

3-25-2022

A Contemporary Shared Governance Structure and Its Role in Managing Nurse Turnover

Kagale Kiwanuka

University of St. Augustine for Health Sciences

DOI: <https://doi.org/10.46409/sr.SKHW8650>



This work is licensed under a [Creative Commons Attribution 4.0 License](https://creativecommons.org/licenses/by/4.0/).

Follow this and additional works at: <https://soar.usa.edu/scholprojects>



Part of the [Maternal, Child Health and Neonatal Nursing Commons](#), and the [Nursing Administration Commons](#)

Recommended Citation

Kiwanuka, K. (2022). *A Contemporary Shared Governance Structure and Its Role in Managing Nurse Turnover*. [Doctoral project, University of St Augustine for Health Sciences]. SOAR @ USA: Student Scholarly Projects Collection. <https://doi.org/10.46409/sr.SKHW8650>

This Scholarly Project is brought to you for free and open access by the Student Research at SOAR @ USA. It has been accepted for inclusion in Student Scholarly Projects by an authorized administrator of SOAR @ USA. For more information, please contact soar@usa.edu, erobinson@usa.edu.

A Contemporary Shared Governance Structure and Its Role in Managing Nurse Turnover

Kagale K Kiwanuka, BSN MS RN

School of Nursing, University of St. Augustine for Health Sciences

This Manuscript Partially Fulfills the Requirements for the

Doctor of Nursing Practice Program and is Approved by:

Dr. Sheri Jacobson, PhD, RN

Dr. Lisa P. Teel, DNP, RN, NEA-BC, CCRN-K

Approved: March 25, 2022


DocuSign Envelope ID: 48404B7C-F6D8-405F-B0F6-874CEAE5A85B

**University of St. Augustine for Health Sciences
DNP Scholarly Project
Signature Form**

| | | |
|-------------------------------------|--------------------------------|-----------------------------|
| Student Last Name: Kagale | First Name: Kiwanuka | Middle Initial: K |
|-------------------------------------|--------------------------------|-----------------------------|

| |
|--------------------------------------|
| E-mail: k.kiwanuka@usa.edu |
|--------------------------------------|

| |
|---|
| <p>Title of DNP Project: A Contemporary Shared Governance Structure and Its Role in Managing Nurse Turnover</p> <p align="center"><i>My signature confirms I have reviewed and approved this final written DNP Scholarly Project. DocuSign electronic signature or wet signature required.</i></p> |
|---|

| Type Name in Blue Box Below | Signature | Date |
|--|---|----------|
| DNP Project Primary Faculty: Dr. Sheri Jacobson | Dr. Sheri Jacobson | 4/8/2022 |
| DNP Project Preceptor: Dr. Lisa P. Teel | | |
| DNP Project Preceptor: | DocuSigned by:  | 4/8/2022 |

1272092769664AF...

Abstract

Practice Problem: Nurse turnover can adversely impact any health system's financial performance and the clinical practice environment, and it is detrimental to patient safety and quality of care.

PICOT: The PICOT question that guided this project was for nurses on a Labor and Delivery and Antepartum unit at a 382-bed community hospital in Austell, GA(P), does the utility of a contemporary shared governance structure in everyday practice (I) compared to the current shared governance structure (C) decrease nurse turnover rates (O) within four weeks (T)?

Evidence: Shared governance permits the reduction of turnover and the intent to leave for nurses by promoting nursing autonomy and engagement, directly linked to decreasing turnover rates.

Intervention: The contemporary shared governance structure facilitated nurse decision-making at the point of care in real-time and interprofessional team collaboration to effect change.

Outcome: Nurse turnover rates compared four weeks prior and post-implementation showed a decrease from 68.26% to 63.08%, translating into a 5.11% drop in turnover rates.

Conclusion: The contemporary shared governance structure facilitated the direct care nurse's ability to make changes at the point of care in collaboration with the interprofessional team using a rolling idea-generating process integrated into everyday practice. The project was clinically significant as it transformed the direct care nurse's autonomy in their practice fostering a positive practice environment in four weeks. This project showed how nurse engagement could be improved when on-demand decision-making in the clinical area was facilitated, resulting in reduced turnover to yield better patient outcomes and overall organization performance.

A Contemporary Shared Governance Structure and Its Role in Managing Nurse Turnover

Nurse turnover can adversely impact any health system's financial performance and the clinical practice environment, and it is detrimental to patient safety and quality of care (Li & Jones, 2013). Moreover, nurse turnover can result in astronomical economic costs of up to \$8.5 million in unfilled vacancies, patient deferment, and employee training (Kelly et al., 2021). Mitigating the risks of nurse turnover is a must because of its monumental cost. Hence because of its adverse effects on organizational financial performance, the clinical practice environment; its detriment to patient safety, quality of care and outcomes, and the consequences of insufficient staffing levels leading to job dissatisfaction and burnout among nurses, every effort should be made to stave off nurse turnover with interventions that improve engagement and nurses' emotional and mental connection to their place of work.

The utility of a contemporary shared governance structure would create a culture that fortifies nursing decision-making incorporated in everyday practice at the point of care and enhance interprofessional collaboration to transform the nursing profession. The contemporary shared governance structure based on Browder et al. (2019) fostering leadership, innovation, and growth through healthcare teams (FLIGHT) model hastens the decision-making process because it does not rely on formal meetings to execute changes as the current shared governance structure does. This contemporary shared governance structure augments nurse engagement by making the unit council chair and coach roles pivotal to the successful execution of the model. Bidirectional communication is permitted in the contemporary structure through interprofessional collaboration allowing full nurse and team engagement to improve clinical outcomes (Oss et al., 2021).

Significance of the Practice Problem

The average cost of a bedside registered nurse (RN) turnover to the health system is about \$40,300 to \$64,000 (Lockhart, 2020). Generally speaking, increased nurse turnover cascades into inadequate nurse-to-patient ratios, leading to increased risk to patient safety, decreased quality of care, and increased mortality (Church et al., 2018). Moreover, nurse turnover reduces the effectiveness and productivity of care delivery and may increase organizational operating costs through the utility of agency workers (Antwi & Bowblis, 2018). Thus, it is not surprising that nurse turnover can significantly impact an organization's profit margin. Healthcare organizations incur costs in advertising to replace lost nurses and train new nurses (Li & Jones, 2013).

The national average nurse turnover rates are 8.8% to 37% depending on the geographical location (Haddad et al., 2020). Internationally, nurse turnover is between 10% to 21% in Europe and 20% in Canada, with an estimated \$1.4 and \$2.1 billion cost to society (Li & Jones, 2013). At the hospital level, while the rolling year nurse turnover rate at the project implementation site in January 2022 was 52.06%, at the unit level that of the Labor, Delivery, and Antepartum Unit was 68.29%. Of note, when surveyed, nurses indicated leaving their current positions due to reasons such as burnout, lack of promotions, lack of autonomy and independence, non-collegial provider and nurse relationships, and a lack of respect (Shaffer & Curtin, 2020). In the final analysis, turnover is mostly a reaction to leadership relationships, so investing in managing it must be a process and not an event to be concluded in quarterly or yearly reviews (Shaffer & Curtin, 2020).

Therefore, to lead through managing nurse turnover, it is essential to be mindful of creating a workplace culture that supports and engages high performers financially, intellectually, and psychologically (Shaffer & Curtin, 2020). Organizations that can fully engage

nurses should expect to see improved patient satisfaction, enhanced patient outcomes, a culture of professionalism, and a sense of practice ownership for nurses (Oss et al., 2021). While there is no hard and fast rule that organizations must implement a particular structure model, the organizational culture ultimately drives the development of models (Porter-O'Grady, 2009).

PICOT Question

For nurses on the Labor, Delivery and Antepartum Unit at a 382-bed community hospital in Austell, GA (P), does the utility of a contemporary shared governance structure in everyday practice (I) compared to the current shared governance structure (C) decrease nurse turnover rates (O) within four weeks (T)?

Population

Registered nurses (Table 1) collaborated with the interprofessional team of providers, unit pharmacists, therapists, nurse technicians, care partners, and unit secretaries for this contemporary shared governance structure to work.

Intervention

The contemporary shared governance structure facilitated real-time decision-making at the point of care and required interprofessional team collaboration to effect change. This structure was crucial to empowering nurses to improve the clinical environment, thereby reducing turnover.

Comparison

The current shared governance structure relied heavily on RN participation without interprofessional collaboration. Ideas for improvement were only discussed at the monthly unit-based council (UBC) meetings causing delays in decision-making at the point of care.

Outcome

Gess et al. (2008) posited that the most vital nurse turnover interventions must improve nurse autonomy and engagement, hence the motivation to adopt a contemporary model.

Timing

The contemporary shared governance structure was used to facilitate reducing nurse turnover in four weeks when compared to the same time the preceding year before the model change.

Evidence-Based Practice Framework and Change Theory

Evidence-Based Practice Framework

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Model, with its three interrelated components of inquiry, practice, and learning, made it possible to integrate available evidence with clinical expertise to address the nurses' needs (Dang et al., 2018). The inquiry component raised questions about whether shared governance was the best approach to addressing nurse turnover. The practice component translated available evidence about shared governance into practice to foster collaborative decision-making and empower the nurses to create change in their practice environment. The learning component allowed adopting the change in practice by applying the new knowledge about shared governance to increase accountability, engagement, and change behavior. Application of the model using the 19 step JHNEBP practice question, evidence, and translation (PET) process, identified the practice problem designed in an answerable question about reducing nurse turnover. The evidence search and synthesis provided recommendations supporting the implementation of shared governance protocols to address nurse turnover. The translating phase permitted the application of evidence into practice (Dang et al., 2018).

Change Theory

Implementation of this practice change used Kotter's eight-step change theory [Appendix A] (Aziz, 2017) to manage resistance to change and maintain successful and sustainable change (Aziz, 2017). Kotter's change theory facilitated adaptability and navigation through transition as the project implementation went through the 19 step PET process of the JHNEBP model. The theory also ensured sufficient and efficient change management during implementation to mitigate the risk of project failure.

Evidence Search Strategy

The evidence search strategy Appendix B was conducted from the Cumulative Index of Nursing and Allied Health Literature (CINAHL), OVID Emcare, ProQuest, PubMed, Ebscohost, OVID Medline, and Wiley Online Library databases. Answering the PICOT question guided the search with keywords shared governance, nurse turnover, nurse retention, and leadership. The initial search yielded 1838 articles. The application of limiters included advanced searches of articles published from 2012 to 2021, with abstracts available, in English, which reduced the articles yielded to 369, of which 56 that met eligibility for review were selected. Eleven articles (Appendix C) were chosen as evidence pertinent to the DNP project question in the final analysis.

The inclusion criteria considered quantitative and qualitative research papers addressing shared governance as an intervention managing retention and turnover for nurses in acute care settings. Articles excluded addressed nursing assistant perception, work-life balance models, job satisfaction outcomes not pertinent to nurse turnover, mentoring programs, the creation of the human-caring environments, studies with employee engagement not related to nursing turnover and retention, ambulatory and other non-acute care settings, nurse executive or nurse leader

engagement, nurse engagement outcomes not related to turnover and retention, articles addressing nursing educational levels, and cultural competence outcomes.

Evidence Search Results

Design Level

The Prisma Diagram Appendix D illustrates the overall summary of results. The design level of primary research evidence Appendix E was determined using the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) level of evidence tool. It included quasi-experimental pre and post-intervention comparison studies, a mixed-methods explanatory sequential design comprising a survey and semi-structured interviews, a hierarchical regression analysis, a cross-sectional multisite survey, a cross-sectional design with a quantitative approach quasi-experiment study, integrative reviews, and quasi-experiment descriptive correlation design study. The design level included three level II, four level III studies, and four level V integrative reviews.

Quality Grade

All the evidence was good grade quality because it was subject-oriented (Ebell et al., 2017). The evidence had findings consistent with the answer to the PICOT question with adequate follow-up (Ebell et al., 2017). For Farley et al. (2019), shared governance implementation improved nurse turnover. Quek et al. (2021) indicated that higher levels of distributed leadership predicted increased employee engagement and job satisfaction and lower turnover intentions. Moreover, creating a shared governance environment that supported nurses' involvement in decision-making resulted in creating a new shift model that led to greater staff retention and patient satisfaction, thereby decreasing turnover (Manyang et al., 2020). Additionally, engaging and committing staff to promote excellent patient outcomes in daily

interdisciplinary practice worked through clear frameworks, methods, and resources supported by shared governance improved retention (Van Bogaert et al., 2018). Stone et al. (2019) indicated that shared governance, as espoused by Magnet®, promoted nurse retention (Stone et al., 2019).

There were positive associations between the involvement of health workers in the hospital decision-making processes and their intention to stay (Ndikumana et al., 2019). Enabling nurse participation in decision-making and developing nursing through shared leadership enhanced the recruitment and retention of a skilled workforce (Pursio et al., 2021). Furthermore, creating positive practice environments enhanced nurse retention and facilitated quality patient care (Twigg et al., 2014). Lower rates of nursing shortages, burnout, job dissatisfaction, and turnover were observed at Magnet® hospitals compared with non-Magnet® hospitals (Marquez-Hernandez et al., 2020). Slatyer et al. (2016) posited that a healthy work environment as depicted by facilities that espoused shared governance promoted the retention of nurses.

Themes with Practice Recommendations

Nurse Turnover

Farley et al. (2019) showed that nursing turnover throughout the implementation of shared governance huddles decreased from 13.7 full-time equivalents (FTE) in 2015 to 6.20 FTE in 2016. For Quek et al. (2021), a full model predicting turnover intention was statistically significant, $p = 0.001$. The addition of distributed leadership Agency (DLA), a 7-item scale assessing involvement in leadership tasks, led to a statistically significant increase in R² of 0.081 $p = 0.001$ (Quek et al., 2021). Manyang et al. (2020) indicated that the shift modification through shared governance protocols led to an 82% decrease in nurse turnover rates after the first six months.

