# Interprofessional Shared Governance:

# Effects on Nurses and Nurse Leaders

By

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## Abstract

Shared governance improves nursing engagement across multiple healthcare settings. Especially after the COVID-19 pandemic, nursing turnover is a significant problem faced by healthcare systems. This Doctor of Nursing practice project aimed to combat nursing turnover and absenteeism by improving the engagement of frontline staff nurses and nurse leaders by implementing a trial of shared governance. As a precursor to discussions about a formalized shared governance structure, a trial of a shared governance foundational framework was completed on several units within a correctional health facility in a public sector healthcare system. The nursing staff, nurse leaders, human resources, the nurses' union, and other interprofessional team members were engaged and empowered to make decisions that impacted their professional practice on a volunteer basis at the unit level. The quantitative comparison of absenteeism and turnover rates among staff nurses and nurse leaders in three months from the previous calendar year versus the same period after implementation was inconclusive. While the overall average turnover rates of both nurse leaders and staff nurses increased post-implementation, the staff nurse turnover decreased on a month-to-month basis immediately following the implementation. Average absenteeism increased in both staff nurses and leaders. Incidental qualitative findings were gleaned as well, including both positive and negative themes associated with the collaboration produced by the project.



**Keywords**

Keywords and phrases include *interprofessional shared governance*, *interprofessional collaboration*, *shared governance*, and *employee turnover*.

## Table of Contents

Tables



Figures

# Chapter I: Introduction

The COVID-19 pandemic created a climate in which healthcare turnover was unprecedented (NSI Nursing Solutions Incorporated, 2022). In 2023, nursing turnover nationally was above 27%, which was greater than the average total national hospital turnover of 25.9%, with each separation costing over $200,000 to an organization on average (NSI Nursing Solutions Incorporated, 2022). The high turnover rate helped create a greater focus on nursing retention as a national healthcare priority. Many methods of retaining nurses were emphasized nationally immediately after the COVID-19 pandemic, including shared governance. Shared governance is an effective method of increasing employee engagement, especially that of staff nurses (Porter O'Grady & Clavelle, 2021). By providing structural empowerment, shared governance is positively correlated with a positive nursing practice environment (Clavelle et al., 2013). In practice, shared governance provides a framework by which the shared decision-making within the organization is accomplished by creating spaces in which the roles and responsibilities of both leaders and frontline staff are clearly delineated to enhance nursing practice (Lindell & Bogue, 2016 & Schot et al., 2020).

The Doctor of Nursing Practice (DNP) practice site was a large, public-sector, metropolitan healthcare system in the Midwest. Most staff were unionized throughout the health system. In 2023, the average nursing turnover rate at the organization was over 12%, yet the costs of replacement with agency nurses were far above the national average. The health system did not have a formal shared governance structure. Staff and frontline nurse leader engagement was an organizational issue and, therefore, a priority. The system's strategic nursing priorities included implementing a formal shared

governance structure for nursing retention. As a result of competing internal priorities, this DNP project was a three-month trial of a foundational shared governance structure on several units within one affiliate of the health system, with the intent being to demonstrate its positive effects on staff nurse and nurse leader engagement. This foundational work aimed to provide a precursor to the system-wide introduction of a formal shared governance structure in the unionized environment. Porter O'Grady (2001) urged nurse leaders in unionized environments to build shared governance structures that included union leaders so that the union could participate in creating a shared strategic vision for the organization. By engaging the union early on in this foundational work, the DNP practice site set the stage for further open discussions of system-wide shared governance with the unionized staff and nurses' union leadership.

## Statement of Problem

The U.S. health system is challenged with low nursing engagement, evidenced by high turnover rates and absenteeism. The DNP project site suffered from issues with nursing turnover and low nursing engagement. One specific problem identified in employee engagement surveys was interprofessional collaboration. Another particular problem was nursing autonomy. With no shared governance structure in place, the practice site was poised for a solution to these issues by introducing interprofessional shared governance.

## Purpose/Aim of the Project

The DNP project's goal was to involve nursing staff, nurse leaders, the nurses' union, human resources, and staffing office professionals in a trial preliminary interprofessional shared governance structure on several units within a unionized public-

sector correctional health facility within the unionized public-sector health system. This pilot trial would lay the foundation for further shared governance discussion and structural empowerment of nurses across the health system. Schot et al. (2020) explained that an important element in advocating for increased interprofessional collaboration is "creating spaces" for collaboration. Shared governance is one such space that can be used to support increased collaboration. The basis of the project was the author's research in the literature regarding interprofessional collaboration and shared governance. The project's outcome goals were improved turnover and absenteeism rates among frontline staff nurses and leaders on the trial units, implying improved engagement.

## Background/Problem of Interest Supported by the Literature

This project's participating healthcare system is a large public sector system in a metropolitan area in the Midwest. The mission-driven health system includes two acute care hospitals, two correctional health facilities, and several ambulatory care centers. The system had been active for more than a century. Unfortunately, several local community hospitals have closed over the past few years. The closure of community hospitals can be catastrophic event for the local population (Clary et al., 2020). These closures led to more acute patients seeking treatment within the health system, creating strains on the system.

Historically, the organization had been physician centric. Communication between providers (physicians, advanced practice nurses, and physician assistants) and nursing was consistently described as negative, and nurses often left the organization due to poor interactions. Poor communication between providers and nurses can lead to adverse patient events (Forbes et al., 2020). The author’s organizational knowledge base also showed that communication between staff nurses and leadership was often negative.

The COVID-19 pandemic intensified vacancy rates, as many nurses left the system to pursue travel nursing assignments (S. Long, personal communication). This exodus of nurses from the system, combined with the ability of nursing staff to choose from many other hospitals in the metropolitan area and sub-optimal hiring practices, created high vacancy rates at the hospital.

The system's stakeholders aimed to improve its quality metrics. During staffing challenges, higher patient acuity, and the COVID-19 pandemic, it was difficult to improve as many quality metrics were solely nursing driven. However, Zielińska-Tomczak et al. (2021) found that interprofessional collaboration leads to improved quality of care. Quality improvement was a priority for facility stakeholders, so interprofessional shared governance became an important objective.

