2020

Evaluation of a Shared Governance Model

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This is to certify that the doctoral study by

Gorda Peters-Joseph

has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MS, Lehman College, 2009

BS, Pace University, 1993

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Shared governance (SG) has been defined as a style of management in which frontline staff and managers work together to improve clinical practice. Guided by the PLAN-DO-STUDY-ACT cycle, the purpose of this project was to evaluate the implementation of the SG model for pediatric services in a US acute care hospital. The practice question explored whether the implementation of the SG model would demonstrate improvements in nurse satisfaction using the culture of safety survey, a change in nurse staff turnover reported as numbers hired, retired, resigned, or transferred, and changes in patient satisfaction measured by survey scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data. Data were analyzed using descriptive statistics for 1 year before the November 2018 implementation and for 1-year postimplementation. Over the analyzed period, nurse turnover was rare with retirement noted as the main reason for leaving the organization. Although not statistically significant, except for nurses' concern for privacy, all HCAHPS subscale scores decreased. Statistically significant changes were detected on 5 out of 12 domains of nurse satisfaction. Respondents' perception that the management was concerned about patient safety and perceptions of staff shortages changed in an unfavorable direction. Positive changes were noted in overall perceptions of safety, manager expectations, and actions for promoting safety. Recommendations for continued review of SG as a focus of positive social change and nurse empowerment were given to the nurse administrators. The findings from this project will further support the use of SG to promote positive social change through improvements in the work environment and nurse empowerment.

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Dedication

This is dedicated to my parents Albert and Miriam Peters whose upbringing instilled the importance of education and whose work ethics established my foundations of focused determination, resilience, and perseverance. Dad, I have followed your firm directive to us when immigrating to the United States "you are going for education". And I have done exactly that!

To my husband Paul and our children Jamal, Siobhan and Dylan who encouraged me to follow my dreams and inspired me to advance my commitment and dedication to the enrichment of healthcare and humanity. To my best friend Alice who encouraged me to stay the course because she believed in me.

I am extremely grateful to the rest of my family, my siblings, nieces, and nephews for their constant support, encouragement, and prayers - for the Lord is my shepherd, Psalm 23.

Acknowledgments

I would like to express my sincere gratitude to the two outstanding, dynamic women who anchored me along the way: Dr Whitehead for her unwavering support, expert counsel and constant encouragement throughout this entire process, and to my preceptor, Dr Malhotra who gave willingly and selflessly of her time, experience and perspective. Your guidance was invaluable! I could not have done it without you and was truly blessed to have you along this journey with me.

To my sister Cherry-Hevelie for spending long days and nights reviewing and correcting my work, thank you for being been my personal doctoral coach. To my brother Roy my military drill sergeant who told me over and over again " you must finish this". Yes I did.

Special thanks goes out to my co-workers and friends who excitedly motivated me to press on. Their eagerness to support me made this experience so much more purposeful.

Table of Contents

List of Tables

Section 1: Nature of the Project

Introduction

Shared governance (SG) has been adopted by many organizations as a vehicle to empower nurses. This model of employee engagement increases nurse's control over their professional practice and is an integral component for hospitals that have attained Magnet designation. SG has been defined as a style of management in which frontline staff and managers work together to improve clinical practice. It extends the power, control, and authority over the clinical practice to practicing nurses and other frontline staff. Beginning at the bedside all the way to senior management, nurses are taking leading roles to influence the model of professional practice and the delivery of care (Gerard, Owens, & Oliver, 2016). The nursing literature identifies SG as important to job satisfaction and retention. Job satisfaction is a global feeling or attitude toward various aspects of a job and is an affective orientation toward work that an employee perceives (Fray, 2011; Baeipour-Divshali et al., 2016).

Problem Statement

Turnover is defined as a costly by-product of lack of staff engagement and/or job satisfaction: causative factors associated with turnover are role ambiguity, role conflict, poor RN to supervisor communication, work stressors, issues with management and burnout (Ong, Short, Radovich & Kroetz, 2017). Nurses who do not have the autonomy and authority to be decision-makers in an organization will more than likely be dissatisfied and less willing to remain at their place of employment. Such dissatisfaction will not only affect nurses, but it will also impact the quality of care received by patients.

SG is an organizational model that provides a structure for shared decision-making among nurses about the practice and clinical outcomes. With successful implementation, SG legitimizes decision making control by nurses over their practice while extending their influence on some administrative areas previously controlled by managers (Giambi, Morath & Morris, 2018). The SG model encourages RNs and administrative leaders to collaborate to determine internal policies controlling nursing clinical practice and quality of care delivery. The concepts of SG models were introduced to improve the RNs work environment, satisfaction with work, and retention. Turnover is identified as a costly by-product of lack of staff engagement and/ or job satisfaction; causative factors associated with turnover are role ambiguity, role conflict, poor RN to supervisor communication, work stressors, issues with management, and burnout (Ong et al., 2017).

Some facilities have implemented SG, but there remains quite a few that have yet to join this movement of empowerment in nursing. The practice at my institution had been one in which rules, policies, and decisions have been dictated by department heads and implemented without the input of nurses. There has been a significant increase in the turnover rate of nurses after spending thousands of dollars on training. The SG model was implemented at the facility with the hope of empowering nurses and improving turnover and nurse satisfaction.

Purpose

The purpose of this project was to evaluate the implementation of the SG model in an acute care hospital in the northeast United States. SG had been implemented for over one year at this facility. An evaluation of the model was needed in order to assess if

the model has impacted nurse and patient satisfaction and nurse retention. The practice question is: Will the implementation of the SG model on children's health services in an acute care hospital demonstrate improvements in nurse satisfaction, nurse retention/turnover, and patient satisfaction?

Nature of the Doctoral Project

This project was an evaluation of a quality improvement initiative implementation of the SG model on children's health service units in a large urban hospital in the northeast. The evaluation followed the steps for the evaluation of an existing quality improvement initiative outlined in the DNP Manual for Quality Improvement Evaluation Projects. De-identified data pre-and postimplementation of the project was obtained The plan was to collect data on staff satisfaction surveys, patient satisfaction surveys, employment data related to nursing workforce retention and turnover, and two surveys completed by nurses at the facility.

Significance

The concept of SG is freely viewed as sharing power at all levels with a goal to increase empowerment and improve practice, well documented at the hospital level (Underwood & Hayne, 2017). Change in autonomy and decision making to include nurses involved in direct patient care will be of major significance. Stakeholders included clinical staff nurses, nurse administration, and other healthcare employees. SG provided all nurses with an opportunity to participate in decision making for the facility. Potential implications for social change include the promotion of a better work environment and increased social harmony. Furthermore, the project is likely to be transferrable to other

organizations because the SG is a very general methodology that even non-healthcare organizations can adopt.

