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TAINA KANNINEN

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Author's address: Department of Nursing Science
University of Eastern Finland
KUOPIO
FINLAND

Doctoral programme: Doctoral programme in Health Sciences

Supervisors: Professor Tarja Kvist, Ph.D.
Department of Nursing Science
University of Eastern Finland
KUOPIO
FINLAND

Professor Arja Häggman-Laitila, Ph.D.
Department of Nursing Science
University of Eastern Finland
KUOPIO
FINLAND

Clinical Nurse Consultant Tarja Tervo-Heikkinen, Ph.D.
Kuopio University Hospital
KUOPIO
FINLAND

Reviewers: Professor Mélanie Lavoie-Tremblay, Ph.D.
Faculty of Nursing
University of Montreal
QUEBEC
CANADA

Docent Kristiina Hyrkäs, Ph.D, Director.
Center for Nursing Research and Quality Outcomes
Maine Medical Center
PORTLAND, MAINE
UNITED STATES

Opponent: Professor Camilla Ann-Louise Koskinen, Ph.D.
Department of Caring and Ethics
University of Stavanger
STAVANGER
NORWAY

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ABSTRACT

Healthcare workforce shortage is a worldwide problem. Extensive research has been executed over the years to clarify factors affecting healthcare work environment. Transformational leadership strategies are found to be effective in reducing turnover and nurse burnout. For more than thirty years different professional governance models have been developed in healthcare organizations to modify leadership into more transformational. There is an increase in the interest towards professional governance nationally and internationally but more research is needed to guide the development. The aim of this study was to identify professional governance interventions and describe and assess the current state of professional governance in Finland with four substudies. The first substudy, an integrative review, was executed to distinguish interventions for strengthening professional governance by searching literature published between January 2007 and May 2020 in the CINAHL, PubMed, Scopus, PsycINFO, Business source, Cochrane, and Medic databases. Twelve studies were identified and the data was analyzed by a narrative synthesis. Three of the interventions created new decision-making structures on various levels to enhance personnels' empowerment and involvement in decision-making. All of the interventions to strengthen

leadership and teamwork decreased exhaustion and disengagement of the teams, improved abilities to handle disagreements, and increased participants' leadership skills. In the second sub-study, the Index of Professional Nursing Governance 2.0 was translated and modified for the use in Finnish healthcare. A cross-sectional survey with 419 nurses from five Finnish University Hospitals was conducted with the modificated instrument to assess the state of professional governance. The sufficient reliability and validity of the instrument for use in Finnish healthcare was confirmed (Cronbach alpha 0.97). The governance score, 203.6, means that the nurses have some input in the decision-making but it was still largely run by the administration. In the third sub-study twelve nurses from one Finnish university hospital were interviewed and documents from 75 council meetings were analyzed to describe the current council structures' benefits, supportive and obstructive factors, and developmental needs. Four councils were identified. Nurse leaders' strong support was seen to be vital for the councils and the main obstructing factor was the pressure of time. The councils enhanced the quality and safety of patient care by increasing nurses ability to report the problems they encountered at the bed side. Councils need more visibility and personnel need more information of the work of the councils. Opening the councils to non-nurses, more guidance from nurse leaders and easily accessible research articles are needed to optimize the work. In the fourth sub-study a descriptive qualitative interview study was conducted to understand the lived experience of the nurses working in the unit practice councils. Sixteen nurses in two clinics of a Finnish university hospital were interviewed and the data was analyzed using thematic analysis. Nurses reported diverse councils or work groups with somewhat unorganized working practices. They saw the work groups as their own creation and not as parts of the organizations' decision-making structure. The work groups can be modified into effective professional governance councils by a thorough education upon joining and by creating common guidelines. Further development and support from all levels of the organization is needed. Future research should re-examine the modified instruments' internal consistency and usability with a more representative sample and explore new and effective

interventions to enhance further progress of professional governance in Finland and internationally.

Keywords: Professional governance, nursing, councils, interview research, Index of Professional Governance, cross-sectional survey, questionnaire, integrative review, intervention

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TIIVISTELMÄ

Terveydenhuollon työvoimapula on maailmanlaajuinen ongelma. Vuosien varrella on tehty runsaasti tutkimusta terveydenhuollon toimintaympäristöön vaikuttavista tekijöistä. Transformationaalisen johtamisen on todettu vähentävän tehokkaasti henkilöstön vaihtuvuutta ja työuupumusta. Yli kolmenkymmenen vuoden ajan terveydenhuollon organisaatioissa on kehitetty erilaisia osallistavan johtamisen malleja transformationaalisen johtamisen kehittämiseksi. Kiinnostus osallistavaa johtamista kohtaan kasvaa niin kansallisesti kuin kansainvälisesti, mutta kehityksen ohjaamiseksi tarvitaan lisää tutkimusta. Tämän tutkimuksen tavoitteena oli kuvata ja arvioida osallistavan johtamisen nykytilaa Suomessa ja tunnistaa osallistavan johtamisen interventioita neljällä osatutkimuksella. Ensimmäisen osatutkimuksen, integratiivinen katsaus, tarkoituksena oli tunnistaa interventioita osallistavan johtamisen vahvistamiseksi etsimällä tammikuun 2007 ja toukokuun 2020 välisenä aikana julkaistua kirjallisuutta CINAHL-, PubMed-, Scopus-, PsycINFO-, Business source-, Cochrane- ja Medic-tietokannoista. Kaksitoista tutkimusta tunnistettiin ja aineisto analysoitiin narratiivisella synteesillä. Kolmella interventiolla, joiden tavoitteena oli lisätä henkilöstön osallistumista ja voimaantumista rakentamalla uusia

päätöksentekorakenteita eri tasoille, vahvistettiin kykyä osallistua päätöksentekoon. Kaikki johtajuuden ja tiimityön vahvistamiseen tähtäävät interventiot vähensivät tiimien uupumusta ja sitoutumattomuutta, paransivat kykyä käsitellä konflikteja sekä lisäsivät osallistujien johtamistaitoja. Toisessa osatutkimuksessa käännettiin ja muokattiin The Index of Professional Nursing Governance 2.0-mittari käytettäväksi suomalaisessa terveydenhuollossa. Mittaria käytettiin kyselytutkimuksessa, jossa kerättiin aineisto 419 sairaanhoitajalta viidestä suomalaisesta yliopistollisesta sairaalasta osallistavan johtamisen tilan arvioimiseksi. Tulokset vahvistavat mittarin riittävän luotettavuuden ja toimivuuden suomalaisessa terveydenhuollossa (Cronbach alpha 0,97). Kokonaispistemäärä (203,6) osoittaa, että sairaanhoitajilla on mahdollisuus jonkin verran osallistua päätöksentekoon, mutta se oli edelleen suurelta osin esimiesten ja hallinnon vallassa. Pistemäärä kaikissa paitsi yhdessä osa-alueessa (Henkilöstö) nousi osallistavan johtamisen pistealueeseen (173–344). Kolmannessa osatutkimuksessa haastateltiin 12 sairaanhoitajaa yhdestä suomalaisesta yliopistollisesta sairaalasta ja analysoitiin asiakirjoja 75: stä asiantuntijaryhmän kokouksesta kuvaamaan sen hetkisen ryhmärakenteen hyötyjä, tukevia ja estäviä tekijöitä sekä kehitystarpeita. Neljä asiantuntijaryhmää tunnistettiin. Hoitotyön johtajien vahva tuki nähtiin elintärkeäksi ryhmille. Ajan puute oli tärkein estävä tekijä. Asiantuntijaryhmät paransivat potilashoidon laatua ja turvallisuutta lisäämällä sairaanhoitajien kykyä ilmoittaa ongelmista hoitotyössä. Asiantuntijaryhmät tarvitsevat enemmän näkyvyyttä, ja henkilöstö tarvitsee enemmän tietoa ryhmien työstä. Työn optimoimiseksi tarvitaan asiantuntijaryhmien avaamista muille kuin sairaanhoitajille, hoitotyön johtajien ohjausta ja helposti saatavilla olevia tutkimusartikkeleita. Neljäs osatutkimus oli kuvaileva laadullinen haastattelututkimus, jossa selvitettiin osastojen erilaisissa työryhmissä työskentelevien sairaanhoitajien kokemuksia. Siinä haastateltiin 16 sairaanhoitajaa suomalaisen yliopistosairaalan kahdesta klinikasta ja aineisto analysoitiin temaattisen analyysin avulla. Sairaanhoitajat raportoivat erilaisista neuvostoista tai työryhmistä, joilla oli jonkin verran järjestäytymättömiä työtapoja. He näkivät työryhmät omana luomuksenaan eivätkä niinkään osana

organisaation päätöksentekorakennetta. Työryhmiä voidaan muuttaa tehokkaiksi osallistavan johtamisen asiantuntijaryhmiksi perusteellisella koulutuksella liittymisen yhteydessä ja luomalla yhteiset toimintaperiaatteet. Edelleen tarvitaan kehitystä ja tukea organisaation kaikilta tasoilta. Tulevaisuudessa tutkimuksessa käännetyn mittarin sisäistä johdonmukaisuutta ja käytettävyyttä on tarkasteltava uudelleen edustavamman otoksen avulla ja tutkittava uusia ja tehokkaita interventioita, joilla vahvistetaan osallistavan johtamisen edistymistä sekä Suomessa että kansainvälisesti.

Avainsanat: Osallistava johtaminen, hoitotyö, neuvostot, asiantuntijaryhmät, haastattelututkimus, Index of Professional Governance, poikittaistutkimus, kyselylomake, integratiivinen katsaus, interventio

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LIST OF ORIGINAL PUBLICATIONS

This dissertation is based on the following original publications:

I Kanninen T., Häggman-Laitila A., Tervo-Heikkinen T. & Kvist, T. 2021. An integrative review on interventions for strengthening professional governance in nursing. Journal of Nursing Management. 29(6), 1398-1409.

II Kanninen T., Häggman-Laitila A., Tervo-Heikkinen T., Hess Jr R.G, & Kvist, T. 2020. Professional governance in Finnish nursing –measured by the Index of Professional Nursing Governance. Scandinavian Journal of Caring Sciences. 00, 1–10.

III Kanninen T., Häggman-Laitila A., Tervo-Heikkinen T. & Kvist, T. 2019. Nursing shared governance at hospitals – it's Finnish future? Leadership in Health Services. 32(4), 558-568.

IV Kanninen T., Häggman-Laitila A., Tervo-Heikkinen T. & Kvist, T. 2021. Nurses' critical reflections of working in unit practice councils-A qualitative interview study. Journal of Nursing Management. 30(1),252-259.

CONTENTS

ABBREVIATIONS

ANA	American Nurses Association
EBP	Evidence based practice
EU	European Union
IPNG	The Index of Professional Nursing Governance
KMO	Kaiser-Meyer-Olkin Test for Sampling Adequacy
PCA	Principal Component Analysis
PhD	Doctor of Philosophy
RN	Registered nurse
TENK	Finnish National Board on Research Integrity
UPC	Unit practice council
WHO	World Health Organization

1 INTRODUCTION

More than half of all healthcare workers around the world are nurses, with a global total of just under 28 million nurses, of which about 74 000 are in Finland (Finnish Nurses Association, 2022). Many countries are facing challenges related to the healthcare workforce; in most cases, more workers are needed to preserve the continuity of essential services (WHO, 2021). Statistics from WHO Europe show that demographic aging in most European countries is increasing the overall need for care, yet also decreasing the interest in care provision among young people. Retirement, along with the recent trend of healthcare professionals leaving the profession, also contribute to the shortage of healthcare workers (WHO Europe, 2021).

There has been extensive research on which factors affect the work environment of healthcare personnel. Certain organizational features, such as a healthy work environment and low patient-to-nurse ratios, are associated with better patient outcomes and improved wellbeing, development, and health among personnel (EU, 2016; Bianchi et al., 2018; Cummings et al., 2018). Moreover, nurse leaders have a significant role in promoting a healthy work environments for the nursing personnel, while responsive management strategies have been found to be effective at reducing turnover (Cummings et al., 2018; Li et al., 2020) and nurse burnout (Wei et al., 2020).

Several high-profile initiatives aimed at achieving adequate staffing and improved work environments have been undertaken in the USA and Australia, with the Magnet Hospital Accreditation Programme as one example (EU, 2016). These initiatives have strong potential, as their implementation showed a positive correlation with structural empowerment and organizational dedication, as well as work environment and quality outcomes (Goedhart, Van Oostveen & Vermeulen, 2017; Weaver et al., 2018).

Health care organizations which achieve excellent nursing and patient outcomes can be awarded Magnet Recognition. The Magnet Model®

includes five components (ANA, 2022), with one of the components, structural empowerment, highlighting the importance of transformational leadership in a healthcare environment. Over the years, this component has stimulated healthcare organizations to develop different professional governance models which shift leadership towards more transformational approaches. Professional governance is an organizational model of empowerment for nurses, which is realized in shared decision-making (Porter-O'Grady, 2003; Porter-O'Grady & Clavelle, 2021). This type of decision-making model involves various councils at different organizational levels, as well as integrative councils, to ensure that the work is aligned with the strategic goals of both nursing staff and the organization (Porter-O'Grady & Clavelle, 2021). Previous literature has demonstrated that the ability to take part in professional governance and decision-making enhances nurses' job satisfaction and retention (Scherb et al., 2011; Hamad & Kehyayan, 2018; Cai, Hall & Siedlecki, 2021) and advances nurses' work engagement (Siller et al., 2016).

Around the world, 580 (3.5.2022) facilities across 12 countries currently hold Magnet status® (ANA, 2022; EU, 2016); however, professional governance is still a relatively new topic in Europe and the Nordic countries. Previous literature on professional governance mainly comes from the United States, while research on this subject in the Nordic countries, including Finland, remains scarce. Nevertheless, there is increased interest towards professional governance in Finland, with some hospitals on the Pathway to Excellence®. As such, it is difficult to find the Finland-specific best practices for creating or strengthening professional governance, and no modified and/or valid instruments for measuring professional governance are available in Finnish.

It is not easy to develop a sufficient professional governance model. Most of the differences regarding empowerment between different organizations or units of an organization can be explained by discrepancies in leadership and professional governance (Allen-Gilliam et al., 2016). As such, there needs to be more insight into Finnish nurses' and nurse leaders' experiences of working in professional governance councils to identify which factors promote and obstruct progress as well as which

interventions are efficient in advancing the progress. Therefore, this doctoral dissertation chronicles several professional governance interventions and describes the current state of professional governance in Finland. The research underlying this thesis was performed in line with the aims of the Department of Nursing Science at the University of Eastern Finland and is related to the field of nursing leadership and management.

2 REVIEW OF THE LITERATURE

2.1 QUANTUM THEORY

Even though the principles of healthcare have evolved over the years, the perceptions of healthcare leadership are still largely influenced by the Newtonian principles of cause and effect (Porter-O'Grady, 2015; Watson et al., 2018). New language is needed and, though adopting a complexity perspective to explain healthcare organizations is not unambiguous (Belrhiti, Nebot Giralt & Marchal, 2018), it is able to better define life and interaction in the complex systems (Porter-O'Grady, 2015).

In this thesis, the world is viewed through the lens of complexity and Quantum thinking. Quantum theory has been refined and applied since the middle of the 20th century. According to this theory, everything is linked and events in one part of the universe have impacts on events in other parts (Porter-O'Grady & Malloch, 2018). This complex entity of continuously intersecting and interacting elements also includes healthcare. The world is unordered, and healthcare is described as "messy" and unpredictable (Belrhiti, Nebot Giralt & Marchal, 2018).

Complexity leadership is a framework that draws from complexity science to show how systems can successfully meet, as well as adapt to, the demands of external and internal forces. Under this framework, organizations are seen as nonlinear and dynamic, with no lasting points of equilibrium. These chaotic organizations require multidirectional leadership, as the actions of leaders will have cascading implications at every level of the organization. Notably, one single leader cannot successfully manage these complex systems; as such, the leaders of these organizations do not act as hierarchical implementers, but rather collaborators who work together to strengthen the adaptability of the system. Leadership is seen as a collective process, the outcome of which is distributive decision-making models that are suited for the complex organization (Porter-O'Grady, 2020; Uhl-Bien, Meyer & Smith, 2020). Individuals own the work, and the knowledge necessary to get work done

is mostly in the hands of those who do the work. This means that the main leadership task is coordinating the elements and facilitating the relationships that are needed for the organization to thrive (Porter-O'Grady & Malloch, 2018).

2.2 STRUCTURAL EMPOWERMENT

The best way to manage crucial relationships in an organization is to empower personnel to be involved in decision-making related to their own work. Workers who can use resources and make decisions over their work are structurally empowered (Kanter, 1977; Laschinger, Sabiston & Kutszcher, 1997). The prevailing literature includes many distinct conceptualizations of empowerment. This thesis draws upon Rosabeth Moss Kanter's Theory of Structural Empowerment (1977) as it provides a practical foundation for planning organizational interventions that will improve work environments in the healthcare setting (Laschinger & Finegan, 2005).

According to Kanter (1977, 1993), employees' behavior is a reaction to the work environment. When an employee feels empowered, they are work-oriented and effective. Kanter feels that the following components are the most important to structural empowerment: access to information; support; resources; and opportunities. The information component refers not only to technical and expert knowledge but also to informal and formal knowledge. In terms of support, an employee must receive feedback, guidance, and advice to be able to make decisions. The vital resources include different supplies, means, and time to carry out the work. Lastly, opportunities refers to a potential for personal development and growth, and the ability to acquire necessary knowledge and skills (Orgambídez-Ramos et al., 2017).

Fragkos, Makrykosta & Frangos (2020) reported a strong correlation between structural empowerment and both organizational commitment and performance. Moreover, structural empowerment was found to exert a significant effect on job performance (Al-Hammouri, Rababah & Ta'an, 2021). Several other studies have connected nurses' perceptions of their

structural empowerment to diminished burnout and higher job satisfaction (e.g., Laschinger, Finegan & Shamian, 2001; Cho, Laschinger & Wong, 2006). Hence, leaders should create an organizational climate that supports personnel to enhance their knowledge and skills, as well as be involved in decision-making related to their work. Without these types of opportunities, employees can feel trapped in their jobs, which will translate to low job expectations and poor organizational commitment (Hess, 2011; Porter-O'Grady, 2019).

2.3 FROM SHARED GOVERNANCE TO PROFESSIONAL GOVERNANCE

Luther Christman (1976) first applied the term ”shared governance” into the field of nursing in the article ”The Autonomous Nursing Staff in the Hospital”. He wrote about how nursing needs to have parity with administration and medicine, and about the importance of organizing these ”major departments” so that each can have their own professional accountability. Christman also demanded the nursing staff to be granted the autonomy for the adequacy and safety of patient care (Christman, 1976).

Porter-O'Grady, one of the first scholars to popularize shared governance in nursing, defined this term as a structural model that enables nurses to influence their work with more extensive professional autonomy (Porter-O'Grady & Finnigan, 1985; Porter-O'Grady, 2003). His model has four antecedents: partnership; equity; accountability; and ownership (Swihart, 2011). A key component of shared governance is that nurses are obligated to demonstrate personal accountability and ownership of their work. Accountability means that one is willing and obligated to determine the best actions to take in every situation, in line with the standards of the profession. Successful shared governance requires partnerships, which are collaborative relationships between personnel and imply that everyone is critical to the effectiveness of the healthcare system. Ownership describes the recognition of work tasks, while equity is related to comparable expectations of employees (Swihart, 2011; Porter-O'Grady, 2019).

Certain concepts, such as shared decision-making and collaborative leadership, are closely related to shared governance. In shared decision-making, patients are engaged in the healthcare process, and allowed to make decidions about their treatment, and/or follow-up (Stiggelbout, Pieterse & De Haes, 2015). Collaborative leadership draws upon the concept of collaboration, which is defined as two or more persons working together for the same aim. In contemporary literature, the practice of collaboration in decision-making has been broadened to patients, who are now considered as active participants, rather than passive recipients, in healthcare (Dickinson et al., 2022).

Another concept that is closely related to shared governance is shared leadership; this concept posits that leadership is a protean lateral process that is dispersed across an entire team (Willcocks & Conway, 2022). Like shared governance, shared leadership is considered as distinct to traditional leadership theories because it emphasizes the distributive nature of leadership. Moreover, both shared governance and shared leadership highlight empowering leaders and positive team environments as antecedents of successful leadership (Hess, 2014; Willcocks & Conway, 2022). In contrast to shared leadership, shared governance is more than a leadership model; it extends beyond leadership because it is an organizational model of empowerment which entrusts nurses with the right to generate and execute actions of their profession (Porter O'Grady & Clavelle, 2021).

The use of the term ”shared governance” began to increase in the 1980s, a time point when the first formal organizational nursing governance models were developed in various American healthcare organizations. At the time, the concept of ”professional governance” was considered too advanced. Today, nurses are more empowered than at the end of the 20th century, and the shift to the term “professional governance” is appropriate (Porter-O’Grady, 2017). Dr. Robert Hess Jr. (1994), a commendable researcher on nursing governance, defined professional governance as an organizational structure that legitimizes nurses’ ownership over their practice and broadens their power in areas earlier controlled by

management. In this thesis, the definition put forth by Dr. Hess is used to clarify professional governance in healthcare.

2.4 PROFESSIONAL GOVERNANCE IN SCIENTIFIC LITERATURE

2.4.1 Literature search

A literature search was performed to identify pertinent and original studies on professional governance. Peer-reviewed literature published in English from 2010 to March 2022 was screened using the CINAHL, Scopus, PubMed and PsycINFO electronic databases. The search strategy included terms such as shared governance, professional governance, and nursing. These terms were then combined with Boolean operators. Original studies and reviews focusing on professional governance in healthcare that involved nurses and nurse leaders were included. Case reports and commentaries were excluded. A total of 1326 papers were identified; of these, 1124 papers were considered irrelevant based on the title, while 137 studies were excluded because the abstract did not meet the inclusion criteria. A total of 48 papers were selected for quality evaluation after the full-text versions of 65 papers were read through. The quality of the studies were evaluated by using a Joanna Briggs Institute critical appraisal tool appropriate for the study design (The Joanna Briggs Institute, 2017) (Figure 1). The overall quality of the included 39 studies was moderate (Appendix 1). A summary of the included studies, earlier literature, and the research of influential scholars of professional governance (Hess, Porter-O'Grady and Swihart) will be presented in this chapter to illuminate different aspects of the issue.

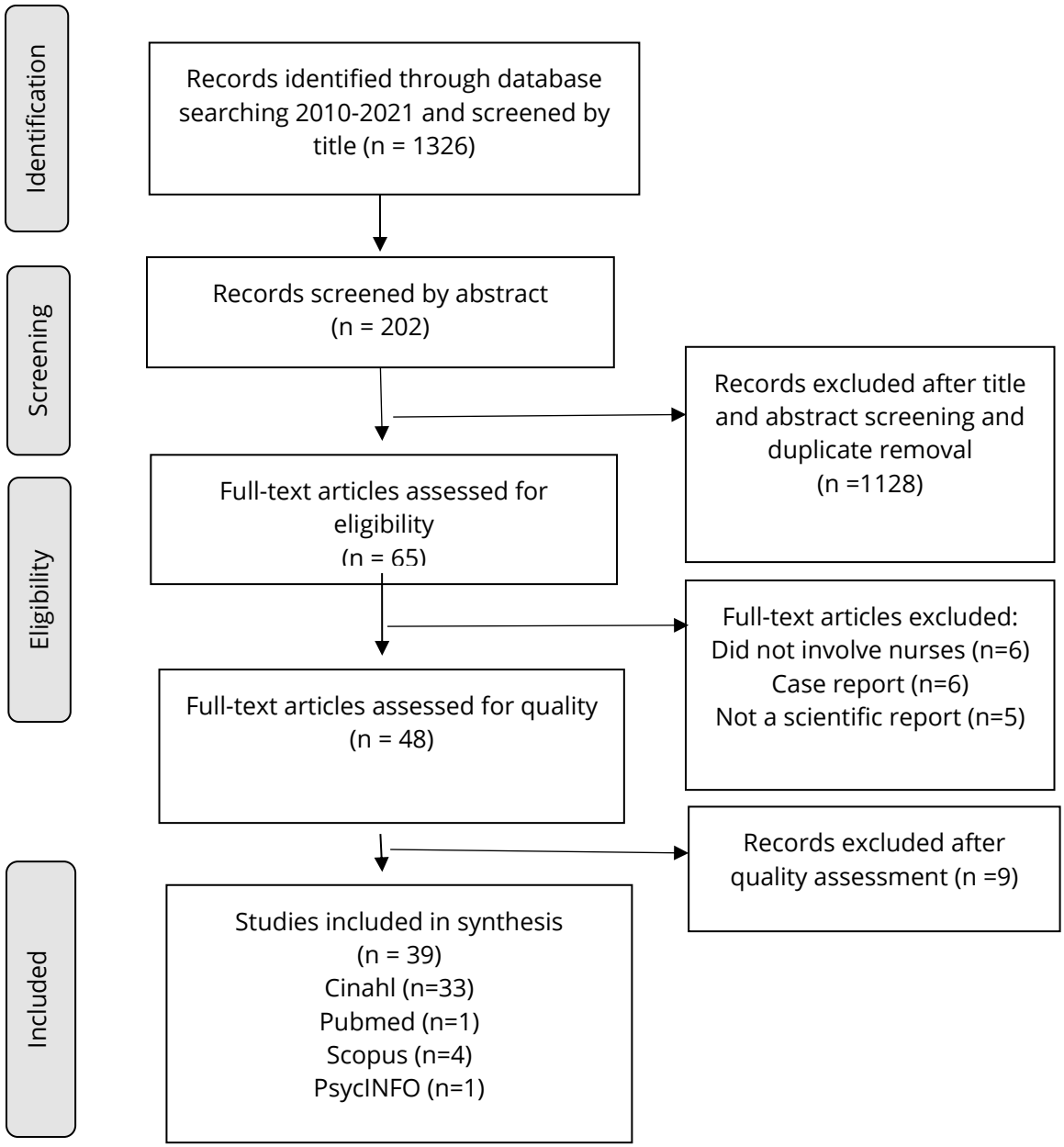

Figure 1. Prisma Flow Diagram of literature search to identify relevant and recent studies on professional governance.

