

IMPLEMENTING SHARED GOVERNANCE
IN RURAL HOSPITALS

by

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A professional paper submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

in

Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

May 2025

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ABSTRACT

Nurse disengagement and high turnover rates present significant challenges in healthcare, particularly in rural hospitals, where resource limitations and staffing shortages exacerbate the issue. Traditional top-down management structures have been identified as a contributing factor to diminished nurse morale, lack of autonomy, and decreased job satisfaction. This has strongly influenced the increase in turnover rates, further straining the healthcare system, making it imperative that hospitals implement interventions to improve job satisfaction and nurse engagement.

A literature review has identified Shared Governance (SG) models as an evidence-based best practice intervention in acute care hospitals, and they correlate with increased job satisfaction, decreased turnover, and improved patient safety and satisfaction. This project provides a framework for creating and integrating SG into rural hospitals, demonstrating its potential to enhance nurse engagement and retention while ultimately improving patient care quality. The intervention involves establishing an SG Council, comprised of direct patient care nurses and other key stakeholders, ensuring that nurses are involved in policy decisions, resource management, and practice improvements. Following the Institute for Healthcare Improvement's (IHI) Plan-Do-Study-Act (PDSA) cycle for iterative improvement, the project's effectiveness will be measured using the Maslach Burnout Inventory (MBI), the Practice Environment Scale of the Nursing Work Index (PES-NWI), and hospital retention data.

The proposed implementation of shared governance holds promise for improving nurse engagement, retention, and job satisfaction in rural hospitals. This QI project emphasizes the importance of nurse empowerment in fostering a positive work culture and improving healthcare outcomes. Continued data collection and evaluation are needed to assess the long-term impact of shared governance on nursing practice and patient care outcomes.

Keywords: Shared Governance, nurse engagement, retention, rural healthcare, quality improvement, nursing leadership.

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Chapter One

Nursing turnover is a growing problem for rural hospitals. The average expense related to each Registered Nurse (RN) turnover costs a facility approximately \$46,100, emphasizing the need for facilities to implement retention interventions (Hooper, 2023). Rural hospitals struggle to recruit and retain nurses partly due to a lack of amenities, limited educational, social, and professional networking and growth opportunities, cultural isolation, and limited resources. This creates larger workloads for existing staff. Additionally, the projected shortfall in nursing is estimated to reach an all-time high of over ten million by 2030 (Bae, 2023). To address and combat these challenges head-on, rural hospitals must implement processes that provide professional development opportunities, foster a supportive and engaging work environment, and empower nurses to take an active role in institutional decision-making regarding patient care.

Shared governance (SG) is one such process that can help rural hospitals with retention and recruitment. It was founded on sociologist Rosabeth Moss Kanter's sociological Theory of Structural Empowerment. Kanter proposed that an employee's work environment influences their behavior and level of engagement and that employee engagement is inherently linked to one's level of decision-making authority (Kutney-Lee et al., 2016). SG emphasizes shared decision-making between the bedside nurses, managers, leaders, providers, and administration regarding resources, research, evidence-based practice projects, new equipment purchases, and staffing (McKnight & Moore, 2022). It has been identified as best practice in acute care hospitals and correlates with increased job satisfaction, decreased turnover, and improved patient safety and satisfaction (Allen-Gilliam et al., 2016).

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Background

In recent years, healthcare systems have faced mounting pressures due to staffing shortages, high levels of burnout among nurses, and the increasing demands of patient care (Bae, 2023). Many organizations struggle with traditional hierarchical structures that limit nurses' ability to influence decisions affecting their practice and patient care quality. This project's facility is no exception and struggles with these same obstacles. This scholarly Quality Improvement (QI) project focuses on the implementation of SG in a 25-bed inpatient Critical Access Hospital (CAH) in rural Montana, specifically the Medical Surgical (MS) unit. Currently, the hospital utilizes a Top-Down approach to implementing changes at all levels within the facility. This approach has created a real disconnect between the administration, nurses, and other healthcare providers responsible for direct patient care. Nurses report feeling unheard, underappreciated, and ill-equipped to do their job safely, often verbalizing confusion as to why the facility is expanding when their equipment is broken, outdated, or in short supply (Nursing Staff, personal communication, September 2024). This project will facilitate a more inclusive and collaborative approach to change and growth by utilizing the SG framework, where nurses can voice their opinions and participate in the decision-making processes.

Purpose

This voluntary, not-for-profit CAH MS unit aims to provide competent, evidence-based, quality care to its community and surrounding area residents. The hospital's mission is to provide the valley with quality, accessible, and personalized healthcare (J. Bush, personal communication, October 7, 2024).

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Patients

The MS unit reported 5461 patient days last year (J. Bush, personal communication, October 7, 2024). Inpatient services include cardiology, medical, neurology, orthopedic surgery, orthopedics, pulmonary, surgical, postpartum, gynecological, and urologic. Patients range in age from 0 to 100+. The patient population has a higher incidence of chronic conditions like cardiovascular disease, diabetes, and mental health issues due to geographical isolation and limited resources.

Professionals

In this facility, 27 RNs work in the inpatient unit, all working 12-hour shifts. Inpatients are defined as patients admitted to MS, Intensive Care Unit (ICU), Postpartum, Observation, Extended Recovery, and Swing Bed. Nurses' years of job experience ranges from new graduate to 25+ years (Nursing Staff, personal communication, September 2024). Each shift has a charge nurse, three to six nurses providing direct patient care, two to four certified nurse's assistants (CNA) and a ward clerk/telemetry technician (Nursing Staff, personal communication, September 2024). Staffing is based on census, acuity, and available staff. Patients often have multiple co-morbidities, requiring nurses to be diligent with their critical thinking and nursing skills. Because this is a CAH, the nurses must have a broad knowledge base as they care for many patients with various needs and diagnoses.

Process

The current processes for suggesting change and educational/skills needs are Find-it-Fix-it, Top-Down, Huddle Idea cards, and one-on-one communication with a manager or supervisor. At quarterly MS staff meetings staff are presented with changes in policy and procedures and notified when or if new equipment is going to be implemented. Currently, there is not a patient-

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care-related committee that discusses best practices, processes, and where policy changes that include inpatient nursing staff.

Patterns

Due to most of the decisions regarding policy and procedure changes typically originating from a Top-Down framework where direct patient care nurses have minimal input, the nurses in the inpatient unit exhibit low engagement in quality improvement, low morale, and feelings of underappreciation (Nursing Staff, personal communication, September 2024). Staff meetings for this unit are held quarterly and are often postponed or canceled for various reasons, contributing to the staff's feeling of disconnect.

Problem

The problem is the nursing staff's increasing rate of disengagement and decreased job satisfaction due to the traditional Top-Down management model. Nurses report they do not feel heard and have feelings of being underappreciated, which leads to diminished morale, reduced job satisfaction, burnout, and potentially higher turnover. Without meaningful opportunities to share their insights and concerns, the frontline nursing staff becomes less invested in hospital goals and quality improvement initiatives. This lack of engagement hinders effective teamwork and communication and can also negatively impact patient outcomes. Research shows that transitioning from the traditional Top-Down management model to SG improves nursing engagement, retention, communication, and patient outcomes (Porter-O'Grady, 2018). Without the adoption of SG, nursing staff may remain disengaged, leading to continued high turnover rates and increased expenditures for the facility. By implementing SG, the facility will empower nurses and promote collaborative decision-making, providing a potential solution, increasing recruitment rates, and decreasing turnover rates.

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Significance

If the problem of disengagement among nursing staff continues to be ignored, the consequences can be severe. High turnover rates not only increase staffing costs but also negatively impact patient safety and satisfaction and decrease morale among staff. Research indicates that engaged nursing teams contribute to lower morbidity and mortality rates, underscoring the importance of fostering an empowered workforce (Spencer Laschinger et al., 2016). Additionally, the lack of SG can exacerbate feelings of burnout and stress among nurses, leading to a vicious cycle that ultimately affects patient care and organizational effectiveness. The absence of SG contributes to increased nurse burnout, dissatisfaction, and attrition (Brooks Carthon et al., 2019). As a result, patients may experience fragmented care, higher rates of adverse events, and longer hospital stays (Brooks Carthon et al., 2019).

In October 2022, statistics reported in Becker's published report showed that the overall nursing turnover rate was 21%, which is an increase of 8.4% from the previous year (Hooper, 2023). The same report identified RN turnover rates in step-down units, emergency departments, behavioral health, and telemetry increasing from 101.3% to 111.4% over the last five years, and the average turnover cost for each RN was \$46,100 (Hooper, 2023). This facility's turnover rate from January 1, 2024, to September 30th was 15%, almost 3% higher than the previous year. Using Hooper's turnover rates, this facility faces a preventable expense that will easily exceed 875,000 dollars.

The problem of nurse disengagement and its effects on patient care is increasing, particularly in the wake of the COVID-19 pandemic, which has exacerbated existing challenges in nursing. This facility utilizes Gallup surveys to measure employee engagement; currently, only 55% of nursing staff is participating in the surveys (down from 75%), and all of the survey

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question scores have declined from the prior survey (J. Bush, personal communication, October 7, 2024). Two of the survey questions that received the lowest scores were “There is someone at work who encourages my development, and at work, my opinions matter” (J. Bush, personal communication, October 7, 2024). Ignoring the need for SG will only exacerbate the effects of decreased job satisfaction and increasing turnover within the facility. These projected effects include deteriorating patient care quality, poor morale, burnout, and the increased costs associated with hiring and training new staff. This situation can lead to a healthcare system that is unable to meet the demands of its growing community.