Summary

The nursing literature contains numerous articles linking SG to increased job satisfaction and retention for nurses. The implementation of SG promotes nursing engagement and ownership of workplace changes and issues, which in turn promotes a healthy work environment with the improved nurse and patient satisfaction (Bieber, & Joachim,2016; Gerard, Owens, & Oliver, 2016; Fray, 2011). The purpose of this project was to evaluate the implementation of the SG model on the children's health services unit in an acute care hospital in the northeast United States. Section 1 identified the project questions and the stakeholders for this project. Section 2 introduced the model framing this project, the evidence supporting SG, the local background and context, and my role in the project.

Section 2: Background and Context

Introduction

Problem Statement

The SG model encourages RNs and administrative leaders to collaborate to determine internal policies controlling nursing clinical practice and quality of care delivery. SG models were introduced to improve the RN's work environment, satisfaction with work, and retention. Turnover is identified as a costly by-product of lack of staff engagement and/ or job satisfaction; causative factors associated with turnover are role ambiguity, role conflict, poor RN to supervisor communication, work stressors, issues with management, and burnout (Ong et al., 2017). In Section 2, I describe the model that will frame this evaluation, the literature relevant to this nursing practice, the background of the facility, and my role in the project evaluation. The purpose of this project was to evaluate the implementation of the SG model in an acute care hospital in the northeast United States. The practice question was: Will the implementation of the SG model on children's health services in an acute care hospital demonstrate improvements in nurse satisfaction, nurse retention/turnover, and patient satisfaction? This section discussed the model supporting this project, the evidence supporting this project, and my role in the project.

Concepts, Models, and Theories

The *Plan, Do, Study, and Act* (PDSA) cycle is a management practice for improving processes. The cycle focuses on small tests and short time frames for the implementation of plans to help drive process improvement. In some cases, PDSA results in immediate improvement, while in others, the plan is amended, and the process

repeated several times before the desired results are achieved. The cycle has proven popular with those who use it because it is simple, does not require the commitment of large amounts of time resources and it is flexible (Donnelly & Kirk, 2015; Ungvarsky, 2016). Table 1 describes the relationship between the PDSA model and the SG evaluation.

Table 1

PDSA Model and SG Evaluation

PDSA model components	SG evaluation activities
Plan: This stage was completed by the facility.	
Do: Implementation in the children's services was completed by the facility.	
Study: This stage of the evaluation will be completed through this DNP project.	The DNP student will obtain appropriate permissions to review the following deidentified data: patient and staff satisfaction surveys, and employment data.
Act: Based on the results of the study stage, recommendations will be identified.	The findings will be presented to stakeholders, and recommendations to make improvements will be formulated.

Definitions

Nurse Retention

Understanding the changing perspectives of new nurses entering the workplace is critical information for nurse leaders who are charged with motivating and retaining these newest members of the nursing team (Tyndall et al., 2019). Nursing retention is the capability of a healthcare organization to retain a qualified nursing workforce (Bieber & Joachim, 2016). Nursing retention is inversely related to nursing turnover. If retention is high, then turnover is low and vice versa. If nurse retention policies are inadequate, then high turnover will result. There are two major groups of factors that drive turnover and

affect retention. The first group of factors refers to voluntary turnover (Bieber & Joachim, 2016). Voluntary turnover occurs when a nurse leaves because of personal reasons, such a better opportunity at other organizations. The second type of turnover is involuntary in nature, and it occurs when a nurse is terminated for reasons, such as disciplinary infarctions or not being able to perform his/her duties appropriately (Bieber & Joachim, 2016). This project will primarily focus on voluntary turnover.

Nurse *S*atisfaction

According to the National Nursing Workforce Survey, the nursing workforce is changing with a continued lowering of the average age of RNs from 50 years in 2013 to 48 years in 2015. Undoubtedly, this is influenced by the influx of younger new graduate nurses (NGNs) and the retirement of aging RNs. Most new nurses entering practice are millennials (born in 1980-1999), a generational cohort that constitutes the largest in history. Millennials look for meaning and purpose in their work, and they will change jobs to find it. Thus, turnover is a critical concern for nurse leaders, and it is a major issue in the management of NGMs (Tyndall et al., 2019).

New graduate nurse research evidences a strong relationship between the quality of the work environment and both job satisfaction and turnover. Job satisfaction and organizational commitment are associated with turnover reduction, a major goal for nurse leaders because turnover is costly and disruptive to healthcare organizations. Previous research demonstrates that organizational and leader behaviors promote skill development and engagement of NGNs. Leader empowering behavior and positive work environments are associated with stronger organizational engagement, increased organizational commitment, and job satisfaction, and, ultimately, decreased turnover

intention in NGMs (Tyndall et al., 2019). Nurse satisfaction refers to the internal emotional and cognitive states of nurses that reflect their satisfaction with the practice environment, compensation policies, and their role within the organization (McCay et al., 2018).

Patient Satisfaction

Satisfaction with care is inherently shaped by an individual's values, expectations, and experiences, such as expecting to have a healthcare provider who includes them in decision-making and thus is a highly subjective measure requiring a nuanced approach to its interpretation. Patients' expectations and values are affected both by factors that are related to the health system, for example, availability of care and by factors outside of the health system, such as an individual's social identity (Larson et al., 2019).

Patient satisfaction is a multidimensional construct for which multiple definitions have been proposed (McCay et al., 2018). For the purpose of this project, patient satisfaction is defined as the extent of the content to which the patient is content with healthcare services provided. Patient satisfaction may be related to the quality of nursing services provided, treatment outcomes, such as remission of cancer, and some other type of care outcome (McCay et al., 2018).

Relevance to Nursing Practice

Shared Governance

SG has been defined as shared decision making based on the principals of accountability, partnership, equity, and ownership. Porter-O'Grady popularized the concept of SG in the 1980s as a strategy to enable nurses to exercise control over nursing practice and the decisions that impact nurses and as a means to promote equality and

parity in the roles, relationships, and responsibilities between nurses and organizational leaders. It is touted as a strategy to transform organizations, improve productivity, empower staff nurses, enhance staff nurse autonomy, increase job satisfaction, and reduce nursing turnover (Anderson, 2011). SG is a nursing management model that gives clinical nurses control over their professional practice while extending their influence over the resources that support it (Weaver, 2018).

