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The Impact of Shared Governance on Nursing Satisfaction and Retention

Melanie Wetmore
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Melanie Wetmore

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Review Committee
Dr. Linda Matheson, Committee Chairperson, Nursing Faculty
Dr. Mattie Burton, Committee Member, Nursing Faculty
Dr. Mirella Brooks, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

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Abstract

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Melanie Wetmore

MSN, Jacksonville University, 2013

BSN, State University of New York College at Brockport, 1995

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Shared governance is a practice model that supports shared decision making between direct care nurses and their leaders. Developed from Kanter's theory of structural empowerment, shared governance allows employees to influence decisions made in an organization. Shared governance has been shown to increase nursing satisfaction, positively impact outcomes, and reduce nursing turnover. The purpose of this project was to examine the relationship between implementation of a system-wide, multihospital shared governance structure and registered nurse (RN) satisfaction, turnover, and perceptions of shared governance. The 3 sources of evidence used in the study were 2016-2017 organizational RN engagement survey results, 2016-2017 organizational RN turnover data, and RN perceptions of shared governance as measured by the Index of Professional Nursing Governance (IPNG) tool. Two similar hospitals within the system were selected for administration of the IPNG survey. Results showed that introduction of a multihospital shared governance structure had an impact on nursing turnover. The biggest change was in new nurse turnover, which reduced from a high of 32.10% to 27.30%. This 4.8% decrease translated in approximately $2 million in savings. A comparison of IPNG survey results showed that the hospital with lower turnover had higher perceptions of shared governance. The potential implications of these finding for social change could be an expansion of shared governance in the organization and social change in the region. Due to the relationship between shared governance and improved patient outcomes, a reduction in mortality and improvement in overall health could be seen for the 1 million patients served in these hospitals.

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Section 1: Introduction

Introduction

Shared governance is a practice model that guides organizational nursing care delivery and professional development (Allen-Gilliam et al., 2016). It empowers the staff closest to the bedside and places them in the role of key decision maker in their own professional practice. Nursing organizations that incorporate principals of shared governance have been shown to impact both nursing and patient focused indicators (Allen-Gilliam et al., 2016). Shared decision making between front line clinical staff and nursing administrators is a hallmark of the American Nurses Credentialing Center's (ANCC) (2014) Magnet Recognition Program, which recognizes organizations for nursing excellence.

Shared governance has been studied in nursing research for over 32 years (Allen-Gilliam et al., 2016). A significant body of knowledge exists to support its use to guide nursing practice in a single hospital setting. Successful implementation of a shared governance structure has been shown to increase employee engagement, increase patient satisfaction, decrease registered nurse (RN) turnover, and improve patient outcomes (Allen-Gilliam et al., 2016). Despite this extensive research, little to no data is available on multihospital system shared governance structures and their impact on RN turnover and satisfaction.

Problem Statement

The focus of this doctoral project was to examine the relationship between implementation of a system wide, multihospital shared governance structure and RN

turnover and satisfaction. Nursing turnover can directly affect organizational ability to drive quality improvement and financial performance (Nursing Solutions, Inc., 2017). The financial implications of turnover can range from $38,900 to $59,700 per RN (Nursing Solutions, Inc., 2017). Each percent reduction in RN turnover can save the average hospital $410,500 per year (Nursing Solutions, Inc., 2017). The current national RN turnover rate for all bedside nurses is 14.6%, and 12.6% if the population is limited to just full time (FT) and part time (PT) nurses (Nursing Solutions, Inc., 2017). Significant variations in rate exist depending upon hospital size, geographic location, specialty, and for-profit status (Nursing Solutions, Inc., 2017). The 16-hospital health system involved in this project is a for-profit system located in the southeastern United States with a range of hospital bed capacity of 100 to 420 beds. Due to its for-profit status and geographical location, the average expected RN turnover rate for this health system should range from 18.8%, for hospitals that have 200-349 beds, to 22.6%, for those hospitals that have 350-420 beds, as shown in Table 1(Nursing Solutions, Inc., 2017). This system's average nursing turnover in January of 2017 was 22.3%, with hospitals within that system that ranged from 17% to 35.3%. The average rate for RN's in their first year of employment was 32.10% and ranged from 16.50% to 55.90% for individual hospitals.

Table 1

Adjusted Turnover Rates

Characteristic	FT/PT RN Turnover Rate (+/- over national average of 12.6%)	Expected Turnover Rate per bed capacity
South East United States	13.9% (+1.3%)	
For-Profit Acute Care	19.1% (+6.5%)	
< 200 Beds	12.9% (+0.3%)	20.7%
200-349 beds	11.0% (- 1.6%)	18.8%
350-500	14.8% (+2.2%)	22.6%

Note. Nursing Solutions, Inc. (2017). 2017 National Healthcare Retention and RN Staffing Report. *NSI Nursing Solutions, Inc.*

In addition to the salary, recruitment, and orientation costs, turnover also impacts quality of care and patient outcomes (Bae, Mark, & Fried, 2010). A consistent staffing workforce has the ability to maintain more efficient workgroup processes and learning. Workgroup processes are those functions that influence the performance of a group, such as cohesion, communication, and group relationships (Bae, Mark, & Fried, 2010). Workgroup learning refers to the knowledge of a group and the ability of the group to share experiences and maintain knowledge (Bae, Mark, & Fried, 2010). In a study of 268 nursing units at 141 hospitals, nursing units with higher turnover had lower levels of workgroup learning and workgroup processes (Bae, Mark, & Fried, 2010). This translated into higher patient falls, lower patient satisfaction scores, and an increase in severe medication events (Bae, Mark, & Fried, 2010). This impact on patient outcomes, makes managing nursing turnover, by focusing on retention, a key organizational priority.

An important aspect of an organizational nursing retention strategy is to examine the key factors that influence nursing turnover. In a longitudinal study of 1,653 newly

licensed nurses, Brewer-Kovner's synthesis model of direct turnover was used to examine predictors of turnover within five categories (Brewer, Kovner, Greene, Cheng, 2009). The five categories were (a) personal characteristics, (b) work attributes and attitudes, (c) job opportunities, (d) work attitudes, and (e) shocks (Brewer, Kovner, Greene, Cheng, 2009). Shocks were positive or negative events that caused a person to leave their position, such as injuries, pregnancy, and workplace violence (Brewer, Kovner, Greene, Cheng, 2009). Within these categories, the variables that resulted in more turnover were: low job satisfaction, low organizational commitment, full time employment status, and workplace injuries. (Brewer, Kovner, Greene, Tukov-Shuser & Djukic, 2011).

Organizations willing to invest in strategies to reduce RN turnover can positively affect the quality of care they provide their patients. In addition, managing turnover can influence an organization's financial viability. Development of shared governance structures that allow RN's to manage their own professional practice can be an important piece of those strategies (Kutney-Lee et al., 2016). The focus of my doctoral project was to determine if implementation of a system wide, multihospital shared governance structure can impact RN turnover and satisfaction at a system level

Purpose

The purpose of this project was to examine the relationship between implementation of a system wide, multihospital shared governance structure and RN turnover, satisfaction, and perception of shared governance. The need to drive organizational performance and nursing retention has made shared governance a priority

for this doctoral project practice setting. This prioritization spurred systematic implementation of hospital wide professional practice councils for each of its 16 area hospitals. Due to the nonuniform implementation of shared governance at each of the facilities in this system, a prescriptive structure was applied that included focus specific councils, service line councils, hospital nurse executive councils, and division nurse executive councils. The structure has been in place since February 2017 and has required substantive human and financial capital to implement and sustain.

Nature of the Doctoral Project

The three sources of evidence that were collected to meet the intent of this doctoral project were RN turnover data, nursing perception of shared governance, and specific RN engagement survey question results for all RN's in the 16-hospital system. Turnover data was measured by utilizing a standard rolling 12-month percentage of FT and PT RN's. Turnover data is calculated by utilizing the following ratio:

$$\frac{\text{RN (Terminations + Resignations) x100}}{\text{Total employed RNs}}$$

Monthly overall turnover rate was trended and compared to the same time period, year to year. This resulted in a comparison of 2016 turnover rates to 2017 turnover. In order to help determine if turnover data was related to shared governance, nursing perception of shared governance was measured and compared at two hospitals within the system. Turnover data was utilized to determine the selected hospitals.

This health care system utilizes an annual engagement survey to measure employee engagement. Two specific survey questions will measure the impact of shared governance and compare 2016 results to 2017. The following questions chosen were

selected based on their relevance to the topic of shared decision making: “sufficient effort is made to get the opinions and thoughts of the people who work here,” and “I am satisfied with the amount of voice I had in the decisions that affect my work.” A year-over-year comparison of performance on these two questions was analyzed using RN-only results. Improvement was considered significant if it met the tools +/- 4% change threshold. In 2016, 59% of surveyed RN’s indicated that sufficient effort was made to get the opinions and thoughts of the people who work here and 52% were satisfied with the amount of voice they had in the decisions that affect their work. This was lower than the company-wide scores on these two questions of 71% and 74%, respectively.

The implementation date for standardization of shared governance was February 2017. As a result, the data comparison was between 2016 data and 2017 data. The anticipated findings were a year-over-year reduction in RN turnover, higher perceptions of shared governance when nursing turnover is reduced, and an improvement on the two employee engagement survey questions. Implementation of a shared governance model requires a significant shift in an organization’s culture (Hess, 2011). Hess (2011) suggested that a period of 3-5 years is required to complete the transition. This doctoral project focused on the first year of the transition.

Significance

Successful transition of a multihospital system to a shared decision-making model of nursing practice can affect patients, staff, and hospitals. This large hospital system in the southeastern United States is one of 12 divisions within a much larger company. This 16-hospital system has over 4,000 licensed beds and treated 1.2 million patients in 2016.

With almost 19,000 employees, it is one of the largest employers in the state and its economic contribution is over $2 billion dollars. A reduction in RN turnover in this health system would have a positive effect on the RN turnover in the region, as well as a positive impact on the finances of the organization. If turnover decreased from 23.6% to the national average of 12.6%, this could be over a 4.5 million-dollar savings for this system (Nursing Solutions, Inc., 2017). In addition, as one of the first divisions to roll out shared governance on a more global level, successful implementation could mean implementation in the other 12 divisions.

