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Shared Governance Effect on Nursing Outcomes

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Bellarmino University

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## **Introduction**

The economy has made it necessary for hospitals to consolidate into integrated systems. Government and private insurance stipulations for reimbursement have become rigorous and dependent on quality and readmission rates. Hospital-acquired infections or injuries are no longer reimbursable (Underwood & Hayne, 2017). The changing landscape has been challenging for the healthcare worker, affecting morale, and in turn, patient care. It is essential for hospitals to perform at the highest level for patient outcomes and safety, in addition to creating healthy work environments for employees. Shared/Transformational Governance is key to developing top functioning hospitals. Involving the staff in decision making creates an improved process, and enhances employee engagement and satisfaction, patient outcomes, and financial status. Improving the quality of health care is a worldwide initiative. Nurses are advocates for high-quality patient care. It is essential for nurse executives and bedside nurses to unite through shared governance to repair broken processes. Collaboration between leadership and staff is vital to determine the issues and find the solutions (Dearmon, Riley, Mestas, & Buckner, 2015).

## **Background and Significance**

Saints Mary and Elizabeth Hospital was founded by the Sisters of Charity of Nazareth in 1874. The facility is a faith-based community hospital serving the south Louisville community. The hospital is vital to the community surrounding it, with loyal employees and patients. The facility is in a lower socio-economic postal zip code, 40215, where 40 percent of residents have no earnings, and there are an extremely high number of single parents and a meager number of families. The percentage of residents 25 and older that did not graduate high school is among the highest in the nation, at 24.2%. The number of individuals with high school diplomas is 63.1%, and the number with college degrees is 12.7% of the population. The average income per

household from wages earned is \$26,569, and the median home value is \$76,900 (United States Zip Codes, 2018). The demographics of the postal zip code impact the environment of our building due to the socio-economic challenges faced by the community and our employees.

The facility has experienced several partnerships and ownership changes and is currently a part of the KentuckyOne Health umbrella of Catholic Health Initiatives. KentuckyOne Health was founded in early 2012 when the Jewish Hospital and Saint Mary & Elizabeth Hospital System joined with Saint Joseph Hospital in Lexington. In late 2012, the University of Louisville Hospital joined KentuckyOne Health, then left the system five years later in July 2017. The Louisville Market of KentuckyOne Health is currently for sale due to financial decline, even though Saints Mary & Elizabeth Hospital is profitable and financially stable. Negotiations with a potential buyer, Blue Mountain Capital Investment, have been underway for nearly two years.

The duration of negotiations has been emotionally stressful for all involved, from the staff level employee to leadership. While looking forward to the new venture and the financial viability, there is uncertainty for employees, beyond the name and potential loss of our faith-based culture.

As a result of this volatility at the corporate level, nursing leadership turnover at Saints Mary and Elizabeth Hospital has been significant, spanning from the nurse manager level to the chief nursing officer (CNO). The current nursing leadership team has a varied tenure in their roles, ranging from 6 months to 3 years. The continuous turnover in nursing leadership has impacted staff morale, and the level of care they provide to patients, although under the direction of the current CNO, turnover has decreased from 47% in 2015/2016 to 21% for 2018 and quality has improved. The fall 2018 LeapFrog Hospital Safety Grade is a C, upgraded from a D rating. The C rating is the hospital's first since the spring of 2015.

While the current CNO has made tremendous progress, the vision is to develop the professional culture even further. The RN turnover was a priority when she arrived as the interim CNO in 2015. During a nursing strategic planning meeting for 2018, the CNO shared her vision to revamp and further develop the Shared Governance structure of the Professional Nurse Practice Council (PNPC) and then start unit-based councils. The impetus to embark on a formal shared governance structure was to empower staff with decision making to improve employee and patient satisfaction, and patient outcomes.

Communication of the strategic plan to include shared/transformational leadership began in early 2018, first with the nurse managers (see Table 4). Communication-related to the development of unit-based councils occurred at the manager meetings, charge nurse meetings, weekly huddles, and staff meetings. Unit Council members were recruited based on expressed interest.

In May and June of 2018, education was provided for nursing leaders and the charge nurses on all units regarding Benner's Novice to Expert Theory, selected as the theoretical basis for nursing at Sts. Mary & Elizabeth, and the proposed council structure. The first unit-based council meetings occurred in May. In July, the PNPC reconvened with the new members to discuss some practice agenda items, including the development of a nursing vision and a nursing peer review process for the facility. All units were represented except one medical-surgical unit and surgery, due to scheduling conflicts. After this meeting, an alternate was requested to attend if the unit-based council chair was unable to represent the unit. Literature was provided to provide background on nursing visions, to include some examples. Discussion at this meeting concluded that the vision should include the community aspect the facility is so proud of.

Currently, the author is the chair of the Professional Nurse Practice Council. Recruitment for either a chair or co-chair(s) has been in progress since the July meeting. As of this writing, I am still recruiting for a chair and co-chair. The author will serve as the executive leader to provide mentorship and support once a chair is in obtained.