Of the 39 studies included in the literature review, most originated from the United States (25 studies = 67%), with the rest of the studies originating from Saudi Arabia (n=3), South Korea (n=2), Finland (n=2), and Lebanon, Turkey, the United Kingdom, China, the Netherlands, Jordan, and Brazil (with one study from each country).

A total of 31 quantitative studies were identified: 20 cross-sectional studies, eight quasi-experimental studies, and three mixed methods studies. The studies mostly focused on nurses. Clavelle et al. (2013) included chief nursing officers and chairs of the councils, Chaudhuri et al. (2013) studied the empowerment of nursing assistants, and both Wilson et al. (2014) and Abd-EL Aliem & Abou Hashish (2021) included nurses and nurse managers in their studies. Moreover, two studies examined professional governance on the organizational level (Kutney-Lee et al., 2016; Gabel Speroni et al., 2021a), while one study investigated professional governance across four different countries (Gabel Speroni et al. 2021b).

In all of the quantitative studies, along with the quantitative parts of the mixed-method studies, several different instruments were utilized to measure for example the current level of professional governance, the effectiveness of the nursing councils or the effectiveness of an intervention at developing professional governance in the organization. Other research focused on the impact of professional governance and transformational leadership practices on nurses' work environment and engagement, the effect of various factors (education, experience, employment, setting) on nurses' perceptions of professional governance, as well as the level of nurses' real and preferred involvement in decision-making. Chaudhuri et al. (2013) examined which factors affect structural empowerment but failed to report the instrument that was used to gather the data (Appendix 1).

The literature search included six qualitative studies. Most of these studies included interviews and content analysis as the data collection method, with one of the mixed-method studies employing the Delphi technique (Lindell Joseph & Bogue, 2018). The qualitative studies equally focused on nurses (Dearmon et al., 2015; Choi & Kim, 2019; Quek et al.,

2020) and nurse leaders (Cox Sullivan et al., 2017; Underwood & Hayne, 2017; Lindell Joseph & Bogue, 2018), with one study (Ott & Ross, 2014) examining nurses' and nurse leaders' personal experiences with professional governance.

The literature review also included two reviews: one scoping review (Kyytsönen et al., 2020) that identified the core elements of shared governance; and one integrative review (Guedes dos Santos et al., 2013) that clarified different types of nursing governance and the impacts on nursing practice and health care. Both of the reviews stated that thematic analysis was used during the data analysis phase.

2.4.2 Professional governance structures

Distributive decision-making is a core element of professional governance (Kyytsönen et al., 2020), and can be realized through different council structures. These councils are the means through which nurses exercise their accountability for professional decisions and actions (Porter O'Grady & Clavelle, 2021). In the Merriam-Webster dictionary (2021), the word "council" is defined as a group elected or appointed as an advisory or legislative body.

In the late 20th century, distinct models of council structures, such as counsellor, congressional, and unit-based, were offered to guide the development of professional governance (e.g., Porter-O'Grady et al., 1997; Swihart, 2011) However, it did not take long for practitioners to realize that a certain structure could rarely be applied in the same way to different organizations, or even in different departments of an organization (Hess 1994). In the past 40 years, numerous healthcare organizations have implemented various professional governance models to create effective decision-making structures.

Organizations have councils at different levels, e.g., house-wide councils, divisional councils, and unit-based practice councils, that are systematically arranged to support the flow of information and empowerment. Regardless of the setting, a partnership between each profession and the

organization must exist, and distributive decision-making must reflect nurses' collective accountability for decision-making (Porter-O'Grady, 2019).

Councils usually have bylaws to guide the work. These bylaws address different areas, such as functioning, membership, leadership, role of the nurse leader, meeting frequency, and responsibilities (Swihart, 2011). Membership should be open to all personnel, including non-nurses. Furthermore, becoming a member of a professional governance council should be voluntary, as the councils are most effective when led by volunteers (Swihart, 2011). Members are expected, for example, to participate in every meeting and to act supportively. The chair of the council can be elected, appointed, or be a volunteer. The chair is mainly responsible for presiding over meetings and assuring commitment to ground rules (Swihart, 2011). A chairperson must have adequate education and support to be successful. Colleagues and nurse leaders are important in supporting the work of councils. The role of a nurse leader is to serve as a mentor to the council chairperson and members, and to ensure that the council's desicions coordinate with organization's strategic plan (Swihart, 2011).

Nurses' perceptions of governance across the organization can vary (Bennett et al., 2012), but empowerment has been found to advance both professional accountability and autonomy, as well as increase work engagement (Barden et al., 2011; Mouro et al., 2013; Siller et al., 2016). Healthcare organizations should foster robust nursing leadership and ensure that an effective professional governance structure is in place to improve nurses' professional practice environment (Meyers & Costanzo, 2015; Allen-Gilliam et al., 2016; Di Fiore et al., 2018; Khraisat et al., 2020; Bloemhof et al., 2021).

2.4.3 Measuring empowerment and professional governance

Over the years, there has been debate over whether professional governance and its corollaries, like empowerment, can be evaluated with an instrument (Porter-O'Grady, 2003). Several instruments have, though, been created to measure different aspects of nurses' work environment. The healthiness of a professional practice environment has been described and measured with, for example, the revised Nursing Work Index and the Practice Environment Scale of the Nursing Work Index. On the other hand, the Leadership Practices Inventory has been used to measure the presence of transformational leadership practices. The distribution of decision-making power and employees' engagement in decision-making are both key parts of professional governance and have been measured using the Utrecht Work Engagement Scale and the Decisional Involvement Scale, among others. In addition, the effectiveness of professional governance councils can be measured using the Council Health Survey, while the Index of Professional Nursing Governance (IPNG) can be used to gauge the actual presence of professional governance in an organization (Table 1).

Table 1. Instruments measuring different aspects of nurses' work environment and their aims, items, response scales and subscales.

Instrument	Aim	Number of items, response scale and subscales
The Nursing Work Index Revised Aiken & Patrician (2000)	To measure nurses' practice environment	57 items 4-point Likert-type scale Four subscales: control over practice, autonomy, the doctor–nurse relationship, and organizational support.
The Practice Environment Scale of the Nursing Work Index Lake (2002)	To measure the quality of the nursing practice environment.	31-items, 4-point Likert scale Five subscales: Nurse Participation in Hospital Affairs; Nursing Foundations for Quality of Care; Nurse Manager Ability, Leadership and Support of Nurses; Staffing and Resource Adequacy; and Collegial Nurse-Physician Relations
The Utrecht Work Engagement Scale Schaufeli et al., (2002)	To assess levels of engagement at work	17-ites, 7-point Likert scale Three subscales: vigor, dedication, and absorption
The Decisional Involvement Scale Havens & Vasey, (2003)	To measure the degree of staff nurses' actual and preferred decisional involvement	21 items 5-point Likert scale Two parts: actual levels / preferred levels of decisional six constructs: unit staffing, quality of professional practice, professional recruitment, unit governance and leadership, quality of support staff practice, and cooperation/liaison activities.

The Leadership Practices Inventory Kouzes & Posner (2012)	To assess how transformational the leadership practices are	30-items, 5-point Likert scale Five dimensions: modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart.
The Council Health Survey Hess et al. (2020)	To measure the effectiveness of professional governance councils	25 items, 5-point Likert scale Three subscales: Structure, Activities, Membership
The Index of Professional Nursing Governance Hess (1998)	To measure the distribution of control, influence, power, and authority	86 items, 5-point Likert scale Six dimensions; control over personnel, access to information, influence over resources supporting practice, ability to participate in organizational decisions, control over practice, and ability to set goals and resolve conflict

During the last 20 years, more than 250 healthcare organizations and systems have used the IPNG to evaluate the implementation of governance models and to track changes (Forum of Shared Governance, 2021). It is a valuable tool as it can be used to benchmark performance with other organizations (Hess, 1998). This instrument is discussed in this thesis because it is currently the most widely utilized instrument for measuring professional governance, and demonstrates sufficient validity and reliability (Hess, 2017).

Dr. Hess created IPNG 2.0 to measure nurses' perceptions of professional nursing governance. Governance is evaluated along a conceptual continuum ranging from traditional governance, which is dominated by administration through shared governance between the management and personnel, to self-governance modes (Hess, 1995) (Table 1 in original publication II). Self-governance means that nursing personnel

have total control over their work in an organization, including hiring their own management personnel; this mode of governance is generally considered as the endpoint for the development of governance (Hess, 2010). The instrument is based on six recognized dimensions of professional governance which have been extrapolated from prior literature, namely, i) control over personnel, ii) access to information, iii) influence over resources supporting practice, iv) ability to participate in organizational decision-making, v) control over practice, and vi) ability to set goals and resolve conflicts (Hess, 1998; Hess, 2011) (Table 2).

Table 2. Elements of professional governance, consequent subscales in IPNG and definition (Original publication II).

Element	Subscale and number of items	Definition
Control over personnel	Personnel 22 items	Who has control over professional work in a formal organization and makes decisions concerning matters like recruitment, salaries, professional and career development, evaluation and disciplinary actions, and patient flows ?
Access to information	Information 15 Items	Who has access to information relevant to governance matters such as the organization's goals and objectives, strategic plans, budget, financial status, and information supporting professional practice and development ?
Influence over resources supporting practice	Resources 13 Items	Who selects, procures, and allocates resources, like nursing services, products used in nursing care and staffing levels that support professional practice ?

Ability to participate in organizational decisions	Participation 12 Items	Who creates and participates in governance activities on different levels ?
Control over practice	Practice 16 Items	Who controls professional practice and makes decisions about daily patient care assignments, patient flows, nursing care delivery models and incorporation of evidence-based practice ?
Ability to set goals and resolve conflict	Goals 8 Items	Who sets goals and engages in conflict-resolving negotiation at various organizational levels ?

The 86 items in IPNG were validated through a survey of 1100 nurses between 1993-1994 with the underlying aim of determining how nurses define governance (Hess, 1995). An overall governance score for the organization, along with scores for different levels of management, individual units, and departments, are generated through responses scored with a five-point Likert scale (Table 1 in original publication II). Higher scores indicate that personnel perceive a greater impact over professional practice and decision-making in their organization (Hess, 2010; Hess, 2011).

The instrument has been used to evaluate the existing situation (Clavelle et al., 2013; Mouro et al., 2013; Siller et al., 2016; Choi & Kim, 2019; Kaddourah et al., 2020; Khraisat et al., 2020; Choi, 2021; Hu et al., 2021) or to evaluate the effectiveness of an intervention (Barden et al., 2011; Bennett et al., 2012; Brull, 2015; Meyers & Costanzo, 2015; Dechairo-Marino et al., 2018; Di Fiore et al., 2018; Weaver et al., 2018). It has also been used to examine how different factors (education, experience, employment, setting, patient satisfaction, and RN satisfaction) influence perceptions of professional governance (Overcash et al., 2012; Gabel

Speroni et al, 2021a), and to compare international IPNG scores (Gabel Speroni et al., 2021b).

According to earlier literature, it is not always self-evident that the principles of a model have been adopted even though an organization has professional governance in place. The IPNG can be used to assess whether nurses truly feel that they are involved in professional decision-making (Weaver et al., 2018). The subscales of the instrument allow organizations to determine which areas require improvement and to develop tailored interventions to address these needs (Bennett et al., 2012; Dechairo-Marino et al., 2018). As interventions for enhancing empowerment take time and need supportive strategies and education (Brull, 2015; Kaddourah et al., 2020; Choi, 2021), using IPNG to measure progress can endorse the work (Barden et al., 2011; Meyers & Costanzo, 2015; Dechairo-Marino et al., 2018).

Previous research has demonstrated that professional governance interventions show significant effects on structural empowerment, job satisfaction and autonomy (Siller et al., 2016; Choi & Kim, 2019; Choi, 2021) and even an early implementation stage can increase empowerment (Barden et al., 2011; Meyers & Costanzo, 2015; Di Fiore et al., 2018). Moreover, several studies have reported that Magnet hospitals demonstrate higher IPNG scores than non-Magnet hospitals; suggesting that the work needed to obtain Magnet status furthers progress towards professional governance and healthy work environments (Bennett et al., 2012; Clavelle et al., 2013; Mouro et al., 2013; Gabel Speroni et al, 2021b; Hu et al., 2021).

2.4.4 Nurses' and nurse leaders' perceptions of professional governance

According to the earlier literature, nurses desire more involvement in decision-making than they are currently experiencing (Bina et al., 2014; Ugur et al., 2017). They have also need more control over nursing practice and patient care (Choi & Kim, 2019) and are energized when given the possibility to create processes to improve their work (Cox Sullivan et al.,

2017). Nurses show increased levels of active participation when activities are planned according to their professional needs and interests (Choi & Kim, 2019). Professional governance provides nurses the opportunity to express their perspectives; as a result, they feel validated and valued in being able to benefit patients and colleagues. Nurses are reported feeling more connected to the wider organization when they were given an opportunity to network with their colleagues (Quek et al., 2020), and disheartened and disempowered when their needs and aspirations are ignored (Dearmon et al., 2015).

Nurse leaders, on the other hand, want personnel to be and feel empowered, but without nurse leaders' active leadership. As such, their aim is to relinquish power and enable teams to make as many decisions as possible (Lindell Joseph & Bogue, 2018). Nurse leaders were found to understand nurses' needs to make decisions and improve care and recognized that nurses would need more active roles to enhance the empowerment of personnel (Cox Sullivan et al., 2017; Lindell Joseph & Bogue, 2018; Nurmeksela et al., 2021). Nurse leaders also felt that investments in developing and facilitating access to information, resources, support, and opportunities in the scope of professional governance would have implications for the participation of personnel (Underwood & Hayne, 2017).

Joint efforts between managers and personnel has been touted as the best way for establishing professional governance and visible employee empowerment (Guedes dos Santos et al., 2013; Lindell Joseph & Bogue, 2018). Moreover, nurse leaders, via their work as mentors or supporters, have a vital role in professional governance (Cox Sullivan et al., 2017; Underwood & Hayne, 2017; Choi & Kim, 2019; Quek et al., 2020; Choi 2021). Other researchers have highlighted how providing education and allowing new nurse leaders to arise from within an organization is important to the success of professional governance (Cox Sullivan et al., 2017; Quek et al., 2020). Moreover, increasing the visibility of councils and celebrating success have been identified as ways in which professional governance efforts can be endorsed (Cox Sullivan et al., 2017; Lindell Joseph & Bogue, 2018).

Nurses can sometimes experience less real involvement than what they would prefer (Scherb et al., 2011). This may be explained by heavy workloads among nurses, which leave little time or energy for governance activities (Cox Sullivan et al., 2017; Choi & Kim, 2019; Quek et al., 2020). Nurses have previously stated that they would like recognition for their work in professional governance (Choi & Kim, 2019; Cox Sullivan et al., 2017), and have requested adequate staffing levels to improve opportunities for participation in decision-making (Choi, 2021). The slow progression of projects, as well as the sheer amount of work involved, sometimes discourage participants (Quek et al., 2020); as such, introducing small projects with a high probability of success is recommended for nurses to feel accomplished and encourage further participation (Cox Sullivan et al., 2017). Some researchers have noted that inadequate time and understanding of the professional governance structure can hinder participation (Cox Sullivan et al., 2017; Quek et al., 2020). Bullying was also reported to be an obstacle for professional governance, with new nurses often experiencing this behavior when trying to suggest their own ideas (Choi & Kim, 2019). Nursing personnel must build a friendly, sustainable, and healthy work environment to ensure wider involvement and efficient communication (Moore & Wells, 2010; Latham et al., 2011).

2.5 SUMMARY OF THE LITERATURE REVIEW

In this thesis, the functioning of an organization is considered through the lens of quantum leadership, i.e., leadership is multidirectional, and leaders are collaborators who work together with personnel to strengthen the adaptability of the system. Furthermore, professional governance is considered based on the theory of structural empowerment highlighting the leader's responsibility for creating an organizational climate in which personnel are involved in the decision-making related to their work. Professional governance is defined as an organizational structure that legitimizes nurses' control over their work and extends their power to areas formerly controlled by management. The empowerment of personnel is realized through different decision-making structures, with

nurses convening to discuss matters related to their work. The whole organization, especially nurse leaders, are needed to support the work of the councils and ensure that council recommendations are aligned with the strategic plan of the organization. Over the years, the Magnet Model®, including the component of structural empowerment, has stimulated healthcare organizations to develop different professional governance models. It has been proven that professional governance significantly increases nurses' work engagement, professional accountability, empowerment, and autonomy. Effective professional governance has also been shown to lead to the positive patient outcomes. The findings of the literature review are summarized in Figure 2.

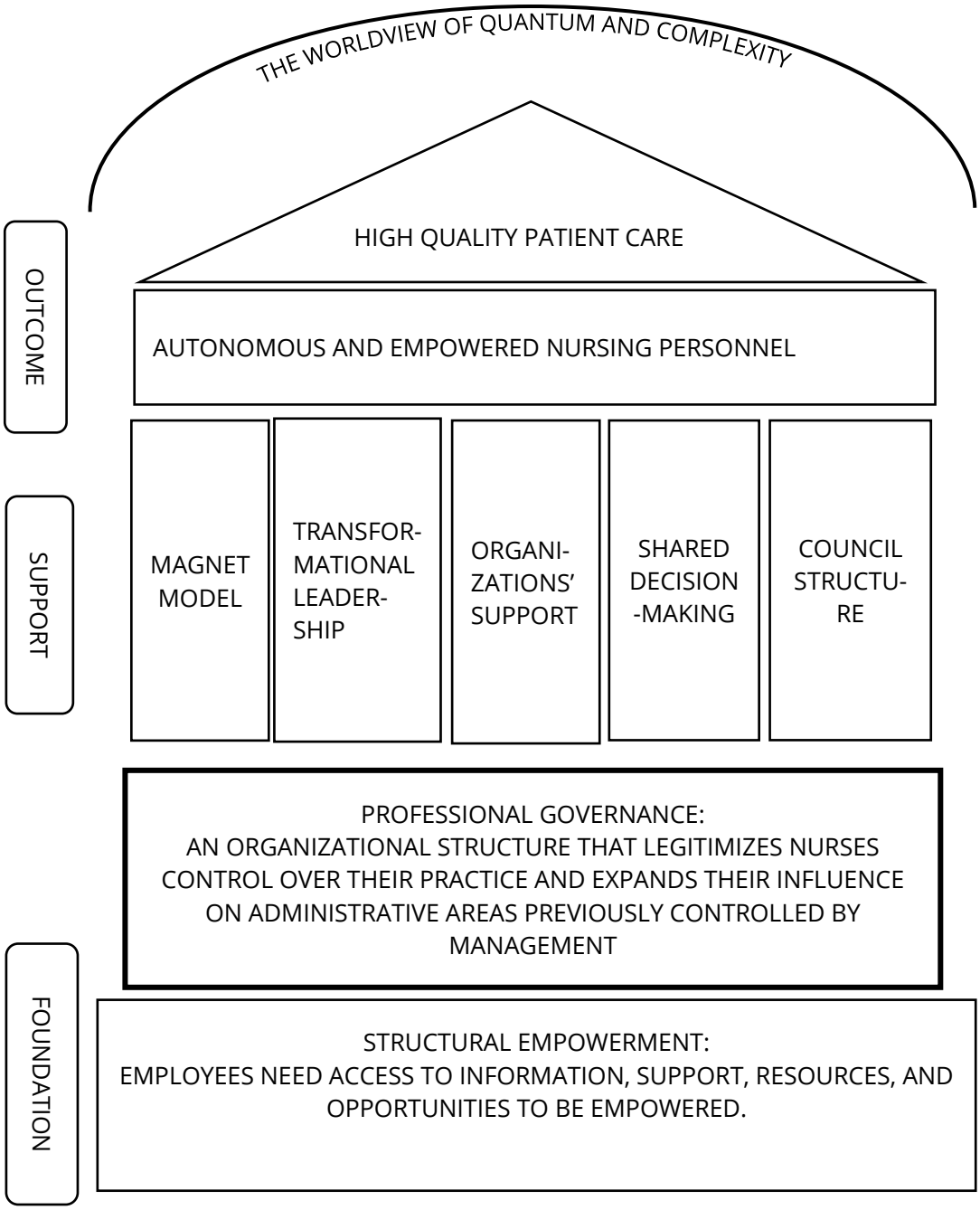

Figure 2. The theoretical and conceptual base of the thesis

3 AIMS OF THE STUDY

The aim of this study was to identify professional governance interventions and describe and assess the current state of professional governance in Finland with four substudies. The findings can help healthcare organization create and strengthen professional governance to empower nursing personnel.
The research presented in this thesis shared the following four objectives:

- To identify evidence-based interventions for strengthening professional governance and describe their outcomes (sub-study I)
- To translate and validate the Index of Professional Nursing Governance 2.0 for use in Finnish healthcare and to assess the state of professional nursing governance in Finland (sub-study II)
- To describe the structure of a professional governance council at one university hospital, along with the associated benefits, supportive and obstructive factors, and developmental needs (sub-study III)
- To describe nurses' experiences of working as members of unit practice councils (sub-study IV).

4 SUBJECTS AND METHODS

The research presented in this thesis applied both qualitative and quantitative descriptive designs. The data collection phases of the presented research included an integrative review, the modification of an instrument, along with a cross-sectional survey, an interview and document study, and an interview (Table 3).

Table 3. Methods of substudies

Sub-study, year, and design	Sample and setting	Data collection and time frame	Data analysis
Sub-study I 2020 An integrative review	12 studies were included.	Databases: CINAHL, PubMed, Scopus, PsycINFO, Business source, Cochrane, and Medic to studies published between January 2007 and May 2020	A qualitative synthesis.
Sub-study II 2016 Modification of the Index of Professional Nursing Governance and a cross-sectional study design.	419 nurses from five Finnish University Hospitals	The IPNG questionnaires were administered in February 2018.	Principal Component Analysis with Varimax rotation, the Pearson Chi-Square test and P values.
Sub-study III 2014	12 nurses in one Finnish university	Semi-structured interviews between April and August in 2014 and	Qualitative inductive

A qualitative descriptive interview and document study.	hospital and documents from 75 council meetings	documents from the council meetings 2009–2014	content analysis
Sub-study IV 2021 A descriptive qualitative interview study.	16 nurses in two clinics of a Finnish university hospital	In-depth interviews between February and April 2021.	Thematic analysis.

*IPNG: The Index of Professional Nursing Governance

4.1 SUB-STUDY I: INTEGRATIVE LITERATURE REVIEW

An integrative review was chosen to gather information about interventions aimed at creating or strengthening professional governance. Whittemore and Knafl's (2005) five-stage, integrative review method was employed to identify studies representing various study designs.

The review process

The first stage of the review process was problem identification; the research question and appropriate search terms were identified by going through a wide range of literature addressing professional governance. The second step of the review process was the systematic literature search; relevant databases were identified with the help of an experienced librarian and the sensitivity and specificity of the search terms were determined through test searches. Articles published between January 2007 and May 2020 were retrieved from seven databases. The search terms are presented in Table 4.