## Significance of the Project

Preliminary shared governance work involving the nurses' union and other interprofessional key stakeholders sets the stage for creating a shared, collaborative vision and enhances relationships between the organization and the union (Porter O'Grady, 2001). This shared vision and enhanced relationship sets the stage for further shared governance planning within an organization. This project provided the preliminary work needed to validate the need for shared governance. Interprofessional collaboration is a priority, according to the WHO (Zielińska-Tomczak et al., 2021). It was anticipated that by increasing interprofessional collaboration, communication would become more effective, and incidences of incivility among care team members would decrease. This change would benefit the organization, as incivility leads to staff attrition and patient safety issues (Conner Black, 2019). The project incorporated evidence from the literature

regarding shared governance, quality improvement, and interprofessional collaboration. The evidence shaped the project and helped to achieve positive outcomes. In addition to reducing absenteeism and turnover, the project aimed to reduce premium labor expenditures, including temporary agency staff, overtime, and registry costs. These changes could save the organization millions of dollars.

## Impact of the Project

The project's goal was to impact the system, future research, and practice. By improving employee engagement and collaboration, the hope was to improve retention, to benefit the organization financially. Increased collaboration promised to lead to improved communication among healthcare team members. The importance of effective communication among all members of the healthcare team cannot be underestimated (Foronda et al., 2021). Effective communication can improve patient outcomes and quality metrics. Improving quality metrics also benefits the organization financially, as each quality issue can cost the organization lost revenue, increased length of stay, and decreased patient satisfaction (Lyford & Lash, 2019). The potential for future research and practice was impacted, as the project laid the foundation for future practice questions, such as the optimal composition of interprofessional teams.

## SWOT and Gap Analysis

The COVID pandemic created numerous challenges for many organizations, and the practice site was still enduring those during project implementation. The long-lasting impacts of the pandemic remain evident.

### *SWOT Analysis*

Prior to implementing the project, a SWOT analysis was conducted to determine

the strengths, weaknesses, opportunities, and threats related to this DNP project. The analysis helped the author to better understand the obstacles and opportunities faced by the practice site, allowing the DNP project to be tailored to the site, increasing the chances of project success.

**Strengths.** Strengths included the organization's strong transformational leadership structure at the executive level. The leaders often exhibited servant leadership qualities conducive to creating a strong shared governance structure. Another strength was the organization's mission focus, which helped to strengthen team dynamics at the unit level, especially in correctional health, as the author's organizational knowledge led her to know. A further strength was the organization's technology governance structure, allowing data requests to be expedited during the project implementation.

**Weaknesses.** A weakness was the organization's high turnover rate for nurses and frontline nurse leaders. Consequently, this weakness made it difficult to retain staff and maintain consistent committee membership. Another weakness was that the quality reporting and data collection systems were difficult to use and inconsistent during the beginning of the project planning stages. This inconsistency made determining performance and goals difficult. Increased volume from neighboring hospitals closing created surges of patients, contributing to staffing crises.

**Opportunities.** Some organizational weaknesses could also be considered opportunities. An opportunity for the organization was the potential for recruitment of staff following the closing of neighboring facilities. This opportunity could act as a pipeline of experienced candidates, potentially making it easier for staff to participate in committee work. Leadership candidates from some of these hospitals were hired during

the project implementation, helping to improve the organization's culture. Opportunities also included the external pressure from the board to improve nursing turnover, which resulted in resource allocation to retention-specific initiatives.

**Threats.** The COVID-19 pandemic and other disease surges were a major threat during the initial stages of project planning, creating increases in patient volume and staffing shortages, making it difficult for committee work to occur at the unit and organizational levels. Competition from other organizations in the metropolitan area was another threat impacting the high turnover rate for the organization. Another threat was the frequent, rapid changes across the health system, affecting stressed resources and staff. Examples of these changes included the introduction of new management processes and tools, changes in leadership, and changes in staffing patterns and patient placement. Strained relations with the nurses' union threatened the project. The nurses went on strike several years before the project implementation, creating tensions between the union, the staff, and leadership.

### *Gap Analysis*

As part of the DNP project, the desired outcome was decreased turnover and absenteeism rates from baseline (pre-intervention), indicating improved engagement among staff nurses and nurse leaders. Nurses had less of a voice in their practice without a shared governance structure. Shared governance structure formation would provide a framework for the desired future state.

**General Organizational Information.** The organization was a large, public-sector system specializing in serving the underserved in the metropolitan area. The trial units were located within the correctional health services organization. There was no

official shared governance structure, and the staff was unionized.

**Specific Improvement Areas.** The creation of a trial of a shared governance structure allowed for greater focus on the relationship between the nurses' union and leadership and initiatives affecting the work of the frontline staff. Specifically, this included scheduling, which helped to drive engagement and quality initiatives. Self-scheduling with a trial of converting from eight-hour shifts to predominantly twelve-hour shifts was the project the shared governance council chose, which allowed staff nurses the autonomy to create the unit's schedule themselves.

**Targets.** As a result of the trial shared governance structure, staff nurses and nurse leaders could participate in shared decision-making at the unit level. The data collection system was another area of focus because of the lack of structure and consistency in data collection tools and methods.

**Current State.** There was no shared governance structure at the time of implementation. One discipline consistently led quality improvement projects with committee members from that same discipline. It was challenging to obtain data with systems that were not user-friendly or accessible. There were no existing unit-based shared governance councils.

**Action Steps.** The trial shared governance council was implemented at the unit level by combining the staff and leadership of three units within the correctional health system. The units were two correctional housing units and one urgent care unit. Interprofessional members included members of the nurses' union, human resources, and staffing personnel. A tracker scorecard was maintained to reflect their meeting compliance and participation. The data collection and reporting processes were improved,

so absenteeism and turnover data retrieval were easier at the unit level.

**Population/Intervention/Comparison/Outcome/Time (PICOT) Question**

The PICOT question related to the project reflected nursing leadership's priorities for the system with a proposed solution and guided the literature review. Will the introduction of a trial shared governance unit-based council comprised of several units of the correctional health organization within a large metropolitan public-sector health system in the American Midwest decrease nursing staff and nurse leader turnover and absenteeism rates post implementation (November 2022 to January 2023) when compared with the previous year, pre-implementation data (November 2021 to January 2022)?

## Chapter II: Literature and Theory Review

The topic of the project was the effect of shared governance on staff nurse and nurse leader turnover and absenteeism. During the project, staff nurses and nurse leaders turnover and absenteeism rates were compared in participating units before and after the intervention.

### Literature Review

The author completed a literature review using the Online Campus Library Services provided by Indiana Wesleyan University. The search included multiple databases, such as Cumulate Index to Nursing, Allied Health Literature, and PubMed. Interprofessional *shared governance* was used as a search term producing more than 15,000 entries. Results were then refined by selecting only peer-reviewed articles, generating greater than 11,000 entries. Articles from 2016 through current were selected, which narrowed the entries to more than 5500. Finally, additional keywords and phrases were used with the original search terms to narrow the results. Those terms included *engagement*, *quality improvement*, *interprofessional collaboration*, and *leadership*. This search generated more than 250 articles pertaining to the subject of the project. The author then reviewed the article abstracts and selected those most applicable to the project to include in the literature review, leaving 25 articles in the final review.