Current issues include variable attendance at the meetings and lack of participation in the peer review process. After the initial meeting, a conference line number was provided for call-in purposes, although the preference for attendance is for the members to be present. The transition of leadership from the author to the staff as chair will be necessary.

### **Purpose**

Given the issues encountered, staff buy-in to having a more significant role in decision-making was uncertain. This led to a plan to assess the current level of staff perceptions of Shared Governance and the progress made to date regarding nurse and patient outcomes. Therefore, the purpose of this project was to evaluate the perceptions of nursing staff regarding shared governance and the changes in nurse engagement and nursing turnover since the initiation of shared governance.

### **Literature Review**

#### **Introduction**

Porter-O'Grady (2009), the father of shared governance, defines the shared leadership model as a professional practice model founded on the principles of partnership, equity, accountability, and ownership. The result is a culturally sensitive and empowered environment which develops a sustainable, accountable culture for excellent patient care (Gallagher-Ford, 2015).

Shared Governance is a professional practice model founded on the principles of partnership, equity, accountability, and ownership. Shared Governance is a leader-staff partnership that encourages collaboration, shared decision making, and responsibility to provide quality care, safety, and work-life satisfaction (Mathias, 2015).

Shared Governance provides the model for assisting nursing and hospitals in obtaining the goal of employee engagement and satisfaction, thus providing improved patient quality and safety. Shared Governance models vary in council structure, level of decision-making authority, and range in composition from the inclusion of only nursing to spanning an interdisciplinary model. Each organization must determine the model that best fits its culture and capabilities.

Literature suggests that Shared Governance improves employee engagement and performance which in turn improves patient quality and safety. Nurses and non-nurses know shared leadership as a practice model that organizes professional responsibilities. Shared Governance promotes maximal employee participation in decision making in their work environment. Nurses are the largest profession in number among the healthcare system; nurses are essential in the delivery of quality healthcare and productivity in healthcare facilities (Young, 2017).

It is crucial for high-performing teams to have a culture of shared decision making while understanding their roles and responsibilities. Staff will continue to perform their positions but have responsibility for the results of the team. Transformational leaders may not always be in a formal leadership role. Transformational Leadership develops the relationships between leadership and staff. Transformational leaders model the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging work from their heart (Zaccagnini & White, 2017).

**Impact on Staff**

Shared Governance empowers nurses. Empowerment gives downward control, sharing authority over decision making. Joseph and Bogue (2016) suggest that leaders will require power competencies to make system-level changes and improve performance. Nursing leadership must be prepared to support unit-based teams creating system-level change. The formation of unit-based councils does not always produce the desired outcome. Leadership must be competent and prepared to support unit level council decisions. Shared Governance is predicated by effective leadership at every level. An intentional effort is required for effective outcomes.

Improvement of nursing engagement with shared governance and transformational leadership is a strategy utilized to escalate the patient experience, which affects the patient outcome, which in turn affects reimbursement. Involvement in shared leadership is related to retention of staff, quality, and safety of patients due to the ability to make decisions about the process and practice on their units (Kutney-Lee et al., 2016).

Nursing cannot progress to meet the demands of a changing society unless nurse managers and staff nurses are engaged. The success of an organization partially depends on the fit of an individual to the culture of the organization. Organizational culture is defined by attitudes, beliefs, customs, and rules to include unwritten rules that have developed over time. Staff nurse engagement begins with the nurse manager's engagement, which is measured by staff nurse engagement, retention, productivity, organizational goal attainment, and profitability (Gray, 2012).

A healthy work environment in hospital nursing is characterized as a safe, empowering, and satisfying culture that promotes optimal health and safety. In healthy work environments, there are good working relationships, bedside nurses are involved in decision making, and the



leadership listens and responds to patient care issues. The CNO is key to creating a healthy work environment and must be devoted to evidence-based practice to lead change in partnership with nurse leaders, bedside nurses, and other disciplines. All patients deserve quality nursing care based on research and best practice. Nurses have an ethical duty to provide safe quality care to patients (Burns, Zedreck Gonzalez, Hoffman, & Fulginiti, 2018).

Employees must know and understand the direction and goal(s) of the organization to develop professional quality. In professional employees with theoretical knowledge, the professional quality will be necessary. Quality is a significant performance measure. Professional quality includes process and product, as well as the input, output, and outcome. There may be many potentially competing understandings of professional performance or quality. It is essential that the goals or priorities of an organization be communicated at every level. Professional quality's meaning comes from values, norms, and beliefs in the profession: though leadership and the facilities structure can influence these. Transformational leadership is built on inspiration and the direction of individual efforts. Transformational leaders boost awareness of the organization's goals. The vision is clear and precise helping the employee develop the same understanding of professional quality. Transformational leadership should be related to professional quality in a positive manner (Anderson, Bjornholt, Bro, & Holm-Peterson, 2018).