Table 4. The databases and search terms in the integrative literature search

Database	Search terms
English databases: CINAHL, PsycINFO, Business source, Cochrane, PubMed, Scopus	("shared leader*" OR "shared manage*" OR "shared governance" OR "participatory management" OR "shared decision making" OR "collaborative governance") AND (chang* OR improv* OR develop* OR enhanc* OR strenghten* OR reshap* OR challeng*) AND nurs*
Finnish database: Medic	("osallistav* joht*" OR "neuvosto*" OR "asiantuntija ryhm*") AND (kehitt* OR vahvist*) AND hoitot*

The initial search returned a total of 3305 studies. Following duplicate removal, two team members processed all of the titles and abstracts (using RefWorks) that met the inclusion criteria. The included studies were peer-reviewed and published in English or Finnish between January 2007 and May 2020 and had an abstract available. The inclusion and exclusion criteria are presented in Table 5.

Table 5. The inclusion and exclusion criteria in in the integrative literature search

Inclusion criteria	Exclusion criteria
Original studies that presented the outcomes of interventions aiming to strengthen professional governance	Studies, where interventions targeted strengthening patient participation
Developmental projects or programs if they aimed to improve the governance style of an organization towards a shared or participative approach.	Reviews

The outcomes had to be scientifically evaluated	
Involved only nurses, or nurses and other healthcare professionals, such as managers and assistants.	Studies involving patients
Different healthcare settings	

During eligibility screening, a total of four researchers read through 112 full-text articles; the process (Figure 1 in original publication I) yielded 21 articles that subsequently underwent quality evaluation.
Data evaluation is the third stage of the process; the quality of the studies was evaluated using appropriate Joanna Briggs Institute critical appraisal tools (The Joanna Briggs Institute, 2017). It was decided in advance to set the cut-off point for the inclusion of studies at 50 % of the total score; a total of 12 studies progressed to the analysis phase.

The fourth stage of the review process was data analysis; for the purposes of managing the data (Whittemore, & Knafl, 2005), convergent information from all of the identified studies was gathered in a matrix (Table 1 of original publication I). Next, the studies were carefully read through. Following data extracting and coding, the primary data were categorized into five subcategories, four main categories, and two core categories according to their goals and content. The last stage of Whittemore and Knafl's (2005) review method is presentation, a stage during which the conclusions of the review process are reported.

4.2 SUB-STUDY II: VALIDATION AND MODIFICATION OF THE INDEX OF PROFESSIONAL NURSING GOVERNANCE AND CROSS-SECTIONAL SURVEY

Instrument modification

The IPNG was translated and modified to fit the context of Finnish healthcare; it was subsequently utilized to evaluate the current state of professional governance in Finland. Permission to modify the IPNG was obtained from Dr. Hess in spring 2016. A back-translation method was used to ensure adequate comparability between the original and translated versions (Cha, Kim & Erlen, 2007). When making the instrument more culturally understandable, the structure of the original IPNG was modified to better adapt to the Finnish language. The final translated version comprised 86 items, which respondents answered using a five-point Likert scale: 1= totally disagree; 2= partly disagree; 3= do not agree or disagree; 4= partly agree; and 5= totally agree. This differed from the scale used in the original instrument (Table 2 in original publication II). Also, when comparing different versions of the instrument, the researchers made the decision to simplify the items of the instrument (Table 2 in original publication II). The researchers paid special attention to ensuring that each translation retained the meaning of the original version. In the final stage, the modified instrument was translated back to the original language for Dr. Hess to approve.

The modified instrument was pilot tested in 2017 with 20 clinical experts (women, average age of 45 years, over 20 years of experience) from one university hospital, who assessed the wording and concepts. According to the results, the statements were understandable, but the length of the instrument was criticized. The construct validity of the instrument was assessed by applying Principal Component Analysis with varimax rotation. The components all had eigenvalues over 1.0, with items loading onto only one component. The communality of every item exceeded 0.4 (Yong & Pearce, 2013), while Kaiser-Meyer-Olkin (KMO) values between 0.8 and 1 were considered adequate (Cerny & Kaiser, 1977). Bartlett's sphericity was used to test the hypothesis that the correlation matrix significantly differed

(at $P < 0.05$) from a corresponding matrix in which correlations between variables are all zero (Arsham & Lovric, 2011). The internal consistency of the instrument and subscales was regarded as acceptable if Cronbach's alpha $\geqq 0.70$ (Cerny & Kaiser, 1977).

Cross-sectional Survey

Chief Nursing Officers of five Finnish University Hospitals were informed about the study and its aims through emails in June 2017, after which they designated units in their organization to participate in the study. The IPNG questionnaire was administered to personnel in February 2018 via an email that contained relevant study information and a link to the questionnaire. A total of 419 participants completed the questionnaire, which reflected a satisfactory respondent to item ratio of nearly 5:1 for the PCA (Watson & Thompson, 2006). Frequencies and percentages were used to categorize and analyze general features of the sample. Differences between nurses' characteristics and governance scores were assessed using the Pearson Chi-squared test. Data were analyzed using SPSS Statistics 25 for Windows (IBM Corporation, Armonk, NY), with $P < 0.05$ set as the threshold for statistical significance.

4.3 SUB-STUDY III: INTERVIEW AND DOCUMENT ANALYSIS STUDY

In the spring of 2014, an interview and document analysis study was conducted to describe the level of development of professional governance in Finnish healthcare.

Setting

The study hospital is one of five university hospitals in Finland, with the population of 247,000 residents. The hospital is one of the largest academic teaching hospitals in Finland (Kuopio University Hospital, 2022). The work of professional governance councils within the hospital began in 2008, in collaboration with the affiliated university.

Participant recruitment

Experienced council members were recruited to participate through a contact person at the study hospital. The chairs of the councils were interviewed first, after which they proposed other members for further interviews (Hennink, Hutter & Bailey, 2020). The PhD student contacted all of the participants and conducted the interviews. Every professional who expressed interest in the research was sent a participant information sheet and consent form.

Data collection and analysis

The semi-structured interviews were performed face-to-face (n=12) between July 2014 January 2015. The themes of the interviews were: functioning of the existing councils; factors supporting or obstructing the councils; and benefits and developmental needs of professional governance within the study hospital. The interviews lasted an average of 30 minutes and were recorded and transcribed (73 pages) for subsequent analysis.

Further information was gathered by contacting the chairs of the councils and asking for relevant documents from council meetings, e.g., memos and minutes. The data consisted of memos from 75 meetings and amounted to 223 pages. The two data sets were combined and analyzed using inductive content analysis, which began with reading through the data (Vaismoradi, Turunen & Bondas, 2013). Any expressions that described council structures, the work of the councils, associated benefits, supportive and obstructive factors, and developmental needs, were extracted, reduced, and grouped based on their similarities and differences. The emerging categories were eventually reduced to main categories (Table 1 in original publication III) (Vaismoradi, Turunen & Bondas, 2013). To enhance the dependability of the analysis, the entire research group discussed the findings until a general agreement was reached. Original quotations were used to demonstrate the voices of the participants (Graneheim, Lindgren & Lundman, 2017).

4.4 SUB-STUDY IV: INTERVIEW STUDY

Nurses' personal experiences of working in a unit practice council (UPC) were explored in an interview study.

Setting

The research was performed in one of Finland's five university hospitals and encompassed two clinics at the hospital. The study hospital is Finland's largest hospital, and together with the affiliated university, it is the largest facility for educating and training Finnish health care personnel. There are 1,7 million residents within the hospital's catchment area (Helsinki University Hospital, 2022). The study hospital has improved and systematically evaluated nursing practices throughout the organization and is on the Magnet Journey®.

Method and participant recruitment

Two clinical nurse specialists served as contact persons recruiting participants by purposive sampling (Hennink, Hutter & Bailey, 2020). The contact persons sent potential participants an email with general information and a request to take part in the study, as well as reminders, between February and April 2021. Additional nurses were recruited via online meetings and by asking the participating nurses to invite their colleagues (Hennink, Hutter & Bailey, 2020). A participant information sheet and consent form were sent to those who were interested, and nurses were considered eligible if they were experienced members of either a unit practice council or unit-based workgroup.

Data collection and analysis

Online individual and focus-group interviews were conducted in spring 2021. The interviews lasted between 27 to 68 minutes and were recorded for the purposes of the analysis. Data saturation was reached after four individual and five focus group interviews (a total of 16 nurses) after which no new issues were identified (Hennink, Kaiser & Weber, 2019; Hennink, Hutter & Bailey, 2020).

Further information concerning participants' work in the group and their expectations of the group was gathered via open-ended questions in an e-mail questionnaire. The chairs of the councils also received an additional e-mail form with open-ended questions (Table 1 in original publication IV) concerning the aims and work practices of the group. The data were analyzed using a qualitative cyclical process of thematic data analysis by Hennink, Hutter & Bailey (2020). The process advanced in the following steps: 1) the transcribed audiotapes and texts from e-mail forms were combined, and the whole text was read thoroughly; 2) all of the data related to participants' accounts of working in a UPC were extracted and coded with descriptive codes; 3) comparison, categorization, and conceptualization of the data were carried out by organizing different codes (89) to 46 groups, resulting in the creation of seven sub-themes and two overarching themes; 4) the final analysis, and report was produced in co-operation with all authors. The credibility and transferability of the findings was strengthened by including participants with various lengths of work experience in a UPC. To enhance the dependability of the analysis, the whole research group discussed the findings until consensus was reached. Appropriate quotations were used to demonstrate the voices of the participants (Graneheim, Lindgren & Lundman, 2017).

4.5 ETHICAL CONSIDERATIONS

Research approvals

All sub-studies covered in this thesis adhered to the ethical principles for research presented by the Finnish National Board on Research Integrity (TENK) (TENK, 2019). For the survey study (sub-study II), an ethical statement was received from the research ethics committee of the Northern Savo Hospital District (285/2016); moreover, study permission was received from each study organization according to their protocols. For the interview studies (sub-study III and IV), approval was sought solely from the study organizations (285/2016, HUS/14/2020), as Finnish research ethical legislation does not demand an ethical statement for interview

studies that only involve personnel and cause no harm or privacy and confidentialty risks.

Participant involvement

Participation in the studies was voluntary, and all participants received both written and oral information. The information provided to participants contained researchers' contact information and a clear explanation of every participant's right to withdraw from the study. All participants in the interview studies signed their written consent before the interview. The themes in the interview studies revolved around nurses' everyday work and the information was not considered sensitive. The only detrimental issue was the time that nurses needed to participate in the study. In the survey study, completing the online questionnaire was considered as giving informed consent. No participants withdrew their data (TENK 2019).

Confidentiality

Research data were stored and protected according to the General Data Protection Regulation (EU, 2016). In the survey study (sub-study II), the link to the questionnaire was sent by a contact person and the responses were anonymous. In the interview studies (sub-study III and IV), the participants were contacted through email and those interested in taking part in the study continued corresponding with the researcher via email. Their email addresses and names were deleted from the PhD student's email inbox after the interview. The signed consent forms, which included personal information, the transcribed interviews, and other data were kept on an external hard drive protected with a password. When the data were analyzed, all names were removed, and the interview participants were given codes for identification. The researcher had the master list including coding key in a separate, secured location. The study results and reports contained no personal information.

5 RESULTS

5.1 PARTICIPANT CHARACTERISTICS

The articles identified in sub-study I were mostly from the United States (75 %) and were published between 2010–2020. The majority of the articles employed quasi-experimental, before-and-after designs, either with a control group (2 studies) or without a control group (8 studies). Furthermore, one quasi-experimental article only included post-test measurements, while one of the identified studies was qualitative. The identified articles included a total of 2547 participants (14–460 participants per a study), most of whom were women with a bachelor's degree. The data were collected using different tools, along with interviews. Descriptive statistics, Pearson correlation coefficient, and/or T-tests were employed to analyze the data. Most of the included articles showed medium methodological quality (Original publication I).

The survey study (Sub-study II) included a total of 419 nurses, more specifically, 92 nurse managers and experts, 298 registered nurses, and 29 practical nurses and nursing assistants. They represented five Finnish university hospitals and were predominantly women (93%) who worked as nurses, nurse leaders, clinical specialists, or in other roles (Table 3 in original publication II).

The first interview study (Sub-study III) involved a total of 12 registered nurses. They worked as nurses, nurse leaders, clinical specialists or as professors, either in the study hospital or the affiliated university (Original publication III). The second interview study (Sub-study IV) comprised 16 nurses (14 registered nurses and two practical nurses, 94% female). All of the participants worked in the study hospital and had been members of councils for a range of two months to over five years (Original publication IV).

5.2 INTERVENTIONS FOR STRENGTHENING PROFESSIONAL GOVERNANCE IN NURSING

The review identified two categories of interventions: interventions to enhance structural empowerment (n = 6); and interventions to reinforce leadership and teamwork (n = 6) (Figures 2 and 3 in original publication I).

Interventions to enhance structural empowerment

Interventions aiming to enhance structural empowerment were divided into two subcategories: creating new structure(s) (n = 5); and evaluating existing structure (n = 1). Regarding the first subcategory, five interventions aimed to enhance the empowerment of personnel, increase the possibilities for participating in decision-making, and strengthen the existing professional governance councils by creating new council structures throughout the organization. The creation of new structures was supported by the provision of different kinds of education or orientation, increasing library access, nurse leaders' support in planning and problem-solving, using videoconferencing to facilitate participation, and securing paid council time. Of these five interventions, three were found to increase the ability of personnel to participate in decision-making (Brull, 2015; Dechairo-Marino et al., 2018; Olender, Capitulo & Nelson, 2020), while two interventions (Moore & Wells, 2010; Meyers, & Costanzo, 2015) reported no change in involvement or empowerment. In the second subcategory, one study (Di Fiore et al., 2018) evaluated existing professional governance and compared it with base-line measurements. No significant changes were reported. All of the studies in this main category were single-center, quasi-experimental studies, with most lacking a control group and demonstrating low-quality evidence.

Interventions to reinforce leadership and teamwork

Interventions with a focus on reinforcing leadership and teamwork were divided into two subcategories according to the content of the intervention: enhancing teamwork (n = 3); and enhancing leadership skills (n = 3). In the first subcategory, three interventions (Latham, Ringl & Hogan,

2011; Adams, Hollingsworth & Osman, 2019; Shiao et al., 2019) aimed at enhancing teamwork. The interventions consisted of practical tools for expressing gratitude and giving suggestions, a mentoring program between professionals and new graduates, and workshops to increase collaboration. The interventions demonstrated positive impacts on exhaustion and disengagement, and they resulted in improved teamwork and conflict management. All of the studies in this subcategory were quasi-experimental, and one study included a control group (Shiao et al., 2019). Each of the studies had a theoretical basis, yet the interventions were new, and the quality of evidence was moderate.

The second subcategory included three interventions (Martin et al., 2012; Lavoie-Tremblay et al., 2018; Moreno, & Girard, 2019) aimed at reinforcing leadership skills among nurse leaders. These interventions utilized succession planning frameworks and two international programs (Teachers Collaborating Across Borders and the Clinical Leadership Programme). All interventions in this subcategory yielded positive results in terms of broadening the participants' views and increasing leadership skills. All of these interventions were based on theory, but the overall quality of evidence was weak because the research used non-validated tools and content analysis to analyse the data.

5.3 THE VALIDATION AND MODIFICATION OF THE INDEX OF PROFESSIONAL NURSING GOVERNANCE 2.0 AND THE STATE OF PROFESSIONAL GOVERNANCE IN FINLAND

Validity and reliability of the translated instrument

The principal component analysis was constrained to six components, labelled according to the original instrument (Table 4 in original publication II). All of the items demonstrated loadings between 0.309 and 0.748 and loaded onto only one factor. Some items in the translated IPNG blended between the components when compared to the corresponding subscales in the original instrument. The Cronbach alpha coefficient for the overall translated scale was 0.97, while the corresponding subscales showed

values between 0.87 and 0.93; the KMO value was 0.94 (Table 5 in original publication II).

Nurses' perceptions of professional governance

The overall score for governance, 203.6 (range 86-430), means that the participating nurses felt that they had some input in decision-making at the organization, but that this was still largely run by the administration. All but one subscale (Personnel) achieved the range of shared governance (173-344) (Table 4 in original publication II). Moreover, at least half (49–58 %) of the participants felt that the governance mode had not yet achieved the level of shared governance, and that the staff only had a minor role in decision-making. A significant relationship between the governance score and work position was detected by a Pearson Chi-squared test (df 6; X^2 = 23.78; $p>0.05$). This means that nurse leaders and experts were prone to answer that nursing personnel are able to make decisions about their work, with the administration having a less significant role in this aspect of decision-making (Table 7 in original publication II).

5.4 PROFESSIONAL GOVERNANCE AT ONE FINNISH UNIVERSITY HOSPITAL

The results of the interviews and document analysis revealed four themes and 12 categories which described council structures, the associated benefits, supportive and obstructive factors, and developmental needs (Table 6).

Table 6. The sub-categories, categories, and themes of the data describing council structure, its benefits, supportive and obstructive factors, and developmental needs.

Sub-category	Category	Theme
Finding members	Members	Council structures and processes
Electing members		
Advertising		
Discussion	Reaching decisions	
Voting		
Education	Matters discussed	
Mapping the needs of the units		
Developing EBP		
Collaboration between councils		
Evaluating the work of the councils	The integration of the functioning of the councils	
Planning the work of the councils		
Working together		

Enthusiastic personnel	Factors supporting the work	The factors supporting and obstructing the work of the councils
Support from the leaders		
Lack of time	Factors obstructing the work	
Lack of understanding		
Lack of skills		
Resistance of change		
Unifying of practices	Benefits to the organization	The benefits of councils as part of professional governance
Networking of the personnel		
Improving of the image		
Support to the decision making		
Improvement of the quality of care		
Making the work of the nurses visible	Benefits to nursing care	
A chance to offer input		
Improving expertise		

Benefitting one's career	Benefits to personnel	
Popularizing the councils	More visibility	Developmental needs of councils
Expanding the councils		
More support	Support and education	
Education needed		
Developing nursing	Sharpening the work	
Implementing decisions		
Sharpening the work		

Council structures and processes

At the time of the interview, there were four formal professional governance councils in the organization, not all of which were active (Figure 1 in original publication III). A professor or a university researcher from the affiliated university supported the councils by acting as chairperson, with nurses as members. The councils seldom met, and mainly dealt with organizing different educational opportunities, discussing issues about the rotation of council members, as well as promoting evidence-based nursing and student guidance. The meeting breifs of the council meetings were published in an Evidence-Based News bulletin.

Factors supporting and obstructing the work of the councils

The analysis revealed that three factors supported the work of councils whereas four factors were obstructions to council work. Strong support from nurse leaders and clinical experts was considered vital for the functioning of councils. The organization supported the councils by offering educational opportunities and adding the development of evidence-based nursing into the organization's strategy. The main obstructing factor was a lack of time. The concept of evidence-based nursing was unfamiliar to personnel, who lacked the skills to locate and adapt information needed to develop their work.

Professional governance-related benefits of councils

The nurses felt that the councils need more visibility, i.e., personnel need more information about the work of the councils. This could be achieved by improving the members' skills at disseminating information. Nurses also felt that the councils should produce more concrete results, possibly through enhancing the working methods and/or focusing on solving units' everyday problems. In addition, participants felt that the work of the councils could be optimized by allowing non-nurses to become members, receiving more guidance from nurse leaders, and gaining access to the latest research articles. Nurses also felt that nurse leaders should advance shared decision-making and take part in the council meetings.

Developmental needs of councils

The nurses felt that the councils need more visibility and publicizing skills for the members. More information of the work of the councils was also needed. Nurses felt that councils should produce more concrete results through enhancing the work methods and by focusing on solving units' everyday problems. Opening the councils to non-nurses, more guidance from nurse leaders and easily accessible research articles are needed to optimize the work. Nurses also felt that nurse leaders should advance shared decision-making and allow taking part in the council meetings.

5.5 NURSES' EXPERIENCES OF UNIT PRACTICE COUNCIL MEMBERSHIP

The results revealed two themes describing nurses' experiences of unit council membership: inchoate unit practice councils with limited working time; and evolving Magnet projects at the organization partly empower nurses. A total of five sub-themes were also identified (Figure 1 in original publication IV).

Inchoate unit practice councils with limited working time

The units at the study hospitals had various council structures, namely, either ”expert workgroups” or ”areas of responsibility”, or then a combination of both. Some nurses reported that nurse leaders had directed the development, while others felt that they could freely establish different work groups. The councils were open to all personnel and created with the aim of developing the work of the unit, increasing the use of evidence-based practice, and providing opportunities to take part in unit decision-making. Most of the nurses agreed that the professional governance design at the organization was undefined and did not realize that they could have an impact on the organization by participating in councils. Nurses reported that the work of the councils received insufficient support, and they would have wanted some guidance. No official education was available, but ex-members and clinical experts were reported to have provided support.

Nurses lacked basic meeting running skills, like keeping minutes, chairing the meeting, as well as group-based and project work skills. After discussions and achieving consensus, the desicions were shared with the nurse leaders for approval. Most of the decisions were positively received but were sometimes also reported to cause stress. The participating nurses felt that the councils were afforded adequate resources, e.g., devices and locations, but sufficient time for the work was seen as a problem. Because nurses work in shifts, it was difficult to find time for the councils to convene; for this reason, the nurses expressed a desire that the nurse leaders would schedule a time for the councils. The responses revealed

that nurse leaders did support the work of the councils, but this was more through the drafting of work plans rather than allotting enough time for council work and exuding general enthusiasm. It was reported that colleagues were positive and respectful about the work of the councils. Nevertheless, nurses wanted more colleagues to join the councils, and expressed a hope for more interactions with other councils.

Evolving Magnet projects at the organization partly empower nurses
Nurses reported joining councils to learn new things, to participate, and develop their work with colleagues. They wanted to be active, share their work experience, and have their opinions about changes within a unit heard. Some of the nurses had previous experience with groups, projects, or post-graduate studies. The nurses generally felt confident working in the councils. The work of the councils concentrated on everyday nursing issues and the information needed for the decision-making was retrieved from the organization's web pages, practical know-how, or literature. Only a few nurses used the Internet when searching for new information. Nurses felt that they were involved in the decision-making of councils, but that the issues were limited to small, everyday matters instead of wider organizational topics. Some of the nurses would have wanted more extensive decision-making power but did not know how to gain it and doubted their know-how. Nurses felt that being a council member was rewarding, improved their professional abilities, and expanded their perspectives and job description. Information related to the progress of a Magnet project at the organization was reportedly hard to find, and the concepts were unfamiliar, which sometimes caused irritation. Nevertheless, the participating nurses felt that the Magnet project was linked with positive effects as it created more transparent and accessible decision-making processes.

5.6 SUMMARY OF THE RESULTS

A total of three interventions that aimed to establish new decision-making structures within an organization led to an increase in the ability of

personnel to engage in decision-making. Furthermore, six interventions that utilized practical tools, a mentoring program, succession planning, and workshops to reinforce leadership and teamwork decreased exhaustion and disengagement, improved conflict management, and increased leadership skills.

The modified IPNG 2.0 presented in this thesis demonstrated adequate reliability and validity for use in Finnish healthcare. Based on the results from this instrument, approximately half of the personnel felt that they were able to make decisions about their work, while a third of the personnel felt that the management made these decisions for them.

Nurse leaders' support was considered vital for the professional governance councils, with insufficient time for council work identified as the main obstructing factor. Participation in councils increased a nurse's ability to report problems witnessed during bedside care, and thus strengthened the quality and safety of patient care. However, the councils need more transparency, and personnel should be more aware of their ability to participate in these councils. The work of councils can be optimized by opening the councils to non-nurses, more guidance from nurse leaders, and better access to the latest research.

Nurses reported that organizations can include diverse councils or work groups that are, in some instances, characterized by unorganized working practices. The work groups can transform into effective professional governance councils by the provision of thorough education and the creation of common guidelines.

6 DISCUSSION

6.1 DISCUSSION OF THE MAIN RESULTS

The research underlying this thesis was conducted with the purpose of identifying professional governance interventions and describing the current state of professional governance in Finland. The results presented in the four appended articles provide unique and novel insight into professional governance in Finland, even in Europe. As such, this thesis plays an important role in broadening research into the Magnet hospital model across Europe.

6.1.1 Interventions for strengthening professional governance in nursing

Many organizations have turned to professional governance in a bid to create healthy and engaging work environments for nursing personnel. This should not be considered any arbitrary development, as the concept of professional governance has been shown to exert benefits numerous times over a history of nearly 40 years (Goedhart, Van Oostveen & Vermeulen, 2017; Hess, 2017; Weaver et al., 2018 ; Porter O'Grady & Clavelle, 2021). Some hospitals have been developing professional governance structures for decades, and these efforts need updating from time to time. Evaluating different strategies for improving the work environment is vital to the adoption of effective interventions (Twigg & McCullough, 2014).