The social significance of enacting shared governance is in its impact on patient satisfaction and outcomes, as well as nursing engagement and turnover. Kutney-Lee et al. (2016) surveyed 20,674 RN's working in 425 hospitals over a 1-year period to evaluate the impact of shared governance on nursing satisfaction and patients. They compared engagement in shared governance to nursing burnout, job dissatisfaction, perception of nursing quality, intention of leaving their job, perception of nursing leadership, and performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (Kutney-Lee et al., 2016). Organizations where nursing engagement in shared governance was highest had the most favorable outcomes in each category (Kutney-Lee et al., 2016). Nurses who reported being the most engaged, versus moderately engaged, in shared governance were 36% less likely to report high burnout, 42% less likely to have high levels of dissatisfaction with their job, and 34% less likely to have intention of leaving their position within 1 year (Kutney-Lee et al., 2016). Hospitals

that support shared decision making with bedside caregivers, have the ability to impact nursing and patient satisfaction as well as patient outcomes.

Summary

Nursing turnover can have significant financial and quality implications for an organization (Bae, Mark, & Fried, 2010). Successful implementation of shared governance had a positive influence on nursing turnover and engagement (Kutney-Lee et al., 2016). This doctoral project focused on the relationship between a system-wide implementation of shared governance, and its impact on overall turnover and performance on two engagement survey questions. The anticipated findings of the project were a reduction in year-over-year turnover and a meaningful increase (i.e. >4%) in performance on the engagement questions related to voice.

Section 2: Background and Context

Introduction

To better comprehend the relationship between implementation of a system-wide shared governance structure and nursing turnover and engagement, it is necessary to delve into the background and context of shared governance. This section is a review of the following topics: concepts, models, and theories; relevance to nursing practice; local background and context; and the role of the DNP student.

Concepts, Models, and Theories

Shared governance has its basis in a sociological theory by Kanter. First introduced in 1977, and revised in 1993, Kanter's theory of structural empowerment indicated that an employee's work environment influences their behavior and level of engagement (Kanter, 1993). In Kanter's theory, workers are more likely to accomplish goals if they have access to power and opportunity structures (Kanter, 1993). Power structures come from the ability to access information, support, and resources that make a task more meaningful (Kanter, 1993). Power can be either formal or informal. Formal power occurs when an employee holds a leadership position (Kanter, 1993). Informal power exists when an employee is able to influence the decisions made in an organization despite not holding a formal leadership position (Kanter, 1993). An example of this influence, in the organizations model of shared governance, is involvement in facility and unit based councils. Opportunity structures refer to an individual's personal opportunity to learn and grow within their profession (Kanter, 1993). These accesses to power and opportunity structures that support employees can empower and make their work more

meaningful (Kanter, 1993). Other similarities with the hospitals shared governance model is employee involvement with policy and protocol development that directly impacts their nursing workflow. As empowerment increases so does employee engagement and retention (Kanter, 1993). If employees lack empowerment, Kanter purposed that productivity and engagement suffer (Kanter, 1993). The principals of Kanter's theory indicate that, as nurses have more governance in their professional practice through involvement in hospital councils, their roles as leaders and feelings of empowerment will grow (Kanter, 1993).

Porter, O'Grady, and Finnegan (1984) first introduced shared governance in nursing. They identified the importance of involving bedside nurses in decision-making related to nursing professional practice (Porter, O'Grady, & Finnegan, 1984). They proposed a flat nursing structure where those nurses closest to the patient held both formal and informal leadership positions on hospital committees (Porter, O'Grady, & Finnegan, 1984). Shared governance through structural empowerment is a key component of the Magnet Model outlined by the American Nurse Credentialing Center (ANCC, 2014). The Magnet Model provides a framework for hospitals and organizations pursuing advancement to Magnet Recognition (ANCC, 2014). The model contains five components: (a) transformational leadership; (b) structural empowerment; (c) exemplary professional practice; (d) new knowledge, innovations, and improvement; and (e) empirical quality results (ANCC, 2014). For the purpose of this doctoral project, the area of focus within the Magnet Model was structural empowerment. Structural empowerment is the use of shared governance to foster shared decision making and support bedside

nurses in their role as key decision maker (ANCC, 2014). The implementation of shared governance within this multihospital system was guided by the principals of structural empowerment in the Magnet Model (ANCC, 2014).

Differences in the use of terms in the literature require a clarification as to their meaning and usage in this doctoral project. The following terms require additional explanation: decision making, shared decision -making, and shared governance. In addition, as several organizations define nursing turnover and engagement differently, these terms also require clarification.

Decision Making

Decision making is the participative process in which a course of action is decided upon (Allen-Gilliam et al. 2016). In shared governance, processes are in place that allow bedside nurses to access information and resources (Hess, 2011). This access enables them to make evidence-based decisions regarding clinical practice concerns and increases their direct control over their practice environment (Hess, 2011).

Shared Decision Making

Shared decision making is when nurses are partners with leaders in the development of policies that guide clinical practice decisions (Gallagher-Ford, 2015). This staff-leader partnership ultimately promotes accountability for improving organizational quality and outcomes (Gallagher-Ford, 2015). The leader's role in shared decision making is to release authority and ensure that staff maintains an adequate level of understanding to make an informed decision (Gallagher-Ford, 2015). Shared decision

making requires a shift in organizational culture from leaders and a commitment from nurses to be involved in the decision-making process (Ballard, 2010).

Shared Governance.

Shared governance is a nursing practice model based on the foundational principals of collaboration, empowerment, equity, accountability, and ownership (Porter-O'Grady, 2012). Organizations that practice shared governance make nurses accountable for their own professional practice and quality outcomes (Anderson, 2011). In addition, they recognize the importance of the bedside nurse's role as key decision maker in advancing their profession practice environment (Anderson, 2011). The structural framework that supports the shared governance model in this doctoral project consists of unit-based councils, facility topic focused councils (practice standards, professional development, caring practice, and clinical informatics) facility nurse executive council, multihospital nurse executive council, and service line councils (i.e. critical care, ER, etc.).

Nursing Turnover

Nursing turnover occurs in an organization when a nurse leaves a full time or part time position (Nursing Solutions, Inc., 2017).. Turnover can be either voluntarily or involuntary. Voluntary turnover occurs when a nurse seeks out an opportunity at another organization (Nursing Solutions, Inc., 2017). Involuntary turnover occurs when a nurse is terminated for not meeting the requirements of their position (Nursing Solutions, Inc., 2017). As a differentiator, first year turnover refers to those employees that terminated employment within 1 year of their hire date (Nursing Solutions, Inc., 2017). For the

purpose of this doctoral project, nursing turnover will include both voluntary and involuntary terminations.

Nursing Engagement

Nursing engagement is the level to which nurses are satisfied with their practice environment (Dempsey & Reily, 2016). Organizational nursing engagement can be directly correlated with nursing turnover and patient outcomes (Dempsey & Reily, 2016). The doctoral project setting uses the TNS Employee Insights survey to measure engagement. In this survey, the questions focused on the amount of voice an employee has have been utilized to examine the impact of shared governance.

Relevance to Nursing Practice

Nursing turnover is a worldwide concern with several countries reporting RN turnover rates in the moderate (12-21%) to high (22-44%) ranges (Li & Jones, 2013). In the United States, nursing turnover rates experienced their first year-over-year decline in several years in 2016 from 15.8% to 12.6% (Nursing Solutions, Inc., 2017). Despite this decline, many hospitals and health systems continue to struggle with turnover and identify RN retention as a key strategic initiative to advance their organizations quality and financial agendas (Nursing Solutions, Inc., 2017). Average nursing turnover for this system in January 2017 was 22.3% and ranged from 17-35.3% within individual hospitals. Due to the high turnover within the doctoral student's home organization, shared governance was instituted in February 2017 as a means of increasing RN engagement and advancing the nursing agenda.

Shared governance is a recognized best practice by multiple organizations and is a well-supported practice in nursing research (ANCC, 2014). The Institute of Medicine's 2004 report, outlined the importance of giving bedside nurses control over their clinical practice through involving them in decisions at all levels of the organization. This nonhierarchical approach to decision-making is a key approach to improving patient safety (IOM, 2004). This report was followed by a second report, which outlined the importance of nurses having an active role in redesigning health care systems and being prepared to become future leaders in health care (IOM, 2011). In addition to the ANCC's Magnet Model, the American Association of Critical Care Nurses (AACN) endorses shared governance by recognizing its role in efficient decision making (AACN, 2009). Efficient decision making is when nurses partner with organizational leadership to advance their practice through the development of policies and the evaluation of nursing practice (AACN, 2009).

The key concepts noted in the nursing literature review for this doctoral project can be divided into two categories; those that examine the measurement of governance as a means of determining effectiveness, and those that examine specific outcomes. A tool for measuring perception of shared governance was first introduced in the literature in the late 1990s (Hess, 1998). Hess (1998) validated the use of the Index of Professional Nursing Governance (IPNG) to examine bedside nurse's perception of shared decision making. This 86-item survey provides a measurement of overall perception of governance and six subscales which represent the dimensions of governance (Hess, 1998). These dimensions are control over people or personnel, access to information that

relates to governance, resources that support professional practice, participation in committees, control over professional practice, and goal setting and the resolution of conflict (Hess, 1998). Using the IPNG, organizations can validate their progress away from traditional decision-making structures towards shared governance structures (Hess, 2010).

Following its original introduction, the IPNG has been used in multiple studies to measure shared governance. Nurses in Magnet hospitals where shared governance was well established have been noted to score higher on overall perception of shared governance than their non-Magnet counterparts (Anderson, 2011). In addition, the IPNG has also been utilized to measure the significant relationship between shared governance and nursing empowerment (Barden, Griffin, Donahue, & Fitzpatrick, 2011). The IPNG has also been a useful tool in measuring perceptions of governance pre-and post-implementation of a shared governance model (Anderson, 2011; Hess, 2011). Due to the previous nonuniform implementation of shared governance at each of the facilities in the doctoral project system, I elected to use the IPNG tool post implementation to compare two hospitals within the system.

Implementation of shared governance as a tool to increase RN engagement and satisfaction is largely reliant on the premise that increasing the decision making of nurses increases their level of satisfaction, and those with increased job satisfaction are less likely to leave their organization (Allen-Gilliam et al., 2016). Allen-Gilliam et al. (2016) followed the impact of shared governance implementation at a community hospital over a period of 5 years. Using the Magnet Model as their study's theoretical framework, the

researchers focused on the five components of the model to advance the professional practice environment at their hospital (Allen-Gilliam et al., 2016). Outcomes were measured through a 219-question survey that contained five instruments. The five instruments were the Nursing Work Index-Revised (NWI-R) for measuring the nurse practice environment, the Shared Governance Survey that measured nurse empowerment, the Index of Work Satisfaction (IWS)-1997 Revision, the Work Practice Breakdown survey, which looked at practice errors, and the Developing Evidence-Based Practice survey for measuring evidence-based practice (Allen-Gilliam et al., 2016). During the 5-year time frame, the organization showed year-over-year improvement for the first 4 years in the respondent nurse's perceptions of: nursing leadership, nurse empowerment, nurse satisfaction, and the professional practice environment (Allen-Gilliam et al., 2016). Year 5 results were impacted by an organizational change, which caused a significant turnover in nursing staff, which affected the progress of all measures (Allen-Gilliam et al., 2016). The year-over-year improvement in nursing indicators in this study supports the importance of measuring engagement post shared governance implementation (Allen-Gilliam et al., 2016). In addition, it underlined the connection between shared decision making and engagement that supports my doctoral project of measuring engagement 1 year following shared governance implementation.

