OO5 – STRUCTURAL EMPOWERMENT

NURSING PROFESSIONAL GOVERNANCE

Provide a description and the policies, procedures, charters, or bylaws of the organization's shared decision-making structure.

- *Provide a description of nursing's structural and operational relationship within the organization's shared decision-making structure.*

Structural Relationship

Professional governance is the shared decision-making structure that NewYork-Presbyterian/Columbia University Irving Medical Center (NYP/Columbia) uses to operationalize strategic plans, Magnet Model components, and the NewYork-Presbyterian Professional Practice Model. The NYP/Columbia professional governance structure consists of campus (organization-wide) councils, unit councils, a Staff Advisory Council, and a Staff Advisory Board. Campus committees include the Nursing Quality and Safety Council; Nursing Practice Council; Recruitment, Retention, Recognition, Respect (R4) Council; Operations Council; Nursing Excellence (Magnet) Council, Nursing Research and Evidence-Based Council; Safe Patient Handling Council; Patient Experience Council; Nursing Pharmacy Committee; and the Nursing Informatics Council. Campus councils, unit councils, and the Staff Advisory Council have bi-directional communication to achieve goals and disseminate information. The Staff Advisory Council has bi-directional communication with the highest level of the professional governance structure, the Staff Advisory Board. **Operational Relationship**

NYP/Columbia nurses assume full responsibility, authority, and accountability for nursing practice, while participating in collegial relationships with other disciplines in the planning, delivery, and evaluation of patient care. Outcomes of professional governance align with the strategic plans and goals. The operational relationships are as follows and are outlined in the Leading Professional Governance Resource Handbook. OO5.1—Professional Governance and Decision-making Structures Policy

OO5.2—Professional Governance Handbook

Staff Advisory Board

The Staff Advisory Board members serve in an advisory capacity to the chief nursing officer and provide reports, updates, escalations, requests, challenges, ideas, and other pertinent information regarding their campus committee work. The structure supports chief nursing officer visibility and accessibility and ensures input is heard and communicated to the NewYork-Presbyterian (enterprise-wide) nursing board by the chief nursing officer. The structure facilitates bi-directional communication among clinical nurses, the chief nursing officer, and the nursing board. Membership includes the chief nursing officer, campus committee chairs/co-chairs, and the Magnet Program director.

Staff Advisory Council

The Staff Advisory Council (day shift Staff Advisory Council and night shift Staff Advisory Council) is responsible for representing department peers in providing counsel to the chief nursing officer on a variety of topics determined by the chief nursing officer and council members. Membership includes unit council chairs/co-chairs, campus committee chairs, patient care directors (nurse managers) and directors of nursing representatives, and other interprofessional members.

Nursing Quality and Safety Council

The Nursing Quality and Safety Council supports a culture of safety. The council monitors and analyzes nursing quality data and safety practices seeking opportunities for continual improvement and evaluates the outcomes. The council develops, revises, and makes recommendations for the Nursing Quality Improvement Plan and provides feedback for annual evaluation of the plan's effectiveness. The Nursing Quality and Safety Council aligns to the Nursing Quality Improvement Plan to detect trends and patterns of performance that affect more than one department or service. The council also ensures quality patient outcomes by reviewing and evaluating data from the National Database for Nursing Quality Indicators (NDNQI) and Maryland Quality Improvement Program (QIP), unit data, and benchmarks, to develop action plans for improvement in collaboration with unit councils. Additionally, the Nursing Quality and Safety Council monitors and ensures compliance with established state, federal, and regulatory standards and collaborates with other disciplines to monitor and evaluate compliance to standards and make recommendations to enhance safety. For example, the Nursing Quality and Safety Council evaluates the results of quality reviews based upon serious adverse events, root cause analyses, and/or other regulatory citations to participate in development and implementation of improvement plans.

Nursing Practice Council

The Nursing Practice Council ensures evidence-based nursing practice, policies, clinical standards, and patient education resources, along with other programs that support professional nursing practice.

Recruitment, Retention, Recognition, Respect (R4) Council

The Recruitment, Retention, Recognition, Respect (R4) Council guides nursing strategy on nurse recruitment, retention, recognition, and engagement initiatives aligned to the organization's strategic needs. The council optimizes the care environment to support quality patient care and career growth of NYP/Columbia nurses. The R4 Council collaborates with unit councils and the Operations Council on the identification, assessment, and alignment of R4 Council goals and objectives. The council reviews data to identify opportunities for improvement – turnover, exit interviews, nurse engagement, and patient experience scores – as well as reviews healthy work environment opportunities. The council also promotes professional growth, lifelong learning, and career progression opportunities such as the clinical ladder, certification, and formal education. The council supports effective communication and a culture of civility, works with Talent Acquisition to identify opportunities to recruit top talent, and identifies opportunities to increase staff engagement and facilitate/collaborate on organization-wide recognition activities.

Nursing Excellence (Magnet) Council

The Nursing Excellence (Magnet) Council supports the journey of excellence and the achievement and maintenance of Magnet designation. The council works to advance nursing professional practices at all levels and settings through the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program®. The council promotes the enculturation of the Magnet Model, the components of which are: Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovation, and Improvement, and Empirical Outcomes.

Nursing Research and Evidence-Based Council

The Nursing Research and Evidence-Based Council plays a pivotal role in championing evidence-based practice and research at NewYork-Presbyterian. This commitment is demonstrated through the council's support for the ethical conduct of research and the implementation of the PEACE Model, which serves as a structured framework for evidence-based practice and nursing research. The council actively maintains comprehensive records of nursing-led research at each campus, with the overarching objective of fostering collaboration and raising staff awareness of nursing research. An integral part of their engagement includes planning and actively participating in the annual NewYork-Presbyterian Research, Evidence-Based Practice, and Innovation Symposium. Beyond the organizational level, the council is dedicated to contributing to

nursing research not only within NewYork-Presbyterian, but also regionally, nationally, and internationally.

Safe Patient Handling Council

The Safe Patient Handling Council is committed to eliminating preventable musculoskeletal injury while safely mobilizing patients through the implementation and evaluation of NYP's Safe Patient Handling Program. The council maintains communication with senior leadership and management regarding the program.

Patient Experience Council

The Patient Experience Council reviews patient experience metrics and best practices and collaboratively plans implementation strategies with the overarching aim of enhancing the overall patient experience. The membership of this council is diverse, encompassing interprofessionals such as clinical nurses, nursing leaders, a quality and patient safety specialist, providers, and representatives from various departments. The interdisciplinary nature of the council ensures a holistic approach, fostering collaboration to drive meaningful enhancements in the quality of patient care and satisfaction.

Nursing Pharmacy Committee

The Nursing Pharmacy Committee maintains a forum for communication and collaboration between Nursing and Pharmacy in order to improve services and resolve issues related to medication management, including procurement, storage, security, distribution, and administration.

Nursing Informatics Council

The Nursing Informatics Council promotes strategic approaches with information technology by mapping innovative solutions to meet nursing's information needs (i.e., communication tools, data reporting, research). The council ensures that clinical applications reflect standards of care, nursing practice, and support patient safety as well as assures that electronic medical record documentation is updated based on nursing practice changes or regulatory requirements in collaboration with the Department of Nursing and other disciplines. The council uses evidence-based research in conducting design sessions and/or review of new requests and provides communication within NewYork-Presbyterian hospitals to disseminate information and obtain user input and feedback regarding informatics and related initiatives (i.e., new system implementation or upgrades). The council provides consultation and recommendations regarding policies and procedures impacting nursing practice and the use of clinical systems, such as downtime and disaster and data recovery, and oversees the change control and change management process by approving requests

to optimize and/or comply with regulatory standards and best practices. The Nursing Informatics Council provides information to promote and support nursing informatics competency for all staff.

Operations Council

The Operations Council reviews and provides recommendations for human and material resource allocation ensuring the efficient use of professional staff, equipment, and supplies for quality and patient safety. OO5.3—Professional Governance Charters Example

Unit Councils

NYP/Columbia unit councils empower nurses who deliver patient care with the authority to identify problems, causes, and solutions. They are the decision-making body for unit practice issues. Membership includes up to 10 elected members, depending on unit size, with nurses and support staff representation. Unit council charters are developed by members and decisions are made by consensus. OO5.4—Unit Council Charters Example

TITLE: PROFESSIONAL GOVERNANCE & DECISION MAKING STRUCTURES

For more information on professional governance and decision-making structure at NYP, refer to <u>NYP Leading Professional Governance Resource Handbook</u>.

APPLICABILITY: All Professional Registered Nurses and Licensed Practical Nurses

DEFINITION of PROFESSIONAL GOVERNANCE (Porter-O'Grady & Clavelle, 2021).
- It is a collaborative decision-making process in which nursing clinical staff and managers make clinical practice decisions.
- It is based on the belief that healthcare professionals working closely with patients are in the best position to make clinical practice and patient care decisions.
- It is a structure that allows the ownership and accountability for nursing practice, competence, quality, and nursing knowledge to be demonstrated by nurses undertaking the clinical work of the profession.
- It fosters nursing ownership of professional accountabilities.

PRINCIPLES OF PROFESSIONAL GOVERNANCE

The fundamental principles (Port-O'Grady, 2019) that affirm and validate the presence of effective and sustainable nursing professional governance structures and practices are:
1. Professional governance is grounded in practicing nurse accountability;
2. Structures are built around professional accountability and clinical decision-making; and
3. Professional governance structure reflects distributive decision-making. These three principles are shared here to clarify the key elements of nursing professional governance and the characteristics essential to its sustainability.

Using the above principles, the NYPH clinical professional nurse assumes full responsibility, authority and accountability for nursing practice, while participating in collegial relationship with other disciplines in the planning, delivery and evaluation of patient care.

<u>Policy Dates</u>:
New: N/A
Supersedes Policy Number: #501   Last Approved Date: 1/2021
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BENEFITS OF PROFESSIONAL GOVERNANCE

For patients
- Higher quality of care (Kutney-Lee et al, 2016)
- Improved patient safety (Kutney-Lee et al, 2016)
- Increased patient satisfaction (Kutney-Lee et al, 2016)

For Healthcare Providers
- Increased satisfaction with work environment (Kutney-Lee et al, 2016; Oss et al, 2021)
- Increased professionalism & autonomy (Clavelle, O'Grady, & Drenkard, 2013; Oss et al, 2021)
- Increased collaboration (Clavelle, O'Grady, & Drenkard, 2013; DiFiore et al., 2018)
- Increased control over practice and solutions to improve practice (Clavelle, O'Grady, & Drenkard, 2013; DiFiore et al., 2018)
- Increased access to information regarding the organization (DiFiore et al., 2018)

For Organizations
- Increased retention of providers and leadership (Quek et al, 2021)
- Engaged stakeholders and organizational committment (Olender, Capitulo, & Nelson, 2020; Quek et al, 2021; Siller, Dolansky, Clavelle, & Fitzpatrick, 2016).
- Improved financial state due to cost savings/reductions

DECISION-MAKING STRUCTURES

Enterprise Level

Policy Dates:
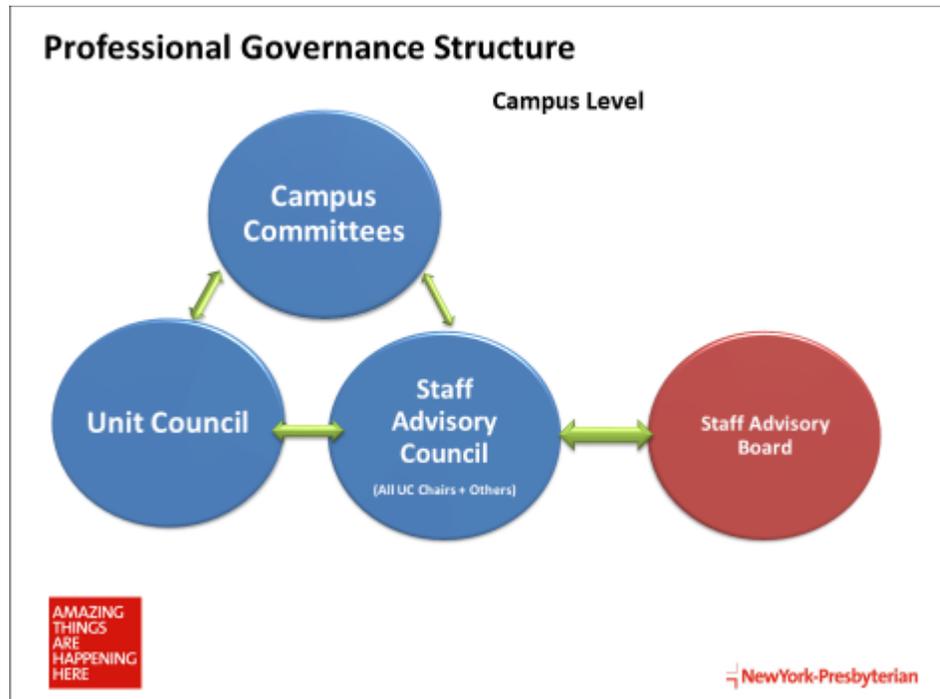New: N/A
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Campus Level

Professional Governance Structure — Campus Level

REFERENCE:

Rivera, R., Shelley, A., and Holskey, M. (2023). Leading professional governance: Resource Handbook. NewYork-Presbyterian Hospital.

American Nurses Credentialing Center, 2021. 2023 Magnet Application Manual. Silver Spring: Maryland.

Clavelle, J., Porter O'Grady, T., Weston, M. and Verran, J. (2016). Evolution of structural empowerment: Moving from shared to professional governance. *JONA*, 46 (6), 308 - 312.

Di Fiore, T. , Zito, A. , Berardinelli, A. , Bena, J. , Morrison, S. , Keck, D. , Kennedy, K. , Stibich, A. & Albert, N. (2018). Staff Perceptions of Decision-Making in a Shared Governance Culture. JONA: The Journal of Nursing Administration, 48 (11), 561-566. Haag-Heitman, B. and George, V. (2009). *Guide for establishing governance: a starter's toolkit*. American Nurses Credentialing Center.

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Date Approved: 02/2023

Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Guidice, M., and Aiken, L. (2016). Nurse engagement in Professional Governance and patient and nurse outcomes. *JONA*, 46 (11), 605-612.

Olender, L. , Capitulo, K. & Nelson, J. (2020). The Impact of Interprofessional Shared Governance and a Caring Professional Practice Model on Staff's Self-report of Caring, Workplace Engagement, and Workplace Empowerment Over Time. *JONA: The Journal of Nursing Administration, 50* (1), 52-58.

Oss, J., Schad, E., Drenth, A., Johnson, L., Olson, J., & Bursiek, A. (2021). Driving Nurse Satisfaction Through Shared Governance. *Nurse Leader, 19*(1), 47-52.

Porter-O'Grady, T. (2019). Principles for sustaining shared/professional governance in nursing. *Nursing Management*, 50 (1): 36-41.

Porter-O'Grady, T. , & Clavelle, J. T. (2021). Transforming Shared Governance: Toward Professional Governance for Nursing. *JONA*, *51*(4), 206–211. https://doi.org/10.1097/NNA.0000000000000999

Quek, S., Thomson, L., Houghton, R., Bramley, L., Davis, S., & Cooper, J. (2021). Distributed leadership as a predictor of employee engagement, job satisfaction and turnover intention in UK nursing staff. *Journal of Nursing Management, 29*(6), 1544-1553.

Siller, J., Dolansky, M., Clavelle, J., & Fitzpatrick, J. (2016). Shared Governance and Work Engagement in Emergency Nurses. *Journal of Emergency Nursing, 42*(4), 325-330.

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Leading Professional Governance

Resource Handbook

Reynaldo R. Rivera, DNP, RN, NEA-BC, FAAN, FAONL
Alexandra Shelley, MS, RN, CV-BC, FNP-BC
Michele Holskey, DNP, RN, NEA-BC

Welcome

Wilhelmina Manzano, MA, RN, NEA-BC, FAAN

I am pleased to introduce you to the *Leading Professional Governance Resource Handbook*. Here at NewYork-Presbyterian, our goal is to facilitate the advancement of professional nursing practice and to provide support to the nursing staff, with the ultimate purpose of improving the quality of patient care. We can achieve this by continuing to define best practices, create a supportive, positive work environment for our staff, promote learning, and prepare our future nurse leaders.

A key component of accomplishing this goal is professional governance, which provides a structure for nurses – wherever they may practice – to embrace ownership and accountability for competence, quality, and nursing knowledge as they perform the clinical work of their profession. This can be realized through collaborative decision making in which clinical nurses and nurse leaders make clinical practice decisions. This *Resource Handbook* provides a practical and detailed guide for developing and implementing a formal professional governance structure that can be easily replicated within the context of your particular healthcare organization.

At NewYork-Presbyterian, the mission of the Department of Nursing is to serve our communities by providing world-class patient- and family-centered care in an innovative, evidence-based, and compassionate professional nursing practice environment. By sharing what we have learned and closely evaluated during the evolution of our own professional governance structure, we seek to empower nurses in organizations throughout the country and worldwide to achieve the universal goal of excellence in patient care for all.

Wilhelmina Manzano

Wilhelmina Manzano, MA, RN, NEA-BC, FAAN
Group Senior Vice President, Chief Nursing Executive, and Chief Operating Officer, Perioperative Services

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Reynaldo R. Rivera is the Director of Nursing Research and Innovation at NewYork-Presbyterian, Assistant Professor of Clinical Nursing, Columbia University School of Nursing, and Associate Professor of Nursing, Frances Payne Bolton School of Nursing, Case Western Reserve University. He is also on the faculty of NewYork-Presbyterian's Nursing Leadership Academy.

Dr. Rivera oversees the implementation of evidence-based initiatives, research studies, and practice innovations that will advance nursing science and improve patient outcomes and care. Dr. Rivera's research and contributions focus on nurse engagement and practice innovations. These include continuing professional education, academic-practice collaboration initiatives, mentoring, writing for publication workshop, narrative nursing, appreciative inquiry, use of liberating structures, and enhancing professional governance.

Dr. Rivera is a board member of the American Association for Men in Nursing Foundation. He has previously served as a board member of the American Organization for Nursing Leadership, Advisory Board of the Duke-Johnson & Johnson Nurse Leadership Program, and The Rockefeller University Heilbrunn Family for Research Nursing, and Past President, American Association of Critical Care Nurses, New York City Chapter, and Philippine Nurses Association of America. Dr. Rivera received his Bachelor of Science in Nursing from the University of the East Ramon Magsaysay Memorial Medical Center, Philippines; Master's in Assessment and Measurement Psychology, Ateneo de Manila University, Philippines; Master's of Education in Nursing, Teachers College, Columbia University, New York; Post Master's in Advanced Nursing Practice, New York University, New York; and Doctor of Nursing Practice, Frances Payne Bolton School of Nursing, Case Western Reserve University, Ohio.

He has received many prestigious awards, such as the Teachers College, Columbia University Outstanding Alumni Award, AACN Flame of Excellence Award, AAMN Lee Cohen Award, AONL Exemplary Nurse Leadership Award, and the Sigma Founders Award for Excellence in Nursing Practice. He is a fellow of the American Academy of Nursing and the American Organization for Nursing Leadership.

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Alexandra N. Shelley is the Magnet Program Director at NewYork-Presbyterian Lower Manhattan Hospital. Ms. Shelley has had many years of experience in implementing and leading professional governance structures and initiatives. She frequently provides education on best practices in operationalizing professional governance and has participated in research exploring professional governance concepts and activities. She received her Master's of Science in Nursing as a Family Nurse Practitioner from Columbia University and her Bachelor of Science in Nursing *magna cum laude* from the University of Pennsylvania. Previously, Ms. Shelley served as a Clinical Program Coordinator, a Research Coordinator, and a clinical nurse in various specialties, including critical care, emergency, and travel nursing.