The complexity view of organizations highlights how day-to-day work occurs via nonlinear networks and relationships through which people try to interact each other within different local social contexts (Uhl-Bien, Meyer & Smith, 2020). If no leadership is allocated, the actions may not be congruous or homogeneous enough to result in adaptive processes (Porter-O'Grady, 2020). Professional governance was developed with the original purpose of supporting organizations in enhancing distributive

decision-making through the creation of structures for nursing personnel to convene and discuss matters (Porter O'Grady & Clavelle, 2021). Building a comprehensive council structure, i.e., councils across every level of the organization with invitations to join extended to all members of the care team, will assure positive interprofessional practices and relationships across the organization (Shiao et al., 2019; Porter-O'Grady et al., 2022). The existence of such councils also advances structural empowerment in that personnel feel supported to enhance their knowledge and skills, as well as be involved in decision-making related to their own work (Porter-O'Grady, 2019).

The mere existence of a council structure does not guarantee successful professional governance. Adequate resources and support are needed, and personnel must be encouraged to participate (Porter-O'Grady et al., 2022). As such, nurse leaders, via their role as mentors or supporters, are vital to successful professional governance (Quek et al., 2020; Choi, 2021). Professional governance, along with the proactivity of managers, is related to contemporary leadership, which does not focus on any particular person, degree, competency, or approach (Porter-O'Grady, 2020), but rather recognizes the complexity of the organizational context and the need for adaptive responses (Porter-O'Grady, 2020; Uhl-Bien, Meyer & Smith, 2020). This highlights the need for collective processes, and the need to amplify the adaptability of both teams and leaders by encouraging partnerships, cooperation, coordination, and distributive decision-making (Shiao et al., 2019).

6.1.2 The state of professional governance in Finnish specialized health care

As previously noted, professional governance has been strongly linked with certain benefits, yet has not been extensively applied in the Nordic countries (Nurmeksela et al., 2021). Some Finnish university hospitals are now pursuing Magnet status and shifting the leadership style towards empowerment through various interventions (Kvist et al., 2019). However, interventions take time to provide noticeable changes, and resources and

evaluations are important to their success. For this reason, it was critical to have an instrument that was suited for the context of Finnish health care. The decision was made to translate a well-established and tested instrument from English and validate it for use in the Finnish healthcare context (Epstein, Miyuki Santo & Guillemin, 2015). The chosen instrument, IPNG, has previously been successfully translated to several languages (Forum for Shared Governance, 2022), and the results of the cross-cultural validation to Finnish demonstrated that the instrument has suitable psychometric properties for use in the Finnish healthcare setting.

Over the years, the issue of empowerment has become contentious as some researchers doubt whether this concept can truly be measured (Porter-O'Grady et al., 2022). The IPNG draws upon Kanter's (1977, 1993) theory of structural empowerment and measures the ability of personnel to take part in, or have access to, six empowering dimensions (Hess, 2011). An overall IPNG governance score that is within the professional governance range (173–344) signifies that nursing personnel feel that they can influence decisions over their work. The overall governance score obtained with the Finnish IPNG, when applied to five Finnish university hospitals, was 203.6. The score is high when considering that only two of the five study hospitals were known to advance professional governance. A similar result was reported by Hu et al. (2021) in that IPNG results from a non-Magnet hospital reached the professional governance range due to the effective implementation of a professional governance model. The result is positive for Finnish healthcare as a whole, and especially relevant for the study hospitals, some of which are working hard to empower personnel. Empowered personnel perform efficiently and demonstrate positive organizational and individual well-being (Fragkos, Makrykosta & Frangos, 2020; Al-Hammouri, Rababah & Ta'an, 2021), something which is very valuable for healthcare organizations that are competing for employees.

A third of the participants felt that the organization was still characterized by a traditional governance style, and a significant interaction between governance score and work position was noted. This can be explained by some units or divisions being more developed and

differences in perspectives between different groups of personnel, i.e., current position and experience (Choi, 2021). Organizations need nurse leaders and experts to have strong confidence in that an intervention will transform the work environment and establish effective professional governance (Choi, 2021; Hess, 2011).

The personnel-related aspect of professional governance was not in the professional governance range and it has previously been reported difficult to establish (Dechairo-Marino, 2018; Hu et al., 2021). Managers, unions, and different laws govern over matters such as salaries, budgets, benefits, recruitment, and the evaluation of personnel; for this reason, it can be difficult to include personnel in all desicion-making (Dechairo-Marino et al., 2018). Each group of personnel has their own accountabilities: managers are responsible for leveraging resources to enable high-quality practices, while nurses are responsible for delivering care to individuals, families, and communities. Nevertheless, a degree of collaboration can exist in decision-making through constant open interaction and discussion (Porter O'Grady & Clavelle, 2021).

6.1.3 The characteristics of professional governance in Finnish healthcare

Professional governance is ultimately a structure providing a context for the nursing personnel to come together and make decisions over their work as practicing professionals(Porter-O'Grady & Clavelle, 2020). Earlier literature has reported a strong link between a decentralized organizational structure, in which nurses and nurse managers extensively cooperate, and nurse's capability to convey their worries and participate to shared decision-making (Bianchi et al., 2018; Twigg & McCullough, 2014). The form and functioning of these structures may vary within an organization, as well as between organizations, but should accommodate the needs of an organization and/or unit (Porter-O'Grady & Clavelle, 2020).

The participants felt, as has been described in earlier research, that there would be no professional governance councils without nurse leaders' strong leadership in the organization (Meyers and Costanzo, 2015; Lindell

Joseph and Bogue, 2018). Numerous studies have highlighted how nurse leaders play an essential part in advancing nursing and improving the work environment (for example, Al-Ruzzieh, Ayaad & Hess, 2022; Porter-O'Grady, et al., 2022). Transformational nurse leaders are tasked with creating and supporting distributive structures and processes for the governance of nursing practice (Porter-O'Grady & Clavelle, 2020). The results presented in this thesis showed that the councils work in a hierarchical manner, as chairs are usually professors or university researchers, with the nursing personnel as members. Nurse leaders and managers are expected to outline the council work by overseeing accordance to organizational aims, finances, and policies (Porter-O'Grady & Clavelle, 2020). On the other hand, after the structure is in place, nurse leaders should act as mentors or supporters (Quek et al., 2020; Choi, 2021), leaving the chairperson and decision-making roles to practicing nurses.

Most of the participants felt that they could not allocate enough time for council work. They found it hard to step away from the busy nursing work and reported that some of their colleagues failed to comprehend the importance of the councils. Earlier research corroborates that a general lack of time and not sufficiently understanding the value of professional governance councils can obstruct their effectiveness (Quek et al., 2020; Bartmess, Myers & Thomas, 2022). This affected the motivation and ability of personnel to express ideas beneficial to patient care and the organization (Quek et al., 2020). Leadership in today's complex organizations needs to be a joint effort between people who want to find ways to solve day-to-day problems (Uhl-Bien, Meyer & Smith, 2020). Nurses' experience and professional knowledge is vital for the ability of an organization to adapt to new pressures; for this reason, nurses should be supported to participate in professional governance councils (Choi, 2021).

Even inchoate councils were found to improve the quality of care, coordinate nursing practices, and inform decision-making. Moreover, the existence of councils was found to strengthen the position of nurses, the visibility of pertinent research topics, and the dissemination of information throughout an organization. The results covered in this thesis suggest that the whole organization is supported by the team spirit of the personnel.

The work of professional governance councils clearly improves the work environment by enhancing nurses' sense of community and by strengthening their abilities to express opinions (Bartmess, Myers & Thomas, 2022).

6.1.4 Nurses' experiences of unit practice council membership

Nurses are the largest group of healthcare workers (WHO, 2021) and occupy a central position when it comes to providing patient care (Hamad & Kehyayan, 2018). Their expertise is critical to healthcare organizations, and professional governance enables them to implement ownership and accountability over their work and nursing knowledge (Porter-O'Grady & Clavelle, 2021). The study organization had created an inclusive professional governance structure to enhance shared decision-making within units and to promote nurses' professional autonomy. Professional governance increases employee engagement by enabling communication, collaboration, transdisciplinary relationships, and distributive decision-making (Quek et al., 2020; Porter-O'Grady, et al., 2022).

The results presented in this thesis indicate that the unit practice councils in the study organization still need strengthening. The councils or workgroups were somewhat unorganized, and the personnel failed to see them as a part of the organization's formal decision-making structure. These councils are at the heart of professional governance. From the viewpoint of complexity leadership, the councils create a time and place for the emergence of an adaptive space. The collective dialog in this adaptive space may reveal new ideas for advancing nursing care and quality patient outcomes (Hamad & Kehyayan, 2018; Uhl-Bien, Meyer & Smith, 2020). Nurses want to develop their own work and nursing care (Al-Ruzzieh, Ayaad & Hess, 2022), and an organizational structure which includes councils enables them to do that (Porter-O'Grady & Clavelle, 2020).

The nurses felt that they were able to exercise their power within the workgroups, while insufficient support and time was seen as a problem. Without support from nurse leaders, professional governance cannot reach the aims of improved participation and a better work environment

(Porter-O'Grady, et al., 2022). In complex, adaptive healthcare organizations, leadership is seen as a collective process (Uhl-Bien, Meyer & Smith, 2020), and the role of the leader is to guide the needed actions to obtain the planned result (Porter-O'Grady, 2020). In the scope of professional governance, nurses should be able to demonstrate individual and collective content accountability by defining their professional practice and standards; otherwise, nurses will remain in the strictly defined role of employees, with no way to develop their work (Porter-O'Grady, 2019).

The research presented in this thesis was performed during the Covid 19 pandemic, which must have influenced the results (Hess, Weaver & Gabel Speroni, 2020). Many council meetings and educational events were canceled, which made it very difficult to focus on professional governance. Even so, nurses have continued to coordinate and facilitate the delivery of patient care in the demanding situations that can occur during a pandemic. Their recilience has shown the value of including nurses in critical decision-making. Professional governance, if successful, can create a sense of professional community that supports the generation of solutions and partnerships that will ultimately benefit patient care (Porter-O'Grady & Pappas, 2022).

6.2 STRENGTHS AND LIMITATIONS

The research underlying this thesis has several strengths and limitations. In each research phase, an adequate methodology and suitable statistical analyses were employed. Moreover, the results were reported according to international reporting guidelines. The research process also involved strong collaboration between research group members to minimize the PhD student's subjective influence on the results and to enhance confirmability (Jensen 2008).

A widely used integrative review method (Whittemore & Knafl 2005) was utilized in the literature review of sub-study I. To enhance methodological robustness, appropriate databases for the topic were identified and the search terms were created with an information specialist. Moreover, two researchers independently conducted the systematic literature searches

and evaluated the quality of the identified papers using a critical appraisal tool. The results were critically synthesized to obtain an overview of the diversity of interventions that had been used to strengthen professional governance. The included studies were judged to demonstrate moderate methodological quality.

A questionnaire was utilized in sub-study II. The questionnaire was pretested, with any necessary changes made after this phase. The internal consistency and usability of the modified Finnish version of the IPNG (sub-study II) was tested, with the results showing high levels of consistency. The study was characterized by a small sample size, which could be explained by the overwhelming number of various questionnaires that the personnel in university hospitals often tackle. The PCA results were satisfactory (Watson & Thompson, 2006), and all of the necessary statistical measures were executed. Only 0.72 % of values for the professional governance-related items of the instrument were missing, so no imputation of missing values was needed.

The strengths of the qualitative research presented in this thesis are predominantly related to the fact that the results provide a contextualized description of participants' experiences of the continuously developing issue of professional governance in Finnish healthcare. The credibility of data collection was enhanced by the creation of a semi-structured interview guide to regulate the process (sub-study III). New participants were interviewed until data saturation was reached, and the accounts were recursive from the first interviews (Fain 2015). To establish confidence in the accuracy of the data, the interviews were recorded, transcribed, and verified by the first supervisor. To enhance the transferability of the results, the research methodology, results, limitations, and recommendations were clearly reported (Polit & Beck 2017). The data were conceptualized to understand the comprehensive significance of what is being expressed and what this means from theoretical perspective and across different contexts. In addition, it is noteworthy that the PhD student had experience in nursing governance, as well as in using qualitative research methods from their master's degree studies (Polit & Beck 2017).

The two interview studies (sub-study III and IV) showed small sample sizes, but the data were rich because the participants reported their lived, first-hand experiences of work in professional governance councils. The first interview-study (sub-study III) recruited participants via snowball sampling, which may have introduced bias by eliminating nurses with more critical opinions of professional governance. The second interview-study (sub-study IV) only included participants from two clinics, which may have influenced the results. Both of these studies focused on professional governance councils in the Finnish healthcare context, which may complicate the transferability of results to other contexts. Also, it should be noted that the sub-study IV was carried out during the Covid 19 pandemic. This clearly restricted the work of councils and may have influenced the findings. Despite the noted limitations, the interview studies contributed new perspectives to the existing literature, mainly by illustrating current state of professional governance and how this has been implemented in Nordic nursing.

6.3 IMPLICATIONS FOR NURSES AND NURSE LEADERS

Nurse leaders are responsible for sustaining the well-being of nursing personnel by, for example, creating healthy work environments. However, they cannot achieve this alone, as leadership requires effort but also benefits both parties. Nurse leaders have been reported to recognize the importance of empowering nurses in decision-making by letting go of traditional management styles and acting as facilitators. Nurses, on the other hand, have been found to desire more decision-making power over their work than what they have traditionally been allotted. When considering the current shortage of educated healthcare professionals, personnel on different organizational levels must respect the professional autonomy of others by working together towards constructive decision-making. Collaboration between nurse leaders and nurses can be expected to increase the attractiveness of nursing as a profession.

Using professional governance to enhance the involvement of personnel in decision-making will improve the overall standard of care.

Personnel need safe venues in which to convene and make decisions over their work; a comprehensive professional governance council structure will enable this. A mere change in decision-making structure cannot be expected to noticeably shift the distribution of authority or nurses' control over practice. Instead, this change needs to be combined with different educational opportunities to enhance leadership skills, efficient communication, and awareness towards professional governance. Increasing council work time and accessibility via the development of appropriate digital environments could facilitate progress. Resources, such as webpages, with clear instructions will make it easier to get started, while bylaws will standardize the work.

The establishment of professional governance is an ongoing process that requires strong support throughout the organization. It has been shown that even an incomplete professional governance model can enhance the quality of care, coordinate nursing practices, and inform decision-making. The current progress towards empowerment clearly needs further support, which should rely on tailored interventions. It is vital that nurse leaders continue to manage on the strategic level to strengthen structural empowerment and pave the way for professional governance. Moreover, professional governance councils should be given official status in organizational decision-making and should be developed to take a clearly interprofessional stance. Personnel who want to take part in the work of these councils should feel that they are supported in their aspirations. Celebrating achievements of the councils and highlighting the outcomes could motivate personnel and justify the sacrifice of stepping away from the bedside.

6.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The result of this study highlighted that further research is necessary to increase our understanding of professional governance in healthcare setting and find innovative ways for successful development. These research needs include:

1) How can interventions be leveraged to further strengthen the professional governance structure. In the future, the context in which an intervention occurs should be distinctly described to facilitate repeatability. This includes using robust methodologies for evaluating the effects of interventions, which should also be clearly reported.
2) The translated and validated IPNG 2.0 instrument requires more research, such as a test-retest procedure to verify the reliability, as well as a re-examination of internal consistency and usability with more representative sample.
3) There is also a shorter version (IPNG 3.0) of the instrument, and further assessment is warranted to determine the potential value of translating it for recurring evaluations.
4) Longitudinal research on professional governance in Finland would benefit researchers' attempts to track progress in the field, clarify the impacts on nursing, and guide further development.
5) International comparative research about different decision-making structures and work practices is needed to provide insight concerning how existing designs can be reformed.

7 CONCLUSIONS

The results presented in this thesis provide encouraging evidence that certain interventions can strengthen existing professional governance structures, increase transformational leadership, and/or fortify collaboration within and between different teams. Publishing the recommendations of future research is always desirable to further the implementation of professional governance in Nordic countries, as well as on a global level. However, high-quality reporting and appropriate methodology are warranted.

A valid and tested instrument, e.g., the Index of Professional Nursing Governance, can be used to measure the level of professional governance in different units as well as across organizational levels. Furthermore, the instrument can be used to follow the progress of professional governance implementation and the overall effectiveness of the process.

The results discussed in this thesis clearly indicate that professional governance is progressing in Finnish healthcare. However, decision-makers must keep in mind that it is crucial to listen to the voices of personnel when designing the next steps. Different educational programs which promote leadership skills, as well as enhance communication and knowledge of professional governance among personnel, may support the advancement of professional governance in Nordic healthcare settings. Lastly, it is important to provide personnel with sufficient practice council time, as well as ensure accessibility through various digital environments.

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APPENDICES

APPENDIX 1. SUMMARY OF THE STUDIES INCLUDED IN THE REVIEW

Author, Year, Country	Goals	Setting and participants	Methods and measurement tools	Outcomes	Quality appraisal
Crossectional studies					
Abd-EL Aliem & Abou Hashish, 2021. Saudi Arabia	To determine the relationship between transformational leadership practices of first-line nurse managers and nurses' organizational resilience and job involvement.	72 nurses a University Hospital in Saudi Arabia	Survey research study The Leadership Practices Inventory, The Organizational Resilience Questionnaire, the Job Involvement Questionnaire	The results show the need for managerial caring to promote the development of nurses.	7/8*
Allen-Gilliam et al., 2016. USA	To examine the impact of shared governance on the professional nursing	218 nurses of a small community hospital	Survey research study Nursing Work Index-Revised (NWI-	Results showed that nursing leadership and SG explained 90%of the variance in the	8/8*

	practice environment.		R), Shared Governance Survey, Index of Work Satisfaction (IWS)-1997 Revision, Work Practice Breakdown Survey, and Developing Evidence-Based Practice.	nursing professional practice environment.	
Al-Ruzzieh, Ayaad & Hess, 2022. Jordan	To identify the relationship between nurses' perceptions of their professional practice work environment and their participation in shared governance councils and to examine the perception of effectiveness of SG councils among nurses who participate in them	580 direct care nurses King Hussein Cancer Center (KHCC), a for-profit, specialized cancer center in Amman, Jordan	the Council Health (CH) instrument, and the Professional Practice Work Environment Inventory (PPWEI)	Nurses who participate in effective SG councils may enhance the PPWE by better handling disagreements and conflicts	7/8*

Barden et al., 2011. USA	To determine the relationship between perceptions of governance and empowerment among nurses working in hospital units in which a shared governance model had been in place for 6 to 12 months.	158 RNs A large tertiary care hospital located in Queens, New York.	Survey research study The Index of Professional Nursing Governance and the Conditions of Work Effectiveness II Questionnaire (CWEQ-II).	Nurses were in an early implementation phase of shared governance and perceived themselves to be moderately empowered.	8/8*
Bennett et al., 2012. Australia	To measure the effect of structured meeting communication processes on nurses' perceptions of professional governance.	225 nurses A large, multisite metropolitan Australian health service	Survey research study The Index of Professional Nursing Governance	There was substantial variation in nurses' perceptions of governance across the 16 wards	8/8*
Chaudhuri et al., 2013. USA	To evaluate factors affecting structural empowerment among nurse aides	362 certified NAs and 10 uncertified NAs 11 nursing homes	Survey research study The questionnaire used for this	Findings suggest race among demographic predictors, emotional exhaustion	5/8*

	in nursing homes.		study was adopted, revised, and developed from existing instruments by Yeatts and Cready.	among personal characteristics, and supervisor support, and shared governance among structural factors, significantly affect nurse aide decision-making.	
Clavelle et al., 2013. USA	To describe the characteristics of shared governance and its relationship with nursing practice environments in Magnet organizations.	95 CNOs and 107 NPC chairs Different magnet organizations in USA	Survey research study The Index of Professional Nursing Governance (IPNG) and the nursing Work Index Y Revised (NWI-R).	In Magnet organizations, the primary governance distribution is shared governance, with most subscales in the IPNG within the shared governance range.	6/8*
Gabel Speroni et al., 2012 a. USA	To examine relationships between IPNG governance score types and unit-based nurse related outcomes; patient	2170 RNs 20 hospitals in 4 countries	Survey research study The Index of Professional Nursing Governance	International units had better IPNG shared governance scores.	7/8*

	satisfaction, and RN satisfaction, by location (United States and international)				
Gabel Speroni et al., 2021b. USA	To examine associations between IPNG type scores and NSIs, patient satisfaction, and RN satisfaction outcomes. A secondary aim was to examine IPNG type scores and these outcomes by Magnet status	205 study units; 20 international hospitals	The Index of Professional Nursing Governance	Although Magnet hospitals had significantly greater IPNG scores than non-Magnet hospitals, both scored as shared governance.	7/8*
Gerard et al. 2016. USA	To report a model to identify specific areas of DI contributing to a gap in perceived versus desired decision making and investigate if	266 nurses St. Vincent's Medical Center, a 476-bed community medical center in Fairfield County Connecticut	Survey research study The Decisional Involvement Scale	Variation in nursing education, years of experience, employment status, and experience with councils can influence nurses desire to participate in an SG model	8/8*

	there is a correlation between involvement in councils and dissonance among nurses.			.	
Hu et al., 2021. China	To explore nursing councils' effectiveness and RNs' perceptions of shared governance in Chinese Magnet and non-Magnet hospitals.	1014 + 932 nurses two teaching tertiary hospitals in a major Chinese city	Council Health instrument, The Index of Professional Nursing Governance	In the Magnet hospital nurses rated their perceptions of council effectiveness and shared governance significantly higher than nurses in the non-Magnet hospital.	7/8*
Kaddoura h et al., 2020. Saudi Arabia	To assess how registered nurses in an outpatient department perceive shared governance	186 nurses a Tertiary Care Hospital in Saudi Arabia	Survey research study The Index of Professional Nursing Governance	The majority of the nurses indicated traditional governance across shared governance scales except in the access information scale.	7/8*
Khraisat et al., 2020.	To obtain a baseline measuremen	307 nurses	Survey research study	The nurses' decision making is	8/8*

Saudi Arabia	t of the degree of shared governance	A children's hospital in Saudi Arabia.	The Index of Professional Nursing Governance	shared by staff and managers in the majority of IPNG subscales which are within the shared governance range	
Kutney-Lee et al., 2016. USA	To examine differences in nurse engagement in shared governance across hospitals and to determine the relationship between nurse engagement and patient and nurse outcomes.	425 Hospitals	Survey research study Participation in Hospital Affairs subscale of the Practice Environment Scale of the Nursing Work Index, the emotional exhaustion subscale of the Maslach Burnout Inventory	A professional practice environment that incorporates shared governance may serve as a valuable intervention for organizations to promote optimal patient and nurse outcomes.	6/8*
Mouro et al., 2013. Lebanon	To determine the perception of registered nurses towards a shared governance environment in hospital	1220 nurses Four main hospitals, three in Lebanon and one in Jordan.	Survey research study The Index of Professional Nursing Governance	The mean total IPNC score (184.28) is within the range of shared governance for the hospitals that are on the Journey to	7/8*

	that are/are not in the Journey to Excellence.			Magnet and significantly higher than the mean total IPNC score (169.41, p<0.001) of the hospitals not pursuing Magnet.	
Overcash et al., 2012. USA	To determine whether nursing education, work experience, certification, employment position, setting, participation in shared governance, and age were related and predictive of scores on the IPNG.	98 nurses A Midwestern cancer hospital	Survey research study The Index of Professional Nursing Governance.	No significant relationships were found among demographic measures and IPNG scores. Nurses who have a role in shared governance and work in the inpatient setting report higher IPNG scores.	8/8*
Siller et al., 2016. USA	To explore the relationship between perceptions of shared governance and the level of work engagement in emergency nurses.	43 nurses No setting reported	Survey research study Index of Professional Nursing Governance, and the Utrecht Work Engagement	A significant positive relationship was found between shared governance and work engagement, indicating that as perceptions of shared	5/8*

			Scale (UWES-9).	governance increase, work engagement increases .	
Ugur et al., 2017. Turkey	To compare the levels of decisional involvement of staff nurses between two organizations	213 nurses One Midwestern health care system in the United States and a nongovernmental University hospital in Turkey.	Survey research study The Decisional Involvement Scale	Both samples preferred more decisional involvement than they currently experienced. Turkish nurses experienced and preferred lower levels of decisional involvement than the U.S. sample	7/8*
Walden et al., 2021. USA	To assess council health within the shared governance environment at Arkansas Children's Hospital.	72 nurses Arkansas Children's Hospital	the Council Health Survey (CHS)	Shared governance is enhanced through a coordinated council infrastructure of interprofessional team members who have a long history of collaborating and have streamlined communication processes for distribution	6/8*

				of important information to key stakeholders	
Wilson et al. 2014. USA	To explore differences between direct care nurses' and nurse managers' perceptions of factors affecting direct care nurses' participation in unit-based and general shared governance activities and nurse engagement.	144 nurses and managers The study was conducted at Shore Health System, a two-hospital, not for profit, rural healthcare system located in Easton and Cambridge	Survey research study The researchers created the study survey based on factors about shared governance derived from the literature review and hospital direct care nurses' perceptions.	Factors ranked as very important included nurses perceiving support from manager to participate in shared governance activities; unit nurses working as a team; direct care nurses participating in shared governance activities won't disrupt patient care; and direct care nurses will be paid for participating beyond scheduled shifts.	5/8*