Shared governance is not a new topic in the literature and is increasingly important in improving outcomes and engaging staff, as evidenced by the number of published articles. Shared governance has engaged staff and empowered practice for almost half a century (Porter O'Grady & Clavelle, 2021). Due to the effectiveness of

shared governance, it is commonly practiced in hospitals worldwide, especially in hospitals pursuing or achieving Magnet status (Olender et al., 2020). It also helps set the stage for improved interprofessional collaboration, which the Centers for Medicare and Medicaid Services identified as a priority in the safe and effective treatment of patients (Strunk, 2020).

The project's goal was three-fold: improved turnover and absenteeism rates, engagement, and enhanced collaboration with the nurses' union. The project proposed a trial structure for shared governance to decrease staff nurse and nurse leader turnover and absenteeism. The initiative was to improve the organization's finances and employee engagement.

According to the literature, nurses participating in interprofessional shared governance are more likely to be retained by the organization (Capitulo & Olender, 2019, Blackstone et al., 2019). According to these authors, higher engagement reduces nurse turnover, which is costly to the organization.

This project enhanced collaboration with the nurses' union strengthening relations with the union leadership by including the nurses' union early in the trial (Porter O'Grady, 2001). Union leaders, staff nurses, and nurse leaders collaboratively worked on shared goals.

The collaborative effect of interprofessional shared governance directly aligns with the priorities of the World Health Organization (WHO) (Zielińska-Tomczak et al., 2021). According to Foronda et al. (2021), enhanced interprofessional collaboration improves communication, which improves patient outcomes, and, in turn, prevents costly and harmful errors, thus reducing the overall cost of care.

The literature review conducted for the project's topic of interprofessional shared governance identified several themes. As a result of the literature review, best practices were developed, and knowledge gaps were identified.

Several important themes applicable to the successful implementation of the DNP project appeared within the review of the literature. The themes were interprofessional collaboration, shared governance, leadership, quality improvement, and employee engagement.

**Interprofessional Collaboration**

The theme of interprofessional collaboration appeared in much of the literature about shared governance. Several authors focused on improving the quality of care with interprofessional collaboration, while others developed tools and produced position statement papers in favor of interprofessional collaboration.

Quality of care improvement was evident in the works of many authors. A focus was on interprofessional collaboration's positive impact on the quality of patient care (Akuamoah-Boateng et al., 2019; Hendrian & Tipton, 2020; Reeves et al., 2017; & Rohm, 2020). Reeves et al. (2017) took an overall look at quality improvement, performing a summary review of nine randomized controlled trials, which identified the need for improved interprofessional collaboration to improve quality. Rohm (2020), Hendrian and Tipton (2020), and Akuamoah-Boateng et al. (2019) took a more specific approach and produced studies demonstrating the effectiveness of interprofessional collaboration on specific quality measures. Rohm (2020), along with Hendrian and Tipton (2020), discussed fall reduction, while Akuamoah-Boateng et al. (2019) emphasized the importance of interprofessional collaboration on discharge dispositions

and length of stay within an intensive care unit.

The importance of interprofessional collaboration in the success and effectiveness of shared governance in healthcare was also an important theme within the literature. Kyytsonen et al. (2020) highlighted its importance in the literature regarding shared governance, Olender et al. (2020) asserted its importance on workplace engagement, and Capitulo and Olender (2019) found the concept to enhance relationship-based care.

Guidelines and tool development were a common sub-theme within the theme of interprofessional collaboration. Two authors presented reviews of guidelines put forth by healthcare agencies. Strunk (2020) and Dilles et al. (2021) reviewed the guidelines on interprofessional collaboration from the Centers for Medicare and Medicaid Services and the WHO producing position papers supporting enhanced interprofessional collaboration. Creating a classification tool (the InterPACT tool) for interprofessional activities took these reviews a step further (Xyrichis et al., 2018), allowing for activities to be classified by an evidence-based tool, with elements of focus being teamwork, collaboration, coordination, and networking.

Interprofessional education and competencies were also a topic important to many researchers. These researchers agreed that interprofessional education and competencies improved the quality and success of organizational initiatives (Adjei, 2022; Brashers et al., 2020; Cox et al., 2016; Keshmiri et al., 2020; Matzke et al., 2021; North, 2020, and Pechacek et al., 2015). Cox et al. (2016) and Keshmiri et al. (2020) focused on the positive effects of interprofessional education of healthcare workers. Brashers et al. (2020) and North (2020) presented more specific articles relating to the positive results gained from basing interprofessional education on specific interprofessional

competencies, such as the Interprofessional Education Collaborative (IPEC) Core Competencies. Adjei (2022) and Matzke et al. (2021) found implementing the TeamSTEPPS program improved interprofessional collaboration, communication, and teamwork. Finally, Pechacek et al. (2015) described the importance of the National Center Data Repository, which allows for data storage regarding interprofessional education and practice data.

**Shared Governance**

Porter O'Grady and Clavelle (2021) most accurately and concisely described the emergence and importance of shared governance as "a systematic organizational model of empowerment for practicing nurses everywhere" (p. 206). In practice, this means shared governance provides a framework for nursing staff autonomy and engagement. Shared decision-making allows nurses to have a voice in their practice. Several authors emphasized shared governance in relation to quality improvement (Hendrian & Tipton, 2020; Capitulo & Olender, 2019; Panayotou et al., 2019). Panayotou et al. (2019) took a broad approach emphasizing the importance of shared governance planning in alignment with organizational goals to improve quality. Capitulo and Olender (2019) explained shared governance could improve various quality metrics. Additionally, Hendrian and Tipton (2020) were more specific in a discussion of the role of shared governance in reducing falls. Several other authors focused on providing structural frameworks for shared governance. Lindell and Bogue (2016) performed several experiments over many years to develop the general theory for multi-level shared governance theory of shared governance (GEMS theory). Kyytsonen et al. (2020) developed a framework for implementing shared governance and discussed its core elements. Other authors focused

on shared governance's positive correlations with improved employee engagement and increased retention (Capitulo & Olender, 2019; Olender et al., 2020). Finally, Keshmiri et al. (2020) discussed the role of shared governance in encouraging shared decision-making for providers.

Porter O'Grady and Clavelle (2021) are among the most forward-looking authors advocating a professional governance structure for nursing, emphasizing sustainability, ownership, and inter-professional collaboration. Professional governance, according to Porter O'Grady and Clavelle (2021), contrasts with shared governance in that professional governance assumes that strong structures exist for nursing to take ownership of their autonomous processes.