Purpose/Aim

The purpose of this QI project is to develop a process to implement SG into this facility as an evidence-based best practice intervention to improve nursing performance, job satisfaction, nurse retention, and recruitment for this CAH. The specific aims identified to measure the success of the SG include decreasing nursing turnover rates by 25% over the next two years and achieving a 20% increase in staff satisfaction survey scores within 18 months of implementation.

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Chapter 2

Literature Review

Rural hospitals face multiple challenges due to limited resources, workforce shortages, and the pressure to bridge the gap in care for underserved populations (Allen-Gilliam et al., 2016). Research shows that transitioning from the traditional Top-Down management model to SG improves nursing engagement, retention, communication, and patient outcomes (Porter-O'Grady, 2018).

In recent years, healthcare systems have faced mounting pressures due to staffing shortages, high levels of burnout among nurses, and the increasing demands of patient care (Bae, 2023). Many organizations struggle with traditional hierarchical structures that limit nurses' ability to influence decisions affecting their practice and patient care quality. The transition towards SG aims to address these challenges by creating a collaborative environment where nurses can voice their opinions and participate in decision-making processes.

Overview

Chapter Two of this QI scholarly project reviews research literature on implementing SG into nursing practice in acute care, specifically in rural hospitals, and its effects on nursing retention and job satisfaction. Included in the chapter are the search strategies used to gather data, the theoretical framework for implementing SG, a literature synthesis, and a summary of findings. For this study, SG is defined as a council created to share decision-making between the bedside nurses and nurse leaders, including resources, nursing research and evidence-based practice projects, new equipment purchases, and staffing (Mcknight & Moore, 2022). Retention is the “organized effort to build an environment that motivates employees to stay in their jobs by applying appropriate policies and interventions to attract and recruit health workers” (Efendi et

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al., 2019, p. 423). Worldwide nursing retention has become a growing problem in healthcare, and Montana is no exception. The Montana Department of Labor & Industry reports that 26% of RNs currently employed in nursing said they plan on retiring or otherwise leaving the nursing field in the next five years, an 8% increase from 2020 (Trautman, 2023). Another competing factor in nurse retention is the adoption of the Nurse Licensure Compact; 78% of Montana's RNs hold a multistate license, increasing competition for in-state employers as they compete with employers in other participating states (Trautman & Watson, 2021). To compete with these external factors, employers must implement internal interventions to increase the retention and recruitment of nurses. Implementing SG will not only meet these needs, but it has also been shown to positively impact patient outcomes and can lead the way for a CAH to meet Magnet hospital criteria, which is a future goal of the facility utilized for this project.

Search Strategy

Research for this QI scholarly project was collected through Montana State University's online library database to identify current practices, evidence-based best practices, and implementation strategies. Research was also gathered to identify the scope and relevance of nursing retention and turnover. The university's research librarian was also utilized to gather relevant research for this project. The search engines utilized include Cumulated Index in Nursing and Allied Health Literature (CINAHL), PubMed, Medline, Cochrane, and OVID. Of these, CINAHL, PubMed, and Medline were the most productive in producing relevant data.

During the database searches, the key terms shared governance, rural, hospital, nursing, nurse practice council, retention, engagement, and job satisfaction were used in various combinations to refine the investigator's results. Gray literature, which provided statistical data on nursing turnover rates and costs related to nursing turnover in hospitals, was also used for this

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project. Before MeSH qualifiers were applied, the databases produced more than two thousand results for the key terms used. The MeSH qualifiers added to refine the data collection included full text, English text, and studies conducted after 2012. These qualifiers reduced the results to 147 studies in total. Those results were then reviewed for context, excluding duplicate studies and studies about nursing students or nursing schools. In total, 19 articles met the criteria for this project. The articles included were of the following study designs: longitudinal, correlational, cross-sectional, expert descriptive research, gray literature, and a systematic review (see Table in Appendix A).

Conceptual/ Theoretical Framework

The Institute for Healthcare Improvement's Model for Improvement, a practical and structured step-by-step process, was created to help guide its users through identifying and addressing problems systematically and efficiently (Ogrinc et al., 2022). It was developed using W. Deming's Theory of Profound Knowledge and a conceptual framework comprised of three fundamental questions to identify the project's aim, measures, and changes (Ogrinc et al., 2022). Deming's theory emphasizes the importance of building knowledge through interactive testing and learning while also recognizing human influences that facilitate an organization's culture toward change, motivation, learning, and collaboration (Leonard, 1997). When conceptualizing a change plan, three questions must be asked: What are we trying to accomplish; How will we know that a change is an improvement; and What changes can we make that will result in the improvement (Ogrinc et al., 2022). These questions will help identify the project aim, tools of measure, and projected desired change, making the process engaging and interesting for the audience.

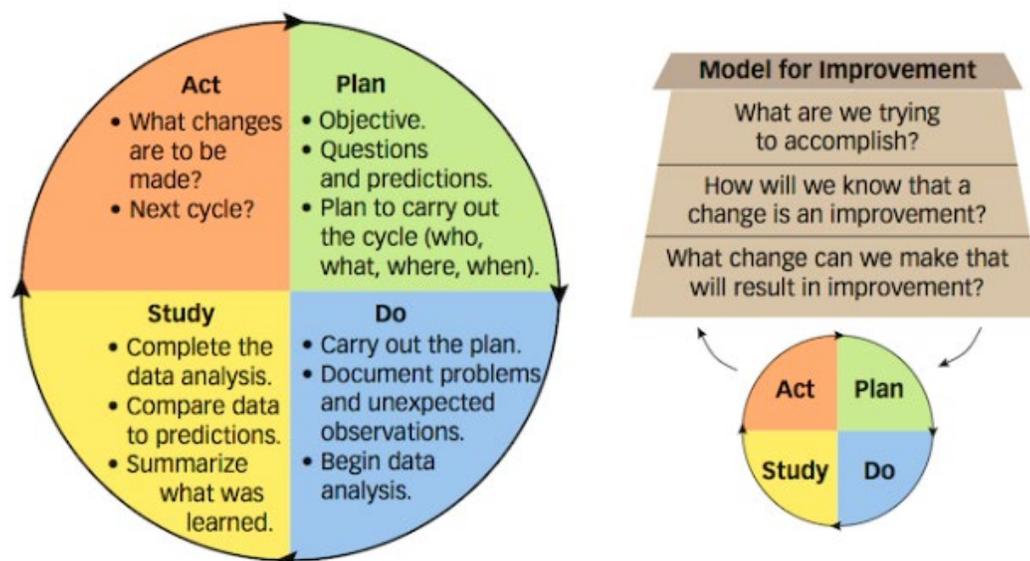
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After identifying the project's aim, measures, and changes, a series of Plan-Do-Study-Act (PDSA) cycles can be used to test whether the interventions or changes will produce the projected outcomes. During the Plan phase, the project aim is used to identify the proposed wanted change along with the tools of measurable metrics of success and implementation plans (Ogrinc et al., 2022). Next, in the Do phase, the plan is executed, and data is collected using the appropriately identified tools of measure (Ogrinc et al., 2022). This then starts the Study phase. The data collected is analyzed and compared to the expected outcome (Ogrinc et al., 2022). Finally, in the Act stage, one decides if the desired outcome has been reached. If the project goal is achieved, then the new process is implemented. If the project goal is not met, necessary changes are identified and implemented in the next PDSA cycle, and the process is repeated until the project goal is met and the new quality improvement process can be implemented (Ogrinc et al., 2022).

The Model for Improvement (MFI) is an appropriate Theoretical Underpinning and Conceptual Framework for creating and implementing SG. It is ideal for this scholarly project because it focuses on continuous improvement, emphasizes measurable outcomes, encourages engagement and accountability, and is a simple and practical framework that supports change and adaptability. All of these attributes align with the fundamental principles of SG.

This model promotes change, allows multiple cycles to identify and address problem areas, and focuses on measurable outcomes. Utilizing the PDSA cycles allows groups to pilot a change, gather data, and adjust strategies based on measured feedback. This ensures that SG remains effective and evolves based on evidence. The Model for Improvement fosters a culture of engagement and accountability, which are core values of SG, and empowers nurses to actively participate in the governance process, identify problems, propose solutions, and track outcomes.

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(Jones, 2018)

Synthesis of the Literature

Relevant research shows that SG positively impacts both nursing staff and the organization. During the literature review, several common themes have been identified. These themes include SG's positive impact and correlation on nursing engagement and job satisfaction, retention and turnover rates among nursing staff, and nurses' perceived empowerment and professional growth. The practical implications and feasibility of implementing SG and the strengths and limitations of current research have also been evaluated.

Impact on Nurse Engagement and Job Satisfaction

A persistent theme in the literature is the role of SG in promoting nurse engagement and increased job satisfaction. Studies such as those by Allen-Gilliam et al.

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(2016) and Jaber et al. (2022) found that SG improves a nurse's perception of decision-making autonomy and empowerment. In longitudinal studies, SG was linked with a sustained enhancement in job satisfaction, highlighting SG's impact in creating a more supportive work environment where nurses feel valued and engaged. Shared governance was also associated with a statistically significant reduction in job dissatisfaction and burnout, particularly in high-stress settings like critical care (Kutney-Lee et al., 2016; Sanchez et al., 2023).