Mixed methods

Choi, 2021.	To ascertain nurse managers'	14 nurse managers	The Index of Professional Nursing	The hindering factors were 'stifled	7/8* 8/10 ***

South Korea	perceptions of shared governance and to explore the factors that facilitate or hinder shared governance based on their experiences.	general and tertiary hospitals in the Seoul and Gyeonggi-do regions	Governance and telephone interviews	atmosphere' and 'lack of opportunity and professionalism'. The facilitating factors were 'managers' encouragement' and 'flexible organizational structure'. Nurse managers' overall perception of nurses' governance was that of shared governance.	
Choi & Kim 2019. South Korea	To investigate the relationships among structural empowerment, professional governance, autonomy, and job satisfaction in the Korean nurses and to provide a more in-depth explanation of the nature	208 nurses Three tertiary care hospitals in Seoul, South Korea	Mixed-method study using the GEMS as a theoretical guide; survey and interviews Condition of Work Effectiveness Questionnaire (CWEQ-II), The Index of Professional Nursing Governance	Decision-making among the Korean nurses fell on a continuum of professional governance directed by managers. The mediating effects of professional governance on the relationships between structural empowerment and autonomy	7/8* 8/10 ***

	of professional governance as a process		(IPNG), the professional autonomy instrument, the Index of Work	and between structural empowerment and job satisfaction were significant.	
Quek et al. 2020. United Kingdom	To investigate how distributed leadership via the Shared Governance program influences employee engagement, empowerment, job satisfaction and turnover intentions among direct care nursing staff in a large UK hospital	116 + 15 nurses an NHS Teaching Hospital Trust	Mixed-methods explanatory sequential design with a survey and semi-structured interviews The Distributed Leadership Agency, The Utrecht Work Engagement Scale, The Minnesota Satisfaction Questionnaire -Short Form, The Turnover Intention Scale	Higher levels of distributed leadership predicted increased employee engagement and job satisfaction, and lower turnover intentions.	6/8* 9/10 ***
Quasi-experimental design					
Bina et al. 2014. USA	To describe the level of RN's actual and preferred DI in the 2010	337 + 140 RNs a rural Midwestern medical center	Intervention study with pre and post measurements	A dissonance exists between the actual and preferred DI of RNs as well as lower mean	7/9* *

	study and to describe the difference in the levels of actual and preferred DI between the 2004 study and the 2010 study in after a new shared governance structure was implemented		The Decisional Involvement Scale	differences in actual and preferred DI of nurses in 2010 as compared with 2004.	
Bloemhof et al. 2021 Netherlands	To evaluate the effects of the implementation of a professional practice model based on Magnet principles on the nurse work environment.	490+ 309 nurses a Dutch teaching hospital.	one group intervention study with pre- and post-test	Significant improvement in the nurse work environment in 17 out of the 19 units. Overall job satisfaction and quality of care increased.	8/9 **
Brull 2015. USA	To increase PG subscale scores and to test whether implementation of shared governance could be done more efficiently and effectively	Mercy Medical Center, 260 nurses	Intervention study with pre and post measurements The Index of Professional Nursing Governance	A rise in self-reported sense of structural empowerment by 6,5%. A significant increase in access to information, control over practice and ability to set	6/9 **

	using a comprehensive and robust education plan.			goals (p=<0.04-0.05).	
Dechairo-Marino et al. 2018. USA	To shift governance toward the center of the governance continuum by allocating more control and influence on the staff.	Catholic community medical center. 240 + 220 nurses.	Intervention study with pre and post measurements The Index of Professional Nursing Governance	A significant increase in overall structural empowerment and all subscales (P = .001)	7/9 **
Di Fiore et al. 2018. USA	To evaluate differences in the shared decision-making perceptions of clinical nurses between initial implementation of a shared governance model and perceptions 3 years later after the model has matured.	Community-based medical center. 303 nurses	Electronical survey The Index of Professional Nursing Governance	There was no difference in the overall sense of structural empowerment	5/9 **
		A clinic system. 57 +	Intervention study with pre	No significant change was	6/9 **

Meyers & Costanzo 2015. USA	To facilitate implementation of a PG structure in an ambulatory care clinic system.	35 registered nurses	and post measurements The Index of Professional Nursing Governance	present in structural empowerment	
Moreno & Girard 2019. USA	To strengthen the internal promotion of nurses to manager or educator positions by integrating a succession planning framework into existing shared leadership councils	An academic medical center in Northern California, 150 nurses	Intervention study with pre and post measurements A balanced scorecard A feedback survey	Results indicate a significant (P < .05) increase in council members' perception of structural empowerment. Leadership competencies as practitioners showed a statistically significant difference (P < .05)	7/9 **
Weaver et al 2018. USA	To determine if clinical nurses perceive they're truly involved in making decisions that affect nursing practice after implementation of the new shared decision-	469 + 326 + 599/ six hospitals	Intervention study with pre and post measurements The 50-item IPNG 3.0 was used and systemwide scores, as well as campus specific	After implementation, governance at these hospitals changed from traditional to shared governance.	7/9**

	making structure		scores, were calculated.		
Interview study design					
Cox Sullivan et al. 2017. USA	To examine the nurse manager perspective surrounding implementation of unit level shared governance	10 nurse managers one Veterans Health Administration facility.	Face-to-face semi-structured interviews	Shared governance may be associated with increased nurse empowerment, self-management, engagement, and satisfaction.	7/10 ***
Dearmon et al. 2015 USA	To describe the process used to build leadership capacity of frontline nurses engaged in change processes to resolve interdisciplinary operational failures.	Twelve frontline nurses a 300 licensed adult bed, academic, tertiary care, hospital with level I trauma center designation, in United States.	Participant observation during audiotaped FI group meetings. Tape recorded session were analyzed using Miles and Huberman guidelines	Mentoring an FI group proved an effective strategy for advancing the nurses' leadership capacity.	7/10 ***
Lindell Joseph & Bogue 2018. USA	To examine C-suite executives" perspectives on	47 executives an 8-hospital system	Three rounds of Delphi surveying	C-suite culture regarding empowerment is passive, but the need for	6/10 ***

	empowerment early in shared governance implementation.			active promotion of an empowering culture is recognized.	
Nurmeksela et a., 2021. Finland	The aim of the study was to describe nurse managers' views of their work in the future.	133 nurse managers Eight Finnish specialized medical care hospitals	One open-ended question in a questionnaire	Four themes were identified 1) a shift from hierarchical leadership to shared governance, 2) an increasing focus on proactive and systematic work, 3) development of evidence-based practices and 4) improvement in the attractiveness and effectiveness of the organization	8/10 ***
Ott & Ross. 2014. USA	To explore the lived experience of nurse managers and staff nurses in shared governance	11 Registered Nurses a community hospital	Semi structured interviews and thematic analysis	When nurse managers partner staff nurses, they can develop an environment empowering shared governance	7/10 ***

Underwood & Hayne 2017. USA	To categorize the system-level, nursing decision-making model structures and processes according to SG, participation, and Kanter empowerment concepts and to identify and describe strategies of system-level SG structures and processes as reported by SCNEs.	11 System chief nurse executives (SCNEs) 32 US healthcare systems	Telephone interview	The presence of the empowerment structures and processes in system-level SG was reported. The greater part of the SCNEs perceived that access to empowering elements influences participation in system-level SG	7/10 ***

Review

Kyytsönen et al., 2020. Finland	To review research on hospital-based shared governance, focusing on its core elements	13 original research articles	Scoping review and a thematic analysis	Six core elements of shared governance were revealed: professionalism, shared decision-making, evidence-based practice, continuous	9/11 ****

				quality improvement, collaboration and empowerment.	
Guedes dos Santos et al., 2013. Brazil	To identify and characterize types of nursing governance, with emphasis on its impact on nursing practice and health care	25 manuscripts	Integrative review and a thematic analysis	Three models of governance were identified: shared governance, clinical governance, and public governance.	8/11 ****

*JBI Critical Appraisal Checklist for Analytical Cross-Sectional Studies, max 8 p
**JBI Critical Appraisal Checklist for Quasi-Experimental Studies, max 9 p
***JBI Critical Appraisal Checklist for Qualitative Research, max 10 p
****JBI Critical Appraisal Checklist for Systematic Reviews and research syntheses, max 11p

ORIGINAL PUBLICATIONS (I – IV)

I

An integrative review on interventions for strengthening professional governance in nursing.

Kanninen T., Häggman-Laitila A., Tervo-Heikkinen T. & Kvist, T.

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REVIEW ARTICLE

WILEY

An integrative review on interventions for strengthening professional governance in nursing

Taina Kanninen RN, MSC, Doctoral Student[1] | **Arja Häggman-Laitila RN, PhD, Chief Nursing Officer/Professor**[1,2] | **Tarja Tervo-Heikkinen RN, PhD, Clinical Nurse Consultant**[3] | **Tarja Kvist RN, PhD, Professor**[1]

[1]Department of Nursing Science, University of Eastern Finland, Kuopio, Finland

[2]Department of Social Services and Health Care, City of Helsinki, Finland

[3]Kuopio University Hospital, Kuopio, Finland

Correspondence
Taina Kanninen, Department of Nursing Science, University of Eastern Finland, Kuopio, Finland. Email: tainkan@uef.fi

Abstract

Aim: To identify the interventions for strengthening professional nursing governance and describe their outcomes.

Background: The ever-changing health care environment requires empowering governance structures and shared decision-making. The costly nature of reshaping governance makes the identification of effective interventions vital.

Evaluation: An integrative review was carried out between January 2007 and May 2020 in the CINAHL, PubMed, Scopus, PsycINFO, Business source, Cochrane and Medic databases. The quality of the 12 included studies was evaluated with the Joanna Briggs Institute critical appraisal tools.

Key issues: Eight studies reported that the implemented interventions had positively influenced organisation regarding creating positive work environments, building new leadership competencies and increasing personnel's ability to take part in decision-making. The overall quality of the evidence was judged to be moderate.

Conclusion: Comprehensive decision-making structures, efficient teamwork and transformational leadership competencies among nurse leaders enable personnel to participate in decision-making. Further research is needed to identify the most effective interventions for improving professional governance.

Implications for Nursing Management: Nurse leaders have to ensure that personnel have adequate opportunities to congregate and decide over matters concerning their work. Positive organisational climate and relational leadership style, along with highly functioning teams, are important prerequisites to nursing councils producing the desired outcomes.

KEYWORDS

evaluation, integrative review, intervention, nursing, professional nursing governance

1 | INTRODUCTION

Health organisations have a history of hierarchical governance characterized by strict lines of command. For this reason, stakeholders in the field of health care have attempted to implement shared governance for over 35 years to engage nursing personnel in organisational decision-making relevant to their professional tasks (Hess, 2011; Porter-O'Grady, 2019). Shared governance, now professional governance (PG), is defined as a 'multidimensional organizational characteristic that encompasses the structure and processes by which professionals direct, control, and regulate goal-oriented efforts' (Hess, 2017, p. 1). PG has become a critical component of the nursing discipline, with the Magnet® and Pathway to Excellence® programmes recognizing its importance by requiring health care organisations to adopt empowering governance structures and shared decision-making (ANCC, 2016, 2019).

Each health care organisation is different and has a unique PG structure. This committee/council structure affords nursing personnel an avenue for addressing clinical and administrative challenges, exercising their professional autonomy and participating in clinical decision-making (Hess, 2017). As such, councils are key to employee engagement and at the heart of PG (Hess et al. 2020; Olender et al., 2020).

It should, however, be noted that the mere existence of a council structure does not guarantee successful PG. The PG structure is but one piece in the whole organisation and its work culture. Councils need resources and support to be effective, and personnel need to be encouraged to participate in PG work. The work of the CNO and other nurse leaders is vital to ensuring that councils produce the desired outcomes. Management support facilitates professional development and involvement of personnel, while access to work empowerment structures builds trust in the management (Brull, 2015; Moore & Wells, 2010). Nursing personnel, on the other hand, need to create a collegial, supportive and fair culture to guarantee equal participation and effective communication (Latham et al., 2011; Moore & Wells, 2010).

When needed, the PG council structure can be renewed or strengthened through different kinds of interventions. A search of the literature revealed a scarcity of reviews covering interventions for strengthening PG. There are, nevertheless, reviews closely connected to our subject. The review by Twigg and McCullough (2014), with 39 papers, covered different strategies related to how enhancing the practice environment and clinical setting helps retain nurses. These strategies included an empowering work environment, shared governance structure, autonomy, professional development, leadership support, adequate numbers and skills, and collegial relationships within the health care team.

Various styles of nursing leadership, along with their outcomes for both the nursing workforce and clinical work environment, have also been recently studied. For example, three reviews synthesized the results from a total of 186 original papers (Bianchi et al. 2018; Cummings et al. 2018; Wei et al. 2020). These reviews demonstrated that it is important for nurse leaders to have relational skills and the ability to work collaboratively in a supportive environment. Furthermore, employee engagement is effective at reducing nurse burnout, while a healthy work environment is essential to promoting nurses' development and health, and vital for the implementation of evidence-based practice (Bianchi et al. 2018; Cummings et al. 2018; Wei et al. 2020). Other research has evaluated interventions that aim to promote teamwork, with the results revealing that effective interventions, including simulation and education, build and maintain highly functioning teams (Richmond Campbell et al., 2020).

All of these reviews stressed the importance of healthy work environment in health care settings, but none suggested the best practices for creating or strengthening PG. Hence, this integrative review aimed to identify empirical evidence of interventions linked to PG and to describe their outcomes. The research was guided by the following questions: (1) What kinds of interventions have been used to strengthen professional nursing governance? And (2) what have been the outcomes—in relation to professional nursing governance—of these interventions?

2 | METHODS

2.1 | Design

This review adopted Whittemore and Knafl's (2005) five-stage integrative review method to allow the inclusion of diverse study designs. The search strategy and the reporting of results followed the PRISMA approach (Liberati et al., 2009). In the first stage of the review process, that is problem identification, a broad range of research articles that had applied various methods to study PG were gathered. The keywords in these articles were collected to identify appropriate search terms and specify the problem that the review addresses.

2.2 | Literature search

The second stage, that is the systematic literature search (Whittemore & Knafl, 2005), involved seven databases: CINAHL; PsycINFO; Business source; Cochrane; PubMed; Scopus; and Medic. The search terms for the English databases were as follows: ("shared leader*" OR "shared manage*" OR "shared governance" OR "participatory management" OR "shared decision making" OR "collaborative governance") AND (chang* OR improv* OR develop* OR enhanc* OR strenghten* OR reshap* OR challeng*) AND nurs*. The search terms used for the Finnish database Medic were ("osallistav* joht*" OR "neuvosto*" OR "asiantuntija ryhm*") AND (kehitt* OR vahvist*) AND hoitot*. An experienced librarian was consulted when the relevant databases were being identified, and the test searches were conducted to determine sensitivity and specificity.

The search was limited to peer-reviewed studies published in English and Finnish between January 2007 and May 2020 that had an abstract available.

The initial search revealed 3,305 studies. The search results were exported to RefWorks, after which duplicates were removed. When the title and abstract met the inclusion criteria, two team members independently assessed the full-text article (n = 112) for eligibility. In the case that the two reviewers disagreed, discussion with a third reviewer was used to reach consensus. This process, which is presented as a flow chart in Figure 1, yielded 12 articles that met the inclusion criteria.

2.2.1 | Inclusion and exclusion criteria

Original studies that presented the outcomes of interventions aiming to strengthen PG were eligible for inclusion in this review. We included developmental projects or programmes that aimed to improve the governance style of an organisation towards a shared or participative approach if the outcomes had been evaluated scientifically. We included studies that involved only nurses, or nurses and other health care professionals, such as managers and assistants, in different health care settings. The initial screening applied a liberal approach to ensure that we did not overlook potentially relevant interventions. We excluded reviews and interventions that targeted strengthening patient participation.

2.3 | Quality evaluation

In the third stage, that is data evaluation (Whittemore & Knafl, 2005), the appropriate Joanna Briggs Institute (JBI) critical appraisal tool was used for each study design (the Joanna Briggs Institute, 2017a, 2017b). The scores were used as an additional criterion for inclusion/exclusion. Two members of the research team appraised the studies independently. JBI has not described a certain cut-off point for the inclusion of studies, and the reviewers were determined in advance to exclude a study if the score was <50%. A total of nine studies were excluded after quality assessment (Figure 1).

2.4 | Data analysis and synthesis

The goal of the fourth stage, that is data analysis (Whittemore & Knafl, 2005), was to extract data from the identified studies into a matrix to synthesize the reported results. The following data were extracted from each of the included studies: author(s), year of publication, country, quality, theory, goals, intervention, setting, participants, tools, analysis and outcomes (Table 1). Each study was read through carefully to identify meaningful sentences related to the studied phenomenon, which were coded with descriptive labels. Extracted data were then converted into systematic categories that describe the common components of PG. To address our first and second research questions, the interventions were categorized into two core categories according to their goals and content. The

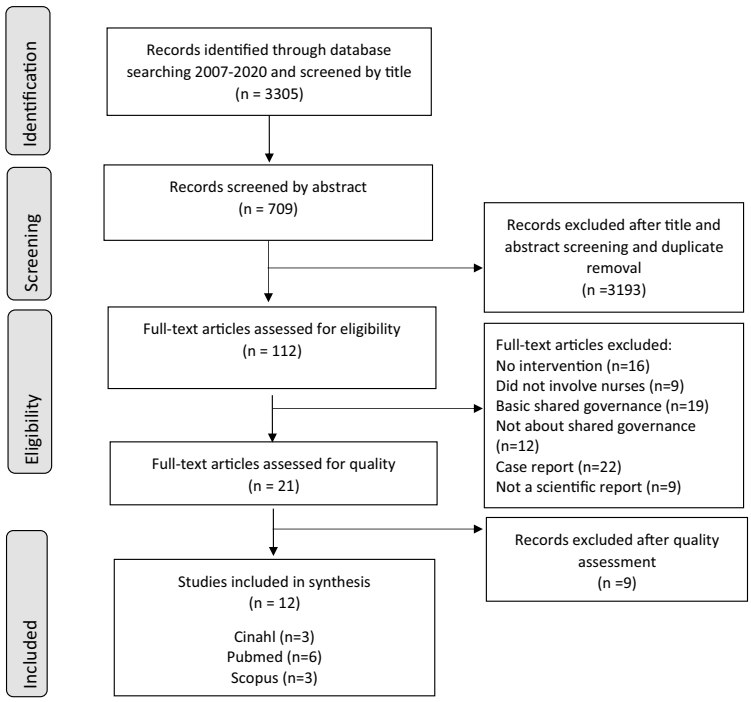

FIGURE 1 PRISMA 2009 Flow Diagram

TABLE 1 Summary of the studies included in the review

Author, year, country, quality appraisal	Theory and goals	Content of the intervention	Setting and participants	Measurement tools and analysis	Outcomes
Pretest–post-test, quasi-experimental and control group design					
Shiao et al., 2019, Taiwan, 8/9[a]	No theory base reported To enhance understanding of cross-profession language and capacity	Implementation of scenario/video-created workshops for training interprofessional collaboration team efficiency skills of nursing trainees	36 nursing trainees, medical students and other profession	Selected items in assessment of Interprofessional Team Collaboration Scale, Attitudes Toward Interprofessional Health Care Teams Scale Data were expressed as mean, the changes in scores were calculated and compared among groups	Statistically significant rise (p <.05) in team performance in the 'partnership', 'cooperation' and 'shared decision-making' domains and the self-assessed 'quality of care delivery'
Moore & Wells, 2010, USA, 7/9[a]	Kanter's theory of structural empowerment To improve the representation and focus of the traditional nursing staff council	Restructuring the systemwide staff nurse councils to four councils. Further upgrades included staff nurses serving as co-chairs and nursing executives partnering in planning meeting agendas ahead and in problem-solving issues during the council meetings	Academic medical centre. 204 nurses.	Conditions for Work Effectiveness Questionnaire, Job Activities Scale Organizational Relationship Scale, Organizational Commitment Questionnaire Inferential statistics using Pearson's r correlations, analysis of variance and regression analysis were completed	No confirmation that participation in councils enhances the nurses' perceptions of empowerment
Pretest–post-test, quasi-experimental and no control group design					
Adams et al., 2019, USA, 6/9[a]	A literature review to identify solutions for nursing burnout and turnover To improve the perception of the clinical practice environment by increasing meaningful recognition, shared decision-making, and leadership support and involvement	Adding a department-specific gratitude board, a thank-you card programme, a practice-based suggestion box, daily leadership rounding and a staff feedback portion added to daily nurse huddles	Emergency department at a community hospital. 30 ED nurses	The Anticipated Turnover Scale, The Oldenburg Burnout Inventory The mean rate of anticipated turnover, exhaustion and disengagement was compared between pre- and post-intervention. An overall total burnout level was determined, and the differences were evaluated with the paired Student's t test	A statistically significant reduction in the self-reported rates of nursing exhaustion and disengagement (p =.004)

Author, year, country, quality appraisal	Theory and goals	Content of the intervention	Setting and participants	Measurement tools and analysis	Outcomes
Brull, 2015, USA, 6/9[a]	No theory base reported To increase PG subscale scores and to test whether implementation of shared governance could be done more efficiently and effectively using a comprehensive and robust education plan	Strengthening shared governance in an organisation with several new councils	Mercy Medical Center, 260 nurses	The Index of Professional Nursing Governance Pre- and post-measurements, a *t* test	A rise in self-reported sense of structural empowerment by 6,5%. A significant increase in access to information, control over practice and ability to set goals (p = <0.04–0.05)
Dechairo-Marino et al., 2018, USA, 7/9[a]	A literature search of nursing shared governance To shift governance towards the centre of the governance continuum by allocating more control and influence on the staff	Enhancing PG structures and processes with 3 new, unit-based councils, having interprofessional strategic planning retreats every year, celebrating SG achievements annually, increasing access to library, equipment and paid SG time, expanding RN staff involvement in department budgeting decisions and educating councils on effective meetings, goals and progress reports.	Catholic community medical centre. 240 + 220 nurses.	The Index of Professional Nursing Governance Descriptive statistics Inferential *t* tests Tukey post hoc testing	A significant increase in overall structural empowerment and all subscales (p =.001)
Latham et al., 2011, USA, 7/9[a]	No theory base reported To institute and evaluate mentoring support for front-line RNs to determine changes in nurse perceptions of their workplace, professional skills and unit governance involvement	Instituting and evaluating mentoring support and a formalized mentor–management workforce environment governance board for front-line RNs.	Two acute care hospitals. 198 front-line nurses and new nurse graduates	Occupational Stress Inventory, the Memletics Questionnaire, the Jung Typology Test, the Professional Practice Environment Scale, the Nursing Services Questionnaire and the Decisional Involvement Scale pre- and post-measurement, *t* test	A statistically improved ability to work in teams (p =.001) and an enhanced ability to handle disagreement and conflict (p =.030).
Martin et al., 2012, Switzerland, 6/9[a]	Kouzes and Posner's theory of learned leader behaviours To promote transformational leadership among nurse leaders to encourage decentralized decision-making and availability of information and support structures to facilitate staff empowerment	Initiation of the Clinical Leadership Programme to develop transformational leadership competencies of nurse leaders at the unit level	The University Hospital Basel. 14 nurse leaders	Leadership Practices Inventory The data were summarized using descriptive statistical methods. For the specific analyses, multivariate analyses of variance were conducted.	Ward leaders significantly (p =.011–0.004) improved the scores in two subscales of their leadership practices—inspiring a shared vision and challenging the process.
Meyers & Costanzo, 2015, USA, 6/9[a]	Kanter's empowerment theory To facilitate implementation of a PG structure in an ambulatory care clinic system	Formation of a stakeholders group, implementation of stakeholder and staff education, development of a specific PG model for the clinic system and evaluation of the implementation process	A clinic system. 57 + 35 registered nurses	The Index of Professional Nursing Governance The independent *t* test A paired *t* test	No significant change was present in structural empowerment

Author, year, country, quality appraisal	Theory and goals	Content of the intervention	Setting and participants	Measurement tools and analysis	Outcomes
Moreno & Girard, 2019, USA, 7/9[a]	Kouzes and Posner's theory of learned leader behaviours To strengthen the internal promotion of nurses to manager or educator positions	Integrating a succession planning framework into the existing shared leadership council structure	An academic medical centre. 150 nurses	A balanced scorecard A feedback survey *t* test	Results indicate a significant (p <.05) increase in council members' perception of structural empowerment. Leadership competencies as practitioners showed a statistically significant difference (p <.05)
Olender et al., 2020, USA, 5/9[a]	Watson's theory of human caring To strengthen staff's self-report of caring, work engagement and workplace empowerment	Implementation of several unit councils and a caring professional practice model.	A 300-bed tertiary teaching facility. Over 800 respondents.	Caring Factor Survey, Utrecht Work Engagement Scale, the Conditions of Work Effectiveness Questionnaire II Descriptive statistics and frequency distributions Factor analysis and reliability testing Pearson's correlation Hierarchal regressions	Work empowerment scores among staff increased progressively and significantly (11%) over time.
Post-test, quasi-experimental and no control group design					
Di Fiore et al., 2018, USA, 5/9[a]	No theory base reported To evaluate the current perceptions of clinical nurses and to guide possibilities to implement interventions to further improve IPNG scores	Evaluation of the existing shared governance and comparing results with base-level measurement	Community-based medical centre. 303 nurses	The Index of Professional Nursing Governance Descriptive statistics and frequency distributions, Pearson's #2 tests and 2-sample *t* tests	There was no difference in the overall sense of structural empowerment
Interview study design					
Lavoie-Tremblay et al. 2014, Canada, 8/10[b]	Rogers' theory of innovation To encourage personnel to identify, implement and test changes that could improve their work practices and environments	Development of change capacities with the TCAB programme	University-affiliated health care organisation. 19 nurses	Three focus groups and three individual interviews The data were analysed using the NVivo	The intervention expanded the participants' vision and taught transformational leadership skills. The work culture of the teams evolved by reinforced sense of group cohesiveness and belonging, as well as awareness of others

[a]JBI Critical Appraisal Checklist for Quasi-Experimental Studies, max 9 p.