Health workers who perceived a high level of involvement in the hospital decision-making processes through the determination of teams for quality improvement in the health care service delivery were more likely to stay in the hospital $p=0.001$; than those who perceived this function as low (Ndikumana et al., 2019). Lower rates of nursing shortages, burnout, job dissatisfaction, and turnover were observed at Magnet® hospitals as they embraced shared governance protocols compared with non-Magnet® hospitals (Marquez-Hernandez et al., 2020).

Nurse Engagement and Autonomy

A unit's employee engagement results improved from 39% (2015) to 71% (2016) and 78% (2017) after huddles implementation through shared governance (Farley et al., 2019). Pursio et al. (2021)'s integrative review demonstrated that understanding the multidimensional nature of professional autonomy was essential to creating attractive work environments. Enabling nurse participation in decision-making and developing nursing through shared leadership enhanced the recruitment and retention of a skilled workforce (Pursio et al., 2021). There was a positive relationship between shared governance and work engagement, indicating that as perceptions of shared governance increased, work engagement increased in a survey of 44 nurses $p < .001$ (Siller et al., 2016).

Intention to Leave and Retention

In emergency nurses, a lack of work engagement was a strong predictor of intention to leave, burnout, and job dissatisfaction (Siller et al., 2016). From a hierarchical regression analysis of a shared governance work environment, the intention to leave the hospital and the profession ranged from 5.7 to 11.6% and 2.5 to 9.9%, respectively (Van Bogaert et al., 2018). Generational characteristics and the professional category were associated with turnover intentions (Van Bogaert et al., 2018). In Stone et al.'s (2019) survey of 2004 nurses working in a

shared governance work environment, eighty-eight percent of the nursing staff had no intention of leaving their current employer within the year (Cronbach α 's 0.89 for composite score).

Furthermore, creating positive practice environments enhanced nurse retention and facilitated quality patient care (Twigg et al., 2014).

The summary of the strength of the body of evidence Figure 1 indicates that shared governance reduced nurse turnover as nurses were involved in decision making [Level II, III, and IV] (Farley et al., 2019; Quek et al., 2021; Manyang et al., 2020; Ndikumana et al., 2019; Marquez-Hernandez et al., 2020). Moreover, nurse engagement and autonomy were essential for enhancing positive work environments, leading to reduced turnover [Level II, III, IV] (Farley et al., 2019; Pursio et al., 2021; and Siller et al., 2016). The intention to leave was decreased, and retention increased correlating with decreased nurse turnover when shared governance was employed because it improved nurse job satisfaction [Level III, and Level V] (Slatyer et al., 2016; Van Bogaert et al., 2018; Stone et al., 2019; Twigg et al., 2014). Based on the evidence, the PICOT question was answered because shared governance emerged as an appropriate recommendation for practice to intervene in decreasing nurse turnover.

Recommendation for Practice

In utilizing the FLIGHT model-based contemporary shared governance structure, the intent was to give every nurse at the bedside in collaboration with other interprofessional team members the opportunity to be involved in their practice environment improvements and champion change (Browder et al., 2019). The contemporary structure for shared governance did away with the monthly meetings. Instead, it used a rolling, idea-generating process integrated into everyday practice whereby any interprofessional team member could identify an issue and promptly start working on a solution. Its premise was that the entire interprofessional team had a

role and responsibility to bring about change at the point of care. However, the council chair and coach roles were designated to RNs alone because nurses are uniquely skilled in managing the patients' primary care at the bedside and within the interprofessional team (Browder et al., 2019).

The proposal for change was brought to the RN unit council chair or RN coach using the situation, background, assessment, recommendation (SBAR) format (Appendix F) by the project lead, who was any interprofessional team member. If the idea for change aligned with organizational goals and initiatives, the change project lead was allowed to select members of the UBC to execute that change to completion (Browder et al., 2019). Progress was to be recorded and monitored on the Unit Council Tracking Log (Appendix G). Both tools were from Browder et al. (2019), whose face validity was ascertained as being used for project initiation and tracking documentation purposes only. The new process put an end to waiting for formal meetings to begin working on given issues or to report the progress on fixing them.

Setting, Stakeholders, and Systems Change

Setting

The DNP scholarly project was implemented on the labor-delivery and antepartum unit of a 382-bed community hospital in Austell, GA. The fifty-year-old hospital employs 2,200 staff members who care for more than 104,000 patients annually. It has a level III trauma and burn center with a designated level II emergency cardiac care center and a joint commission primary stroke center.

Organization Mission and Vision

The organization sought the American Nurses Credentialing Center (ANCC) Pathway to Excellence® designation, earned when organizations demonstrate a commitment to creating a

positive practice environment for nurses (American Nurses Credentialing Center, 2020). Its nursing mission is to provide a structure that improves quality and professional practice through shared decision-making across the entire organization. The nursing vision is to empower innovation through collaboration. Implementing the contemporary FLIGHT model-based shared governance structure enabled staff engagement, supportive leadership, and effective communication. It also created change that aligned with organizational goals of creating a positive practice environment conducive to meeting the requirements of a Pathway to Excellence® designation.

The Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

A SWOT analysis Appendix H assessed the organization's standing before implementing the change by determining what was lacking to reduce the chances of failure (MindTools, n.d.). It is a valuable framework in helping to minimize risk providing the best possible opportunity for success in project implementation (MindTools, n.d.).

Organizational Support

Support for implementing the contemporary shared governance structure was confirmed with nursing leadership. The new structure aligned with the organization's nursing professional model principles of shared leadership, exemplary practice, teamwork, creative innovations, and professional development.

Stakeholders

Participants

All RNs ($n=57$) on the Labor- Delivery and Antepartum Unit (Table 2) full-time, part-time, and per diem, on all shifts and all days of the week in collaboration with all the interprofessional team members facilitated implementation.

Systems Change

Aligned with organizational goals and objectives, at a micro-level of system change, new protocols and policies of the contemporary shared governance reinforced the concepts of professional governance partnerships, equity, ownership, and accountability. At a meso level, shared decision-making empowered nurses to become transformational leaders participating in the communities they serve. The contemporary structure of shared governance produced nurses willing to challenge the process to create new solutions for existing problems; bring others to share in the vision of new and better possibilities, inspire others to act, and take an active role in the change as transformational leaders (Browder et al., 2019). At a macro level, nurses were empowered to make decisions in their areas of practice, use power effectively to move causes that yield positive interactions with the patient and better outcomes forward. As well as produce nurse leaders capable of creating viable succession plans that encourage the nursing profession's growth and sustainability.

Implementation Plan with Timeline and Budget

Implementation Plan

Project Objectives

As the project was expected to go beyond the pilot to full spread, its main aim was to reduce nurse turnover through enhancing interprofessional collaboration, direct care nurse decision-making, and engagement within the clinical environment by the:

1. Increase in direct care nurse decision-making and participation in the shared governance structure as evidenced by 50% of RNs volunteering to become members of the clinical practice improvement implementation team, unit council chairs, or coaches within three months of implementing the FLIGHT model-based shared governance protocol.

2. Decrease in overall unit nurse turnover by 50% within three months of implementing the FLIGHT Model-based shared governance protocol.
3. Increase in interprofessional team collaboration within three months of implementing the FLIGHT model-based shared governance protocol, as evidenced by members of the interprofessional team suggesting at least three ideas for clinical environment improvement projects.

Met Objectives

While the project is ongoing, four weeks post-implementation was the time frame allotted for data collection for outcome analysis for the DNP project. Despite the time constraints, three ideas for change were executed to completion; two of the projects had nurses as leads, and one was led by an interprofessional team member. Furthermore, nurse turnover was reduced by 5.11%. Stated objectives remain on target to be met in three months post project implementation.

Communication about the Contemporary Shared Governance Structure

Communication to the nurse participants and the interprofessional team was attained through providing visual management system boards at the nurse's station (Appendix I); in huddle notes (Appendix J), in in-person meetings, and PowerPoint® presentations (Appendix K). The Nursing Shared Governances Bylaws (Appendix L) addressed all the team's roles and responsibilities.

Project Manager (PM) Role

Oversight of the implementation of the contemporary shared governance model was managed by the DNP student, who was the PM. The PM was the subject matter expert. To be successful, the PM had to possess people skills, leadership skills, effective verbal communication, listening skills, integrity, ethical behavior, solid team building, conflict

management, critical thinking, problem-solving, and the ability to balance priorities (Krahn & Hartment, 2006).

EBP and Change Models used to Guide the Recommended Practice Change

Dang and Dearholt (2018)'s JHEBP PET model guided implementing the shared governance contemporary structure, adopted from Browder et al. (2019)'s FLIGHT model. It directed the identification and recruitment of the nurses, interprofessional team, and stakeholders, the development of the EBP question, securing evidence, and summarizing evidence to develop recommendations for change based on the evidence synthesis that was translated into practice (Dang & Dearholt, 2018). Kotter's theory 8-step process guided change management to facilitate successful implementation [Appendix M] (Browder et al., 2019).

For step one, applying for the Pathway to Excellence® designation amid high nurse turnover rates established a sense of urgency to create a positive work environment for nurses. The nurses and interprofessional team members who championed change were step two's guiding coalition. Step three compared the current and new shared governance models, which illustrated what nurse autonomy, would look like facilitating the creation of a vision and strategy. For step four, huddles, in-person meetings, PowerPoint® presentations, and visual management systems were utilized to communicate the change vision.

Step five was illustrated by supportive nurse leadership empowering nurses to practice autonomously to change the clinical environment. For step six, short-term wins were acknowledged by recognizing the project leads and their ideas for change in leadership meetings. Step seven consolidated gains to further change by presenting completed projects at leadership forums. Step eight incorporated the new changes in everyday practice to improve the clinical practice environment to reduce turnover (Arnoux-Nicolas et al., 2016).

Timeline for the Contemporary Shared Governance Structure

The timeline (Appendix N); rollout (Appendix O), and steps for the adoption of the new model followed an adaptation of the 19 steps JHNEBP (PET) model with the main categories including 1) the process steps from when the practice problem was identified; 2) the evidence search about the problem, 3) creation of an action plan, 4) implementation of the protocol, 5) data collection, 6) evaluation of outcomes, 7) determining the next steps, and 8) dissemination plan (Johns Hopkins University School of Nursing, 2017).

Budget

The organization allows two hours per RN per month towards shared governance activities. So, the budget was based on the cost of the average hourly pay for RNs in the organization (Table 2). There were no formal council meetings with the new model, which translated into cost savings for the organization. Still, each council chair and coach will continue to require one-time onboarding training for six hours.

Results

The project included all the nurses ($n=57$) on the labor and delivery and antepartum units and interprofessional team members. Only those on family leave of absence (FMLA) were excluded. Appendix P shows the variables.

Determining the Impact of Intervention

The project data collection period was four weeks. Appendix Q, an evidence-based tool developed from validated turnover indicators (Gess et al., 2008), provided data on the intrinsic effect of nurse turnover on the unit. A two-tailed independent samples *t*-test was conducted to examine whether the turnover mean was significantly different between the six month rolling pre-and post-intervention turnover categories one and two, respectively. Shapiro-Wilk tests were

conducted to determine whether a normal distribution could have produced turnover categories one and two (Razali & Wah, 2011). The result of the Shapiro-Wilk test for category one was not significant based on an alpha value of .05, $W = 0.84$, $p = .224$ neither was that of category two based on an alpha value of .05, $W = 0.94$, $p = .530$. This suggested that a normal distribution could not be ruled out in either category indicating that the normality assumption was met (Razali & Wah, 2011). The two-tailed independent samples t -test was significant based on an alpha value of .05, $t(4) = -5.58$, $p = .005$, indicating the null hypothesis can be rejected. Table 2 suggests that the mean turnover was significantly different between the pre-and post-intervention categories. Figure 2 presents the bar plot of the means. However, while there was not a statistically significant improvement in turnover after the project implementation when compared to the same time the year before, still there was a 5.11% drop in turnover from January 2022, when the project was implemented, to 63.08% in February 2022 at the end of the four weeks data collection period.

Process and Balance Measures

Three ideas for change were executed by the end of the DNP project data collection period, indicating the project's effectiveness [Appendix S] (East Lancashire Hospitals, n.d.). Furthermore, any unintended problems from the project will be detected and rectified long after the pilot spreads hospital-wide (East Lancashire Hospitals, n.d.).

Clinical Significance

Team collaboration, nurse camaraderie, nurse autonomy, and engagement emerged with the changes in the practice environment. Also, an increased likelihood of improving the patient experience and safety came out of this project (Appendix R). When nurses suggested improvements for change, the team worked in unison to make changes proposed by colleagues to

execute them to completion. This produced a positive and healthy work environment for the nurses, directly correlated with a decrease in intent to leave (Kutney-Lee et al., 2016).

Data Integrity

Health Insurance Portability and Accountability Act (HIPAA) considerations were not applicable. The turnover data were generated from the human resources (HR)'s repository with read-only access for the PM. The data were stored at the system and not the hospital level to maintain its integrity. Moreover, due to the nature of its storage, the data could not be inappropriately manipulated to affect its interpretation.

Internal Review Board (IRB)

Approval for implementation went through the Hospital's IRB and the University of Saint Augustine for Health Sciences (USAHS) Ethical and Protocol Review Committee (EPRC). Participation was voluntary with implied consent upon participation and could withdraw at any time. Additionally, nurse participants were identified by numbers for documentation purposes without other identifiers leading back to them. No patients were included in the project.

Impact

Addressing the Practice Problem and Altering Practices

At implementation in January 2022, the nurse turnover rate for the unit was at its highest at 68.29%, with staffing levels 34% lower compared to the same time the previous year. The project allowed nurses to become more engaged as they autonomously championed change at the point of care. Nurses can create a work environment conducive to improving turnover and patient outcomes when allowed to work autonomously (Wei et al., 2018). The project implementation also increased department nursing leadership support.

Project Insights and Future Implications

Attaining nurse participant buy-in, especially when core staffing numbers are low, can be challenging because of the perceived demands on time commitment and workload (McKnight & Moore, 2021). Lack of motivation for nurses to participate can be a genuine concern that can hinder the project's progress and success. Nurses need to know why their participation is vital for the project's success. Involving off-shift nurses who work at night and on weekends is essential and requires a dedicated plan to make them feel included (McKnight & Moore, 2021). Other recommendations include encouraging leadership buy-in to support nurses in gaining autonomy. This shared governance model encouraged interdisciplinary team collaboration, permitted consideration of the diversity of thought, and improved engagement and productivity.