Retention and Turnover Rates among Nursing Staff

Factors such as burnout, limited support from leadership, and a lack of professional development opportunities were identified as major contributors to nurse turnover. Research has shown that SG helps mitigate these issues by enabling participatory decision-making and increasing professional support. Colosi (2024) highlighted that healthcare facilities with strong SG frameworks report lower turnover rates and higher retention in units with high burnout potential, such as emergency and intensive care units.

Perceived Empowerment and Professional Growth

The studies utilized for this project also consistently support the notion that SG strengthens nurses' sense of empowerment and promotes professional growth and opportunities. Kneflin et al. (2016) and Olender et al. (2020) illustrated that SG facilitates interdisciplinary collaboration and empowers nurses to engage in continuous quality improvement and EBP implementation. Nurses reported greater satisfaction with their professional roles when involved in SG, noting that it allows them to contribute to the policy and practice decision-making process. Shared governance enhances job satisfaction and nurses' perceptions of their professional competency and worth within the healthcare setting.

Practical Implications and Feasibility

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The evidence suggests that SG is feasible and effective in enhancing nursing practice environments, particularly in high-stress acute care settings. SG is minimally invasive, poses little risk, and can be implemented across multiple healthcare settings with organizational support. The practical benefits of SG (increased nurse retention, improved job satisfaction, and enhanced perception of nursing autonomy and empowerment) affirm the potential of SG as a foundational structure in nursing management (Allen-Gilliam et al., 2016).

Strengths and Limitations of Current Research

The reviewed studies collectively provide a strong foundation of evidence supporting the benefits of SG, but they also present several limitations. Strengths include the broad overview that cross-sectional studies provide and the ability of longitudinal studies to track outcomes over time. Limitations of these studies include the limited ability for causal inference and restricted generalizability. Another limitation identified was the potential for bias due to the reliance on self-reported measures. However, the use of validated tools such as the Maslach Burnout Inventory (MBI) and the Practice Environment Scale of the Nursing Work Index (PES-NWI) enhances the reliability of self-reported findings. The MBI is a widely recognized instrument that measures occupational burnout across multiple dimensions. Christina Maslach and her colleagues created the MBI that focuses on three core subscales: Emotional Exhaustion, Depersonalization (or Cynicism) and Reduced Personal Accomplishment (Maslach et al., 2012). Emotional Exhaustion reflects the depletion of emotional resources, Depersonalization involves an impersonal and detached response to recipients of one's care or service and Reduced Personal Accomplishment assesses the individual's sense of ineffectiveness and lack of achievement at work (Maslach et al., 2012). Internal consistency (Cronbach's alpha) values for the MBI's subscales typically exceed 0.70, indicating reliable measurement (Lin et al., 2022). The MBI's

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factor structure has been replicated in numerous studies across diverse professional and cultural settings, adding to its generalizability and cross-cultural applicability (Schaufeli et al., 2009). Its widespread adoption as the “gold standard” for burnout assessment underscores researchers' and practitioners' confidence in the instrument's validity and utility.

The PES-NWI is designed to evaluate the characteristics of the nursing practice environment that affect nurse satisfaction, retention, and the quality of patient care (Aiken & Patrician, 2000). It is a refinement of the original Nursing Work Index that focuses on organizational attributes supporting professional nursing practice, including nurse autonomy, control over the practice setting, and the quality of nurse-physician relations (Aiken & Patrician, 2000). Internal consistency metrics for the PES-NWI commonly exceed 0.80 for its subscales, indicating strong reliability (Aiken & Patrician, 2000). Its adoption in large-scale, multisite studies further reinforces the PES-NWI's credibility as a measure of the nursing practice environment (Lake, 2002).

Summary

Current evidence supports this QI scholarly project of implementing SG as an evidence-based intervention to improve nurse retention and job satisfaction. Shared governance has been proven to be a sustainable and cost-effective intervention that will propel this CAH into a relevant and competitive organization. With Montana's increase in retiring nurses and the competitive market that compact licensure has opened for many nurses, the hospital must act and provide nurses with opportunities to grow in both skill and knowledge and to empower nurses to be engaged in their profession while also supporting their autonomy. Shared governance allows for all these interventions and attributes and several others related to patient outcomes, which are not discussed in this paper.

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The purpose of this scholarly project is to identify how the implementation of SG in this rural CAH, compared to the current absence of SG, will promote nursing retention, job satisfaction, and the implementation of EBP in patient care and nursing practice. To accomplish its aim, this project will utilize the relevant performance metrics of retention rates, job satisfaction scores, and surveys. Each metric will have a target goal with benchmarking. Data sources will include historical data, industry reports, and stakeholder input. Quality control will be regulated by systematically tracking the key metrics identified in the quality planning phase and implementing corrective actions. Data visualization tools will also be utilized to enable real-time analysis and intervention. The QI process will utilize PDSA cycles to identify goals, develop an action plan, implement the plan, collect and analyze data, and modify, expand, or discontinue the initiative.

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Chapter Three

Overview

The purpose of this quality improvement (QI) project is to implement and evaluate a shared governance (SG) model in a rural Critical Access Hospital (CAH) in Montana to enhance nursing engagement, reduce burnout, and increase nursing retention. A microsystem assessment identified the need for a structured approach to empower bedside nurses and bridge the gap between frontline staff and leadership. This QI project is supported by the research presented in Chapter Two, which highlights SG as an effective strategy for promoting nurse autonomy, fostering collaborative decision-making, strengthening nurse engagement, and increasing nursing retention (Kaddourah et al., 2020). The project follows the Institute for Healthcare Improvement's (IHI) Plan-Do-Study-Act (PDSA) cycle to facilitate iterative improvements. As a hypothetical proposal, the project serves as a structured model for implementing SG in rural CAHs, with the overarching goal of creating a resilient and engaged nursing workforce that delivers high-quality, evidence-based care tailored to the unique challenges of rural healthcare settings, while also improving retention rates. This project will utilize the Maslach Burnout Inventory (MBI) (Appendix C) and the Practice Environment Scale of the Nursing Work Index (PES-NWI) (Appendix D) to measure nurse burnout and perceptions of the work environment, as well as data from the hospital's human resource department to measure employee satisfaction surveys and retention rates.

Design of the Quality Improvement Project

Project Design

The IHI Model for Improvement is the theoretical framework that will be utilized for this clinical project. This model's PDSA cycles emphasize the iterative testing of small changes to

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refine interventions, allowing for continuous evaluation and timely adjustments to optimize nurse engagement and leadership involvement (Institute for Healthcare Improvement [IHI], 2022). The IHI framework supports sustainable, data-driven improvements that align with the unique needs of a CAH setting by guiding the structured implementation and continuous refinement of SG in real time. Chapter Two discusses the IHI Model for Improvement in further detail.

Settings, Target Population, and Stakeholders

The QI project will be implemented in the MS unit of a 25-bed CAH in rural Montana. This unit reported 5461 patient days last year and serves a predominantly Medicare/Medicaid patient population with a wide diversity of acute and chronic health conditions who range in age from 0-100+ and is staffed with nurses whose work experience ranges from new graduates to 20+ years of nursing. The microsystem assessment of this unit in Chapter One further discusses the project setting, patient population demographics, and staffing. The target population for this project includes bedside nurses, nurse leaders, managers, and administrative personnel. The primary stakeholders for this proposed QI project are the nursing staff, hospital administration, the quality improvement committee, and patients.

Planning and Project Intervention

A microsystem assessment was performed to identify causative factors. This assessment revealed that nurses felt a lack of professional autonomy, that they felt underappreciated, that their ideas and concerns were unheard, and that they had limited growth opportunities. Nurses reported feelings of emotional and physical exhaustion. They were frustrated that the administration makes most decisions without input from the bedside nurse who directly interacts with and cares for the patients. It was also noted that this hospital had an above-average turnover rate compared to like-sized hospitals. Recognizing the gap between the current hierarchical

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structures and the desire for collaborative practice, nurse managers and nursing staff agreed that a change was needed. Through open discussion about the need to address and change the current cultural resistance and communication barriers, the implementation of SG was identified and widely supported as a feasible, cost-effective, sustainable intervention that has the potential to be equally beneficial to administration, management, nursing staff, and patients.

To understand the current staffing issues and identify a sustainable solution, baseline data will be collected from nurse surveys, exit interviews, and self-reporting that identified increased burnout, poor morale, disengagement, and increased turnover rates in the MS unit as the primary negative influences on the current culture. In the project's planning phase, the project facilitators will collaborate with nursing leadership, human resources, and direct patient care nurses. This will be essential to ensure the data accurately reflects unit-wide experiences. A project timeline, stakeholder engagement strategy, and communication plan will be developed to support transparency and ensure that the input of nurses directly caring for patients is prioritized throughout the process. Additionally, scheduling focus groups and feedback sessions will help validate survey results and align the intervention with staff-identified needs.

Challenges

Hypothetical challenges to establishing and implementing SG in this CAH include staff hesitancy to assume new responsibilities due to a perceived increased workload and resource constraints related to scheduling, administrative support, collaboration, and conflict resolution skills (McKnight & Moore, 2022). Other challenges identified include obtaining financing, sustained support, and involvement by all stakeholders. These concerns will be preemptively addressed with the early involvement of nursing staff in planning, transparent communication of

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goals, visible leadership support, brief, structured meetings on a rotating schedule, and short, easily accessed workshops to guide role expectations (McKnight & Moore, 2024).