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Michele Holskey is Magnet Program Director at NewYork-Presbyterian. Prior to her appointment to this position in 2022, Dr. Holskey served as Director of Nursing Excellence/Magnet Recognition and as an internal nurse excellence consultant for NewYork-Presbyterian. Dr. Holskey is an experienced nurse leader and former Chief Nurse Executive who has spent a significant portion of her career facilitating and writing about the contributions of professional nurses to patients, organizations, professions, and communities. Previous positions included serving as Assistant Professor at Jefferson College of Health Sciences in Roanoke, Virginia, and Coastal Carolina University in Conway, South Carolina; and in a variety of nurse leader and advanced practice clinical and leadership positions for Carilion Clinic in Roanoke. Dr. Holskey earned her Doctor in Nursing Practice in Clinical Leadership from Case Western Reserve University and Master's of Science in Nursing and Bachelor of Science in Nursing degrees from the University of Virginia.

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NewYork-Presbyterian Department of Nursing

Leading Professional Governance Resource Handbook

NewYork-Presbyterian Department of Nursing

Leading Professional Governance Resource Handbook

Strategic Alignment

The NewYork-Presbyterian organizational and nursing strategic plans identify how it will accomplish its mission(s), achieve its vision, and differentiate itself from other organizations. Strategic alignment helps to link the organization's goals to nurses' daily work. This helps the nursing team understand how their contributions move the organization forward. Strategic alignment connects and prioritizes the work of nursing to match the direction of others in the organization. When everyone is on the same page, NewYork-Presbyterian and the Department of Nursing can achieve their goals faster and more efficiently.

NewYork-Presbyterian is one of the nation's most comprehensive, integrated academic healthcare systems, encompassing 10 hospitals across the Greater New York area, nearly 200 primary and specialty care clinics and medical groups, and an array of telemedicine services.

A leader in medical education, NewYork-Presbyterian Hospital is the only academic medical center in the nation affiliated with two world-class medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons. This collaboration means patients have access to the country's leading physicians, the full range of medical specialties, latest innovations in care, and research that is developing cures and saving lives.

NewYork-Presbyterian Hospital is a renowned academic medical center committed to excellence in patient care, research, education, and community service. Based in New York City, it is one of the nation's largest and most comprehensive hospitals and a leading provider of inpatient, ambulatory, and preventive care in all areas of medicine. With some 2,600 beds and more than 6,500 affiliated physicians and 20,000 employees, NewYork-Presbyterian sees more than 2 million visits annually, including close to 15,000 infant deliveries and more than 310,000 emergency department visits.

NewYork-Presbyterian has four major divisions:

NewYork-Presbyterian.
NewYork-Presbyterian is comprised of the following eight campuses:
- NewYork-Presbyterian/Columbia University Irving Medical Center
- NewYork-Presbyterian/Weill Cornell Medical Center
- NewYork-Presbyterian Allen Hospital
- NewYork-Presbyterian Brooklyn Methodist Hospital
- NewYork-Presbyterian Lower Manhattan Hospital
- NewYork-Presbyterian Morgan Stanley Children's Hospital
- NewYork-Presbyterian Westchester
- NewYork-Presbyterian Westchester Behavioral Health

Strategic Alignment

NewYork-Presbyterian Regional Hospital Network.
The NewYork-Presbyterian Regional Hospital Network is comprised of the following hospitals located in the New York metropolitan area:
• NewYork-Presbyterian Hudson Valley Hospital, Cortlandt Manor, Westchester County
• NewYork-Presbyterian Queens, Flushing
• Gracie Square Hospital, Manhattan (affiliate organization)

NewYork-Presbyterian Medical Groups.
NewYork-Presbyterian Medical Groups expands coordinated healthcare delivery across the region by connecting medical experts with patients in their communities. NewYork-Presbyterian Medical Groups in Hudson Valley, Westchester, Queens, and Brooklyn increase access to primary care, as well as specialty care in collaboration with Weill Cornell Medicine Columbia physicians.

NewYork-Presbyterian Community and Population Health.
NewYork-Presbyterian Community and Population Health encompasses ambulatory care network sites and community healthcare initiatives, including NewYork Quality Care – the Accountable Care Organization jointly established by NewYork-Presbyterian, Weill Cornell Medicine, and Columbia.

> The NewYork-Presbyterian organizational and nursing strategic plans identify how it will accomplish its mission(s), achieve its vision, and differentiate itself from other organizations.

NewYork-Presbyterian Mission and Vision

Mission
In collaboration with two renowned medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons, NewYork-Presbyterian is dedicated to:
• Educating the next generation of healthcare professionals
• Developing groundbreaking research
• Advancing innovative, patient-centered clinical care
• Serving the needs of our local, national, and global community

Vision
To be the #1 integrated academic health system in the nation in high-quality patient-centered care, education, and research.

Strategic Plan

Comprehensive Care for All

Deliver Best-in-Class Quaternary and Tertiary Care

Lead in Quality, Patient Experience & Outcomes · Deliver an Exceptional Consumer Experience · Grow Our Network · Pioneer in Health Justice

Build a Proactive Digital Future

Best People and Amazing Places to Belong

Align with Columbia and Weill Cornell

Foundational Goals.
NewYork-Presbyterian has three foundational goals as indicated in blue. At the bedrock of that foundation is our partnership and alignment with two of the best medical faculties in the country, Columbia and Weill Cornell Medicine. The second foundational goal is something that all of us must work on every day, making this an amazing place to belong. Making this an amazing place to belong is how we attract and retain the best people. And to be successful and unstoppable, we must have the best people. The third foundational goal is for us to continue to prioritize and be proactive as we build our digital future.

Essential Goals.
There are four essential goals identified in the circles that we will continue to work on:
• To lead in quality, patient experience, and clinical outcomes
• To deliver an exceptional consumer experience
• To grow our network, which means expanding our reach physically, virtually, and digitally so we can continue to meet the evolving demands of our patients
• To be a pioneer in health justice, which is why we created the Dalio Center for Health Justice

As we work on these seven goals, we come together on how we differentiate ourselves from other health systems, not just in New York, but worldwide, by providing the best-in-class, tertiary, and quaternary care. Tertiary care and quaternary care are the most complex care and are powered by our commitment to research, education, and the latest technology. This all merges to ensure that we provide comprehensive care for all. We do that from the first to the last day of life. We do that from simple to complex, and we do it for every patient at every location.

Strategic Alignment

Strategic Initiatives

Strategic initiatives provide the roadmap to achieve our vision and identify the primary areas on which we need to focus so that we can realize our goals and continue to do the very best for our patients and their families at all times. Our strategic initiatives support our ultimate goal: We Put Patients First. In everything we do, we must make patients our first priority and strive to provide them with the highest quality, safest, and most compassionate care and service.

Access.

Improve and Expand Access NewYork-Presbyterian will continue to work to improve and expand access to its hospitals and campuses so that patients can receive care promptly.

Engagement.

Engage Staff and Patients Engaged staff are actively involved in the work they do and the care they provide to patients and their families. Engaged staff help to deliver the highest quality, most compassionate care and service, and ultimately the best patient experience. The annual Employee Engagement Survey helps to identify how staff can work together to strengthen engagement at NewYork-Presbyterian.

At the same time, patients are encouraged to actively participate in their own health and recovery. Patients are provided with tools and educational materials to help them manage their own care.

Health and Well-being.

Enhance Health and Well-being NewYork-Presbyterian is committed to fostering health and well-being as part of its patient care and community service mission and as an integral part of its culture. NYPBeHealthy is a comprehensive wellness and prevention program for employees offering resources that include well-being coaches, healthy food choices in the cafeterias, exercise programs, and weight management plans to help meet individual health goals.

Value.

Deliver and Demonstrate Value NewYork-Presbyterian strives to deliver the highest quality care as efficiently, effectively, and as safely as possible. NewYork-Presbyterian continues to implement Initiatives to help reduce unnecessary clinical variability, promote quality and safety, and achieve efficiency, as well as to seek opportunities to streamline processes and reduce unnecessary costs through its HERCULES and Operational Excellence programs.

High Reliability.

Provide Highly Reliable, Innovative Care NewYork-Presbyterian seeks to provide the highest quality and safest care to every patient during every interaction by focusing on developing highly reliable processes, enhancing its culture of safety, and reducing variability in care.

Culture

NewYork-Presbyterian Hospital's culture is defined by a set of core beliefs, which guide interactions with patients and with each other. The strengths of this culture and these core beliefs help NewYork-Presbyterian continue to deliver the best care possible while meeting the challenges ahead.

Respect   Every Person Counts
Teamwork   Working Together
Excellence   Exceptional Quality and Service
Empathy   Listen, Understand, and Respond
Innovation   Creative Ideas, Cutting Edge Solutions
Responsibility Honoring Our Past, Ensuring Our Future

Strategic Alignment

Department of Nursing Mission and Vision

Nursing Mission
To serve NewYork-Presbyterian's communities by providing world-class patient- and family-centered care in an empowering and innovative professional nursing practice environment.

Nursing Vision
To be the world leader in nursing.

Nursing Philosophy and Professional Practice Model
The philosophy of nursing is influenced by NewYork-Presbyterian's and the Department of Nursing's Mission, Vision, Culture, and Value. The essence of nursing is caring. At NewYork-Presbyterian, nursing strives to meet the needs of patients across the continuum of care in a compassionate, competent, and culturally sensitive manner. This is accomplished by assessing, planning, and communicating among patients, families, and other health professionals. This approach is holistic in scope and respectful of patients' rights. At NewYork-Presbyterian, every person and every role counts.

The NewYork-Presbyterian Professional Practice Model (PPM) [Appendix A] articulates the distinctive role nurses play in building a culture of patient- and family-centered care. It exemplifies how nurses practice, collaborate, communicate, and develop professionally and transform nursing practice through innovation. The NewYork-Presbyterian Philosophy and Professional Practice Model represents the premise that nurses at all levels are actively involved in the decision-making process and have a voice in the attainment of strategic goals. Professional governance is the foundational platform that prioritizes and aligns nurses' decision making and strategic initiatives. Participation in professional governance councils and committees fosters the values of advocacy, autonomy, and collaboration. Drawing on research and evidence-based practice, the nurse grows professionally while representing his or her peers and serving the patients and families within NewYork-Presbyterian.

The NewYork-Presbyterian Philosophy and Professional Practice Model recognizes that nursing care is organized around the needs of the patient and family, that quality outcomes and patient experience are measures of the patient- and family-centered care delivery system, and that the inter-professional collaborative team approach is fundamental to nursing practice.

Nursing Strategic Plan 2023-2026

Themes/ Areas of Focus	Goals
Professional Development and Education	• Foster ongoing learning as the foundation for professional growth and advancement of nursing practice • Increase the nurses' knowledge of the recommendations of the *Future of Nursing Report* • Support structures and processes to enhance the integration of nurses to NewYork-Presbyterian
Quality and Safety	• Cultivate outstanding nursing practices in the delivery of quality and safe care • Improve nursing engagement in quality and safety activities • Establish structure and process to promote health equity related to nursing quality in delivery of care
Advancing Care	• Improve infrastructure to share and integrate best practices by strengthening the partnership with professional governance committees • Incorporate *Future of Nursing Report* recommendations that align with the Professional Practice Model • Expand Academic Practice Research Fellowship Program at all campuses • Expand Mentoring Program at all campuses
Technology and Innovations	• Support nurses' workflow at bedside for increased patient-centric and coordinated care through technology and innovation
Nursing Engagement	• Support a culture of diversity, inclusion, and equity • Promote health and well-being • Cultivate a culture of joy and appreciation
Patient-Family Experience	• Foster an environment where patients, families, all clinical teams, and support services collaborate as partners to improve patient experience • Address the root causes of health inequity to improve overall health and well-being of our communities

Strategic Alignment

Magnet Recognition Program®

The American Nurses Credentialing Center (ANCC) Magnet Recognition Program® exists to elevate nursing practice and patient care. The international program is the highest distinction that a healthcare organization can achieve for nursing excellence. NewYork-Presbyterian's strategic initiatives and the Nursing Strategic Plan align with the Magnet® Model components:

- Transformational Leadership
- Structural Empowerment
- Exemplary Professional Practice
- New Knowledge, Innovations, and Improvements
- Empirical Outcomes

To achieve Magnet designation organizations create and sustain a culture where nurses at all levels and settings thrive within an interprofessional, collaborative, data-driven practice environment. A Magnet culture is grounded in evidence and professional standards representing the enculturation of the Magnet Model components. Organizations with Magnet designation demonstrate the contributions of nurses to patients, the organization, and the communities it serves. Empirical measurements of quality outcomes are necessary, including innovations, and advancing the nursing profession.

How to Achieve Strategic Alignment

To transform nursing practice on NewYork-Presbyterian's journey for excellence, nurses must understand the importance of strategic alignment. The first step toward transformation begins with establishing a shared vision among leaders, staff, and teams at all levels and settings. The shared vision translates the NewYork-Presbyterian mission and culture to the organization's strategic initiatives, which are replicated and applied to the Department of Nursing strategic plan.

The NewYork-Presbyterian Nursing Strategic Plan is operationalized with dedicated leaders who ensure enculturation of the Magnet Model components with organizational goals. These initiatives, including the Nursing Strategic Plan, are adopted by leaders at each campus. Units and service lines then align unit-specific goals to the strategic initiatives and plans. These structures serve as the foundation for a Magnet culture, innovation, and nursing excellence. When every one is aligned, NewYork-Presbyterian can achieve its goals effectively and efficiently.

Nursing priorities and decisions that impact their practice emerge through ongoing communication, collaboration, and decision making among all inter-professionals. These structures strengthen and align over time, enabling nurses to communicate how their individual and team contributions assist NewYork-Presbyterian in achieving its mission. When nurses embrace the Magnet culture, connect with the mission, and engage others in strategies and goals, nursing practice aligns with the journey for excellence.

Tips for Strategic Alignment

- Title meeting agenda items to reflect the themes or categories of strategic plans, Magnet Model components, and the NewYork-Presbyterian Professional Practice Model (PPM). [Appendix A]

- Include discussion of strategic plans/Magnet/PPM as a standing agenda item.

- When presenting or collating committee/council goals and objectives, write explicitly how they align to strategic plans/Magnet/PPM.

- Before embarking upon a new council/committee project or initiative, ask the members how it aligns with strategic plans/Magnet/PPM.

- Acknowledge and recognize committee members for accomplishments and specifically include how they met a goal in strategic plans/Magnet/PPM.

Yiset Taveras, BSN, RN-BC, and Denver Cheng, BSN, RN, MEDSURG-BC, NewYork-Presbyterian Allen Hospital

Professional Governance Basics

What is Professional Governance?
Porter-O'Grady & Clavelle (2021)

- It is a collaborative decision-making process in which clinical nurses and nurse leaders make clinical practice decisions.
- It is based on the belief that healthcare professionals working closely with patients are in the best position to make clinical practice and patient care decisions.
- It is a structure that allows the ownership and accountability for nursing practice, competence, quality, and nursing knowledge to be demonstrated by nurses undertaking the clinical work of the profession.
- It fosters nursing ownership of professional accountabilities.

Principles of Professional Governance
Porter-O'Grady & Clavelle (2019)

Professional governance is the structure through which we operationalize NewYork-Presbyterian's strategic plans, Magnet Model components, and the NewYork-Presbyterian Professional Practice Model. The fundamental principles that affirm and validate the presence of effective and sustainable nursing professional governance structures and practices are:

1. Professional governance is grounded in practicing nurse accountability.
2. Structures are built around professional accountability and clinical decision making.
3. Professional governance structures reflect distributive decision making.

These three principles clarify the key elements of nursing professional governance and the characteristics essential to its sustainability.

Using the above principles, the NewYork-Presbyterian professional nurse assumes full responsibility, authority, and accountability for nursing practice, while participating in collegial relationships with other disciplines in the planning, delivery, and evaluation of patient care. Outcomes of professional governance align with the strategic plans, goals, and Magnet Model empirical outcomes and are described in Benefits of Professional Governance.

Benefits of Professional Governance

For Patients
- Higher quality of care
  (Kutney-Lee et al., 2016)
- Improved patient safety
  (Kutney-Lee et al., 2016)
- Improved patient experience
  (Kutney-Lee et al., 2016)

For Healthcare Providers: Nurses and Interprofessional Teams
- Increased satisfaction with work environment
  (Kutney-Lee et al., 2016; Oss et al., 2021)
- Increased professionalism and autonomy
  (Clavelle, O'Grady, & Drenkard, 2013; Oss et al., 2021)
- Increased collaboration
  (Clavelle, O'Grady, & Drenkard, 2013; DiFiore et al., 2018)
- Increased control over practice and solutions to improve practice
  (Clavelle, O'Grady, & Drenkard, 2013; DiFiore et al., 2018)
- Increased access to information regarding the organization
  (DiFiore et al., 2018)

For Organizations
- Increased retention of nurses
  (Quek et al., 2021)
- Engaged stakeholders and organizational commitment
  (Olender, Capitulo, & Nelson, 2020; Quek et al., 2021; Siller, Dolansky, Clavelle, & Fitzpatrick, 2016)
- Improved financial state due to cost savings/reductions

The NewYork-Presbyterian clinical professional nurse assumes full responsibility, authority, and accountability for nursing practice, while participating in collegial relationships with other disciplines in the planning, delivery, and evaluation of patient care.

Professional Governance Basics

Professional Governance and Decision Making

Haag-Heitman, B. and George, V. (2010). Guide for establishing governance: A starter's toolkit. American Nurses Credentialing Center.

Clinical practice accountabilities are responsibilities delivered by clinicians to provide safe quality care in compliance with clinical policies and performance standards in the best interest of patients.

Management accountabilities are responsibilities of nurse leaders to efficiently, effectively, and systematically deliver high quality, safe clinical care. The nurse leader's role includes providing necessary resources, coaching and mentoring the clinical nurses in leadership skills development, and engaging nurses in quality and financial initiatives. Nurse leaders clear the path for clinical nurses in accomplishing organizational goals. They must ensure that what is recognized and rewarded is encouraged and sustained in the organization.

Shared decision making involves shared responsibilities between nurse leaders and clinical nurses, an essential structure to integrate self-regulation at the organizational level.

> Nurse leaders clear the path for clinical nurses in accomplishing organizational goals. They must ensure that what is recognized and rewarded is encouraged and sustained in the organization.

Exercise

Identify the group which makes the decision for each of the areas identified:

Area of Responsibility	Decision-Making Group
Budget	
Holiday coverage	
Patient experience	
Hiring	
RN satisfaction/engagement	
Salary	
Disciplinary action	
Use of new equipment	
Frequency of dressing changes	
Type of gloves used for dressing changes	

Notes

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An Infrastructure for Professional Governance

Driving the Organizational Goals

- The goal of professional governance is partnership and collaboration.
- It fosters autonomy, responsibility, and accountability.
- Leadership develops the structure and staff determines the best process in which to meet the expected outcome.
- Professional governance initiatives should be linked with the organizational goals and drive patient and organizational outcomes.
- Each professional governance committee should have a standardized agenda in which staff lead, in partnership with NewYork-Presbyterian leadership, to achieve optimal clinical/patient outcomes.