[b]JBI Critical Appraisal Checklist for Qualitative Research, max 10 p.

core categories were divided into four main categories, which also included five subcategories: goals and theory; content of the intervention; setting and participants; measurement tools and analysis; and outcomes.

3 | RESULTS

3.1 | Descriptive results

A total of 12 studies were selected for this review. The studies were carried out in the USA (n = 9), Canada (n = 1), Taiwan (n = 1) and Switzerland (n = 1). The publication period ranged from 2010 to 2020. Most of the studies were quasi-experimental, uncontrolled and before-and-after studies (n = 8). A further two quasi-experimental studies included a control group, and another included only post-test measurements. The review also included one qualitative study that applied interviews to collect data (Table 1).

The sample size in the included studies varied from 14 to 460 participants, with seven studies including more than 100 participants. Most of the studies (n = 9) included a large proportion of female registered nurses with a bachelor's degree (mean age: 49,5 years). Some of the studies failed to report the demographics of the study participants. The Index of Professional Nursing Governance was employed in four studies to measure the outcomes, while the remaining studies applied several validated and non-validated tools, along with interviews. Most of the studies used descriptive statistics to describe the participants' demographic variables. Several studies employed the Pearson correlation coefficient and/or t test to examine the relationships between study variables (Table 1).

3.2 | Quality of studies

The quality assessment revealed that most of the included studies were of medium quality (median score: 6,4; range: 5–8). Discrepancies in quality assessment were mainly related to limited information about adjustment for confounders and differences between groups in the follow-up stage. Most of the quasi-experimental studies had no control group, and two studies only achieved a 55% quality score as the employed methods could not determine causality (Di Fiore et al., 2018; Olender et al., 2020). The only qualitative study included in this review (Kyytsönen et al. (2020), Lavoie-Tremblay et al. 2014) failed to position the researcher culturally or theoretically and did not specify how the researcher may have influenced results (Table 1).

3.3 | Interventions to strengthen professional nursing governance

The interventions described in the studies included in this review employed different strategies to reach their goals and were divided into two main categories: interventions to enhance structural empowerment (n = 6); and interventions to reinforce leadership and teamwork (n = 6) (Figure 2).

3.3.1 | Interventions to enhance structural empowerment

Interventions aiming to enhance structural empowerment were divided into two subcategories according to content: creating new structure(s) (n = 5); and evaluating existing structure(s) (n = 1) (Figure 2).

3.3.2 | Creating new structure(s)

The goal of five of the interventions described in the identified studies was to enhance staff involvement and empowerment, as well as the work of existing nursing councils, by establishing new decision-making structures. Three interventions were based on Kanter's empowerment theory (Meyers & Costanzo, 2015; Moore & Wells, 2010) and Watson's theory of human caring (Olender et al., 2020). The study by Dechairo-Marino et al. (2018) was based on a literature review on nursing shared governance, while Brull (2015) did not report a clear theoretical foundation (Table 1).

The described interventions aimed to create one council for one division (Meyers & Costanzo, 2015), three new councils at the unit level (Dechairo-Marino et al., 2018) or hospital level (Moore & Wells, 2010), or several new councils at different levels of the organisation (Brull, 2015; Olender et al., 2020). Various types of education or orientation were offered to either the whole staff or different stakeholders to make the intervention more efficient (Table 1).

In addition, interventions included increased library access, paid council time, expanding staff involvement in department budgeting decisions (Dechairo-Marino et al., 2018), staff nurses serving as co-chairs and nursing executives partnering with the council co-chairs for planning and problem-solving (Moore & Wells, 2010). Videoconferencing between clinics was also offered to ensure that nurses could attend the meetings (Meyers & Costanzo, 2015), and unit managers were afforded leadership empowerment programmes so that they could support council work (Olender et al., 2020; Table 1).

The participants in these studies were nurses working in different health care organisations in the USA. The tools applied in these studies to measure the impact of the intervention were validated and have been previously used on the international level (e.g. Caring Factor Survey, Utrecht Work Engagement Scale, the Conditions of Work Effectiveness Questionnaire II and the Index of Professional Nursing Governance). The results were analysed through appropriate statistical methods, such as the t test (Table 1).

The interventions presented in three studies yielded significant outcomes in the strengthening of structural empowerment

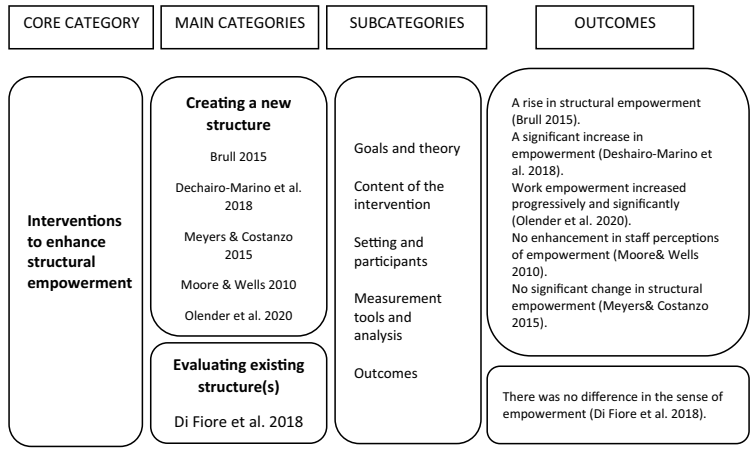

FIGURE 2 Interventions to enhance structural empowerment and their outcomes

(Brull, 2015; Dechairo-Marino et al., 2018; Olender et al., 2020). Notably, the interventions increased employees' ability to participate in decision-making and thus created a more empowering work environment. Dechairo-Marino et al. (2018) also reported a significant post-intervention rise in employees' sense of having control over practice. Two of the studies (Meyers & Costanzo, 2015; Moore & Wells, 2010) did not report statistically significant differences as the pre- and post-implementation outcomes indicated traditional governance (Table 1).

Evidence of how these interventions can facilitate the creation of new governance structures remains limited, and it was not possible to conclude whether future interventions would result in similar outcomes. All of the studies were quasi-experimental and mostly uncontrolled. The findings are difficult to interpret due to the lack of a comparison group. One of the identified studies was controlled (Moore & Wells, 2010) yet did not include randomization. Hence, it is difficult to determine whether the described outcome is a result of the intervention. The studies employed over 1,200 participants, but—as they were single-centre studies—the quality of the evidence must be ranked as low.

3.3.3 | Evaluating existing structure(s)

Di Fiore et al. (2018) described a case from an organisation that had evaluated nurses' perceptions of current shared decision-making three years after PG had been implemented. No clear theoretical foundation was reported. The intervention included an evaluation of the existing shared governance and a comparison of the results with baseline measurements. The intervention was conducted in a single hospital with over 300 nurses and only implemented post-intervention measurements. The data were collected with a validated tool and then analysed with appropriate statistical methods. The intervention did not cause any significant changes at the hospital as the post-implementation outcomes indicated that traditional governance still existed. The presented evidence was of low quality (Table 1).

3.4 | Interventions to reinforce leadership and teamwork

interventions with a focus on reinforcing leadership and teamwork were divided into two subcategories according to the content of the intervention: enhancing teamwork ($n = 3$); and enhancing leadership skills ($n = 3$) (Figure 3).

3.4.1 | Enhancing teamwork

A total of three studies (Latham et al., 2011; Adams et al., 2019; and Shiao et al., 2019) described interventions aimed at reinforcing shared decision-making, enhancing multiprofessional teamwork and battling disengagement by using locally developed programmes. Adams et al. (2019) utilized a review on nursing burnout and turnover as a theoretical base, while the other two studies lacked a theoretical foundation (Latham et al., 2011; Shiao et al., 2019).

Adams et al. (2019) designed their intervention around practical tools, such as a department-specific gratitude board, a thank-you card programme, a practice-based suggestion box, daily leadership rounding and staff feedback during daily nurse huddles. Latham et al. (2011) created a mentoring support programme for professional RNs and new graduates and a formal mentor–management workforce environment governance board. Shiao et al. (2019) created scenario/video workshops to enhance interprofessional collaboration and the team efficiency skills of nursing trainees (Table 1).

These three studies involved a total of 264 nurses, new graduates and trainees, with two studies set in a health care setting. Shiao et al. (2019) failed to report the setting of the study. The studies applied a total of ten validated tools (e.g. Interprofessional Team Collaboration Scale, the Anticipated Turnover Scale and the Decisional Involvement Scale, among others) and relevant statistical methods to measure outcomes. All of these studies reported significant outcomes; more specifically, both exhaustion and disengagement decreased and employees' abilities to work in teams and handle conflicts improved. Furthermore,

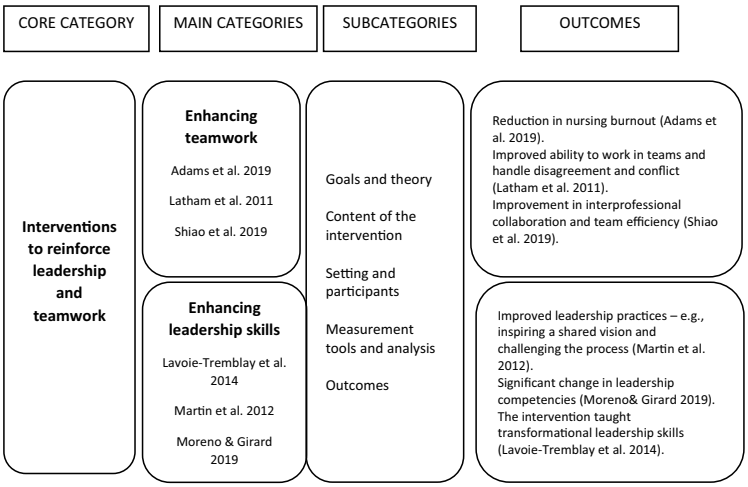

FIGURE 3 Interventions to reinforce leadership and teamwork, and their outcomes

team culture improved in terms of group cohesiveness, belonging and awareness of others (Table 1).

All three of these studies used quasi-experimental methods, with one including a control group (Shiao et al., 2019). As such, the evidence was assessed to be of moderate quality. The outcomes are based on a single population, which makes the robustness and generalizability of the evidence questionable. Furthermore, all of the interventions were utilized for the first time. Thus, further research from different health care settings and larger populations is needed to evaluate the effectiveness, appropriateness and feasibility of the described interventions.

3.4.2 | Enhancing leadership skills

Interventions to reinforce leadership skills sought to empower staff by promoting transformational leadership among nurse leaders. All of these interventions had a theoretical base, for example Kouzes' and Posner's theory of learned leader behaviours (Martin et al., 2012; Moreno & Girard, 2019) and Rogers' theory of innovation (Lavoie-Tremblay et al. 2014) (Table 1).

Moreno and Girard (2019) used locally developed programmes, whereas the two other interventions were internationally utilized. Moreno and Girard (2019) integrated a succession planning framework into the existing shared leadership council structure. Lavoie-Tremblay et al. (2014) used modules of the TCAB programme to teach nurses how to use teamwork to identify, implement and test changes that will likely lead to improvements. Martin et al. (2012) utilized the Clinical Leadership Programme to educate ward leaders on transformational leadership competencies. All of these interventions offered an extensive package of learning modules, such as lectures, coaching, individualized development plans, action learning and simulation workshops. A total of 183 nurses and nurse leaders working in health care organisations in Switzerland, Canada and the USA participated in these studies (Table 1).

Only Martin et al. (2012) used a validated measurement tool, the Leadership Practices Inventory and appropriate statistical methods. Moreno and Girard (2019) utilized scorecards and surveys, while Lavoie-Tremblay et al. (2014) employed focus groups and individual interviews. Martin et al. (2012) and Moreno and Girard (2019) reported significant increases in the participants' leadership skills, for example inspiring a shared vision and working as council chairpersons. Lavoie-Tremblay et al. (2014) reported that the intervention expanded the participants' outlooks and taught transformational leadership skills (Table 1).

The studies involved single-centre populations, which makes the robustness and generalizability of the evidence questionable. Of these three studies, two applied quasi-experimental methods, while one was an example of qualitative research. Due to the use of non-validated measurement tools and content analysis, the evidence was assessed to be of low quality.

4 | DISCUSSION

Health care organisations are reforming nurses' work environments to be more empowering and professional. As a result, hundreds of development projects aimed at aligning the work of an organisation with Magnet requirements have been published over the years. As interventions consume both resources and time, an organisation must carefully consider which approach will be the most effective (Hess, 2011). The studies included in this review reported various multicomponent interventions, which were divided into two main categories based on how they targeted PG: interventions to enhance structural empowerment; and interventions to reinforce leadership and teamwork.

Using PG structures to create a more empowering work environment enhances staff involvement in decision-making, which—in turn—improves professionality among nurses and the overall standard of care (Hess, 2017; Twigg & McCullough, 2014). Three accounts

of interventions belonging to the first main category created several new councils on both organisation and unit levels, as well as amplified the effects through extensive education. They reported significantly positive outcomes in increased employees' ability to participate in decision-making and a sense of control over practice. The evidence was judged to be of low to moderate quality (Evans, 2003). Earlier reviews have strongly linked decentralized organisational structure, along with cooperation between nurse managers and nurses, to nurse's ability to express their concerns and contribute to shared ownership (Bianchi et al., 2018; Twigg & McCullough, 2014).

It is important to state that the existence of a decentralized decision-making structure does not alone guarantee the empowerment of nursing personnel. A positive organisational climate and transformational leadership are essential contextual factors for successful PG. Some of the research included in this review reported that implementing different kinds of education and a succession planning framework promoted transformational leadership and improved employees' leadership skills. Although the evidence in the presented studies was of low quality, relational leadership styles, such as transformational leadership, have been shown to significantly empower staff and foster a healthy work environment (Cummings et al., 2018; Wei et al., 2020).

Even though interventions can be an effective method for improving leadership among nurses, it should be noted that leadership practices are heavily influenced by the complex structures within an organisation and cannot solely rely on the abilities of single nurse leaders (Cummings et al., 2021). For this reason, employees from all levels of the organisation must collaborate to create a healthy and productive work environment in which the leaders can succeed. Distinct interventions to enhance teamwork were reported in three of the included studies. These interventions, which utilized mentoring, simulation workshops and practical tools (e.g. a gratitude board), all produced significant outcomes. The interventions were characterized by a high degree of heterogeneity, which made it difficult to generalize which features made them successful. Nevertheless, the results demonstrate that various types of teamwork interventions, such as simulation, can positively impact health care processes and outcomes (Richmond Campbell et al., 2020).

To the best of our knowledge, this is the first integrative review that has identified and categorized various interventions for strengthening PG. The interventions covered in this review were heterogeneous, and therefore, the outcomes will not necessarily be reproducible. Hence, further research is a prerequisite to any reliable recommendations. Also, the results of this review emphasize that more robust research methods are warranted to strengthen the current knowledge base, while the context of each intervention should be clearly described to enhance the replicability of the results.

4.1 | Strengths and limitations

The validity of this review was enhanced by two researchers independently conducting the systematic literature search, and that the literature search was completed with the help of a science library information technician. We were stringent in following the methodological approach of Whittemore and Knafl (2005), which has been extensively applied to literature reviews on nursing. The research team commented on the whole review process and quality assessment.

The overall methodological quality of the included studies was judged as moderate. Many of the studies included limited sample sizes and used non-validated tools. The studies were also limited to three geographical areas (the USA, Canada and Switzerland), were solely reported in the English language and were conducted in various health care settings.

5 | CONCLUSION

This review was conducted to identify previously reported interventions for strengthening PG and describe their outcomes. According to the reported outcomes, eight interventions achieved positive results in relation to the strengthening of PG. However, it is important to state that the evidence base included in this review was judged to be of low quality; as such, no strong recommendations can be given at this time, and further research is needed to reliably state which interventions are most effective at improving PG.

Comprehensive and efficient PG structures increase the ability of personnel to participate in decision-making. The functioning of councils within PG structures can be improved by ensuring transformational leadership competencies among nurse leaders. This will also enhance teamwork, resulting in increased staff empowerment and a higher overall standard of care.

Future research must include robust research designs and clear descriptions of the context to reliably evaluate the effectiveness of various PG interventions. Researchers can provide high-quality empirical evidence by applying relevant theories, previously validated tools and the appropriate statistical methods.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The findings of this review highlight how influential nurse leaders can be in creating a healthy work environment that will retain and develop nursing personnel. Professional governance has been found to result in empowerment and professionalism, both of which enhance care quality. As such, it is the responsibility of the CNO and other nurse leaders to ensure that personnel have adequate opportunities to congregate and decide over matters concerning their work. Relational leadership style, along with highly functioning teams, are important prerequisites to nursing councils producing the desired outcomes.

Nurse leaders can utilize interventions such as those introduced in this review to implement and strengthen evidence-based measures for empowering nursing personnel. Choosing an effective intervention is not easy, as results achieved in one setting may not be replicable to another context. For this reason, leaders should be

aware that contextual factors can largely affect PG, leadership practices and teamwork within an organisation. Educated nurse leaders, a positive work culture and support throughout the organisation are necessary for successful PG.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

Ethical approval

An ethical approval is not needed in a literature review.

ORCID

Taina Kanninen https://orcid.org/0000-0003-0355-2225
Tarja Kvist https://orcid.org/0000-0001-5974-8732

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II

Professional governance in Finnish nursing –measured by the Index of Professional Nursing Governance.

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EMPIRICAL STUDIES

Professional governance in Finnish nursing – measured by the Index of Professional Nursing Governance

Taina Kanninen RN, MSC, Doctoral Student[1] | Arja Häggman-Laitila RN, PhD, Chief Nursing Officer, Professor[1,2] | Tarja Tervo-Heikkinen RN, PhD, Clinical Nurse Consultant[3] | Robert G. Hess Jr PhD, RN, FAAN, Executive Vice President[4,5] | Tarja Kvist RN, PhD, Professor[1]

[1]Department of Nursing Science, University of Eastern Finland, Kuopio, Finland

[2]Department of Social Services and Health Care, City of Helsinki, Helsinki, Finland

[3]Kuopio University Hospital, Kuopio, Finland

[4]Education Programs & Credentialing, On Course Learning, Brookfield, WI, USA

[5]Wisconsin, Founder & CEO, Forum for Shared Governance, Hobe Sound, FL, USA

Correspondence
Taina Kanninen, Heikintie 11, Villähde, Finland.
Email: tainkan@uef.fi

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Abstract

Aim: To translate and validate the Index of Professional Nursing Governance (IPNG) 2.0 and assess the state of professional nursing governance in Finland.

Background: Raising and maintaining quality of care while retaining staff are common problems in healthcare globally. Professional governance is a modern way to tackle them, but a reliable instrument is needed to measure the state of nursing governance in Finland, and elsewhere.

Methods: The IPNG that was translated into Finnish by forward-backward translation, culturally adapted and pilot tested with 20 nurses. A sample of 419 nurses was utilised in a cross-sectional study to assess the state of professional governance in Finland 2018.

Results: Principal component analysis yielded six components with good Cronbach's α values. The results clearly indicate that the IPNG version developed and evaluated in this study has suitable psychometric properties for use in Finnish healthcare settings. The validated IPNG scores indicate that nursing governance in Finland is in the professional governance range. The staff have some input in the governance of Finnish healthcare organisations. However, this perception is strongest among the nurse leaders and experts; other groups do not perceive much change yet.

Conclusion: Participants, particularly nurse leaders in Finland, had self-reported impact in decision-making. The translated IPNG has acceptable internal consistency and can be used to assess healthcare organisations' governance models in Finland and broader in Nordic countries and Europe.

KEYWORDS

cross-sectional survey, Index of Professional Nursing Governance, nurse, professional governance, questionnaire

INTRODUCTION

Nursing shortage is a frequently discussed issue in health care, as it poses major, ongoing problem all over the world. There are an estimated 7.3 million nurses and midwives in Europe, but this is too few to meet current and projected future needs (1). Thus, healthcare organisations around the world are trying to resolve nursing shortage, partly by attracting new workforces and partly by trying to retain existing nurses. The workforce turnover is high, nurses leaving causes productivity losses and inadequate staffing decreases care quality (2).

Thus, several high-profile initiatives to ensure safe nurse staffing and improve work environments have been developed and applied around the world, such as legislative regulation of nurse to patient ratios and the Magnet Hospital Accreditation Program. Such initiatives' potential effectiveness has been confirmed by detection of strong positive relationships not only between structural empowerment and organisational commitment, but also between investments in nurses' professional practice work environments and quality outcomes (3, 4).

In Europe, however, these evidence-based practices in work force planning have been rarely implemented to date. Findings from RN4CAST studies show that hospital quality, safety and staff retention problems are common in all European countries, and Finland is no exception (5). Previous studies have also shown that nursing personnel in Finland are likely to be dissatisfied with the nursing process and their ability to obtain feedback from their nurse leaders. They also reportedly regard their managers' transformational leadership qualities as moderate and their nurse directors as distant (6, 5, 7).

BACKGROUND

The characteristics of the working environment predetermine working behaviours and when there are resources and opportunities in the work context, professionals feel power to perform the tasks. Professional governance (PG) is a way to actualise better work environments and structural empowerment (8, 9). PG has a history of 25 years in the healthcare industry and has been defined as multidimensional organisational characteristics that encompass the structure and processes through which professionals direct, control and regulate one another's goal-oriented efforts (4). Multiple studies over the years have shown that PG can lead to empowered personnel and quality care (10, 11, 12).

Recognised elements of PG include control over personnel, access to information, influence over resources supporting practice, ability to participate in organisational decisions, control over practice and ability to set goals and resolve conflict (13). The main issue connected to the control over personnel element is who has control over professional work in a formal organisation and makes decisions concerning matters like recruitment, salaries, professional and career development, evaluation and disciplinary actions, and patient flows. Healthy, well-supported, educated and motivated staff improve patients' care experience and outcomes, so adequate compensation (including sufficient salaries and flexible contracts) is a basic requirement to retain the nursing workforce (13, 14, 1).

The access to information element concerns who has access to information relevant to governance matters such as the organisation's goals and objectives, strategic plans, budget, financial status and information supporting professional practice and development. In many organisations, governance is primarily controlled by management. The responsibility for managing professional practice should, however, be shared by nursing staff and leaders, and in order to empower staff, they should be engaged in identifying areas for improvement (14). In addition, evidence-based practice should be enabled by allocating sufficient time, research and access to evidence sources (1).

The resources supporting practice element of PG concerns responsibility for selecting, procuring and allocating resources, like nursing services, products used in nursing care and staffing levels that support professional practice. Effective service delivery requires appropriate processes to ensure that adequate staff will be available at the right time. Nurses must be able to conduct their work in ways that are successful, efficient, safe and timely (1). Lack of resources may clearly impair the provision of quality service and is a direct predictor of burnout (15).

The participation element refers to who creates and participates in governance activities on different levels. Successful professional governance structures have been linked to a positive nursing practice environment. An effective structure with true sharing of decision-making between management and nursing personnel will also contribute to optimal patient outcomes. Management must ensure that patient care is not disrupted as a result of personnel's involvement in professional governance activities and that staff are paid for participation (16).