Framework Guidance

For this QI project, the investigator will utilize the IHI Model for Improvement as the guiding framework to develop and implement an SG model tailored to the needs of a rural CAH. The Model for Improvement focuses on three key questions that, when answered, define the aim, identify measures to evaluate success, and select changes that will lead to improvement (Ogrinc et al., 2022). These principles align with the objectives of SG by emphasizing iterative testing, stakeholder engagement, and data-driven decision-making. To ensure the intervention effectively enhances nurse engagement and reduces burnout, the investigator incorporated insights from a microsystem assessment, nurse feedback, and organizational priorities. The MBI and the PES-NWI will serve as outcome measures to evaluate the impact of SG on nurse well-being and workplace perceptions. The structured implementation of SG through the PDSA cycle will facilitate continuous refinement and sustainability of the intervention.

Proposed Implementation Procedures

The proposed implementation of this QI project will follow the IHI PDSA cycle to ensure an iterative and data-driven process. The project will be divided into four phases to ensure adequate refinement (see Appendix E). The QI project proposal will be presented to the hospital's board and foundation members for funding approval.

The first phase, the planning stage, will involve forming an SG council composed of bedside nurses, nurse leaders, and key stakeholders to guide the initiative. The first step will include securing leadership and frontline staff buy-in by engaging stakeholders early and emphasizing the benefits of SG, such as improved nurse engagement, increased autonomy, and

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influence in hospital policy. Initial engagement will occur through information-sharing sessions led by nursing leadership, where staff will be invited to participate in council development and decision-making processes. A multidisciplinary Shared Governance Council will be established, composed of bedside nurses, clinical supervisors, and nurse managers. Initial council members will be obtained through a volunteer and nomination process. Council members will receive training and education sessions to ensure they understand their roles, responsibilities, and decision-making authority. A key focus of this phase will be establishing realistic metrics for evaluating success, such as job satisfaction, burnout reduction, and patient care improvements. This council will identify priority issues affecting nursing practice and propose evidence-based solutions.

During this phase, staff input will be collected through surveys and focus groups to understand concerns, identify priorities, and shape the structure of the SG model. The council will establish clear goals, define roles, and create protocols for collaborative decision-making, ensuring that these processes align with the hospital's policies and mission. Education sessions will be conducted to introduce the concept of SG and provide training on leadership skills, decision-making strategies, and evidence-based practice.

Phase Two, the “Do” phase, SG activities, will be piloted in the MS unit, with regular meetings to discuss staffing, workflow, and clinical decision-making issues. Staff will be encouraged to bring forward concerns and propose solutions, which will be evaluated and implemented when appropriate. Minutes and decisions made during the meetings will be documented and shared to promote transparency. To encourage active participation, nurse managers and leaders will mentor and support council members, ensuring their voices are heard and their recommendations are considered when making organizational decisions.

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In the “Study” phase (Phase Three), data will be collected through a multifaceted approach to ensure a comprehensive evaluation of nurse burnout, engagement, and retention. Anonymous surveys will be disseminated via an online survey engine to capture quantitative data using the MBI (Maslach & Jackson, 1981) and the PES-NWI (Lake, 2002). These instruments provided reliable measures of emotional exhaustion, depersonalization, personal accomplishment, and work environment perceptions. In addition, retention and employee engagement data will be extracted from Human Resources records and compiled using Excel spreadsheets. This administrative data includes nurse turnover rates, length of service, and results from standard employee satisfaction surveys. The combination of these data sources will then be analyzed using descriptive statistics, paired t-tests, and repeated-measures ANOVA to identify significant changes over time and assess the impact of the SG intervention on nurse outcomes. The results will be compared to baseline data to identify areas of improvement and challenges requiring further intervention. Monthly feedback sessions with council members and staff will be conducted to assess the implementation's effectiveness and identify areas for improvement.

The final “Act” phase (Phase Four) will focus on adjusting and refining the SG model based on the outcomes and feedback gathered. The estimated timeframe for this project is approximately nine months. Appendix E provides a visual breakdown of each of the project's phases, detailing the steps, goals, and estimated time frame for each phase. The project has an estimated budget of six thousand dollars (Appendix F). Funding acquired from the project's budget will cover the cost of staff training and education materials, printing and communication resources (newsletters, handbooks), data collection tools (MBI & PES-NWI assessments), SG recognition and incentives (awards, certificates), and any miscellaneous costs that may occur.

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If the pilot is successful, this project hopes the model will be expanded to all nursing units within the hospital. Continuous education and mentorship will remain a priority to sustain engagement and ensure that the model evolves to meet the changing needs of the nursing staff and the organization. The structured yet flexible and iterative implementation approach of the PDSA cycle aims to create a sustainable SG model that promotes nurse empowerment, enhances job satisfaction, and improves nurse retention in rural CAHs.

Evaluation Tool and Outcome Measures

To evaluate the effectiveness of the SG QI Project, data will be gathered from validated assessment tools and key performance indicators to measure its impact on nurse engagement, burnout reduction, and job satisfaction. The MBI and the PES-NWI will be the primary evaluation tools used to measure nurse engagement, burnout, and work environment perceptions (Maslach & Jackson, 1981; Aiken et al., 2002). The MBI will assess nurses' emotional exhaustion, depersonalization, and personal accomplishment, which are key indicators of burnout. The PES-NWI will measure nurses' perceptions of job satisfaction, autonomy, and participation in decision-making, critical elements influenced by SG structures.

The evaluation will include pre-and post-intervention assessments to compare baseline data with results after the implementation of SG. Data collection will occur at regular intervals, focusing on quarterly reviews to assess the sustainability of improvements. The outcome measures will allow for adjustments to be made in real-time based on feedback from nurses using a continuous PDSA cycle to ensure the success of the intervention.

Expected outcomes include the fruition that SG fosters a supportive work environment, as evidenced by increased PES-NWI scores reflecting higher job satisfaction and nurse autonomy, aligning with the project's aim to promote nurse-led decision-making. A reduction in

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reported emotional exhaustion and decreased nurse burnout, as well as continued participation in SG committees, demonstrate nurse engagement and leadership in practice improvements.

Summary

This QI project aims to implement and evaluate a SG model in a rural CAH to enhance nurse engagement, reduce burnout, and improve nurse retention. A microsystem assessment identified significant challenges, including lack of professional autonomy, disengagement, and high turnover rates among nursing staff. Grounded in the IHI Model for Improvement, the project follows the PDSA cycle to iteratively refine SG structures, ensuring they are sustainable and practical within a resource-constrained rural healthcare setting. The MBI and the PES-NWI will serve as primary outcome measures, assessing nurse burnout, engagement, and perceptions of workplace autonomy. The project's structured four-phase implementation plan focuses on council formation, staff education, pilot testing, and iterative refinements based on ongoing data collection. Expected outcomes include improved nurse participation in decision-making, increased job satisfaction, and reduced emotional exhaustion, ultimately leading to improved retention rates. Through continuous monitoring and stakeholder engagement, this initiative seeks to foster a resilient, empowered nursing workforce that enhances the quality of care in a rural healthcare setting.

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Chapter Four

Introduction

The purpose of this quality improvement (QI) project was to develop a process for establishing, implementing, and evaluating the impact of shared governance (SG) on the medical-surgical (MS) unit in a rural Critical Access Hospital (CAH) in Montana. More specifically, the project will explore how SG would elicit enhanced job performance, job satisfaction, and nursing engagement while promoting recruitment and increasing nurse retention as predicted from the project's literature review. A literature review identified SG as an evidence-based approach that empowers bedside nurses to participate in the decision-making processes, leading to improved job satisfaction, autonomy, and increased retention rates. This chapter provides a summary of the SG QI project, discusses findings from the literature review, explores the alignment of the intervention with the Institute for Healthcare Improvement's (IHI) Model for Improvement framework, and outlines anticipated challenges. This chapter will also discuss the implications of this project for practice, education, and policy while emphasizing the role of the Clinical Nurse Leader (CNL) in facilitating and sustaining SG.

QI Project Summary

A microsystem assessment of the CAH's MS unit identified issues related to nurse disengagement, burnout, and high turnover rates. Surveys and motivational interviews found that limited decision-making authority for bedside nurses, inadequate and fractured communication between leadership and staff, feelings of underappreciation, and a lack of structured professional development opportunities had the highest negative impact on bedside nurses. The literature review identified SG as a feasible and cost-effective solution to empower nurses, improve communication, promote professional growth, and enhance job satisfaction (Porter-O'Grady,

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2018). The QI project is anticipated to facilitate the implementation of a structured SG council with various leadership roles and scheduled decision-making meetings, allowing bedside nurses to have a voice in policies and other initiatives that affect their practice.

The IHI Model for Improvement guided the implementation, utilizing Plan-Do-Study-Act (PDSA) cycles to refine the governance structure; due to the model's iterative nature, the project facilitators were able to make real-time changes, decreasing delays in the development and implementation process (Institute for Healthcare Improvement, 2017). The effectiveness of SG as an intervention will be measured using pre- and post-intervention surveys utilizing the Maslach Burnout Inventory (MBI) to assess burnout levels and the Practice Environment Scale of the Nursing Work Index (PES-NWI) to evaluate nursing perceptions of professional autonomy and work environment. Pre- and post-intervention hospital retention and job satisfaction data will be collected from the human resource department. The anticipated outcomes included increased nurse engagement, increased job satisfaction scores, improved retention rates, and greater nurse participation in decision-making processes.