NewYork-Presbyterian Professional Governance Structure Campus Level
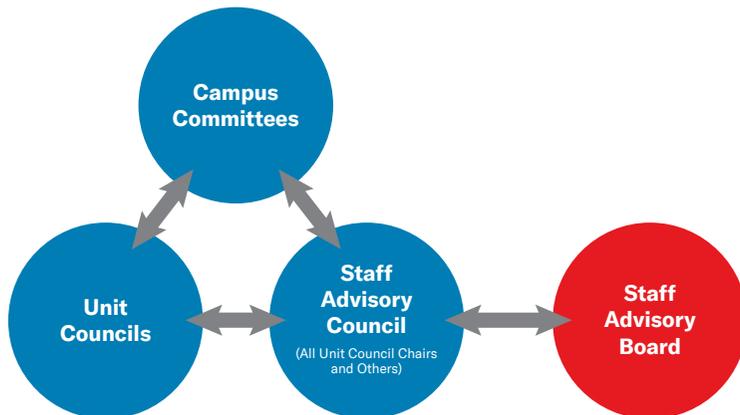
Council/Committee Member Roles and Responsibilities

Council/Committee Member Role	Responsibilities
Chairperson	• Communicates meeting times, dates, and location to members • Prepares an agenda • Facilitates the discussion and seeks consensus • Conducts succession planning for chair role [Appendix H] • Keeps council on the agenda and on time
Co-Chairperson	• Assists the chairperson • Acts as chair when the chairperson is not present
Recorder	• Prepares minutes • Maintains attendance • Submits minutes to chairperson
Member	• Attends meetings • Participates in discussion and is involved in decision making processes • Completes assigned tasks • Communicates information from meetings and gets feedback from other unit colleagues • Shares ideas for improvement initiatives • Ad hoc members may attend as warranted
Patient Care Director/ Leadership Sponsor	• Facilitates establishment of council/committee • Supports clinical nurses in making decisions through council/committee • In conjunction with the chairperson and co-chairperson, collaborates with other departments to achieve goals • Celebrates council/committee successes • Identifies and removes barriers to success

Professional governance is a collaborative decision-making process in which clinical nurses and nurse leaders make clinical practice decisions.

An Infrastructure for Professional Governance

Unit Council

- Decision-making body for unit practice issues
- Empowers nurses who deliver care with the authority to identify problems, causes, and solutions
- Membership – up to 10 elected members, depending on unit size, with nurses and support staff representation
- Chairperson and co-chairperson – typical term is two years
- Unit charter developed by unit staff
- Decision by consensus

Building and Implementing a Unit Council

Engage patient care director in the unit council process.
- Meet with unit patient care director to identify best strategies that will minimize barriers in the implementation of the unit council.
- Collaborate to identify gaps and learning needs of the unit council.

Identify key staff (key change agents) on the unit who will partner in planning, leading, and sustaining the unit council.

Promote the idea of the unit council to colleagues.
- Educate staff regarding shared clinical decision making and how their unit council will provide an opportunity for staff to have more input in unit/department activities.
- Post communications (flyers, e-mails, etc.) asking for volunteers to serve on the unit council.
- Recruit passionate individuals.

Provide coaching and mentorship for unit council members regarding their roles.

Create a unit charter.
- Collaborate with staff in completing a unit charter that supports unit goals and priorities.

Develop a problem list or work list.
- Ask staff members to share three unit issues that they would like the unit council to address.
- Gather feedback for a suggestion box and its location for the unit.
- Ensure alignment with strategic plan and organizational priorities (see section on Strategic Alignment, pages 7-8).
- Prioritize problem list as needed.

Begin unit council meetings.
- Keep to the agenda; avoid side issues.
- Ask co-chair or recorder to help act as a facilitator and timekeeper to keep the meeting focused on agenda items.
- Have the patient care director attend the first three to six meetings.
- Stay positive and solution based.
- Reinforce with staff that they should take problems and issues to unit council members.

Developing a Unit Council Charter

A unit council charter is a document that identifies elements of governance for the unit council.

Elements.
- Philosophy/purpose
- Meetings – frequency, attendance requirements
- Membership – composition, eligibility, elections, term of office, vacancies, responsibilities of members
- Officers (chair and co-chair) – eligibility for office, elections, term of office, and duties of office
- Decisions by consensus
- Communication process – notification of meetings, meeting agenda, minutes, and reporting recommendations to unit staff

Voting privileges.
- Chair/co-chair
- Staff – all members are eligible to vote and must be present at the time the vote is held
- Support staff – are eligible to vote if the proposal relates to their scope of practice
- Patient care director – serves in an advisory capacity and as such is not eligible to vote

See sample unit council charter. [Appendix B]

> Professional governance provides a structure for nurses – wherever they may practice – to embrace ownership and accountability for competence, quality, and nursing knowledge as they perform the clinical work of their profession.

An Infrastructure for Professional Governance

Code of Conduct
- Council members work in a manner consistent with professional nursing practice, are respectful, act responsibly, and cooperate with other members of the team.
- Council members are responsible to communicate unprofessional behavior, conflicts of interest, and deviation from council charter stipulations to the chair and council sponsor.
- Council members attend the council meetings for the terms in which they are a member.
- Council members absent for more than three meetings in one year (unless previously excused) may be dismissed from the role of member, chair, or co-chair. Any barriers to attending meetings on an ongoing basis should be brought to the attention of the chair and sponsor.
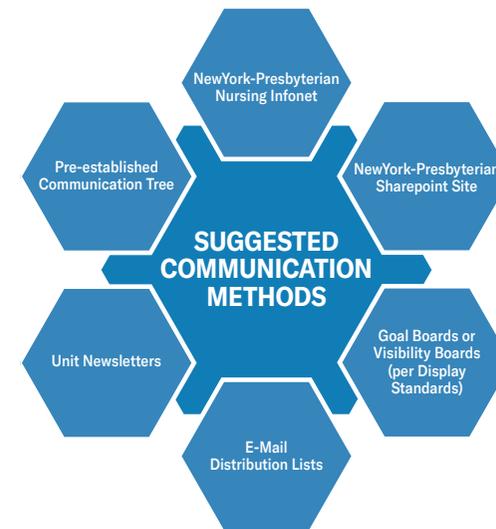
Tips for Building Consensus

Consensus *does not* mean that everyone be in complete agreement.

- All staff need to have a clear understanding of consensus for it to work.
- It is a decision-making process that includes all unit council members in making the decision.
- Everyone gets an opportunity to voice their opinion.
- Viewpoints are discussed until a motion emerges that wins general approval.
- All members must agree that they can "live with" the final decision.
- Consensus is based on compromise and the ability to find common ground.
- Consensus enhances acceptance of the solution and willingness to implement it.
- The process helps alleviate resentment, division, and efforts to undermine the decision.

Communication Methods

A bidirectional communication process is foundational to the success of professional governance. There are many different methods that can be utilized to ensure that information and decisions made are communicated to all appropriate stakeholders. The method selected can depend on many different factors, including the characteristics and preferences of team members, but utilizing multiple methods of communication is most effective in getting the message across. Below are some of the many options available for communicating information pertaining to professional governance meetings.

SUGGESTED COMMUNICATION METHODS
- NewYork-Presbyterian Nursing Infonet
- NewYork-Presbyterian Sharepoint Site
- Goal Boards or Visibility Boards (per Display Standards)
- E-Mail Distribution Lists
- Unit Newsletters
- Pre-established Communication Tree

Campus Committees and Councils

Guiding Principles
- Each campus should have quality and safety, nursing research and evidence-based practice, practice, and informatics committees to support the work across NewYork-Presbyterian campuses.
- Campus committees have open communication with unit councils, the Staff Advisory Council, and the Staff Advisory Board.
- Each campus may develop additional committees to meet the campus-specific need; these committees may be ad hoc.
- Campus committees should be led by a clinical nurse.

An Infrastructure for Professional Governance

Campus-Based Professional Governance Structure
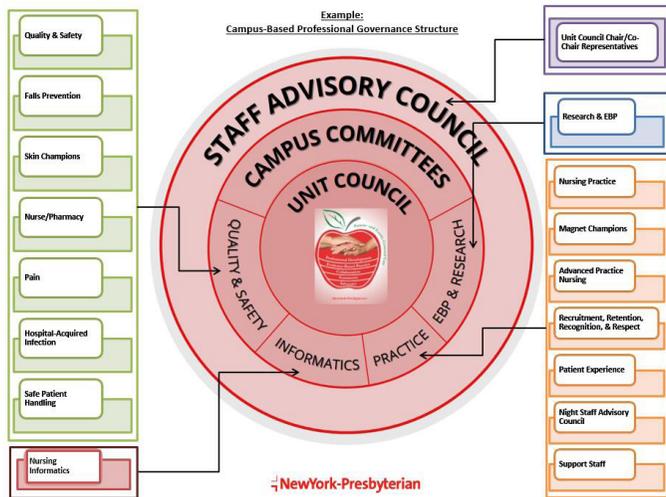
Specific committees and professional practice models may vary by campus.

Staff Advisory Board

- The Staff Advisory Board members serve in an advisory capacity to the vice president/chief nursing officer and provide reports, updates, escalations, requests, challenges, ideas, and other pertinent information regarding their campus committee work.
- The structure supports chief nursing officer visibility and accessibility and ensures input is heard and communicated to the NewYork-Presbyterian nursing board by the chief nursing officer. The structure facilitates bi-directional communication among clinical nurses, the chief nursing officer, and the nursing board.
- Membership includes the vice president/chief nursing officer and campus committee chairs/co-chairs as determined by the site's vice president/chief nursing officer.

Staff Advisory Council

- Responsible for representing department peers in providing counsel to the vice president of nursing/chief nursing officer at each campus on a variety of topics determined by the vice president and council members
- As indicated by the campus vice president of nursing/chief nursing officer, membership could include unit council chairs/co-chairs, campus committee chairs, patient care directors and directors of nursing representatives, and other interprofessional members

Nursing Research and Evidence-Based Practice Council

- Supports and facilitates evidence-based practice and research among NewYork-Presbyterian nurses
- Supports the ethical conduct of research
- Implements the PEACE Model as a framework for evidence-based practice and research utilization [Appendix F]
- Maintains an accurate record of nursing-led research at each campus, with the goal of increasing research collaboration and staff awareness in nursing research
- Plans and participates in the NewYork-Presbyterian-wide annual Research, Evidence-Based Practice, and Innovation Symposium
- Participates in the development of mechanisms for increasing nursing research within NewYork-Presbyterian, as well as regionally, nationally, and internationally
- Supports the development and implementation of journal clubs [Appendix G]

Nursing Quality and Safety Council

- Supports a culture of safety
- Develops, revises, and makes recommendations for the Nursing Quality Improvement Plan and provides feedback for annual evaluation of the effectiveness of the plan
- Aligns the Nursing Quality Improvement Plan with the Hospital Quality Plan to detect trends and patterns of performance that affect more than one department or service
- Ensures quality patient outcomes by reviewing and evaluating data (e.g., NDNQI, Maryland QIP, unit data, and benchmarks) to develop action plans as needed to drive improvement in collaboration with unit practice councils in the Department of Nursing
- Monitors and ensures compliance with established state, federal, and regulatory standards
- Collaborates with other disciplines to monitor and evaluate compliance to standards and make recommendations to enhance continuous quality improvement and safety
- Monitors and analyzes data relative to nursing quality and safety practices seeking opportunities for continual improvement; evaluates outcomes in conjunction with these initiatives
- Evaluates results of quality reviews based upon serious adverse events, root cause analyses, and/or other regulatory citations in order to participate in development and implementation of improvement plans

An Infrastructure for Professional Governance

Nursing Practice Council

- Ensures evidence-based nursing practice, policies, clinical standards, and patient education resources, along with other programs that support professional nursing practice

Nursing Informatics Council

- Promotes strategic approaches with information technology by mapping innovative solutions to meet nursing's information needs (i.e., communication tools, data reporting, research)
- Ensures that clinical applications reflect standards of care, nursing practice, and support patient safety
- Assures that electronic medical record documentation is updated based on nursing practice changes or regulatory requirements in collaboration with the Department of Nursing and other disciplines
- Utilizes evidence-based research in conducting design sessions and/or review of new requests
- Provides communication within NewYork-Presbyterian to disseminate information and obtain user input and feedback regarding informatics and IT-related initiatives (i.e., new system implementation or upgrades)
- Provides consultation and recommendations regarding policies and procedures impacting nursing practice and the use of clinical systems such as downtime and disaster and data recovery
- Oversees the change control and change management process in approving requests to optimize and/or comply with regulatory standards and best practices
- Provides information to promote and support nursing informatics competency for all staff

> NewYork-Presbyterian's goal is to facilitate the advancement of professional nursing practice and to provide support to the nursing staff, with the ultimate purpose of improving the quality of patient care.

Recruitment, Retention, Recognition, Respect (R4)

- Guides nursing strategy on nurse recruitment, retention, recognition, and engagement initiatives within the organization and the nursing community
- Assists nursing staff to optimize the care environment in order to support quality patient care and career growth
- Aligns initiatives with the organization's strategic needs
- Collaborates with unit councils and the operations council on the identification, assessment, and alignment of R4 goals and objectives
- Reviews data to identify opportunities for improvement – turnover, exit interview, nurse engagement, and patient experience scores
- Reviews healthy work environment opportunities
- Promotes professional growth, lifelong learning, and career progression opportunities such as the clinical ladder, certification, and formal education
- Supports effective communication and a culture of civility
- Works with Talent Acquisition to identify opportunities to recruit top talent
- Identifies opportunities to increase staff engagement and facilitate/collaborate on campus-specific recognition activities

Successful Implementation

Strategies for Success

Implementing professional governance within an organization takes time. Following are several strategies to use to overcome the most common barriers and ensure successful implementation.

Bidirectional communication between councils and leadership.
It is important that the leadership sponsor of every council have open communication with the chairs/co-chairs of the councils they facilitate. This open, bidirectional communication between council chairs and leadership will ensure that the work the council is doing is meaningful and supported by both the frontline teams as well as leadership. Working in partnership to accomplish common goals will make the council's work most effective. There may also be times when the council chairs require advocacy from their leadership sponsor, and having established open, bidirectional communication will facilitate the conversation of advocacy between the council chairs and their leadership sponsor.

Dissemination of information from hospital-wide committees to unit councils.
For successful professional governance implementation to occur it is crucial for members of hospital-wide committees to go back to their unit and share their learnings and information with their unit council. This way the work being done by the hospital-wide committees is being shared and disseminated

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across all levels of the organization. If this dissemination of information does not happen, then the work done by the hospital-wide committees will be ineffective in driving change.

Ensuring representation from every unit at all hospital-wide committees.
Representation from every unit will give ample opportunity for dissemination of information as mentioned above.

Patient care director and the unit council.
Each unit council meeting should include a standing report from the patient care director. In this report out, the patient care director will share any new updates with the team, as well as follow up and close the loop on any outstanding items the team wanted to hear more about. Additionally, having the patient care director attend a part of every unit council meeting will allow patient care directors insight into how they can assist with resource allocation or advocacy on behalf of the unit council with senior leadership for unit needs.

Committee/council charter.
Every committee and council (including the unit council) should have a charter. This charter will house the mission, vision, and purpose of the council. A council charter will also outline membership tenure, timelines, and roles within the council. The charter should be reviewed annually.

Goal setting.
At the beginning of every year, all committees/councils should have a goal setting discussion to outline what they want to achieve in the coming year. The goals for the council are aligned with unit goals and nursing strategic plans, which ensure the overall alignment with the NewYork-Presbyterian strategic initiatives. The goals outlined in this session will help to inform and develop monthly agendas to work towards those goals.

Event planning.
The yearly planning of recognition events or any event should be laid out at the beginning of the year to allow for adequate time to plan and execute events.

> For successful professional governance implementation to occur it is crucial for members of hospital-wide committees to go back to their unit and share their learnings and information with their unit council.

Implementing Professional Governance: Barriers and Strategies

Barriers	Strategies
Resistance to Culture Change	Resistance to culture change is to be expected. Continue to drive and remind teams of the importance of shared governance structures to ensure that the voices of those doing the work are being heard. Ensuring the dissemination of information will help with resistance to change and transparent communication between committee/council leadership and chairs/co-chairs. Additionally, encourage feedback from those participating in meetings and solicit their opinions on changes that they want to implement and work to make those changes happen as a committee/council.
Time Management Skills	Time management can be difficult during a meeting, especially if there is robust conversation. At the beginning of every meeting, assign a timekeeper. This person will ensure that the allotted time for each agenda item is adhered to. If the conversation surrounding the current topic is necessary and goes over the allotted time, the chair/co-chair can make the decision to continue the conversation as long as it remains productive. Be mindful of the topics not covered in the agenda and make sure they carry over to the next month's agenda.
Time Commitment to Attend Meetings	Finding the time to commit to attending meetings can be difficult. Be sure to have leadership's buy-in and support in assisting to find ways of allowing team members the time to attend meetings. Some units have scheduled shared governance days when unit council members are off patient assignments but come in for professional governance work and are compensated for their time doing this work.
Communication: Expressing Ideas Clearly and Objectively	Being able to communicate effectively can be challenging for some members. To help with this barrier, members should make written notes of the main points they want to address and speak in a concise and focused manner. If the presentation begins to go off topic, the speaker should stop and recenter their thoughts to return the discussion to their main points.
Competing Priorities	If members of the team are citing competing priorities as a reason for not being able to attend meetings, suggest they utilize time management skills. If this does not address their attendance, reassess their commitment to the group. It is understandable if a team member cannot commit due to other priorities. In this case, identify a replacement member.
Meeting Times	Set meeting times have both pros and cons. The pro is that the meeting time is expected and scheduled to occur at the same time and place every month. However, if the group agrees, meeting times can change and vary depending on when staff are most available. Meeting times can also alternate or occur during change of shift.

An Infrastructure for Professional Governance

Facilitating Professional Governance Meetings

Characteristics of a Chair and Co-Chair

Gatekeeper	• Ensures that the agenda is followed, that everyone who wants to speak has the opportunity to do so, and that no one member dominates the meeting
Devil's Advocate	• Challenges a consensus that may be emerging prematurely without sufficient thought
Consensus Builder	• Identifies and highlights areas of agreement among members
Supporter and Advocate	• Gives genuine praise to participants when it is due • Advocates to bring to the table issues that are raised by peers
Joker	• Relieves tension and reminds members of common bonds

Professional Governance Tool Kit

Templates for developing agendas, reporting minutes, UPC SMART goal setting and action planning, and presenting a unit council charter will help in the implementation of professional governance meetings. [Appendix C and Appendix D]

Setting the Agenda

Agenda items.
- Establish standing agenda items, such as reviewing and approving minutes, member recognition, moments of success, and reporting out from representatives. Develop agenda items based on meeting purpose. For example, the Nursing Quality and Patient Safety Council may include standing agenda items such as Keepsafe events review and NDNQI clinical indicators performance review.
- Follow up on action items from previous meeting minutes and identify any continuing work required.
- Other agenda items may include current initiatives led by the council or those implemented campus-wide.

Meeting length.
- Establish the appropriate meeting length. Most council meetings are scheduled for an hour. Be realistic with time frame given for each agenda item and end on time. Assign a timekeeper and adhere to allocated time for each topic.

Sequence agenda items.
- Be strategic in setting up the sequence of agenda items. Assess issues and topics that build on or complement each other. Start with low hanging fruit/easy wins first, then move on to more complex discussions.
- Delineate information sharing versus problem solving, decision making, or brainstorming. Be judicious when accepting requests for agenda time. Be sure to understand the topic to be presented. For information sharing, check if this can be disseminated in another way such as e-mail communication.
- Let team members know when feedback, decisions, or brainstorming are required so they have clear expectations.

Meeting logistics.
- Use the agenda template and fill out required fields completely. This includes date, time, location (in person, virtual, or hybrid), name of council, and chair/co-chair leaders for the meeting.
- Send the meeting agenda and minutes beforehand, including any background materials needing review or to be prepared before taking part in meeting.

Tips for Facilitating Meetings

Make sure there is a clearly stated objective or purpose for the meeting and an expectation of outcomes and aligned deliverables. Meetings without clearly stated objectives can be more easily diverted by individual opinions and grievances resulting in a counterproductive meeting that has lost focus of its purpose.