Evidence has demonstrated the benefits of a strong SG structure (also referred to as professional governance) in a professional nursing culture (Weaver, 2018). A culture of SG has the ability to transform nursing relationships and decision-making processes and enhance bidirectional communication. It is important to distinguish between an organization that proclaims a culture of SG and one that truly exemplifies SG where clinical nurses have a voice. The literature also shows that when organizations are able to fully engage nurses, there are several benefits, including improved patient and nurse satisfaction, greater nurse retention, enhanced clinical outcomes, a culture of professionalism, and a sense of ownership in practice (Oss et al., 2020).

Although multiple views on what SG is exist, the most common view is that the SG is a framework for collaboration among healthcare providers who manage themselves in a decentralized manner with authority spread across multiple individuals (McKnight & Moore, 2020). It can be said that SG is a partnership among diverse groups of healthcare professionals with the goal of improving patient experience, increasing accountability, facilitating clinical decision-making, and promoting evidence-based research (McKnight & Moore, 2020). SG networks are committed to patient-centered care delivered with compassion and empathy. To be successful with SG initiatives, healthcare organizations

that adopt the SG framework must commit themselves to putting their staff and patient first (McKnight & Moore, 2020).

SG is a structural model for framing professional practice within an organizational format. After 25 years of research and development, basic principles that undergird the appropriate and sustaining structures of SG have become well established. Understanding, translating, and applying these principles will help those implementing nursing-related SG to build a strong professional structure, which can serve as a framework for constructing and expressing professional practices, processes, and relationships (Porter-O'Grady, 2012).

SG and Nurse Satisfaction

Job satisfaction is described as one's affective or emotional reaction to one's job, resulting from approving of one's achievement with desired outcomes (Cranny et al. 1992). It is one of the most researched outcomes at work, revealing that job satisfaction is significantly associated with emotional abilities and experiences (Diefendorff and Richard, 2003). In particular, the emotional nature of nursing itself and nurses' need to regulate the way in which they express or suppress their emotions influence their job satisfaction and performance (Bartram et al., 2012) (Mikyoung & Keum-Seong, 2019).

SG has been documented to improve nurse job satisfaction. Improvements in job satisfaction are believed to occur due to the increased nurse engagement that can be enabled by SG culture (Fisher, et al., 2016). In the SG environment, nurses themselves select optimal approaches for resolving practice problems, which enables them to minimize the level of stress and burnout with predictable increases in job satisfaction.

Another factor associated with SG that increase nurse satisfaction is higher job autonomy – an important enabler of creativity (Li et al., 2018).

Job satisfaction and the quality of the work environment have been reported as significant work-related factors impacting nurse retention outcomes (Al Maqbali, AbuAlRub, & Al Blooshi, 2018; Al Maqbali, 2015; Fallatah, et al., 2017). In the past decade, the influence of the work environment on nurses' work satisfaction and job retention has been extensively studied. Interestingly, most of these studies have focused on the direct relationship between work environment and nurse turnover intentions or the relationship between nurse turnover and job satisfaction (Al Sabei et al., 2020).

SG and Nurse Retention

Nurse retention and nurse turnover are significant issues for every healthcare organization. In the United States, the rates of turnover are reported to be between 10 and 15% (Li & Jones, 2013). Turnover is very costly in financial terms. Data indicate that cost of hiring a new nurse may range between $37,700 and $58,400 (Fisher et al., 2016). These costs include direct hiring costs, such as recruiter fees or training and opportunity costs. In addition, nurse turnover is associated with the loss of expertise that may compromise the organizational capability to deliver high-quality patient care (Fisher et al., 2016).

Owen, Boswell, Opton, Franco, and Meriwether (2018) described the implications of SG on nurse retention. Specifically, they pointed out that SG promotes nurse work engagement and improves job satisfaction. Changes in these two constructs reduce job turnover. Owen et al. (2018) go as far as to suggest that work engagement is a key mediator of job satisfaction that has a profound impact on retention and turnover.

Furthermore, they pointed out that the implementation of SG was a cost-effective way to reduce nursing turnover and improve a variety of other patient outcomes.

SG and Patient Satisfaction

Substantial evidence suggests that SG improves patient satisfaction. For instance, Owen et al. (2018) conducted a cross-sectional study and found that in SG units, patients were more likely to recommend a hospital to their friends and facility and more often gave a top rating to the facility. Patients were also more satisfied with process outcomes, such as receiving care promptly, staff explaining medications, and having excellent pain control. Owen et al. (2018) proposed that the SG increased the work engagement of nurses, which, in turn, led to improved patient outcomes. Fisher et al. (2016) also proposed that SG empowers nurses to deliver care in innovative ways to satisfy the expectations of patients and increase their level of satisfaction. However, there is a gap in the literature with respect to improving patient outcomes. This project will not only examine the impact of SG on nurses but also on patient-specific outcomes, such as patient satisfaction.

Local Background and Context

Several years ago, there were leadership changes at my institution. At one of the very early meetings with a new chief nursing officer, she asked her leadership group this question, "What would you want me to do for you?" I had been waiting for an opportune time to present my wish, and I quickly asked that the SG model be implemented. Subsequently, this large urban hospital began the SG implementation approximately two years ago. SG was implemented at the hospital to allow nursing staff and hospital leadership to collaboratively make decisions in order to promote positive outcomes for

patients, staff, and the health system as a whole. The SG model was implemented initially throughout the entire hospital but later became a corporate-wide project for all 15 hospitals under the leadership of the Senior Chief Nursing Executive (SCNE). Due to variations in hospital structures, it is necessary to provide the organizations SG reporting structure that reports to the SCNE. A visual representation of the corporate reporting structure can be seen in Figure 1. The SG reporting structure begins at the top with the SCNE then to the Chief Nursing Officer (CNO) from the individual hospitals who are responsible for the system-wide councils. These councils include the council of nurse educators and nine system-wide councils. The structure includes, quality, EBP, research and innovation, magnet champions professional, nursing information system advisory, system advanced practice/NP, wound care, value analysis, care management, social work and respiratory. Due to variations in the services provided by each hospital there are eight specialty practice councils under the command of their CNO and the nurse's union internally. The reporting structure of each hospital wide council includes magnet/ professional practice, night shift advisory, advanced practice/NP council, recruitment and retention, and policy and procedure council. The nursing units and nursing councils form the foundation for SG within the institution. This structure provides the framework in which nurses at all levels can investigate, develop, implement, and evaluate standards of practice and care. The foundation of our care is rooted in our Nursing Professional Practice Model (PPM) based on Jean Watson's Caring Theory. The committees usually meets monthly or more often, if necessary, to review current policies and procedures. If necessary, change to SG policies and procedures are made. The retention and recruitment committee is charged with developing educational materials and new staff orientation.