Sustainability Maintenance

Creating policies that infuse contemporary shared governance into everyday practice will ensure adoption. Formally providing education about the protocol will help build a foundation of knowledge (McKnight & Moore, 2021). Creating activities that ensure continued discussion about the model will weave it into clinical practice.

Project Expansion

In anticipation of the pilot expansion hospital and system-wide, specific process changes born out of the project are now being highlighted in leadership safety huddles and daily meetings. Furthermore, the visual management boards on the units will incorporate the new contemporary shared governance model.

Ongoing Evaluation for Change Effectiveness

An increase in the number of change ideas will indicate improved staff engagement in creating a positive clinical practice environment. With that, the expectation is that nurse turnover

will continue to improve. Unit Nurse Managers will be responsible for measuring ongoing project success.

Limitations

Data collection was limited to four weeks, so it was not as robust as a more extended period would have allowed. Decisions about data collection duration can impact outcome measurements (Feely et al., 2020). Furthermore, at implementation more than one-third of the nursing staff was from agencies, which caused a lack of motivation and commitment to make suggestions for change. These barriers influence staff attitudes and may impact their engagement during the implementation process (Geerling et al., 2018). Another limitation was the extent to which the direct care nurse was knowledgeable about how their role was pivotal to the project's success. This was evident in the reluctance to propose ideas for change. Lastly, the team did not find using the Unit Council Tracking Log convenient, making it necessary to create flexible boundaries to get the work done (Leybourne, 2011). Project progress was communicated via electronic mail, huddles, and the team's confidential social media account. Hence, creating an electronic version of the log for future projects may be necessary.

Dissemination Plan

Applying the critical elements of a dissemination plan as a guide, which include knowing the why, what, to whom, how and, when; the purpose of the contemporary shared governance protocol was addressed, and the timing and methods of sharing the new protocol were articulated during the project (Agency for Healthcare Research and Quality, 2014). While the project was underway, progress was reported to the leadership team during safety huddles. The nurse that created the process to assist patients in alerting staff when they feel unsafe at home was recognized in the safety huddles and the leadership meeting. After the project was completed, the

outcome was reported to the Hospital's Clinical Practice Council and the staff. The Hospital's Clinical Practice Council helped raise awareness about the new shared governance model to the staff and invoked excitement about implementation on other units. The new protocol was then incorporated into everyday practice for the direct care nurses.

The manuscript will be submitted to the Scholarship and Open Access Repository (SOAR@USA) and presented at a Sigma Theta Tau conference. The abstract will be submitted for a concurrent oral session at the 2022 Sigma Mu Phi at-Large Research Day Conference. A poster presentation about the project will be made at the Alpha Alpha Alpha (AAA) chapter SIGMA inaugural DNP Scholarly Project Symposium at USAHS. The manuscript will also be submitted to the Journal of Nursing Management online per its author guidelines and undergo the peer review process before publication.

Conclusion

The contemporary FLIGHT Model-based shared governance was adopted to address the harmful effects of nurse turnover, including poor patient outcomes, decreased organizational performance, nurse job dissatisfaction, and disengagement at a community hospital. Recognition of the need to enhance nurse participation in decision-making in the clinical environment, nurse autonomy, and engagement underscored the organization's need to foster a positive practice environment for the nurses that embodied the pillars of ANCC's Pathway to Excellence® (American Nurses Credentialing Center, 2020). These pillars include shared decision-making, the well-being of the nurses, professional development, enhanced safety and quality in practice, and leadership.

The contemporary shared governance protocol was used to facilitate shared decision-making strengthen the interprofessional teams' collaboration and nursing engagement because it

incorporated shared governance in everyday practice. The contemporary model allowed the entire interprofessional team members to take ownership of the environment in which they work by enabling them to make improvements as close to the patient's point of care as necessary. All team members were responsible for suggesting and executing improvements in the practice environment. This positive impact on the direct care nurse's autonomy in practice directly correlated with a drop in nurse turnover rates within four weeks of adopting the contemporary shared governance structure.

References

- Agency for Healthcare Research and Quality. (2014, June). *Quick-start guide to dissemination for practice-based research networks*. https://pbrn.ahrq.gov/sites/default/files/AHRQ%20PBRN%20Dissemination%20QuickStart%20Guide_0.pdf
- American Nurses Credentialing Center. (2020). *Overview*. American Nurses Association. <https://www.nursingworld.org/organizational-programs/pathway/overview/>
- Antwi, Y. A., & Bowlblis, J. R. (2018). The impact of nurse turnover on quality of care and mortality in nursing homes: Evidence from the great recession. *American Journal of Health Economics*, 4(2), 131–163. https://doi.org/10.1162/ajhe_a_00096
- Arnoux-Nicolas, C., Sovet, L., Lhotellier, L., Di Fabio, A., & Bernaud, J. L. (2016, May 12). *Perceived work conditions and turnover intentions: The mediating role of meaning of work*. *Frontiers*. <https://www.frontiersin.org/articles/10.3389/fpsyg.2016.00704/full>
- Aziz A. M. (2017). A change management approach to improving safety and preventing needle stick injuries. *Journal of Infection Prevention*, 18(5), 257–262. <https://doi.org/10.1177/1757177416687829>
- Browder, B., Fuentes, G., Holm, R., B., Macy, D., & Middlemiss, J. (2019). *Rethinking your unit council structure*. Sigma Theta Tau International.
- Church, C. D., He, Z., & Yarbrough, S. (2018). Factors influencing organizational commitment and turnover in nurse residents. *The Journal of Continuing Education in Nursing*, 49(10), 482–488. <https://doi.org/10.3928/00220124-20180918-09>
- Dang, D., & Dearholt, S., & Johns Hopkins University. (2018). *Johns Hopkins nursing evidence-based practice: Model and guidelines* (3rd ed.). Sigma Theta Tau International.

- Dang, D., & Dearholt, S. (2017). Appendix H: Evidence synthesis and recommendation tool. In *Johns Hopkins nursing evidence-based practice: Model and guidelines (3rd ed.)*. Sigma Theta Tau International.
- Ebell, M. H., Siwek, J., Weiss, B. D., Woolf, S. H., Susman, J., Ewigman, B., & Bowman, M. (2004). Strength of recommendation taxonomy (SORT): A patient-centered approach to grading evidence in the medical literature. *American Family Physician, 69*(3), 548–556.
- East Lancashire Hospitals. (n.d.). *Process, outcome and balancing measures*.
https://www.ehub.elht.nhs.uk/uploads/2/0/9/6/20960734/step_3_-_types_of_measures.pdf
- Farley, H., Hartig, A. & Rutledge, C. (2019). Shared governance approach to implementing change of shift huddle. *Journal of Nursing Care Quality, 34*(3), 194-196. doi: 10.1097/NCQ.0000000000000389.
- Feely, A., Wall-Wieler, E., Roos, L. L., & Lix, L. M. (2020). Effect of study duration and outcome measurement frequency on estimates of change for longitudinal cohort studies in routinely-collected administrative data. *International Journal Of Population Data Science, 5*(1), 1150. <https://doi.org/10.23889/ijpds.v5i1.1150>
- Geerligs, L., Rankin, N., Shepherd, H., & Butow, P. (2018). Hospital-based interventions: a systematic review of staff-reported barriers and facilitators to implementation processes. *Implementation Science, 13*(1), 1–17. <https://doi.org/10.1186/s13012-018-0726-9>
- Gess, E., Manojlovich, M., & Warner, S. (2008). An evidence-based protocol for nurse retention. *The Journal of Nursing Administration, 38*(10), 441–447.
<https://doi.org/10.1097/01.NNA.0000338152.17977.ca>

Gordon, D. W., & Smith, A. M. (2022). Leveraging shared governance to build a healthier work environment in a NICU. *Neonatal Network*, 41(1), 59–61.

Graban, M. (2020, December 31). *Picking on the PICK chart*. Lean

Blog. <https://www.leanblog.org/2014/07/picking-on-the-pick-chart/>

Haddad L., M, Annamaraju P., & Toney-Butler T. J. (2020 Dec 14) *Nursing shortage-StatPearls [Internet]*. <https://www.ncbi.nlm.nih.gov/books/NBK493175/>

Intellectus Statistics [Online computer software]. (2021). *Intellectus Statistics*.

<https://analyze.intellectusstatistics.com/>

Johns Hopkins University School of Nursing. (2017). *Johns Hopkins nursing evidence-based practice: PET management guide*. https://hsl.upstate.edu/uploads/20200214-jhneb/2017_Appendix-A_PET-Management-Guide.pdf

Kelly, L. A., Gee, P. M., & Butler, R. J. (2021). Impact of nurse burnout on organizational and position turnover. *Nursing Outlook*, 69(1), 96–102.

<https://doi.org/10.1016/j.outlook.2020.06.008>

Krahn, J., & Hartment, F. (2006). *Effective project leadership: A combination of project manager skills and competencies in context*. Project Management Institute, Inc.

<https://www.pmi.org/learning/library/leadership-project-manager-skills-competencies-8115>

Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Del Guidice, M., & Aiken, L. H. (2016). Nurse engagement in shared governance and patient and nurse outcomes. *The Journal Of Nursing Administration*, 46(11), 605–612.

<https://doi.org/10.1097/NNA.0000000000000412>

- Leybourne, S. A. (2011, October 22). *Improvisation and project management: What, when, and how*. Project Management Institute, Inc. <https://www.pmi.org/learning/library/improvisation-project-management-6305>
- Li, Y., & Jones, C. B. (2013). A literature review of nursing turnover costs. *Journal of Nursing Management, 21*(3), 405–418. <https://doi.org/10.1111/j.1365-2834.2012.01411.x>
- Lockhart, L. (2020). Strategies to reduce nursing turnover. *Nursing Made Incredibly Easy!*, *18*(2), 56. <https://doi.org/10.1097/01.NME.0000653196.16629.2e>
- Manyang, C., Stene, J., Pagel, E. M., & Niesen, C. (2020). A balancing act: managing workload while improving nurse and patient satisfaction. *Gastroenterology Nursing, 43*(4), 298–302. <https://doi.org/10.1097/SGA.0000000000000446>
- Marquez-Hernandez, V. V., Belmonte-Garcia, T., Gutierrez-Puertas, L., & Granados-Gamez, G. (2020). Original research: How magnet hospital status affects nurses, patients, and organizations: A systematic review. *American Journal of Nursing, 120*(7), 28. <https://doi.org/10.1097/01.NAJ.0000681648.48249.16>
- McKnight, H., & Moore, S. M. (2020, August 16). *Nursing shared governance - StatPearls - NCBI bookshelf*. National Center for Biotechnology Information. <https://www.ncbi.nlm.nih.gov/books/NBK549862/>
- McKnight, H., & Moore, S. M. (2021, September 20). *Nursing shared governance - StatPearls - NCBI bookshelf*. National Center for Biotechnology Information. <https://www.ncbi.nlm.nih.gov/books/NBK549862/>
- MindTools. (n.d.). *SWOT analysis: – How to develop a strategy for success*. https://www.mindtools.com/pages/article/newTMC_05.htm

- Moher, D., Liberati, A., Tetzlaff, J. & Altman, D.G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, 151(4), 267 (<http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00135>).
- Myers, M., Parchen, D., Geraci, M., Brenholtz, R., Knisely-Carrigan, D., & Hastings, C. (2013). Using a shared governance structure to evaluate the implementation of a new model of care: the shared experience of a performance improvement committee. *The Journal of Nursing Administration*, 43(10), 509–516.
<https://doi.org/10.1097/NNA.0b013e3182a3e7ff>
- Ndikumana C., Tubey R. & Kwonyike J. (2019). Involvement in decision-making processes and retention of health workers: Findings from a cross-sectional study in the Rwandan public district hospitals. *Pan African Medical Journal*, 34.
<https://doi.org/10.11604/pamj.2019.34.129.16514>
- Oss, J. A., Schad, E. A., Drenth, A. R., Johnson, L. M., Olson, J. M., & Bursiek, A. A. (2021). Driving nurse satisfaction through shared governance. *Nurse Leader*, 19(1), 47–52.
<https://doi.org/10.1016/j.mnl.2020.03.019>
- Overbaugh, K. J. (2020). Advance care planning: An update for the medical-surgical nurse in the age of COVID-19. *MEDSURG Nursing*, 29(5), 299–307.
- Pine, R., & Tart, K. (2007). Return on investment: Benefits and challenges of a baccalaureate nurse residency program. *Nursing Economic\$,* 25(1), 13–39.
- Porter-O'Grady, T. (2009). *Interdisciplinary shared governance: Integrating practice, transforming health care*. Jones & Bartlett Learning. Healthcare (2nd ED.). Jones and Bartlett Publishing: Sudbury, MA

- Pursio K, Kankkunen P, Sanner-Stiehr E., & Kvist T. (2021). Professional autonomy in nursing: An integrative review. *Journal of Nursing Management*. doi:10.1111/jonm.13282
- Quek, SJ, 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*. 00: 1– 10.
<https://doi.org/10.1111/jonm.13321>
- Razali, N. M., & Wah, Y. B. (2011). Power comparisons of shapiro-wilk, kolmogorov-smirnov, lilliefors and anderson-darling tests. *Journal of Statistical Modeling and Analytics*, 2(1), 21-33.
- Shaffer, F. A., & Curtin, L. (2020). Nurse turnover: Understand it, reduce it. *American Nurse Today*, 15(8), 22.
- Siller, J., Dolansky, M. A., Clavelle, J. T., & Fitzpatrick, J. J. (2016). Shared governance and work engagement in emergency nurses. *Journal of Emergency Nursing*, 42(4), 325–330.
<https://doi.org/10.1016/j.jen.2016.01.002>
- Slatyer, S., Coventry, L. L., Twigg, D., & Davis, S. (2016). Professional practice models for nursing: a review of the literature and synthesis of key components. *Journal of Nursing Management*, 24(2), 139. <https://doi.org/10.1111/jonm.12309>
- Stone, L., Arneil, M., Coventry, L., Casey, V., Moss, S., Cavadino, A., Laing, B., & McCarthy, A. L. (2019). Benchmarking nurse outcomes in Australian Magnet® hospitals: Cross-sectional survey. *BMC Nursing*, 18(1), 1–11. <https://doi.org/10.1186/s12912-019-0383-6>
- Tang, J. H., & Hudson, P. (2019). Evidence-based practice guideline: Nurse retention for nurse managers. *Journal of Gerontological Nursing*, 45(11), 11–19.
<https://doi.org/10.3928/00989134-20191011-03>