Agree on time blocks and keep the team moving to stay on time. Setting time limits forces a guardrail for the group, offers a way to corral discussion and debate, and avoids irrelevant discussions. For example, the facilitator may say, "We're going to present the material with 15 minutes to discuss. At the 15-minute mark, we move on." Some groups may consider setting a timer.

After each time block, recap the discussion and restate any decisions. During each recap, the facilitator should highlight deliverables/action items discussed in that time block.

Before moving on to a new subject, make sure the group comes to some consensus. Two or three players can dominate most meetings. The facilitator should ask some of the less vocal members of the team for their thoughts. Some of the best ideas come from the people who are observing and processing the information, but who are not always vocal. It is a good way to try and encourage quiet members to speak and demonstrate that their thoughts are valuable.

An Infrastructure for Professional Governance

Tips for Facilitating Meetings (continued)

Watch for rabbit holes. The facilitator should watch for topics that typically sidetrack the group to avoid restating and rehashing what isn't working and what needs to change.

Watch for team members' soapbox. Different members of the team may revisit many of the same issues over and over again. Use the time restrictions to help manage a person who is on a soapbox.

Use the parking lot to "park" rabbit holes, soapbox topics, and recurring themes. People need to be heard, but in order to make progress, the facilitator and group need to agree to table certain issues. For example, a facilitator may say, "We hear you. We're going to park that issue for now. We will address it, but not right now."

Anticipate issues and consider ways to move people from opinions and value statements to discussions about the facts and options. This can be the most critical step. Preparation for facilitating a good meeting can take almost as much time as the meeting itself. By anticipating that some members are going to dominate the discussion, the facilitator should be prepared with a tool or mechanism to address the frustrations of some group members and resolve the situation with a statement such as, "I hear you. What do we want to do about it?"

Ask someone to scribe during the meeting. Writing down individuals' thoughts, observations, and statements can be helpful later in the meeting or on another occasion. On a flipchart, post their comments, key points, and topics so the group can easily recap. This demonstrates that everyone knows they've been heard.

Encourage involvement and guide the group to discuss next steps. Questions such as these will encourage involvement: What ideas do you have? What has been your experience in implementing this process on your unit? When would be the best time to meet for follow up?

At the end of the meeting, a strong facilitator will recap any decisions, actions to be taken, owners, and timing.

Case Scenarios

Case scenarios can be used as an engaging exercise with the team to further solidify meeting facilitation skills. Review the case scenarios below and discuss possible reactions with members.

Case 1: You are leading a meeting and notice that Padma has gradually begun to dominate the discussion. What should you do?
Thank Padma for her thoughts and input and try to solicit feedback/thoughts from other participants. Occasionally others in the group may be weary of sharing their ideas and thoughts, especially if they differ from the person who has been dominating the discussion. As a chair/co-chair, directly asking others for their input will let them know that their voice is valued and needs to be heard.

Case 2: Antonio has arrived late for the past three staff meetings. What should you do?
Check in with Antonio. It is important to give each other the benefit of the doubt and to see if the meeting day/time may not be realistic for Antonio to attend. Antonio could also be pre-occupied with personal matters that require his focus to be elsewhere. By reaching out and giving him the opportunity to share if he so chooses, you can devise a solution that would help make it easier for Antonio to attend the meetings. However, if after making adjustments to facilitate Antonio's attendance he is still unable to make the meetings, advise him that if he cannot commit he can step down and assist in finding a replacement for the time being.

Case 3: You have been leading a meeting and notice that participants have fallen silent. What should you do?
As the chair/co-chair, it is important to solicit feedback about the reasons why participation has diminished. Perhaps the objective of the meeting was met and there is simply nothing else to discuss. If that is the case, recap the meeting and end it early. Another reason for participants' silence could be confusion about the topic. Try to determine if members understand what is being discussed. In addition, if one or two individuals are dominating the discussion, this can also cause others in the group to stop contributing.

An Infrastructure for Professional Governance

Case 4: **When discussing different approaches to solving a problem, some participants may react negatively to the suggestions, interrupt others, and disturb the meeting. What should you do?**
In these situations, it is important to remind everyone that they are attending the meeting for the same purpose and state that purpose explicitly. Also remind participants that all ideas and suggestions are to be respected and valued. Through a variety of thoughts and perspectives issues can best be solved.

Case 5: **During a meeting the group keeps returning to a specific agenda item and appears to be fixated on or confused about it. What should you do?**
The first step would be to recap what has already been discussed and any decisions made. Next, ask the group for feedback to see if they understand what has been discussed. It may be time to end the meeting because the objectives have already been met.

Case 6: **During the course of a meeting, you notice that participants keep repeating points already made. What should you do?**
This could be because participants are not clear on what has already been discussed and the decisions made. This would be a good opportunity to recap the meeting thus far.

Sara Kress, BSN, RN, CCRN, CSC; Sabrina Furia, BSN, RN; Mohammad Kashif Islam, BSN, RN; Charlotte Horn, BSN, RN, CCRN, CSC; and Madeline Tsang, BSN, RN, NewYork-Presbyterian/ Weill Cornell Medical Center

Implementing Unit Council and Committee Projects

Professional governance structures provide a forum for nurses and inter-professional team members to identify and discuss opportunities for change in clinical practices or clinical settings. For instance:
- Identifying an improved process for documentation within the electronic medical record (EMR) could be discussed with a nursing informatics council
- A member of the unit council was reviewing a nursing journal and read about an evidence-based practice that reduced the incidence of falls prompting the unit council to pilot this change
- When a pilot on a best practice to care for a central line is successful, the nursing practice council is charged with incorporating the practice into formal policy.

A good first step in the successful implementation of improvements led by professional governance councils or committees is ensuring that goal setting and action planning is taking place. Templates are provided to aid in this process. [Appendix C and Appendix D] After the council or committee has set goals for improvement projects, they are ready to lead the practice change needed to meet those goals.

Practice change in and of itself can feel burdensome, overwhelming, and sometimes daunting, but when broken out into tangible steps, the aspect of practice change can become much more manageable. Among the steps important to consider when embarking on a practice change project are:

Step 1: **Identify members and/or committees and councils that will be a part of the project/change team and engage them as stakeholders.**
Change team members should consist of those who will help drive the project forward and implement the change. A good tip is to include clinical experts on the team who can offer advice and have experience in driving change. These individuals can include advanced practice nurses, nurse researchers, nurse leaders, and/or nurses with past project experience. The list should include both active and passive stakeholders to ensure a well-rounded group of professionals. Active stakeholders will include those who will be affected by, or will directly affect, the proposed change (e.g., nurses). Passive stakeholders will include those who may not be directly affected by the change but who could be involved in the success or the hindrance of the proposed change (e.g., patient care director).

An Infrastructure for Professional Governance

Identify professional governance committees that will act as stakeholders for the proposed change. Think about the examples that were used earlier – is it a technology change? Then contacting the nursing informatics council would be a good place to begin. Is the change one that effects the quality of care that is delivered to patients? Then the quality and patient safety committee would be a recommended resource. Unit-specific projects are often best suited for the individual unit council. Remember, it is appropriate to reach out to different councils and committees to find the right fit for the proposed change. This group will be one that supports the change and helps drive the process in the right direction.

Step 2: **Seek administrative support from local leadership (i.e., patient care director, director of nursing, chief nursing officer).**
When pitching plans to leaders, craft an "elevator speech" or brief presentation that outlines the problem or current state, the proposed intervention, measurement of progress, and the benefits/outcomes of the change. Gaining administrative support ensures the work is aligned with the organization's vision.

Step 3: **Develop an implementation plan.**
Implementation, simply stated, means putting something into effect. The implementation plan should include the objective/goal/aim of what the project is trying to accomplish, an estimated timeline for completion of each phase and next steps, clarified and defined roles for each team member (i.e., champion, education lead, project lead, sponsor), and specific measurements to be collected or tracked. When developing an implementation plan, it is important to consider any barriers or obstacles that may be faced and incorporate these obstacles into the plan. One barrier that is almost a certainty with every project is resistance to change. There are a number of reasons why stakeholders may resist a proposed change but anticipating these barriers will enable the plan to be developed accordingly. See page 22 for "Strategies for Success" when facing resistance to change.

Step 4: **Carry out the implementation plan.**
To help ensure a successful implementation, it is important to first hold a launch meeting with the team and stakeholders to build excitement, discuss deliverables, ensure everyone is clear on their roles and responsibilities, and to finalize the project timeline. Depending on the scale of the project, the launch meeting can also be used to discuss when and where to pilot or test the intervention and determine the feasibility, scalability, and safety of the proposed change.

When thinking about the proposed change, it is important to consider the effects the change will have at both a local and global level. With any project, once the success has been determined on a local level, plan to expand the project to other units and locations. It is important to think more broadly while being focused to ensure success on multiple levels.

Step 5: **Evaluate the outcomes.**
Evaluating the successes or failures of your evidence-based practice change is critically important to the process. Without this key step, it can be challenging to know if its goals have actually been achieved. Determining how to evaluate the outcomes of a change should be identified early in the evidence-based practice change process and should not be an afterthought. A good rule of thumb is to incorporate evaluation plans into the initial project planning phase.

While the formal step of evaluation typically occurs in the later stages of a project, it is important to remember that some form of evaluation has likely already occurred when the problem was identified and the decision made for an evidence-based practice change. Understanding that evaluation can occur during multiple stages of the project helps highlight the fundamental importance of building this step into the project plan. Remember, data comes in many shapes and sizes. If unsure what data to utilize or what data sources are available seek support from the local leadership team.

Step 6: **Disseminate the findings.**
Knowledge sharing is vital to the advancement of nursing practice both locally and globally. An unfortunate part of many evidence-based practice changes or projects is that oftentimes the work is not shared or disseminated with others. When developing a project plan, it is encouraged to incorporate dissemination plans into the conversation and build it into the process. It is also important to remember that there are multiple avenues to explore when deciding how to disseminate the work. Consider writing a manuscript to have the work published in a journal, and/or crafting a poster or developing a podium presentation for local or national conferences. [Appendix E] Regardless of the vehicle for dissemination, this will help ensure that the work is shared beyond the point of implementation.

All in all, implementing improvements through practice change is something that can be accomplished by anyone – from a novice professional to an advanced project manager with years of experience – as long as each step of the project is followed. From there, the structures that are already established and in place can be leveraged to help support the ideas, drive the project forward, and advance successes globally.

An Infrastructure for Professional Governance

Measuring Professional Governance

Why Measure Professional Governance?

As nurses identify opportunities for strengthening professional governance, they can evaluate the effectiveness of their strategies using proven tools and frameworks. The following tools can be administered at various stages of the journey to enhance autonomy and accountability and to foster collaborative interprofessional relationships.

Index of Professional Nursing Governance (IPNG)
Robert Hess

Hess, R. G. (1998). Measuring nursing governance. *Nursing Research*, 47(1), 35-42.

- This study supported the validity and reliability of an 88-item instrument for measuring RN perceptions of professional nursing governance in hospital settings.
- Results include a distribution score indicating professional nursing governance on a continuum from traditional governance to shared governance to self-governance. These are nursing specific and do not include interprofessional governance. A score between 86 and 172 represents traditional governance; a score between 177 and 344 represents shared governance; and a score of 345 or more represents self-governance. The IPNG provides group scoring by level of management, unit, and department groups.
- The newer condensed 50-item INPG 3.0 is available with permission at Forum for Shared Governance: https://sharedgovernance.org/?page_id=70

Index of Professional Governance (IPG)
Robert Hess

Swihart, D. & Hess, R. (2014). *Shared governance: A practical approach to transforming interprofessional healthcare.* (3rd ed.). HCPro.

- The Index of Professional Governance measures governance among all healthcare professionals.
- The newer condensed 50-item INPG 3.0 is available with permission at Forum for Shared Governance: https://sharedgovernance.org/?page_id=70

Council Health Survey
Robert Hess, Jennifer Bonamer, Diana Swihart, and Stacey Brull

Hess, R., Bonamer, J. Swihart. D. & Brull, S. (2020). Measuring council health to transform shared governance processes and practice. *JONA: The Journal of Nursing Administration*, 50(2), 104-108. https://doi.org/10.1097/NNA.0000000000000849

- This 25-item survey allows nurses to measure council effectiveness at either the unit or division level categorized by structure, activities, and membership. This is helpful for council chairs to measure the engagement of council members since the heart of professional governance and its ultimate success begins at the unit/division level.
- The Council Health Survey is available with permission at Forum for Shared Governance: https://sharedgovernance.org/?page_id=70

Professional Governance Scale
Marla Weston, Joyce Verran, Joanne Clavelle, and Tim Porter-O'Grady

Weston, M., Verran, J., Clavelle, J., & Porter-O'Grady, T. (2018). Professional governance scale: Instrument development and content validity testing. *Advances in Nursing Science*, 41(2), 188-198. https://doi.org/10.1097/ANS.0000000000000200

- This 75-item scale measures the attributes and characteristics of the concept of professional governance and its attributes of accountability, professional obligation, collateral relationships, and decision making.
- It is helpful to understand the presence of structures that support professional governance and specific behaviors exhibited by nurses within the patient care team and healthcare organization.

An Infrastructure for Professional Governance

The Nursing Practice Council Effectiveness Scale and General Theory for Effective Multilevel Shared Governance (NPCes GEMS™)
Courageous Healthcare, Inc.

Bogue, R. J., Joseph, M. L., & Leobold, C. (2009). Shared governance as vertical alignment of nursing group power and nurse practice council effectiveness. *Journal of Nursing Management, 17*, 4-14.

- GEMS, GEMS Theory, General Theory for Multilevel Shared Governance, GEMS NPCes Self-Assessment, and the GEMS logo are trademarks of Courageous Healthcare, Inc. For information and customer support, contact GEMS@courageoushealthcare.com.
- This 22-item scale is a valid and reliable survey tool for assessing the effectiveness of unit-level nursing practice councils based on the GEMS theory. The NPCes GEMS™ provides the stage of the council's maturity or progress among the three stages of practice council effectiveness: the foundational, empowering, and aligning stages. The NPCes GEMS™ also helps to identify areas of strong or weak vertical alignment. Vertical alignment is important since nurses, managers, and leaders share cognitive understanding and a commitment to common goals.

Appendices

References

Appendix A

Professional Practice Model and Patient- and Family-Centered Care Delivery System

The NewYork-Presbyterian Professional Practice Model (PPM) articulates the distinctive role nurses play in building a culture of patient- and family-centered care. It exemplifies how nurses practice, collaborate, communicate, and develop professionally and transform nursing practice through innovation. It is built upon the premise that nurses at all levels are actively involved in the decision-making process and have a voice in the attainment of NewYork-Presbyterian's organizational goals. Participation in professional governance councils and committees at the campus or cross-campus level fosters the values of advocacy, autonomy, and collaboration. Drawing on research and evidence-based practice, nurses grow professionally while representing their peers and serving the patients and families within NewYork-Presbyterian.

Elements of the Professional Practice Model and Schematic
- **NewYork-Presbyterian Allen Hospital**
- **NewYork-Presbyterian/Columbia University Irving Medical Center**
- **NewYork-Presbyterian Lower Manhattan Hospital**
- **NewYork-Presbyterian Morgan Stanley Children's Hospital**
- **NewYork-Presbyterian/Weill Cornell Medical Center**
- **NewYork-Presbyterian Westchester Behavioral Health**
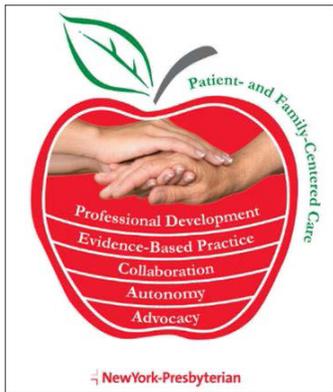
This image represents the Big Apple (the nickname for New York City) with the hands depicting the warm relationship between nurses and patients and families. This relationship is built on the five essential elements of nursing practice, unified by one purpose: patient- and family-centered care.

Advocacy.
Empower patients, families, communities, and colleagues to ensure culturally competent and compassionate care

Autonomy.
Foster self-directed practice through critical thinking and accountability

Collaboration.
Promote interprofessional communication and coordination of patient- and family-centered care

Evidence-Based Practice.
Integrate clinical expertise, scientific findings, and patient preference to improve outcomes

Professional Development.
Commit to personal, clinical, and scholarly growth to optimize the patient experience

Holskey, M. P., & Rivera, R. R. (2020). Optimizing Nurse Engagement: Using Liberating Structures for Nursing Professional Practice Model Development. *JONA: The Journal of Nursing Administration*, 50(9), 468-473. https://doi.org/10.1097/NNA.0000000000000918
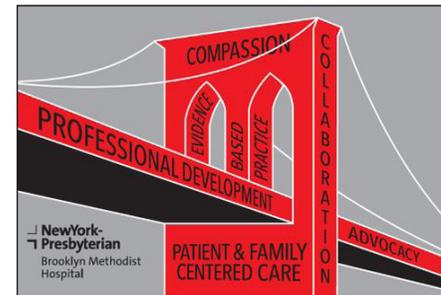
The Professional Practice Model draws inspiration from the iconic Brooklyn Bridge. The six tenets of the PPM – Patient and Family Centered Care, Advocacy, Evidence-Based Practice, Professional Development, Compassion, and Collaboration – are all built upon each other and, much like a bridge, need a solid foundation to be structurally safe and sound.

Elements of the Professional Practice Model and Schematic
- **NewYork-Presbyterian Brooklyn Methodist Hospital**

Compassion.
Provide empathetic care without bias or judgment.

Advocacy.
Empower patients, families, communities, and colleagues to ensure culturally competent care.

Collaboration.
Promote interprofessional communication and coordination of patient- and family-centered care.

Evidence-Based Practice.
Integrate clinical expertise, scientific findings, and patient preference to improve outcomes.
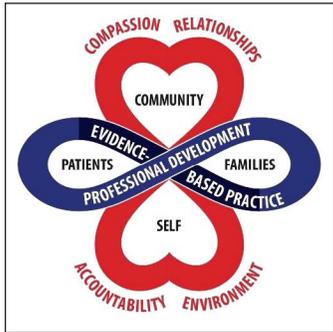
Professional Development.
Commit to personal, clinical, and scholarly growth to optimize the patient experience.

Appendix A

Elements of the Professional Practice Model and Schematic
• NewYork-Presbyterian Westchester

This schematic illustrates a framework through which nursing staff are empowered to act with a reasonable degree of autonomy and confidence within a governance structure of professional clinical decision making.

Relationships.
Through effective communication, transparency, equity, and recognition, we establish mutually nurturing partnerships with our nursing colleagues, inter-professional teammates, patients, their families, and the community-at-large.

Compassion.
The essence of every interaction.

Evidence-Based Practice.
We foster a culture of appreciative inquiry rooted in the principles of quality, safety, and education to continuously improve empirical outcomes.

Accountability.
We honor the trust of our community through integrity, advocacy, and exemplary professional practice.

Environment.
From our practice settings to interpersonal interactions, we collaboratively create an atmosphere that promotes holistic health and well-being.

Professional Development.
We advance nursing practice through self-actualization, mentorship, and the quest for ever-evolving knowledge.

Elements of the Professional Practice Model and Schematic
• NewYork-Presbyterian Hudson Valley Hospital

Our stethoscope symbolizes our diligent assessment and care of the patient's physical condition while our hearts are open to their emotional, spiritual, and cultural needs. Our hands represent our ability to grow and change so that we can provide the comfort that our patients and our community need.

Caring.
Philosophy of Caring: We strongly believe in caring for the patient, the family, and the community with open hands and hearts while being attentive, nonjudgmental, comforting, patient, respectful, and sensitive. Caring extends to ourselves and each other.