There is also an arbitration mechanism/NYSNA nursing practice council, aligned with the committees, that enables peaceful resolution of conflicts related to contract negotiations. The purpose of the magnet/professional development council is to foster clinical advancement and growth of the clinical staff. The manager/policy & procedure council provides a forum for direct care nurses to utilize evidence based practice in their clinical practice. Night Shift advisory council is the representation of all councils so as to keep the night shift current with SG practices. Although SG policies change over time, the underlying principle is simple. Nurses and other healthcare providers are given as much authority as possible in managing the operation of their respective units. The role of the top management is mostly informing SG agents about challenges and opportunities faced by the healthcare system. In response to their input, the SG committee, in collaboration with the staff, plans on how to respond to these challenges and/or take advantage of opportunities. The process is democratic, everyone has an opportunity to be heard, and everyone's suggestions are considered. Historically this approach has been very successful because high-quality decisions have been typically made. Also, the SG approach resulted in a high level of staff satisfaction and a low level of conflict.

The hospital structure includes the CNO chairs, co-chairs, and two members from each division within the service lines. The purpose of this council is to support the hospital SG structure at the facility and division level and maintain department involvement at the division level.

This project evaluated the SG implementation on the children's services unit of a 460-bed hospital in a large public health system. The number of beds allocated to pediatric care is approximately 200, but it can vary by converting beds available at other

units. These beds include state-of-the-art neonatal intensive care and pediatric intensive care units. Specifically, the children's health services consist of an 8-bed pediatric intensive care unit (PICU), a 33-bed general pediatric ward with the capability to perform ambulatory infusions for multiple pediatric subspecialties, and a 25-bed neonatal intensive care unit (NICU).

The system provides broad ranges of services for all ages from birth up to the age of twenty on. Pediatric services include a pediatric emergency division, an ambulatory primary care division and services for routine immunizations, dental services, nutrition counseling, well-child services, asthma and diabetes care, mental health screenings, obesity prevention, and much more. These preventive services are especially relevant in the context of the federal law known as the Affordable Healthcare Act (ACA). Among other things, the ACA emphasizes the importance of preventive care in order to prevent expensive and preventable conditions. In addition, the organization provides delivery services, newborn care, breastfeeding consultations, intensive neonatal care, and much more.

Role of the DNP Student

I am employed at the organization that follows SG practices. Implementation of SG is not a discrete event, but rather an ongoing process that requires monitoring and period adjustments to ensure that the change can proceed in an unimpeded manner. I followed the components of the PDSA model, as described in Table 1, to complete the evaluation of the SG implementation on children's services in a 1000 bed facility. My motivation was to become a better leader by gaining a deeper understanding of the linkage between SG practices and workforce outcomes.

Summary

This section introduced the PFSA model, the context for the project, evidence supporting the importance of SG, and my role in the project. The practice question is: Will the implementation of the SG model on children's health services in an acute care hospital demonstrate improvements in nurse satisfaction, nurse retention/turnover, and patient satisfaction? Section 3 discussed the planning, implementation, and evaluation of this project. The analysis of the data was introduced.

Section 3: Collection and Analysis of Evidence

This project evaluated the impact of the SG model implemented on the children's services at a large urban hospital in the northeast. The SG model was implemented in November 2018, with the goal of reducing nurse turnover, increasing nurse job satisfaction, and improving patient satisfaction. In Section 3, I discuss\the sources of evidence that were provided for the project evaluation and the analysis and synthesis of the data.

Practice-Focused Question(s)

The practice question was: Will the implementation of the SG model on children's health services in an acute care hospital demonstrate improvements in nurse satisfaction, nurse retention/turnover, and patient satisfaction?

Published Outcomes and Research

Relevant publications were located using major academic databases that include Nursing Reference Center Plus, PubMed, Google Scholar, CINAHL, Ovid Nursing Journals, Academic Search Premier ProQuest Nursing & Allied Health Source, Joanna Briggs Institute EBP Database, and MEDLINE. Search terms utilized were *shared governance, nursing, and shared governance, job satisfaction and shared governance, patient satisfaction and shared governance, nurse satisfaction and shared governance, hospitals, and shared governance.* The search was also limited to within the last 5 years and English language peer-reviewed journals.

Sources of Evidence

Data was analyzed for 1 year before the November 2018 (October 2017-October 2018) implementation and for one year after implementation (November 2018 - November 2019).

Nursing Turnover

Tracking nursing turnover was accomplished by analyzing historical data. Data was collected through the human resource department that records hiring and separation events. In addition, there are payroll records that can be used to determine changes in staffing complement over time, along with arrivals and departures of employees. All data can be extracted from the human resources department database automatically by running simple queries. This data is currently used for planning purposes, and it is easily retrievable in the de-identified data from the database.

This data is accessible at all organizational levels because of its importance in making decisions. Turnover rates can be calculated based on any period, but monthly, quarterly, and annual turnover reports are routinely generated for purposes not directly related to the purposes of this study. These reports break down turnover rates by voluntary and involuntary.

Nurse Satisfaction

Nurse are surveyed annually through human resources regarding workplace satisfaction. Unfortunately, this data is not separated by units but is reported as hospital-wide data.

Patient Satisfaction

Hospital Consumer Assessment of Healthcare Providers and Systems (HCHAPS): Patients' Perspectives of Care Survey includes 29 questions about the patient's perception of their hospital stay. This survey is collected continuously from every patient. Upon discharge, each patient receives an invitation to complete this survey over email. Scores are recorded and stored in the organization's management information system database. For the purposes of this project, HCAPHS scores will be abstracted from the database and analyzed to determine a possible impact of SG on patient satisfaction scores.

Participants

This project aligns with the DNP Manual Quality Improvement Evaluation. The partner organization will not be identified. All data were provided to me with no identifying information. The site approval form for the quality improvement evaluation doctoral project was signed by the facility and submitted by me to the Walden University IRB. The IRB approval number was 07-06-20-0745388.

Analysis and Synthesis

Data for nursing turnover, nurse job satisfaction, and patient satisfaction was routinely collected by the organization. De-identified data was provided to me from the organizational database.

Summary

The purpose of the project was to examine the impact of SG implementation of nurse retention, job satisfaction, and patient satisfaction and IPNG results. The practice question is: The practice question was: Will the implementation of the SG model on children's health services in an acute care hospital demonstrate improvements in nurse

satisfaction, nurse retention/turnover, and patient satisfaction? In Section 3, I discuss the evidence that will be analyzed and the method of analysis. In Section 4, I present the findings and recommendations from the evaluation of the data.

Section 4: Findings and Recommendations

Introduction

In this section, I analyze how patient satisfaction and nursing workforce turnover changed between the preimplementation to the postimplementation periods. In this analysis, the preimplementation period included lasted October 2017 through October 2018 while the postintervention period stretched from November 2018 to November 2019.