- Twigg D., & McCullough K. (2014). Nurse retention: A review of strategies to create and enhance positive practice environments in clinical settings. *International Journal of Nursing Studies*, 51(1):85-92. doi:10.1016/j.ijnurstu.2013.05.015
- Van Bogaert, P., Van heusden, D., Sloomans, S., Roosen, I., Van Aken, P., Hans, G., & Franck, E. (2018). Staff empowerment and engagement in a magnet® recognized and joint commission international accredited academic center in Belgium: A cross-sectional survey. *BMC Health Services Research*, 18 <http://dx.doi.org/10.1186/s12913-018-3562-3>
- Van Camp, J., & Chappy, S. (2017). The effectiveness of nurse residency programs on retention: A systematic review (2), 128–144. <https://doi.org/10.1016/j.aorn.2017.06.003>
- Wei, H., Sewell, K. A., Woody, G., & Rose, M. A. (2018). The state of the science of nurse work environments in the United States: A systematic review. *International Journal Of Nursing Sciences*, 5(3), 287–300. <https://doi.org/10.1016/j.ijnss.2018.04.010>
- World Health Organization. (2002). *Innovative care for chronic conditions: Building blocks for action*. World Health Organization.
https://www.who.int/chp/knowledge/publications/iccc_ch2.pdf
- Yildiz, B., Yildiz, H., & Ayaz Arda, O. (2021). Relationship between work-family conflict and turnover intention in nurses: A meta-analytic review. *Journal of Advanced Nursing*, 77(8), 3317–3330. <https://doi.org/10.1111/jan.14846>

Table 1

**Demographic Characteristics of Pre-Implementation Participant Group on the Labor,
Delivery and Antepartum Unit**

| Characteristics | Pre- implementation <i>n</i> | Percentage |
|---|---|-------------------|
| Years of Experience as a Nurse | | |
| <1 | 7 | 12.28% |
| 1 to 5 | 20 | 35.08% |
| 6 to 10 | 5 | 8.77% |
| 11 to 15 | 9 | 15.80% |
| >15 | 16 | 28.07% |
| Basic Level of Nursing Education | | |
| Associates | 9 | 12.28% |
| BSN | 48 | 84.21% |
| Specialty Certifications | | |
| OB-RNC | 13 | 22.80% |
| Shift | | |
| Day | 35 | 61.40% |
| Night | 22 | 38.60% |

Appendix A

Kotter's Change Theory

Step 1 Created the urgency

- By discussing the need for change with nursing staff

Step 2 Formed a powerful coalition

- By eliciting staff buy-in to support the need for change to improve staff retention and the practice environment.

Step 3 Created a vision of how the change will make the future look and align with its vision and mission.

- By illuminating a future where staff is empowered to make decisions about their work environment.

Step 4 Communicated the vision

- In staff meetings, and visual management boards.

Step 5 Empowered the action

- By highlighting the detrimental effects of nurse turnover.

Step 6 Celebrated all small wins

- Through staff acknowledgments with every progress made in the process.

Step 7 Constantly built on the new change momentum

- By cultivating a culture of continuous improvement.

Step 8 Spread the new change to the rest of the organization

- After ensuring the staff supported the transition to make it sustainable.

Appendix B

Evidence Search Strategy

| DATA BASE | Key Terms/Subject Headings | Initial Search Restrictions/Limits | Yield | Cumulative Total to be Screened |
|----------------------------|---|---|-------|---------------------------------|
| PROQUEST | (NURSING SHARED GOVERNANCE) AND PEER(yes)) AND PEER(yes) AND (NURSE TURNOVER) AND PEER(yes) | Last 10 Years Peer Reviewed Scholarly Journals Narrowed To Nurses | 1346 | 153 |
| PUBMED | (shared governance OR shared leadership) AND (nurse turnover OR retention) | Advanced Search Abstract English 2012-current | 206 | 119 |
| CINAHL | (shared governance) AND (nurse turnover OR nurse retention) | Abstract Available 2012-01-01-Current English | 139 | 37 |
| EBSCOHOST | (shared governance OR shared leadership) AND (nurse turnover OR retention) | 2012-01-01-Current Abstract Available English | 75 | 34 |
| OID EMCARE | (shared governance or shared leadership) and (nurse turnover or retention)).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] | 2012-current Abstract Available English | 35 | 7 |
| OID MEDLINE | (shared governance or shared leadership) and (nurse turnover or retention)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] | 2012-current Abstract Available English | 30 | 12 |
| WILEY ONLINE LIBRARY | shared+governance+in+nursing | Advanced search Select Keyword 2012 to Current | 7 | 7 |

Appendix C

Summary of Primary Research Evidence

| Citation | Design, Level Quality Grade | Sample Sample size | Intervention Comparison (Definitions should include any specific research tools used along with reliability & validity) | Theoretical Foundation | Outcome Definition | Usefulness Results Key Findings |
|--|--|---|---|------------------------|--|---|
| Farley, H., Hartig, A. & Rutledge, C. (2019). Shared governance approach to implementing change of shift huddle. <i>Journal of Nursing Care Quality</i> , 34 (3), 194-196. doi: 10.1097/NCQ.0000000000000389. | Quasi experimental study Pre and post intervention comparison Level II Quality Grade: Good | Nurse (new graduates, agency and fulltime) at a 24-bed medical telemetry hospital unit located in the northeastern United States, | Change of shift huddle with a shared governance approach Comparison Pre and post intervention staffing | None identified | The nursing turnover over the course of this implementation decreased from 13.7 FTE in 2015 to 6.20 FTE in 2016. The unit's employee engagement result improved from 39% (2015) to 71% (2016) and 78% (2017). Safety climate scores also increased (from 68% in 2013 and 77% in 2015) to 86% in 2017 after huddles were implemented. | Shared governance implementation improved nurse turnover |
| Quek, SJ, 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. <i>Journal of Nursing Management</i> . 00: 1– 10. https://doi.org/10.1111/jonm.13321 | Mixed-methods explanatory sequential design Comprising a survey and semi-structured interviews Level III Quality Grade: Good | 116 direct care nursing staff | Participating in distributed leadership via the Shared Governance program n=96 participants n=20 non-participants | None Identified | The full model predicting turnover intention (Step 2) was statistically significant (R2 = 0.231, F(10,105) = 3.149, p = .001; adjusted R2 = 0.157), and the addition of DLA led to a statistically significant increase in R2 of 0.081 (F(1,105) = 11.077, p = .001). | Higher levels of distributed leadership predicted increased employee engagement and job satisfaction, and lower turnover intentions. Staff also felt more empowered and committed to the organization |

| | | | | | | |
|--|---|---|--|-----------------|--|---|
| | | | | | | despite some challenges experienced in implementing the Shared Governance program. |
| Manyang, C., Stene, J., Pagel, E. M., & Niesen, C. (2020). A balancing act: managing workload while improving nurse and patient satisfaction. <i>Gastroenterology Nursing</i> , 43(4), 298–302. https://doi.org/10.1097/SGA.0000000000000446 | Quasi experimental study Pre and post intervention comparison Descriptive study created shared governance environment supported nurses' involvement In gastrointestinal endoscopy unit Level II Quality Grade: Good | Pre-implementation survey from nurses (n = 183) | Post-implementation survey from nurses (n = 140). | None identifies | The shift modification led to an 82% decrease in nurse turnover rates after the first 6 months | The created shared governance environment supported nurses' involvement in decision-making and creating a new shift model that led to greater staff and patient satisfaction and decrease in turnover rates |
| Van Bogaert, P., Van heusden, D., Sloomans, S., Roosen, I., Van Aken, P., Hans, G., & Franck, E. (2018). Staff empowerment and engagement in a magnet® recognized and joint commission international accredited academic center in Belgium: A cross-sectional survey. <i>BMC Health Services Research</i> , 18 http://dx.doi.org/10.1186/s12913-018-3562-3 | Hierarchical regression analysis to determine the principles of the ANCC Magnet Recognition Program® estimated strength of associations with demographic characteristics (block-1), Professional category (block-2), work characteristics (block-3) and work engagement or burnout dimensions (block-4) as explanatory variables of job satisfaction and turnover intention and quality of care as outcome variables. Level III Quality Grade: Good | Nurses (N = 864 or 65% response rate) | Registered nurses N = 668 (84.3%), midwives N = 49 (5.7%), licensed practice nurses N = 83 (9.6%) and nurse managers N = 64 (7.4%) | None Identified | Intention to leave the hospital and the profession ranged from 5.7 to 11.6% and 2.5 to 9.9%, respectively. Generational characteristics and Professional category was associated with turnover intentions. | Engaging and committing staff to promote excellent patient outcomes in daily interdisciplinary practice works through clear frameworks, methods and resources supported by governance and policy structure that makes outcomes visible and accountable. |
| Stone, L., Arnell, M., Coventry, L., Casey, V., Moss, S., Cavadino, A., Laing, B., & McCarthy, A. L. (2019). Benchmarking nurse outcomes in Australian Magnet® hospitals: Cross-sectional survey. <i>BMC Nursing</i> , 18(1), 1–11. https://doi.org/10.1186/s12912-019-0383-6 | Cross-sectional multisite survey set in all three Australian Magnet®-designated | Nurses (n=2004) participated in the survey (response rate 45.9%). | Nurses who did not participate in the survey (n=2362) | None Identified | Eighty eight percent had no intention of leaving their current employer within the | Shared governance as espoused by Magnet promotes |

| | | | | | | |
|---|---|--|--|------------------------|--|---|
| | <p>organizations. Two items measured job satisfaction and intent to stay in current employment.</p> <p>Level III</p> <p>Quality Grade: Good</p> | | | | <p>next 12 months (Cronbach α's 0.87–0.9 for subscales and 0.89 for composite score).</p> | <p>nurse retention</p> |
| <p>Ndikumana C., Tubey R. & Kwonyike J. (2019). Involvement in decision-making processes and retention of health workers: Findings from a cross-sectional study in the Rwandan public district hospitals. <i>Pan African Medical Journal</i>, 34. https://doi.org/10.11604/pamj.2019.34.129.16514</p> | <p>Cross-sectional design with quantitative approach Quasi experiment</p> <p>Level II</p> <p>Quality Grade: Good</p> | <p>With a population of 469 health workers from 3 hospitals, a sample of 252 respondents was considered. Data collection was done by use of survey questionnaire. Health workers in 3 hospitals (n=252) Participated in Survey questionnaire</p> | <p>Non-survey participants (n=217)</p> | <p>None identified</p> | <p>Findings revealed that health workers who perceived a high level of involvement in the hospital decision-making processes through the determination of teams for quality improvement in the health care service delivery were more likely to stay in the hospital (OR=100.111; P=0.001; CI=5.984-16.747) than those who perceived this function as low.</p> | <p>Although there are positive associations between involvement of health workers in the hospitals decision-making processes and the intentions to stay, the existing level of staff involvement may have a negative effect on retention capacity in the public district hospitals.</p> |
| <p>Siller, J., Dolansky, M. A., Clavelle, J. T., & Fitzpatrick, J. J. (2016). Shared governance and work engagement in emergency nurses. <i>Journal of Emergency Nursing</i>, 42(4), 325–330. https://doi.org/10.1016/j.jen.2016.01.002</p> | <p>Quasi-Experiment descriptive correlation design study</p> <p>Level III</p> <p>Quality Grade: Good</p> | <p>43 emergency nurses recruited through the ENA Web site. Participants completed a demographic questionnaire, the Index of Professional Nursing Governance Tool, and the Utrecht Work Engagement Scale.;</p> | <p>Non-survey participants (n=45)</p> | <p>None identified</p> | <p>The mean total work engagement score indicated average engagement (M = 4.4, standard deviation = 1.2). A significant positive relationship was found between shared governance and work engagement, indicating that as perceptions of shared governance increase, work engagement increases (r (41) = 0.62, P < .001) lack of work engagement specifically was a strong predictor of</p> | <p>Shared governance is a vehicle that can be used by emergency nursing leaders to increase work engagement among emergency nurses.</p> |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | intention to leave, burnout, and job dissatisfaction | |
|--|--|--|--|--|--|--|--|

