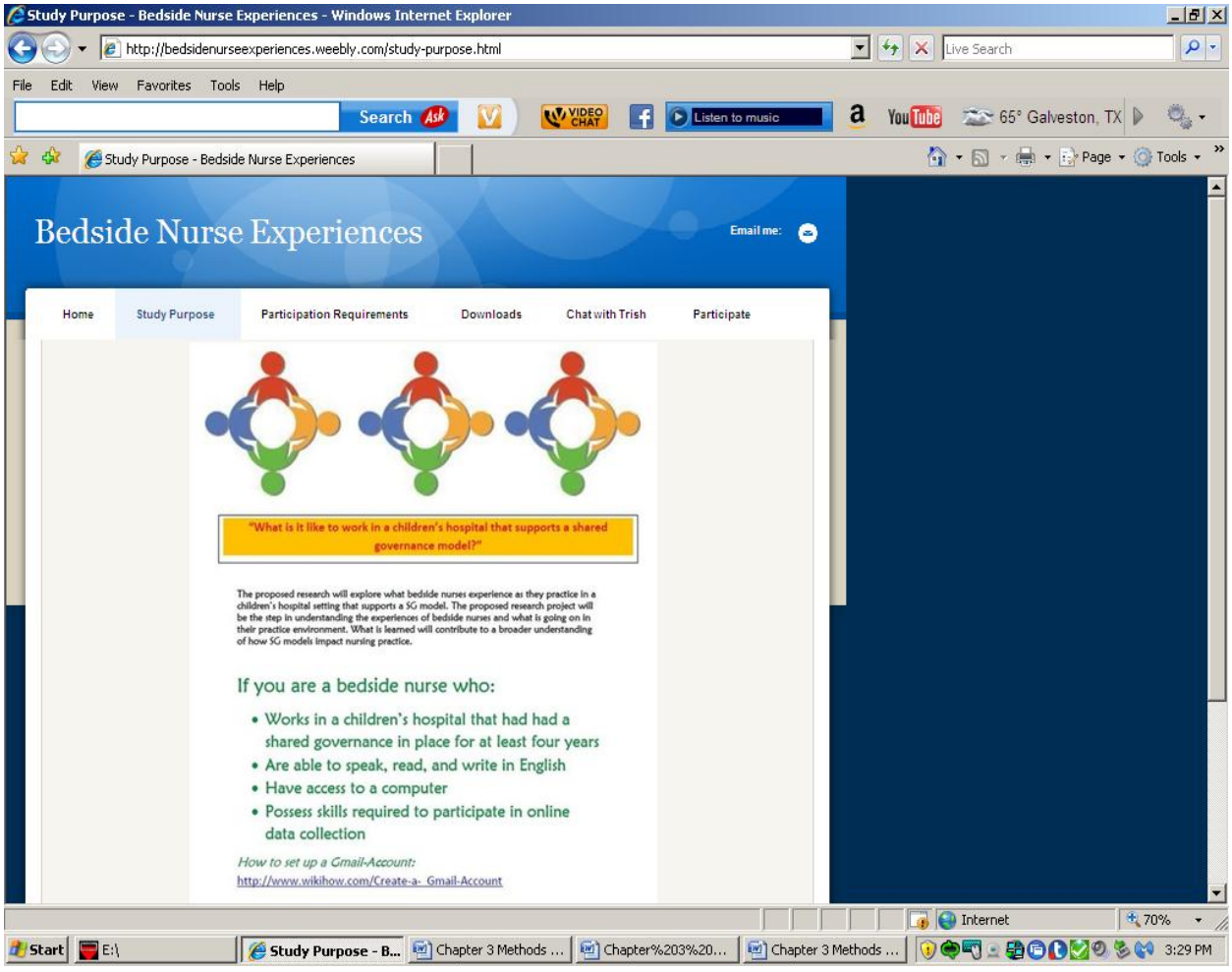
CONCLUSIONS

Shared governance (SG) has been used as a framework by hospitals to attract and retain nurses, to improve quality of care, and by those seeking Magnet designation (ANCC, 2014). Although SG has been shown to benefit the healthcare system and increase nursing satisfaction, little research has explored the experiences of bedside nurses in established shared governance environments. This Classical Grounded Theory study explored the experiences of bedside nurses working in children's hospitals with an established shared governance