Predictors of nursing turnover include perceptions and satisfaction with the nursing environment, perceived job opportunities outside of the organization, and personal characteristics (Brewer et al., 2011). Nurses who report high levels of job

satisfaction have higher levels of organizational commitment and are less likely to seek out opportunities outside of their organization (Price, 2004).

In order for shared governance to impact retention and engagement, organizational commitment to implementation and long-term sustainability is necessary (Ballard, 2010). Ballard (2010) identified the characteristics of successful and unsuccessful shared governance implementations. Key factors associated with successful implementation include (a) policies and processes that support integration of shared governance, (b) leadership support at all levels of the organization, and (c) a structure that defines and delineates organizational roles (Ballard, 2010). Factors associated with failed implementation were (a) lack of role delineation, (b) poor leadership support, and (c) not enough organizational resources (Ballard, 2010). This study underlines the importance of supporting shared governance at every organizational level. The model of shared governance that has been implemented at this organization, requires leadership support from both front line leaders and executives.

The literature that supports this doctoral project is largely based on hospital-based research and data. However, there is data that supports the impact of shared governance on multiple hospitals and health systems. Magnet hospitals are largely recognized for having an ongoing commitment to shared governance (ANCC, n.d.). The average turnover for Magnet hospitals in the United States is 11.90%, 18% lower than the national turnover rate average of 14.6% (ANCC, n.d.). Studies of multiple hospitals where shared governance was in place indicated that nurses reported the highest engagement with shared governance versus low engagement, had 80% higher rates of job

satisfaction and intent to leave the position within one year was 71% lower (Kutney-Lee et al., 2016; Stumpf, 2001).

This doctoral project attempts to answer the gap in nursing practice by determining if implementation of a system-wide, multihospital shared governance structure can impact RN turnover and satisfaction at a system level. A review of the literature reveals that while several publications have measured RN's perceptions of governance across several health systems and hospitals (Hess 1998; Hess 2011), only a few have addressed factors that impact turnover and satisfaction.

Local Background and Context

The need to institute a shared governance structure within this hospital system was supported by both the RN turnover rates and the employee engagement results. In January of 2017, prior to instituting a multihospital shared governance structure, division and facility FT/PT RN turnover rates were well over the national average of 12.6%, and the adjusted range of 18.8-23.4%, which accounts for geography, for-profit status, and bed size (Nursing Solutions, Inc., 2017). RN turnover rates for this division ranged from 17-35% and averaged 22.30%. First year RN turnover rates ranged from 16.50% to 55.90% and averaged 32.1%. Performance on the 2016 Employee Engagement survey, taken annually in June, indicated that 59% of participating RNs felt that sufficient effort was made to get the opinions and thoughts of people who worked there, and 52% indicated they were satisfied with the amount of voice they had in decisions that affected their work. Overall company performance on these two questions was 71% and 67%, respectively.

The hospital system where this project is being conducted is located in the southeastern United States and consists of 16 hospitals and four freestanding emergency rooms. From north to south the system spans 156 miles and extends 56 miles inland from the west coast of Florida. The system contains no Magnet hospitals and each of the facilities is accredited by The Joint Commission. The individual facilities each have their own mission statement, but function under the overall mission statement of the organization:

> Above all else, we are committed to the care and improvement of human life. In pursuit of our mission, we believe the following value statements are essential and timeless: We recognize and affirm the unique and intrinsic worth of each individual. We treat all those we serve with compassion and kindness. We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity. We act with absolute honesty, integrity, and fairness in the way we conduct our business and the way we live our lives.

Due to variations in hospital structures and terms, it is important to provide an overview of the organizational structure, operational processes, and local terms unique to this health system. The reporting structure of the facilities within the system include hospital level executives (i.e. chief operating officer, chief financial officer, chief nursing officer (CNO), chief executive officer) that report to a division level chief financial officer, president, and chief nurse executive (CNE). Operational processes, policies, and benchmarks are standardized at the division level, but can be slightly modified at the

facility level to meet local needs. Two local terms that need clarification are division and CNE.

The division refers to the collective of all of the hospitals included in the project. The corporate structure of the organization are divisions that roll up into one of two groups. The divisions each have a president that oversees operations and reports to a group president who in turn reports to the COO of the company

The CNE is a division level position responsible for setting the vision of nursing within division hospitals. The CNE chairs the division's nurse executive council in the shared governance structure. Shared governance within this division, was implemented through utilization of standardized facility and divisional organizational structures. The facility organizational structure includes four facility practice councils, representatives on service line councils, and a nurse executive council. A visual representation of the facility organizational structure can be seen in Figure 1. The four facility practice councils are: caring practice, professional development, practice standards, and clinical informatics. The focus of the caring practice council is to foster nursing celebrations, recognition of staff members, and improve the patient experience. The professional development council's purpose is to foster professional growth of the direct clinical caregivers. The practice standards council focus is to provide a mechanism for direct care nurse to utilize evidence based practice in their clinical practice and promote safe patient care management. The clinical informatics council's focus is to utilize and maximize technology to advance the clinical agenda. In addition to the four-practice councils, each organization has representation on seven service line councils that focus on advancing

performance within a given area of focus. The seven service line councils are: Emergency Department, Surgical Services, Critical Care, Medical-Surgical, Women's and Pediatrics, Behavioral Health, and Wound Care. The facility nurse executive council includes the nursing leadership of the hospital and is chaired by the CNO. Its purpose is to guide and support the shared governance structure at the facility, to support facility-level decisions, and to make recommendations to the division executive council.

Figure 1. *Facility Organizational Structure*

The division level organizational structure includes the CNO's and Assistant Chief Nursing Officer's (ACNO) from each hospital, facility chairs from each council, and the chairs from each service line council. The division nurse executive council is chaired by the CNE. The purpose of the council is to support the shared governance

structure at the facility and division levels, to maintain accountability for shared governance involvement at each facility, and to promote direct care nursing involvement in decision-making at a division level. A visual representation of the division organizational structure can be seen in Figure 2.

Figure 2 *Division Organizational Structure*

Role of the DNP Student

This student's professional role is ACNO at one of the 16 hospitals within the division. In fulfillment of this role, I participate in local facility shared governance councils, chair one of the multihospital service line councils, and attend the division level multihospital Nurse Executive Council's meetings. Outside of my hospital, I have a

collegial working relationship with their executive leadership but, don't directly participate in their facilities' shared governance structures. The only exception is my preceptor's site where I assisted with implementation of a unit-based council in the emergency room.

This student's motivation for choosing shared governance as a project was to evaluate the unique nature of the shared governance structure within this healthcare system. In addition, the organizational structure of this hospital system allows for transparency of data across the system. This transparency makes it possible to evaluate retention and engagement with pre-and post-implementation utilizing data already available within the system.

Summary

In summary, this doctoral project attempted to address the current gap in nursing practice about the relationship between a multihospital shared governance structure and RN turnover and engagement. Existing data that tracked engagement and turnover over time were used in addition to the IPNG survey. Analysis was focused on determining the post implementation impact of shared governance.

Section 3: Collection and Analysis of Evidence

Introduction

The focus of this doctoral project was to examine the relationship between implementation of a system-wide, multihospital shared governance structure, and RN turnover and satisfaction. A review of the available literature indicated that shared decision making increases RN engagement and satisfaction by allowing nurses to take an active role in shaping their professional practice environment (Kutney-Lee et al., 2016; Stumpf, 2001). This increased engagement and satisfaction decreases an employee's intent to leave, and results in lower organizational turnover (Brewer et al., 2011). In this section, the following topics will be reviewed: the practice focused question, sources of evidence, and analysis and synthesis.

Practice Focused Question

The practice-focused question for this doctoral project was *What is the relationship between implementation of a system-wide wide, multihospital shared governance structure, on RN turnover, results on specific employee engagement questions at a system level, and perceptions of shared governance for two hospitals within that system?* The Institutional Review Board approval number given to this project was 04-10-18-0634225. The system level impact of shared governance was evaluated through the utilization of rolling 12-month turnover rates, and comparison of 2016 and 2017 RN responses on voice question on the employee engagement survey. In January 2017, prior to the implementation of a standardized shared governance structure, rolling 12-month turnover rates within this system were 17-35% and averaged 22.30%. First year

rolling 12- month turnover rates for the individual hospital ranged from 16.50% to 55.90%, with an average division rate of 32.1%. In addition, RN performance on the 2016 Employee Engagement survey indicated that only 59% of participating RNs felt that sufficient effort was made to get the opinions and thoughts of people who worked there, and only 52% indicated they were satisfied with the amount of voice they had in decisions that affected their work. This was well below the overall company performance on these two questions, which was 71% and 67% prospectively.

Sources of Evidence

The first source of evidence for this project was facility and system-level turnover rates. Data collection was facilitated through human resources by using facility termination and employee data. Data is automatically generated using a computerized system called Lawson that tracks personnel and payroll information. Data was confirmed at a facility level using local hiring and termination information. Confirmed data was compiled automatically and published internally for trending purposes. Access to the data is available at all levels of the organization and is transparent across the system. Turnover rates are available on an ongoing monthly basis and there are no limitations inherent to the data. RN turnover rates are a direct measurement of the involuntary and voluntary terminations within an organization (Nursing Solution's, 2017). RN turnover data was evaluated by utilizing a standard rolling 12-month percentage of FT and PT RNs. First year RN turnover rates were also evaluated. First year turnover was an important measure for this organization, as many of the facilities had struggled with hiring and retaining new employees. The monthly overall turnover rate, as well as first year RN turnover, was

trended and compared to the same time period of the previous ear. As shared governance was implemented in February 2017, 2016 turnover rates were used to determine if an improvement in turnover was noticed post implementation. While many factors can influence turnover, there had been no significant internal organizational changes outside of shared governance that were not also present in 2016. External influences on turnover should also remain constant, although year-over-year adjustments may be evident.