Appendix C

Summary of Systematic Reviews (SR)

| Citation | Quality Grade | Question | Search Strategy | Inclusion/Exclusion Criteria | Data Extraction and Analysis | Key Findings | Usefulness/Recommendation/Implications |
|---|--------------------------------|--|--|---|---|---|--|
| Pursio K, Kankkunen P, Sanner-Stiehr E., & Kvist T. (2021). Professional autonomy in nursing: An integrative review. <i>Journal Of Nursing Managemen t.</i> doi:10.1111/j onm.13282 | Level V Quality Grade: Good | For nurses on a Labor-Delivery and Antepartum unit at a 382-bed community hospital (P), does the utility of a contemporary shared governance structure in everyday practice (I) compared to the current shared governance structure (C) decrease nurse turnover rates (O) within four weeks (T)? | The search from CINAHL, PubMed, Scopus and PsycINFO databases was undertaken to identify studies on the focal topic in July 2019 identified 27 relevant studies published between 2000 and 2019. Elements describing nurses' professional autonomy were independence in decision-making and ability to utilize one's own competence. Themes relating to nurses' professional autonomy were shared leadership, professional skills, inter- and intra-professional collaboration and healthy work environment. | Inclusion Criteria: Inclusion criteria were empirical studies with quantitative or qualitative designs, in English, and published in peer-reviewed journals with an available abstract between January 2000 and July 2019. Exclusion Criteria: Studies that on other types of health care professionals or nursing students, explored patients' autonomy, concerned practice in medical establishments other than hospitals, concerned nurses' practice and roles in prescribing medicines or explored nurses' empowerment without connection to autonomy. | Combinations of relevant terms, formed using the Boolean terms AND and OR, were applied in searches of all the databases: (nurse OR "nursing staff") AND ("professional autonomy" OR "clinical autonomy") AND ("decision mak**" OR "making decisions") AND (nursing OR "patient care" OR "professional role") (File S1). Integrative Review from four data bases. Quality was systematically evaluated using critical appraisal tools. PRISMA guidelines were followed. Inductive content analysis was used to analyze current knowledge of the focal subject. | Understanding the multidimensional nature of professional autonomy is essential to create attractive work environments. It is important to enable nurses to participate in decision-making and develop nursing through shared leadership to enhance the recruitment and retention of a skilled workforce. | The findings have anticipated utility for supporting nursing practice and nurse leaders' understanding of approaches to foster nurses' professional autonomy |
| Twig D., & McCullough K. (2014). Nurse retention: A review of strategies to | Level V Quality Grade: Good | For nurses on a Labor-Delivery and Antepartum unit at a 382-bed community hospital (P), does the utility of a contemporary shared governance structure in everyday practice (I) compared | A literature search was undertaken in February 2012 of the major healthcare-related databases: Cinahlplus, Medline and Proquest. Thirty-nine papers were | Inclusion Criteria: The keywords "nurs* AND practice AND environment" were used initially. Additional keywords "retention strategies" were also searched. Abstracts were reviewed and articles which included an aim to | The keywords "nurs* AND practice AND environment" were used in the first instance. Additional keywords "retention strategies" were also searched. Abstracts | Creating positive practice environments enhances nurse retention and facilitates quality patient care. | Managers and administrators should assess and manage their practice environments using a validated tool to guide and evaluate |

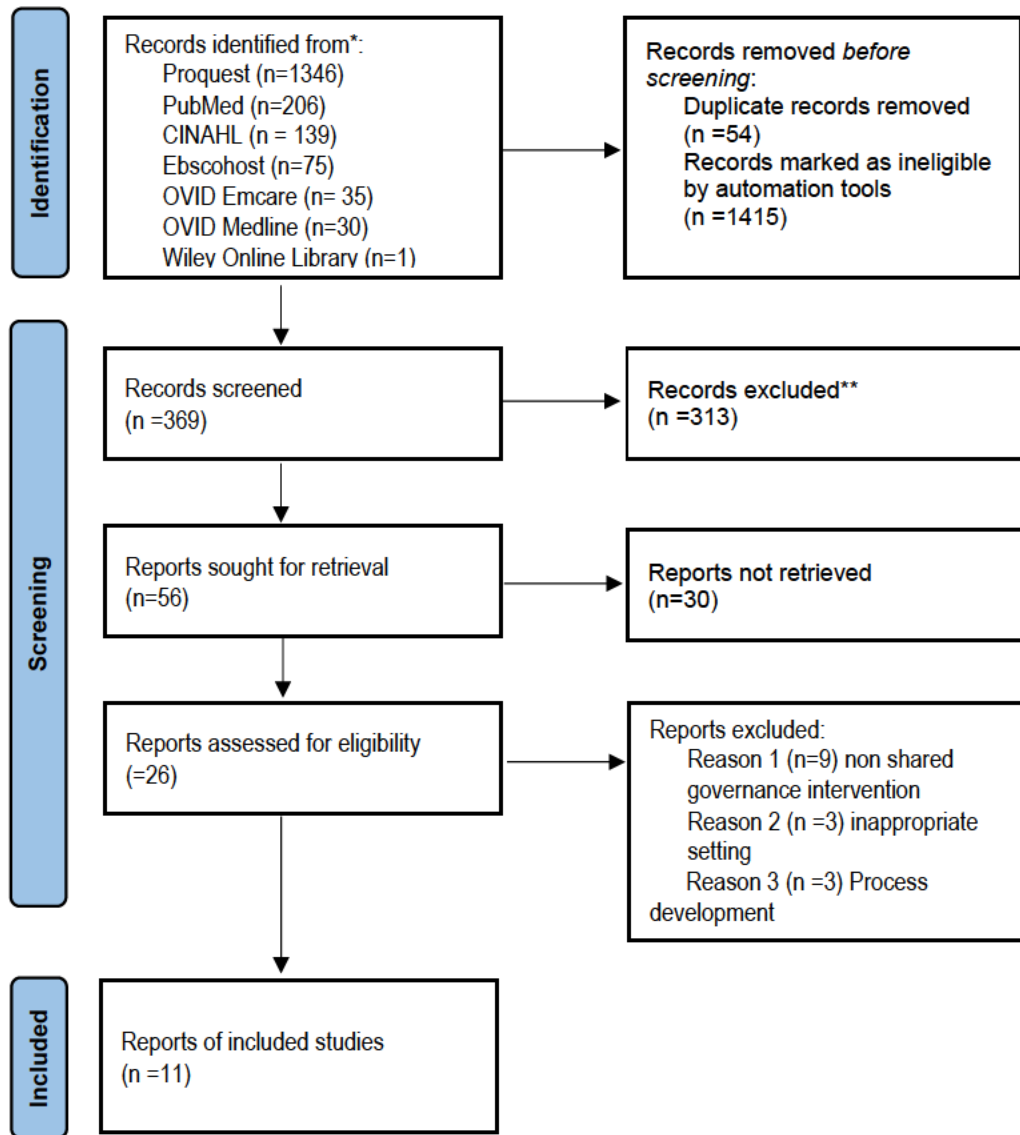
| Citation | Quality Grade | Question | Search Strategy | Inclusion/ Exclusion Criteria | Data Extraction and Analysis | Key Findings | Usefulness/Recommendation/ Implications |
|---|--|--|---|---|--|--|--|
| <p>create and enhance positive practice environments in clinical settings. <i>International Journal of Nursing Studies</i>. 51(1):85-92. doi:10.1016/j.ijnurstu.2013.05.015</p> | | <p>to the current shared governance structure (C) decrease nurse turnover rates (O) within four weeks (T)?</p> | <p>reviewed in detail for reported strategies aimed at creating a positive practice environment. All articles were published within the last 12 years</p> | <p>improve the practice environment of nurses were identified. Exclusion Criteria: Articles focused on the physical environment such as health and safety considerations, or the article was not written in English</p> | <p>were reviewed and articles which potentially outlined strategies were identified. Reference lists were scanned for other potential articles. Articles in languages other than English were excluded. Lake's Practice Environment Scale of the Nursing Work Index provided a framework from which to assess the strategies. Thirty-nine papers reported strategies for creating a positive practice environment. Only two articles reported on a pre-test post-test evaluation of the proposed strategy. Strategies included: empowering work environment, shared governance structure, autonomy, professional development, leadership support, adequate numbers and skill mix and collegial relationships within the healthcare team</p> | | <p>intervention</p> |
| <p>Marquez-Hernandez, V. V., Belmonte-Garcia, T., Gutierrez-Puertas, L., & Granados-Gamez, G.</p> | <p>Level V Quality Grade: Good</p> | <p>For nurses on a Labor-Delivery and Antepartum unit at a 382-bed community hospital (P), does the utility of a contemporary shared governance structure in everyday practice (I) compared to the current shared governance structure (C)</p> | <p>In January 2018, the databases CINAHL, ProQuest, PubMed, and La Biblioteca Cochrane Plus were searched for relevant studies. The reference lists of selected articles were also examined to identify</p> | <p>Inclusion Criteria: Only original comparative studies exploring outcomes in Magnet and non-Magnet hospitals or in Magnet, Magnet-aspiring, and non-Magnet hospitals were included. All study designs Exclusion Criteria: Studies in</p> | <p>The initial database search yielded a total of 163 studies. Topics unrelated to Magnet status were discarded, leaving 129 studies. After eliminating 66 duplicates, we began the critical analysis of the title and abstract of 71</p> | <p>On the whole, lower rates of nursing shortages, burnout, job dissatisfaction, and turnover were observed at Magnet hospitals compared with non-Magnet hospitals</p> | <p>This review provides nursing managers and administrators with the most recent evidence demonstrating that Magnet hospitals because they embody shared governance have better nursing work</p> |

| Citation | Quality Grade | Question | Search Strategy | Inclusion/ Exclusion Criteria | Data Extraction and Analysis | Key Findings | Usefulness/Recommendation/ Implications |
|---|--|---|--|---|---|--|---|
| <p>(2020). Original research: How magnet hospital status affects nurses, patients, and organization s: A systematic review. <i>American Journal of Nursing</i>, 120(7), 28. https://doi.org/10.1097/01.NAJ.0000681648.48249.16</p> | | <p>decrease nurse turnover rates (O) within four weeks (T)?</p> | <p>additional studies. The PRISMA statement was followed, and established methods for systematic review were used to produce a narrative summary. The quality of the reviewed studies was assessed according to the 22-item Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist for observational studies.</p> | <p>which the hospitals sampled didn't include recognized Magnet hospitals or Magnet and Magnet-aspiring hospitals were discarded. To avoid including studies with a selection bias, those with less than a 50% response rate were also discarded, since a lack of response may distort a sample and consequently affect the study's results and conclusions. And study samples showed high degrees of variability and statistically significant differences, which would make it hard to associate a study's results with the characteristics of Magnet hospitals</p> | <p>studies. Another 28 articles about the experience of pursuing and maintaining Magnet recognition did not clearly demonstrate associated results and were also discarded. Of the remaining 43 studies subjected to full-text critical analysis, 22 were excluded for not meeting eligibility criteria. The remaining 21 studies met all eligibility criteria and are included in this review.</p> <p>Nursing-related outcomes. Magnet hospitals were associated with lower levels of job dissatisfaction,6, 22 burnout,6, 22 nurse turnover,26 and consequent cost savings. One study found greater retention and satisfaction rates among nurses in Magnet hospitals, with less intent to leave.</p> | | <p>environments and are associated with better outcomes for nurses, patients, and organizations than non-Magnet hospitals. This evidence should inform future decision-making with regard to pursuing Magnet designation.</p> |
| <p>Slatyer, S., Coventry, L. L., Twigg, D., & Davis, S. (2016). Professional practice models for nursing: a review of the literature and</p> | <p>Level V Quality Grade: Good</p> | <p>For nurses on a Labor-Delivery and Antepartum unit at a 382-bed community hospital (P), does the utility of a contemporary shared governance structure in everyday practice (I) compared to the current shared governance structure (C) decrease nurse turnover rates (O) within four weeks (T)?</p> | <p>The search was undertaken using five electronic databases: CINAHL, MEDLINE, EMBASE, Scopus and ISI Web of Science. Initially, a search was conducted using six terms: professional and practice and model and magnet and nurs* and conceptual framework. The search</p> | <p>Inclusion Criteria: All English language papers up until August 2014 that described the development and/or implementation and/or evaluation of a nursing PPM were included. It was decided not to limit the inclusion criteria to current literature (i.e. previous 5 years) in order to studies capture seminal works in the area.</p> | <p>A review of English language papers published up to August 2014 identified 51 articles that described 38 professional practice models. Articles were subjected to qualitative analysis to identify the concepts common to all professional practice models.</p> | <p>A professional practice model provides the foundations for quality nursing practice. This review is an important resource for nurse leaders who seek to advance their organization in a journey for excellence through the implementation of a professional practice model.</p> | <p>The essential elements of a professional practice model; theoretical foundation and six common components, are clearly described. These elements can provide the starting point for nurse leaders' discussions with staff to shape a professional practice model that is</p> |

| Citation | Quality Grade | Question | Search Strategy | Inclusion/ Exclusion Criteria | Data Extraction and Analysis | Key Findings | Usefulness/Recommendation/ Implications |
|---|---------------|----------|---|--|------------------------------|--------------|---|
| synthesis of key components. <i>Journal of Nursing Management</i> , 24(2), 139. https://doi.org/10.1111/jonm.12309 | | | terms were adapted for the different databases, and all terms were searched with Medical Subject Headings and as key (text) words. Prominent concepts identified in this preliminary review informed a further search using key words: shared governance and shared leadership and advancement programs and peer review and autonomy and decision-making. | Exclusion Criteria: Studies not pertaining to PPM | | | meaningful to direct care nurses. A healthy work environment promoted the retention of nurses |

Appendix D

PRISMA Flow Chart of Evidence



Note. Prisma flow chart diagram from “Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement,” by D. Moher, A. Liberati, J. Tetzlaff, & D. G. Altman, 2009, *Annals of Internal Medicine*, 151(4), p. 267 (<http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00135>). Copyright 2009 by The American College of Physicians.

Appendix E

Levels of Evidence

| | Farley et al. (2019) | Quek et al. (2021) | Manyang et al. (2020) | Van Bogaert et al. (2018) | Stone et al. (2019) | Ndikumana et al. (2019) | Pursio et al. (2021) | Twigg et al. (2021) | Marquez-Hernandez et al. (2020) | Siller et al. (2016) | Slatyer et al. (2016) |
|---|----------------------|--------------------|-----------------------|---------------------------|---------------------|-------------------------|----------------------|---------------------|---------------------------------|----------------------|-----------------------|
| Level I: Experimental study, randomized controlled trial (RCT) or Systematic review of RCTs, with or without meta- analysis | | | | | | | | | | | |
| Level II: Quasi-experimental study or SR of quasi-experimental studies with or without SR | X | | X | | | X | | | | | |
| Level III: Non experimental study; SR of a combination of RCTs, quasi-experimental and nonexperimental studies | | X | | X | X | | | | | X | |
| Level IV: Clinical practice guidelines or Consensus panels/position statements | | | | | | | | | | | |
| Level V: Integrative reviews; Literature reviews; Case reports | | | | | | | X | X | X | | X |

Note. Levels of Evidence from Dang, D., & Dearholt, S. (2017). *Evidence synthesis and recommendation tool*. In *Johns Hopkins nursing evidence-based practice: Model and guidelines* (3rd ed.). Copyright© 2019 by Sigma Theta Tau International.