Patient satisfaction data came from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. HCAHPS is a standardized survey used by thousands of healthcare organizations across the nation. These scores are aggregated into a single national database to enable benchmarking. Turnover and retention data were provided by the human resources department. All data were analyzed using Statistical Package for the Social Sciences (SPSS) version 27.0.

Findings and Implications

Patient Satisfaction

Patient satisfaction comparisons were made for three units serving pediatric patients. The inpatient stay satisfaction data came from two units. Unfortunately, only a limited analysis of satisfaction with inpatient stays could be conducted due to the extremely low sample sizes (Table 2). For the preintervention and postintervention periods, only four and 12 responses were available. Ratings ranged from five to 10. The higher the rating the stronger the satisfaction.

Table 2

Satisfaction Ratings for Inpatient Stays

	Preimplementation	Postimplementation
Global rating*		
5		8.5% (n = 1)
6		8.5% (n = 1)
7	25% (n = 1)	
8		25% (n = 3)
9-10	75% (n = 3)	58% (n = 7)
Recommend the hospital		
Probably yes	25% (n = 1)	50% (n = 6)
Definitely yes	75% (n = 3)	50% (n = 6)
Total responses	4	12

A significantly larger sample was available for satisfaction with emergency department stays. The data came from the HCAHPS survey submitted to a random group of patients seen in the emergency department. Neither individual-level data nor patient demographic characteristics were available for the analysis. Responses ranged from 133-139 in pre-implementation to 78-81 postimplementation. These summary characteristics, reflecting patient satisfaction with nursing care among pediatric patients in the emergency department, are presented in Table 3.

All subscale scores, except for nurses' concern for privacy, decreased following the SG implementation. Despite the apparent changes in means, the change was not statistically significant. Independent samples t-tests (equal variances were assumed) were used to make between-period comparisons (Polit & Beck, 2017). At a 0.05 level of significance, differences between the periods were not statistically significant. Based on these data there was no evidence that there were changes in patient satisfaction scores for

emergency room visits and inpatient stays. In fact, unfavorable changes in patient satisfaction were observed. The drop in ED scores could also be related to events not connected to SG implementation.

Table 3

HCAHPS Survey Scores for Emergency Department

	Preimplementation			Postimplementation				
				M	*SD*	*n*		*M*
Nurses overall	76.5	26.5	139	73.8	26.9	81	-0.72	0.24
Nurses courtesy	78.6	27.5	138	75.3	28.9	81	-0.83	0.20
Nurse took time to listen	77.7	26.7	137	75.0	28.7	80	-0.69	0.25
Nurses attention to your needs	75.9	29.0	137	74.7	28.9	78	-0.29	0.39
Nurses informative re treatments	74.8	28.5	134	70.3	29.5	80	-1.09	0.14
Nurses concern for privacy	75.4	28.0	133	76.0	24.3	78	0.16	0.56

Nursing Staff Turnover

Over the analyzed period, there was no evidence that nursing staff turnover changed significantly. Resignations and retirements were relatively rare events. Data from three units were obtained from the human resource department for pre and post-intervention periods. Summary turnover data is presented in Table 4.

Table 4

Staff Turnover

	Unit 1		Unit 2		Unit 3	
	Pre	Post	Pre	Post	Pre	Post
Retired	1	-	-	2	-	-
Hired	-	7	2	2	-	-
Resigned/Transferred	-	2	2	-	5	1

The data indicate that the major reason for staff departure was retirement. Only two resignations took place in Unit 1, both during the post-implementation period. One of these

two resignations was due to childcare issues, and another one was a transfer to a sister hospital. In unit 2, there were only two resignations – both during the pre-implementation period. The stated reason for one of these resignations was a transfer to a sister hospital to work during the daytime. Another resignation occurred because the nurse moved to a different state.

During the pre-intervention period, five nurses resigned or transferred out from unit 3. One of these resignations occurred because a nurse moved out-of-state, two resignations were for unknown reasons, and one nurse transferred to a homecare unit. In the post-implementation period, only one nurse resigned because she moved out of state.

There was no unexplained turnover, and there no comments to suggest that organizational climate or the SG somehow affected turnover outcomes one way or another. All resignations can be explained with natural factors unrelated to job satisfaction or the organizational environment.

Nurse Satisfaction

At this facility nurse satisfaction data is obtained through the culture of safety survey (Appendix A). These domains include:

- Overall Perceptions of Safety.
- Frequency of Events Reported.
- Manager Expectations & Actions Promoting Patient Safety.
- Organizational Learning - Continuous Improvement
- Teamwork Within Units.
- Communication Openness.
- Feedback and Communication About Error

- Non-punitive Response to Error
- Staffing.
- Hospital Management Support for Patient Safety
- Teamwork Across Hospital Units.
- Hospital Handoffs & Transitions.

The survey is administered every 2 years. Changes in distributions of scores for each domain are analyzed in the corresponding section. For data collected before the SG implementation, 390 valid responses for each question were available. In 2019, after SG implementation, the number of valid responses available for each ranged between 257 and 268.

Overall Perceptions of Safety

Table 5 shows the distribution within each year. For each question, a chi-square test was used to compare if the distribution of responses between 2017 and 2019 was statistically significant. There was a statistically significant change in distribution between 2017 and 2019 for questions Qa10 and Qa17. Through time, the proportions of staff members responding positively to these questions decreased. For Qa10 the proportion of positive responses went down from 43.3% to 34.4%. Similarly, for Qa17, the proportion of positive responses decreased from 35.6% to 25.2%. Because these questions were reverse-coded, these reductions represent favorable changes.

Table 3

*Within Year Distribution of Responses for Overall Perceptions of Safety Domain**

Qa15		Qa18		Qa10**		Qa17**	
2017	2019	2017	2019	2017	2019	2017	2019

Positive	53.8%	48.1%	59.2%	50.4%	43.3%	34.6%	35.6%	25.2%
Neutral	16.7%	16.2%	20.0%	25.6%	17.4%	25.2%	14.1%	19.5%
Negative	29.5%	35.7%	20.8%	24.4%	39.2%	40.2%	50.3%	55.3%

* Percentages represent within year proportions.
** Chi-square test was significant at 0.05 level.

Supervisor/Manager Expectations & Actions Promoting Patient Safety

At 0.05 level of significance, there were no changes in the distribution of responses for Qb11, Qb12, and Qb14 (Table 6). However, the change in Qb13 was statistically significant. This question was worded as follows "Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts." Positive responses to this question are indicative of the increased risk of patient safety. Therefore, the decrease from 60.5% in 2017 to 53.8% in 2019 represents an improvement in patient safety because staff members are less likely to take shortcuts.