Discussion

The literature review for this project supported and reinforced the hypothesis that organizations that utilized structured SG models experience lower turnover rates, increased interdisciplinary collaboration, and higher-quality patient outcomes (Kutney-Lee et al., 2016). Unexpectedly, some literature suggested that SG can initially increase nurses' workload perceptions, as SG requires additional time outside direct patient care and may deter participation (McKnight & Moore, 2022).

Furthermore, limited literature exists on the application of SG in rural CAHs, which often face unique resource constraints. This potential gap in implementation research data suggests

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that further studies should be done to explore how SG can be tailored specifically to rural healthcare environments. Despite limited evidence directly supporting SG in rural CAHs, the overall evidence strongly supports the effectiveness of SG in improving staff morale and job satisfaction, reducing burnout, and enhancing workplace collaboration.

Benefits and Challenges

One of SG's key benefits is its ability to foster a sense of professional autonomy among nurses. When bedside staff have a voice in decision-making, job satisfaction improves, leading to better retention and reduced burnout (Spence Laschinger et al., 2012). However, the implementation process may encounter resistance, particularly from nurses who are unfamiliar with SG principles or feel hesitant about taking on leadership roles. Additionally, resource constraints in CAHs with limited staffing may pose challenges in scheduling governance meetings and maintaining engagement.

To address these barriers, the project proposed an educational initiative to familiarize nurses with the SG model and encourage participation. The use of PDSA cycles allowed for continuous refinement, ensuring that the governance structure remained feasible and adaptable to staff needs.

Implications and Recommendations

Implications for Practice

The implementation of SG has the potential to significantly improve nurse engagement, reduce burnout, and increase retention in rural CAHs. By providing nurses with decision-making power, organizations can foster a culture of collaboration and accountability, ultimately leading to improved patient outcomes. Nurse leaders should support SG councils by actively

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participating in meetings, ensuring that nurses' voices are valued, and by allocating time for staff participation without disrupting patient care or creating an added burden for the nurse.

Implications for Policy

At the policy level, hospital administrations should incorporate SG into institutional policies to ensure its sustainability. As governance grows and advocates change, its members will have direct access to shaping policies and procedures to implement EBP to provide the best patient care while meeting the organization's mission and vision for the community. To help offset any costs, the organization could advocate for state and government funding and support programs that assist rural hospitals in implementing SG models.

CNL Role

To address the evolving demands of healthcare, the CNL role was introduced to nursing, and the American Association of Colleges of Nursing (AACN) established nine essential competencies necessary to enhance quality patient care outcomes (American Association of Colleges of Nursing, 2007). This project required the facilitator to apply these competencies while conducting microsystem analysis, implementing evidence-based practice, making data-driven decisions, ensuring accountability for outcomes, and managing resources and advocacy efforts.

The CNL plays a pivotal role in the implementation, promotion, and sustainability of SG initiatives. As a systems-level leader, the CNL bridges the gap between bedside nurses and hospital leadership, ensuring that governance structures align with institutional priorities. By advocating for nursing staff, the CNL fosters a work environment that encourages engagement, autonomy, and professional development.

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In rural CAHs, where resource limitations pose unique challenges, the CNL's expertise is particularly valuable in sustaining SG. Their role in advocating for policies that support shared decision-making ensures that governance initiatives remain aligned with organizational objectives and patient care priorities. By supporting ongoing staff education, promoting leadership development, and driving continuous quality improvement efforts, the CNL helps establish a culture of collaboration, accountability, and excellence in nursing practice.

Conclusion

The anticipated outcomes of this QI project indicate that implementing SG is a practical, fiscally responsible intervention to enhance nursing engagement, reduce burnout, and improve retention in a rural CAH. Bedside nurses gain greater professional autonomy and job satisfaction through structured participation in decision-making. The project utilizes the IHI Model for Improvement to iteratively refine the governance structure, ensuring sustainability. While challenges related to resource limitations and staff resistance are anticipated, educational initiatives and leadership support were critical in overcoming these barriers. Continued evaluation and adaptation will be essential to ensuring SG's long-term success and expansion across the CAH and in rural healthcare settings.

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Appendix A

Full citation	Theoretical basis for study – if none say NA or NONE	RCT? Correlation? Meta Analysis? Also what's the hypothesis/research question	Number, Characteristics, Attrition rate & why?	Independent variables (e.g., IV1 = IV2 ⇒) Dependent variables (e.g., DV =)	What scales were used to measure the outcome variables (e.g., name of scale, author, reliability info [e.g., Cronbach alphas])	What stats were used to answer the clinical question (i.e., all stats do not need to be put into the table)	Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)	Strengths and limitations of the study Risk or harm if study intervention or findings implemented Feasibility of use in your practice Remember: level of evidence + quality of evidence = strength of evidence & confidence to act Use the USPSTF grading schema http://www.ahrq.gov/clinic/3rduspstf/ratings.htm
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. <i>The Journal of Nursing Administration</i> , 46(5), 257–264. https://doi.org/10.1097/NA.0000000000000340	American Nurses Credentialing Center Magnet Model	Longitudinal study with descriptive design evaluate the long-term impact of shared governance implementation on nurse outcomes (e.g., satisfaction, empowerment) in a small community hospital.	218 nurses. Characteristics: Nurses from a small community hospital were surveyed over 5 years. The attrition rate was not reported	IV1 = Implementation of shared governance; IV2 = Time (measured at multiple points over 5 years) DV1 = Nurse job satisfaction; DV2 = Nurse empowerment; DV3 = Perception of decision-making autonomy	Nursing Work Index-Revised (NWI-R) Cronbach's alpha ranging from 0.80 to 0.96, Shared Governance Survey, Index of Work Satisfaction (IWS)-1997 Revision, Work Practice Breakdown Survey, Developing EBP, with internal reliability reported through Cronbach's alpha =0.87	Descriptive statistics, paired t-tests, and repeated measures analysis of variance (ANOVA) All significance levels set at P<.05 NWI-R SGS IWS PES	Statistically significant improvements in nurse job satisfaction, decision-making autonomy, and empowerment after the implementation of shared governance, with sustained positive effects over the 5-year period Perception of SG (p < 0.05) Work satisfaction improved by 9 SD (p < 0.01)	Strengths: The longitudinal design allows for the assessment of the sustainability of shared governance effects over time. Limitations: The single-site study in a small community hospital limits generalizability to larger or more diverse settings. Minimal Risk Highly feasible Level of Evidence = III Quality of Evidence = Moderate Strength of evidence: Moderate confidence to act

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<p>Bae, S.-H. (2023). Comprehensive assessment of factors contributing to the actual turnover of newly licensed registered nurses working in acute care hospitals: a systematic review. <i>BMC Nursing</i>, 22(1), 31. https://doi.org/10.1186/s12912-023-01190-3</p>	<p>Price's conceptual framework</p>	<p>Systematic Review To identify and synthesize factors contributing to the actual turnover of newly licensed registered nurses (NLRNs) in acute care hospitals.</p>	<p>10 studies included in the systematic review. Characteristics: Studies examining newly licensed registered nurses in acute care hospitals. No attrition rate applicable as this is a systematic review.</p>	<p>IV1 = Individual factors (e.g., job satisfaction, burnout); IV2 = Organizational factors (e.g., staffing levels, leadership support); IV3 = External factors (e.g., economic conditions, labor market) DV = Actual turnover of newly licensed registered nurses (NLRNs)</p>	<p>systematic review does not use scales itself but reports on scales used in the primary studies Maslach Burnout Inventory (MBI) Minnesota Satisfaction Questionnaire (MSQ) Cronbach's alphas 0.80 to 0.90. Revised Nursing Work Index (NWI-R) 0.80 and 0.96 Turnover Intention Scale (TIS-6) 0.85 to 0.90.</p>	<p>Meta-analysis techniques where applicable, descriptive synthesis for studies that could not be quantitatively pooled. Descriptive Statistics: Regression Analysis: Multiple regression analyses Cox Proportional Hazards Models</p>	<p>individual factors such as job dissatisfaction, burnout, and lack of support were strongly associated with NLRN turnover. Organizational factors, particularly staffing shortages and leadership support, were also key contributors. External factors, including labor market conditions, played a role but were less consistent across studies. lower job satisfaction significantly associated with higher turnover ($p < 0.01$) poor nurse work environments significant predictors of turnover ($p < 0.05$) turnover intention ($p < 0.01$)</p>	<p>Strengths: Comprehensive review of various factors contributing to NLRN turnover, inclusion of diverse studies. Limitations: Variability in study designs and measures across included studies; some studies lacked sufficient statistical rigor, limiting generalizability. No direct harm High feasibility Level of Evidence = I Quality of Evidence = Moderate to high Strength of evidence: High confidence to act</p>
<p>Brooks Carthon, J. M., Hatfield, L., Plover, C., Dierkes, A., Davis, L., Hedgeland, T., Sanders, A. M., Visco, F., Holland, S., Ballinghoff, J., Del Guidice, M., & Aiken, L. H. (2019). Association of nurse engagement and nurse staffing on patient safety. <i>Journal of Nursing Care Quality</i>, 34(1), 40–46. https://doi.org/10.1097/N CQ.0000000000000334</p>	<p>Donabedian's conceptual model of health care quality</p>	<p>Correlational Study To explore the association between nurse engagement, nurse staffing, and patient safety outcomes in acute care settings.</p>	<p>26,960 registered nurses from 599 hospitals. Characteristics: Nurses in various acute care settings, diverse backgrounds, and experience levels. No attrition rate provided as it is a cross-sectional study.</p>	<p>IV1 = Nurse engagement; IV2 = Nurse staffing levels DV = Patient safety outcomes (e.g., falls, pressure ulcers, infection rates)</p>	<p>Nurse engagement was measured using validated tools, including the Practice Environment Scale of the Nursing Work Index (PES-NWI). Patient safety outcomes were derived from hospital-reported safety data. Reliability of the PES-NWI reported with</p>	<p>STATA version 14.2 Significance set up at $p < 0.05$, 2-tailed</p>	<p>31% (n=227) engaged 37% (n=223) mod engaged 21% (n=124) slightly engaged 4% (n=25) minimally engaged 1-unit increase in engagement lowered the odds of an unfavorable safety grade by .71 (95% CI = .68–.75) or a decrease of 29%. ($p < .001$).</p>	<p>Strengths: Large sample size, national data, validated measurement tools for nurse engagement and safety. Limitations: Cross-sectional design limits causal inference; reliance on self-reported engagement and hospital-reported safety data may introduce bias. Minimal Risk Feasible with organizational support Level of Evidence = III Quality of Evidence = High Strength of evidence: Moderate to high confidence to act</p>