**Leadership**

The work of several authors supported the importance of leadership in shared governance. Researchers found that leadership support of staff and encouraging staff participation in shared government was crucial for staff empowerment (Kyytsonen et al. 2020; Olender et al. 2020; Hendrian & Tipton 2020). Panayotou et al. (2019) focused on structure discussing, the importance of the role of nurse leaders in the strategic planning process for shared governance, with strategic planning being essential for the success of shared governance. Porter O'Grady and Clavelle (2021) emphasized the role of the leader in the transition from shared governance to professional governance.

Core competencies were another topic related to leadership apparent in the literature. Leading with emphasis on the core competencies for interprofessional collaboration was supported by several authors (Brashers et al., 2020, & North, 2020). These authors discussed the importance of the core competencies for interprofessional

collaboration to the successful leadership of teams and projects, emphasizing the importance of leadership in instilling the competencies within the workforce.

**Quality Improvement**

Shared governance has historically helped drive quality improvement projects by providing frameworks for communication and collaboration amongst interprofessional team members (Porter O'Grady & Clavelle, 2021). Many authors discussed the importance of an interprofessional approach to quality improvement (Akuamoah-Boateng et al., 2019; Cox et al., 2016; Dilles et al., 2021; Capitulo & Olender, 2019; & Reeves et al., 2017) emphasizing the positive effects collaboration has on quality. Anderson et al. (1994) and Ciobanu (2016) presented the theoretical basis for quality improvement. Kyytsonen et al. (2020) emphasized the importance of shared governance on quality improvement. Interprofessional collaborative initiatives within a quality improvement framework demonstrated positive results on fall reduction (Hendrian & Tipton, 2020; & Rohm, 2020). Porter O'Grady and Clavelle (2021) discussed the potential for improved ownership over quality with the transition from shared governance to nursing professional governance, promising improved quality improvement.

**Employee Engagement**

A final theme identified was that employee engagement improved when shared governance was implemented as a quality improvement initiative. Ciobanu (2016) identified quality improvement as integral to employee engagement, while other authors presented shared governance as the cause of improved employee engagement (Kyytsonen et al., 2022; & Olender et al., 2020). In addition, Porter O'Grady and Clavelle (2021) expanded upon the concept and explained that transitioning to professional governance

will enhance ownership of practice, which provides more opportunities for the development of the nursing profession.

A review of the literature on shared governance demonstrated the interconnectedness of several concepts central to the project. The importance of shared governance to employee engagement and quality improvement was apparent. The importance of strong leadership to successful shared governance, and interprofessional collaboration to quality improvement and shared governance were also evident.

**Best Practices**

From the recurrent themes described in the previous section, the author gleaned best practices that could be used for further research and practice. One apparent best practice in the research was the classification of interprofessional collaborative activities to determine their usefulness in research and effectiveness. Tools to evaluate interprofessional activities in research, such as the InterPACT tool (Xyrichis et al., 2018), could be used to standardize research and help to determine best practices. This tool was not used for the DNP project, as the interprofessional activity was not classified for broader research.

Another best practice identified was the use of interprofessional collaborative quality improvement. Interprofessional collaboration was demonstrated by Hendrian and Tipton (2020) and Rohm (2020) to reduce falls effectively in acute care settings. Akuamoah-Boateng et al. (2019) used interprofessional collaboration in their research on length of stay and discharge disposition, demonstrating that it improved quality. This information helped the author provide background information to leaders when discussing the importance of shared governance.

Perhaps the most critical practice identified in the literature was the use of shared governance within hospitals to engage staff in making decisions about their own practice, which leads to buy-in and retention (Porter O'Grady & Clavelle, 2021). Engaging the interprofessional team brings a variety of perspectives and ideas to the table, which results in improved quality and alignment with organizational goals (Hendrian & Tipton, 2020; Kyytsonen et al., 2020; Capitulo & Olender, 2019; Olender et al., 2020; Panayotou et al., 2019). In doing so, the organization can align its daily operations with strategic initiatives. The DNP project was structured to enhance staff voice in their practice to improve engagement and retention, which aligned with the organization's strategic priorities.

### Gaps in Knowledge

A gap in the knowledge identified in the literature review process is the optimal composition of interprofessional shared governance teams. This gap leads to the questions of which professions should have representation on the unit-level shared governance teams and the optimal size for a shared governance team. Porter O'Grady and Clavelle (2021) discussed the transition from shared governance to professional governance, leading the author to question what further evidence exists for the effectiveness of this proposed change to practice.

## Review of Theory

The theoretical basis for the project was composed of models and theories drawn from several disciplines. Many theories contributed in small part to the project work of the shared governance council. However, GEMS theory was the overarching theoretical framework for project implementation.

GEMS theory provided the project's theoretical framework, emphasizing that small, unit-level changes are important to the project's success (Lindell & Bogue, 2016).

**General Theory for Effective Multi-Level Shared Governance**

The overarching theoretical framework for project planning and implementation was the GEMS theory, which Lindell and Bogue (2016) used to manage changes through shared governance. The GEMS theory allows organizations to implement and sustain changes by encouraging a shared governance structure (Lindell & Bogue, 2016). GEMS theory was applicable specifically to this DNP project as it showed the effectiveness of shared governance in improving outcomes organizationally and within specific units. GEMS theory determined the project's scope and appropriate leadership support during the planning stages. The GEMS theory provided the needed structure for the shared governance council implementation. The theory outlined nine core competencies needed for effective leadership in shared governance. The author used these to educate the trial council's leaders. The theory also assigned roles and responsibilities to all parties within the shared governance team, which guided the council's meetings.

The theory outlined the needed actions by leadership to make shared governance implementation successful. Lindell & Bogue, 2016 provided a graphic of a stepwise set of leadership competencies required for implementation of shared governance. These nine steps were organized into three distinct phases, from the most basic and foundational to the most strategic (Lindell & Bogue, 2016). The DNP project's implementation began with foundational actions, such as assisting with group formation and task-setting and progressed through management support initiatives and then to interprofessional aspects.

**Relationship-Based Care Model**

The relationship-based care model (RBC) has been used to enhance nursing care through collaboration among disciplines (Capitulo & Olender, 2019). The basis of the RBC model is that it transforms nursing care through deliberate, collegial, and collaborative relationships within the care team (Capitulo & Olender, 2019). This model applied to the DNP project because the interprofessional integration into shared governance structure created robust opportunities and enhanced outcomes (Capitulo & Olender, 2019). This model provides a framework for organizational cultural change (Capitulo & Olender, 2019). After the RBC model implementation, relationships are improved across the organization. The trial shared governance project council collaborated with other disciplines, such as human resources and the nurses' union, to drive their projects forward, strengthening relationships among disciplines and departments.