model. Study data consisted of demographic data and interviews with eighteen bedside nurses and the researcher's memos. Data analysis utilized Classical Grounded Theory techniques to derive a substantive theory, *Being Heard*, which is enacted through a process of *voicing*. The substantive theory has implications for healthcare and, potentially other organizations and industries, where information available to point-of-service employees can enhance achievement of institutional goals.

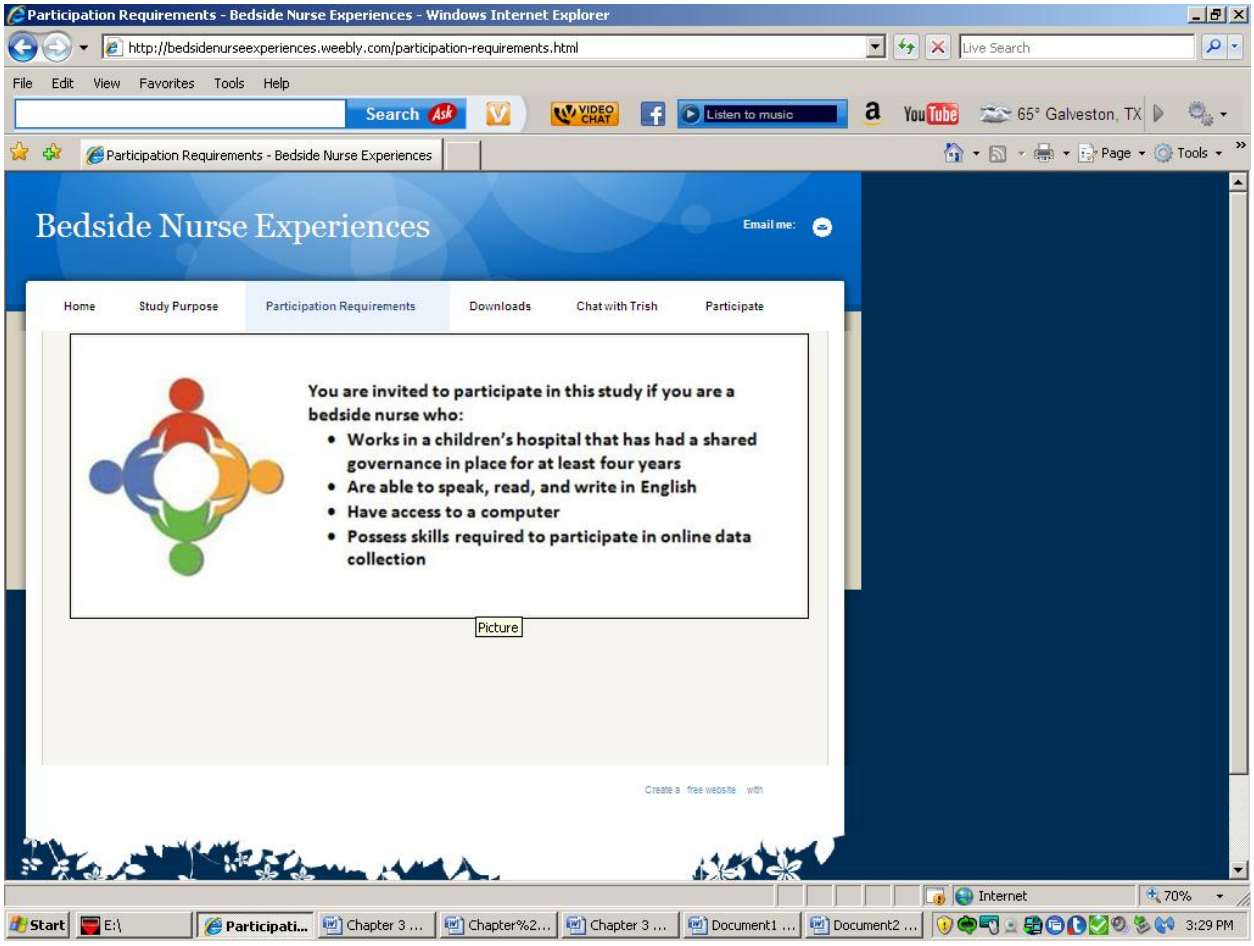
Appendix A: Screen Shot of Website Home Page