Control over practice in this context refers to who controls professional practice and makes decisions about daily patient care assignments, patient flows, nursing care delivery models and incorporation of evidence-based practice. Nurse managers and directors have important roles to play in the provision and maintenance of working conditions. Support for good unit-level practice enables nurses to meet or exceed professional standards and fulfil goals in patient care (3).

The goal setting and conflict resolution element refer to who sets goals and engages in conflict-resolving negotiation at various organisational levels. All organisations are

TABLE 1 Classes of governance and associated ranges of points according to the original IPNG

Class	Points	Dominant group
Traditional governance	86-172	Management/administration only
Shared governance	173-257	Primarily management/administration with some staff input
	258	Equally shared by staff and management/administration
	259-344	Primarily staff with some management/administration
Self-governance	345-430	Staff only

responsible for setting and implementing goals and policies in accordance with national expectations, local needs, and promotion of their staff's health, well-being and a good work-life balance (1). It is highly important for healthcare organisations to clearly convey their goals and empower nurses to embrace them (17).

To evaluate whether an organisation's governance is empowering and professional, it must be measured. Thus, various instruments to measure nurses' participation in professional governance have been presented (9) and a new instrument is in development (18). The Index of Professional Nursing Governance (IPNG) was chosen for this study as it has been used in more than 250 international healthcare organisations during the last 20 years to evaluate implementation of their management models (12).

Hess (8) created the IPNG for measuring professional governance along a conceptual continuum from traditional, through shared to self-governance models. Since the original inception of the IPNG, some of the items' language had become outdated, no longer conveying the original intent. In 2013, an international team of multigenerational nurses updated the language of a few items, creating the IPNG 2.0. Subsequent psychometrics have remained unchanged (11, 4). Hess has since continued to advance the questionnaire (19).

Finnish hospitals have recently started initiatives to establish more shared decision-making processes. Given the importance of positive work environments, a reliable instrument is needed to assess nurses' work environment and provide indications of areas of governance that require attention. Currently, no such instrument in Finnish is available. Partly to assist these efforts and gauge progress, there is a need for an instrument that is adapted to Finnish culture and healthcare settings.

AIM

Aims of the study presented here were as follows:

1. to translate the Index of Professional Nursing Governance (IPNG) 2.0 into Finnish and validate it;
2. to assess the state of professional nursing governance in Finland.

METHODS

Modification of the Index Professional Nursing Governance for use in Finnish healthcare settings

The original IPNG 2.0

The IPNG measures the governance of hospital-based nurses, based on a model of governance derived from the literature, in six dimensions: personnel, information, resources, participation and practice (20). Those six dimensions are covered by 86 items. Respondents use a 5-point Likert scale to identify the group that dominates certain areas of governance stated in the items, ranging from 'management/administration only' (1p), through 'equally shared by staff and management/ administration' (3p) to 'staff only' (5p). The points for each dimension, and overall governance, are then summed, analysed and used to place the organisation's governance on the continuum from traditional to self-governance (Table 1) (9, 19).

The IPNG has previously been translated, from its original language, American English, into Arabic, British English, Chinese, French, German, Korean and Portuguese (12). Its psychometric properties have been tested several times. Andersson (10) reported that Cronbach α coefficients for internal consistency for the total scale of the IPNG and subscales ranged from 0.85 to 0.97, when used in two hospitals (one a Magnet® and the other a non-Magnet hospital) in the USA. Lamoureux et al(11) used the IPNG in Florida, USA, and reported very high reliability for each of the six subscale scores and the total score (Cronbach α values ≥0.94). Dechairo-Marino et al(14) applied it in their 2nd ANCC Magnet® survey in Southern California, USA, and reported high reliability, with Cronbach's alpha coefficients of 0.97 for the whole scale and 0.88–0.94 for the subscales ($n = 489$).

Translation and modification of the IPNG for use in Finnish settings

Dr Hess gave permission to use and modify the IPNG for Finnish health care in spring 2016. The IPNG has not been

previously translated into Finnish, and an instrument from another culture can only be used after stringent cultural adaptation (21). Thus, the IPNG was translated using back-translation method, because it is a well-known method to maintain equivalence between the original and translated versions (21).

In this process, it was first translated into Finnish by an independent professional translator, then translated back to English by another independent professional translator. Next, the two versions of the instrument were compared by all the authors, who have relevant expertise of instrument development (21). In this stage, the semantic and conceptual equivalence of the versions were evaluated, and linguistic aspects of cultural differences in nursing governance were discussed and reflected upon. It became clear that the design of the instrument had to be slightly modified in order for the items to be simpler in Finnish.

In the original IPNG, participants are asked to identify whether management or personnel dominate certain areas of governance (Table 1), but in the Finnish version, they are asked whether they agree with statements that the nursing personnel can undertake, or participate in, a range of governance-related activities (Table 2). Care was taken to ensure that each translated item retained as close as possible meaning to the item in the original version.

The finalised Finnish instrument was once again translated into English, and Dr Hess approved the back translation and changes made to the instrument in 2016. It was pilot tested in 2017, by asking 20 clinical experts from the study context to check the wording and find culture-common concepts. Shared governance as a whole is not a common concept in Finland, so following the pilot test some items were slightly adjusted to make them culturally understandable. For example, the word council is not familiar in Finnish healthcare settings and it was changed by the workgroup. Short, simple sentences and active voice were used in efforts to ensure that the content and meaning in the translated version were the same as in the original (21).

The Finnish version comprises 86 items and the respondents answer using the following 5-point Likert scale (which differs from the original instrument's scale): 1 = totally disagree, 2 = partly disagree, 3 = do not agree or disagree, 4 = partly agree and 5 = totally agree. As in the original IPNG, the responses are summed to calculate an overall score ranging from 86 to 430.

Validity and reliability

Principal component analysis with Varimax rotation was applied to assess the instrument's construct validity. Considered components all had eigenvalues over 1.0, with items loading only on one component, and communality for every value (indicating the relation between the item and all other items) exceeding 0.4.(22) Kaiser–Meyer–Olkin (KMO) values between 0.8 and 1 were considered adequate, as values >0.6 indicate that there are sufficient items for each component (23). Bartlett's sphericity was used to test the hypothesis that the correlation matrix significantly differed (at $p < 0.5\%$) from a corresponding matrix in which correlations between

TABLE 2 Examples of the changes made to the items and scaling in the translation process

Original IPNG	Finnish IPNG
Title: In your organisation, please circle the group that PARTICIPATES in the following activities	Title: In your organisation, please choose the option that best matches your opinion; Nursing personnel participates in
Participation in unit committees for clinical practice 1 2 3 4 5	Unit committees for clinical practice 1 2 3 4 5
Participation in unit committees for administrative matters, such as staffing, scheduling and budgeting 1 2 3 4 5	Unit committees for administrative matters, such as staffing, scheduling and budgeting 1 2 3 4 5
Participation in nursing departmental committees for clinical practice 1 2 3 4 5	Nursing departmental committees for clinical practice 1 2 3 4 5
Scaling: 1 = Management/administration only 2 = Primarily management/administration with some staff input 3 = Equally shared by staff and management /administration 4 = Primarily staff with some management /administration input 5 = Staff nurses only	Scaling: 1= Totally disagree, 2= Partly disagree, 3= Do not agree or disagree, 4= Partly agree 5= Totally agree

variables are all zero (24). The internal consistency of the whole scale and subscales was regarded as acceptable if Cronbach's $\alpha \geqq 0.70$ (23).

Nurses' perceptions of involvement in decision-making

Design, settings and subjects

The modified and translated IPNG was applied in a cross-sectional, self-report survey of staff in units of five Finnish University Hospitals nominated by their Chief Nursing Officers. Cross-sectional studies are frequently used to assess prevailing characteristics of a population, and groups within populations, at a certain point in time. They cannot be used to determine causal relationships but can provide a useful springboard for further research. In such studies, data are often obtained using self-report surveys, as they provide a relatively quick, inexpensive and convenient approach for collecting information (25). Participants in this study were nurse managers and experts ($n = 92$), registered nurses ($n = 298$), and personnel with other nursing positions (practical nurses and nursing assistants, $n = 29$).

Data collection

The Chief Nursing Officers of the five hospitals included in the study were contacted in June 2017 through emails providing information about the study and its aims. Each of these officers nominated a unit in her/his hospital to participate in the study in accordance with their research practices. To maintain anonymity, a contact person from each study hospital was chosen to administer the IPNG questionnaires, which were sent by emails together with information about the study's aims, contact details and a link to the questionnaire in February 2018. Reminders to complete the electronic questionnaires used to collect IPNG data were sent through the contact persons in each study hospital until mid-April 2018. The contact persons also reminded personnel about the questionnaire in staff meetings and via intranet.

Sample size

According to recommendations by Watson and Thompson, (26) at least 5–10 subjects were required per item of the instrument for rigorous principal component analysis (PCA). As the Finnish IPNG has 86 items, ideally the sample should have included at least 430 respondents. Altogether 420 questionnaires were collected, one was rejected because it was not completed. Thus, the sample size was satisfactory, as data from 419 questionnaires were available for the PCA, giving an item to respondent ratio of very nearly 5:1.

Data analyses

Participants' general characteristics were categorised and analysed using frequencies and percentages (gender, age, degree, position, years in nursing and years in organisation). Differences between nurse's characteristics and governance scores were assessed using the Pearson chi-square test and calculating P values. Data were analysed using IBM SPSS Statistics 25 for Windows, and $p < 0.05$ was regarded as statistically significant.

Ethical aspects

The research ethics committee of the Northern Savo Hospital District issued approval (no. 285/2016) for the study in April 2017. All of the hospitals included in the study were contacted in June 2017 to seek approval according to their protocols and final approvals were obtained, from all the hospitals, in December 2017. Participation in the survey was voluntary and anonymous. No identifiable information was collected from the participants to maintain confidentiality.

RESULTS

Characteristics of respondents

The respondents ($n = 419$) were nurses (23–54 years old) from five Finnish University Hospitals, working as RNs, nurse leaders, specialists or in other roles. Most (93%) were women and registered nurses (75%) and had been working as nurses over 10 years (70%), and in the same organisation for over 10 years (48%). Their characteristics are summarised in Table 3.

Psychometric properties of the translated IPNG

Validity

The wording and overall structure of the translated instrument were evaluated by a group of 20 expert nurses in 2017. They represented the main sample well (95% women, 22–45 years old, registered nurses with over 21 years of experience, working as specialised nurses or nurse managers in the same university hospital for over 9 years). Content validity, particularly the congruence

between words and their cultural meaning, was assessed and after reviewing suggestions of the expert nurses, some items were reformulated to enhance their comprehensibility. In accordance with the hypothesised subscales, the PCA was constrained to six principal components (PCs), which were labelled following names of the subscales in the original instrument (Table 4).

TABLE 3 Characteristics of the nursing respondents ($n = 419$)

Variable	*n*	%
Gender ($n = 416$)		
Male	26	6
Female	390	94
Age ($n = 284$)		
Under 25	66	23
25–34	108	38
35–54	110	39
Degree ($n = 416$)		
RN	313	75
Higher degree	68	16
Other[a]	35	9
Position ($n = 418$)		
Nurse leaders and experts	92	22
Nurses	297	71
Other[a]	29	7
Years in nursing ($n = 394$)		
Under 5	45	11
5–10 years	74	19
Over 10	275	70
Years in organisation ($n = 385$)		
Under 5	117	30
5–10 years	83	22
Over 10	185	48

[a]Practical nurses and nursing assistants.

Items linked to the PCs (and hence subscales) 'Information', 'Participation' and 'Goals' in the Finnish version included most or all of the items linked to the corresponding subscales in the original IPNG 2.0, but some items linked to the PCs 'Personnel', 'Practice' and 'Resources' were merged. All of the items loaded on only one of the factors, with loadings between 0.309 and 0.748. No negative item-total correlations were found. The PCs, numbers of items, means, scores, Cronbach's alpha coefficients and percentages of explained variance for each PC are detailed in Table 5.

Reliability

Cronbach alpha coefficients for the six subscales and overall scale of the Finnish version of the IPNG were over 0.87 and 0.977, respectively (Table 6), indicating that it has high reliability in terms of internal consistency. In addition, the KMO value obtained was 0.94, indicating that there were sufficient items for each factor and the sphericity test indicated that the data set easily met Bartlett's criterion for PCA ($p < 0.01$).

Nurses' perceptions of involvement in decision-making

To define the governance style of the participants' organisations, scores for the overall governance scale and each of the six subscales were calculated and compared with the ranges of the previously mentioned PG modes (Table 6). The overall score was 203.6, indicating that the nurses' perceived their hospitals to be run largely by management/administration with some staff input (Table 4).

The subscale scores provide information of specific aspects of governance. Subscale scores ranged between 19.6 and 55.7, which is within the PG spectrum for all subscales except Personnel (see emboldened values in Table 6).

TABLE 4 Components (subscales of the original and Finnish IPNG), and their definitions.

Component	Definition in original IPNG	Definition in Finnish version
1. Personnel	Who has control over professional work in a formal organisation?	Personnel's control over personnel and structures
2. Information	Who has access to information necessary for controlling practice and influencing the allocation of organisational resources?	Personnel's access to information
3. Practice	Who is empowered with formal authority by the organisation?	Personnel's control over professional practice
4. Participation	Who determines and participates in structures that provide a vehicle for making governance decisions in the organisation?	Personnel's control over participation
5. Goals	Who has the ability to promote, negotiate, and manage conflict and goals within the organisation?	Personnel's ability to negotiate conflicts
6. Resources	Who has influence over the resources that support professional work?	Personnel's control over resources

TABLE 5 Summary of results of PCA and reliability tests of the Finnish version of the IPNG

Component	Number of Items	Loadings	Cumulative variance explained	Cronbach's α
1. Personnel	23	0.356–0.702	34.1%	0.932
2. Information	15	0.349–0.746	40.3%	0.934
3. Practice	20	0.309–0.713	45.0%	0.932
4. Participation	12	0.434–0.712	48.1%	0.914
5. Goals	7	0.343–0.748	50.9%	0.892
6. Resources	9	0.350–0.734	53.3%	0.876
Instrument	86	0.309–0.748	53.3%	0.977

A third of the participants of both genders and all ages who worked bedside with a degree in nursing or other subject and had been in nursing over 5 years felt that the governance style in their organisation was traditional, with nurses having little or no impact in any decision-making (28%–44%). Half or more of nearly all the distinguished groups felt that the governance model was primarily management/administration-led with some staff input (49%–58%). However, substantial proportions (12%–30%), especially of nursing personnel with higher degrees working as nurse leaders or experts who had been in nursing <5 years, felt that the governance style was primarily staff-led with some management/administration input. The Pearson chi-square test detected a significant interaction (df 6; $\chi^2 = 23.78$; $p > 0.05$) between work position and the governance scores. Nurse leaders and experts were more likely to feel that the decision-making power in matters concerning nursing was delegated to nursing personnel and that administration only played a minor role (Table 7).

DISCUSSION

Psychometric properties of the translated IPNG

Results of the study indicate that the translated IPNG instrument has sufficient reliability and validity for use in Finnish healthcare settings. Validity is defined as an instrument's ability to measure the attributes of construct (27). In this study, it was assessed by PCA, a statistical method commonly used during instrument development to analyse relationships among large numbers of variables. A component is a construct associated with a combination of test items. Ideally, all of the items should be associated with only one of the components, (28) as is the case in this study, so no items were deleted. In addition, the KMO value (0.94) and results of Bartlett's test ($p < 0.1$) confirmed that the data set is suitable for PCA. The identified six subscale structure accounts for 53.3% of the total observed variance, which is acceptable (29).

Cronbach's alpha coefficient is a frequently used statistic to assess internal consistency, and the most widely used by nurse researchers for this purpose (27). A clinically used instrument should have an alpha coefficient alpha of at least 0.90. The coefficients obtained for both the subscales and overall instrument in this study (>0.87 and 0.977, respectively) easily met this reliability criterion.

Nurses' perceptions of involvement in decision-making

This study provided new information, as professional nursing governance has not been previously studied in Finland

TABLE 6 Scores for the subscales and overall governance

Subscale	Number of items	Definition	Scale	Mean in this study	Score in this study[a]	Range for Professional Governance
1. Personnel	23	Control over personnel and structures	1–5	1.53	35.360	47–92
2. Information	15	Access to information	1–5	2.34	**35.198**	31–60
3. Practice	20	Control over professional practice	1–5	2.78	**55.708**	41–80
4. Participation	12	Control over participation	1–5	2.54	**30.585**	25–48
5. Goals	7	ability to negotiate conflicts	1–5	2.79	**19.570**	15–28
6. Resources	9	Control over resources	1–5	2.65	**23.888**	19–36
Instrument	86		1–5	3.06	**203.62**	173–344

[a]The subscale scores that fall into the professional governance range are bolded.

TABLE 7 Overall governance scores calculated from responses of indicated groups of nursing staff.

Groups of nursing staff ($n = 419$)	Traditional governance	Primarily management/ administration with some staff input	Primarily staff with some management/ administration	Total	Pearson Chi-Square	*p*
Gender ($n = 416$)						
Male	8/31%	14/53%	4/16%	26/100%	0.53	0.974
Female	125/32%	201/52%	64/16%	390/100%		
Age ($n = 284$)						
Under 25	24/37%	32/49%	10/14%	66/100%	1.2	0.878
25–34	35/32%	58/54%	15/14%	108/100%		
35–54	35/32%	55/50%	20/18%	110/100%		
Degree ($n = 416$)						
RN	106/34%	163/52%	44/14%	313/100%	11.616	0.200
Higher	12/18%	38/56%	18/26%	68/100%		
Other[a]	14/40%	17/49%	4/11%	35/100%		
Position ($n = 418$)						
Nurse leaders and experts	16/18%	48/52%	28/30%	92/100%	23.78	0.010
Nurses	104/35%	157/53%	36/12%	297/100%		
Other[a]	13/44%	12/41%	4/15%	29/100%		
Years in nursing ($n = 394$)						
Under 5	9/ 20%	25/56%	11/24%	45/100%	6.456	0.168
5–10 years	21 / 28 %	43/58%	10%14%	74/100%		
Over 10	96/35%	139/51%	40/14%	275/100%		
Years in organization ($n = 385$)						
Under 5	35/30%	61/52%	21/18%	117/100%	1.316	0.859
5–10 years	28/34%	42/51%	13/15%	83/100%		
Over 10	60/32%	100/54%	25/14%	185/100%		

[a]Practical nurses and nursing assistants.

or other northern countries. Earlier studies showed that nursing personnel in Finland regard managers' transformational leadership qualities as moderate and their nurse directors as distant (5, 6, 7). The overall governance score in this study (203.6) places decision-making in the included hospitals within the PG spectrum (173–344) and roughly half or more of nearly all the included groups of nursing personnel felt that they had influence in nursing decisions.

The results indicate that nursing personnel have access to information, influence over resources supporting their practice, control over their practice and ability to both set goals and resolve conflicts. This is encouraging for Finnish health care as a whole, and specifically the included university hospitals, which are actively developing their management style while pursuing Magnet status (7).

However, in this study a third of the participants in all groups felt that the governance style is still traditional. This is not surprising because even when overall governance is good, some units or divisions may be more advanced than others, and managers and personnel may have different expectations (10, 11). The IPNG subscale scores can be used to identify the least developed areas and required actions, but the sample in this study was too small to allow more specific analysis.

Nursing personnel who had higher degrees and/or worked as nurse leaders or experts had stronger belief that PG was present in their organisations than the other groups, and a significant interaction was detected between work position and the governance scores. These findings are consistent with expectations, as nurse leaders and experts are more likely to feel that decision-making in nursing-related matters has been largely delegated to nursing personnel. They are also consistent with both earlier literature, as nurse leaders and executives tend to report higher PG scores than other personnel, (10, 13) and requirements to establish PG, as nurse leaders and experts play crucial roles in transforming the work environment and need strong faith in such initiatives.

Scores obtained for the subscales Information, Participation, Practice, Goals and Resources are in the PG range, but not the score for the Personnel subscale. Participation, Information and Resources components of PG

are easiest to establish according to previous studies, and their scores tend to reach PG levels before the overall scores (13, 14). Some of the organisations included in this study had been developing different kinds of empowering structures for up to 10 years, which could explain the relatively good results for the goal setting and controlling resources components.

It should be noted that although the importance of the Personnel subscale as a component of PG is easy to grasp, many organisations struggle to establish personnel-related aspects of PG. Decisions regarding matters such as budgeting, salaries, benefits, recruitment and evaluating personnel are generally controlled by managers, laws and unions, and it is difficult to empower personnel in this respect (13, 14).

Limitations and future research

Although the translated instrument showed good reliability, several implications for future research were identified. One of the aims of this study was to modify and test the Finnish version of the IPNG, and there is a need to re-examine its internal consistency and usability with a larger, more representative sample. This would also yield generalisable results and facilitate formulation of action plans from the obtained scores.

When translating an instrument, care should be taken to ensure that it measures the same content in each of the cultures. As no results obtained with previous translations of the IPNG have been reported, the consistency of the factor structure cannot be judged yet. Thus, more research is needed, including a test-retest procedure to corroborate the Finnish IPNG's reliability.

The original IPNG is rather large (86 items), and a smaller version has been developed (IPNG 3.0). When an instrument is long, the results may be affected by participants becoming tired or bored. This probably explains at least some missing values in the data. The questions dealing with characteristics of the participants yielded most of the missing values (6%–32%). Most of the participants were women and 32% did not reveal their age. However, only 0.72% values were missing for specifically PG-related items of the instrument. As there was no imputation of missing values, care was taken to avoid misleading conclusions about the connection between age and the overall governance score. Further research is needed to assess the potential value of translating and applying the shorter version.

CONCLUSION

The results clearly indicate that the IPNG version developed and evaluated in this study has suitable psychometric properties for use in Finnish healthcare settings. The instrument appears to be reliable and simple to administer. There have been no previous analyses of PG in Nordic countries and modifying the questionnaire for application in Finnish contexts has enabled PG to be measured and compared internationally.

The overall score obtained in this study was 203.6, indicating that the staff have some input in the governance of Finnish healthcare organisations. However, this perception is strongest among the nurse leaders and experts; other groups do not perceive much change as yet. Thus, there is a clear need to boost progress towards empowerment through interventions tailored for specific organisations. Inter alia, as there is still little knowledge of PG in Nordic countries, various kinds of education programs to strengthen leadership skills, effective communication and overall knowledge of PG would be helpful. Increasing practice council time and accessibility, as well as staff involvement and developing digital environments to facilitate it, would precipitate the progress.

Establishment of PG is an ongoing process that requires strong effort and leadership from nurse leaders, but the resulting increase in personnel's commitment and empowerment will be highly beneficial for their organisations. The IPNG can be used to gauge current PG, assess changes in governance, tailor interventions for improvement and ensure that all the personnel feel the changes.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHOR CONTRIBUTIONS

The authors confirm contribution to the paper as follows: study conception and design: Taina Kanninen, Arja Häggman-Laitila, Tarja Tervo-Heikkinen, Tarja Kvist; data collection: Taina Kanninen; analysis and interpretation of results: Taina Kanninen, Arja Häggman-Laitila, Tarja Tervo-Heikkinen, Robert Hess, Tarja Kvist ; draft manuscript preparation: Taina Kanninen with input from all authors. All authors reviewed the results and approved the final version of the manuscript.

ETHICAL APPROVAL

The research ethics committee of the Northern Savo Hospital District issued approval (no. 285/2016) for the study in April 2017.

ORCID

Taina Kanninen https://orcid.org/0000-0003-0355-2225

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III

Nursing shared governance at hospitals – it's Finnish future?

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IV

Nurses' critical reflections of working in unit practice councils-A qualitative interview study.

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Nurses' critical reflections of working in unit practice councils—A qualitative interview study

Taina Kanninen RN, MSC, Doctoral Student[1] |
Arja Häggman-Laitila RN, PhD, Chief Nursing Officer, Professor[1,2] |
Tarja Tervo-Heikkinen RN, PhD, Clinical Nurse Consultant[3] |
Tarja Kvist RN, PhD, Professor[1]

[1]Department of Nursing Science, University of Eastern Finland, Kuopio, Finland

[2]Department of Social Services and Health Care, Helsinki, Finland

[3]Kuopio University Hospital, Kuopio, Finland

Correspondence
Taina Kanninen, Heikintie 11, Villähde, Finland.
Email: tainkan@uef.fi

Abstract

Aim: This study aimed to describe nurses' experiences of working as members of unit practice councils.

Background: Health care organisations worldwide want personnel to participate in decision-making. Unit practice councils promote unit-level decision-making over unit-specific issues. Despite extensive research on shared decision-making, few studies have examined the experiences of nurses serving as members of these councils.