Compassion.
We believe in treating each patient within the context of their family and community and respect each individual's cultural and religious beliefs. Protecting the patient from harm, teaching patients, relieving pain, and promoting wellness through a holistic approach are the hallmarks of compassion. We are open to the human connection, remaining supportive of the patient and family from birth to the end of life.

Teamwork.
Teamwork is evident in our nursing practice. We believe working together every day will allow us to achieve patient-centered goals and is the best way to ensure optimal patient outcomes.

Collaboration.
We strive to provide exceptional care through an interprofessional team approach that focuses on open conversation and shared decision making.

Accountability.
We believe that it is essential to empower ourselves in our clinical practice. This is accomplished through education in best practices and a commitment to lifelong learning. Active participation in shared governance forums allows us to maintain an autonomous, responsible professional practice.

Appendix A

Quality and Safety.
Nurses at NewYork-Presbyterian Hudson Valley Hospital strive to improve patient safety by promoting quality in nursing care. Quality improvement comes in many forms: advocacy, research, collaboration, and a commitment to continuously improving nursing practice.

Leadership.
At NewYork-Presbyterian Hudson Valley Hospital transformational leadership occurs in all settings and the nurses actively participate in organizational decision making through shared governance councils, committees, and task forces. Nurses move in and out of the roles of leader and follower as the needs arise, helping each other to advance nursing practice and grow to fulfill their individual and collective potential.

Exemplary Professional Practice.
Nurses at NewYork-Presbyterian Hudson Valley Hospital view nursing as both an art and a science. As scientists, we engage in evidence-based practices and research development utilizing the resource of our Research Council. We critically view our practice, analyze potential and real problems, and seek new information to apply to practice. We monitor the outcomes and revise our care as needed. As artists, we are reflective in our practice and incorporate personal insights gained from our nursing practice and experience. We are centered on the human interaction that occurs when scientific competence combines with a moral and ethical component. Our personalized care is the heart of our practice.

Elements of the Professional Practice Model and Schematic
• NewYork-Presbyterian Queens

The image depicted is the iconic Unisphere, located in Flushing Meadows-Corona Park. The schematic of the Unisphere with hands represents our support and commitment to the communities we serve. The Unisphere is encircled by the six essential elements of nursing practice, which support the delivery of patient- and family-centered care.

Advocacy.
Empower patients, families, communities, and colleagues to ensure culturally competent and compassionate care.

Autonomy.
Foster self-directed practice through critical thinking and accountability.

Collaboration.
Promote interprofessional communication and coordination of patient- and family-centered care.

Evidence-Based Practice.
Integrate clinical expertise, scientific findings, and patient preference to improve outcomes.

Professional Development.
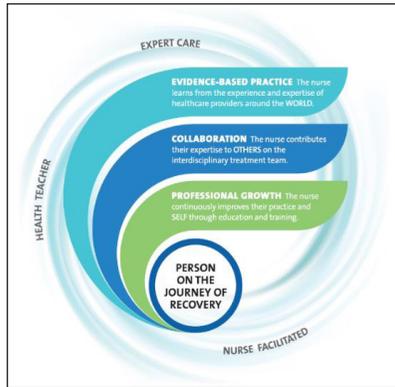Commit to personal, clinical, and scholarly growth to optimize the patient experience.

Diversity.
The acceptance and support of each individual and their uniqueness.

Appendix A

Elements of the Professional Practice Model and Schematic
- **Gracie Square Hospital**

The schematic represents the purpose and vision of Gracie Square Hospital's professional practice model to encourage, empower, and support each nurse on their professional journey and to guide care that focuses on meeting the individual needs of each person on their journey of recovery.

Professional Growth.
Continuously advancing nursing practice though active engagement in the journey for knowledge.

Health Teacher.
Sharing knowledge and expertise openly in a friendly and compassionate atmosphere.

Collaboration.
Approaching each interaction with fellow nurses, interdisciplinary teammates, recovering persons, families, and the community as a partnership for working towards a mutual outcome.

Nurse Facilitated.
Driving person-centered recovery in harmony with the core values of professional nursing practice.

Evidence-Based Practice.
Centered on improved outcomes, quality, and safety, nurses foster a care environment that utilizes the most recent research evidence to guide and improve their practice.

Expert Care.
The culmination of a healthcare culture based in respect, integrity, teamwork, compassion, empathy, quality, and excellence focusing on the person on their journey of recovery.

Patient- and Family-Centered Care Delivery System

Patient- and family-centered care is defined as designing processes and structuring work and interactions around each patient and their family.

The Institute for Patient- and Family-Centered Care® defines family as "two or more persons who are related in any way – biologically, legally, or emotionally. Patients and families define their families. In the patient- and family-centered approach, the definition of family, as well as the degree of the family's involvement in health care, is determined by the patient, provided that he or she is developmentally mature and competent to do so. The term 'family centered' is in no way intended to remove control from patients who are competent to make decisions concerning their own health care. In pediatrics, particularly with infants and young children, family members are defined by the patient's parents or guardians." Learn more at http://www.ipfcc.org/faq.html.

The governing principles of the patient- and family-centered care system ensure dignity and respect, information and knowledge sharing, empowered participation and shared decision making, collaboration and engagement, coordination of care, and professional nursing practice.

Guiding Principles of Patient- and Family-Centered Care
- Caring is central to nursing
- Engaging patients and families in care
- Developing personal and professional self
- Promoting interprofessional collaboration
- Creating a healing environment for self, clinical colleagues, patients, families, communities, and populations
- Using the nursing process to plan and provide individualized, quality health care and achieve optimal outcomes for health consumers

Appendix A

Actualizing Our Care Delivery System

The development of a caring and trusting relationship and a leveling of power must initially occur to allow for the effective execution of patient- and family-centered care. Trust and the elimination of power differentials are critical if the patient and family are to ultimately engage in their care.

Patient- and Family-Centered Care (PFCC)
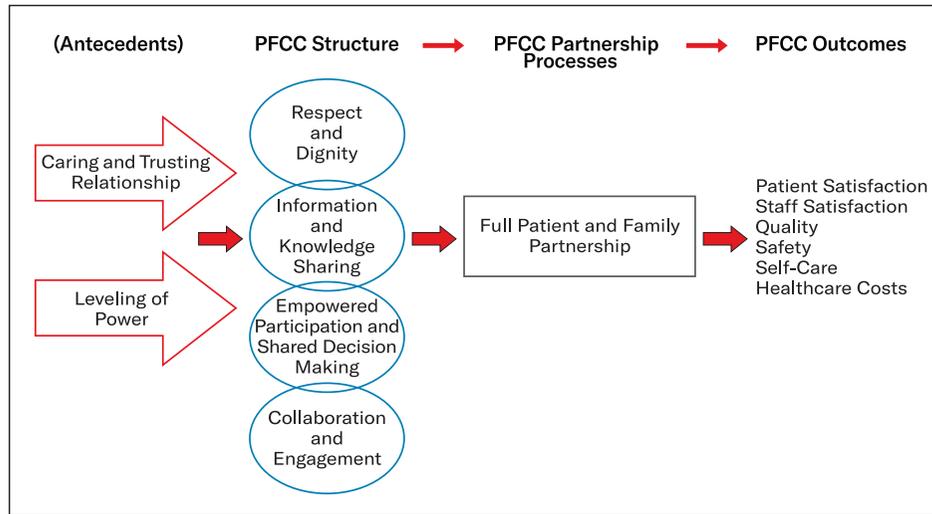
Source: Mastro, K., Flynn, L. & Preuster, C. (2014). Patient-and family-centered care: a call to action for new knowledge and innovation. *JONA: The Journal of Nursing Administration,* 44(9), 446-451.

Theoretical Perspectives

Clinical nurses participated in interactive activities with their colleagues to identify the nursing theoretical frameworks that were most consistent with patient- and family-centered care, the care delivery model of NewYork-Presbyterian. Nurses self-reflected upon nursing theories and the relationships among the metaparadigm concepts of person, environment, health, and nursing; see tables on pages 45-46.

Theoretical Perspectives Based on Peplau, Leininger, Watson, and Swanson

Theory	Person	Environment	Health	Nursing
Peplau Interpersonal Relations*	Self-system composed of biochemical, physiological, and interpersonal characteristics and needs	External factors essential to human development, including the presence of caring others (nurses and others)	Health illness continuum: Health is a forward movement of human processes in the direction of creative, constructive, and productive personal and community living	A significant therapeutic interpersonal process that enhances health
Leininger Transcultural Care Diversity and Universality*	Cultural beings, including individuals, families, groups, communities, and total cultures and institutions	The totality of an event or situation or particular experiences and interactions, including physical, ecological, sociopolitical, and cultural settings	A state of well-being that is culturally defined, valued, and practiced, and that reflects the ability of individuals or groups to perform their daily role activities in culturally expressed, beneficial, and patterned lives	A learned humanistic and scientific discipline and profession focused on human care phenomena and activities to assist, support, facilitate, and enable individuals or groups to maintain or regain their well-being (health) in culturally meaningful and beneficial ways
Watson Caring*	Caring-healing practices honoring deeper meanings regarding life… considering the relational, intuitive, and receptive ways of knowing and being	Caring-healing architecture that is transformative and can potentiate wholeness	Positive state of physical, mental, and social well-being; high level of overall physical, mental, and social functioning	A sacred architect critical to the healing process, creating healing space, and facilitating health and wholeness through caring
Swanson Caring	Not defined Implied: Recipients of nursing care	Not defined Implied: All environments in which nurses work Henvironments in which nurses work Healthy work environments are those that support capable, committed nurses practicing caring	Not defined Implied: Goal of nursing caring interventions	Informed caring for the well-being of others. Caring processes (maintaining belief, knowing, being with, doing for, and enabling) through which nurses demonstrate that they care about patients and care for them through clinical activities

* Source: Theoretical Perspectives. In Fitzpatrick, J. J., & Whall, A. L. (Eds.). *Conceptual Models of Nursing* (2005, 4th ed). Prentice Hall. Upper Saddle River, NJ.

Appendix A

Theoretical Perspectives Based on Peplau, Leininger, Watson, and Swanson
(continued)

Theory	Person	Environment	Health	Nursing
Relationship-Based Care	Not defined Implied: Recipients of nursing care	Not defined Implied: All environments in which nurses work	The state of harmony and healing experienced when one person connects with another	Care of self, care of patients and families, and care of clinical colleagues
Benner Novice to Expert	Not defined Implied: Recipients of nursing care	Not defined Implied: All environments in which nurses work	Not defined Implied: Goal of nursing interventions	Five levels of nursing: novice, advanced beginner, competent, proficient, and expert; nursing includes caring, clinical judgment, and wisdom

NewYork-Presbyterian Nursing Theory

Theory	Person	Environment	Health	Nursing
NewYork-Presbyterian Nursing Theory	Holistic beings; includes individuals, families, groups, communities, and total cultures and institutions; encompasses needs, attitudes, beliefs, and behavior	Physical, ecological, sociopolitical, and cultural settings and support systems that facilitate and promote healthy personal and interpersonal growth; healthy work environments promote professional growth and facilitate individuals working beyond their potential to achieve positive outcomes	Positive state of physical, mental, and social well-being that is culturally defined, valued, and practiced; an experience of harmony and healing, enhanced when one being connects to another	A learned scientific and humanistic profession focused on the interpersonal caring process that assists patients and families to move toward holistic harmony and healing and honor the deeper meanings in life

Holskey, M. P., & Rivera, R. R. (2020). Optimizing Nurse Engagement: Using Liberating Structures for Nursing Professional Practice Model Development. *JONA: The Journal of Nursing Administration*, 50(9), 468-473. https://doi.org/10.1097/NNA.0000000000000918

Appendix B

Sample Unit Council Charter

Purpose
The unit council is established to guide the continuing development of nursing practice in the unit and to act as the decentralized decision-making body for the unit. The unit council provides advice to the patient care director and the director of nursing relative to the practice of nursing and unit operations. Specifically the purposes of the council are to:
- Address the nursing practice needs of all members of the nursing staff.
- Participate in the development of best practice standards of nursing in conjunction with the medical center quality and safety programs.
- Promote quality nursing care and outcomes of patients and families.
- Identify clinical problems and solve clinical issues that affect nursing practice specific to the unit using evidence-based practice.
- Promote the continuing development of professional nursing practice on the unit.
- Share best practices in order to standardize aspects of clinical care.

Responsibilities of the Unit Council
- Receive professional nursing concerns related to nursing practice and the delivery of patient care and problem solve in collaboration with the patient care director and other unit leadership as clinically appropriate.
- Report on hospital-wide committee work relevant to improving the patient and family experience, hospital operations, and RN satisfaction and employee engagement.
- Disseminate information to all staff on the unit.
- Monitor nursing practice on an ongoing basis and make recommendations for improvement, as needed.

Decision Making and Recommendations
- The unit council will use consensus building as its principal method for decision making.

Attendance
- Council members are expected to attend all meetings. Members will notify the coordinating council chair prior to the council meeting if they cannot attend. An alternate representative for the department may be requested.
- If a member has two or more absences within a calendar year, they will be requested to consider resigning or to recommit to active membership.

Appendix B

Frequency of Meetings

- Include how often meetings will occur, as well as dates, times, and locations if available.

Membership

Membership of the unit council is comprised of registered professional nurses and patient care support staff elected by the clinical nurses and patient care support staff assigned to the unit. The patient care director acts as an advisor to the council or committee.

Eligibility.

To be eligible to serve on the unit council one must be a full or part time employee who has completed at least six months of employment.

Elections.

Representatives and alternates to the unit council will be elected by clinical nurses and patient care support staff via secret ballot. Elections will be held over the first two weeks of December.

Chair.

Selected by membership for a two-year tenure. The duties of the chair are as follows:

- Plan the agenda for all meetings of the unit council.
- Preside at all meetings of the unit council.
- Call special meetings of the council, as needed, or requested by the director of nursing.
- Appoint ad hoc committees as the need arises.
- Mentor the co-chair to assume the position of chair.

Co-Chair.

Selected by membership for a two-year tenure. The duties of the co-chair are to:

- Assume the duties of the chair in the absence of the chair.
- Assist the chair in the performance of duties.

Term of Office.

Unit council elected members will serve a term of one year with the option of accepting a second-year term if re-elected. Elected members will assume office on January 1st. All terms will expire December 31st of the year elected to office.

Vacancies.

The chair, on advice and consultation of the co-chair and the patient care director, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.

Reporting Structure.

- Agenda and meeting minutes will be distributed to all staff for review prior to each meeting.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the unit council by reporting back to all staff of the unit and eliciting input regarding items under consideration.

Appendix C

Professional Governance Tool Kit Templates

Agenda Template

Chair: _____

Chair: _____

Co-Chair: _____

Sponsor: _____

Executive Sponsor: _____

<<insert hospital name>>
<<insert name of meeting/forum>>
<<insert date and time>>
<<insert location of meeting room>>

1. Welcome/Call to Order

2. Member Recognition

3. Review of Minutes

4. Announcements/Correspondence

   a. Examples: upcoming events

5. Standing Committee Reports

   a. Examples: Quality and Safety, EBP/Research, Nursing Practice, Patient Experience (Care Coordination, Patient Education, Patient Engagement/Patient Centered Care, Pain, Courtesy and Respect), Employee Engagement (knowing what is expected of me at work, fellow employees committed to doing quality work), RN Satisfaction (RN-RN Teamwork, Autonomy, Leadership Access and Responsiveness, Professional Development) and Operational Excellence

6. Old Business

7. New Business

8. Adjournment and Next Meeting

   a. List date/time/venue of next meetings

Minutes Template

Topic/Action	Discussion	Decision	Follow-Up Date and Responsible Person
The meeting was called to order at [time] by [chair name]. Quorum* Minutes	A quorum was present. Minutes of [date] accepted as submitted. Minutes of [date] accepted with the following revisions:		

Quorum* – a majority of all members

Recorder: _____

Minutes Reviewed/Approved by Chair: _____ Date: _____

Source: DeVries, M. A. 1998. *The New Robert's Rules of Order.* Second Edition, New York: Signet Publications.

Name/Credentials – example: BSN, MSN, DNP, RN, Certification	Title	Unit	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Appendix D

SMART Goal Setting and Action Planning

Unit: _____

Goal: _____

Check to ensure this is a S.M.A.R.T. goal! ❑ Specific ❑ Measurable ❑ Agreed ❑ Realistic ❑ Time Frame

Action Steps	Quantifiable Measurement (methodology/ numerical value)	Resource Requirements (time, people, financial)	Person Responsible	Targeted Completion Date	Status IP, C, D (In Progress, Complete, Delayed) Quantify Numerically

• **S**pecific – includes important details
• **M**easurable – identifies if/when you succeed
• **A**greed – is it acceptable to those who are impacted? Is there buy-in?
• **R**ealistic – is it attainable?
• **T**ime Frame – includes specific period for accomplishment

Adopted from Methodist Hospital in Houston, TX

Appendix E
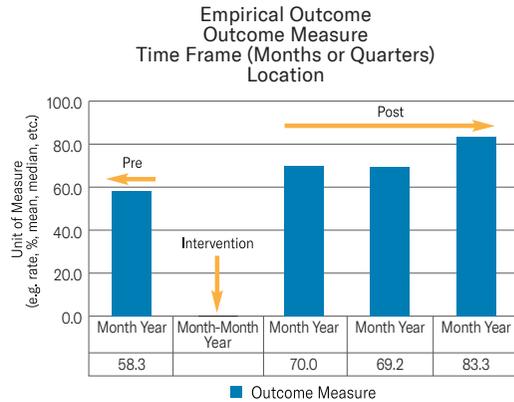
Poster Presentations

Purpose
A poster is a graphical display of information that may be used to convey research, an evidence-based practice project, or quality improvement activity.

Guidelines
1. A poster must be able to connect with the viewers, direct and hold their attention, and provide easily digestible information.
2. Limit the text to about one-fourth of the poster space and use "visuals" to tell your story.
3. The entire poster should not fill the entire working area. Use white spaces to offset content.
4. The poster generally should read from left to right and top to bottom. Number the individual panels or connect the panel with arrows.
5. Check with the sponsoring organization for specific poster dimensions.
6. Text should be readable from five feet away.
7. Make presentations aesthetically pleasing.
8. Poster content must be concise; focus on "showing" not "telling."
9. Research posters should include the following sections:
   a. Introduction
      i. Research question and hypothesis
      ii. Study rationale
      iii. Background and significance of question (literature review)
   b. Methods
      i. Study design
      ii. Study timeline, including start date and completion date
      iii. IRB approval date
         1. Name of the principal investigator
         2. Name and role of nurse at organization involved in study if different from principal investigator
      iv. Research sample (study participants, sample size)
      v. Data collection methods
   c. Results
   d. Discussion
      i. Summary and implication of findings
10. Quality improvement posters must include pre-implementation, implementation, and post-implementation data, along with time periods and dates. See figure on page 54 for example of quality improvement data presentation.