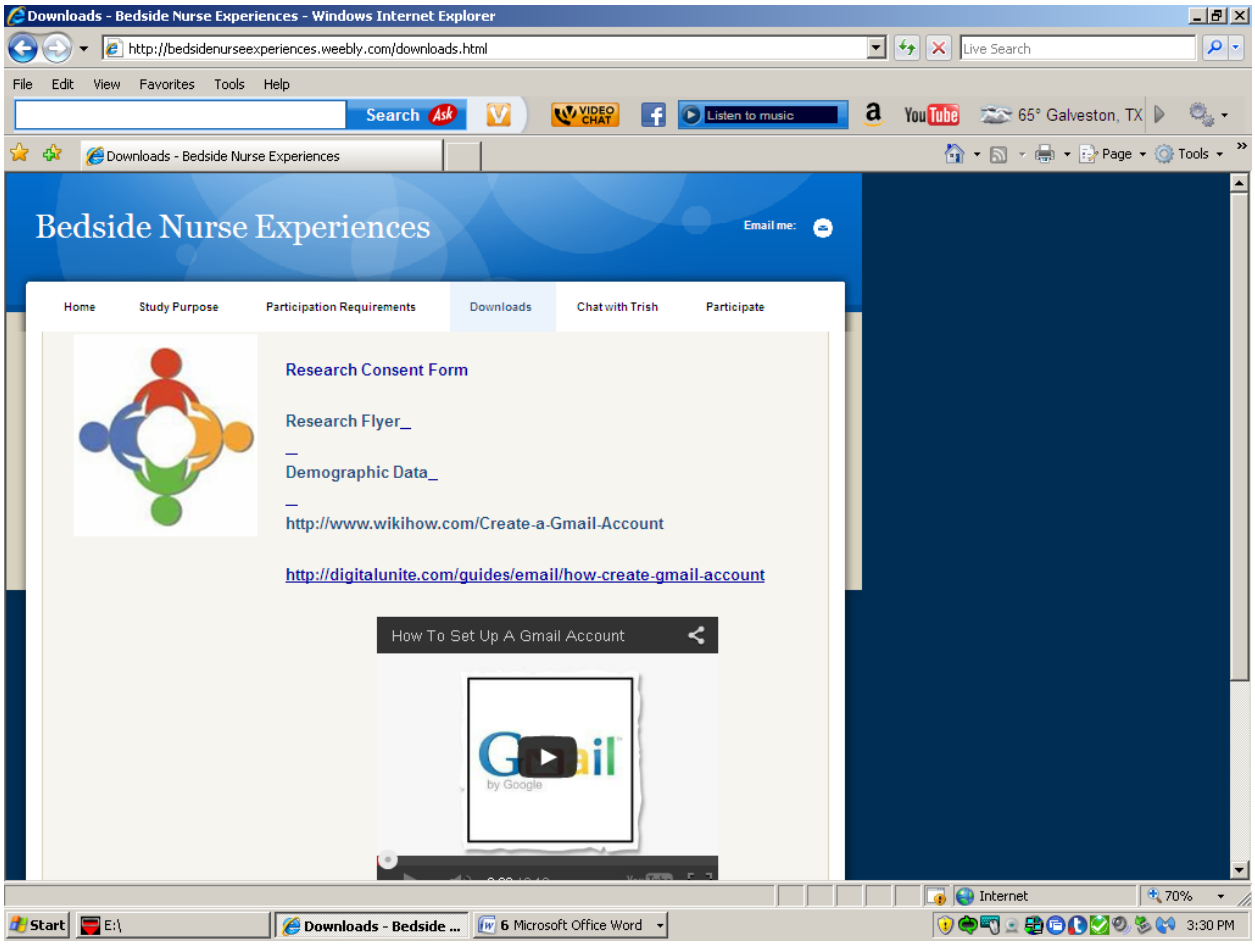
Appendix B: Screen Shot of Study Purpose