The second source of evidence for this project was the 2016 and 2017 annual employee engagement survey. The employee engagement survey is taken yearly in June and is administered by a third-party vendor that specializes in employee engagement surveys. Those employees eligible to take the survey have been employed for more than 44 days and are not a contracted service. Computers in the human resources departments and throughout each of the facilities were made available for employees to complete the surveys. The survey was also accessible to employees from their personal computers and mobile devices. The survey was promoted by facility leaders, as well as through facility emails, mailings, and progress reminders. Responsiveness was tracked throughout the 2-week time period of availability, and updates on participation were provided on a daily basis. The purpose of the employee survey was to measure facility-level and organizational progress on 10 key areas that drive employee engagement. The key areas are (a) leadership: immediate supervisor, (b) leadership: senior management, (c) staffing: work role, (d) staffing: workload, (e) voice, (f) rewards, (g) culture, (h) quality, (i) outcomes, and (j) safety and security. The survey questions that relate to each of these areas are rated on a standard Likert scale with the responses of strongly disagree,

disagree, neither disagree nor agree, agree, strongly agree. Participants were also able to select the option of "don't know" for each of the questions. Following completion of the survey data is compiled and made available to leaders at all levels of the organization. Question data is presented in the form of a percentage of the employees who indicated that they agreed or strongly agreed with the intent of the question. A year-over-year comparison is found to be significant if the survey results were + or - 4% from the previous year. The area of focus most relevant to shared decision making is voice and the two questions are *sufficient effort is made to get the opinions and thoughts of the people who work here* and *I am satisfied with the amount of voice I had in the decisions that affect my work*. RN participation in the employee is generally around 65-70% with around 4,000-4,500 nurses responding. For the purpose of this project, only RN responses were evaluated for year-over-year changes.

The third source of evidence for this doctoral project, was a comparison of the perception of shared governance at two facilities within the 16-hospital system. The tool chosen to measure perceptions of shared governance was the IPNG. The hospitals selected for this comparison were chosen based on their year over year progress with RN turnover. A hospital with improvement in RN turnover was compared with a hospital that saw worsening turnover. Facilities that have a similar patient volume and capacity were chosen for comparison. For the purpose of this doctoral project, eligible participants were RN's working in either outpatient or inpatient units within these two hospitals. No restrictions as to job title, hours worked, length of time employed, union involvement, involvement in shared governance, or education were enforced. A sample size of 88

participants had been determined using the population level, confidence level of 95%, and confidence interval of 10%. The survey was made available to participants on the nursing units and collected in designated receptacles to ensure anonymity. Informed consent was obtained through utilization of a standard adult consent form.

The IPNG as a validated instrument for measuring governance was first established in studies published in 1988 (Hess, 1998; 2011). The tool was tested in four phases: assessment of content for validity, assessment of feasibility, assessment of reliability, and validity (Hess, 1998). During phase one the content of the tool was tested and a level of 0.90 was set as a threshold for content validity using Popham's Average Congruency Score (Hess, 1998). Following modification, the tool was found to have a score of 0.95 (Hess, 1998; 2011). Feasibility was examined in Phase 2 and resulted in no changes to the proposed tool (Hess, 1998). Phase 3 determined that each of the scales had a Cronbach alpha subscale reliability ranging from 0.85-0.90 and an overall reliability of 0.95 (Hess, 1998; 2011). Phase 4 focused on correlation of two data sets administered 1 month apart (Hess, 1998; 2011). The test-retest correlation was found to be 0.77 using a Pearson product-moment correlation. (Hess, 1998; 2011). This validation of the IPNG instrument, for measuring perceptions of shared governance, makes it ideal for use in this doctoral project.

The 86-item IPNG survey (Appendix B) provides a measurement of overall perception of governance and six areas or dimensions (Hess, 1998; 2011). These dimensions are: control over people or personnel, access to information, resources that support professional practice, participation, control over professional practice, and goals

and conflict resolution (Hess, 1998; 2011). For the purpose of this doctoral project the tool had not been modified and permission to utilize this tool was given in January of 2017 (Appendix C).

Participation in this doctoral study and completion of the IPNG survey was done on a voluntary basis. No incentives were provided to participants and participants were not individually identified in the collection process. As part of the agreement to use the tool, a summary of findings will be reported to the Forum for Shared Governance. Permission to conduct the study has been given by division leadership (Appendix A).

Analysis and Synthesis

The three sources of information included in this project are RN turnover data, employee engagement results, and IPNG survey data. Implementation of a year-over-year comparison was conducted to analyze and synthesize the data for the first two measures. Turnover data at this organization is measured utilizing a rolling monthly percentage and was generally presented using an excel graph format. As the implementation month was February of 2017, year-over-year comparison data included January 2016 to December of 2016 and January 2017 to December 2017. The turnover data included two data sets. These two data sets were overall FT/PT RN turnover data and first year FT/PT RN turnover. Data integrity was ensured at a facility and corporate level through utilization of payroll and personnel information. The employee engagement survey data was reported to the organization from a third-party source. The survey data didn't include personal information beyond occupation and department of the individual as to maintain the confidential nature of the survey. The facility received information from the annual

survey in the form of department, hospital, skill mix, and shift data. The data included in this project included a year-to-year comparison of RN results on the two voice questions. Analysis of the data was conducted through a third-party source and change was considered significant if there is a + or - 4% change in the results. For the purposes of this project, 2016 data was compared with 2017 data for a year-over-year comparison.

Analysis of the IPNG survey was conducted using the IPNG scoring criteria. These criteria assess a hospitals governance structure using a scale that ranges from traditional to self-governance (Hess, 1998. Data from both organizations were compared to determine variations in the perceptions of governance as well as variations in the subscales of: control over people or personnel, access to information, resources that support professional practice, participation, control over professional practice, and goals and conflict resolution (Hess, 1998).

Summary

The 16 hospitals included in this project had been challenged with RN overall and first year turnover rates well above the national average. In an attempt to increase RN satisfaction with their practice environment and reduce turnover, a standardized shared governance structure was implemented in February of 2017. This doctoral project reviewed RN turnover data and engagement survey performance from 2016 and 2017 to examine the relationship between shared governance and these two measures.

Section 4: Findings and Recommendations

Introduction

The purpose of this doctoral project was to examine the relationship between implementation of a system-wide, multihospital shared governance structure and RN turnover, engagement, and perceptions of shared governance. A review of the turnover and employee engagement data prior to implementation of shared governance indicated that turnover rates averaged 22.30%, well above the national average of 12.6%, and division performance on the two voice questions on the employee engagement survey, was 12-15% below that of the entire company (Nursing Solutions, 2017).

Three sources of evidence were used to attempt to answer the practice focused question. The first source was facility and system-level turnover rates. Turnover data is collected through human resources by using facility termination and employee data. RN turnover rates are a direct measurement of the involuntary and voluntary terminations within an organization. RN turnover data was evaluated by utilizing a standard rolling 12-month percentage of FT and PT RN's. The monthly overall turnover rate, as well as first year RN turnover, was trended for 2017 and compared to 2016 data. The second source of evidence for this project was the 2016 and 2017 annual employee engagement survey. The employee engagement survey is taken yearly in June and is administered by a third-party vendor that specializes in employee engagement surveys. The two yes or no questions evaluated were *sufficient effort is made to get the opinions and thoughts of the people who work here* and *I am satisfied with the amount of voice I had in the decisions that affect my work*. RN responses were evaluated for year-over-year changes. The third

source of evidence for this doctoral project was a comparison of the perception of shared governance at two facilities within the 16-hospital system. The tool chosen to measure perceptions of shared governance was the IPNG. The hospitals selected for this comparison were chosen based on their year over year progress with RN turnover. A hospital with improvement in RN turnover was compared with a hospital that saw worsening turnover. Facilities that have a similar patient volume and capacity were chosen for comparison. Eligible participants included RN's working in either outpatient or inpatient units within these two hospitals and participation was completely voluntary.

Findings and Implications

A review of the data collected was conducted in two parts. Part 1 was to compare RN engagement and turnover data for 2016 versus 2017. Following trending and analysis of these results, Part 2 included the selection of two hospitals that participated in a survey to determine RN perceptions of shared governance. The following section will review and analyze RN engagement results, RN turnover data, and a detailed analysis of survey results.

A high level of employee engagement can be directly tied with improved organizational performance and patient outcomes (Brunges & Foley-Brinza, 2014). Due to this relationship, many organizations conduct an annual survey to measure engagement (Brunges & Foley-Brinza, 2014). The division in this study conducted an annual survey of engagement in June. Participation in the survey was voluntary and anonymous. Question data is presented in the form of a percentage of the employees who indicated that they agreed or strongly agreed with the intent of the question. In 2016, 4,340 division

RN's took the employee engagement survey. On the questions related to voice 59% said sufficient effort was made to get the opinions and thoughts of the people who work in their facilities and 52% said they were satisfied with the amount of voice they had in the decisions that affected their work. This is lower than the whole company performance of 71% and 67% respectively. In 2017, 4,178 RN's took the survey. Performance on the voice questions increased to 61% on the sufficient effort is made to get the opinions and thoughts of the people who work here. The amount of voice in decision making remained unchanged at 52%.

The change in year over year performance on the employee engagement results (see Table 2) was not found to be significant. The tool administrator considers a change to be significant if there is a 4% change in results. Possible causation of this results is, the short time frame between the kick off of the system-wide, multihospital shared governance structure and the survey. Shared governance began in February of 2017 and the survey was administered in the beginning June. This 4-month time frame may not have been enough to influence the perceptions of the participants.

Table 2
RN Engagement Results 2016 vs. 2017

Survey Question	Sufficient effort is made to get the opinions and thoughts of the people who work here	I am satisfied with the amount of voice I have in the decisions that affect my work
2016 Participants	4340	4340
2016 % Favorable	59%	52%
2016 Overall Company % Favorable	71%	67%
2017 Participants	4176	4178
2017 % Favorable	61%	52%
2017 Overall Company % Favorable	71%	66%
2016-2017 Variance (+/- 4 %) Considered significant	+2%	0%

As discussed above, nursing turnover can directly affect organizational ability to drive quality improvement and financial performance (Nursing Solutions, Inc., 2017). The introduction of shared governance as a tool to decrease nursing turnover in this system began in February 2017. In January of 2017 rolling 12-month FT/RN turnover rates within this system ranged from 17-35% and averaged 22.30%. First year FT/PT RN rolling 12-month turnover rates for the individual hospitals in January 2017 ranged from 16.50% to 55.90%, with an average division rate of 32.1%. In order to prepare hospital turnover rates for analysis, facility names were redacted and each facility was assigned a corresponding letter. This redaction allows each facility's data to remain anonymous. When comparing hospital rolling 12-month turnover rates for the time period of January 2016-December 2017 significant variability is noted for both FT/PT RN Turnover (see Figure 3) and first year turnover (see Figure 4). A review of division turnover for the

same time period showed FT/PT turnover rates remaining consistently between 20-22% (see Figure 5). The biggest change in the 2016-2017 time period can be seen in Full Time/Part Time <12 Months RN Turnover (see Figure 6) which reached a high of 32.10% in January of 2017 and progressively decreased to 27.30% in December of 2017. This change could be related to the incorporation of new nurses into the culture of shared governance as part of the orientation process.