### Interprofessional Learning Continuum Model

At the suggestion of the Institute of Medicine, the interprofessional learning continuum (IPLC) model was created (Cox et al., 2016). This model provided an effective framework for the DNP project because it focuses on learning within an interprofessional structure, which could enhance collaboration and improve outcomes (Cox et al., 2016). Cox et al. (2016) explained that an important source of interprofessional education occurs within the workplace. The DNP project allowed the interprofessional team to learn and grow together as the members navigated their quality improvement initiatives.

## Alignment of Theory

Although several theories helped to set the framework for the project, the GEMS

theory was most prevalent in the project work. Utilizing GEMS theory, the author created a trial unit-based council structure so that leadership could gain experience managing in this new structure. As the leadership team becomes more confident in leading within a shared governance environment, unit/department-based councils will launch throughout the system and large, system-wide councils will be incorporated for sustainment.

Due to the interconnected themes found in the literature, the success of the DNP project was supported by the importance placed on the important concepts: shared governance, interprofessional collaboration, quality improvement, leadership, and employee engagement. Layering GEMS Theory, the Relationship-Based Care Model, and the IPLC Model onto the themes provided a theoretical and structural framework to drive change.

# Chapter III: Method

This project focused on the trial development and implementation of a shared governance structure at the unit level in a Midwest public health system. The project's effect on frontline staff nurse and leader engagement was measured by comparing turnover and absenteeism rates one year before and immediately after implementation. After receiving a letter from Indiana Wesleyan University stating that the project was exempt from institutional review board review (see Appendix A), a trial unit-based practice council was implemented on several units within the correctional health affiliation of the health system.

## Design of the Project

The project was a quantitative, quasi-experimental, pre and post evaluation design. The project was quasi-experimental because the participating units were chosen based on the unit leaders' willingness and engagement in the project, and which units were open for the project's duration. Because of the necessity of closing multiple units at the practice site and the leadership turnover, the quasi-experimental design was used. Another factor in recruitment of participating units was the word-of-mouth willingness of staff and leaders. Following leadership's discovery of units with staff interested in participating, those units were selected, resulting in a purposive sample.

A unit-based practice council was formed of frontline nurses, nurse leaders, and interprofessional members, such as human resources professionals, staffing office members, and the nurses' union representatives. The author provided participating unit-based councils structured meeting agenda templates (Appendix B) and meeting minute templates (Appendix C). A scorecard (Appendix D) was maintained for the participating

unit to record progress. The unit-based council had the autonomy to select its topics of interest and potential actionable projects, such as self-scheduling or fall reduction. The unit-based council chose self-scheduling as its topic of interest and ultimately performed a trial of self-scheduling with predominantly twelve-hour shifts.

A pre and post design was used for data collection. Staff nurse and leader turnover rates and absenteeism rates for three months were compared in a year over-year fashion. Data were collected for three months immediately following implementation, from November 2022 through January 2023. Because the three month post-implementation period was November 2022 through January 2023, the pre-implementation period selected was November 2021 through January 2022.

**Setting**

The setting of the project was a public-sector healthcare system within a metropolitan area in the Midwest. The system was a mission-driven organization with a reputation for treating patients regardless of their insurance status. The system included a large teaching hospital, a small community hospital, two correctional health facilities, a public health department, and several ambulatory care facilities. Three nursing units within the correctional health portion of the system took part based on the word-of-mouth willingness of the staff and their leadership to participate.

**Population**

The population of interest was the health system’s nursing staff and nurse leadership of the health system. The frontline nursing staff was unionized and represented by a large nurses' union. The nursing staff and nurse leaders from the participating units were invited to participate. The population was a convenience sample, which was sub-

optimal (Andrade, 2021). However, the staff and leaders of the participating units were included because of previously cited reasons. Recruitment was via word-of-mouth after a shared governance retreat. The retreat was held synchronously in-person and virtually via Microsoft Teams due to in-person meetings restrictions at the organization. The retreat included executive nurse leaders from across the system. After the retreat, word-of-mouth recruitment began. A leader spoke with the author and stated that their staff was willing to participate and desired to trial self-scheduling as part of the council's focus. Leaders and frontline staff willing to participate were recruited to join the project. Participants were informed that participation was voluntary and that they could withdraw from the project anytime.

The eligibility criteria included that the units stayed open for the duration of the project and that the participants were willing to commit to meeting at least once per month. Exclusion criteria included any temporary units or units with participants who were unwilling to commit to the meetings.

Participants included frontline staff nurses, nurse leaders from the units and the system, staffing office professionals, human resources professionals, and nurses' union leadership members. Nurse leaders supported the councils by attending meetings. Interprofessional members took part in councils based on their area of expertise. All charge and frontline staff nurses managed by the nursing unit leaders were eligible to participate, regardless of tenure or position.

The tenure of the nurse leader and tenure within the system may have affected the nurse's willingness to participate. Being a unionized health system, many nurses and nurse leaders with long tenure resist change which may impact data analysis. The tenure

of any staff nurses who left the organization during the project was analyzed and recorded.

Meetings were held at least monthly. During self-scheduling planning and implementation, ad-hoc meetings and unit-based council meetings occurred. The council addressed concerns about the staff's daily practice, including patient safety issues, scheduling, call-offs, and work-life balance topics. Leaders empowered the staff to propose potential solutions to issues. Ultimately, the meeting' focused on the self-scheduling trial with the concurrent use of predominantly twelve-hour shifts. The manager empowered the staff to nominate schedule balancers and provide the managers with a balanced schedule, which would then be reviewed by the leaders and ultimately published. The human resources professionals and the representatives from the nurses' union supported the process and ensured that where potential contract violations might have occurred, a resolution was addressed.

## Data Collection

A comparison was made between turnover rates in participating units for the three months one year prior to implementation and the same three months post-implementation. This data was collected from the human resources department database, with all identifying employee information redacted to protect anonymity. Absenteeism rates were collected from the scheduling system for the same periods, pre- and post-implementation for staff nurses. The nurse finance department provided nurse leaders' absenteeism rates redacting identifying information to ensure anonymity. To protect anonymity, data was reported as a rate in full-time equivalents. Both data sets were separated as frontline staff nurses and nurse leaders. Results were analyzed using

Microsoft Excel software. The author also collected confidential qualitative data during shared governance meetings. Data was entered in a tabular format and divided into positive and negative themes. Project data was kept in a secure server on a password-protected computer in a locked office and will be stored for three years after the project's end.