Appendix C: Screen Shot of Participant Inclusionary Criteria



Appendix D: Screen Shot of Downloads



Appendix E: Research Consent Form

RESEARCH CONSENT FORM

You are being asked to participate as a subject in the research project entitled, Experiences of Bedside Nurses who practice in a Shared Governance Culture, under the direction of Trish Carr, MSN, RNC-NIC.

PURPOSE OF THE STUDY

The purpose of this study is to assess what bedside nurses experience as they practice in a shared governance culture. You are being asked to participate because you are a bedside nurse practicing in an accredited hospital that promotes a shared governance nursing model.

RISKS OF PARTICIPATION

There are minimal risks of participation in this research project. The risks are loss of confidentiality and fatigue during the interview.

You are encouraged to choose a time and place for the interview where you will have privacy and minimal interruptions. You can participate in the study anonymously by setting up an anonymous Gmail account. Findings from the study w will be reported as aggregates; any quotations that are used will not contain information that could be used to identify you or your employer.

I will assess whether you are fatigued during the interview by asking questions such as "Do you want to continue?" If you become fatigued we can end the interview entirely or continue at a later time.

NUMBER OF SUBJECTS PARTICIPATING AND THE DURATION OF YOUR PARTICIPATION

The anticipated number of subjects involved in the study will be 25. The length of time for your participation is limited to the interview which should be completed in less than two hours.

BENEFITS TO THE SUBJECT

The direct benefits to you may include self-reflection of practice experiences although this benefit cannot be guaranteed.

REIMBURSEMENT FOR EXPENSES

There will be no reimbursement for participation in this study

COSTS OF PARTICIPATION

There will be no cost for participation in the study.

ADDITIONAL INFORMATION

1. If you have any questions, concerns or complaints before, during or after the research study, you should immediately contact Trish Carr 361-779-5217.
2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty
3. If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information, you may contact the Institutional Review Board Office, at (409) 266-9475.

The purpose of this research study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent at any time. You may withdraw your consent by notifying Trish Carr at 361-779-5217. You will be given a copy of the consent form you have signed.

Informed consent is required of all persons in this project. Whether or not you provide a signed informed consent for this research study will have no effect on your current or future relationship with UTMB.

Signature of Subject	Date
Date	Signature of Person Obtaining Consent

Appendix F: Research Flyer

What are your experiences?

You are invited to participate in an online synchronous interview exploring:

What is it like to work in a hospital that supports a shared governance model?

Trish Carr MSN RNC-NIC, Doctoral Student, The University of Texas Medical Branch Galveston Texas

Who: *Bedside Nurses who work in a children's hospital that has had a shared governance model in place for at least 4 years*

What is involved: *Online Interview that will take up to 90 minutes*

When: *Scheduled at your convenience*

If you are interested in sharing your experiences please email, phone or text:
361-779-5217, www.bedsidenurseexperiences@gmail.com