The most commonly publicized feature of shared governance is empowerment. The efficient approach to the shared governance model has focused on committee structure, nurse-driven quality improvement, accountability, evidence-based practice implementation, and practice control. Structural empowerment manifests by employee awareness of the structure that expedites performance; psychological empowerment represents the employee's reaction to those structures. Empowerment exists when employees perceive there is access to both the formal and

informal structures. Structural empowerment is connected to changes in psychological empowerment and job satisfaction. Hardwiring shared leadership into the culture of an organization requires leadership and staff support, the positioning of workflow, and diligence to communication. Outcomes of engagement, empowerment, and satisfaction are found in shared leadership structures (Owen, Boswell, Opton, Franco, & Meriwether, 2018).

A cross-sectional survey at a medical center hospital suggests that leadership styles and employee empowerment play a key role in promoting commitment to the organization. The goal of the study was to test a conceptual framework relating leadership styles of managers to the nurses' perception of empowerment and the commitment level. The findings indicate leaders in the acute care hospital setting can strengthen the commitment of nurses by their leadership style. Transformational and Transactional leadership styles positively affect commitment, job satisfaction, and turnover (Asiri, Rohrer, Al-Surimi, Da'ar, & Ahmed, 2016).

Shared Governance maximizes all the human resources through empowering individuals and providing them with an opportunity to take a leadership role, formal or informal. The demands of hospital leadership are significant and too significant for one person. Shared leadership gives power to the most qualified individuals to intensify their capabilities. Delegating closer to the bedside and allowing team members to be responsible for challenging issues are vital to the shared leadership model. Employees will feel more like partners and become more engaged in creating improved outcomes for the organization, the team, and themselves (Goldsmith, 2010). A descriptive, correlational study on reasons for turnover in Magnet and Non-Magnet hospitals provides empirical data suggesting that the work environment is a crucial factor in nurse turnover (Park, Gass, & Boyle, 2016).

Control over decisions in nursing practice is an essential issue for nurses, especially in hospitals where traditional hierarchy authority is prevalent. Research shows us that nurses who participate in shared decision making have greater control over their nursing practice and greater job satisfaction. Hospitals with shared governance have lower turnover and better patient outcomes. Facilities with shared decision making found that nurses are more accountable and empowered in their nursing practice. Shared governance encourages employees to function as a manager, with a personal stake in the success of the organization (Murray, et al., 2016).

The results of a descriptive correlational study performed to determine the relationship between perceptions of governance and empowerment in a shared governance model supports the concept, as shared governance developed so did empowerment. A statistically significant correlation ( $P < .0001$ ) was found between perceptions of empowerment and availability of opportunity, information, and support. Shared governance provides vital communication between leadership and staff nurses, improving job satisfaction and recruitment and retention. Hess' IPNG tool was used to measure the perception of the nurses, with a score of 157.61 indicative of traditional shared governance in the early implementation phase. Shared governance is an essential part of professional practice in Magnet Hospitals. Nurses must be empowered to make decisions about their practice (Barden, Quinn, Donahue, & Fitzpatrick, 2011).

Empowerment and its effect on control over nursing practice, job satisfaction, leader behavior, work effectiveness, opportunity and organizational trust effect commitment to organizations. Employees with access to resources, information, growth opportunity, and support have high levels of work effectiveness. Moore and Wells (2010) utilized a quasi-experimental prospective design to determine if participation in a system nurse council improves perceptions of workplace empowerment and organizational commitment. They did not find a

statistically significant difference pre and post-intervention, however, qualitative results indicate that staff nurses' councils have achieved significant results. The councils provide a professional growth opportunity.

### **Conceptual Framework**

Benner's Novice to Expert Theory (1984) guided this project and was adopted as the facility's mid-range nursing theory. Benner's Theory identifies five levels of competency: novice, advanced beginner, competent, proficient, and expert. The levels of skill development are based on knowledge of actual nursing practice, the knowledge that accrues over time in applied science. The Novice to Expert Theory explores the understanding that develops from the actual practice of nursing and defines practical and theoretical knowledge. Interactional causal relationships between events teach us the effect, however "knowing that" is different than "knowing how." Extending practical knowledge by theory-based scientific investigations and "know-how" through clinical expertise in the practice of nursing (Benner, 1984).

Benner's Theory for this project will apply to the level of shared/transformational leadership present, and staff readiness for it in the facility. The staff will progress from novice to expert as Sts. Mary & Elizabeth Hospital develops shared leadership. Leadership and staff will grow from "knowing-that" to "knowing-how" shared leadership improves employee engagement and satisfaction, and patient outcomes and satisfaction.