Methods: A descriptive qualitative study design was used with semi-structured interviews of 16 nurses in two clinics of a Finnish university hospital. Interviews were analysed using thematic analysis.

Results: The analysis revealed two themes describing nurses' experiences as members of unit practice councils: (i) inchoate unit practice councils with insufficient allocated working time and (ii) partial empowerment of nurses through the organisation's evolving Magnet project.

Conclusions: Unit practice councils in the studied organisations are inchoate and unable to effectively advance shared decision-making or support nurses' professional autonomy. In the future, the councils require constant support from all leadership levels of the organisation.

Implications for Nursing Management: Sharing decision-making power could be a win–win situation where nurse leaders relinquishing power over certain matters gain time to immerse in wider issues. While acknowledging different organisational roles, there is room for trusting each other's professionality and respecting autonomous work.

KEYWORDS
interview research, nursing, professional governance, qualitative research, shared decision-making, unit practice council

1 | INTRODUCTION

Health care organisations are constantly searching ways to improve patient care and quality. Professional governance promotes shared decision-making and nurse engagement and has been shown to influence nursing workforce outcomes including quality of care. Professional governance is actualized in the form of nursing councils in which nursing personnel congregate to discuss matters concerning their work. For the organisation to flourish, these decision-making micro-organisms must be efficient and empowered (Hess et al., 2020; Jordan, 2016).

1.1 | Background

For over 30 years, professional governance have encouraged nurse leaders to give nurses meaningful control over their practice (Hess et al., 2020). The concept of the model has evolved over time; it is currently defined as an organisational framework giving nurses at all levels professional autonomy and involvement in decision-making processes (Hess et al., 2020). This decision-making is done in a matrix of councils with authority over and accountability for professional practice (Clavelle et al., 2013). Varying structures have been described in the literature and on the internet (e.g., Johns Hopkins All Children's Hospital, 2021; Jordan, 2016) including house-wide councils, divisional councils and unit practice councils. Unit practice councils are important component of the professional governance structure enabling shared unit-level decision-making about unit-specific issues (Jordan, 2016). The purpose of these councils is to address clinical practice issues by searching the literature to identify solutions, recommend evidence-based solutions to nurse leaders and implement those solutions (Franklin et al., 2014). Careful planning, creation of common bylaws, education of nurses and leadership support are essential for successful and sustainable councils.

All members of a unit have a role in the council. The voluntary membership can be open to all unit staff, including non-nurses (Franklin et al., 2014). Members are expected, among other things, to attend all council meetings and to act professionally throughout. The chair's responsibilities include presiding over meetings and ensuring adherence to ground rules (Jordan, 2016). Colleagues support the work and nurse leaders serve as guides and mentors and ensure that the council's recommendations align with the organisation's strategic plan (Franklin et al., 2014).

The support of nurse leaders is vital for the work of the councils (Cox Sullivan et al., 2017; Gabel Speroni et al., 2021), but many times nurse leaders and personnel have different perceptions about what the meaning of the council is and how shared governance really is (Hamad & Kehyayan, 2018; Hess, 2011). Nurse managers are more often found to perceive that nurses are involved in decision-making (Choi, 2021; Hess, 2011) while nurses do not see any difference in governance and can be confused about the role of the councils (Hamad & Kehyayan, 2018). The current study set out to gain a deeper understanding about the lived experience of nurses working as unit practice council members. The research questions are as follows: What are the everyday work practices of the unit practice councils? What is nurses' understanding of the meaning and goals of the work? The results are used to highlight and offer some practical solutions to areas where targeted support from the nurse leaders could strengthen and clarify the shared journey towards professional governance.

2 | THE STUDY

2.1 | Aim

This study aimed to describe nurses' experiences of working as members of unit practice councils.

2.2 | Methods

A descriptive qualitative design was chosen to better understand the subjects of the research questions from the perspective of the nurses themselves (Hennink et al., 2020). Individual in-depth interviews and focus group discussions were undertaken between February and April 2021. The interviews were conducted online to ensure accessibility for participants because the Covid-19 pandemic prohibited face-to-face meetings.

2.3 | Sample and setting

The participants were nurses working in two clinics at one of Finland's five university hospitals. The organisation has had a professional governance model for some time, but a more orderly form of the model was introduced in 2018. A purposive sampling strategy was used to ensure that participants were experienced members of a unit practice council (Hennink et al., 2020). Clinical nurse specialist in each clinic provided mailing lists of potential participants, who were invited to participate via an email providing general information on the study's nature and purpose. Additional nurses were recruited via direct contact during an online council meeting and by snowballing (Hennink et al., 2020). In total, 16 nurses agreed to share their experiences.

2.4 | Data collection

The interview questions revolved around nurses' experiences of working in the councils. Follow-up questions were used to obtain more information (Hennink et al., 2020). The interviews were recorded with the participants' approval and lasted approximately 27 to 68 min. The sample size of five focus group discussions and four individual interviews was deemed to have yielded adequate data saturation as the

majority of issues across the data were identified. In qualitative research, three to six focus groups are considered enough when the interviews are not stratified by any characteristic of the participants (Hennink et al., 2020). As the aim of the study was to understand the issues, four individual interviews were carried out to provide richness and strengthen the emerging theory.

Sociodemographic information on the participants (age, gender, occupation, level of education and work experience in nursing and in the council) was gathered via an email questionnaire with open-ended questions about nurses' personal goals and working capabilities. Nurses working as chairs were asked to give further information via another email form containing open-ended questions about the working practices of their council (Table 1).

2.5 | Ethical considerations

The study was approved by the Helsinki University Hospital review board on 3.12.2020 (HUS/14/2020). The ethical regulations governing Finnish research do not require ethical permission for interview studies that do not involve patients, cause no harm and do not involve intervention in the physical integrity. Informed consent was obtained from all respondents before each interview, and participants were given identification numbers to ensure anonymity (Finnish National Board on Research Integrity, 2019).

TABLE 1 The data gathered during interviews and from the open-ended questions

Interview guide
What kind of workgroups/councils exist on the unit?
What is on the UPC's agenda?
How is information gathered to support the UPC's work?
How are the outcomes received?
What kind of support exists for the group?
How should the group's work be developed?
What makes you take part in the work?
How has your membership of the UPC affected your expertise or career?
Open-ended questions for nurses
Why did you become a member?
Which personal abilities do you use in your work with the group?
Do you feel that you need extra education/support to work in the group?
What are your aims for your own work in the group?
What are your hopes/wishes for the work of the group?
Open-ended questions for chairs
What is the aim of the group?
How often are the meetings?
What are the occupations of the members?
How does one become a member/the chair?
What is on the agenda?
Where do the items on the agenda originate?
How does the group work to address the items?
How are the outcomes presented to nurse leaders and personnel?
What kinds of resources/education/support/instructions have been given to the group?

Abbreviation: UPC, unit practice council.

2.6 | Data analysis and rigour

The authors did not know the participants before conducting the interviews but were familiar with the theory of professional governance. Care was taken to make the researchers' contribution to all aspects of the thematic analysis process explicit. The analysis of the data was carried out by the authors alone.

To analyse the data, the qualitative cyclical thematic data analysis process described by Hennink et al. (2020) was followed. The process features five core tasks, namely, description, comparison, categorization, conceptualization and theory development, and was carried out in four phases. In Phase 1, audiotapes were transcribed verbatim and read thoroughly. The texts from the email forms were added to the data, increasing the total amount of text to 76 pages (with font size 11 and line spacing 1). In Phase 2, the description task was performed by reading and re-reading the transcripts in order to extract all relevant statements, which were then coded using descriptive codes. In Phase 3, the tasks of comparison, categorization and conceptualization were carried out in order to organize the data in a systematic and meaningful way. To avoid personal bias of the analysis, the findings were discussed on various steps during the analysis within the research group until consensus was reached. The initial codes (89) were combined into 46 groups of codes that were in turn grouped into seven subthemes and finally two themes (corresponding to the subheadings of the results section). In Phase 4, the final analysis and theory development were performed.

3 | FINDINGS

3.1 | Demographics of the participants

Sixteen nurses participated: 14 registered nurses and 2 practical nurses (94% female, average age almost 40 years, range: 20–59). The most common level of education was university of applied sciences (63%) and work experience in nursing for over 10 years. Length of experience as a council member ranged from 2 months to over 5 years.

3.2 | Nurses' experiences of working as a member of a unit practice council

Two themes and five subthemes emerged from the analysis (Figure 1). Quotations are presented to illustrate the findings. Each quotation is labelled based on its origin: individual interview (Interview), a focus group discussion (Group) or a response to an open-ended question (Question) followed by the number of the interview or discussion. Quotes are also labelled with the education level and participant number.

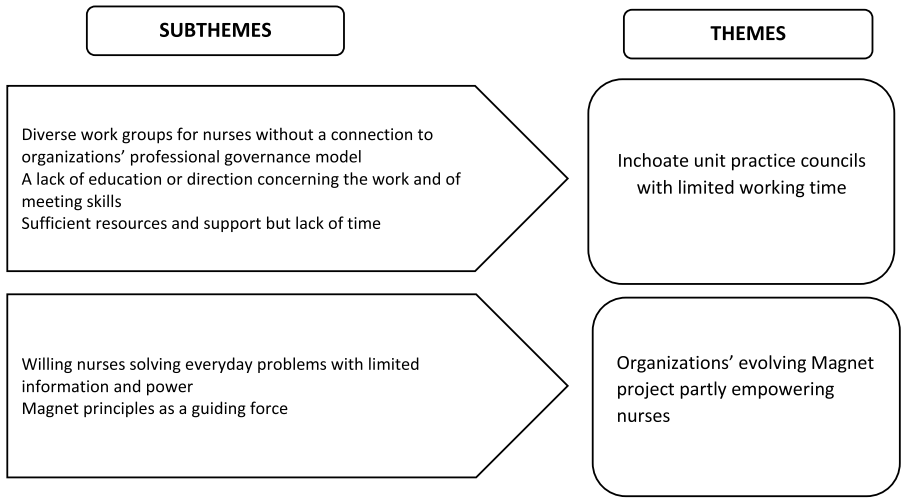

FIGURE 1 Subthemes and themes describing the nurses' experiences of working in a unit practice council

3.2.1 | Inchoate unit practice councils with limited working time

Diverse workgroups for nurses without a connection to organisations' professional governance model

Nurses reported that their units had alternating council structures that had been in operation for periods ranging from 2 months to 10 years. Some units had one council called an 'expert workgroup' that handled all issues. Other units had created workgroups focusing on specific issues such as patient safety or hygiene. These workgroups were called 'areas of responsibility' and consisted of a few (one to three) nurses who met to discuss and solve specific issues. In addition, some units had both a unit practice council and individual nurses in charge of specific issues.

The establishment of the councils had been driven from both the bottom and the top of the organisation. In some units, nurse leaders were reported to have given suggestions, while other nurses felt that they could freely choose the council structure in their units and were able to form new councils if needed. All willing personnel were able to participate, but most of the council members were nurses. In some units, other personnel such as a secretary, a physiotherapist, a doctor or a nurse leader also attended the council meetings. Most of the nurses that chaired a council stated that their council's aim was to develop the work of the unit. Strengthening theory-based nursing and nursing personnel's ability to participate in decision-making were also mentioned.

> Well, we have a variety of groups. We have a hygiene group, a student group, a malnutrition group, a fall prevention-group, … a group for every major organizational aim. People just create their own groups according to their interests. (Interview 3, Registered Nurse 9)

> I have just realized that it's more about us trying to coordinate our own units and polish them into diamonds. (Group 1, Registered Nurse 1)

When shown an illustration of their organisation's professional governance design, some of the nurses recognized it and felt that the personnel understood that their council belong to such a design. Most of the nurses, however, felt that they either did not know or did not understand the professional governance design and were unaware of the function of their workgroup as a council. Some of them saw their council as a discussion group for the unit and felt that the units' personnel were totally unaware of its purpose.

> I do not remember seeing that circle (professional governance design) in our group, I believe we just formed this group, and the chair takes part in the coordinating council, that's it. (Interview 2, Registered Nurse 8)

A lack of education or direction concerning the work and of meeting skills

Most of the councils had irregular working practices during their meetings and for determining the roles of participants. Meetings were held with varying frequencies 2–10 times per year; the chairs were either selected from a pool of volunteers or fell by default to whoever had established the council. Most of the councils had no secretary and only a few kept minutes. The nurses felt that the participants lacked basic meeting skills and there were few directions for the councils' work. Some nurses reported that the organisation had provided

some general directions; however, many of the nurses felt that they designed their own working practices. The nurses would have preferred to have some structured guidance, especially during the early days of the councils.

> There are no basic skills, we do not know how to write minutes or to send out invitations correctly. (Interview 4, Registered Nurse 14)

> In the beginning I would have hoped for concrete instructions saying 'this is the aim of the council; this is what is expected of you'. (Interview 1, Registered Nurse 5)

Decisions were made through joint discussion. Nurses felt that the discussion in the meetings was free and equal, and compromises were easily reached. In most cases, the decisions had to be approved by nurse leaders after which the minutes and decisions from the meetings were communicated to colleagues through email or by discussion in other unit meetings. Most nurses felt that the decisions were received positively and that colleagues accepted the decisions if explained clearly. However, some decisions were met with resistance and were felt to impose excessive stress. In such cases, the nurses tried to influence their colleagues by setting an example. Sometimes more creative solutions were needed.

> I try to influence the discussion through an informal WhatsApp™ group, it is a kind of a back door. (Interview 3, Registered Nurse 9)

Most of the chairs reported that no official education on working in a council had been made available but that they had received mentoring from ex-members or support from clinical experts. The desire for official education varied. Nurses felt that they needed extra education on groupwork, working on projects and the role of the chair. There was also a desire for education on computer skills such as online meetings and searching for information. Documenting minutes and reporting their outcomes were considered difficult.

> I myself would want more education on how a group works. (Question, Chair 5)

> The discussion in the council remains unregistered as people lack documentation skills. (Interview 4, Registered Nurse 13)

Sufficient resources and support but lack of time

According to the nurses that worked as chairs, the councils had sufficient material resources (e.g., electronic devices and venues). Allotting adequate time for the work was seen as the responsibility of the members themselves. Most of the chairs felt that nurse leaders supported the councils and would grant the time needed for the work. Further support from the nurse leaders was expected to help create systematic workplans and comprehensible goals for the councils. Nurses felt that nurse leaders could increase enthusiasm for the council's work by showing public support.

> There is not always visible enthusiasm from the leaders to drive matters forward. We see the defects but no green light from the nurse leader to take things further. (Interview 4, Registered Nurse 13)

Nurses said that most of their colleagues on the unit reacted positively to the council. The atmosphere within the units was considered respectful and favourable to the council's development. Nurses wanted more energy and activity in the council work and for more members to join in. However, they felt that some colleagues were afraid of being seen to fail as council members and did not want to join. They therefore wanted to emphasize to colleagues that participation in small unit-based projects and decision-making was sufficient. Nurses also hoped for more opportunities to interact with other councils within the organisation to gain more support for their own council work.

> It does not always have to be anything amazing, just small things, but when it is all documented and we can all see that hey we have done this and this, somehow it just creates the kind of mentality that we can get things done. (Group 1, Registered Nurse 3)

The time needed for the council was presented as a major problem: Most of the nurses felt that it was difficult to find enough time or energy due to their busy daily schedules and shift patterns. Nurses were also reluctant to leave patients and risk overloading their colleagues. They would have preferred to have nurse leaders allocate specific time in their work schedules to justify spending time away from the bedside. Several nurses stated that regular time should be set aside for council meetings to allow them to proceed efficiently.

> If it were preplanned in the work schedule, you would feel able to focus on the meetings in good conscience. (Group 5, Practical Nurse 2)

3.2.2 | Organisations' evolving Magnet project partly empowering nurses

Willing nurses solving everyday problems with limited information and power

Nurses had different reasons for joining a council; they wanted to develop nursing care in their units and to address specific issues. They also wanted to be involved in the work of the unit, to work together with colleagues and to have opportunities to utilize and develop their own know-how. Nurse leaders were also seen to encourage participation in the councils.

> I wanted to take part in planning the changes in our unit. I also like developing the unit's work. (Question, Practical Nurse 1)

> My head nurse suggested to start the work. I can use it to deliberate and develop units' work. (Question, Registered Nurse 8)

The nurses' objectives relating to their own work in the council were to be active, to encourage others to join in and to share their own experiences. They also wanted to take part in the changes within the unit and to have a chance to make their voices heard. Most of the nurses felt that their personal preparedness to work was good as they had a lot of work experience and previous experience with groups and projects. They described themselves as being positive and open to development, and some of them saw their post-graduate studies as a valuable asset. However, some nurses also voiced concerns relating to inability to retrieve information or implement outcomes.

> I am open to development and new ideas. I also want to advance issues and come up with solutions. (Question, Registered Nurse 7)

> I am weaker in implementation of decisions. My ability to organize is not so strong. I get stuck in information retrieval, studying things, and reporting them. (Question, Registered Nurse 8)

Most of the matters discussed in the councils arose from events that occurred during everyday nursing within the unit, the quality of the nursing or documentation. All staff within the unit were able to raise matters of concern, and some items came straight from the organisation. The needed information for decision-making was searched in various sources. Most of the nurses used their organisation's own web pages or consulted experts. Only a few nurses searched actively on the net for material such as evidence-based guidelines. Some of the nurses reported that their decisions were based on practical knowledge of their colleagues or the literature.

> The pain expert (nurse) brought us some papers. She had printed out some papers, that I believe were instructions from the organization. When we are contemplating our own practices, it (our information) comes from practical experience. (Interview 2, Registered Nurse 8)

Most nurses reported that they are free to make decisions within their own council and felt trusted to develop patient care. However, their decision-making scope was considered very limited, and it was felt that larger issues were decided elsewhere. Some nurses felt that they lacked real decision-making power and that their managers exerted tight control over their activities. Nurses felt that they did not know how to raise attention about specific issues or problems and would have liked to have more chances to exert influence on a wider scale.

> If we feel that we need to change for example the way patients are guided in some issues, there is no one forbidding us from doing that, so I do think that we are trusted to know how to take care of our patients as far as nursing goes. (Group 1, Registered Nurse 3)

Magnet principles as a guiding force

Nurses were aware of the organisation's Magnet® project and reported it having positive effects. It was seen to have made the decision-making process more visible and more accessible to all staff. New staff members were included in the process, and different opinions were valued. As for their own role in the unit's decision-making, nurses reported that taking part in the councils was rewarding and had positively influenced their own expertise and career while also expanding their perspective and broadening their job description. New opportunities had opened, and they felt encouraged to develop themselves further, for example, through studying.

> It used to be the old cranks with a lot of know-how that took part in developing the unit but now everyone is equal, including newly graduated staff with the latest information and skills. (Group 1, Registered Nurse 2)

> Taking part in one thing encourages you to do other things (nursing school). (Group 2, Registered Nurse 7)

Some nurses reported that the work of the council was a source of stress and that the Magnet® project had not made any visible difference. Most of the nurses felt that the Magnet® Hospital concept was vague and that information on the organisation's Magnet® project and professional governance model were hard to find. The organisation was reported to have held various events relating to the Magnet® project, and some of the nurses had participated in them. The current pandemic was felt to have confused the situation because it demanded a lot of attention. Nevertheless, the project as a whole was regarded as a source of irritation.

> We set up these workgroups years ago, and I've not seen any changes recently. (Group 2, Registered Nurse 3)

> I am starting to feel a bit allergic to this magnet model. (Group 5, Registered Nurse 16)

4 | DISCUSSION

This study is one of the first in Europe to investigate nurses' experiences of working in unit practice councils, and while it was undertaken in Finland, the findings are consistent with those of earlier

studies and are likely to be internationally relevant. Professional decision-making structures are being created in the studied organisation, and the councils are a part of the organisation's professional governance structure designed to promote shared decision-making at the unit level and support nurses' professional autonomy. The findings of this study show, however, that the unit practice councils of the study organisation are not advanced enough to deliver the promised results. Further development and support from all levels of the organisation is thus needed. The ongoing Covid-19 pandemic will have affected the studied organisation's ability to advance its Magnet® project as planned, which would have affected the results presented herein.

Nurses described their units as having different kinds of councils or workgroups with somewhat unorganized working practices. They saw their workgroups more as their own creation than as parts of the wider organisational decision-making structure. If the organisation's existing workgroups are not managed systematically, all the effort and time invested in them may be wasted. Without clear aims, reported outcomes and documented minutes, it is impossible for nurse leaders to direct the work of a council or take wider advantage of the new and improved practices.

The best way to create an effective professional governance council structure and get everybody aboard is to ensure that everyone receives a thorough education upon joining (Cox Sullivan et al., 2017). The organisation's existing employee workgroups can be transformed into councils by creating common guidelines. These guidelines should not be too strict because they must be adaptable to the needs of individual units and clinics, but they must also be clear enough to guide the council's work (Jordan, 2016).

The nurses in this study wanted to be involved in developing the work of their units and saw themselves as positive, competent and open to development. They reported being able to freely make decisions within their council but were unaware of their options for addressing wider issues or participating in higher decision-making councils. Nurses feeling hesitant to take part in decision-making or being limited to small unit level issues has been reported earlier (Scherb et al., 2011).

Nurses are highly educated professionals with professional autonomy and accountability to secure the safety and health of their patients (Porter-O'Grady, 2019; Pursio et al., 2020). Without effective distributional decision-making structures throughout the organisation, nurses are left in the role of employees with no ownership of their work and no accountability, forcing them to forget their professional role (Hess, 2011; Porter-O'Grady, 2019). There are certain legal restrictions relating to nurses' professional autonomy (Pursio et al., 2020), and shared decision-making is particularly challenging when applied to issues generally controlled by management such as resources, recruitment of personnel and budgets (Scherb et al., 2011). However, the literature does provide some examples of nursing personnel participating in the making of decisions in these administrative areas, with positive outcomes in terms of increased empowerment (Hess, 2011; Scherb et al., 2011). In the future, this should be advanced by developing new interventions to verify nurses realm of decision-making power and by substantiating their results with research.

4.1 | Limitations

Decision-making processes and nurses' involvement in decision-making may vary between different clinics even within the same organisation, so limiting the selection process to two clinics may have influenced the results obtained. The study was also limited to a specific Finnish context, which may hamper transferability to other contexts. We collected data during the Covid-19 pandemic, which limited the work of the unit practice councils and the whole professional governance structure within the organisation and may have influenced the findings. It will therefore be necessary to continue studying the development of the councils and nurses' perceptions of council membership in other settings and circumstances.

5 | CONCLUSIONS

The findings presented herein show that the unit practice councils of the study organisation are inchoate and unable to effectively advance shared decision-making or support nurses' professional autonomy. Inspiring and comprehensive marketing campaigns can raise much needed enthusiasm and encourage nurses to participate in councils. Clear awareness of the professional governance council structure enhances councils' ability to connect with each other and strengthens the flow of information through the organisation. A positive organisational culture, comprehensive education, ongoing assistance and adequate resources are vital for effective council work. This study is one of the first in Europe to investigate nurses' experiences of working in a unit practice council, and its findings can be used to support the development of decision-making structures and the empowerment of nurses within European health care.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Behind every professionally and autonomously working team of nurses is a professional nurse leader who has trust in the ability and accountability of the team. Sharing decision-making power does not have to mean that one's gain is equivalent to another's loss. It could be a win–win situation where a nurse leader relinquishing power over certain matters gains time to immerse oneself in wider issues like finding ways to distribute scarce resources, supporting collaboration between councils on different levels and on different units or training and mentoring new council members. While acknowledging the organisational goals and proscribed lines of authority guiding different roles, there is certainly room for trusting each other's professionality and showing it by respecting autonomous work.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

ETHICS STATEMENT

The study was approved by the Helsinki University Hospital review board on 3.12.2020 (HUS/14/2020).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Taina Kanninen https://orcid.org/0000-0003-0355-2225
Arja Häggman-Laitila https://orcid.org/0000-0003-2013-173X
Tarja Tervo-Heikkinen https://orcid.org/0000-0003-4277-3215
Tarja Kvist https://orcid.org/0000-0001-5974-8732

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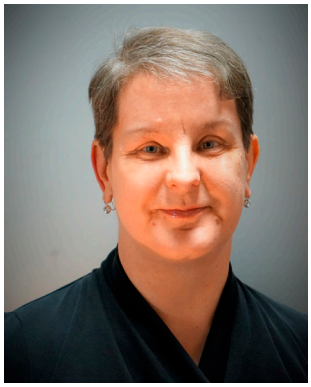

TAINA KANNINEN

Professional governance is a contemporary organization model of empowerment for nursing personnel. It has been shown to produce positive results in organizational dedication, as well as work environment and quality outcomes. There is an increased interest towards professional governance in Finland, but more research is needed to guide the development. This doctoral dissertation chronicles several professional governance interventions and describes its' current state in Finland.

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