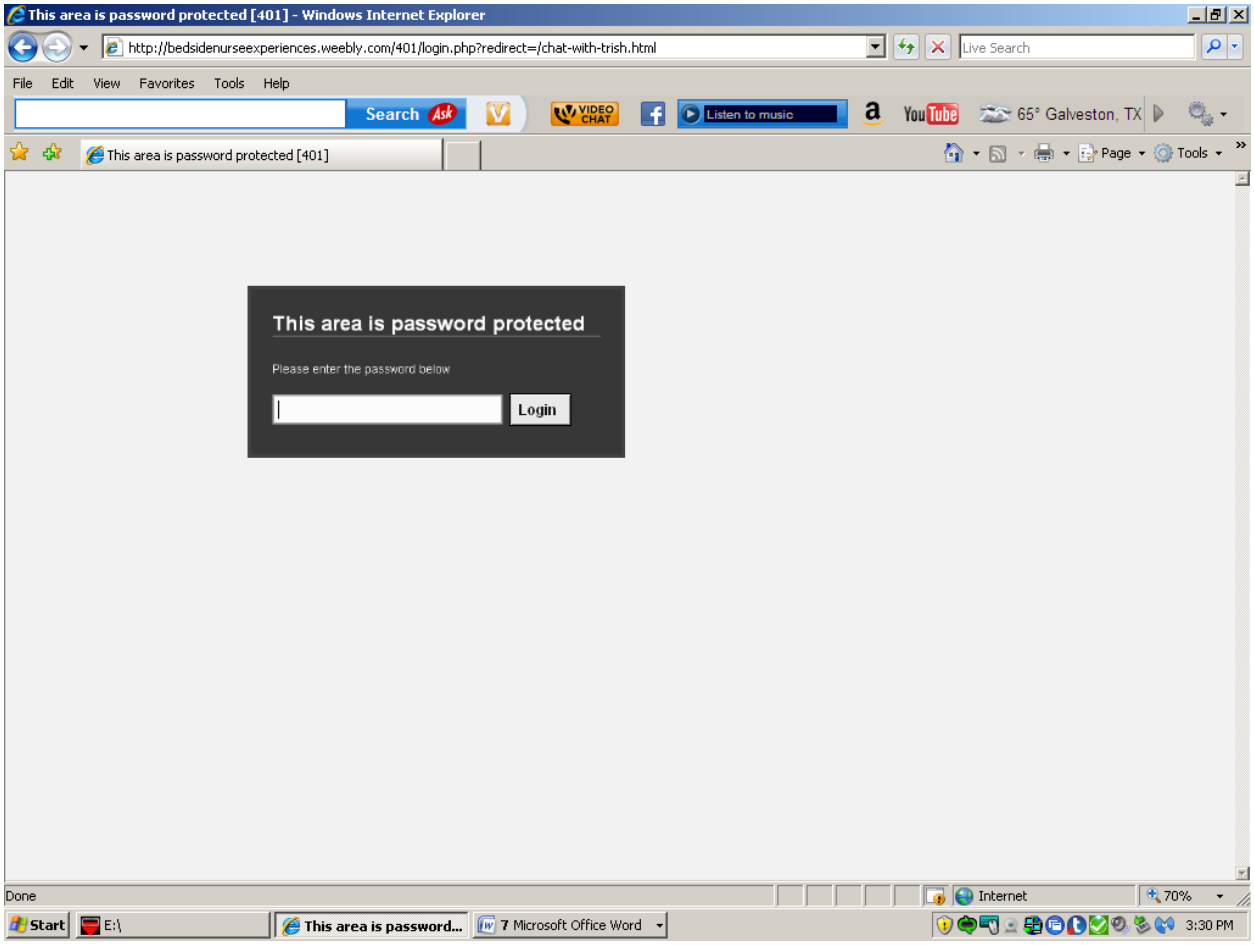
For more information please log on to the following link:
http://bedsidenurseexperiences.weebly.com/index.html

Appendix G: Demographic Data

Demographic data:

Section I: Demographics	Answer	Comments
Age		
Gender	☐ Male ☐ Female	
City and State where you Practice		
Section II: Race/Ethnicity		
• White Non Hispanic	☐	
• Black Non-Hispanic	☐	
• Hispanic White	☐	
• Hispanic Black	☐	
• American	☐	
• Indian/Alaskan Native	☐	
• Asian/Pacific Islander	☐	
• Other	☐	
Section III: Level of Education		
• AND	☐	
• Diploma/Certificate	☐	
• BSN	☐	
• MSN	☐	
• PhD Nursing	☐	
• Other	☐	
Section IV: Experience		
Total years of nursing experience		
Have you ever worked in a institution that does not practice shared governance?	☐Yes ☐No	
Total years experience in current institution.		