The methods used during the implementation of this DNP project were a direct product of the nature of the organization. Because of the high leadership and staff turnover, a quasi-experimental method with a convenience sample was used. This design posed limitations in the project but allowed for a greater opportunity for completion due to the limited timeframe for implementation.

# Chapter IV: Results

While the study design was a quasi-experimental, quantitative, pre-post design, valuable qualitative data was also collected. This data was vital to the practice implications and recommendations. The overall positive effects of the shared governance trial may not be reflected in the data from the three-month trial. Positive themes were reflected in the qualitative data.

## Results of Data Collection/Analysis

The data collected and analyzed was primarily quantitative, as was the intent of the project. However, due to the nature of the project and the author's attendance at some of the shared governance meetings, confidential qualitative data was collected and analyzed.

### Quantitative Analysis

Quantitative analysis was performed on the turnover and absenteeism rates for staff nurses and nurse leaders in a pre-post manner. Data were collected at the following levels: units participating in the unit-based council shared governance structure, the overall correctional health entity, and overall system levels for staff nurses and nurse leaders. No distinction was made between charge nurses and other staff nurses at the staff nurse level. Additionally, the tenure of all staff nurses who departed was collected and analyzed for modes to maintain confidentiality.

#### *Turnover*

Turnover for staff nurses and nurse leaders was analyzed as average rates from pre to post and monthly throughout the post-implementation period. Data were analyzed for trends, and the tenure of staff nurses who departed was monitored.

**Staff Nurse Turnover Rates.** Overall, the staff nurse turnover rate for the units participating in the shared governance council increased from 0.3% pre-implementation to 1.6% post (Table 1). However, the turnover rates steadily decreased monthly during the post-implementation period on these units, from 2.3% in November 2022, to 1.9% in December 2022 to 0.5% in January 2023 (Figure 1), demonstrating improvement during this time. Within the correctional health entity, the trends mirrored the test units. The average turnover rate for the correctional health entity from the pre-period was 0.5%, while post it increased to 1.4% (Table 1). However, during the post-period, it also steadily decreased from 2.1% in November 2022 to 1.7% in December 2022 to 0.4% in January 2023 (Figure 1). For the system, the staff nurse turnover rates decreased from an average of 1.8% pre to an average of 1.4% post (Table 1).

**Staff Nurse Turnover by Tenure.** Staff nurse turnover by tenure (Table 2) was collected and compared from pre to post-implementation periods. For the system in the pre-period, the modes were demonstrated in the two-to-five year and fifteen-to-twenty-five year tenure periods. Post implementation, the modes for the system were demonstrated in the fifteen-to-twenty-five year and twenty-nine year and over tenure period, indicating a shift to losing fewer nurses who had just started with the organization. For the correctional health entity in the pre-period, turnover tenure modes were demonstrated in the one-to-two year and two-to-five-year tenure periods, while post, they were seen in the two-to-five year, five-to-seven year, and fifteen-to-twenty-five year tenure periods. For the test units, the tenure mode was demonstrated pre-implementation in only the one-to-two year tenure period, while post implementation, modes were seen in the two-to-five year, five-to-seven year, and fifteen-to-twenty-five

year tenure periods. These rates demonstrated a shift to losing staff in their first year of employment.

**Nurse Leader Turnover Rates.** Overall, nurse leader turnover in the units participating in the shared governance council increased from 0% to 28% from pre to post-periods (Table 3). This trend increased steadily from 12.5% in November 2022 to 14.3% in December 2022 to 57.1% in January 2023 (Figure 2). The correctional health entity as a whole also followed these patterns. Pre-turnover rates for leaders averaged 0% and post averaged 18.9% (Table 3). In the correctional health entity, the post-implementation period demonstrated a steadily increasing turnover in the entity akin to that of the test units (Figure 2). The system average also increased pre to post, from 0.8% pre to 4.6% post (Table 3). For the system, however, the post-implementation period demonstrated an increase from 3.9% in November 2022 to 7% in December 2022, with a subsequent decrease to 2.8% in January 2023 (Figure 2).

### *Absenteeism*

Absenteeism was defined as the use of benefit time, meaning both unplanned and preplanned absences from work. Absenteeism could be the result of vacation time or sick time. Due to the limitation of the data collection within the system there was no way to identify unplanned absences separate from planned absences.

**Staff Nurse Absenteeism Rates.** In the participating units, absenteeism increased from 13.6% pre to 14.8% post (Table 4). This area also demonstrated a steadily increasing rate over the post-implementation period, with November 2022 demonstrating a 4.5% absenteeism rate, December 2022 demonstrating a 22.3% absenteeism rate, and January 2023 reaching a 25% absenteeism rate. Within the correctional health entity,

absenteeism rates decreased from pre to post period, with the pre-implementation period demonstrating a 28% absenteeism rate and post decreasing to 18% (Table 4). The system demonstrated an increase in absenteeism from the pre-period to the post-period, with the pre-period demonstrating a 13.6% absenteeism rate and the post-period demonstrating a 14.8% absenteeism rate (Table 4).

**Nurse Leader Absenteeism Rates.** Absenteeism rates for nurse leaders were collected for the same periods. The pre-absenteeism rate for the trial units was 16.3%. The correctional health absenteeism rate averaged 19.5%, and for nurse leaders across the system it averaged 17.2% (Table 5). All areas demonstrated month-to-month variance, with all areas decreasing in absenteeism rates from November 2021 to December 2021 and then increasing in absenteeism rates from December 2021 to January 2022. The absenteeism rates for nurse leaders increased from the previous year in every area, with average absenteeism rates for the trial units being 31.3%, for correctional health, the average was 27.4%, and the average absenteeism rates across the system being 25.0% (Table 5). The month-to-month trends were similar in all areas, yet opposite the pattern found from the previous year. All areas increased in absenteeism rates from November 2022 to December 2022 and then decreased from December 2022 to January 2023.

## Qualitative Analysis

Many themes became apparent from the author's listening to statements made during the shared governance meetings. Both staff nurses and nurse leaders felt that the shared governance council offered more benefits than drawbacks. Positive themes that staff nurses verbalized were better work-life balance due to being able to trial twelve-hour shifts, feeling less stress at home, and enhanced collaboration. Positive themes

identified by nurse leaders overlapped in many ways with those of the staff nurse. They included enhanced collaboration, better relationships with the union, and an overall feeling that the staff was happier. Negative themes identified by leaders and staff nurses included hand-off and issues with staff floating to other units.

## Discussion

Turnover and absenteeism rate comparisons between areas and from pre-implementation to post-implementation provided interesting insights into the potential effects of shared governance across the system.