## **Methods and Procedures**

### **Participants**

Nursing areas included in this project were two intermediate units, two medical-surgical units, and the nurse flex team. There is a nurse manager for each of the nursing units; with recent approval for the addition of an assistant nurse manager for each unit on the night shift and one day shift for the largest unit. The flex pool reports to a registered nurse project manager. There is a total of approximately 105 registered nurses for the included areas. The nurse managers were responsible for initiating a unit-based council for each of their areas of responsibility with support from nursing leadership. The staff determines topics that affect their unit and potentially the hospital.

### **Setting**

As previously mentioned, this project took place at Saints Mary and Elizabeth Hospital, a community hospital in the 40215 postal zip code of south Louisville, Kentucky. The average daily patient census is 104, with a range from 80 to 132. The facility has two medical-surgical units, two intermediate units, and two intensive care units. The intensive care units are not included in this project due to being under the leadership of a different nursing director.

### **Measures**

Assessment of staff's perception of the current state of implementation of shared leadership will be determined using the Index of Professional Nursing Governance (IPNG). Hess developed the Index of Professional Nursing Governance (IPNG) with the purpose of measuring the level of shared governance. Also, the tool provides evidence of the connection between

shared decision making and professional, organizational, and patient outcomes (Weaver, Hess, Williams, Guinta, & Paliwal, 2018).

In 2017, IPNG 3.0 was designed by factor analysis to reduce the tool to a 50-item version, while maintaining its validity and reliability. Items are scored on a 5-point Likert scale ranging from decision-making by nursing management/administration only (1) to equally shared by clinical nurses and nursing management (3), to clinical nurse only (5). The tool is a six-dimensional model that includes measurement of: professional control over practice, organizational influence of professionals over resources that support practice, corporate recognition of control and influence, facilitating structures of professional control and influence, liaison between professional and administrative groups for access to information, and the alignment of organizational and professional goals and negotiation of conflict (Weaver, Hess, Williams, Guinta, & Paliwal, 2018).

To determine the impact of shared decision making on RN engagement the annual engagement survey was used. In past years HealthStream administered the employee satisfaction survey through the work email system. As a result of the pending divestiture the full employee engagement survey was not done in the Louisville Market of KentuckyOne Health the last two years. A modified Performance Culture Assessment survey was created by the human resource department with six simple questions based on the employee's immediate leader; designed to measure only employee engagement. Demographic data is included in the engagement survey to provide information at the department level.

Impact on engagement was also measured by looking at nursing staff turnover. This number is based on voluntary turnover and determined by the human resources department. The voluntary turnover tracked by human resources does not include terminations for cause.

## **Procedure**

The IPNG was administered by the facilities SurveyMonkey from April 3 to May 16, 2019. The purpose and risk were explained. Participation was encouraged by email, nursing leadership meetings, CNO Meeting, Nursing Leadership Meeting, unit - based counsels, and Professional Nurse Practice Council, staff meetings, face to face small groups, individually, and signage. A thank you process to include candy was used to encourage participation and show appreciation.

Additional demographic data was added for the purposes of this project to include age, gender, marital status, years of experience, education levels, employment status, certifications and participation in and satisfaction with counsels.

Bedside registered nurses were requested to participate in the IPNG 3.0 survey by email with the link to SurveyMonkey embedded. An information sheet was included at the beginning of the SurveyMonkey. The information sheet explained the purpose of the research study, risks, and confidentiality. Consent was assumed by the completion of the survey. The emails were sent on eight different dates, weekly over six weeks to remind staff of the opportunity to participate in the assessment survey.

The 2019 employee engagement was conducted from March 26 to May 16, 2019. The staff were encouraged to participate by leaders, human resources, and signage. The engagement survey link was sent to each employee's work email address. The survey could be completed on computers in the work environment or from home computers and personal cell phones.

Turnover statistics for the units participating in the project were obtained from the facilities human resource department's monthly and annual data collection.

### **Ethical Considerations**

There were no potential risks to participants in this project. The survey was anonymous and reported in aggregate only. The survey provides an opportunity for staff to share their opinion and leadership to obtain feedback. The project was reviewed by the IRB.

### **Data Collection**

Bedside registered nurses were requested to participate in the IPNG 3.0 survey by email with the link to SurveyMonkey embedded. An information sheet was included at the beginning of the SurveyMonkey. The information sheet explained the purpose of the research study, risks, and confidentiality. Consent was assumed by the completion of the survey. The emails were sent on eight different dates, weekly over eight weeks to remind staff of the opportunity to participate in the survey. In addition, direct solicitation was used by the author rounding on the four participating units at least weekly.

### **Statistical Analysis**

Characteristics of the nurses were summarized using frequencies and percentages for categorical factors (gender, marital status, education basic level, highest education level, employment status, title of current position, unit worked, certification and type, active in shared governance councils, satisfaction with impact of shared governance, and overall satisfaction with shared governance). Means and standard deviations (SD's) were used to describe continuous data (age, years of experience, and years in current position). Descriptive stats will be used to summarize the results of the IPNG 3.0. Each domain of the IPNG 3.0 survey contained a different



number of items (ranging from five to twelve). The analysis was performed using IBM SPSS software version 24.