Appendix E

Sample Graph and Data Table

Empirical Outcome
Outcome Measure
Time Frame (Months or Quarters)
Location

	Month Year	Month-Month Year	Month Year	Month Year	Month Year
Outcome Measure	58.3		70.0	69.2	83.3

Poster Presentation Templates

Evidence-Based Template
Authors Names and Credentials
NewYork-Presbyterian Weill Cornell Medical Center

Problem Identification
- Background
  - Explain what the problem is and why it is important.
  - Discuss what led the team to investigate the topic.
- State the clinical question that is being investigated using the **PICO-TS** format:
  - P Patient Population
  - I   Intervention or Issue of Interest
  - C Comparison of Issue of Interest
  - O Outcome of Interest (Desired)
- Define current practice at NewYork-Presbyterian as it relates to the topic

Evidence Review
- Provide brief summary of the relevant evidence reviewed.
- Include professional standards, clinical practice guidelines, meta analyses, systematic reviews, etc.
- Include a minimum of three current nursing references sited in APA format published within past 5 years

- **Place your main findings here**
- **Emphasize the important message**
- **Use plain English throughout**

Appraise Evidence
- Address your PICO or research questions
  - For evidence-based practice projects, describe how studies were appraised for quality and level of evidence
- Describe study strengths and limitations of the evidence
- Include a table summarizing evidence and study quality

Conduct Research or Change Practice
- Summarize key findings
- Based on the evidence review and appraisal, discuss if conducting research or a practice change is recommended

Evaluation
- Describe how the team plans to evaluate the practice change

References
- Cite references in APA format

For more information, please contact: Authors' Names, Credentials, Titles, Work Email and/or phone number

Research Study Template
Authors Names and Credentials
NewYork-Presbyterian Columbia University Irving Medical Center

Background
- Describe study background to answer the "so what"
- Provide brief literature review – cited literature should be published within past 5 years, including professional standards, clinical practice guidelines, meta analyses, systematic reviews, etc.
- Include your purpose statement, which reflects your **PICO** question
- State study hypothesis

Methods
- Study Design
- Describe sample population (study subjects, sample size, and location of study)
- State the data collection period
- Describe how data were collected and/or analyzed
- Describe analyses performed
- If research was conducted, provide details of the Institutional Review Board (IRB) approval, including the Principal Investigator

- **Place your main findings here**
- **Emphasize the important message**
- **Use plain English throughout**

Results
- Address your PICO or research questions
- Findings may be presented in a table or bar chart

Discussion
- Summarize key findings
- Discuss how results are similar and/or different from the evidence
- Describe study strengths and limitations
- Specify study implications
- Provide recommendations for practice change and/or future research

References
- Cite references in APA format

For more information, please contact: Authors' Names, Credentials, Titles, Work Email and/or phone number

Appendix F

NewYork-Presbyterian PEACE Model for Evidence-Based Practice and Research Utilization

Nursing evidence-based practice and research are integral to improved patient care and outcomes. Despite studies that show evidence-based practice is better for patients and is associated with increased nurse engagement, nurses report that research findings are implemented in their hospital less than 50 percent of the time (Melynk et al., 2012). The Office of Evidence-Based Practice and Research at NewYork-Presbyterian is committed to building a culture of inquiry by facilitating evidence-based practice and research among clinical nurses.

Differentiating Research, Evidence-Based Practice and Quality Improvement

Research "Inquiry Driven"	Evidence-Based Practice "Evidence Driven"	Quality Improvement "Data Driven"
"Systematic inquiry that uses disciplined methods to answer questions or solve problems. The ultimate goal of research is to develop, refine, and **expand knowledge**." (Polit & Beck, 2021) IRB approval required	The conscientious use/integration of the best **research evidence** with **clinical expertise** and **patient preferences** in nursing practice. (Adapted from Sackett, D., Strauss, S., Richardson, W. S., Rosenberg, W., & Haynes, B. (2000). Churchill Livingstone.)	"Systematic, data-guided activities designed to bring about **immediate improvement** in health care delivery in particular settings." (Lynn et al., 2007, p. 667)

Research.
- Systematic investigation to refine, develop, and generate new knowledge
- Institutional review board required to ensure the protection of human subjects
- Must be conducted in accordance with federal, institutional, and ethical guidelines
- Determine whether activity is research:
  - Is the activity designed to contribute to generalizable knowledge?
  - Will the activity be conducted using information gathered from humans? (e.g., conducting a medical chart review of patients, surveying patients, staff, etc.)
  - If the answer to both questions above is yes, the activity is research and Institutional Review Board (IRB) approval is needed.

Carter, E. (2021). Evidence-based practice, research, and quality improvement. In Rivera, R. and Fitzpatrick, J. (Eds). *The PEACE Model: Evidence-Based Practice Guide for Clinical Nurses* (pp. 1 -13). Indianapolis, IN: Sigma

Appendix F

Quality Improvement.
• Data driven
• Systematic, data guided, intended for immediate improvement

Evidence-Based Practice.
• Evidence driven
• Conscientious use of the best research evidence in nursing practice

Why is Evidence-Based Practice Important?
• Critical to patient care and outcomes
• Incorporated into professional practice model
• Use the best evidence available to inform nursing practice

How is Evidence-Based Practice Incorporated into Care at NewYork-Presbyterian?
• Nursing practice at NewYork-Presbyterian is generally grounded in the evidence but may not be apparent.
• Policies and procedures have been developed to guide evidence-based nursing practice.

NewYork-Presbyterian's PEACE Model
• Model of evidence-based practice utilization
• Developed by NewYork-Presbyterian nurses for clinical nurses
• Provides guidance on
  ◦ How to conduct evidence-based practice
  ◦ When to change practice
  ◦ When to conduct research

Watch PEACE Model on YouTube:
https://www.youtube.com/watch?v=fhnwSDanNvM

Rivera, R. and Fitzpatrick, J. (2021). *The PEACE Model: Evidence-Based Practice Guide for Clinical Nurses.* Indianapolis, IN: Sigma.

How to Appraise Study Quality
• Appraise the evidence that appears highest in the hierarchy of scientific evidence for its quality and applicability to practice.

Rivera, R. and Fitzpatrick, J. (2021). *The PEACE Model: Evidence-Based Practice Guide for Clinical Nurses.* Indianapolis, IN: Sigma.

Literature Search Assistance
• Librarians at the Augustus C. Long Health Sciences Library at Columbia University (library.cumc.columbia.edu), the Samuel J. Wood Library at Weill Cornell Medicine (library.weill.cornell.edu), NewYork-Presbyterian Westchester Behavioral Health, NewYork-Presbyterian Queens, and NewYork-Presbyterian Brooklyn Methodist Hospital are outstanding resources. Assistance can be requested of librarians at the campus level.

• For information on how NewYork-Presbyterian staff can access the medical college libraries, call:
  Augustus C. Long Health Sciences Library: (212) 305-3605
  Samuel J. Wood Library: (646) 962-2570

Appendix F

Building a Culture of Inquiry and Scholarship

Structure	Process	Outcomes
Evidence-Based and Research Committee (Professional Governance)	• Active participation in committee	• Increase in nurses' engagement • Members are able to articulate the difference between research, evidence-based practice and quality improvement • Members are able to articulate the use of the PEACE Model
Academic Practice Research Fellowship Program (competitive two-year program for clinical nurses)	• Clinical nurses' participation in the Academic Practice Research Fellowship Program	• Increase the number of nurse-led research projects
Professional Development Program	Active participation in the following educational programs: • The PEACE Model Deep Dive • Annual Research, Evidence-Based Practice, and Innovation Symposium • Publication workshop • Special program on symptom science	• Increase the number of nurse-led research projects • Dissemination of evidence-based practice, quality improvement, and research findings
Nurse Residency Program	• Nurse residents utilize the PEACE Model for their evidence-based practice projects	• Increase number of evidence-based practice projects • Dissemination of quality improvement activities, evidence-based practice projects, and research studies through podium and poster presentations
Graduate Programs through Columbia University	Participation in graduate programs targeted for NewYork-Presbyterian staff: • Master's program in clinical leadership • PhD in nursing	• Increase the number of nurses with graduate degrees in nursing
Communication	Resources are available on the Infonet regarding: • Approved IRB studies • Publications • Library access • Abstract submission links via different organizations	• Improve communication about programs and available resources to all nurses at all levels

Appendix G

Implementing a Journal Club

Journal clubs support a culture of inquiry and research literacy. They provide interactive, activity-based learning that is proven to help increase appraisal ability and research skills. Journal clubs also help to connect available evidence to the knowledge base in order to translate to and inform nursing practice and contribute to positive patient care outcomes.

Deenadayalan, Y., Grimmer-Somers, K., Prior, M., & Kumar, S. (2008). How to run an effective journal club: A systematic review. *Journal of Evaluation in Clinical Practice,* 14(5), 898-911.

Consider introducing a journal club to your professional governance committee or unit council to foster professionalism, expand knowledge, and promote evidence-based practice.

Tips for Organizing a Journal Club

• Consider a meeting place and format (i.e., in person, virtual, or hybrid).

• Decide on meeting frequency. Some journal clubs are conducted monthly, others quarterly. Consider conducting the meetings at least several times per year to stay up to date with the latest evidence.

• Determine the length of time dedicated to the journal club and whether it will be a stand-alone meeting or incorporated into another meeting.

• Use a critical framework and structured questions to help guide the content of the journal club. An example is provided in this appendix.

Häggman-Laitila, A., Mattila, L. R., & Melender, H. L. (2016). A systematic review of journal clubs for nurses. *Worldviews on Evidence-Based Nursing,* 13(2), 163-171.

Conducting Journal Club Meetings

Deenadayalan, Y., Grimmer-Somers, K., Prior, M., & Kumar, S. (2008). How to run an effective journal club: A systematic review. J*ournal of Evaluation in Clinical Practice*, 14(5), 898-911.)

Häggman-Laitila, A., Mattila, L. R., & Melender, H. L. (2016). A systematic review of journal clubs for nurses. *Worldviews on Evidence-Based Nursing*, 13(2), 163-171.

• Identify a leader for each journal club. Rotate leaders to foster engagement by the journal club membership.

Appendix G

- Have the leader select an article.
  - Consider topics that relate to current initiatives, perceived clinical problems, or other issues identified by the committee or its members

Berger, J., Hardin, H. K., & Topp, R. 2011. Implementing a virtual journal club in a clinical nursing setting. *Journal for Nurses in Staff Development,* 27(3), 116-120.

  - Socialize the journal club article topic for interested clinicians. Consider distributing flyers or e-mails highlighting the topic.

- Prepare for the journal club.

Russell, C. L., Bean, K. B., & Barry, D. 2006. How to develop a successful journal club. International Transplant Nurse Society.

  - Share the journal article and critical framework/discussion questions well ahead of time.
  - Ensure the journal club lead is prepared to lead by summarizing the article and facilitating discussion.
  - Remind journal club members of the discussion/meeting.

- Conduct the journal club using the provided framework or similar approach.
  - Ensure discussion of any discrepancies between current evidence and practice or opportunities to translate findings into practice.

- Evaluate the journal club.
  - Gather feedback for improvement.
  - Confirm the journal club lead for the next meeting.
  - Follow up with journal club members in subsequent meetings to determine any changes in practice.

Following are questions that you and your colleagues can use to evaluate the randomized controlled trial research literature.

Malloch, K. & Porter-O'Grady, T. (2006). Introduction to evidence-based practice in nursing and health care. Boston: Jones and Barlett.

Were the results valid?
- Were patients randomized? Was randomization concealed?
- Were patients analyzed in the groups to which they were randomized?
- Were groups shown to be similar in all known determinants of outcomes or were analyses adjusted for differences?
- Were patients aware of group allocation? Were clinicians aware of group allocation?
- Were outcome assessors aware of group allocation? Was follow up complete?

What are the results?
- How large was the intervention effect?
- How precise was the estimate of the intervention effect?

How can I apply the results?
- Were the study patients similar to the patients in your clinical setting?
- Were all important outcomes considered?
- Are the likely intervention benefits worth the potential harm and costs?

For non-interventional studies, use the following types of questions to review the article:

Were the results valid?
- How were the subjects selected and are they similar to the patient population of your organization?
- Are the procedures for recruiting subjects and collecting data well described?
- Do these procedures appear to be consistent?
- Did the researcher give attention to using valid and reliable tools to capture the study data?

What are the results?
- Was the researcher looking for relationships between variables or comparing differences between groups on the variables of interest?
- Are there any significant relationships or differences?

How can I apply the results?
- What is the implication of the findings for:
  - nursing practice
  - research needs
  - educational use

Appendix H

Succession Planning

Succession planning is an evidence-based leadership strategy in which high-performing nurses are identified and developed to ensure leadership continuity within an organization. For purposes of professional governance, the organization seeks to sustain bench strength among the councils and committees in order to execute the nursing strategic plan and sustain clinical excellence. Each organization provides empowering succession planning structures that improve the nursing practice environment, job satisfaction, and patient outcomes.

Guiding Principles.
- Nursing leaders are visionary when they anticipate leadership gaps in professional governance leadership and plan accordingly to advance emerging nurse leaders with the knowledge, competencies, and behaviors needed for success.
- Emerging nurse leaders can be identified through peer feedback, self-report, mentorship relationships, performance/potential matrix, and performance reviews, to name a few.
- Sponsors, chairs, and members seek to identify future leaders and officers in governance positions in order to ensure a smooth transition of council and committee purpose and leadership.
- When emerging leaders are identified, professional development plans are documented that include specific goals for leadership development.
- All nurses are encouraged to establish a mentorship relationship. Setting professional development goals can link their work in professional governance to succession planning and personal growth. Goals include:
  ○ networking
  ○ managing projects
  ○ decision making
  ○ delegating
  ○ facilitating a meeting
  ○ speaking publicly
  ○ seeing the big picture
  ○ enhancing leadership skills
  ○ advancing conflict resolution

References

American Nurses Credentialing Center, 2021. *2023 Magnet Application Manual.* Silver Spring: Maryland.

Berger, J., Hardin, H. K., & Topp, R. (2011). Implementing a virtual journal club in a clinical nursing setting. *Journal for Nurses in Staff Development,* 27(3), 116-120.

Bogue, R. J., Joseph, M. L., & Leobold, C. (2009). Shared governance as vertical alignment of nursing group power and nurse practice council effectiveness. *JONA: The Journal of Nursing Administration*, 17, 4-14.

Cato, K., Sun, C., Carter, E., Liu, J., Rivera, R., Larson, E. (2019). Linking to improve nursing care and knowledge: Evaluation of an initiative to provide research support to clinical nurses. *JONA: The Journal of Nursing Administration,* 49(1), 42-47.

Carter, E. J., Mastro, K., Vose, C., Rivera, R., & Larson, E. L. (2017). Clarifying the Conundrum: Evidence-Based Practice, Quality Improvement, or Research?: The Clinical Scholarship Continuum. *JONA: The Journal of Nursing Administration*, 47(5), 266-270.

Carter, E., Rivera, R., Gallagher, K., Cato, K. (2018). Targeted interventions to advance a culture of inquiry at a large, multicampus hospital among nurses. *JONA: The Journal of Nursing Administration*, 48(1), 18-24.

Clavelle, J. T., O'Grady, T. P. & Drenkard, K. (2013). Structural Empowerment and the Nursing Practice Environment in Magnet® Organizations. *JONA: The Journal of Nursing Administration*, 43(11), 566-573.

Clavelle, J., Porter-O'Grady, T., Weston, M. & Verran, J. (2016). Evolution of structural empowerment: Moving from shared to professional governance. *JONA: The Journal of Nursing Administration*, 46(6), 308-312.

Deenadayalan, Y., Grimmer-Somers, K., Prior, M., & Kumar, S. (2008). How to run an effective journal club: A systematic review. *Journal of Evaluation in Clinical Practice*, 14(5), 898-911.

Di Fiore, T., Zito, A., Berardinelli, A., Bena, J., Morrison, S., Keck, D., Kennedy, K., Stibich, A., & Albert, N. (2018). Staff Perceptions of Decision-Making in a Shared Governance Culture. *Journal of Evaluation in Clinical Practice*, 48(11), 561-566.

Fineout-Overholt, E., Melnyk, B. M., Stillwell, S. B., & Williamson, K. M. (2010). Evidence-based practice, step by step: Critical appraisal of the evidence Part III. *American Journal of Nursing*, 110(11), 43-51.

References

Haag-Heitman, B. & George, V. (2009). Guide for establishing governance: A starter's toolkit. *American Nurses Credentialing Center.*

Häggman-Laitila, A., Mattila, L. R., & Melender, H. L. (2016). A systematic review of journal clubs for nurses. *Worldviews on Evidence-Based Nursing*, 13(2), 163-171.

Hess, R. (2021). Forum for Shared Governance.

Hess, R. G. (1998). Measuring nursing governance. *Nursing Research*, 47(1), 35-42.

Hess, R., Bonamer, J., Swihart, D., & Brull, S. (2020). Measuring council health to transform shared governance processes and practice. *JONA: The Journal of Nursing Administration,* 50(2), 104-108.

Holskey, M. P., & Rivera, R. R. (2020). Optimizing Nurse Engagement: Using Liberating Structures for Nursing Professional Practice Model Development. *JONA: The Journal of Nursing Administration*, 50(9), 468-473.

Institute for Patient- and Family-Centered Care website (www.ipfcc.org) 2015, December 17.

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.

Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Guidice, M., & Aiken, L. (2016). Nurse Engagement in Professional Governance and Patient and Nurse Outcomes. *JONA: The Journal of Nursing Administration*, 46(11), 605-612.

Lynn, J., Baily, M. A., Bottrell, M., Jennings, B., Levine, R. J., Davidoff, F., Casarett, D., Corrigan, J., Fox, E., Wynia, M. K., Agich, G. J., O'Kane, M., Speroff, T., Schyve, P., Batalden, P., Tunis, S., Berlinger, N., Cronenwett, L., Fitzmaurice, J. M., Dubler, N. N., James, B. (2007). The ethics of using quality improvement methods in health care. *Annals of Internal Medicine,* 146(9), 666-673.

Malloch, K. & Porter-O'Grady, T. (2006). Introduction to evidence-based practice in nursing and health care. Boston: Jones and Barlett.

Mastro, K., Flynn, L. & Preuster, C. (2014). Patient- and family-centered care: A call to action for new knowledge and innovation. *JONA: The Journal of Nursing Administration,* 44(9), 446-451.

Melnyk, B. M., Fineout-Overholt, E., Gallagher-Ford, L., & Kaplan, L. (2012). The state of evidence-based practice in U.S. nurses: Critical implications for nurse leaders and educators. *JONA: The Journal of Nursing Administration*, 42:410-417.

Moreno, J. & Girard, A. (2019). Capitalizing on an existing shared governance structure in developing leadership succession planning. *JONA: The Journal of Nursing Administration*, 49(4), 193-200.

Nursing Administrative Policy No. 104A, Nursing Care Delivery System – Patient- and Family-Centered Care. NewYork-Presbyterian Infonet.

O'Grady, T. P., & Clavelle, J. T. (2021). Transforming Shared Governance: Toward Professional Governance for Nursing. *JONA: The Journal of Nursing Administration,* 51(4), 206-211.

Olender, L., Capitulo, K., & Nelson, J. (2020). The Impact of Interprofessional Shared Governance and a Caring Professional Practice Model on Staff's Self-report of Caring, Workplace Engagement, and Workplace Empowerment Over Time. *JONA: The Journal of Nursing Administration,* 50(1), 52-58.

Oss, J., Schad, E., Drenth, A., Johnson, L., Olson, J., & Bursiek, A. (2021). Driving Nurse Satisfaction Through Shared Governance. *Nurse Leader*, 19(1), 47-52.

Polit, D. & Beck, C. (2021). Resource manual for nursing research: Generating and assessing evidence for nursing practice, 11th Edition. Wolters Kluwer Health – Lippincott Williams & Wilkins.

Porter-O'Grady, T. (2019). Principles for sustaining shared/professional governance in nursing. *Nursing Management*, 50(1): 36-41.

Quek, S., Thomson, L., Houghton, R., Bramley, L., Davis, S., & Cooper, J. (2021). Distributed leadership as a predictor of employee engagement, job satisfaction and turnover intention in U.K. nursing staff. *Journal of Nursing Management,* 29(6), 1544-1553.

Rivera, R., Gallagher, K., Fitzpatrick, J., Carter, E., & Manzano, W. (2016). Leadership Through Scholarly Dissemination: The NYP Nursing Experience. *Nurse Leader*, 14(2):142-143.