Appendix H: Chat Room



IRB APPROVED

FORM VALID THROUGH

JUL 02 2013

RESEARCH CONSENT FORM

JUL 01 2014

You are being asked to participate as a subject in the research project entitled, Experiences of Bedside Nurses who practice in a Shared Governance Culture, under the direction of Trish Carr, MSN, RNC-NIC.

PURPOSE OF THE STUDY

The purpose of this study is to assess what bedside nurses experience as they practice in a shared governance culture. You are being asked to participate because you are a bedside nurse practicing in an accredited hospital that promotes a shared governance nursing model.

RISKS OF PARTICIPATION

There are minimal risks of participation in this research project. The risks are loss of confidentiality and fatigue during the interview.

You are encouraged to choose a time and place for the interview where you will have privacy and minimal interruptions. You can participate in the study anonymously by setting up an anonymous Gmail account. Findings from the study w will be reported as aggregates; any quotations that are used will not contain information that could be used to identify you or your employer.

I will assess whether you are fatigued during the interview by asking questions such as "Do you want to continue?" If you become fatigued we can end the interview entirely or continue at a later time.

NUMBER OF SUBJECTS PARTICIPATING AND THE DURATION OF YOUR PARTICIPATION

The anticipated number of subjects involved in the study will be 25. You will be interviewed a minimum of one time; which is expected to take 30 to 60 minutes, but will not exceed 90 minutes. The researcher may need to contact you again if question should arise during data analysis, but you will not be contacted for follow-up interviews more than twice and no follow-up interview will exceed 30 minutes.

BENEFITS TO THE SUBJECT

The direct benefits to you may include self-reflection of practice experiences although this benefit cannot be guaranteed.

REIMBURSEMENT FOR EXPENSES

There will be no reimbursement for participation in this study

COSTS OF PARTICIPATION

There will be no cost for participation in the study.

PROCEDURES RELATED to this RESEARCH

A participant will be interviewed a minimum of one time. The initial interview is expected to take thirty to sixty minutes, but will not exceed ninety minutes. With consent, participants may be contacted by the researcher following the initial if clarification is needed or questions arise during data analysis. Participants may withdraw from this study at any time. No participant will be contacted for follow-up interviews without their expressed consent nor will they be contacted more than twice. Follow-up interviews will be limited to thirty minutes or less.

This study will use an online format at a secured password-protected online website developed specifically for this study
http://sharedgovernanceexperiences.weebly.com/index.html
Participant consent and data collection processes will occur during synchronous typed online interactions between the researcher and participants.

The study website will include detailed information regarding the study, how the researcher may be contacted, and instructions for participating in the study interview process. The site contains information on how you, as a participant, may interact anonymously within the online format if you so choose by creating an anonymous email account used specifically for this study and interview process. The study site contains a copy of this Research Consent Form. Please print a copy of this consent form for your records.