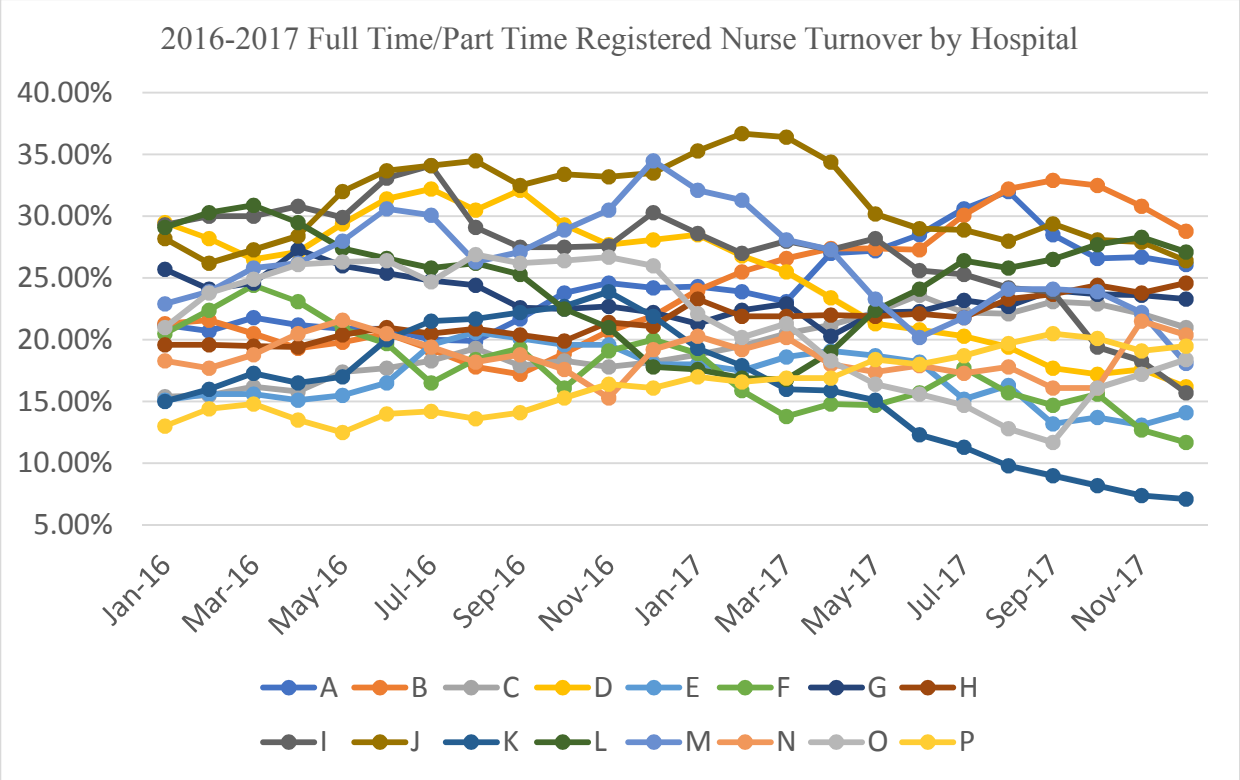

Figure 3. 2016-2017 Full Time/Part Time RN Turnover by Hospital

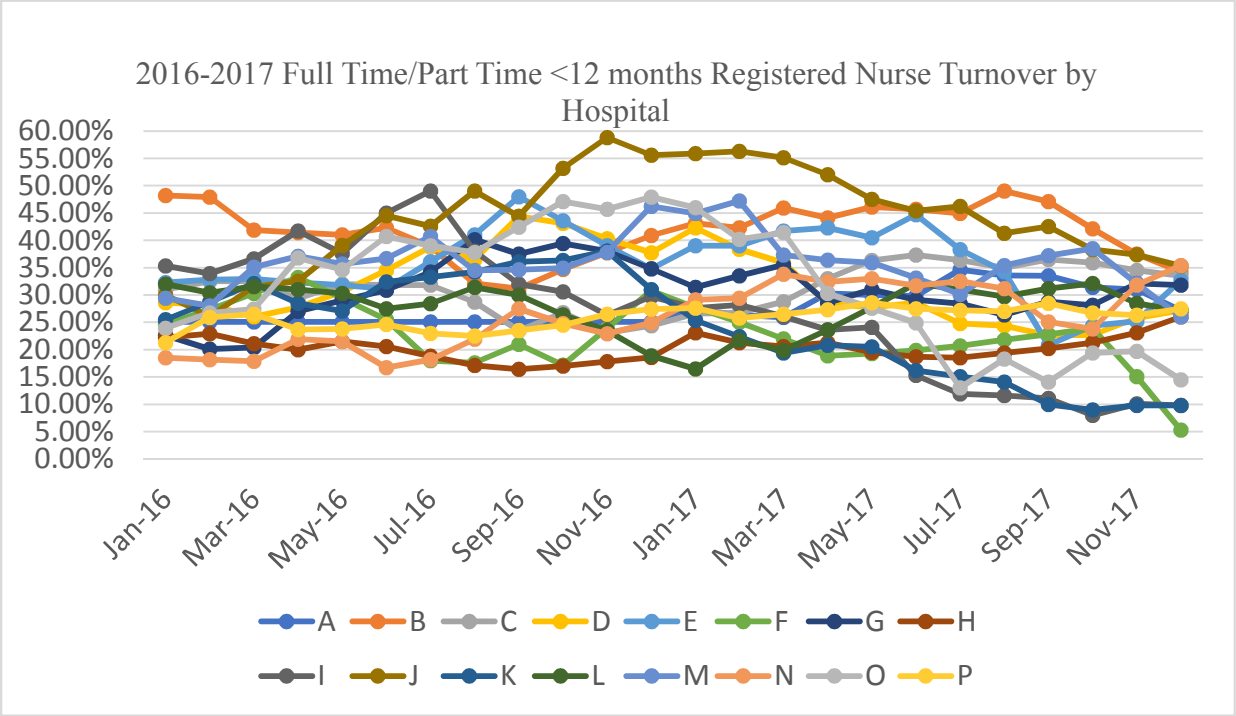

Figure 4. 2016-2017 Full Time/Part Time <12 Months RN Turnover by Hospital

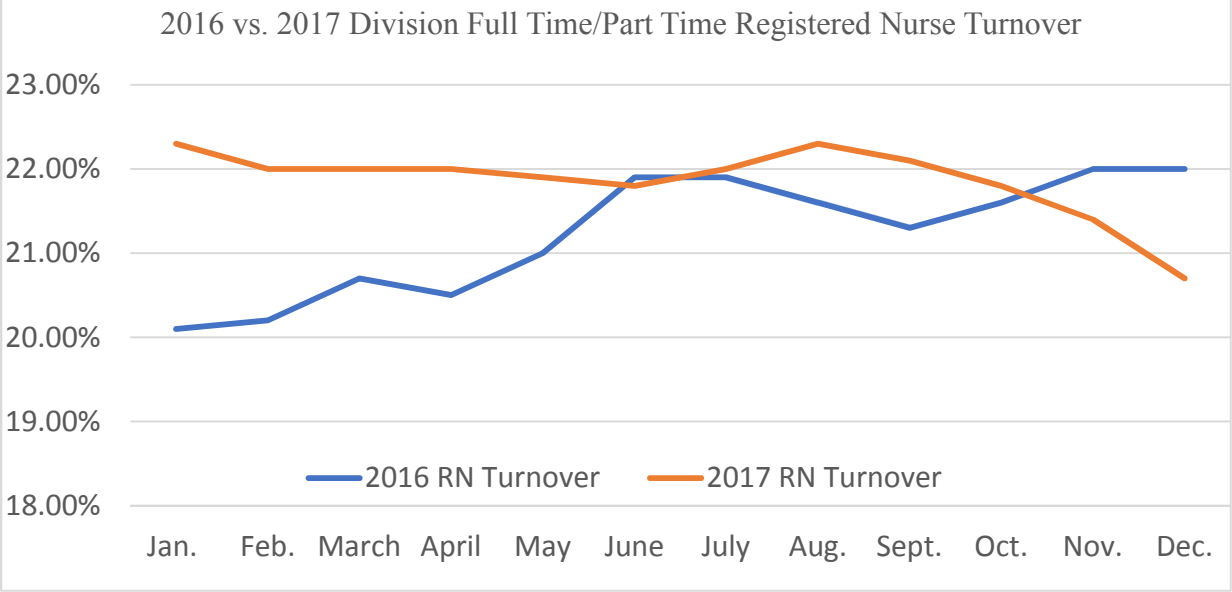

Figure 5. 2016 vs. 2017 Division Full Time/Part Time RN Turnover

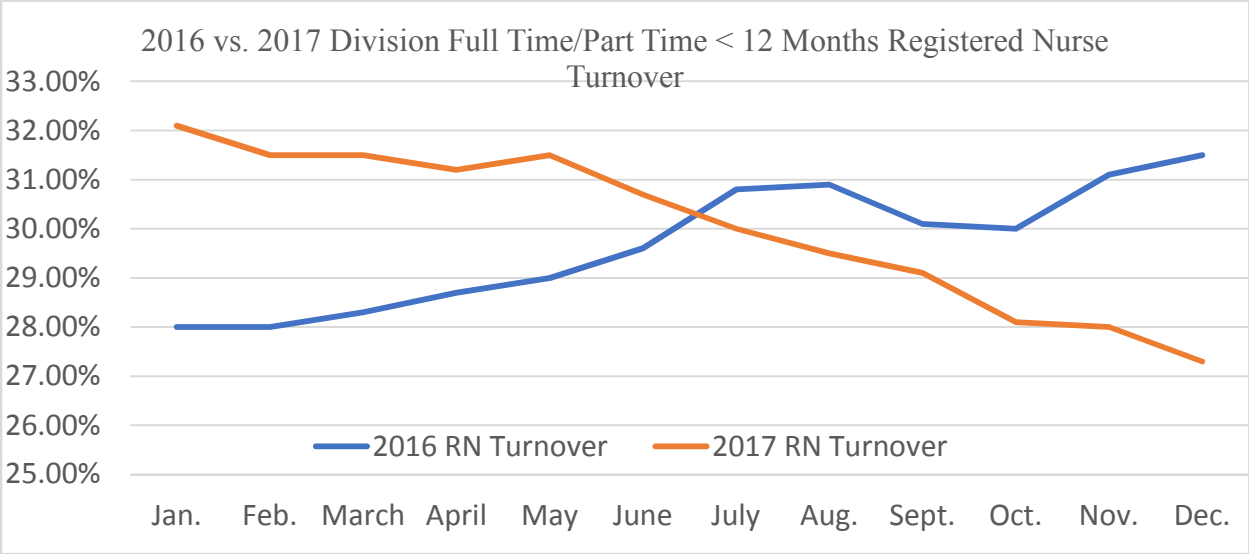

Figure 6. 2016-2017 Division Full Time/Part Time <12 months RN Turnover

Yearly average hospital turnover rates by bed count were analyzed to further examine variances in results (see Table 3). The expected turnover results (see Table 1), were utilized as a benchmark for comparison for FT/PT RN turnover rates. This same benchmark was not applied to first year turnover as that comparison was not utilized in the literature (Nursing Solutions, Inc., 2017). In 2016, seven out of the 16 hospitals had average FT/ PT RN turnover rates at or below the expected turnover rates. In the <200 bed category Hospital F and E had turnover rates less than 20.7%. Hospital N and P in the 200-349 bed category and Hospitals B, C, and H were below the expected turnover results for their category. A comparison of 2016 to 2017 FT/PT RN average turnover rates showed that 11 out of 16 hospitals had a reduction in turnover that ranged from 0.3% to 8.4% and averaged 4%. Hospitals O, D, and K had reductions greater than 7% while Hospital B saw an 8.9% increase in turnover.

An analysis of first year turnover showed 2016 averages to be much higher and range from 19.50% to 42.28%. Hospitals M, E, I, O, D, and B had average rates over 34%. The 2017 average rates for the same category ranged from 16.04% to 46.10%. Hospitals M, E, J and B continued to have rates over 34% with facility B (43.5%) and J (46.10%) having the highest rates. A comparison of 2016 to 2017 FT/PT first year RN turnover rates showed that 9 out of 16 hospitals had a reduction in turnover that raged from 0.78% to 19.03% and averaged 6.9%. Hospitals I (-19.03%) and K (-15.89%) had the greatest reductions in turnover.

Table 3
Hospital Turnover Rates by Bed Count

Facility	Bed Count	Expected Turnover Rate per Bed capacity	2016 Average FT/PT RN Turnover Rate	2017 Average FT/PT RN Turnover Rate	Year over Year Change	2016 Average FT/PT RN <1yr Turnover Rate	2017 Average FT/PT RN <1yr Turnover Rate	Year over Year Change
F	100	20.7%	20.03%	15.16%	-4.9%	24.90%	20.20%	-4.70%
M	138	20.7%	27.90%	24.71%	-3.2%	35.89%	36.18%	+0.28%
E	155	20.7%	17.58%	16.31%	-1.3%	36.31%	35.24%	-1.07%
I	183	20.7%	29.93%	24.29%	-5.6%	36.31%	17.28%	-19.03%
O	201	18.8%	25.45%	17.07%	-8.4%	37.50%	25.78%	-11.72%
D	204	18.8%	29.33%	21.23%	-8.1%	34.70%	29.07%	-5.63%
N	215	18.8%	18.83%	18.52%	-0.3%	21.24%	30.77%	+9.53%
G	237	18.8%	24.36%	22.66%	-1.7%	31.17%	30.39%	-0.78%
K	280	18.8%	19.64%	12.44%	-7.2%	31.93%	16.04%	-15.89%
J	288	18.8%	31.42%	30.89%	-0.5%	42.28%	46.10%	+3.83%
A	290	18.8%	21.74%	27.04%	+5.3%	25.10%	30.08%	+4.98%
P	290	18.8%	14.33%	18.45%	+4.1%	24.43%	27.21%	+2.77%
L	307	20.7%	26.03%	23.22%	-2.8%	28.45%	26.76%	-1.69%
B	383	20.7%	19.89%	28.79%	+8.9%	39.85%	43.50%	+3.65%
C	422	20.7%	17.32%	21.60%	+4.3%	28.96%	33.38%	+4.42%
H	425	20.7%	20.31%	22.89%	+2.6%	19.50%	21.08%	-1.58%
Division			21.23%	21.86%	+0.6%	29.96%	30.04%	-0.08%

Note. Nursing Solutions, Inc. (2017). 2017 National Healthcare Retention and RN Staffing Report. *NSI Nursing Solutions, Inc*

In order to further determine the relationship between shared governance and nursing turnover and retention, two hospitals were chosen from the 16 to have nurses surveyed regarding their perceptions of shared governance at their facility. The two hospitals selected were Facility B and Facility K. These two hospitals have a similar average daily census of 270-285 patients and offer similar services. Facility B has seen an increase in both hospital average turnover rates, as well as rolling 12 month turnover rates for both FT/PT RN's, and first year FT/PT RN's. In contrast, Facility K has seen a decrease in all turnover metrics. The process for data collection was the same at the two hospitals and was as follows: the survey was promoted through distribution of a flyer advertising the study (Appendix E), the survey was distributed in staff mailboxes and made available on the nursing units, and lastly the survey was collected at designated areas on each nursing unit. Analysis of the IPNG survey data followed the recommendations in the scoring guidelines. They included calculating the responses and analyzing the participants, calculating the variables and means for governance and the six subscales, determining Cronbach's alpha scores to assess internal consistency reliability for governance and the six subscales, and comparing the means of governance scales (dependent variable) by groups for observable differences and use ANOVAs to look for significant differences.

Participation in the survey was voluntary and included RN's from the two hospitals. A goal of 88 participants was set prior to administration of the survey however, only 50 surveys were received during the designated collection phase. Facility B had a total of 19 participants with the remaining 31 coming from Facility K. In order to

maintain strict anonymity, the demographic section of the collection tool was limited to questions about position, hours worked, and closest city to where the hospital was located (Appendix B). The Forum for Shared Governance recommends surveying nurses at all levels of the organization in order to gain a better understanding of the overall perceptions of governance (Hess, 2010). As shown in Table 4, bedside nurses made up 54% of the participants. All of those surveyed at Facility K were full time employees and only one of the participants at Facility B was part time.

Table 4
Index of Professional Nursing Governance Survey Participants

Characteristic	Facility B	Facility K