## Results

### Description of Sample

The number of nurses who participated was 44 of the 105 who were sent the email invitation containing the survey link for a 41.9% (n = 44) participation rate. Participation from the four nursing units was spread evenly with seven to nine participants from each of the four units, and 13 flex team nurses for a total of 44 participants. The mean nurse age was 43.55 years (SD 10.77), the majority were the female gender at 84.1% (n = 37), and 61.4% (n = 27) were married. Basic education preparation was evenly distributed between associate degree at 47.7 % (n = 21) and baccalaureate degree at 50% (n = 22). The highest educational degree was the baccalaureate degree at 52.3 % (n = 23), followed by an associate degree at 36.4% (n = 16). Most of the participants employment status was full time at 90.9% (n = 40). Most of the position titles were bedside nurses at 84% (n = 37), followed by charge nurse at 0.09% (n = 4), and assistant nurse managers at 0.06% (n = 3) participation. Both charge nurses and assistant nurse managers provide some level of bedside patient care.

The mean number of years practicing nursing was 13.47 years, with a median of 10.5 years. The mean number of years working at Sts. Mary and Elizabeth Hospital was 7.95 years, with the number of years in current position mean of 4.95 years. Only 18.1% (n = 8) of participants had obtained a specialty certification. The involvement in shared governance activities was only 22.7% (n = 10) of the participants, leaving 77.3% (n = 34) with no involvement.

**Table 1****Cronbach Alpha Internal Reliability**

<b>IPNG 3.0 Domain</b>	<b>Cronbach Alpha</b>	<b>Number of Items</b>
<b>Professional Control</b>	<b>0.810</b>	<b>08 Items</b>
<b>Organizational Influence</b>	<b>0.675</b>	<b>08 Items</b>
<b>Organizational Recognition</b>	<b>0.704</b>	<b>12 Items</b>
<b>Facilitating Structure</b>	<b>0.804</b>	<b>08 Items</b>
<b>Liaison</b>	<b>0.854</b>	<b>09 Items</b>
<b>Alignment</b>	<b>0.944</b>	<b>05 Items</b>

**Nurses Perception of Shared Governance**

The Likert scale response options on the IPNG ranged from 1 to 5, with 1= nurse manager/administration only, to 5 = clinical nurses only. IPNG score of 3 is the midpoint in governance being equally shared by leadership and bedside nurses. The forty-four bedside nurses from four units and the flex team completed the IPNG 3.0 survey. Reliability is high as the Cronbach's Alpha total score was .80 with a range from 0.675 to 0.944 for the six domains of the IPNG 3.0 tool. The Cronbach's Alpha indicated good internal consistency reliability as indicated in Table 1.

In evaluating the IPNG 3.0 scores for the 44 participants, the mean overall score for nurses' involvement in clinical decision-making was 1.62 (SD .55031) which indicates decisions are made by nurse leaders predominantly. In this study, the level of shared governance was perceived to be low as reflected by all six domain scores and means less than 2.0. The mean domain scores ranged from 1.53 (SD .45) for the group that participates to 1.97 (SD .55) for the

group that influences. Has access to information score was 1.63 (SD .55), official authority score was 1.64 (SD .40), group that controls score was 1.68 (SD .51), and the group that has ability to score was 1.71 (SD .72). The domain scores echoed the perception that decision-making was primarily dictated by nurse leadership with some input from the bedside nurse.

### **Nurse Satisfaction**

The IPNG 3.0 satisfaction with the impact of shared governance on nursing or patient care was measured by a Likert scale of 1-5, with 1 representing the lowest and 5 representing the highest level of satisfaction. Selection of 1 and 2 on the scale was 22.8% (n = 10), 31.8% (n = 14) selected a rating of 3, 36.4% (n = 16) selected 4, and 6.8% (n = 3) selected 5. The participants in the shared governance process may be more engaged, the non-participants perception may alter the results.

The IPNG 3.0 nurse survey satisfaction with their professional practice within the facility was measured with the same Likert scale of 1 to 5, 1 representing lowest satisfaction and 5 representing the most satisfied. Selection of 1 and 2 on the scale was 11.4% (n = 5), 27.3% (n = 12) selected a ranking of 3, 45.5% (n = 20) selected 4, and 15.9% (n = 7) selected 5.

### **Engagement Performance Culture Assessment**

In 2019 Sts. Mary and Elizabeth Hospital's overall results improved in five of the six categories over the 2018 results and are above Catholic Health Initiatives (CHI) system average in all six categories (See Table 2). Sts. Mary and Elizabeth's results were below the CHI system average in 2018. The six categories are communication, constructive feedback, conflict management, personal recognition, representing issues to administration, and manager trust.