Data for the study will consist of demographic data and other interview data collected during the online interview within the secure password-protected website. Interview questions will be divided into two basic parts: collection of demographic data and question regarding your perceptions of plagiarism. Demographic data that will be collected include age, gender, ethnicity. Interview questions used to explore your perceptions of plagiarism are:

1. What is it like to be a nurse working in a SG environment?
2. How have you been involved in the SG process?
3. What are the pros and cons of working in a SG environment?
4. What does the term shared governance mean to you?
5. How do your own experiences with SG compare with what you have read or heard about SG?
6. The literature says SG is supposed to empower nurses and help them feel they have a greater voice in decisions that affects their practice. Has that been your experience? Could you give me some examples?
7. Do you think SG affects the quality of care you/your hospital can deliver? How?
8. Is there anything else that you would like to tell me about your experiences working in a SG environment?
9. Would you be willing to have me contact you again if I have additional questions?
10. If you have additional thoughts or questions about the study topics, please feel free to contact me at 361-779-5217 or*sharedgovernance.experiences@gmail.com*

11. Thank you for participating in my study. I will send you a copy of the study results once I have it completed.

PROCEDURES FOR WITHDRAWAL FROM THE STUDY

All participation is voluntary. You may refuse to participate, or discontinue participation in this study at any time including prior to the interview, during the interview, and at the end of the interview. You may withdraw from the study at any time by notifying the research by email, phone, or text. You may refuse to be contacted by the researcher. You may refuse to participate in any future interviews.

ADDITIONAL INFORMATION

1. If you have any questions, concerns or complaints before, during or after the research study, you should immediately contact Trish Carr 361-779-5217.

2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty

3. If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information, you may contact the Institutional Review Board Office, at (409) 266-9475.

The purpose of this research study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent at any time. You may withdraw your consent by notifying Trish Carr at 361-779-5217. You will be given a copy of the consent form you have signed.

Informed consent is required of all persons in this project. Whether or not you provide a signed informed consent for this research study will have no effect on your current or future relationship with UTMB.

Signature of Subject	Date
Date	Signature of Person Obtaining Consent

Appendix J: Letter to CNO

March 10, 2013

Hello, my name is Trish Carr, AVP of Nursing Operations at Driscoll Children's Hospital in Corpus Christi TX. I met with some of you during the CNO conference to discuss my proposal for my dissertation that will examine experiences of bedside nurses who are working in pediatric hospitals with established shared governance cultures (at least 4 years or more). I am a student in the Nursing PhD program at the University of Texas Medical Branch (UTMB) in Galveston Texas. I am contacting you asking your permission to recruit bedside nurses at your hospital to participate in my study. If you are willing to allow me access to your nurses, I would need your assistance in distributing my study recruitment fliers, either by posting the fliers in your hospital, distributing them through your hospital email system, or any method that you would recommend.

My goal is to develop my proposal, defend it, and then submit the proposal to the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB) for approval within the next 2-3 months so that I can begin participant recruitment and data collection during the summer. I plan to collect data using online semi-structured synchronous interviews, which means the nurses who are interested in participating in my study would not have to travel; they only would need to be willing and able to participate in one on line data collection session. Any information that would identify study participants or their institutions will be removed prior to data analyses.

I am asking CNOs who are willing to allow me to recruit their bedside nurses to write a letter to that effect and include in the letter how they want me to recruit their nurses. I will be glad to answer any questions you may have or to discuss my research with you further. You may contact me at patricia.carr@dchstx.org or 361-779-5217. Thank you for your support and consideration of my request.

Sincerely,

Trish Carr RN MSN RNC-NIC
Driscoll Children's Hospital
3533 S. Alameda
Corpus Christi TX. 78412

Appendix K: IRB Amendment Letter

UTMB
The University of Texas Medical Branch

OFFICE OF RESEARCH SUBJECT PROTECTIONS
Institutional Review Board

25-Sep-2013

MEMORANDUM

TO: Patricia Carr, MSN, RNC-NIC/Carolyn A. Phillips, PhD
Grad School Biomedical Science

FROM: Aristides Koutrouvelis, MD
Chairman, IRB #1
Institutional Review Board 0158

SUBJECT: IRB # 13-0264 - **Administrative Approval** of a Revised Protocol and Revised Research Consent Form
Experiences of Bedside Nurses Practicing in a Shared Governance Environment