N	19 (38%)	31 (62%)
Full Time Status	19 (100%)	30 (96.8%)
Part Time Status	0	1 (3.2%)
Staff	10 (52.6%)	17 (54.8%)
Manager or Above	9 (47.4%)	14 (45.2%)

The total sample was used to calculate the overall variable of governance (all 86 questions) and the six subscale variables, which represent the six dimensions of governance, using the scoring key) was used to analyze the data for reliability and observable differences between groups. Cronbach's alpha reliability coefficient was calculated for governance and the six subscales. The output showed strong internal consistency for each variable with the alpha coefficients ranging from 0.86 to 0.92, with only two variables scoring below 0.9. An ANOVA was used to evaluate difference in results between groups. There was no significant difference in the means for the group's FT versus PT employees or the group managers versus bedside staff. (Polit, 2010).

The data was divided by facility for further analysis. The means for governance and the subscales were measured and compared using SPSS. A missing answer on one of the questions resulted in one less survey being included for the variable governance and information for Facility K. Table 5 provides a review of the mean scores for the variable of governance and the subscales. Means in bold indicate a value that falls within the range of shared governance. Facility K had mean scores that fell in the shared governance range for all variables with the exception of personnel. This indicates that nurses at this facility believe there is shared decision making for all dimensions of governance with the exception of who controls personnel and staffing. This is consistent with current practice, as decisions about staffing levels and positions are controlled at a senior leadership and division level and does not allow for input from staff or front line leaders. Only Facility B scored within the shared governance range for information. The reason for this scoring may be related to the information provided to staff regarding the shared governance structure at all hospitals within the division (Hess, 2010).

Table 5
Hospital Comparison- Mean Scores for Subscales and Governance

Scale	Mean Range for Shared Governance Facilities	Facility B Mean Score	Facility K Mean Score
Personnel	45-88	30.47	32.90
Information	31-60	**33.11**	**35.43**
Resources	27-52	26.53	**32.42**
Participation	25-48	23.84	**30.19**
Practice	33-64	25.78	**33.58**
Goals	17-32	14.63	**18.32**
Governance	173-344	154.37	**183.70**

Note. A bolded mean- Indicates results within the expected range for shared governance
Hess, R. (2010). The measurement of professional governance: Scoring guidelines and benchmarks. *Forum for Shared Governance.*

The introduction of a multihospital shared governance structure in February of 2017 does appear to have had an impact on nursing turnover. The biggest change was seen in new nurse turnover which progressively reduced from a high of 32.10% in January of 2017 to 27.30% in December of 2017. A comparison of two hospitals within the system further supported the impact of shared governance on nursing turnover. Facility K, which had a reduction in nursing turnover throughout 2017, had higher nurse perceptions of shared governance than Facility B, which had rising turnover rates. The impact of shared governance on nursing engagement was not substantiated. This is potentially related to the short time frame between implementation of shared governance and the administration of the employee engagement survey.

The implications of these findings, could render further support for shared governance within this division. The financial repercussions of nursing turnover can range from $38,900 to $59,700 per RN. Each percent reduction in RN turnover can save the average hospital $410,500 per year (Nursing Solutions, Inc., 2017). The reduction in new nurse turnover of 4.8% translates in close to two million dollars in savings for this division. This is important because, since its introduction in February of 2017, shared governance has required a financial investment to compensate employees for attending the various required meetings. This project demonstrates an initial return on investment and could render support for further financial investment. The social impact of further reductions in RN turnover in this health system would have a positive effect on the RN turnover in the region (Nursing Solutions, Inc., 2017). In addition, further evolution of shared governance could impact patient satisfaction and outcomes, as well as nursing

engagement and turnover. Kutney-Lee et al. (2016) found that organizations that had higher nursing engagement in shared governance had better performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Recommendations

The transition to a shared decision making model, requires a significant shift in organizational culture (Hess, 2011). This shift may require several years to complete, as well as ongoing evaluation to ensure a move back towards more traditional governance models doesn't occur. Hess (2011) suggests that a period of 3 to 5 years is required to complete the transition to a true shared governance model. This doctoral project has evaluated the progress year 1 post implementation. Future recommendations are to continue to monitor compliance with shared governance by reviewing council minutes, accomplishments, and attendance. This review ensures that each organization is complying with the facility and division structures, as well as supporting shared decision making at all levels of the organization. An additional recommendation would be to pair leaders and staff nurses from high performing shared governance organizations with those that had opportunities so they could learn from each other. This tactic could be utilized several years into the process to address any outlier hospitals.