Table 4

*Within Year Distributions of Responses for Supervisor/Manager Expectations and Actions Promoting Patient Safety Domain**

	Qb11		Qb12		Qb13**		Qb14	
	2017	2019	2017	2019	2017	2019	2017	2019
Positive	57.2%	57.1%	55.4%	57.1%	60.5%	53.8%	57.9%	57.1%
Neutral	15.1%	18.0%	15.1%	16.9%	19.2%	28.6%	16.7%	20.7%
Negative	27.7%	24.8%	29.5%	25.2%	20.3%	16.9%	25.4%	21.4%

* Percentages represent within year proportions.
** Chi-square test was significant at 0.05 level.

Staffing

There were statistically significant changes for distribution of responses for each question on this domain (Table 7). The Qa2 item was phrased as follows "We have enough staff to handle the workload." The percentage of responses on this subscale changed from

18.2% to 10.4% and the overwhelming majority of responses were negative. Items Qa5, Qa7, and Qa14 were reverse-coded which means that positive responses are not favorable to patient safety. For Qa5, the proportion of individuals responding negatively increased from 43.8% to 53.0% which indicates that the staff perceives that they work less of overtime. As indicated by the increase in the number of positive responses from 45.9% to 59.3% on Qa7, was unfavorable because it suggests that the organization has to rely on agency nurses more than necessary. There was also a reduction in a perception from 30.5% to 20.% that healthcare teams operated in a "crisis mode".

Table 5

*Within Year Distributions of Responses for Staffing Domain**

	Qa2**		Qa5**		Qa7**		Qa14**	
	2017	2019	2017	2019	2017	2019	2017	2019
Positive	18.2%	10.4%	34.4%	26.1%	45.9%	59.3%	30.5%	20.5%
Neutral	8.2%	9.3%	21.8%	20.5%	20.5%	25.0%	20.8%	20.9%
Negative	73.6%	80.2%	43.8%	53.0%	33.6%	14.9%	48.7%	58.6%

* Percentages represent within year proportions.
** Chi-square test was significant at 0.05 level.

Hospital Management Support for Patient Safety

Table 8 indicates that there were statistically significant improvements on Hospital Management Support for Patient Safety domain. These changes are not all favorable because the proportion of respondents who had positive perception that the management provided a work climate that promoted patient safety decreased from 60% in 2017 to 44% in 2019. Similarly, the proportion of respondents who had positive perception that the actions of the management prioritized patient safety decreased from 62% in 2017 to 49% in 2019. One the other hand, lower proportion of respondents (32% in 2019 vs. 46% in 2017) believed that

management was focused on patient safety only after an adverse event.

Table 6

*Within Year Distributions of Response Hospital Management Support for Patient Safety Domain**

Table 3

HCAHPS Survey Scores for Emergency Department

	Preimplementation			Postimplementation				
				M	*SD*	*n*		*M*
Nurses overall	76.5	26.5	139	73.8	26.9	81	-0.72	0.24
Nurses courtesy	78.6	27.5	138	75.3	28.9	81	-0.83	0.20
Nurse took time to listen	77.7	26.7	137	75.0	28.7	80	-0.69	0.25
Nurses attention to your needs	75.9	29.0	137	74.7	28.9	78	-0.29	0.39
Nurses informative re treatments	74.8	28.5	134	70.3	29.5	80	-1.09	0.14
Nurses concern for privacy	75.4	28.0	133	76.0	24.3	78	0.16	0.56

	Qf1**		Qf8**		Qf9**	
	2017	2019	2017	2019	2017	2019
Positive	60.0%	43.6%	61.5%	49.2%	45.9%	31.8%
Neutral	16.9%	20.1%	16.7%	19.7%	13.3%	21.2%
Negative	23.1%	36.4%	21.8%	30.7%	40.8%	45.8%

* Percentages represent within year proportions.
** Chi-square test was significant at 0.05 level.

Non-punitive Response to Error

The changes on Qa8 item suggest that the staff was less likely to perceive that their errors were held against them. In 2017, 30.3% of staff members thought that the management was holding them accountable for their mistake. In 2019, the proportion decreased to 26.3%. Change on items Qa12 and Qa16 were not significant at 0.05 level.

Table 7

Within Year Distributions of Response for Nonpunitive Response to Error

Table 3

HCAHPS Survey Scores for Emergency Department

	Preimplementation			Postimplementation				
				M	*SD*	*n*		*M*
Nurses overall	76.5	26.5	139	73.8	26.9	81	-0.72	0.24
Nurses courtesy	78.6	27.5	138	75.3	28.9	81	-0.83	0.20
Nurse took time to listen	77.7	26.7	137	75.0	28.7	80	-0.69	0.25
Nurses attention to your needs	75.9	29.0	137	74.7	28.9	78	-0.29	0.39
Nurses informative re treatments	74.8	28.5	134	70.3	29.5	80	-1.09	0.14
Nurses concern for privacy	75.4	28.0	133	76.0	24.3	78	0.16	0.56

	Qa8**		Qa12		Qa16	
	2017	2019	2017	2019	2017	2019
Positive	30.3%	26.3%	29.7%	26.3%	21.3%	17.3%
Neutral	19.7%	30.5%	20.5%	27.8%	23.3%	30.5%
Negative	50.0%	43.2%	49.7%	45.9%	55.4%	51.9%

* Chi-square test was significant at 0.05 level.

Patient Safety Domains with No Changes between 2017 and 2019

There was no statistically significant change on seven out of twelve domains of patient safety. Even though there were no notable changes on these domains, they all had a significant proportion of unfavorable responses, which indicates that a significant potential for improvement exists.