**Table 2**

**Difference in PCA Results Between 2018 and 2019**

**Percent Responding Satisfied or Very Satisfied**

<b>PCA Engagement Item</b>	<b>2018</b>	<b>2019</b>
<b>Communication: How openly and honestly your supervisor communicates</b>		
2A - Medical Surgical	92%	89%
3A - Intermediate	42%	58%
4BC - Medical Surgical	87%	100%
5BC - Intermediate	42%	100%
Flex Team	NA	100%
CHI	NA	81%
<b>Constructive Feedback: Letting you know when and how your work can be improved</b>		
2A - Medical Surgical	92%	89%
3A - Intermediate	54%	50%
4BC - Medical Surgical	93%	100%
5BC - Intermediate	54%	100%
Flex Team	NA	94%
CHI	NA	81%
<b>Conflict Management: How well conflicts are managed in your department</b>		
2A - Medical Surgical	75%	100%
3A - Intermediate	38%	50%
4BC - Medical Surgical	80%	100%
5BC - Intermediate	38%	100%
Flex Team	NA	100%
CHI	NA	72%
<b>Personal Recognition: The amount of recognition your supervisor gives you for a job well done</b>		

2A - Medical Surgical	67%	89%
3A - Intermediate <b>*Includes do not know responses</b>	42%	17% -* 50%
4BC - Medical Surgical	80%	100%
5BC - Intermediate	42%	100%
Flex Team	NA	94%
CHI	NA	77%
<b>Representing Issues to Administration: How well your supervisor communicates the needs of your department to administration</b>		
2A - Medical Surgical	58%	78%
3A - Intermediate	31%	58%
4BC - Medical Surgical	80%	100%
5BC - Intermediate	31%	90%
Flex Team	NA	100%
CHI	NA	74%
<b>Manager Trust: The degree to which you trust your immediate supervisor</b>		
2A - Medical Surgical	75%	94%
3A - Intermediate <b>*Includes do not know responses</b>	31%	42% - *58%
4BC – Medical Surgical	100%	100%
5BC - Intermediate	31%	90%
Flex Team	NA	100%
CHI	NA	78%

### Turnover

Voluntary employee and bedside registered nurse turnover for the four nursing units (2A, 3A, 4BC, 5BC) involved in this project were both slightly up year over year for fiscal year 2017 and 2018. The flex team turnover remains at 0% for the same two years. Unit based employee turnover for the four units involved in this study for the fiscal year 2017 was 22.59% and fiscal year 2018 was 23.73%. Fiscal year 2019 unit-based turnover declined slightly to 22.92%. Fiscal year 2019 coincides closely with the implementation of the unit-based councils and updated configuration of the Professional Nurse Practice Council. Unit based councils were initiated in May 2018 and the fiscal year is July 1, 2018 to June 30, 2019. Bedside registered nurse

turnover for the fiscal year 2017 was 22.99% with the fiscal year 2018 at 24.9%. Fiscal year 2019 bedside registered nurse turnover was 24.96.

## **Discussion**

### **Summary of Findings**

The results of the IPNG 3.0, Performance Culture Assessment, and Turnover outcomes indicate that this shared governance project and the nursing strategic plan may have had a positive impact on the facility measures. While the IPNG 3.0 score of 1.62 indicated that the staff perceived that decisions are still made by nurse leaders primarily, the IPNG questions on satisfaction with the impact of shared governance and satisfaction with professional practice were ranked 1, 2, or 3 on the point Likert scale 54.6% (n = 23) and 38.7%(n = 17) respectively. Furthermore, this is not much lower than Di Fiore et al (2018) reported, after three years of work on shared governance. Clavelle et al (2013) reported lower IPNG total and subscales scores ranging from 1.35 to 1.48. In addition, Dechairo-Marino et al (2018) reported lower response rates for both pre and post structure redesign with 33% and 29% (adjusted to 26%) respectively; with shared governance levels pre-intervention with three of six score domains in the shared governance range and post-intervention five of six domains. Similarly, Hess (2011) found scores falling below the minimum shared governance score in two Veterans Administration hospitals in the early years of implementation of shared governance. Bina et al's., (2014) results in 2004 and 2010 were also were below the actual and preferred shared governance levels in a Midwestern medical center.

The 2019 PCA results for the nursing units that participated in the study improved from the 2018 results. While the 2018 PCA results likely reflect the impact of vacant manager positions on the two intermediate units (3A and 5BC), during the four to five months prior to the

survey open period, 2019 scores show that engagement has increased especially on 5BC.

The Shared Governance Model was implemented in May 2018, one to two months after the 2018 PCA Survey closed. Some of the unit-based councils are still working on participation, while others are thriving. The Professional Nurse Practice Council that the unit-based chairs attend monthly has good attendance and we are increasing the number of decisions made on processes that effect their nursing practice.