Strengths and Limitations

This project examined the relationship between implementation of a system-wide, multihospital shared governance structure and RN turnover, satisfaction, and perception of shared governance. The project strengths were the data collection tools utilized and the data analysis process. The data collection tools utilized were all unable to be influenced

by the researcher. The turnover and engagement data were both collected as ongoing routine measures of organizational performance. The use of the IPNG tool to measure perceptions of shared governance lent additional support to the strength of the project. It is a validated instrument which has been utilized in multiple studies to measure perceptions of shared governance (Anderson, 2011; Barden, Griffin, Donahue, & Fitzpatrick, 2011; Hess, 1998; Hess, 2010). The use of the SPSS software to perform statistical analysis provided an additional layer of accuracy which allowed for a more detailed analysis of the results (Polit, 2010).

The limitations on the project are in the sample size of the IPNG survey participants. Prior to survey administration, a desired sample size of 88 participants was determined with a goal of 44 per facility. Unfortunately, despite extending the survey collection phase by a few days, only 50 surveys were obtained. Upon review of the surveys, it was noted that one survey participant had missed answering one of the questions related to the subscale information. As a result, one less survey was included for the variables governance and information for Facility K as well as the overall assessment of the same.

There is an opportunity to have future projects that further examine the impact of shared governance on this division. Hess (2010) recommends surveying organizations prior to implementation of shared governance and 2 years post implementation. In addition to resurveying the two facilities involved in this project, expanding the data collection to all hospitals would provide further clarity as to the relationship between shared governance and turnover. In addition to monitoring perceptions of shared

governance and turnover data, performance on the voice questions of the employee engagement survey would be important to trend as well. Other variables that could be monitored and assessed our hospital acquired conditions and infections and performance on the HCAHPS survey.

Section 5: Dissemination Plan

Dissemination of the results of this doctoral project will be a key factor in obtaining continued support for shared governance. There are three venues where this information will be disseminated. The first two will be at the Nurse Executive Councils of the two hospitals that participated in the survey. Council participants include bedside nurses and facility leadership. The third venue will be a division leadership meeting. Participants include both nursing and nonnursing executive leaders. Dissemination of the project to the broader nursing profession could include a poster presentation at the Academy of Medical-Surgical Nurses annual convention in September of 2018.

Analysis of Self

A reflection on the progress of this doctoral project, as well as my own individual growth as a practitioner, scholar, and project manager has been an important part of this project's completion. Throughout this project's development, implementation, and evaluation I have learned that attention to detail, self-determination, and flexibility are key factors in any research project. As a practitioner and a leader, I learned that supporting shared governance can be challenging and time consuming but has the potential to positively impact division hospitals. As a scholar, I learned the importance of thoroughly researching a project as well as using validated tools like the IPNG survey to support the results. As a project manager, I learned the importance of setting strict goals and timelines and the implications and delays that occur when they are not followed. Each of these learnings will be instrumental to my success as a nurse executive. I have

been able to use the research project to support the development and evaluation of new service lines as well as new care delivery models within my current organization.

The biggest challenge for me in the completion of this project was in separating my professional role from my scholarly one. As the ACNO of one of the hospitals, I had to be careful not to have my role impact IPNG survey participation. I was able to do this by making the process for obtaining the surveys as anonymous as possible by using a distribution and collection process that eliminated personal discussion between myself and potential participants. While this limitation was instrumental in protecting the participants, I believe this limited the number of responses I was able to obtain.

Summary

Shared decision making between front line clinical staff and nursing administrators is a hallmark of the ANCC (2014) Magnet Recognition Program, which recognizes organizations for nursing excellence. Shared governance is a key organizational initiative to drive both nursing and patient focused outcomes. The focus of this doctoral project was to determine the relationship between implementation of a multihospital division-wide shared governance structure and RN turnover, engagement, and perceptions of shared governance. The project outcome showed a year over year reduction in new nurse turnover division-wide and an overall reduction in nursing turnover at the majority of the hospitals within the division. When a comparison of perceptions of shared governance at two hospitals was conducted, the hospital with the lower turnover had higher perceptions of shared governance.

References

American Nurses Credentialing Center (2014). 2014 Manual Updates. Retrieved from http://www.nursecredentialing.org/2014-MagnetManualUpdates

American Nurses Credentialing Center (n.d.). Magnet Model. Retrieved from http://www.nursecredentialing.org/Magnet/ProgramOverview/New-Magnet-/M./odel

American Nurses Credentialing Center (n.d.). Average magnet organization characteristics. Retrieved from http://www.nursecredentialing.org/CharacteristicsMagnetOrganizations.aspx

American Association of Critical Care Nurses (2009). Interdisciplinary shared governance: Integrating practice, transforming health care, 2d ed. *Critical Care Nurse*, (4), 79. Retrieved from http://ccn.aacnjournals.org/content/29/4/79.2.full.pdf+html?sid=f141d344-65eb-48e1-8e28-fe764e1b079e

Anderson, E. F. (2011). A case for measuring governance. *Nursing Administration Quarterly 35*(3). doi:10.1097/NAQ.0b013e3181ff3f42.

Allen-Gilliam, J., Kring, D., Graham, R., Freeman, K., Swain, S., Faircloth, G., & Jenkinson, B. (2016). The Impact of Shared Governance Over Time in a Small Community Hospital. *Journal of Nursing Administration*, *46*(5). doi:10.1097/NNA.0000000000000340

Bae, S., Mark, B., & Fried, B. (2010). Impact of nursing unit turnover on patient outcomes in hospitals. *Journal of Nursing Scholarship*, *42*(1), 40-49. doi:10.1111/j.1547-5069.2009.01319.x

Ballard, N. (2010). Factors associated with success and breakdown of shared governance. *Journal of Nursing Administration*, *40*(10). doi:10.1097/NNA.0b013e3181f2eb14

Barden, A., Griffin, M., Donahue, M., & Fitzpatrick, J. (2011). Shared governance and empowerment in registered nurses working in a hospital setting. *Nursing Administration Quarterly 35*(3).

Anderson, E. F. (2011). A case for measuring governance. *Nursing Administration Quarterly 35*(3). doi: 10.1097/NAQ.0b013e3181ff3f42.

Allen-Gilliam, J., Kring, D., Graham, R., Freeman, K., Swain, S., Faircloth, G., & Jenkinson, B. (2016). The Impact of Shared Governance Over Time in a Small Community Hospital. *Journal of Nursing Administration*, *46*(5). doi:10.1097/NNA.0000000000000340

Bae, S., Mark, B., & Fried, B. (2010). Impact of nursing unit turnover on patient outcomes in hospitals. . *Journal of Nursing Scholarship*, *42*(1), 40-49. doi:10.1111/j.1547-5069.2009.01319.x

Ballard, N. (2010). Factors associated with success and breakdown of shared governance. *The Journal of Nursing Administration*, *40*(10). doi:10.1097/NNA.0b013e3181f2eb14

Brewer, C., Kovner, C., Greene, W., Tukov-Shuser, M., & Djukic, M. (2011). Predictors of actual turnover in a national sample of newly licensed registered nurses employed in hospitals. *Journal of Advanced Nursing, 68*(3). doi:10.1111/j.1365-2648.2011.05753.x

Brunges, M. & Foley-Brinza, C. (2014). Projects for increasing job satisfaction and creating a healthy work environment. *Association of Perioperative Registered Nurses Journal, 100*(6). doi:10.1016/j.aorn.2014.01.029

Dempsey, C. & Reilly, B. (2016). Nursing engagement: What are the contributing factors for success? *Online Journal of Nursing Issues 21*(1). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-21-2016/No1-Jan-2016/Nurse-Engagement-Contributing-Factors-for-Success.html

Gallagher-Ford, L. (2015). Leveraging shared governance councils to advance evidence-based practice: the EBP Council journey. *Worldviews on Evidence-Based Nursing*, *12*(1). doi:10.1111/wvn.12062

Hess, R. (1998). Measuring shared governance. *Nursing Research, 47*(1). Retrieved from http://journals.lww.com/nursingresearcholine/pages/default.aspx

Hess, R. (2010). *The measurement of professional governance: Scoring guidelines and benchmarks*. Voorhees, NJ: Forum for Shared Governance.

Hess, R. (2011). Slicing and dicing shared governance: In and around the numbers. *Nursing Administration Quarterly 35*(3). doi:10.1097/NAQ.0b013e3181ff387d

Institute of Medicine. (2004). Keeping patients safe: Transforming the work environment of nurses. Retrieved from https://www.ncbi.nlm.nih.gov

Institute of Medicine. (2011). The Future of Nursing: Leading Change, Advancing Health. Retrieved from http://books.nap.edu/openbook.php?record_id=12956&page=R1

Kanter R. (1993). *Men and Women of the Corporation*, *2nd ed*. New York, NY: Basis Books

Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., & ... Aiken, L. H. (2016). Nurse Engagement in Shared Governance and Patient and Nurse Outcomes. *Journal of Nursing Administration*, *46*(11). doi:10.1097/NNA.0000000000000412

Li, Y., & Jones, C. B. (2013). A literature review of nursing turnover costs. *Journal of Nursing Management*, *21*(3). doi:10.1111/j.1365-2834.2012.01411.x

Institute of Medicine. (2004). *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington (DC): National Academies Press Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK216190/doi: 10.17226/10851

Nursing Solutions, Inc. (2017). 2017 National Healthcare Retention and RN Staffing Report. *NSI Nursing Solutions, Inc.* Retrieved from http://www.nsinursingsolutions.com/Files/assets/library/retentioninstitute/NationalHealthcareRNRetentionReport2017.pdf

Polit, D. (2010). *Statistics and data analysis for nursing research* (2nd ed.). Upper Saddle River, NJ: Pearson Education Inc.

Porter-O'Grady, T. (2012). Reframing knowledge work: Shared governance in the postdigital age. *Creative Nursing, 18*(4). Retrieved from http://dx.doi.org/10.1891/1078-4535.18.4.152

Stumpf, L.R. (2001). A comparison of governance types and patient satisfaction outcomes. *Journal of Nursing Administration, 31*(4).