Rivera, R. & Fitzpatrick, J. (2021). T*he PEACE Model: Evidence-Based Practice Guide for Clinical Nurses.* Indianapolis, IN: Sigma.

References

Robert, N. & Finlayson, S. (2015). *Fundamentals of Magnet Toolkit.* American Nurses Credentialing Center.

Russell, C. L., Bean, K. B., & Barry, D. (2006). *How to develop a successful journal club.* International Transplant Nurse Society.

Sackett, D., Strauss, S., Richardson, W. S., Rosenberg, W., & Haynes, B. (2000). Churchill Livingstone.

Siller, J., Dolansky, M., Clavelle, J., & Fitzpatrick, J. (2016). Shared Governance and Work Engagement in Emergency Nurses. *Journal of Emergency Nursing,* 42(4), 325-330.

Speroni, K., Wisner, K., Ober, M., Haines, F., Walters, C., & Budhathoki, C. (2021). Effect of shared governance on nurse-sensitive indicator and satisfaction outcomes by Magnet® Recognition status. *JONA: The Journal of Nursing Administration,* 51(7/8), 379-388.

Spoon, R. (2015, April 12). *8 Tips for Facilitating Better Meetings.* ArchPoint Consulting.

Swihart, D. & Hess, R. (2014). S*hared governance: A practical approach to transforming interprofessional healthcare.* (3rd ed.). HCPro.

Swihart, D. & Hess, R. (2018). *Shared governance: A practical approach to transforming interprofessional healthcare.* HCPro.

Tahan, H. M., Rivera, R. R., Carter, E. J., Gallagher, K. A., Fitzpatrick, J. J., Manzano, W. (2016). Evidence-Based Nursing Practice: The PEACE Framework. *Nurse Leader*, 14(1): 57-61.

Weston, M., Verran, J., Clavelle, J., & Porter-O'Grady, T. (2018). Professional governance scale: Instrument development and content validity testing. *Advances in Nursing Science,* 41(2), 188-198.

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Notes

Staff Advisory Board Charter

Purpose:
- The NYP-CUIMC Staff Advisory Board is responsible for ensuring that NYP/CUIMC Nursing's mission, vision, and strategic goals in are alignment with NYPH Department of Nursing's and the NYP Enterprise's mission, vision, and strategic goals.
- Campus Committee Chairs/Co-Chairs and the Vice President/Chief Nursing Officer serve on the Staff Advisory Board for the purposes of planning, problem resolution, dissemination and exchange of critical information, and amplifying the voice of the clinical nurse to the highest level of nursing leadership.

Function:
- The Staff Advisory Board members serve in an advisory capacity to the Vice President/Chief Nursing Officer and provide reports, updates, escalations, requests, challenges, ideas, and other pertinent information regarding their campus committee work.

Meetings:
- The Staff Advisory Board meets monthly. Additional meetings may be scheduled as needed and may be requested by any standing member of the Board.
- Standing Agenda items may include:
  - Professional governance activity report from chairs (updates, escalations/requests, challenges, ideas)
  - Current/planned initiatives
  - Nursing practice ideas/updates/concerns
  - Recommended agenda items for the Staff Advisory Council (SAC)

Memberships:
- The Staff Advisory Board consists of the Vice President/Chief Nursing Officer and chairs/co-chairs of the following campus committees:
  - Research, EBP, & Innovation Council
  - Quality & Patient Safety Council
  - Nursing Practice Council
  - Patient Experience Council
  - Recruitment, Retention, Recognition, & Respect Council (R4)
  - Day Staff Advisory Council (DSAC)
  - Night Staff Advisory Council (NSAC)
  - Operations Staff Advisory Council (OSAC)
  - Nursing Pharmacy Committee
  - Nursing Excellence (Magnet) Council
  - Nursing Informatics Council (NIC)
- Additional members and/or guests to be examined on a consistently recurring basis.

NewYork-Presbyterian
Department of Nursing

CUIMC Staff Advisory Council Charter

Purpose:
The purpose of the Staff Advisory Council (SAC) is to facilitate communication between the Chief Nursing Officer (CNO) and direct care clinical RNs. The SAC promotes professional development of clinical RNs through educational offerings, staff presentations, and investigations of best practice. The SAC fosters interdisciplinary collaboration providing an opportunity for all disciplines to address needs identified by clinical RNs.

Responsibilities of SAC members:
- Represents their unit/department serving as the primary point of contact for SAC activities.
- Delivers communication regarding the journey to excellence to unit/department colleagues.
- Assures dissemination of information related to SAC meeting discussions at the unit/department level.
- Informs others about unit/department activities that support the journey to excellence.
- Engages others, embraces change and enthusiastically communicates messages from SAC meetings.
- Attends and actively engages in scheduled SAC meetings.

Decision Making and Recommendations:
The SAC will use consensus building as its principle method for decision making.

Attendance:
- SAC members are expected to attend 80% of all meetings.
- Members will provide notification if they cannot attend a meeting; an alternate representative for the unit/department may be requested.
- If a member has 2 or more absences within a calendar year, he/she will be requested to consider resigning or to recommit to active membership.

Frequency of Meetings:
- Monthly face-to-face meetings on the 4th Wednesday of each month from 0800-1000.
- Work may need to be completed between meetings.

Membership:
Membership is comprised of a minimum of 2 RNs representing both shifts from each unit/department in CUIMC. Ad hoc members may include staff from other disciplines.

- *Eligibility:* To be eligible to serve on SAC one must be a full or part time employee who has completed at least 6 months of employment at NYP and is in good standing.

- *Elections:* Chair and Co-Chair will be elected by SAC members via secret ballot. Elections will be held annually in December. The Chair shall serve a term of one year. The Co-Chair shall serve for a term of one year. The Co-Chair succeeds to the Chair at the end of the one-year term as Co-Chair. The Chair becomes Immediate Past Chair, the Co-Chair becomes the Chair, and the newly elected Co-Chair begins their role on January 1st.

- *Chair***:** Selected by membership for 1 year tenure. The duties of the chair are as follows:
  - Plan the agendas for all meetings in collaboration with the CNO.
  - Preside at all SAC meetings.
  - Appoint ad hoc committees as the need arises in collaboration with the CNO.

- o Mentor the Co-Chair to assume the position of Chair.

- *Co-Chair:* Selected by membership for 1 year tenure. The Co-chair will become Chair after 1 year. The duties of the Co-Chairperson are as follows:
    - o Assume the duties of the Chair in the absence of the Chair.
    - o Assist the Chair in the performance of duties.

- *Immediate Past Chair:* Serve 1 year tenure immediately following role as Chair. The duties of the Immediate Past Chair are as follows:
    - o Serve as mentor for Chair and Co-chair.
    - o Assist the Co-chair with duties in the absence of the Chair.

- *Term of Office:* Elected members will assume office on January 1st. All terms will expire December 31st of the year elected to office. Elected members will serve a terms as follows:
    - o Co-Chair: 1 year term, then serve 1 year as Chair.
    - o Chair: 1 year term, then serve 1 year as Immediate Past Chair.
    - o Immediate Past Chair: 1 year term, then return to SAC member.

- *Vacancies:* The Chair, on advice and consultation of the Co-Chair and the CNO, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.

Reporting Structure:
- Agenda and meeting minutes will be distributed to all SAC members for review prior to each meeting.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the SAC meetings by reporting back to all staff of the unit/department and eliciting input regarding items under consideration.

Administrative Support:
- CNO will serve as administrative facilitator for the SAC.
- Administrative assistant support will be provided for SAC meetings.

Review:
- SAC members will be reviewed annually with CNO, DONs and PCDs.
- SAC Charter will undergo annual review by Chair, Co-Chair and CNO.

Sun setting:
SAC meetings will continue to assure open communication with CNO.

NewYork-Presbyterian
Department of Nursing

CUIMC Night Staff Advisory Council Charter

Purpose:
The purpose of the Night Staff Advisory Council (NSAC) is to facilitate communication between the Chief Nursing Officer (CNO), direct care clinical RNs, and colleagues from multiple disciplines. The NSAC promotes professional development of clinical RNs through educational offerings, staff presentations, and investigations of best practice. The NSAC fosters interdisciplinary collaboration providing an opportunity for all disciplines to address needs identified by clinical RNs.

Responsibilities of NSAC members:
- Represents their unit/department serving as the primary point of contact for NSAC activities
- Delivers communication regarding the journey to excellence to unit/department colleagues
- Assures dissemination of information related to NSAC meeting discussions at the unit/department level
- Informs others about unit/department activities that support the journey to excellence
- Engages others, embraces change and enthusiastically communicates messages from NSAC meetings
- Attends and actively engages in scheduled NSAC meetings

Decision Making and Recommendations:
The NSAC will use consensus building as its principle method for decision making.

Attendance:
- NSAC members are expected to attend 80% of all meetings.
- Members will provide notification if they cannot attend a meeting. An alternate representative for the unit/department may be requested.
- If a member has 2 or more absences within a calendar year, he/she will be requested to consider resigning or to recommit to active membership.

Frequency of Meetings:
- Monthly face-to-face meetings on the 2nd Thursday of each month from 2200 – 2330
- Work may need to be completed between meetings

Membership:
Membership is comprised of a minimum of 1 RN representing night shift from each unit/department in CUIMC. Ad hoc members may include staff from other disciplines.

- *Eligibility:* To be eligible to serve on NSAC one must be a full or part time employee who has completed at least 6 months of employment at NYP and is in good standing.

- *Elections:* Chair and co-chair will be elected by NSAC members via secret ballot. Elections will be held annually in December. The Chair shall serve a term of one year. The Co-Chair shall serve for a term of one year. The Co-Chair succeeds to the Chair at the end of the one-year term as Co-Chair. The Chair becomes Immediate Past Chair, the Co-Chair becomes the Chair, and the newly elected Co-Chair begins their role on January 1st.

- *Chair***:** Selected by membership for 1 year tenure. The duties of the chair are as follows:
  - Plan the agendas for all meetings in collaboration with the CNO
  - Preside at all NSAC meetings
  - Appoint ad hoc committees as the need arises in collaboration with the CNO

- - Mentor the Co-Chair to assume the position of Chair

- *Co-Chair:* Selected by membership for 1 year tenure. The Co-chair will become Chair after 1 year. The duties of the Co-Chairperson are as follows:
  - Assume the duties of the Chair in the absence of the Chair
  - Assist the Chair in the performance of duties

- *Immediate Past Chair:* Serve 1 year tenure immediately following role as Chair. The duties of the Immediate Past Chair are as follows:
  - Serve as mentor for Chair and Co-chair
  - Assist the Co-chair with duties in the absence of the Chair

- *Term of Office:* Elected members will assume office on January 1st. All terms will expire December 31st of the year elected to office. Elected members will serve a terms as follows:
  - Co-Chair: 1 year term, then serve 1 year as Chair
  - Chair: 1 year term, then serve 1 year as Immediate Past Chair
  - Immediate Past Chair: 1 year term, then return to NSAC member

- *Vacancies:* The Chair, on advice and consultation of the Co-Chair and the CNO, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.

Reporting Structure:
- Agenda and meeting minutes will be distributed to all NSAC members for review prior to each meeting.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the NSAC meetings by reporting back to all staff of the unit/department and eliciting input regarding items under consideration.

Administrative Support:
- CNO will serve as administrative facilitator for the NSAC
- Administrative assistant support will be provided for NSAC meetings

Review:
- NSAC members will be reviewed annually with CNO, DONs and PCDs
- NSAC Charter will undergo annual review by Chair, Co-Chair and CNO

Sun setting:
NSAC meetings will continue to assure open communication with CNO.

TITLE: CROSS-CAMPUS NURSING PRACTICE COUNCIL (CC-NPC) CHARTER

PURPOSE:
The CC-NPC as part of the professional governance councilor model provides oversight to professional nursing practice and the review and approval of nursing practice standards. The charge of the CC-NPC is to review and approve standards that delineate safe and quality nursing care to patients and families and to foster evidence-based practice among professional nursing staff. The council's work supports the Hospital and the Department of Nursing's mission and vision.

RESPONSIBILITY OF THE COUNCIL:
Topics reported to the Council may include, but are not limited to: a summary of revised, new and deleted standards; the rationale for the approval of site-specific standards, the presentation of complex or unresolved practice issues for discussion and the introduction of innovative, evidence-based practice change. Also see Nursing Administration Policy #590 – Professional Nursing Practice Standards.

The following clinical services report as scheduled on nursing clinical standards:

Ambulatory Care Network	Neuroscience
Psychiatry	Obstetrics
Critical Care & Burn	Pediatrics
Interventional Cardiology	Perioperative Services (Endoscopy
Emergency Department	/Bronchoscopy & PACU)
Medical-Surgical	Interventional Radiology
Transplant	Hemodialysis
Rehabilitation	Apheresis
Skin Care	Vascular Services

The CC-NPC provides final approval on the annual/biennial review of nursing clinical standards.

Other nursing councils will provide updates at least annually on their activities, including annual goals and outcomes. These nursing councils are:

Product Standardization and Review Council
Patient & Family Education Council
Nursing Informatics Council
Nursing Website and Communication Committee

Policy Dates:
New: N/A
Supersedes # 212   Last Approved Date: 06/2021
Revised: N/A
Reviewed: 06/2023 (Adopted by NYP-BMH 10/2022)
Date Approved: 06/2023

ATTENDANCE:
   A. Council members are expected to attend all meetings. Members will notify the CC-NPC chair prior to meeting if they can not attend. An alternate representative for the service may be requested.
   B. Chairs of the Clinical Practice Committees (e.g. Medical Surgical Nursing, Critical Care, Pediatrics) report on nursing practice standards and other nursing practice issues that require discussion or review.
   C. If a member has 2 or more absences with a calendar year, he/she will be requested to consider resigning or to recommit to active membership.

FREQUENCYOF MEETINGS
The Council holds a minimum of ten meetings each year.

MEMBERSHIP OF THE COUNCIL
The CC-NPC membership is comprised of nurse leaders including Clinical Nurse Managers, Patient Care Directors, Program Directors, and/or Directors of Nursing.

CHAIR OF THE COUNCIL
The Council is chaired by the Senior Director of Professional Nursing Practice.

REPORTING STRUCTURE OF THE COUNCIL
   A. Updates to Senior Nursing Leadership on significant changes in nursing policy or practice will be presented to Senior Nursing Leadership and the Nursing Board as needed for approval prior to implementation by the Director of Professional Nursing Practice.
   B. Unresolved differences in practice between sites will be presented to Senior Nursing Leadership and the Nursing Board for final resolution by the Director of Professional Nursing Practice.

APPROVALS:

Cross Campus Nursing Practice Council	06/2023
Nursing Board	06/2023

Policy Dates:
New: N/A
Supersedes # 212   Last Approved Date: 06/2021
Revised: N/A
Reviewed: 06/2023 (Adopted by NYP-BMH 10/2022)
Date Approved: 06/2023

NewYork-Presbyterian Columbia University Irving Medical Center
Recruitment, Retention, Recognition & Respect (R4) Charter

Purpose:
The purpose of the R4 Council is to develop, promote and support initiatives designed to improve recruitment and retention efforts for clinical RNs, as well as recognition of the entire clinical team, inclusive of clinical RNs, provider colleagues and support team members. In addition, the R4 Council focuses on the continued efforts to enhance the culture of respect throughout NYP/CUIMC.

Responsibilities of R4 Members:
- Represents their unit/department serving as the primary point of contact for R4 activities
- Explains characteristics of an excellent organization and how they relate to daily work
- Develops and delivers communication regarding R4 activities to unit/department colleagues
- Coordinates R4 activities for their unit/department
- Informs others about unit/department activities that support R4 initiatives
- Engages others, embraces change and delivers enthusiastic messages related recruitment, retention, recognition and respect
- Attends scheduled meetings

Decision Making and Recommendations:
The R4 will use consensus building as its principle method for decision making.

Attendance:
- Members are expected to attend 80% of all meetings.
- Members will provide notification if they cannot attend a meeting. An alternate representative for the unit/department may be requested.
- If a member has two or more absences within a calendar year, he/she will be requested to consider resigning or to recommit to active membership.

Frequency of Meetings:
- Monthly face-to-face meetings on the fourth Wednesday of each month from 1500 – 1600
- Work may need to be completed between meetings

Membership:
Membership is comprised of a minimum of one RN from each unit/department in NYP/CUIMC. Ad hoc members may include staff from other disciplines.

- *Eligibility:* To be eligible to serve as a R4 members one must be a full or part time employee who has completed at least six months of employment at NYP and is in good standing.

- *Elections:* Chair and co-chair will be elected by R4 members via secret ballot. Elections will be held annually. The Chair shall serve a term of one year. The Co-Chair shall serve for a term of one year. The Co-Chair succeeds to the Chair at the end of the one-year term as Co-Chair. The Chair becomes Immediate Past Chair, the Co-Chair becomes the Chair, and the newly elected Co-Chair begins their role on January 1st.

- *Chair*: Selected by membership for one year tenure. The duties of the chair are as follows:
    - Plan the agendas for all meetings in collaboration with Magnet Program Director/Coordinator

- Preside at all R4 meetings
- Appoint ad hoc committees as the need arises in collaboration with Magnet Program Director/Coordinator
- Mentor the Co-Chair to assume the position of Chair

- *Co-Chair*: Selected by membership for one year tenure. The Co-chair will become Chair after one year. The duties of the Co-Chairperson are as follows:
  - Assume the duties of the Chair in the absence of the Chair
  - Assist the Chair in the performance of duties

- *Immediate Past Chair:* Serve one year tenure immediately following role as Chair. The duties of the Immediate Past Chair are as follows:
  - Serve as mentor for Chair and Co-chair
  - Assist the Co-chair with duties in the absence of the Chair

- *Secretary:* Serve one year tenure. The duties of the Secretary are as follows:
  - Takes minutes/attendance during R4 meetings.
  - Reviews minutes with Magnet Program Director/Coordinator after meetings for completeness.
  - Assures minutes are distributed prior to the next R4 meeting.

- *Term of Office:* Elected members will assume office on January 1st. All terms will expire December 31st of the year elected to office. Elected members will serve a terms as follows:
  - Co-Chair: 1 year term, then serve 1 year as Chair
  - Chair: 1 year term, then serve 1 year as Immediate Past Chair
  - Immediate Past Chair: 1 year term, then return to R4 member

- *Vacancies:* The Chair, on advice and consultation of the Co-Chair and the Magnet Program Director/Coordinator, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.

Reporting Structure:
- Agenda and meeting minutes will be distributed to all R4 members for review prior to each meeting.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the R4 meetings by reporting back to all staff of the unit/department and eliciting input regarding items under consideration.

Administrative Support:
- Magnet Program Director/Coordinator will serve as administrative facilitator for the R4
- Administrative assistant support will be provided for R4 meetings

Review:
- R4 members will be reviewed annually with Magnet Program Director/Coordinator, DONs and PCDs
- R4Charter will undergo annual review by Chair, Co-Chair and Magnet Program Director/Coordinator

Sun setting:
R4 meetings will continue until otherwise determined by NYP/CUIMC nursing leadership.

NewYork-Presbyterian Columbia University Irving Medical Center
Nursing Excellence Council Charter

Purpose:
The Nursing Excellence Council assumes responsibility to foster a continued commitment to Magnet® and journey of excellence initiatives. The members will spearhead and support activities designed to promote the growth and development of clinical nurses throughout CUIMC.

Responsibilities of Nursing Excellence Council members:
- Represents their unit/department serving as the primary point of contact for Magnet® related activities
- Explains characteristics of an excellent organization and how they relate to daily work
- Develops and delivers communication regarding the journey to excellence to unit/department colleagues
- Coordinates education and other Magnet® related activities for their unit/department
- Informs others about unit/department activities that support the journey to excellence
- Engages others, embraces change and delivers enthusiastic messages related to Magnet® designation
- Prepares for and participates in the Magnet® site visit
- Attends scheduled meetings

Decision Making and Recommendations:
Members will use consensus building as its principle method for decision making.