### Turnover

In both the project units and the correctional health entity, turnover rates for staff nurses increased from the pre to the post-period. This increase contrasted with the system, which demonstrated a decrease from pre to post-implementation. However, turnover rates steadily decreased during the post-implementation period within the correctional health entity and test units, which was promising. The decrease in turnover rates could demonstrate a lagging positive correlation between the implementation of shared governance and staff nurse retention. The modes of tenure of staff nurses who separated from the organization demonstrated a shift to losing fewer staff nurses hired within the last two years. This change demonstrated a shift to fewer staff nurses quitting in their first two years of employment.

Nurse leader turnover increased in each area. The system demonstrated a higher turnover of nurse leaders. This change potentially indicated that the effects of shared governance did not immediately benefit the retention of nurse leaders.

### Absenteeism

Staff nurse absenteeism increased from pre to post-implementation in both the tests units and the system while decreasing within the correctional health entity. Comparing year-to-year, the rates were expected to decrease due to all staff being fully vaccinated against COVID-19 (S. Long, personal communication). However, monitoring influenza-like symptoms and increased communication reminders regarding staying home when experiencing symptoms may have contributed to increased absenteeism for nurses. Additionally, many staff did not take planned vacations in the pre-implementation period but verbalized they were more comfortable taking vacation during the post-implementation period, as e COVID rates and patient acuities had decreased from previous years. Finally, a factor that may be correlated with increased absenteeism rates is the optimization project of the staff scheduling system. This project involved training for managers (S. Long, personal communication), which may have improved compliance with placing benefit time into the system, thereby increasing reported absenteeism rates.

Nurse leader absenteeism rates increased from pre to post-implementation at the system, correctional health, and trial unit levels. Several factors may have contributed to this trend. Many nurse leaders expressed burnout from long hours and increased stress levels associated with their jobs. Many organizational changes occurred during the year preceding the shared governance trial, including structural changes within the leadership team. These changes may have correlated with increased absenteeism. Additionally, many leaders delayed vacations during the COVID-19 pandemic and took time off during the post-implementation period.

## Implications for Practice

Several practice implications were identified from this project. While the average

turnover rates in the practice areas increased from the previous year, they did decrease month-to-month during post-implementation. It is promising that implementing structural empowerment, as well as listening to nurses' voices, was associated with an immediate and steady decrease in employee turnover.

Another practice implication based on this work is that computerized staff scheduling applications should be implemented with proper manager training. The fact that the pre-implementation absenteeism data may have been skewed due to poor leadership training reinforced this point. Self-scheduling is an initiative to improve employee morale and work-life balance. The shared governance trial team implemented a self-scheduling project with a trial of twelve-hour shifts in collaboration with human resources and staffing office personnel. The effects of this project on future absenteeism are yet to be determined. However, the overall positive themes that emerged from the qualitative data demonstrate a positive perception of the initiative.

Another practice implication that can be derived from the data is that leadership support in the shared governance process should start long before the process begins. The increasing turnover of leaders during the post-implementation period may be positively correlated with the trial shared governance implementation. Although leadership support was given, shared governance leadership should ideally be included in leader onboarding into an organization.

Finally, engaging the nurses’ union early in the shared governance planning and implementation allows for opportunities for enhanced collaboration. Collaboration helps to drive initiatives in a positive direction and improves rapport between the union, staff nurses, and leaders.

## Limitations

Limitations to this project were numerous. The trial was performed in three units within the adult division of the correctional health entity. The project needs expansion to determine its overall efficacy within the organization. The data collection period was limited to three months. Data collection should continue for a longer post-implementation period to determine the project's lasting effects. Data collection posed another limitation. Prior to project planning and implementation, the systems used by the healthcare system to collect absenteeism and turnover data were inconsistent and difficult to use. Historical data came from multiple sources and was not validated. Continued optimization of the data collection tools is necessary to expand the project for sustainability.

## Recommendations

Future research recommendations are informed by the gaps in knowledge identified during the literature review process. First, the author recommends research focus on the various disciplines comprising shared governance committees. This research would help to determine the optimal composition of shared governance councils. Another recommended focus of future research is the size of shared governance teams. Research could help identify the optimal size. Finally, future research into professional governance as an option instead of shared governance would help inform and equip to make effective decisions.

Recommendations for the organization stem from the practice implications. First, the site should begin planning the implementation of a shared governance structure. The evidence for this is that turnover began declining in the test units and division immediately after the implementation of the project team. This planning should begin

with leadership education on shared governance based on interprofessional and shared governance competencies, such as the IPEC Core Competencies and those included in the TeamSTEPPS program. An important element in this implementation will be to include members of the nurses' union from the planning phases to build rapport and create spaces for increased collaboration and the creation of a shared vision (Porter O'Grady, 2001). The organization should also monitor the trial results for a longer time, as one quarter of data is insufficient to demonstrate the long-term effects.

Wellness initiatives aimed at work-life balance should be considered across the organization as a staff and leader stress reduction and retention program. The qualitative themes that emerged from the staff nurses centered around work-life balance and supported this recommendation. Romano et al. (2022) explain that wellness programs aimed at resiliency can help reduce burnout stress among hospital staff. A final recommendation is that collaborative efforts between the staff nurses, leaders, and nurses' union continue to drive forward positive change across the organization (Porter O'Grady, 2001).

The DNP project aimed to improve engagement and retention of both frontline staff nurses and nurse leaders by implementing a trial interprofessional shared governance structure within an area of one entity within a large public health system. While the quantitative results were largely inconclusive, the incidentally obtained qualitative results showed promise. Positive themes regarding collaboration, improved relationships, and work-life balance were evident in this data. Recommendations for future practice include implementing leadership training to enhance the sustained future roll-out of system-wide shared governance.

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# Appendices

## Appendix A

## IRB Exemption Letter from Indiana Wesleyan University


Institutional Review Board
4201 South Washington Street
Marion, IN 46953

Tel: 765-677-2090
Fax: 765-677-6647

### Notice of Exemption

Interprofessional Shared Governance: Effects of Nurses and Nurse Leaders
Title of Research Topic

Lisa Shuttz, Ruth Eby
Investigator(s)

1764.22
IRB ID Number

The IWU Institutional Review Board (IRB) has reviewed your proposal and has determined that your proposal is exempt from further review by the IRB because the proposed project does not constitute human subjects research. Federal regulations that establish the authority of the IRB provide a specific definition of human subjects research which defines the scope of IRB authority. Your project falls outside the federal definition of human subjects research and is therefore not subject to IRB review.

Please note that this exemption regards only the oversight of human subjects research by the IRB. The IRB has not reviewed any other aspects of the research project and makes no judgement on the merits of the project or its methodologies. All research executed at IWU must conform to all applicable state and federal laws and regulations and to all applicable IWU policies.