Figure 1

Summary of the Strength of the Body of Evidence for Recommendation for Practice

| | Nurse Turnover | Nurse Engagement and Autonomy | Intention to Leave and Retention |
|--|--|---|---|
| Level II · Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis | Quasi-experimantal study (Farley et al., 2019) Quasi-experimantal study (Manyang et al.,2020) Quasi-experimantal study (Ndikumana et al., 2019) | Quasi-experimantal study (Farley et al., 2019) | |
| Level III · Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis | Mixed-methods explanatory sequential design Comprising a survey and semi-structured interviews (Quek et al., 2021) | Quasi-Experiment descriptive correlation design study (Siller et al., 2016) | Quasi-Experiment descriptive correlation design study (Siller et al., 2016) Hierarchical regression analysis (Van Bogaert et al., 2018) Cross-sectional multisite survey (Stone et al., 2019) |
| Level V · Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence | Literature Review (Marquez-Hernandez et al., 2020) | Integrative Review (Pursio et al., 2021) | Literature Review (Tigg et al., 2014) Literature Review (Slatyer et al., 2016) |

Note. Levels of Evidence from Dang, D., & Dearholt, S. (2017). *Evidence synthesis and recommendation tool.* In *Johns Hopkins nursing evidence-based practice: Model and guidelines* (3rd ed.). Copyright© 2019 by Sigma Theta Tau International.

Appendix F

FLIGHT Model Based Protocol SBAR Tool

| FLIGHT Model Based Protocol SBAR Tool | |
|---|--|
| <p>The decentralized unit based council of the FLIGHT model based shared governance protocol is designed to assist all staff in finding solutions to identified problems in everyday practice. Use this form to detailing each part of problem and provide ideas on how to solve the problem. Complete this form and bring it to the unit chair council or coach.</p> <p>Who are the stakeholders affected by this change? Patients, nurses, technicians, providers,</p> | |
| <p>Situation: What is the problem/idea?</p> | <p>The nurses' station East and West Hallway satellites unable to monitor hall way traffic</p> |
| <p>Background: What is the clinical significance, hospital policy or standard of practice surrounding this problem?</p> | <p>Staff is frequently unaware of visitors approaching the nurses' station.</p> |
| <p>Assessment: What is the identified problem?</p> | <p>Compromise to patient information being discussed at the nurses' station and staff safety</p> |
| <p>Recommendations: What can be done to correct this problem? Is the proposed change feasible?</p> | <p>Connect satellites to monitors with cameras to allow staff to see who is approaching the nurses' station at all times.</p> |
| <p>pharmacists and therapists and everyone concerned about safety and protecting patient information. Please provide a list of participants interested in working on this idea/problem: RN project lead, Information Technology, two nurses, one technician, RN coach (Nurse Manager). Submitted by: <u>Project Lead, RN</u> Date: <u>8/6/2021</u></p> | |
| <p>For Unit Council Chair/Coach Use Only:</p> | |
| Category | <p>Patient Satisfaction <input type="checkbox"/> Staff Satisfaction <input type="checkbox"/> Quality/Safety <input type="checkbox"/></p> |
| Disposition | <p>Priority Project-Active <input type="checkbox"/> Project in Queue <input type="checkbox"/></p> |
| Time/Budget | <p>_____ Hours _____ Manager or Director <div style="text-align: center;">Approval</div> Project Start Date _____ Project End _____ Date _____</p> |

Note. FLIGHT Model Protocol SBAR Tool from Browder, B., Fuentes, G., Holm, R., Macy, D., & Middlemiss, J. (2019). *Rethinking your unit council structure*. Sigma, p. 49. Copyright 2019 by Sigma Theta Tau International

Appendix G

Unit Council Tracking Log

| Unit Council Tracking Log To be used by the project lead and project members | | | | |
|--|-------------|--------------|----------------------------|------------------------------|
| NAME | DATE | HOURS | PROJECT DESCRIPTION | UNIT COUNCIL SIGN OFF |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Turn completed log in to the Unit Council Chair and Coach

Note. FLIGHT Model Protocol SBAR Tool from Browder, B., Fuentes, G., Holm, R., Macy, D., & Middlemiss, J. (2019). Rethinking your unit council structure. p. 180. Copyright© 2019, by Sigma Theta Tau International

Appendix H

Strength, Weaknesses, Opportunities, Threat (SWOT) Analysis



Appendix I

Visual Management



Photo of the FLIGHT Model Shared Governance Lane Created by The PM On the Unit's Visual Management Board

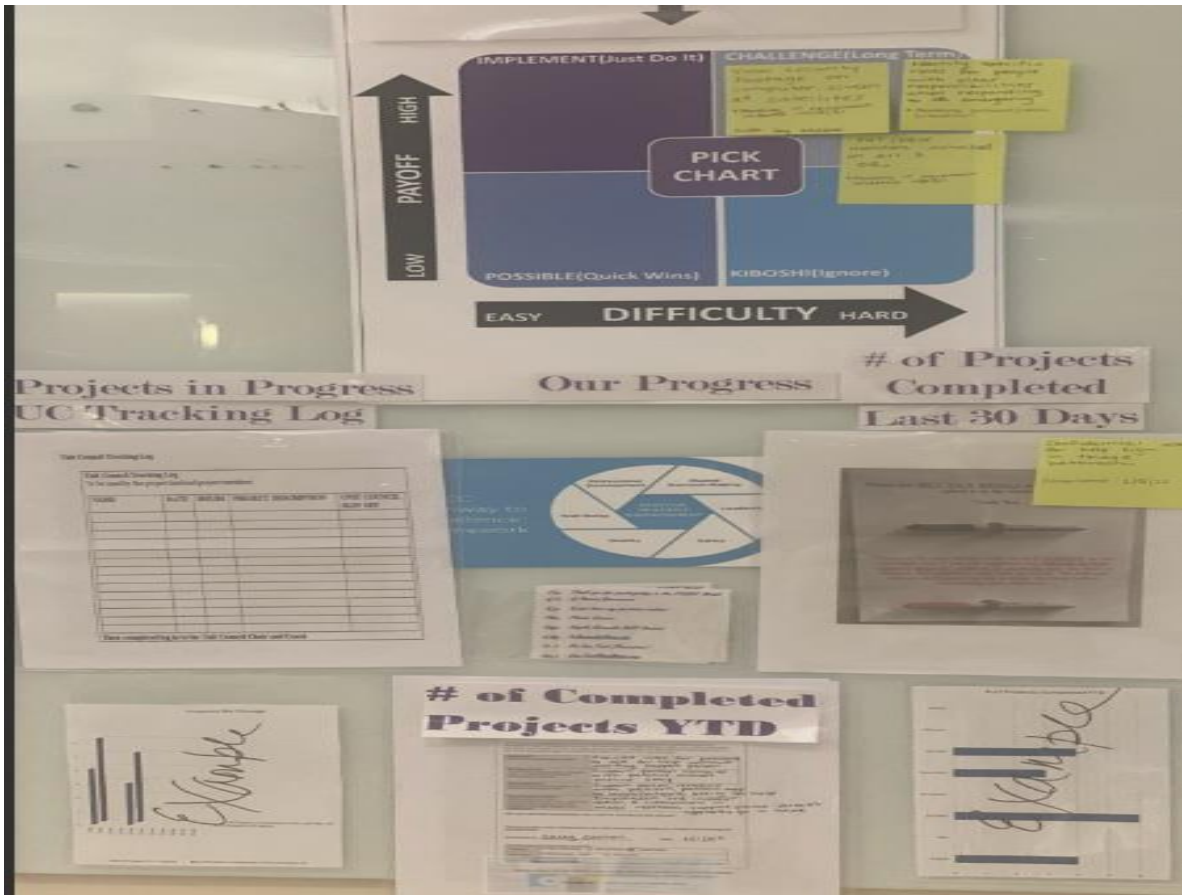


Photo illustrates how the team used the visual management board to facilitate implementing ideas for change. Based on complexity, the team placed an idea for change on the possible, implement, challenge, and kibosh (PICK) chart on a sticky note in a given quadrant and completed an SBAR. Once approved, project progress would be documented on the UC Tracking Log under the "projects in progress" category. Upon completion, documentation about the project was placed in the sleeve of either the projects completed in the last 30 days or year to date (YTD). The PM plotted the graphs for the projects in progress and those completed during the project.

**Appendix J
Huddle Note**

Huddle Talking Points

**New FLIGHT Model Based Shared Governance
Who Wants to Try?**

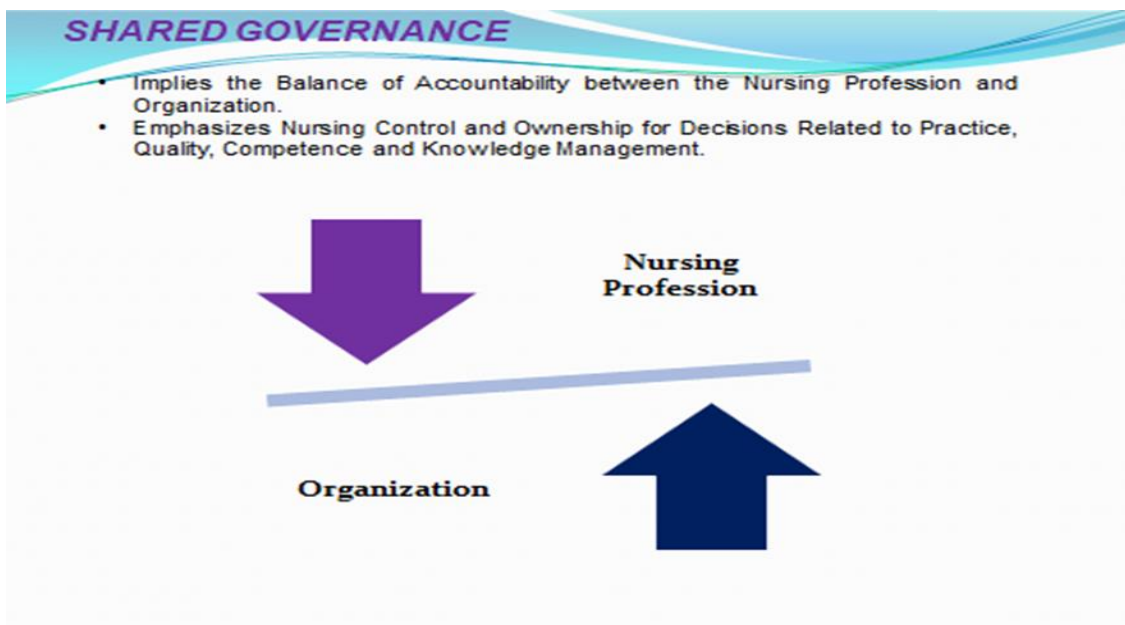
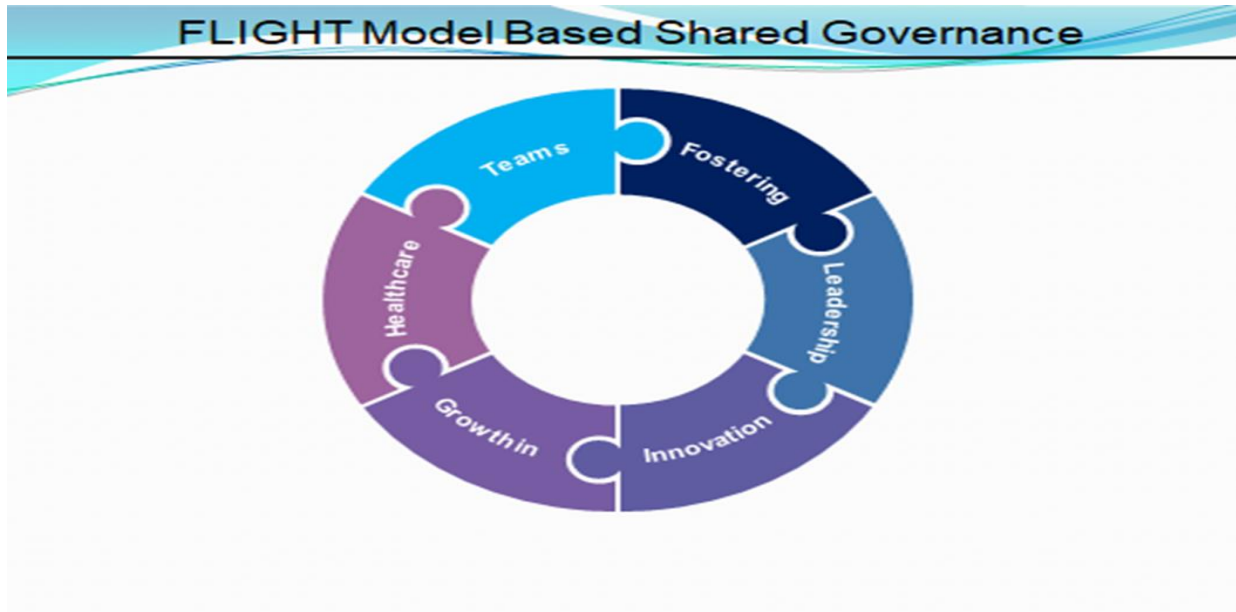
1. All Interprofessional Team Members (RN, Technicians, Unit Secretaries, Providers, and Pharmacists) are the Unit-Based Council
2. Only RNs Can Be Council Chair And Coach.
3. Council Chair And Coach Approve The Change Proposal But Take On An Oversight Role During Execution.
4. Any Team Member May Propose An Idea For Change During Everyday Practice And Lead The Change.
5. No More Monthly Meetings.
6. Ideas For Change Are Proposed During Everyday Practice.
7. Ideas For Change Drive The Process.
8. THE TEAM SUGGESTS AND MAKES THE CHANGE.