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					Cronbach's alpha > 0.80			
Colosi, B. (2024). 2024 NSI National Health Care Retention & RN Staffing Report. NSI Nursing Solutions, Inc. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf	NA	Gray Lit. Provides an annual assessment of national trends in nurse retention, turnover, and staffing challenges in U.S. hospitals.	Data collected from 272 healthcare organizations representing over 760,000 nurses. No attrition reported as this is a cross-sectional report based on aggregated national data.	IV1 = Organizational retention practices; IV2 = Staffing levels; IV3 = Nurse demographics (e.g., years of experience, specialty) DV1 = RN turnover rates; DV2 = Retention rates; DV3 = Staffing vacancies	NA	Descriptive statistics, including percentages and averages, along with trend analyses over time.	national RN turnover rate in 2023 was reported at 22.5% average cost of turnover per RN was approximately \$52,100 Retention rates varied across regions and specialties, with critical care units and emergency departments experiencing the highest vacancy rates.	Retention rates varied across regions and specialties, with critical care units and emergency departments experiencing the highest vacancy rates. Minimal Risk Highly Feasible Level of Evidence = V Quality of Evidence = Moderate Moderate to high confidence to act
Gallagher-Ford, L. (2015). Leveraging shared governance councils to advance evidence-based practice: the EBP Council journey: Leveraging shared governance councils to advance evidence-based practice. <i>Worldviews on Evidence-Based Nursing</i> , 12(1), 61–63. https://doi.org/10.1111/wvn.12062	N/A	Descriptive Expert Describes the process and benefits of using shared governance councils to promote and implement evidence-based practice in nursing settings.	N/A	N/A	N/A	N/A	N/A	Strengths: Provides practical insights into how shared governance can be used to integrate EBP into nursing practice. Limitations: Lacks empirical data or formal evaluation of the approach described. Minimal risk Highly feasible Level of Evidence = V Quality of Evidence = NA Strength of evidence: Low to moderate confidence to act based on practical value but lacking empirical research.
Jaber, A., Ta'an, W. F., Aldalaykeh, M. K., Al-Shannaq, Y. M., Oweidat, I. A., & Mukattash, T. L. (2022). The perception of shared governance and engagement in decision-making among nurses. <i>Nursing Forum</i> , 57(6), 1169–1175.	NA	cross-sectional, descriptive design To assess nurses' perceptions of shared governance and their level of engagement in decision-making in healthcare settings.	111 RNs Characteristics: diverse clinical settings, varying levels of experience. No attrition was reported since it is a cross-sectional study.	IV1 = Perception of shared governance; IV2 = Demographic factors (age, experience, educational level)	The Index of Professional Nursing Governance (IPNG) was used to measure perceptions of shared governance, with high	Descriptive statistics, correlation analysis, and regression analysis IPNG was 113 (SD = 26.28).	Nurses with higher perceptions of shared governance reported significantly higher engagement in decision-making processes. Significant correlations were found between age, experience, and higher	Strengths: Large sample size, validated measurement tools. Limitations: Cross-sectional design limits the ability to infer causality; results may not be generalizable to all healthcare settings outside of the study context. Minimal risk

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<p>https://doi.org/10.1111/nurf.12817</p>				<p>DV = Engagement in decision-making</p>	<p>reliability (Cronbach's alpha > 0.94). Likert response scale.</p>		<p>engagement in decision-making.</p>	<p>High feasibility Level of Evidence = III Quality of Evidence = Moderate Strength of evidence: Moderate</p>
<p>Kaddourah, B., Al-Tannir, M., Kakish, S., & AlFayyad, I. (2020). Perception of shared governance among registered nurses in ambulatory care center at a tertiary care hospital in Saudi Arabia. <i>Cureus</i>, 12(6), e8736. https://doi.org/10.7759/cureus.8736</p>	NA	<p>Correlational, cross-sectional study explore the perception of shared governance among registered nurses in a tertiary care ambulatory care center</p>	<p>186 registered nurses. Characteristics: Nurses working in ambulatory care settings at a tertiary hospital No attrition noted</p>	<p>IV1 = Perception of shared governance (measured through surveys); IV2 = Demographics of nurses (e.g., age, experience) DV = Perceived level of shared governance among nurses</p>	<p>The Index of Professional Nursing Governance (IPNG), with Likert scale Cronbach's alpha of 0.94,</p>	<p>Descriptive statistics, independent t-tests, and ANOVA Pearson correlation relationship between shared governance perception and job satisfaction</p>	<p>significant difference ($p < 0.05$) based on educational level positive correlation ($r = 0.68, p < 0.01$)</p>	<p>Strengths: Use of a validated tool (IPNG), inclusion of nurses from different backgrounds and experience levels. Limitations: Single-site study, limited generalizability, self-reported data may introduce bias. No risk Feasible for practice Level of Evidence = III (cross-sectional, non-experimental study); Quality of Evidence = Moderate due to single-site study but reliable measurement tool. Strength of evidence: Moderate confidence to act.</p>
<p>Kneflin, N., O'Quinn, L., Geigle, G., Mott, B., Nebrig, D., & Munafo, J. (2016). Direct care nurses on the shared governance journey towards positive patient outcomes. <i>Journal of Clinical Nursing</i>, 25(5-6), 875-882. https://doi.org/10.1111/jocn.13114</p>	NA	<p>Descriptive, longitudinal study To describe the journey and outcomes associated with the implementation of shared governance by direct care nurses and its impact on patient outcomes.</p>	<p>Data collected from direct care nurses over several years in a large hospital system. No specific sample size or attrition rate provided, but the study focuses on nurses across multiple departments participating in shared governance.</p>	<p>IV1 = Implementation of shared governance; IV2 = Engagement of direct care nurses DV1 = Nurse-related outcomes (e.g., job satisfaction, empowerment); DV2 = Patient outcomes (e.g., hospital-acquired conditions,</p>	<p>IPNG Cronbach's alpha of 0.94 Nursing Worklife Survey (NWS): Cronbach's alpha of 0.91</p>	<p>Descriptive statistics, independent t-tests, and ANOVA</p>	<p>significant positive correlation ($r = 0.72, p < 0.01$) was found between higher shared governance perceptions and improved patient outcomes higher perceptions of governance also reported higher satisfaction with their work environment ($r = 0.68, p < 0.01$).</p>	<p>Strengths: Longitudinal design allows for tracking changes over time, highlighting the ongoing benefits of shared governance on nurse and patient outcomes. Limitations: Lacks detailed statistical analyses, and the generalizability is limited due to a single healthcare system. Minimal risk High feasibility Level of Evidence = III Quality of Evidence = Moderate Strength of evidence: Moderate</p>

