THE EFFECT OF SHARED GOVERNANCE ON NURSE ENGAGEMENT AND RETENTION

By

Lanae' McAllister

Doctor of Nursing Practice Project submitted to the faculty of

Division of Doctoral Nursing

in the School of Nursing

at Indiana Wesleyan University

in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice

APRIL 2023

Acknowledgments

First, I would like to praise God for the abundance of blessings He provided me throughout my doctoral journey. Only through His endless grace and mercy could I reach this accomplishment.

I am incredibly grateful to Dr. Beth Bailey for serving as my Project Advisor. Her knowledge and endless encouragement were invaluable, and I appreciate all the ways she provided support. My sincere thanks also go to the rest of my project team: Allyson Hurst for serving as my Project Mentor, Mike Bottomley for his assistance with data analysis, and Dr. Rik Lovelady for being a wonderful editor.

To my parents, Jan and Deanna Maller, I would not be where I am today without your love and support. From the early days of helping me read for last-minute book reports to giving feedback on this paper, everything I have ever accomplished (academically and otherwise) stems directly from you. I love you both, and let it be documented here forever that you are both “The Fun One.”

Last but absolutely not least, my deepest gratitude goes to my husband and daughter, Graham and Riley, for filling my life with endless laughter and love. Thank you for all the hugs and encouragement to keep me going when I wanted to stop, and most importantly, for being my very best friends. There are no words to adequately express my love for you both.

Abstract

The 2021 national average for nurse turnover in the United States was 27.1%. Healthcare organizations lose an average of $7.1 million annually due to the current nursing shortage crisis. Empowering nurses is critical to increasing nurse engagement and improving retention. Nursing shared governance models positively affect nurse engagement, job satisfaction, and retention, resulting in higher quality nursing care and better patient outcomes. This study aimed to implement a nursing shared governance structure and evaluate the impact on nurse engagement and retention rates. The general theory for effective multilevel shared governance construct guided project implementation. Nurse engagement was measured using the Utrecht Work Engagement Scale as a pre/post questionnaire. Monthly nurse turnover rates were collected to monitor retention. Data analysis was completed using an independent samples *t*-test. However, there was insufficient evidence to suggest a significant relationship between shared governance and nurse engagement or retention. Small sample sizes and short study duration resulted in inconclusive results that could not determine a significant relationship between nursing shared governance and nurse engagement or retention. Future projects should seek to replicate the process with larger sample sizes, utilize a more prolonged study timeframe, and consider using a control group to strengthen result quality.

Table of Contents

Chapter I: Introduction

Companies with work environments that promote high levels of employee engagement outperform their competitors in terms of having better job satisfaction rates, higher levels of employee retention, and increased profitability (Kutney-Lee et al., 2016). According to Carthon et al. (2019), "Engagement has been defined as worker inclusion in organizational decision-making, inter-professional collaboration, and opportunities for professional development" (p. 41). When workers are engaged, they are energetic and enthusiastic about their work and often report feeling fully immersed in their roles (Wan et al., 2018). Engaged employees are often willing to put in extra effort and go beyond what is asked of them in their daily tasks. This positive mindset creates an appealing work environment and can encourage coworkers to behave in a similar manner. Occupational engagement is not limited to the individual and may be experienced collectively to expand to the department and organizational levels (Schaufeli & Bakker, 2004).

Nurses comprise the largest population of healthcare professionals; thus, maintaining high nurse engagement can significantly benefit healthcare facilities and patients. Healthcare organizations with a highly engaged nursing workforce report enhanced clinical outcomes, and patients of these facilities report being more satisfied with their care (Oss et al., 2021; Ong et al., 2017). Increasing nurse engagement is also linked to improved nurse retention. Increased nursing tenure positively impacts healthcare by producing higher unit morale and teamwork while lowering the risk of adverse events, such as patient infections or medical errors (Zaheer et al., 2021). Unfortunately, due to the COVID-19 pandemic, nurses are experiencing higher levels of

burnout, resulting in rising rates of disengagement and turnover (American Hospital Association, 2022). In a 2021 study by Shah et al., 68.6% of nurses reported leaving the bedside due to burnout, and 59.5% resigned due to stressful work environments (p. 1).

High nurse turnover can be extremely costly and negatively impact a healthcare organization's bottom line. The significant financial implications of nurse turnover are due to the high expenses of nurse recruitment, new-hire orientation costs, overtime pay, and agency costs to maintain minimum staffing levels (Ong et al., 2017; Wan et al., 2018). The average cost of turnover for a bedside nurse in the United States is estimated to be $64,000, meaning the average hospital loses between $5.2 - $9.0 million due to nurse turnover (Ong et al., 2017; Nursing Solutions Inc., 2022). Hospitals that improve their nurse retention rates by even one point could save an average of $262,300 per year (Nursing Solutions Inc., 2022).