Table 8

Summary of the Analysis in Patient Safety

Patient safety domain	Changed?	Comments
Overall perceptions of safety	Yes	Favorable change. In 2019, respondents indicated that serious errors were less likely to occur and safety issues were less of a problem
Frequency of events reported	No	

Manager expectations & actions promoting patient safety	Yes	Favorable change. Respondents perceived that there was less pressure to take safety critical shortcuts.
Organizational learning - continuous improvement	No	
Teamwork within units	No	
Communication openness	No	
Feedback and communication about error	No	
Nonpunitive response to error	Yes	Lower proportion of respondents felt that staff errors were held against them.
Staffing	Yes	The proportion of staff members who felt they had enough staff to hand workload decreased from 18.2% to 10.4%. Agency nurses had to be used often. "Crisis mode" operations decreased from 2017 to 2019
Hospital management support for patient safety	Yes	In 2019, the lower percentage of staff believed that the management was serious about patient safety.
Teamwork across hospital units	No	
Hospital handoffs & transitions	No	

Summary

The analysis suggests that between the pre-implementation and post-implementation periods, there were no changes in patient satisfaction or nurse turnover. Due to the small sample size, these findings should be deemed as inconclusive (Polit & Beck, 2017). Also, over the analyzed period, the organization underwent many changes related to the implementation of the SG initiative. Because of the multitude of changes, it is not possible to attribute the observed outcomes or lack thereof to any particular factor (Polit & Beck, 2017). Table 10 summarizes the culture of safety survey results. Statistically significant changes

were detected only on five out of twelve domains of patient safety. The most notable changes occurred on Staffing and Hospital Management Support for Patient Safety domains. All items on these domains changed between 2017 and 2019. Changes were largely favorable as respondents were less inclined to report concerns with patient safety. Respondents' perception that the management was concerned about patient safety also changed in an unfavorable direction. Additionally, respondents were less likely to believe that errors were held against staff members who committed them. Significantly, respondents perceived that staff shortages were a problem, but on the other hand, respondents reported that staff was required to work longer hours.

Recommendations

Based on the review of the evidence, several recommendations were made to nursing administration. Nurse satisfaction with shared governance data should be collected more frequently and reported by service categories and units. The 88-item Index of Professional Nursing Governance (IPNG) should be used to assesses perceptions of nurses of the extent to which the SG culture was implemented in the organization. The INPG is a survey instrument that measures the professional nursing governance of hospital-based nurses. The IPNG has demonstrated excellent validity and reliability throughout its development... Since the initial development, the IPNG has been used by numerous nurse administrators and researchers to validate hospital SG models and pinpoint areas for intervention (Hess, 1998). This tool assesses six dimensions of SG that include participation, control over professional practice, professional practice support and resources, access to information, control over staff, and conflict resolution.

The experience of this project revealed that turnover data was difficult to access and

special efforts required to generate easy-to-understand turnover reports. Because of these difficulties, nurse executives may not have good visibility into workforce turnover and the reasons behind it. As a result, their ability to make appropriate and timely decisions may be severely impaired. Accordingly, it is important to streamline turnover data collection and availability. For example, the IT department may be asked to design a database query and reports about staff turnover and make this data available on an appropriate performance dashboard.

Similarly, the availability of patient satisfaction data for inpatient stays is very limited. In 2019 satisfaction data for only 12 patients were collected. This is not sufficient for making decisions that address patients' concerns in a timely manner. For this reason, it is critical to increasing the frequency of collection of data on patient satisfaction. Finally, the organization must begin the collection of IPNG and NWSQ data to obtain better visibility into the implementation of the SG initiative.

It is also recommended to establish an outcome review committee that meets every two weeks to evaluate outcomes, identify root causes of inadequate outcomes, and propose steps to remediate problems. One of the functions of the committee should be establishing and maintaining a performance dashboard with all relevant outcomes. The dashboard may be updated from time to time to reflect the changing needs of the organization and its leadership.

The data also suggests that there were decreases in patient satisfaction with nursing care at the emergency department. These decreases should be investigated to identify the causes of patient dissatisfaction and implement remedial actions to ensure that patient satisfaction scores stay high. Data collection forms should include additional fields where patients can provide reasons for giving a particular score.

Contribution of the Doctoral Project Team

This project was made possible by the participation of several individuals. Specifically, the director of the nursing services allowed me to gain access to the necessary data to complete the project. A human resource director provided access to staff turnover data. A hospital IT specialist assisted in accessing organizational systems to collect patient and nurse satisfaction data. In addition, there were multiple consultations with nurses and executives who assisted in data collection and provided invaluable input for the project.

Strengths and Limitations of the Project

The practice question is: Will the implementation of the SG model on children's health services in an acute care hospital demonstrate improvements in nurse satisfaction, nurse retention/turnover, and patient satisfaction? Although data was not as robust as expected, a major strength of this project was the identification of the need to review and revise data collection methods and availability on nurse and patient satisfaction.

One significant limitation is that the project utilized a pre-test/post-test non-experimental design (Polit & Beck, 2017). As a result, the internal validity of the project is subpar. Despite expectations that patient satisfaction would increase following the implementation of the SG, the opposite was observed. It is difficult to interpret this finding because many factors unrelated to SG could have affected patient satisfaction. For example, low staffing levels or higher than expected patient inflow could have affected the outcomes. It was also problematic that individual-level patient data was no available for the analysis.

Another limitation is that IPNG and NSWQ scores were unavailable. Without IPNG and NSWQ scores, it is not possible to determine whether SG became rooted in the organizational culture or additional SG promoting interventions are necessary. If the latter is

true, then the interpretation of other changes needs to be adjusted. Similarly, NSWQ scores would have provided additional insight into the organizational climate.

In addition to the above-mentioned issues, it was not possible to make meaningful comparisons between patient satisfaction scores for inpatient stays due to the extremely low sample sizes. Similarly, sample sizes for staff turnover data were also limited to enable robust analysis of workforce outcomes.

Section 5: Dissemination Plan

Multiple venues will be utilized for the dissemination of the project and include verbal, written, and mixed approaches. Colleagues in the hospital and health system will be verbally informed about the project and encouraged to read this manuscript. In addition, I will organize a formal presentation where I will describe the project in detail and answer questions from participants. This presentation will be video recorded and made available for online viewing by publishing it on an online video platform, such as YouTube. In addition, I hope to deliver the presentation at nursing conferences. Finally, I plan to submit an article about the project to a peer-reviewed nursing journal.

Analysis of Self

I was fortunate to have had an opportunity to participate in the implementation of the SG initiative that unfolded over several years at a hospital that is a part of a larger healthcare system. As a nurse leader, I had a vested interest in the success of her department and the overall success of the entire hospital. Over this period, significant changes have occurred within the organization. I personally had a chance to discuss SG with staff nurses and learn from them. These discussions enabled me to earn trust, respect, and support from the team and learn how to identify opportunities for improvement. In turn, my ability to lead and motivate staff has increased tremendously.

Competencies described by the Essentials of Doctoral Education for Advanced Nursing Practice were also exercised by the author of this project. American Association of Colleges of Nursing's (AACN) Essential I describes the scientific underpinnings of nursing practice and requires that nursing practices be based on scientific principles, or evidence obtained using the scientific method. I developed and exercised competencies

delineated in Essential I by applying the scientific method and proven theories to facilitate quality improvement (AACN, 2006).