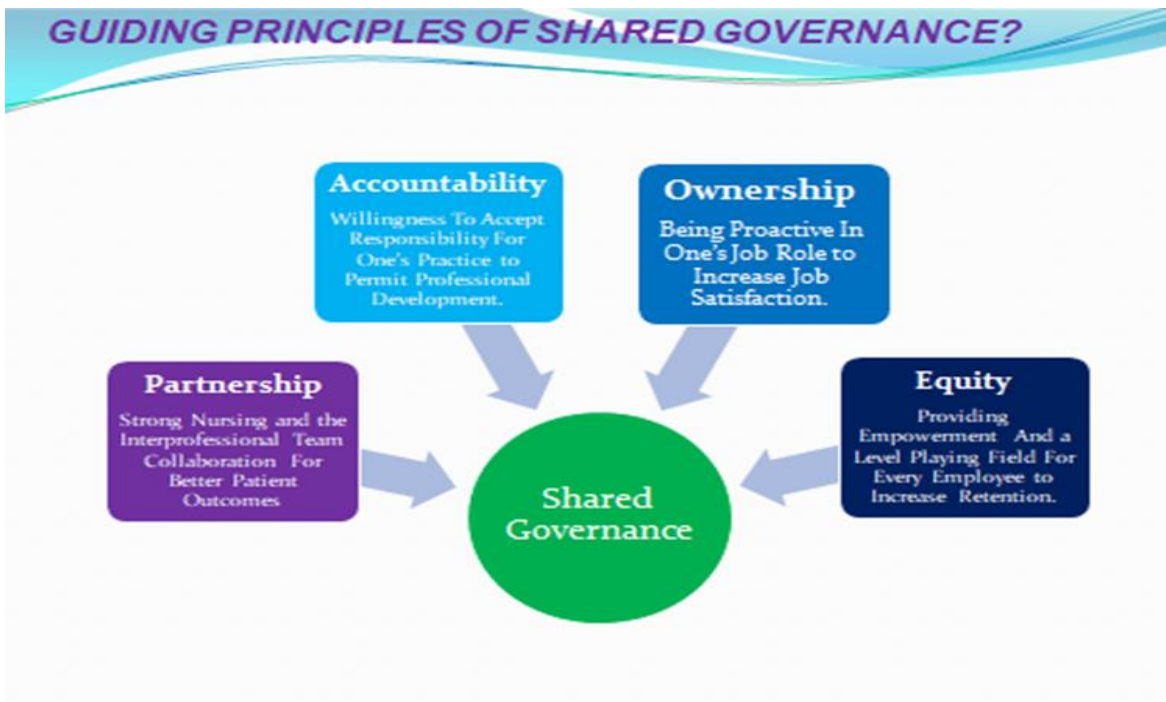
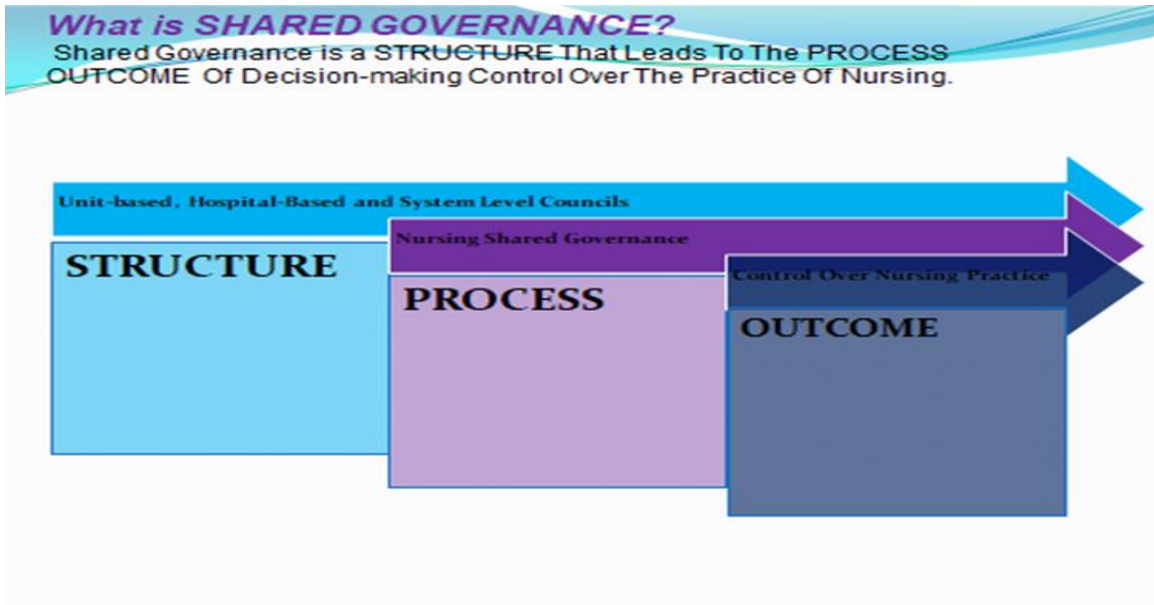
*Privileged and Confidential: Peer Review, Medical Review, and/or Patient Safety Work Product protected pursuant to O.C.G.A. §§ 31-7-15, 31-7-130 et seq., 31-7-140 et seq., and the Federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§ 299 et seq.

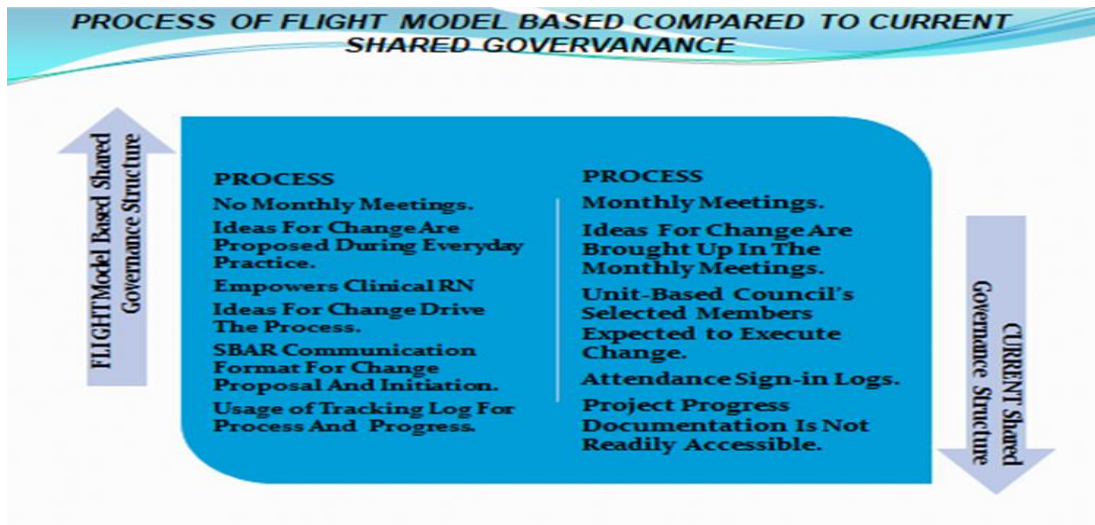
8/9/2021

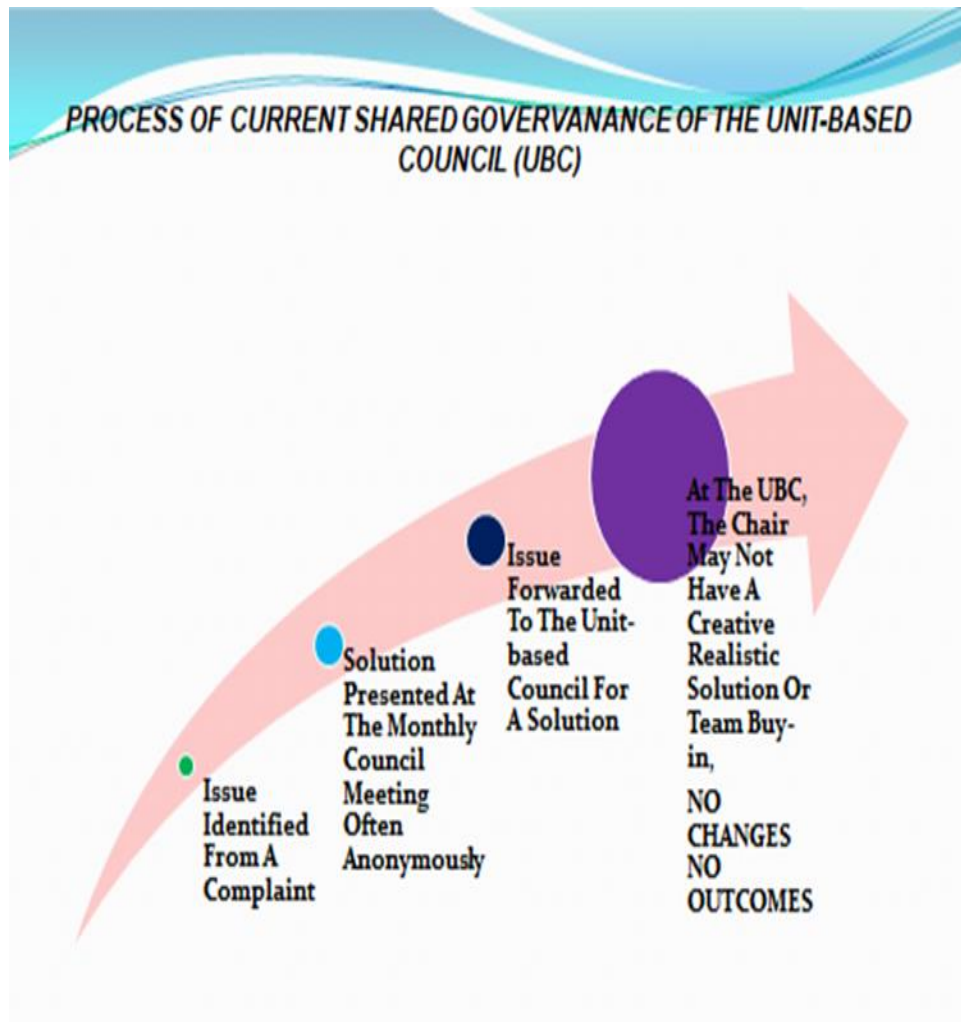
Appendix K

PowerPoint® Presentation

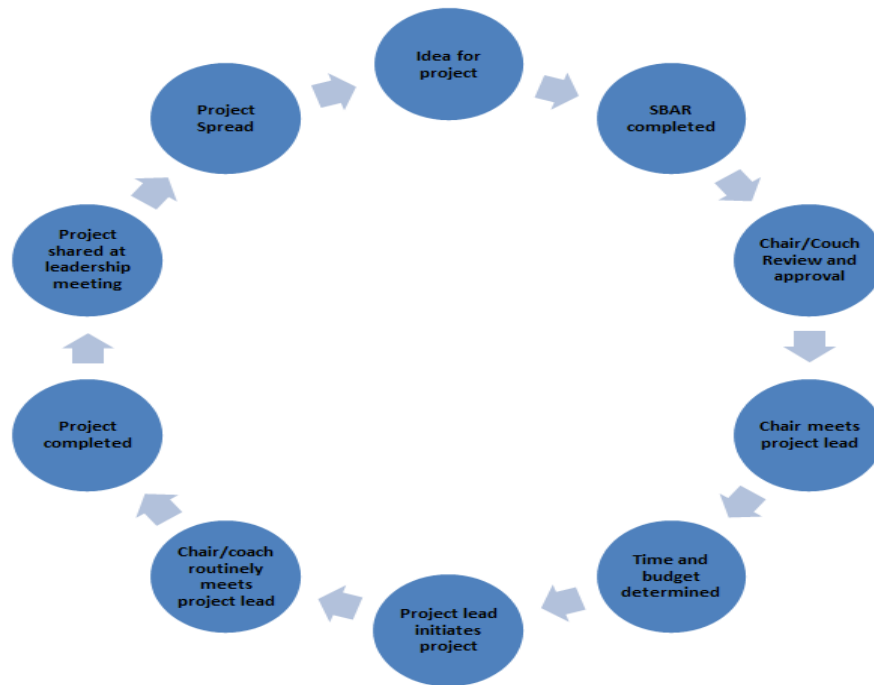








FLOW OF IDEA FOR CHANGE IMPLEMENTATION AND SPREAD



New Model Of Shared Governance

WHO WANTS TO TRY?

References

- Browder, B., Fuentes, G., Holm, R., B., Macy, D., & Middlemiss, J. (2019). *Rethinking your unit council structure*. Sigma Theta Tau International.

Appendix L

Nursing Shared Governance Protocol and Bylaws

Vision: Empowering innovation through collaboration

Mission: To provide the structure that improves quality and professional practice through shared decision-making across the entire organization

GENERAL PURPOSE

The foundation of professional nursing practice for the organization is the Nursing Professional Practice Model (PPM) is fundamentally driven by five Components that advance professional nursing practice: 1) Shared Leadership, 2) Exemplary Practice, 3) Teamwork, 4) Creative Innovations, and 5) Professional Development. It provides the framework for decision-making related to nursing standards of care, nursing documentation tools, and any other issues related to nursing practice. Shared governance (SG) through the FLIGHT model based shared decision-making support shared-decision making at the unit, facility, and system levels with the emphasis on unit councils as the foundation for evidence-based practice and innovative collaboration for nursing excellence.

FUNDAMENTAL COUNCIL STRUCTURE

1. All members of the interprofessional team are members of the unit-based council.
2. Each council shall have an RN chair and coach.
3. System level Shared Governance meeting is held monthly (at minimum), and the schedule posted in advance.
4. There are no formal unit-based council meetings
5. Unit based council members meet as needed for shared decision making to suggest, execute and implement change projects.

FLIGHT Model based Shared Governance Bylaws

1. All members of the interprofessional team of the unit compose of the unit council
2. The unit council is decentralized and specific project meetings occur among project team to develop and evaluate implementation
3. The unit chair and coach are clinical nurses who oversee all projects but may not necessarily be involved in every project
4. The project lead is any member of the interprofessional team who proposes the project idea. It may be a nurse, pharmacist, physician, nursing aide or unit secretary
5. Unit council chairs and coaches hold project leads accountable, update leadership on project progress and drive timely project completion
6. Unit council chairs and coaches can volunteer or may be appointed for the role.
 - a. The unit council chair commitment is usually two years support for an upcoming chair is done during the handoff period
 - b. If multiple RNs are interested in the role then applications can be posited and team members may elect the candidates
 - c. The coaches are selected from the unit's nurse leadership team. Coaches may volunteer or will be delegated to the role.