Unit-based turnover rates are above the national average but there is a slight decrease from 23.73% in 2018 to 22.92% in 2019. There are several factors that affect employee turnover, to include the pending divestiture, engagement of staff, lack of state-of-the-art technology (physician order entry, documentation and medication delivery system). As previously mentioned there has been a great deal of nurse manager turnover at Sts. Mary and Elizabeth Hospital. While the two medical-surgical units, 2A and 4BC have had the same manager since 2016, the two intermediate level units, 3A and 5BC have had 4 and 3 managers respectively. The two intermediate units are very busy, which contributes to the difficulty of the nurse manager role and the turnover for those two units. In addition to and as a result of the multiple managers, staff have developed inappropriate behaviors that are challenging to control and change.

The nurse manager role is a front-line leader and difficult, potentially the hardest in the hospital. Some of the factors that make the nurse manager role difficult are 24-hour responsibility for staffing, staff, patient, and physician concerns and issues. Much work has been done at Sts. Mary & Elizabeth Hospital to decrease the demands and stress of the nurse manager position, to include the addition of assistant nurse managers on the night shift. The house supervisors assist with staffing. The department support assistants have extended responsibilities to include tracking time and attendance, writing discipline for the manager, tracking mandatory

requirements to include notifying employees, and other duties as assigned. The delegation of duties allows the nurse manager to utilize their time to develop the shared governance practice model. In addition, the demands for accountability from higher level nursing and non-nursing leadership for quality outcomes and financial viability is another level responsibility and stress.

The nurse managers supporting staff participation in shared governance activities may lead to empowerment of nursing staff to develop meaningful improvements to bedside care. Nurse managers should serve as coaches, facilitators, and mentors to remove barriers to shared governance. Understanding the qualities of nurse managers who are able to successfully implement and maintain shared governance models may assist other nurse managers with successful methods of implementation. Understanding the characteristics of nurse leaders that contribute to successful shared governance models will be important for developing competencies for other nurse leaders (Sullivan, Norris, Brown, & Scott, 2017).

### **Significance and Potential Implications**

Many stakeholders may benefit from effective shared governance. When leaders trust the wisdom of staff and allow them to make meaningful changes, the culture changes quickly for the better; the outcomes are both qualitative and quantitative, improving clinical and safety outcomes (Wessel, 2012). The structure of the current shared leadership model will continue to evolve. Leadership must be able to think critically and strategically, communicate, articulate a clear vision, possess emotional intelligence, motivate and build strong teams and networks. Involving the staff in the decision-making process develops support for the change and implementation of best practices.

The principal stakeholders of this project or process change are the patients, staff nurses, human resource department, nurse leaders (managers, directors, and the vice president of



nursing), the hospital president, physicians, and the community. Successful implementation of shared governance improves employee engagement and satisfaction, decreases employee turnover, improves patient outcomes, increases patient satisfaction, and improves financial status of the hospital as a result.

The second phase will include ancillary departments which will broaden the benefit by improving processes that the staff perform on a daily basis throughout the facility. By developing improved processes lead by staff, the facility can provide better care delivery. The discharge process for patients involves planning for care at home and the obstacles that may cause readmission. Improved care during hospitalization may reduce readmission rates. Centers for Medicare and Medicaid and the facility monitor readmission rates due to the financial penalty associated with less than 30-day readmissions. Not only is this financially important, but important for quality care and reducing healthcare costs long term.

### **Potential Barriers to Implementation and Sustainability**

Staff participation is key and the most significant concern for the success of this project. The leadership of the facility will need to diligently keep the focus on shared decision-making and encourage staff to participate in decisions about their practice. During meetings such as clinical operations, nursing leadership, and safety huddle the CNO and nursing directors are encouraging and promoting referral of decisions on nursing practice to both unit-based councils and the Professional Nurse Practice Council. Ancillary department leaders have begun to request agenda time at the Professional Nurse Practice Council.

The PNPC and unit-based councils still experience low attendance and participation. Current scheduling practices of three 12-hour shifts per week may be a barrier, since some staff may not want to come to a meeting on a day off. The staff has been provided a conference line

to encourage participation when being present is not possible for both unit-based councils and the Professional Nurse Practice Council. While use is infrequent, we encourage and offer the option of conference line call-in monthly at the Professional Nurse Practice Council. Another suggestion is to have an alternate council representative. Some areas such as the emergency department, ICU, and surgery have alternate representatives. The Professional Nurse Practice Council meets monthly and the participation has improved over the last six months, with only one-unit representative absent instead of two or three during the first six months. There have been a few months when all units were represented. This meeting is placed in the electronic scheduling system as a reminder. Dinner is provided for the meeting as well.

### **Limitations**

There were limitations to this project. The IPNG 3.0 was lengthy at 66 questions with the demographic questions, which may have affected the response rates. The return rate was 41.9%, which was sufficient to provide reliable data and better than the author anticipated due to the length of the survey. However, a 50% participation rate or greater would have been preferred. Additionally, the project did not include the two intensive care units which are under the leadership of a different director. The turnover of nurse managers on the two intermediate units has been difficult for staff, which in turn affects the project and many other aspects of unit performance.