The Institutional Review Board acknowledges receipt of your Request for Protocol/Consent Changes submitted on 09/18/13 requesting approval of a revised protocol and revised Research Consent Form. The protocol was revised to include the following: "At the conclusion of each first interview the participant will be offered a one-time gift of a twenty dollar (US) gift card to either Starbucks or Target as a token of appreciation for their time to participate in the interview. The participant's choice of gift card will be sent by mail to the participant within ten days of the conclusion of the interview." The 'Reimbursement for Expenses' section of the research consent form was revised to reflect this change. The revised protocol and revised research consent form were**reviewed and approved through an expedited review process by the IRB on 9/24/13.**

This project will require **annual** review by the IRB and will expire on **July 01, 2014. Research that has not received approval for continuation by this date may not continue past midnight of the expiration date.**

The research consent form with the date of the IRB approval has been uploaded into InfoED. Please use this consent form with the IRB approval date and make additional copies as they are needed. **In accordance with amendments to 21 CFR Parts 50, and 812 effective 12/5/96, consent forms must be dated when consent is obtained.**

AK/rk

Document Uploaded: Research Consent Form

Appendix L: Interview Question Guide

Semi-structured Interview Questions:

These are questions that were used to guide the interview process. The first question (1) is the "grand tour" question. The participants' responses led to the development of next questions. Questions 2-7) were used when necessary. Otherwise question were developed throughout the interview process in order to follow the CGT methodology.

1. Can you tell me about your experiences working in your hospital? If you were to use words to describe what you experience in your work, environment what would those be?
2. What does the term shared governance mean to you?
3. How do your own experiences with SG compare with what you have read or heard about SG?
4. What are the pros and cons of working in a SG environment?
5. The literature says SG is supposed to empower nurses and help them feel they have a greater voice in decisions that affects their practice. Has that been your experience? Could you give me some examples?
6. Do you think SG affects the quality of care you/your hospital can deliver? How?
7. Is there anything else that you would like to tell me about your experiences working in a SG environment?
8. Would you be willing to have me contact you again if I have additional questions?
9. If you have additional thoughts or questions about the study topics, please feel free to contact me at 361-779-5217 or*sharedgovernance.experiences@gmail.com*
10. Thank you for participating in my study. I will send you a copy of the study results once I have it completed.

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Vita

Patricia Lee Severance Carr was born April 15, 1954 in Houston Texas to Patrick and Mary Severance. She received an Associate Degree in Nursing in 1976 from Galveston Junior College in Galveston, Texas; a Bachelor's Degree in Nursing in 2005 from UTMB, Galveston, Texas; a Master's of Nursing in 2007 from Texas A&M Corpus Christi, Texas. She holds an RNC-NIC certification in neonatal nursing. Patricia has spent most of her nursing career (37 years) working in neonatal intensive care. She has served as a staff nurse, transport nurse, and Director of the NICU. She currently works as the Assistant Vice President of Nursing Operations at Driscoll Children's Hospital in Corpus Christi, Texas. She participated in the development of the Critical Care Orientation Program for neonatal intensive care units in children's hospitals. She helped facilitate a wound care program at Driscoll Children's Hospital and presented a poster on the success of the program at the ANA Conference February 7-9, 2014: "Collecting the Data: Now What?" Patricia is a sub-investigator in the Maker Nurse initiative, led by MIT's Little Devices Lab supported by the Robert Wood Johnson Foundation to honor the inventive spirit of nurses across America and bringing nurse making to the forefront of health care. Patricia is the wife of William Harvey Carr (39 years) and the mother of three wonderful children, William Patrick Carr, Brian Allen Carr, Mary Elizabeth Carr Frady; a wonderful daughter and son-in law Rebecca Leigh Carr and Zachary Hardin Frady, and grandmother (YaYa) to three perfect and beautiful granddaughters, Georgia Elise Carr (5), Josephine Lee Carr (4 months) and Noelle Elizabeth Frady (2 years).