Competencies included in Essential II include systems thinking, organizational policy, and leadership (AACN, 2006). There was an ample opportunity to exercise these competencies during the implementation of SG. I interacted with the staff, participated in meetings, and, in collaboration with stakeholders, developed solutions at micro, meso, and macro levels.

As outlined in the Essential III, I applied evidence-based principles and analytical methods when implanting the project and evaluating outcomes (AACN, 2006). All action steps taken in this project were based on the published evidence and incorporated into the evidence translation model. Outcomes were selected for tracking based on a review of research supporting that these outcomes may be affected by the SG practices.

Interprofessional collaboration competencies (Essential VI) played a central role in this project (AACN, 2006). If SG is to be summarized, then it is all about collaboration. Without collaboration, SG is not possible. To a large extent, mastering effective collaboration strategies was a significant component of SG implementation. The author had many opportunities to develop and follow collaborative processes, manage conflicts, build relationships, and to find common ground with diverse groups of stakeholders. These activities provided an invaluable hands-on experience for managing nursing teams.

As outlined by Essential VIII, I had the opportunity to mentor junior nurses to assist them in achieving a high level of excellence in their nursing practice (AACN, 2006). At the same time, the author was able to learn from senior colleagues by observing

them role-modeling effective mentorship and leadership practices. These observations were very effective in helping the author to understand what it takes to be an effective mentor.

Summary

This DNP project explored how SG affected staff turnover, patient satisfaction, and nurse job satisfaction. Although no definite conclusion can be made about the impact of SG on these outcomes, this project highlights the practical challenges that accompany large projects. It also discovers new opportunities for improvement. For example, in addition to its main purpose, the project identified significant gaps in patient satisfaction data. Liquidation of these gaps will further strengthen the healthcare organization on its path towards quality improvements.

In Section 5, describe the plan to disseminate this work to the institution experiencing the problem in practice. Include the following subsections:

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Appendix: Culture of Safety Survey

Overall Perceptions of Safety

1) Qa15. Patient safety is never sacrificed to get more work done.
2) Qa18. Our procedures and systems are good at preventing errors from happening.
3) Qa10 It is just by chance that more serious mistakes don't happen around here (R).
4) Qa17 We have patient safety problems in this work area/department/unit (R).

Frequency of Events Reported

1) Qd11. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
2) Qd12. When a mistake is made but has no potential to harm the patient, how often is this reported?
3) Qd13. When a mistake is made that could harm the patient. but does not, how often is this reported?

Manager Expectations & Actions Promoting Patient Safety

1) Qb11. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
2) Qb12. My supervisor/manager seriously considers staff suggestions for improving patient safety.
3) Qb13. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts (R)
4) Qb14 My supervisor/manager overlooks patient safety problems that happen over and over (R)

Organizational Learning - Continuous Improvement

1) Qa6. We are actively doing things to improve patient safety
2) Qa9. Mistakes have led to positive changes here
3) Qa13. After we make changes to improve patient safety, we evaluate their effectiveness.

Teamwork Within Units

1) Qa1. People support one another in this work area/department/unit
2) Qa3. When a lot of work needs to be done quickly, we work together as a team to get the work done
3) Qa4 In this work area/department/unit, people treat each other with respect.
4) Qa11 When one area in this work area/department/unit gets really busy, others help out.

Communication Openness

1) Qc12. Staff will freely speak up if they see something that may negatively affect patient care
2) Qc14 Staff feel free to question the decisions or actions of those with more authority

3) Qc16. Staff are afraid to ask a question when something does not seem right (R)

Feedback and Communication About Error

1) Qc11 We are given feedback about changes put into place based on event reports

2) Qc13. We are informed about errors that happen in this work area/department/unit

3) Qc15. In this work area/department/unit, we discuss ways to prevent errors from happening again

Non-punitive Response to Error

1) Qa8. Staff feels like their mistakes are held against them (R)

2) Qa12. When an event is reported, it feels like the person is being written up, not the problem (R).

3) Qa16. Staff worry that mistakes they make are kept in their personnel file (R) staffing.

Hospital Management Support for Patient Safety

1) Qa2. We have enough staff to handle the workload

2) Qa5. Staff in this work area/department/unit work longer hours than is best for patient care (R)

3) Qa7. We use more agency/temporary staff than is best for patient care (R)

4) Qa14. We work in "crisis mode" trying to do too much, too quickly (R)

Teamwork Across Hospital Units

Teamwork Across Hospital Units

1) Qf4. There is good cooperation among facility work areas/departments/units that need to work together

2) Qf10. Facility work areas/departments/units work well together to provide the best care for patients

3) Qf2. Departments/work areas/units do not coordinate well with each other (R)

4) Qf6. it is often unpleasant to work with staff from other work areas/departments/units (R)

Hospital Handoffs & Transitions

1) Qf3 Things "fall between the cracks" when transferring patients from one work area/department/unit to another (R)

2) Qf5. Important patient care information is often lost during shift changes (R)

3) Of7. Problems often occur in the exchange of information across facility work areas/departments/units(R)

4) Qf11. Shift changes are problematic for patients in this facility (R)

3) Qc16. Staff are afraid to ask a question when something does not seem right (R)

Feedback and Communication About Error

1) Qc11 We are given feedback about changes put into place based on event reports

2) Qc13. We are informed about errors that happen in this work area/department/unit

3) Qc15. In this work area/department/unit, we discuss ways to prevent errors from happening again

Non-punitive Response to Error

1) Qa8. Staff feels like their mistakes are held against them (R)

2) Qa12. When an event is reported, it feels like the person is being written up, not the problem (R).

3) Qa16. Staff worry that mistakes they make are kept in their personnel file (R) staffing.

Hospital Management Support for Patient Safety

1) Qa2. We have enough staff to handle the workload

2) Qa5. Staff in this work area/department/unit work longer hours than is best for patient care (R)

3) Qa7. We use more agency/temporary staff than is best for patient care (R)

4) Qa14. We work in "crisis mode" trying to do too much, too quickly (R)

Teamwork Across Hospital Units

Teamwork Across Hospital Units

1) Qf4. There is good cooperation among facility work areas/departments/units that need to work together

2) Qf10. Facility work areas/departments/units work well together to provide the best care for patients

3) Qf2. Departments/work areas/units do not coordinate well with each other (R)

4) Qf6. it is often unpleasant to work with staff from other work areas/departments/units (R)

Hospital Handoffs & Transitions

1) Qf3 Things "fall between the cracks" when transferring patients from one work area/department/unit to another (R)

2) Qf5. Important patient care information is often lost during shift changes (R)

3) Of7. Problems often occur in the exchange of information across facility work areas/departments/units(R)

4) Qf11. Shift changes are problematic for patients in this facility (R)