ROLES AND RESPONSIBILITIES

Project Team Lead will be any member of the interprofessional team with a clinical environment improvement idea willing to execute it to completion

1. Writes project SBAR
2. Meets with unit council chair and coach for approval and determine milestones and timeline
3. Collaborates with peers to execute the project
4. Logs project hours

Project team members, any member of the unit's interprofessional team

Unit Council Chair will be a Clinical Unit Nurse

1. Provides project oversight
2. Reviews and approves employee SBAR
3. Communicates project progress to upper management
4. Builds team support

Coach, will be Unit-Based Frontline Leader

1. Reviews and approves employee SBAR
2. Mentors project lead

3. Oversees multiple projects at a time

Unit Manager, Unit Decision-Maker

1. Provides insight or resource on budgetary constraints

2. Provides final budgetary approvals

3. Mentors team members (Fuentes et al, 2019).

Director or Executive Director, Division Administrator

1. Provides insight on health system priorities

2. Provides guidance on utility of FLIGHT Model process

3. Mentors team members

Appendix M

Kotter's Change Theory to Guide the Recommended Practice Change

1. **Step One: Establish A Sense of Urgency.** As the organization started the groundwork towards applying for the Pathway to Excellence® designation, which required providing evidence of a positive practice environment for nurses, creating an atmosphere of shared governance that encouraged nurse engagement, participation, and interprofessional team collaboration was vital. The need to revamp the current shared governance structure was crucial.
2. **Step Two: Create A Guiding Coalition.** Identification and recruitment of a team of nurses and other interprofessional team members who felt the urgency and the need to advocate for change was necessary.
3. **Step Three: To Develop a Vision and a Strategy.** It was necessary to compare the present and future, clarifying the new structure's benefits and enabling the staff's input on their expected future.
4. **Step Four: To Communicate the Change Vision.** Forms of communications such as PowerPoint presentations, usage of huddles notes, and the creation of visual management systems at nurses' stations and all over the hospital were utilized.
5. **Step Five: Empowering Broad-Based Action.** Was demonstrated through investing in employees and maintaining visible leadership support of nurses recruited to council chairs, coaches, and interprofessional collaboration.
6. **Step Six: Acknowledging Short-Term Wins.** Was achieved through leadership recognizing and championing staff participation and the idea generation of clinical practice environment improvement initiatives to build morale and motivation.
7. **Step Seven: To Consolidate Gains and Foster Further Change.** For every completed project, the project lead would be allowed to present the project at leadership meetings to encourage more participation and create a sense of accomplishment for the staff.
8. **Step Eight: Anchoring New Approaches in Culture.** Was achieved through improved communication and articulating every team member's responsibility in maintaining a positive clinical environment favorable to reduced turnover(Arnoux-Nicolas et al., 2016).

Appendix O

Roll Out

1. After Internal Review Board (IRB) approval, the project manager (PM), who was the DNP student, met with unit nurse leadership to discuss project implementation.
 - a. Due to time constraints the roll out process had to be compressed.
2. The PM created a FLIGHT model lane on the unit's visual management board (Appendix I), including a PICK chart (Grabau, 2020) at the team's request to facilitate on going communication.
3. Due to time constraints and skeletal staffing, initial introduction of the project was made at the team huddle, with donuts served to motivate the team.
 - a. The entire core nursing team became the steering committee members for the DNP project.
 - b. Date for implementation was pushed back due to changes in the implementation unit and IRB approval delays.
 - c. Protocol was discussed in weekly huddles with the staff by the PM at the visual management board.
4. Education about the project was facilitated in person by the PM using huddle notes (Appendix J), and Power Point® presentations (Appendix K).
5. The current RN unit-based council chair continued to serve in that role.
6. The RN coach was the unit's nurse leader due to the staffing shortage.
7. Once education was provided to the entire team, the team started proposing ideas for change in the clinical practice environment.
8. The project lead and members worked on problem-solving, documenting project progress via email, and updating the visual management board's PICK chart.
9. The PM evaluated the intervention against the outcome of decreased turnover six weeks after implementation.
10. The intervention's effectiveness would be reported to the staff in the monthly team meeting by the PM.

Table 2

Budget

| Cost to Organization | Monthly Hours | Total Cost | Yearly Hours | Total Cost |
|---|----------------------|-------------------|---------------------|------------------------|
| Council Chair | 6 hours x \$42/hour | \$ 252 | 72 x \$42/hour | \$3024 |
| Coach | 6 hours x \$42/hour | \$ 252 | 72 x \$42/hour | \$3024 |
| Project Leads (4 hours each x potentially managing 3 projects at a time) | 12 hours x \$42/hour | \$ 504 | 144 x \$42/hour | \$6048 |
| Project members (3 hours x 2 members/project) | 18 hours x \$42/hour | \$756 | 216 x \$42/hour | \$9072 |
| Total Expenses | 42 hours x \$42/hour | \$ 1764 | 504 x \$42/hour | <u>\$21,168</u> |

Appendix P

Types of Data

| | Variable Name | Variable Description | Data Source | Possible Range of Values | Level of Measurement | Time Frame for Collection |
|-------------------|----------------------------|---|---|--|-----------------------------|----------------------------------|
| Population | Years Employed | Number of Years in Position | Human Resources | 0-40 | Ratio | Onset of Intervention |
| | Level of Education | Educational Degree | Human Resources | 1_Diploma 2_Associate 3_BSN 4_MSN 5_DNP | Nominal | Onset of Intervention |
| | Specialty Certification | Certification | Human Resources | 1_Yes 2_No | Dichotomous | Onset of Intervention |
| Event | Shift | Shift in which the proposal for change idea occurred | Contemporary Shared Governance Activity Completion Documentation Tool | 1_Day 2_Night | Dichotomous | Onset of Intervention |
| | Day of the Week | Day of the week the proposal for change idea occurred | Contemporary Shared Governance Activity Completion Documentation Tool | 0_Sunday 1_Monday 2_Tuesday 3_Wednesday 4_Thursday 5_Friday 6_Saturday | Nominal | Onset of Intervention |
| Outcome | Rolling Year Turnover Rate | Rates at which Nurses leave and are replaced | Rolling Year Turnover Rates Comparisons pre and post intervention | 0-100% | Ratio | Pre and post Intervention |
| | Rolling Year Terminations | Number of Terminations | Rolling Year Terminations Comparisons pre and post Interventions | 0-50 | Ratio | Pre and post Intervention |

Appendix Q

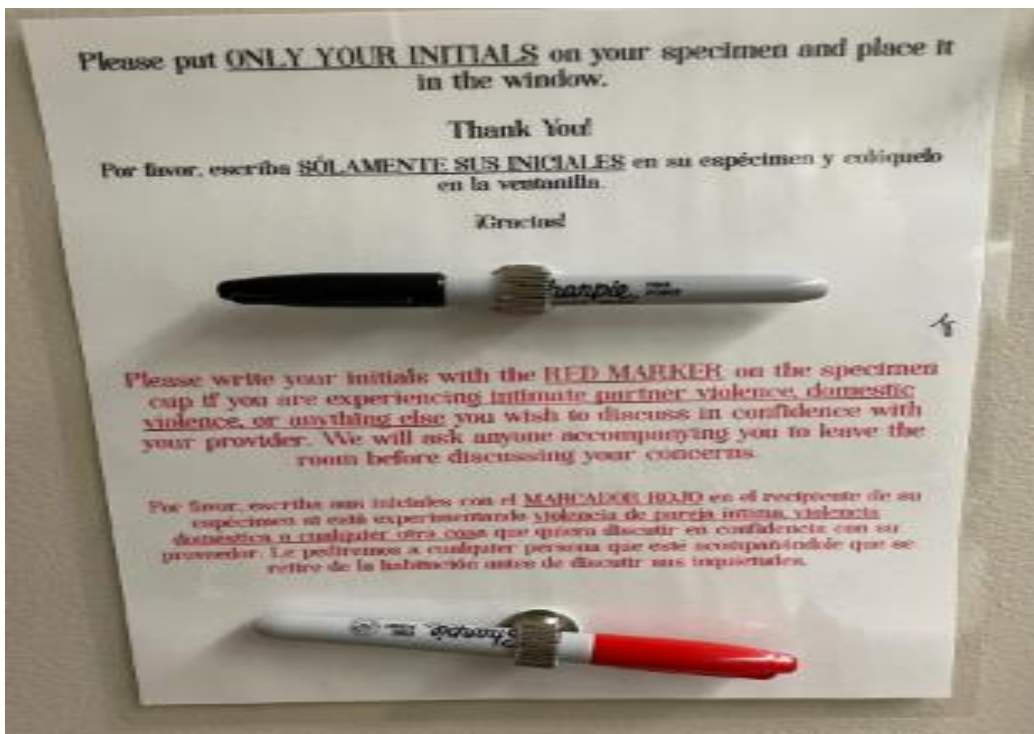
Nursing Turnover Measurement Form

| Indices | Definition | Formulas | Rate |
|-------------------------|---|--|---------------|
| Accession Rate | The percentage of new nurses who stay after the project implementation | $(\text{Number of new nurses hired} / \text{Average number of staff nurse employed}) \times 100$ | 16.67% |
| Separation Rate | The number of nurses that leave after the implementation of the project | $(\text{Number of nurses who quit} / \text{Average number of staff nurse employed}) \times 100$ | 4.87% |
| Stability Rate | The percentage of nurses employed at the beginning of the project and those who stay at the end of the project intervention | $(\text{Number of nurses at the beginning who remained} / \text{Average number of staff nurse employed}) \times 100$ | 6.5% |
| Instability Rate | The percentage of nurses employed at the beginning of the project but leave at the end of the project | $(\text{Number of nurses at the beginning who quit} / \text{Average number of staff nurse employed}) \times 100$ | 7.01% |
| Survival Rate | The percentage of newly hired nurses who stay after the project implement | $(\text{Number of new nurses who remained} / \text{Average number of staff nurse employed}) \times 100$ | 26.31% |
| Wastage Rate | The percentage of newly hired nurse that leave after the three months after the project implementation | $(\text{Number of new nurses who quit} / \text{Average number of staff nurse employed}) \times 100$ | N/A |

Note. Nursing Turnover Measurement Form from Gess, E., Manojlovich, M., & Warner, S. (2008). An evidence-based protocol for nurse retention. *The Journal of Nursing Administration*, 38(10), 441–447. <https://doi.org/10.1097/01.NNA.0000338152.17977.ca>


Appendix R

Implementation of a Patient Confidential Request for Help Process in the Triage Bathroom



Appendix T

Copyright Permission to use the Nursing Turnover Measurement Form

 Header

Thank you for your order!

Dear Mrs. Kagale KIWANUKA,

Thank you for placing your order through Copyright Clearance Center's RightsLink® service.

Order Summary



| | |
|---------------|---|
| Licensee: | Mrs. Kagale KIWANUKA |
| Order Date: | Jul 27, 2021 |
| Order Number: | 5117360320922 |
| Publication: | Journal of Nursing Administration for Individuals |
| Title: | An Evidence-Based Protocol for Nurse Retention |
| Type of Use: | Dissertation/Thesis |
| Order Ref: | doi: 10.1097/01.NNA.0000338152.17977.ca |
| Order Total: | 0.00 USD |

View or print complete [details](#) of your order and the publisher's terms and conditions.

Sincerely,


Copyright Clearance Center


Tel: +1-855-239-3415 / +1-978-646-2777
customercare@copyright.com
[https://link.edgepilot.com/s/41288683/KVYsQlwwxUuBsPqW85GXPg?](https://link.edgepilot.com/s/41288683/KVYsQlwwxUuBsPqW85GXPg?u=https://myaccount.copyright.com/)
[u=https://myaccount.copyright.com/](https://myaccount.copyright.com/)



Appendix U

Permission of Use the FLIGHT Shared Governance Model

[External] Permission to use the Fostering Leadership, Innovation, and Growth through Healthcare Teams (FLIGHT) model for DNP Project 

 You forwarded this message on Sun 10/3/2021 9:51 PM



Dustin Sullivan <dustin@sigmanursing.org>

Fri 9/24/2021 12:06 PM

To: Kagale K Kiwanuka

Cc: Roxanne Holm <roxanne.holm@johnmuirhealth.com>



Kagale,

My name is Dustin Sullivan, and I am the publisher at Sigma Theta Tau International. Sigma published the book containing the FLIGHT model (*Rethinking Your Unit Council Structure*) and hold the copyright, and the authors forwarded your request to me. I am happy to approve your request to reuse the model in your project. The terms you've spelled out are reasonable and acceptable. If you consider publishing your work later, another permissions request will likely be needed depending on the type of publication you're looking into, but for now you should be fine.

Best of luck with your research and with your continuing studies!

Dustin

Dustin R. Sullivan, MPS

Sigma, Publisher

550 W. North St.

Indianapolis, IN 46202 USA

888.634.7575 (US/Canada toll-free)

Direct Line: +1.317.917.4965

Fax: +1.317.634.8188

Email: dustin@stti.org

Web: SigmaNursing.org.

CONFIDENTIALITY NOTICE: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or information otherwise protected by law. Any unauthorized review, use, disclosure, or distribution of this email message and its content is prohibited. If you receive this message in error or are not the named recipient, please contact the sender by reply email, delete this email from your computer and destroy any copies of the original message.

Table 2

Two-Tailed Independent Samples t-Test for Rolling_6_Month_Turnover by

Pre_and_Post_Intervention

| | 1 | | 2 | | | | |
|--------------------------|----------|-----------|----------|-----------|----------|----------|----------|
| Variable | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>t</i> | <i>p</i> | <i>d</i> |
| Rolling_6_Month_Turnover | 25.07 | 11.97 | 64.87 | 3.08 | -5.58 | .005 | 4.55 |

Note. N = 6. Degrees of Freedom for the *t*-statistic = 4. *d* represents Cohen's *d*.

Figure 2

The Mean of Rolling_6_Month_Turnover by Levels of Pre_and_Post_Intervention with 95.00% CI Error Bars