### **Plan**

Maintaining emphasis and focus on shared governance leadership model will be key. Often important items are not successful because of the difficulty of hardwiring the process and the energy required to maintain progress. Attendance at the unit-based council meetings is low and will require manager's dedication to shared governance to improve. The success of shared

governance in the facility will require leadership support by providing the time, resources, and decision-making authority for staff. The literature is consistent on the need to evaluate and review the state of governance on an ongoing basis. Restructure is common as hospitals are in a constant state of change.

Mentoring the chairs of the unit-based councils and the hospital council is essential, to include leader development programs to facilitate autonomy. The literature suggests commitment to key supportive mechanisms is needed, which does not necessarily require large amounts of resources or significant organization change. Change in attitude of both leaders and bedside staff is key and development of autonomy which brings personal accountability, shared power and influence to help develop and maintain shared governance.

The IPNG 3.0 will be used to measure the staff perception again in April of 2020 by SurveyMonkey to assess growth in shared governance. Shared Governance structure will be re-evaluated with the results of the 2020 survey and annually. The author will perform periodical literature reviews for guidance and sharing with the Professional Nurse Practice Council. Use of a paper version of the IPNG 3.0 for the Professional Nurse Practice Council members would provide the perception of the shared governance model by active participants.

### **Impact of the Potential Sale**

The Louisville Market of KentuckyOne Health has been for sale for two years by Catholic Health Initiatives. The pending sale and divestiture from KentuckyOne Health creates uncertainty at Sts. Mary and Elizabeth Hospital as well as the other facilities who share our Medicare provider number. A capital investment company has been interested in purchasing the divesting facilities since the announcement in the spring of 2017. A local university with an associated hospital attempted to make the acquisition during the last year with financial funding

for the purchase but did not have the capital investment dollars needed. The university's bid on the purchase delayed the potential acquisition by capital investment company. The uncertainty creates unrest among staff and leaders alike. Two of the four inpatient nursing directors (emergency department and surgery) have left the organization. In addition, recruitment for both staff and leader positions are a challenge when we do not know who our owner will be. At the current time negotiation with the capital investment is thought to be nearing a final stage.

Due to the length of time this divesture or sale has taken, Catholic Health Initiatives has become extremely focused on the productivity of all departments and facilities over the last two months. Action Plans were requested for all departments not meeting 100% productivity. There was not a capital budget process in 2017 and 2018 for needed equipment purchases. All of these factors impact the shared governance process, but nursing leadership has maintained focus on moving forward with this important strategic initiative as well as many others.

### **Conclusion**

There has been progress in developing the shared governance practice model in this community hospital. However, the perception of staff is lower than desired as reflected in the IPNG score. The Performance Culture Assessment scores are greatly improved and will facilitate the development of shared governance. While turnover is higher than the national average, there was a slight decline in 2019 despite the pending divesture. There will need to be a continued focus on developing the practice model and structures. Leadership will need to continue to support and develop the shared governance practice model by including staff nurses in decision-making about their practice. As a result, Sts. Mary and Elizabeth Hospital will achieve improved quality of care and patient outcomes for the community they serve.

**Table 3. Domains of the IPNG 3.0 Tool and Overview of Themes**

<b>Domain Name<sup>a</sup></b>	<b>Factor Name<sup>b</sup></b>	<b>Items Themes (Number of Items)</b>
Professional Control	Professional control	Professional control over bedside care, policies, procedures, nursing qualifications, ancillary staff, discipline, education, products, model of care (8)
Organizational Influence	Group that influences	Organizational influence over assignments, unit flow of patients, department resources, salaries, benefits, bedside activities, and new positions (8)
Official Authority	Official Authority	Mandatory credentialing, organizational charts, guidelines for discipline, procedures for hiring, policies on promotions to leadership, procedures determining assignments, monitoring and obtaining supplies, control of patient flow, process for annual unit budgets, procedures for adjusting salaries, raises, and benefits, formal mechanisms for consulting nursing and non - nursing support services (12)
Group that Participates in Activities	Group that Participates	Unit committees for admin matters, nursing department committees for admin matters, interprofessional committees for collaborative practice, hospital admin committees for employee benefits and strategic planning, forming new unit committees, new nursing department committees, new interprofessional committees, new administrative committees (8)
Group that has Access to Information	Has Access to Information	Compliance for regulatory nursing practice, unit, and nursing department goals, organization strategic plans, results of patient satisfaction surveys, physician and nurse satisfaction, nurse turnover and vacancies, nurse satisfaction with the practice, nurse satisfaction with salaries and benefits, management's opinion of bedside nursing practice (9)
Group with Ability to	Ability to	Negotiate conflicts among professional nurses, between professional nurses, and physicians, other healthcare services, management, and administration (5)

<sup>a</sup>Hess reflects names used in the research



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