Attendance:
- Members are expected to attend 80% of all meetings.
- Members will provide notification if they cannot attend a meeting. An alternate representative for the unit/department may be requested.
- If a member has two or more absences within a calendar year, he/she will be requested to consider resigning or to recommit to active membership.

Frequency of Meetings:
- Monthly meetings on the fourth Wednesday of each month from 1500 – 1600
- Work may need to be completed between meetings

Membership:
Membership is comprised of a minimum of one RN from each unit/department in CUIMC. Ad hoc members may include staff from other disciplines.

- *Eligibility:* To be eligible to serve one must be a full or part time employee who has completed at least six months of employment at NYP and is in good standing.

- *Elections:* Chair and co-chair will be elected by members via ballot. Elections will be held annually. The Chair shall serve a term of one year. The Co-Chair shall serve for a term of one year. The Co-Chair succeeds to the Chair at the end of the one-year term as Co-Chair. The Chair becomes Immediate Past Chair, the Co-Chair becomes the Chair, and the newly elected Co-Chair begins their role after elections.

- *Chair***:** Selected by membership for one year tenure. The duties of the chair are as follows:
  - Plan the agendas for all meetings in collaboration with Magnet Program Director/Coordinator
  - Preside at all Nursing Excellence Council meetings

- Appoint ad hoc committees as the need arises in collaboration with Magnet Program Director/Coordinator
- Mentor the Co-Chair to assume the position of Chair

- *Co-Chair*: Selected by membership for one year tenure. The Co-chair will become Chair after one year. The duties of the Co-Chair are as follows:
  - Assume the duties of the Chair in the absence of the Chair
  - Assist the Chair in the performance of duties

- *Immediate Past Chair:* Serve one year tenure immediately following role as Chair. The duties of the Immediate Past Chair are as follows:
  - Serve as mentor for Chair and Co-chair
  - Assist the Co-chair with duties in the absence of the Chair

- *Term of Office:* Elected members will assume office after elections. All terms will expire December 31st of the year elected to office. Elected members will serve a terms as follows:
  - Co-Chair: one year term, then serve one year as Chair
  - Chair: one year term, then serve one year as Immediate Past Chair
  - Immediate Past Chair: one year term, then return as member

- *Vacancies:* The Chair, on advice and consultation of the Co-Chair and the Magnet Program Director/Coordinator, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.

Reporting Structure:
- Agenda and meeting minutes will be distributed to all members for review prior to each meeting.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the Nursing Excellence Council meetings by reporting back to all staff of the unit/department and eliciting input regarding items under consideration.

Administrative Support:
- Magnet Program Director/Coordinator will serve as administrative facilitator
- Administrative assistant support will be provided for meetings

Review:
- Members will be reviewed annually with Magnet Program Director/Coordinator, DONs and PCDs
- Charter will undergo annual review by Chair, Co-Chair and Magnet Program Director/Coordinator

Sun setting:
Meetings will continue between Magnet® designation periods with members serving as champions for CUIMC journey to excellence and related activities.

TITLE: NURSING/PHARMACY COMMITTEE – SITE SPECIFIC

PURPOSE:
Maintain forum for communication and collaboration between Nursing and Pharmacy in order to improve services and resolve issues related to medication management including procurement, storage, security, distribution and administration.

FUNCTIONS:
1. Identify opportunities for improvement related to medication management. Evaluate issues referred to the committee.

2. Develop and recommend action plans for resolution of identified problems or operational improvements.

3. Utilize findings from quality monitoring related to medications management to improve service and patient safety.

4. Establish task forces or subcommittees to develop and implement action plans and/or pilot programs when appropriate. Monitor progress and evaluate effectiveness of subcommittees and programs.

5. Refer significant policy issues to Nursing and Pharmacy Executive Bodies.

6. Refer issues/solutions to the Joint Nursing & Pharmacy Subcommittee of the Formulary & Therapeutics Committee and other committees/departments as indicated.

CHAIRPERSONS:
Co-chaired designees from Nursing and Pharmacy.

MEMBERSHIP:
Representatives from professional nursing and nursing leadership from each Nursing Division as designated by the campus' Vice President of Nursing & Chief Nursing Officer. Representatives from the Pharmacy Administrative group involved with medications management as designated by the Site Directors of Pharmacy. Ad hoc members as needed.

MEETING: A minimum of 10 times per year.

MINUTES:
Recorded by the Pharmacy or Nursing chairperson or a designee and distributed to members, Directors of Pharmacy, Pharmacy Managers, Pharmacy Apothecary in Chief, Vice President for Nursing & Chief Nursing Officer, Director of Professional Nursing Practice, Director - Nursing Quality and Safety and Director of Nursing Education.

DOCUMENT MANAGEMENT: Department of Pharmacy

APPROVALS:

 Nursing Board   11/2023

OPERATIONS STAFF ADVISORY COUNCIL
CHARTER

I. **PURPOSE, MISSION AND VISION**
   A. PURPOSE

   The Operations Staff Advisory Council (OSAC) is responsible for representing the voice of their peers on a variety of topics determined by the collective members of the committee. OSAC serves as a centralized forum of practice improvement for all areas that fall under the operations division. Decision making occurs through collaboration and participation of the nursing staff with the guidance of operational leadership and executive sponsors, utilizing a shared governance approach.

   B. MISSION

   To promote an interdisciplinary affiliation among the different operations departments in NYP-CUIMC.

   C. VISION

   Through full representation from each department's Unit Council (UC) our vision is to standardize care, share best practices, and improve quality care of patients and family members.

II. **DECISION MAKING AND RECOMMENDATIONS**
   A. Members will use consensus building as its principle method for decision making.

III. **MEMBERSHIP**
   A. Membership is comprised of UC members (preferably UC Chairs/Co-chairs) from various operations departments, PCD's and DON representatives, including but not limited to the following areas:

Emergency Department	ARIC
Cath Lab	Infusion Center
EP Lab	OR
23 Hour Unit	Eye OR
TEE	Eye Institute
General Radiology	Cystoscopy
IR/INR	PACU
Radiation Oncology	ASU
Endoscopy	Hemodialysis

   B. *Eligibility:* To be eligible to serve on OSAC one must be a full or part time employee who has completed at least six months of employment at NYP and is in good standing.

C. **Officers:** There will be the following officers in the OSAC: Chair, Co-Chair and Recorder. Each subcommittee can have a Chair and Co-Chair.

D. **Elections:** Chair, co-chair and recorder will be elected by OSAC members via ballot. Elections will be held annually. The Chair shall serve a term of one year. The Co-Chair shall serve for a term of one year. The Co-Chair succeeds to the Chair at the end of the one-year term as Co-Chair. The Chair becomes Immediate Past Chair, the Co-Chair becomes the Chair, and the newly elected Co-Chair begins their role after elections. The recorder shall serve a term of one year.

E. Ad hoc members may include staff from other disciplines.

F. PCD, DON and Executive sponsors act as advisors to the Operations Staff Advisory Council.

IV. **ROLES**
   A. Chairperson: Selected by membership for a one year tenure. The duties are as follows:
      a. Determines agenda in collaboration with PCD/DON facilitators
      b. Confirms meeting times, dates and location to members
      c. Presides over the meetings, guides discussions, and seeks consensus for decisions
      d. Calls special meetings or planning meetings as needed
      e. Mentors the Co-chair to assume the position of Chair
   B. Co-chair: Selected by membership for one year tenure. The co-chair will move into the chair role after one year. The duties are as follows:
      a. Assume the duties of the chairperson in the absence of the Chairperson
      b. Assist the Chairperson in the performance of duties
   C. Immediate Past Chair: Serve one year tenure immediately following role as Chair. The duties of the Immediate Past Chair are as follows:
      a. Serve as mentor for Chair and Co-chair
      b. Assist the Co-chair with duties in the absence of the Chair
   D. Recorder: Selected by membership for one year tenure. The duties are as follows:
      a. Take notes of discussion and decisions agreed upon that include:
         i. Exact words of recommendations
         ii. Names of those responsible for future actions
      b. Write the minutes and submit to the chair no later than a week of the meeting
      c. Maintains attendance
   E. Facilitator (PCD or DON; not an elected role)
      a. Keeps council on the agenda and on time
      b. Ensures each member has a chance to contribute
      c. Facilitates consensus in decision making

d. Ensures professional social media presence to promote engagement, make announcements, and share our accomplishments with a broader audience.
F. Vacancies:
a. The Chair, on advice and consultation of the Co-Chair and the facilitator(s), has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.
G. Members
a. Attend 80% of the meetings
b. Participate in discussion
c. Complete assigned tasks
d. Share information to their respective units

V. MEETINGS

A. Meetings will occur the fourth Wednesday of each month from 11AM to 12PM. Meetings can be in person or via Zoom as necessary.

VI. COMMUNICATION

A. Notification of Meetings
a. A list of scheduled meeting dates and times will be distributed to all council members at the first meeting held in January. Adjustments to the schedule must be completed and agreed upon prior to the close of the meeting.
B. Meeting agenda
a. The agenda will be distributed to each member via email prior to the meeting
C. Minutes
a. Approved Minutes of the meeting will be distributed to the members via email
D. Reporting to Departments
a. Each member is responsible to communicate what was discussed to their respective departments/units

VII. AMENDMENTS

This Charter can be amended at any time by a 2/3 majority vote of all council members.

Surgical Intensive Care Unit
2023-2024 Unit Council Charter

Purpose:

The Unit Council is established to guide the continuing development of nursing practice in the unit and to act as the decentralized decision-making body for the unit. The Unit Council advises the Patient Care Director (PCD) and the Director of Nursing (DON) relative to the practice of nursing and unit operations. Specifically, the purposes of the council are to:

- Address the nursing practice needs of all members of the nursing staff.
- Participate in the development of best practice standards of nursing in conjunction with hospital standards, quality, and safety programs.
- Promote quality nursing care and outcomes for patients and families.
- Identify clinical problems and solve clinical issues that affect nursing practice specific to the unit using evidence-based practice.
- Promote the continuing development of professional nursing practice in the unit.
- Share best practices in order to standardize aspects of clinical care.

Responsibilities of the Unit Council:

- Address professional nursing concerns related to nursing practice and the delivery of patient care and problem-solve in collaboration with the PCD and other unit leadership as clinically appropriate.
- Report on hospital-wide committee work relevant to improving patient and family experience, hospital operations, RN satisfaction, and employee engagement.
- Disseminate information to all staff on the unit.
- Monitor nursing practice on an ongoing basis and make recommendations for improvement as needed.

Decision-Making and Recommendations:

- The Unit Council will use consensus building as its principal method for decision-making. All decisions will be presented within the Unit Council for a majority vote. Final decisions are up to the discretion of the PCD.

Attendance:

- Council members are expected to attend at least 80% of meetings. Members will notify the Coordinating Council chair if they cannot attend before the council meeting. An alternate representative for the department may be requested.
- If a member has 2 or more absences within a calendar year, he/she will be requested to consider resigning or recommit to active membership.

Frequency of Meetings:

- Meetings take place in person every fourth Wednesday of the Month. Attached is a link with meeting dates, times and locations.
- Meetings between Unit Council leadership may occur as frequently as required, either in-person or via Zoom when deemed necessary.

Membership:

Membership of the Unit Council is composed of Registered Professional Nurses and Patient Care Support Staff elected by the clinical nurses and Patient Care Support Staff assigned to the unit. The PCD acts as an advisor to the Council/Committee.

- **Eligibility:** To be eligible to serve on the Unit Council one must be a full or part-time employee who has completed at least 6 months of employment at NYP.

- **Elections:** Representatives and alternates to the Unit Council will be elected by clinical nurses and patient care support staff via secret ballot. Elections will be held over the first two weeks of December. During extenuating circumstances, elections may be altered by unit management at their discretion.

- **Chair:** Selected by the membership for a tenure to complete at the end of 2024. The duties of the chair are as follows:

    o Review the agenda as created by the chair "in-training" and assist in completion.
    o Preside at and lead all meetings of the Unit Council.
    o Call special meetings of the council, as needed or requested by the PCD and/or DON.
    o Involve the SAICU Medical Directors every month in unit council meetings and any pertinent discussions.
    o Appoint ad hoc committees as the need arises.
    o Plan monthly book club readings in collaboration with PCD, co-chairs, and any other interested members of unit council.

- **Day shift co-chair**: Selected by the membership for a tenure to start July 2023 and complete at the end of 2024. The Duties of the day shift Co-Chairperson are to:

    o Disseminate the information and updates discussed during UC meetings to staff on day shift.
    o Bring any information, questions, comments, or concerns from day shift staff to UC meetings to be discussed.
    o Reach out to potential collaborators via email and invite them to join UC meetings
    o Assist in planning of Charge Nurse meetings, to occur at minimum 1 week prior to Unit Council meeting.
    o Assume the duties of the Chair in the absence of the Chairperson.
    o Assist the Chair in the performance of duties where applicable
    o Preside at all Unit Council meetings

- **Night shift Co-Chair:** Selected by the membership for a tenure to start July 2023 and complete at the end of 2024. The Duties of the night shift Co-Chairperson are to:

    o Send out Committee Report slides within 3 weeks prior to the next UC meeting, and follow up on submissions to confirm completion.
    o Disseminate all information and updates discussed during UC meetings to staff on night shift.
    o Bring any information, questions, comments, or concerns from night shift staff to UC meetings to be discussed.
    o Assist the Chair in the performance of duties where applicable.
    o Assume the duties of the Chair in the absence of the Chairperson.
    o Preside at all Unit Council meetings

- **Recorder:** Selected by the membership for tenure to start July 2023 and complete at the end of 2024. The Duties of the Recorder are to:

- o   Record meeting minutes for all unit council and leadership meetings.
- o   Share completed minutes by the end of the week after the UC meeting occurred for all staff to review.
- o   Send out a reminder email including the last meeting's minutes the week prior to the next scheduled UC meeting for all staff to review.
- o   Send out essential updates "bullets" to the unit via e-mail and WhatsApp by **Friday morning** after the previous meeting
- o   Assume the duties of the Co-Chair in the absence of the Chairperson.
- o   Preside at all Unit Council meetings

- **Term of Office:** Unit Council elected members will serve a term of one year with the option of accepting a second-year term if re-elected. Elected members will assume office on January 1st.

- **Vacancies***:* The Chairperson, on advice and consultation of the Co-Chairperson and the PCD, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.

Reporting Structure:

- The agenda and meeting minutes will be distributed via email and WhatsApp to all staff for review at minimum 1 week prior to each meeting.
- Unit Council Report out will be distributed three weeks prior to the meeting, and sent to management a week prior for review.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the Unit Council by reporting back to all staff of the unit and eliciting input regarding items under consideration.

Annual Report

Annual reports summarizing the work of the unit council will be prepared by the council chairperson, co-chairperson, and PCD no later than December 16th.

Interventional Cardiology Unit Council Charter

Purpose:

The Unit Council is a nurse-led council that works collaboratively with other members of the interdisciplinary team. The Unit Council's goal is to guide the continuing development of professional practice in the unit and to act as the decentralized decision making body for the unit. The Unit Council provides input to assist the Patient Care Director (PCD) and the Director of Nursing (DON) in guiding the practice of nursing and unit operations. Specifically the purposes of the council are to:

- Address the nursing practice needs of all members of the nursing staff.
- Participate in the development of best practice standards of nursing in conjunction with the medical center quality and safety programs.
- Promote quality nursing care and outcomes of patients and families.
- Identify clinical problems and solve clinical issues that affect nursing practice specific to the unit using evidence-based practice.
- Promote the continuing development of professional nursing practice on the unit.
- Share best practices in order to standardize aspects of clinical care.

Responsibilities of the Unit Council:

- Receive concerns related to professional practice and the delivery of patient care and problem solve in collaboration with the PCD, medical team and other unit leadership as clinically appropriate.
- Report on hospital wide committee work relevant to improving patient and family experience, hospital operations, employee satisfaction and engagement.
- Disseminate information to all staff on the unit.
- Monitor professional practice on an ongoing basis and make recommendations for improvement, as needed.

Decision Making and Recommendations:

- The Unit Council will use consensus building as its principal method for decision making.

Membership:

Membership of the Unit Council is comprised of volunteers, Registered Professional Nurses and Patient Care Support Staff. The PCD acts as an advisor to the Council/Committee.

- The following subcommittees will be part of the UPC unit council.
    - To be determined by incoming Unit Council leadership and UPC shared decision making.

Leadership:

Eligibility: To be eligible to serve as Chair or Vice-chair on the Unit Council, one must be a full or part time registered nurse in good standing and has completed at least 6 months of employment in the Interventional Cardiology Unit at NYP Columbia.

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Elections: Elected officers (Chair, Vice-Chair, and Recorder) to the Unit Council will be elected by the staff in the Interventional Cardiology Unit via secret ballot. Elections will be held annually as determined by the UC. Prior to the election, each candidate will present to the staff about why they want to be elected to the position, contributions to their own professional development and the growth of the department in the past, and their ideas for the department going forward.

- **The Following Leadership Positions will be elected:**

    o *Chair:* the duties of the Chair with assistance of Vice-Chair are as follows:
        - Plan the agendas for all meetings of the Unit Council.
        - Preside at all meetings of the Unit Council.
        - Call special meetings of the council, as needed or requested by the PCD/DON.
        - Appoint ad-hoc committees as the need arises.
        - Mentor the Vice-Chair to assume the position of Chair.
    o *Vice-Chair:* Selected by membership for 1 year tenure. The Vice-chair will become Chair after 1 year. The duties of the Vice-Chairperson are as follows:
        - Assume the duties of the Chair in the absence of the Chair
        - Assist the Chair in the performance of duties

    o ***Immediate Past Chair:*** Serve 1 year tenure immediately following role as Chair. The duties of the Immediate Past Chair are as follows:
        - Serve as mentor for Chair and Vice-chair
        - Assist the Vice-chair with duties in the absence of the Chair

    o ***Recorder***: Serve 1 year tenure.
        - Takes notes of discussion and decisions agreed upon that include:
            - Exact words of recommendations.
            - Names of those responsible for future actions.
            - Write the minutes and submit to the chair no later than a week of the meeting.
        - Write the minutes and submit to the chair no later than a week of the meeting.

- *Vacancies:* The Chair/Vice-Chair, on advice and consultation of the PCD, has the authority to fill vacancies as they occur. The successor will serve until the next scheduled election.
- *Term of Office:* Elected members will assume office after annual elections are finalized. All terms will expire one year elected to office.
    o Elected members will serve a terms as follows:
        - **Vice-Chair**: 1 year term, then serve 1 year as Chair, if they choose
        - **Chair:** 1 year term, then serve 1 year as Immediate Past Chair
        - **Immediate Past Chair**: 1 year term, then return to general membership

Meetings:
- Meetings will at least once a month and at the discretion of the UC Leadership team
- Date and time of future meetings will be determined by incoming chair/vice-chair in shared decision making with the committee.

Attendance:

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- Council members are expected to attend at least 80% of UC meetings. Members will notify the Coordinating Council chair prior to the council meeting if they cannot attend. An alternate representative for the department may be requested.
- Attendance expectations to be determined by incoming Unit Council leadership and UPC shared decision making.

Reporting Structure:

- Agenda and meeting minutes will first be submitted to the PCD for approval and then distributed to all staff for review.
- Members will be responsible for keeping colleagues informed regarding activities, discussions, decisions, and projects of the Unit Council by reporting back to all staff of the unit and eliciting input regarding items under consideration.

Action Plan:
- Annual action plan summarizing the work of the unit council has accomplished will be prepared by the council vice-chair persons and PCD at the end of the year.