Comments:

Ph.D.

Chair, Institutional Review Board

9/6/2022
Date

## Appendix B

## Shared Governance Meeting Agenda Template

## Unit-Based Council Monthly Meeting Agenda

**Unit_____ Date_____ Chairperson_____**

| Issue to Be Discussed | Quality, Safety, Or Service? | Suggested Action Item for Solution | Responsible Parties | Due Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Recognition and Celebrations:**

**Special Topics:**

**Next Meeting Date:**

## Appendix C

## Shared Governance Meeting Minutes Template

### Unit-Based Council Monthly Meeting Minutes

**Date_____ Time_____ Unit_____**
**Chairperson_____ Recorded by_____**

**Attendees:**

| Topic | Discussion | Action Item | Due Date | Responsible Party |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Recognition:**

**Special Topics:**

**Date of Next Meeting:**

## Appendix D

## Shared Governance Scorecard Template

### Unit-Based Council Meeting Compliance Annual Tracker FY 23

**Unit_____ Division_____ Entity_____**

| Month | Met? (Y/N) | Date | Time | Location | # of Attendees (Staff) | Management Participation? (Y/N) |
|---|---|---|---|---|---|---|
| December | | | | | | |
| January | | | | | | |
| February | | | | | | |
| March | | | | | | |
| April | | | | | | |
| May | | | | | | |
| June | | | | | | |
| July | | | | | | |
| August | | | | | | |
| September | | | | | | |
| October | | | | | | |
| November | | | | | | |
| | | | | | | |
| Ad Hoc: | | | | | | |
| | | | | | | |
| Total Meetings | | | | | | |

# Tables

## Table 1

*Staff Nurse Turnover Rates Pretest and Posttest*

| | Pretest | Posttest |
|---|---|---|
| Trial Units | 0.3 | 1.6 |
| Correctional | 0.5 | 1.4 |
| System | 1.8 | 1.4 |

*Note.* This table expresses turnover rates as a percentage.

**Table 2**

*Tenure of Staff Nurse Turnover (Modes)*

| | **Pre-Test Mode Tenure (Years)** | **Post-Test Mode Tenure (Years)** |
|---|---|---|
| **Trial Units** | 1-2 | 2-5 & 5-7 & 15-25 |
| **Correctional Health** | 1-2 & 2-5 | 2-5 & 5-7 & 15-25 |
| **System** | 2-5 & 15-25 | 15-25 & >29 |

*Note.* The tenure of staff nurses who left their positions in the pre-implementation and post-implementation time periods is depicted.

**Table 3**

*Nurse Leader Turnover Rates Pretest and Posttest*

| | Pretest | Posttest |
|---|---|---|
| Trial Units | 0 | 28 |
| Correctional | 0 | 18.9 |
| System | 0.8 | 4.6 |

*Note.* This table expresses turnover rates as a percentage.

**Table 4**

*Staff Nurse Absenteeism Rates Pretest and Posttest*

| | Pretest | Posttest |
|---|---|---|
| Trial Units | 5.1 | 17.3 |
| Correctional | 28 | 18 |
| System | 13.6 | 14.8 |

*Note.* This table expresses absenteeism rates as a percentage.

**Table 5**

*Nurse Leader Absenteeism Rates Pretest and Posttest*

| | Pretest | Posttest |
|---|---|---|
| Trial Units | 16.3 | 31.3 |
| Correctional | 19.5 | 27.4 |
| System | 17.2 | 25 |

*Note.* This table expresses absenteeism rates as a percentage.

# Figures

## Figure 1

*Posttest Staff Nurse Turnover (Month-to-Month) by Area*

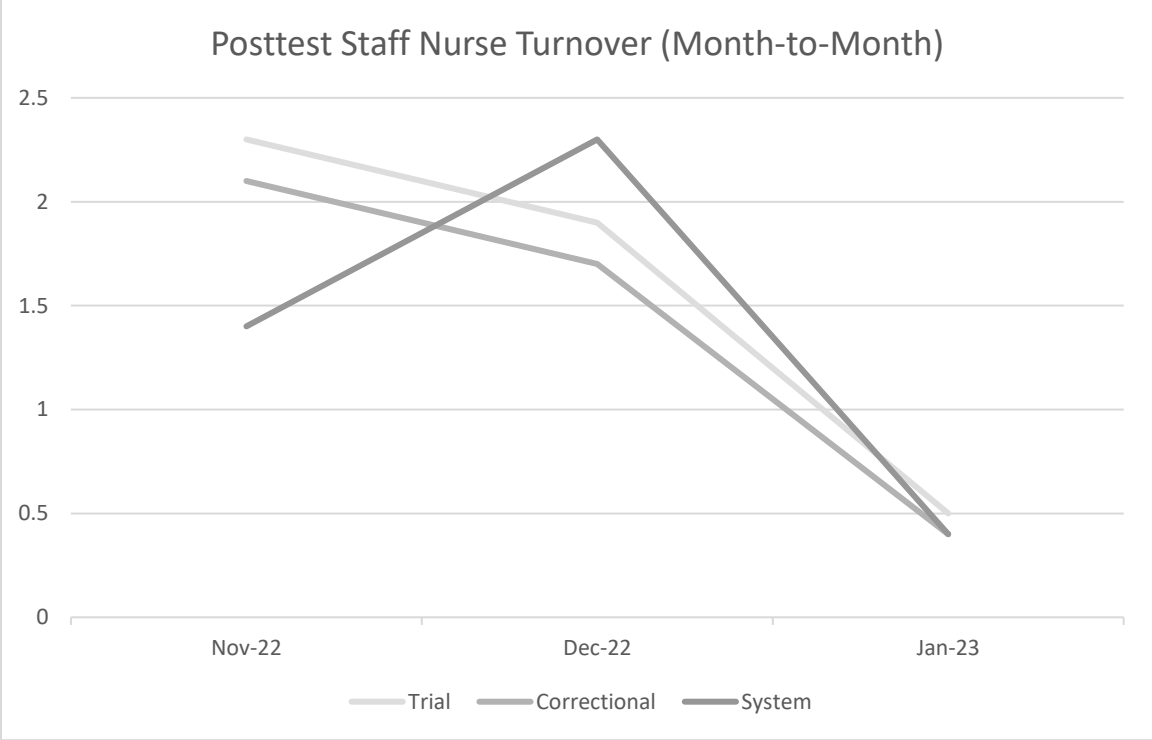

**Figure 2**

*Posttest Nurse Leader Turnover (Month-to-Month) by Area*