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				patient satisfaction)				
Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Del Guidice, M., & Aiken, L. H. (2016). Nurse engagement in shared governance and patient and nurse outcomes. <i>The Journal of Nursing Administration</i> , 46(11), 605–612. https://doi.org/10.1097/NA.0000000000000412	N/A	cross-sectional observational Relationship between nurse engagement in SG and patient outcomes	20,674 RN 425 non-federal acute care hospitals. Varying level of nurse engagement No attrition noted	IV1 = Nurse engagement in shared governance; IV2 = Hospital shared governance structures DV1 = Patient outcomes (e.g., mortality, failure-to-rescue); DV2 = Nurse outcomes (e.g., burnout, job satisfaction)	PES-NWI Cronbach's alpha 0.82–0.93 Maslach Burnout Inventory (MBI) Cronbach's alpha 0.90 Job satisfaction scale Cronbach's alpha of 0.85.	Multivariate regression analysis Descriptive Statistics Correlation Analysis	higher job satisfaction ($p < 0.01$) and lower burnout ($p < 0.05$) positive correlation ($r = 0.65$, $p < 0.01$) was found between higher shared governance engagement and job satisfaction, while a negative correlation ($r = -0.58$, $p < 0.01$) was observed with burnout.	Strengths: Large sample size, national data, use of validated measurement tools. Limitations: Correlational design cannot determine causality; self-reported data subject to bias. Minimal risk High feasibility. Level of Evidence = III Moderate confidence
Olender, L., Capitulo, K., & Nelson, J. (2020). The impact of interprofessional shared governance and a caring professional practice model on staff's self-report of caring, workplace engagement, and workplace empowerment over time. <i>The Journal of Nursing Administration</i> , 50(1), 52–58. https://doi.org/10.1097/NA.0000000000000839	Watson's theory of human caring and appreciative inquiry	a descriptive, longitudinal design. To explore the impact of interprofessional shared governance and a Caring Professional Practice Model on staff's perceptions of caring, workplace engagement, and empowerment over time.	1,244 interprofessional staff members participated across two time points. No specific attrition rate	IV1 = Implementation of interprofessional shared governance; IV2 = Caring Professional Practice Model (CPPM) DV1 = Staff self-report of caring; DV2 = Workplace engagement; DV3 = Workplace empowerment	Caring Assessment Tool-Administration (CAT-Adm), Utrecht Work Engagement Scale (UWES), Conditions of Work Effectiveness Questionnaire-II (CWEQ-II). Reliability of scales was high, with Cronbach's alpha values above 0.80.	Descriptive statistics, paired t-tests, and repeated measures analysis of variance (ANOVA)	strongest relationship was found between work engagement and empowerment ($r = 0.668$, $P < .001$) work engagement and caring ($r = 0.295$, $P < .001$) empowerment and caring ($r = 0.147$, $P = .006$)	Strengths: Large sample size, longitudinal design, validated scales, and interprofessional approach. Limitations: Single health system limits generalizability; self-reported data may introduce bias. Minimal risk High feasibility. Level of Evidence = III Quality of Evidence = High Strength of evidence: High confidence to act

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<p>Sanchez, N., Turner, K., Hermis, K., Richardson, G., Ngo, B., Leach, M., & Novak, N. (2023). Impacts of shared governance on ambulatory nursing engagement. Nurse Leader. https://doi.org/10.1016/j.mnl.2023.09.003</p>	NA	<p>Descriptive, cross-sectional study</p> <p>To assess the impact of shared governance on ambulatory nurses' engagement and how it influences their work environment and professional satisfaction.</p>	<p>150 ambulatory nurses participated in the study across multiple outpatient settings. No attrition rate is reported since the study is cross-sectional.</p>	<p>IV1 = Implementation of shared governance</p> <p>DV1 = Nursing engagement; DV2 = Professional satisfaction; DV3 = Perception of work environment</p>	<p>Nursing engagement and satisfaction were measured using a modified version of the Utrecht Work Engagement Scale (UWES), and the Practice Environment Scale of the Nursing Work Index (PES-NWI) was used to measure perceptions of the work environment. Reliability data (Cronbach's alpha > 0.85) was provided for both scales.</p>	<p>Descriptive statistics, correlation analysis, and multiple regression analysis</p>	<p>a significant increase in the report of active involvement in a shared governance program from 6% preimplementation to 29.6% postimplementation (p = 0.001).</p>	<p>Strengths: Use of validated tools, diverse sample of nurses across ambulatory settings. Limitations: Cross-sectional design limits the ability to determine causality, and the study may not be generalizable beyond ambulatory care.</p> <p>Minimal risk High feasibility</p> <p>Level of Evidence = III</p> <p>Quality of Evidence = Moderate</p> <p>Strength of evidence: Moderate confidence to act</p>
<p>Spence Laschinger, H. K., Wong, C. A., & Grau, A. L. (2012). The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout and retention outcomes: a cross-sectional study. <i>International Journal of Nursing Studies</i>, 49(10), 1266–1276. https://doi.org/10.1016/j.ijnurstu.2012.05.012</p>	<p>integrated Avolio et al.'s (2004) authentic leadership model, Einarsen et al.'s (1998) notion of workplace bullying, and Leiter and Maslach's (2004) burnout model to examine workplace factors that influence new graduate retention outcomes.</p>	<p>cross-sectional survey design</p> <p>test a model linking authentic leadership to new graduate nurses' experiences of workplace bullying and burnout, and subsequently, job satisfaction and intentions to leave their jobs..</p>	<p>342 newly graduated nurses in their first two years of practice</p> <p>No attrition rate mentioned</p>	<p>IV1 = Authentic leadership; IV2 = Structural empowerment</p> <p>DV1 = Experiences of workplace bullying; DV2 = Burnout levels; DV3 = Retention intentions</p>	<p>The Authentic Leadership Questionnaire (ALQ)</p> <p>Conditions of Work Effectiveness Questionnaire-II (CWEQ-II).</p> <p>Maslach Burnout Inventory (MBI), and Retention intentions were measured by self-reported intentions to stay. Cronbach's alphas ranging from .70 to .90</p>	<p>Structural equation modeling (SEM), correlation analysis, and multiple regression</p>	<p>Authentic leadership was significantly associated with lower workplace bullying and burnout, mediated by structural empowerment. Higher empowerment predicted lower burnout and greater retention intentions. Authentic leadership indirectly influenced nurse retention through its impact on workplace empowerment and reduction of bullying</p>	<p>Strengths: Use of validated measurement tools, strong sample size of newly graduated nurses. Limitations: Cross-sectional design limits causal inferences, and self-reported data may be subject to bias.</p> <p>Minimal risk High feasibility</p> <p>Level of Evidence = III</p> <p>Quality of Evidence = High</p> <p>Strength of evidence: Moderate to high confidence to act</p>

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<p>Wilson, J., Speroni, K. G., Jones, R. A., & Daniel, M. G. (2014). Exploring how nurses and managers perceive shared governance. <i>Nursing</i>, 44(7), 19–22. https://doi.org/10.1097/01.NURSE.0000450791.18473.52</p>	NA	<p>Descriptive, cross-sectional survey study</p> <p>To explore and compare how nurses and nurse managers perceive the effectiveness and impact of shared governance in their clinical practice settings</p>	<p>144 participants nurses and nurse managers</p> <p>multiple healthcare facilities.</p> <p>Characteristics include a mix of frontline nurses and managerial staff.</p> <p>No attrition rate as it was a cross-sectional survey.</p>	<p>IV1 = Role (nurse or nurse manager)</p> <p>DV1 = Perceptions of shared governance effectiveness;</p> <p>DV2 = Perceived impact on decision-making and workplace empowerment</p>	Undisclosed Survey tools	<p>Descriptive statistics</p> <p>independent t-tests,</p> <p>ANOVA</p> <p>Fisher exact tests and Chisquare analysis</p>	<p>direct care nurses perceiving support by unit manager (very important overall = 84.0%, direct care nurses = 83.0%, managers = 93.3%)</p> <p>direct care nurses perceiving nurses on unit work as team (very important overall = 79.0%, direct care nurses = 76.6%, managers = 100%, $P = 0.05$)</p>	<p>Strengths: Offers valuable insights into differences in perceptions between nurses and managers. Limitations: Small sample size, lack of reliability data for the survey tool, and limited generalizability due to the study's specific setting.</p> <p>Minimal risk</p> <p>Moderate Feasibility</p> <p>Level of Evidence = III</p> <p>Quality of Evidence = Low to moderate</p> <p>Strength of evidence: Moderate confidence to act</p>
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Appendix B

Definitions of Key Terms

- **Critical Access Hospital (CAH)**- is a designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services (CMS), they cannot exceed a 25 acute care inpatient beds, be located more than 45 miles from another hospital, provide emergency care services year round 24 hours a day, and have an average patient length of stay of 96 hours (*Critical access hospitals (CAHs)*).
- **Retention**-“organized effort to build an environment that motivates employees to stay in their jobs by applying appropriate policies and interventions to attract and recruit health workers” (Efendi et al., 2019, p. 423).
- **Shared Governance (SG)** -a council created to share decision-making between the bedside nurses and nurse leaders, including resources, nursing research and evidence-based practice projects, new equipment purchases, and staffing (Mcknight & Moore, 2022).
- **Top-Down Management**- The top-down approach to management is when company-wide decisions are made solely by leadership at the top (Asana, 2024).

Appendix C

Burnout Self-Test Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) is the most commonly used tool to self-assess whether you might be at risk of burnout. To determine the risk of burnout, the MBI explores three components: exhaustion, depersonalization and personal achievement. While this tool may be useful, it must not be used as a scientific diagnostic technique, regardless of the results. The objective is simply to make you aware that anyone may be at risk of burnout.

For each question, indicate the score that corresponds to your response. Add up your score for each section and compare your results with the scoring results interpretation at the bottom of this document.