Appendix A: Site Approval Letter of Cooperation

Appendix A

Site Approval Letter of Cooperation

April 5, 2018

Dear Melanie Wetmore,

Based on my review of your research proposal, I give permission for you to conduct the study entitled The Impact of Shared Governance on Nursing Turnover and Engagement within the Hospital Corporation of America's West Florida Division. As part of this study, I authorize you to utilize facility and division turnover data and employee engagement results. In addition, I authorize you to promote, disseminate, and collect data on nursing perception of nursing shared governance by utilizing the Index of Professional Nursing Governance (IPNG) tool. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: to allow you, the doctoral student to distribute the IPNG tool to our employees. This approval to use our organization's data pertains only to this doctoral project and not to the student's future scholarly projects or research (which would need a separate request for approval). We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in Proquest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Appendix B: Index of Professional Nursing Governance

PROFESSIONAL GOVERNANCE

Please provide the following information. The information you provide is IMPORTANT. Please be sure to complete ALL questions. Remember confidentiality will be maintained at all times.

Today's Date_____

1. Please circle the city in which your hospital is located:

2. Please select which best describes your position at this facility:

   ____Bedside/Charge Nurse

   ____Manager or Above

3. Employment Status:
   ____Full-time, 36-40 hours per week

   ____Part-time, less than 36 hours per week (specify number of hours/week): _____

4. Please rate your overall satisfaction with your professional practice within the organization (1 = lowest, 5 = highest): 1 2 3 4 5

In your organization, please circle the group that CONTROLS the following areas:

1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART I

1. Determining what nurses can do at the bedside 1 2 3 4 5

2. Developing and evaluating policies, procedures and protocols related to patient care 1 2 3 4 5

3. Establishing levels of qualifications for nursing positions. 1 2 3 4 5

4. Evaluating nursing personnel (performance appraisals and peer review) 1 2 3 4 5

5. Determining activities of ancillary nursing personnel (assistants, technicians, secretaries) 1 2 3 4 5

6. Conducting disciplinary action of nursing personnel 1 2 3 4 5

7. Assessing and providing for the professional/educational development of the nursing staff 1 2 3 4 5

8. Making hiring decisions about RNs and other nursing personnel 1 2 3 4 5

9. Promoting RNs and other nursing personnel 1 2 3 4 5

10. Appointing nursing personnel to management and leadership positions 1 2 3 4 5

11. Selecting products used in nursing care 1 2 3 4 5

12. Incorporating evidence-based practice into nursing care 1 2 3 4 5

13. Determining models of nursing care delivery (e.g. primary, team) 1 2 3 4 5

In your organization, please circle the group that INFLUENCES the following activities:

1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART II

14. Determining how many and what level of nursing staff is needed for routine patient care 1 2 3 4 5

15. Adjusting staffing levels to meet fluctuations patient census and acuity 1 2 3 4 5

16. Making daily patient care assignments for nursing personnel 1 2 3 4 5

17. Monitoring and procuring supplies for nursing care and support functions 1 2 3 4 5

18. Regulating the flow of patient admissions, transfers, and discharges 1 2 3 4 5

19. Formulating annual unit budgets for personnel, supplies, equipment and education 1 2 3 4 5

20. Recommending nursing salaries, raises and benefits 1 2 3 4 5

21. Consulting and enlisting the support of nursing services outside of the unit (e.g. clinical experts such as psychiatric or wound care specialists, diabetic educators) 1 2 3 4 5

22. Consulting and enlisting the support of services outside of nursing (e.g. dietary, social service, pharmacy, human resources, finance) 1 2 3 4 5

23. Making recommendations concerning other departments' resources 1 2 3 4 5

24. Determining cost-effective measures such as patient placement and referrals or supply management (e.g. placement of ventilator-dependent patients, early discharge of patients to home healthcare) 1 2 3 4 5

25. Recommending new services or specialties (e.g. gerontology, mental health, birthing centers) 1 2 3 4 5

26. Creating new clinical positions 1 2 3 4 5

27. Creating new administrative or support positions 1 2 3 4 5

According to the following indicators in your organization, please circle which group has OFFICIAL AUTHORITY (i.e., authority granted and recognized by the organization) over the following areas that control practice and influence the resources that support it:

1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART III

28. Written policies and procedures that state what nurses can do related to direct patient care 1 2 3 4 5

29. Written patient care standard/protocols and quality assurance/ improvement processes 1 2 3 4 5

30. Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises 1 2 3 4 5

31. Written process for evaluating nursing personnel (performance appraisal and peer review) 1 2 3 4 5

32. Organizational charts that show job titles and who reports to whom 1 2 3 4 5

33. Written guidelines for disciplining nursing personnel 1 2 3 4 5

34. Annual requirements for continuing education and inservices 1 2 3 4 5

35. Procedures for hiring and transferring nursing personnel 1 2 3 4 5

36. Policies regulating promotion of nursing personnel to management and leadership positions 1 2 3 4 5

37. Procedures for generating schedules for RNs and other nursing staff 1 2 3 4 5

38. Acuity and/or patient classification systems for determining how many and what level of nursing staff is needed for routine patient care 1 2 3 4 5

39. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity 1 2 3 4 5

40. Procedures for determining daily patient care assignments 1 2 3 4 5

41. Daily methods for monitoring and obtaining supplies for nursing care and support functions 1 2 3 4 5

42. Procedures for controlling the flow of patient admissions, transfers and discharges 1 2 3 4 5

43. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education 1 2 3 4 5

44. Procedures for adjusting nursing salaries, raises and benefits 1 2 3 4 5

45. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g. clinical experts such as psychiatric or wound care specialists, diabetic educators) 1 2 3 4 5

46. Formal mechanisms for consulting and enlisting the support of services outside of nursing. (e.g. dietary, social service, pharmacy, human resources, finance) 1 2 3 4 5

47. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass) 1 2 3 4 5

48. Location, design and access to office space, staff lounges and charting areas 1 2 3 4 5

49. Access to office equipment (e.g. smart phones, computers and copy machines) and the Internet 1 2 3 4 5

In your organization, please circle the group that PARTICIPATES in the following activities:

1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART IV

50. Participation in unit committees for clinical practice 1 2 3 4 5

51. Participation in unit committees for administrative matters, such as staffing, scheduling and budgeting 1 2 3 4 5

52. Participation in nursing departmental committees for clinical practice 1 2 3 4 5

53. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting 1 2 3 4 5

54. Participation in interprofessional committees (physicians, other healthcare professions and departments) for collaborative practice 1 2 3 4 5

55. Participation in hospital administration committees for matters such as employee benefits and strategic planning 1 2 3 4 5

56. Forming new unit committees 1 2 3 4 5

57. Forming new nursing departmental committees 1 2 3 4 5

58. Forming new interprofessional committees 1 2 3 4 5

59. Forming new administration committees for the organization 1 2 3 4 5

In your organization, please circle the group that has ACCESS TO INFORMATION about the following activities:

1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART V

60. The quality of nursing practice in the organization 1 2 3 4 5

61. Compliance of nursing practice with requirements of surveying agencies (The Joint Commission, state and federal government, professional groups) 1 2 3 4 5

62. Unit's projected budget and actual expenses 1 2 3 4 5

63. Organization's financial status 1 2 3 4 5

64. Unit and nursing departmental goals and objectives for this year 1 2 3 4 5

65. Organization's strategic plans for the next few years 1 2 3 4 5

66. Results of patient satisfaction surveys 1 2 3 4 5

67. Physician/nurse satisfaction with their collaborative practice 1 2 3 4 5

68. Current status of nurse turnover and vacancies in the organization 1 2 3 4 5

69. Nurses' satisfaction with their general practice 1 2 3 4 5

70. Nurses' satisfaction with their salaries and benefits 1 2 3 4 5

71. Management's opinion of the quality of bedside nursing practice 1 2 3 4 5

72. Physicians' opinion of the quality of bedside nursing practice 1 2 3 4 5

73. Nursing peers' opinion of the quality of bedside nursing practice 1 2 3 4 5

74. Access to resources supporting professional practice and development (e.g. online resources, CE activities, journals and books, library) 1 2 3 4 5

In your organization, please circle the group that has the ABILITY to:

1 = Nursing management/administration only
2 = Primarily nursing management/administration with some staff nurse input
3 = Equally shared by staff nurses and nursing management/administration
4 = Primarily staff nurses with some nursing management/administration input
5 = Staff nurses only

PART VI

75. Negotiate solutions to conflicts among professional nurses	1 2 3 4 5
76. Negotiate solutions to conflicts between professional nurses and physicians	1 2 3 4 5
77. Negotiate solutions to conflicts between professional nurses and other healthcare services (respiratory, dietary, etc)	1 2 3 4 5
78. Negotiate solutions to conflicts between professional nurses and nursing management	1 2 3 4 5
79. Negotiate solutions to conflicts between professional nurses and the organization's administration.	1 2 3 4 5
80. Create a formal grievance procedure or a process for resolving internal disputes	1 2 3 4 5
81. Write the goals and objectives of a nursing unit	1 2 3 4 5
82. Write the philosophy, goals and objectives of your department.	1 2 3 4 5
83. Formulate the mission, philosophy, goals, and objectives of the organization.	1 2 3 4 5
84. Write policies and procedures for your work group	1 2 3 4 5
85. Determine departmental policies and procedures	1 2 3 4 5
86. Determine organization-wide policies and procedures	1 2 3 4 5

Appendix C: Permission to use the IPNG

Melanie Wetmore

January 13, 2017

Dear Melanie:

You have permission to use my instruments, the Index of Professional Governance (IPNG), or the Index of Professional Governance (IPG), to measure governance at the facilities in Florida and associated states for your doctoral work with the Walden University. In return, I require that you:

- Report summary findings to me from the use of the IPNG/IPG, including reliability analysis, for tracking use and evaluating and establishing the validity and reliability of the IPNG, and for possible research publication without identification of the institutions.
- Credit the use and my authorship of the IPNG/IPG in any publication of the research involving the IPNG.

I will email Word documents of the current versions of the IPNG/IPG, along with Scoring Guidelines. I will waive usual charges because of your student research. I will forward an SPSS codebook for data entry, if you want. You might want to customize the demographic section for your study. Any modifications to the instruments need to be sent to me for approval.

Please don't hesitate to call upon me to discuss your process or if you need help managing the data. If you need me to perform data entry and analysis and to generate a formal report with benchmarking, there is a fee. I am also available for onsite speaking or consultation. Thanks for thinking of the IPNG and the Forum for Shared Governance. Good luck with your survey.

Sincerely,

Robert Hess, RN, PhD, FAAN
Founder, Forum for Shared Governance

Appendix D: Promotional Flyer