Questions:	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
Section A:	0	1	2	3	4	5	6
I feel emotionally drained by my work.							
Working with people all day long requires a great deal of effort.							
I feel like my work is breaking me down.							
I feel frustrated by my work.							
I feel I work too hard at my job.							
It stresses me too much to work in direct contact with people.							
I feel like I'm at the end of my rope.							
Total score – SECTION A							

Questions:	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
Section B:	0	1	2	3	4	5	6

I feel I look after certain patients/clients impersonally, as if they are objects.							
I feel tired when I get up in the morning and have to face another day at work.							
I have the impression that my patients/clients make me responsible for some of their problems.							
I am at the end of my patience at the end of my work day.							
I really don't care about what happens to some of my patients/clients.							
I have become more insensitive to people since I've been working.							
I'm afraid that this job is making me uncaring.							
Total score – SECTION B							

Questions:	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
Section C:	0	1	2	3	4	5	6
I accomplish many worthwhile things in this job.							
I feel full of energy.							
I am easily able to understand what my patients/clients feel.							
I look after my patients'/clients' problems very effectively.							
In my work, I handle emotional problems very calmly.							
Through my work, I feel that I have a positive influence on people.							
I am easily able to create a relaxed atmosphere with my patients/clients.							
I feel refreshed when I have been close to my patients/clients at work.							
Total score – SECTION C							

SCORING RESULTS – INTERPRETATION

Section A: Burnout

Burnout (or depressive anxiety syndrome): Testifies to fatigue at the very idea of work, chronic fatigue, trouble sleeping, physical problems. For the MBI, as well as for most authors, “exhaustion would be the key component of the syndrome.” Unlike depression, the problems disappear outside work.

Total 17 or less: Low-level burnout

Total between 18 and 29 inclusive: Moderate burnout Total over 30: High-level burnout

Section B: Depersonalization

“Depersonalization” (or loss of empathy): Rather a “dehumanization” in interpersonal relations. The notion of detachment is excessive, leading to cynicism with negative attitudes with regard to patients or colleagues, feeling of guilt, avoidance of social contacts and withdrawing into oneself. The professional blocks the empathy he can show to his patients and/or colleagues.

- Total 5 or less: Low-level burnout
- Total between 6 and 11 inclusive: Moderate
- burnout Total of 12 and greater: High-level burnout

Section C: Personal Achievement

The reduction of personal achievement: The individual assesses himself negatively, feels he is unable to move the situation forward. This component represents the demotivating effects of a difficult, repetitive situation leading to failure despite efforts. The person begins to doubt his genuine abilities to accomplish things. This aspect is a consequence of the first two.

Total 33 or less: High-level burnout

Total between 34 and 39 inclusive: Moderate burnout Total greater than 40: Low-level burnout

À high score in the first two sections and a low score in the last section may indicate burnout.

Note: Different people react to stress and burnout differently. This test is not intended to be a scientific analysis or assessment. The information is not designed to diagnose or treat your stress or symptoms of burnout. Consult your medical doctor, counselor or mental health professional if you feel that you need help regarding stress management or dealing with burnout.

C. Maslach, S.E. Jackson, M.P. Leiter (Eds.), Maslach Burnout Inventory manual (3rd ed.), Consulting Psychologists Press (1996)

Appendix D

Practice Environment Scale of the Nursing Work Index (PES-NWI)

Modified from the 2018 NDNQI RN Survey with Practice Environment Scale

For each item, please indicate the extent to which you agree related to YOUR CURRENT JOB.

Nurse Participation in Hospital Affairs

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree.</i>		1	2	3	4	5
1	There is a career development/clinical ladder opportunity.					
2	There is an opportunity for staff nurses to participate in policy decisions.					
3	The chief nursing officer is highly visible and accessible to staff.					
4	The chief nursing officer is equal in power and authority to other top-level hospital executives.					
5	There are opportunities for advancement.					
6	The organization has an administration that listens and responds to employee concerns.					
7	Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).					
8	Staff nurses have the opportunity to serve on hospital and nursing committees.					
9	Nursing administrators consult with staff on daily problems and procedures.					

Nursing Foundations for Quality of Care

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
1	Active staff development or continuing education programs are available for nurses.					
2	The administration expects high standards of nursing care.					
3	A clear philosophy of nursing that apparent in the patient care environment.					
4	Work with nurses who are clinically competent.					
5	There is an active quality assurance program.					
6	A preceptor program for newly hired RNs.					

7	Nursing care is based on a nursing model rather than a medical model.					
8	Up-to-date nursing care plans for all patients.					
9	Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next.					

Autonomy

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
1	As RNs, we have sufficient input into the program of care for each of our patients.					
2	RNs on our unit have a good deal of control over our own work.					
3	As RNs, we are free to adjust our daily practice to fit patient needs					

Professional Development Opportunity

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
1	RNs have career development opportunities on our unit.					
2	RNs on our unit have support for pursuing nursing degrees.					
3	RNs on our unit have opportunities for career advancement.					

Professional Development Access

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
1	RNs on our unit have access to regional and national conferences.					
2	On our unit, RNs have access to regular in-service programs.					
3	RNs on our unit have access to continuing education.					

Nurse Manager Ability, Leadership, and Support of Nurses

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
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1	There is a supervisory staff that is supportive of the nurses.					
2	Supervisors use mistakes as learning opportunities, not for criticism.					
3	The nurse manager is a good manager and leader.					
4	Praise and recognition for a job well done.					
5	A nurse manager who backs up the nursing staff in decision-making, even if the conflict is with a physician					

Staffing and Resource Adequacy

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
1	Adequate support services allow me to spend time with my patients.					
2	Enough time and opportunity to discuss patient care problems with other nurses.					
3	Enough registered nurses to provide quality patient care.					
4	Enough staff to get the work done.					

Collegial Nurse-Physician Relations

<i>Response options: (5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree</i>		1	2	3	4	5
1	Physicians and nurses have good working relationships.					
2	A lot of teamwork between nurses and physicians.					
3	Collaboration (joint practice) between nurses and physicians					

Nurse-Nurse Interaction Scale

Stem: Based on your experience, please indicate your agreement or disagreement with the following statements about your unit and the RNs you work with. Response options: strongly agree (6), agree (5), tend to agree (4), tend to disagree (3), disagree (2), strongly disagree (1).

		1	2	3	4	5	6
1	RNs I work with count on each other to pitch in and help when things get busy.						
2	There is a good deal of teamwork among RNs I work with.						
3	RNs I work with support each other.						

Job Enjoyment Scale

Stem: Based on your experience, please indicate your agreement or disagreement with the following statements about your unit and the RNs you work with. Response options: strongly agree (6), agree (5), tend to agree (4), tend to disagree (3), disagree (2), strongly disagree (1).

		1	2	3	4	5	6
1	I know what is expected of me at work.						
2	I have the materials and equipment to do my work right.						
3	At work, I have the opportunity to do what I do best every day.						
4	In the last seven days, I have received recognition or praise for doing good work.						
5	My manager or someone at work seems to care about me as a person.						
6	There is someone at work who encourages my development.						
7	At work, my opinion seems to count.						
8	The mission or purpose of my company makes me feel my job is important.						
9	My coworkers are committed to doing quality work.						
10	I have a best friend at work.						
11	In the last six months, someone at work has talked to me about my progress.						
12	This last year, I have had opportunities at work to learn and grow.						

13	At work, I am treated with respect.						
14	My organization cares about my overall well-being.						
15	I have received meaningful feedback in the last week.						

Based on your experience, how many RNs who provide direct patient care on your unit would you say:

Stem: Based on your experience, please indicate your agreement or disagreement with the following statements about your unit and the RNs you work with. Response options: strongly agree (6), agree (5), tend to agree (4), tend to disagree (3), disagree (2), strongly disagree (1).

		1	2	3	4	5	6
1	Consistently use effective conflict management skills to prevent and/or resolve disagreements.						
2	Demonstrate respect for the contributions to patient care of RNs on my unit.						
3	Consider root causes of adverse events or errors rather than placing blame.						
4	Share accountability for the quality of patient care with RNs on my unit.						
5	Understand the roles, knowledge, and skills of RNs on my unit.						

(2018 NDNQI RN Survey with Practice Environment Scale, 2018)

Appendix E

Phase 1: Planning (Months 1-2)

- Secure executive leadership and frontline nursing staff buy-in
- Conduct initial SG education and awareness sessions
- Establish the Shared Governance Council (SGC) with bedside nurses, managers, and clinical supervisors
- Develop policies and procedures for council operations
- Train council members on governance structure and decision-making

Phase 2: Initial Pilot and Implementation (Months 3-7)

- Introducing SG framework to Med/Surg unit
- Conduct baseline data collection using MBI and Nursing PES-NWI
- Begin monthly SGC meetings
- Monitor participation levels, engagement, and decision-making effectiveness
- Conduct staff feedback sessions to identify barriers and areas for improvement

Phase 3: Evaluation and Refinement (Months 7-8)

- Analyze mid-project results from MBI and PES-NWI
- Identify areas for improvement in SG operations
- Make necessary adjustments based on feedback and data findings
- Expand SG initiatives to additional hospital departments
- Maintain engagement through continued staff education and communication

Phase 4: Full Implementation and Sustainability (Month 9)

- Roll out SG hospital-wide
- Conduct final evaluation of project impact using MBI and PES-NWI
- Establish long-term strategies for maintaining and evolving SG
- Present outcomes and recommendations to hospital leadership
- Transition of the SG framework into a permanent operational structure

Appendix F

Category	Estimated Cost
Staff training & education materials	\$1,000
Printing and communication resources (newsletters, handbooks)	\$500
Data collection tools (MBI & PES-NWI assessments)	\$3,500
Shared Governance recognition and incentives (awards, certificates)	\$500
Miscellaneous (unexpected costs)	\$500
Total Estimated Cost	\$6,000