The project facility was a small Midwest rehabilitation hospital experiencing high levels of nurse disengagement and turnover. In 2021, the facility had multiple nurses resign, including the unit manager, associated with feeling overwhelmed and experiencing burnout following the stressful work conditions of the COVID-19 pandemic. The leadership team recognized that nurses were disengaged and sought to strategically improve nurse engagement and morale and to reduce nurse turnover. One way to effectively engage nurses is by implementing a nursing shared governance model.

Statement of Problem

The facility stakeholders used a traditional administration driven governing structure, which limited nurses' autonomy and adversely affected engagement levels. The negative impacts of nurse disengagement included job dissatisfaction, decreased

productivity levels, increased nurse turnover rates, and reduced patient outcomes (Dempsey & Reilly, 2016: Carthon et al., 2019).

Purpose/Aim of the Project

A shared governance structure may improve nurse engagement and reduce the adverse effects associated with nurse turnover. The project aimed to implement a nursing shared governance structure in a small Midwest rehabilitation hospital and evaluate the impact on nurse engagement and retention rates.

Background/Problem of Interest Supported by the Literature

The term nurse engagement describes nurses' satisfaction with their jobs and their level of commitment to their local organization and the entire nursing profession (Dempsey & Reilly, 2016). Engaged nurses have an emotional connection to their role and are passionate about their work. Nurses with high engagement often seek to provide the highest level of patient-centered care and make genuine connections with their patients. Healthcare organizations that foster high nurse engagement document better patient outcomes, improved work satisfaction, lower nursing-related medical errors, and lower nurse turnover (Dempsey & Reilly, 2016; Hisel, 2020). Conversely, disengaged nurses lack a connection to their role and can negatively impact patient care.

Nurses become disengaged for a multitude of reasons. Dall'Ora et al. (2020) found a direct correlation between nurse disengagement and adverse job characteristics, such as heavy workloads, poor staffing conditions, long shifts, and a lack of autonomy. A disengaged nursing workforce can negatively impact patient outcomes and decrease productivity. Productivity loss may occur from nurses demonstrating negative attitudes toward coworkers and patients, frequently calling in sick, taking longer than usual to

complete routine tasks, and lacking the motivation to go above and beyond when necessary (Dempsey & Reilly, 2016). The negative impacts of nurse disengagement include job dissatisfaction and increased nurse turnover rates (Dempsey & Reilly, 2016; Carthon et al., 2019). Nurses dissatisfied with their position and lacking connection to their team have an increased risk of leaving their position. High nurse turnover rates are costly and have been linked to having negative impacts on patient outcomes (Carthon et al., 2019).

According to Ong et al. (2017), the level of employee engagement within an organization directly correlates to its employees' decision-making authority. Many organizations utilize a shared governance model that involves a nonhierarchical structure where employees are empowered to participate in organizational-level decision-making on policies and procedures (Carthon et al., 2019). A nursing shared governance model allows bedside nurses to use their expertise to influence hospital policies, procedures, and protocols that directly impact patient outcomes. Nursing shared governance is widely recognized for its positive effects on nurse job satisfaction, retention, and high patient satisfaction scores (Ong et al., 2017).

Nursing shared governance is also essential for hospitals seeking the prestigious Magnet Recognition from the American Nurses Credentialing Center. Magnet hospitals maintain a strong reputation for high-quality nursing care, innovative work, transformational leadership, and structural empowerment. Through nursing shared governance models, Magnet hospitals promote nursing autonomy and foster positive provider-nurse relationships, improving employee satisfaction rates and nurse engagement (Shah et al., 2021).

Significance of the Project

Disengaged nurses are more likely to leave their position for other job opportunities. According to Wan et al. (2018), high nurse turnover rates can harm the unit's morale and increase the workload of the remaining team members. The loss of nursing staff can negatively impact patient outcomes, mainly if it results in a higher nurse-to-patient ratio. Nurse turnover has significant financial implications due to reduced productivity rates, expensive nurse recruitment, new-hire orientation costs, and lower patient satisfaction rates that diminish potential reimbursement (Wan et al., 2018). In 2021, the United States' national average for nurse turnover was 27.1%, translating to the average hospital losing $7.1 million to nurse turnover. In fact, in the past five years alone, the average hospital in the United States has turned over 95.7% of its nursing workforce (Nursing Solutions Inc., 2022). According to the American Hospital Association (2022), "Without a resilient and sufficient health care workforce, our hospitals – the backbone of our nation's health care system – will be unable to operate" (p. 3). It is essential that healthcare organizations prioritize strategies to increase and maintain high levels of nurse engagement that will help reduce nurse turnover and support positive patient outcomes.

Impact of the Project

Through shared governance, nurses can collaborate with other nurses and healthcare professionals to identify issues and determine practical solutions. Many hospitals succeed in improving quality metrics such as patient satisfaction scores, decreasing patient falls, and fostering nurse-nurse teamwork through shared governance initiatives (Brennan & Wendt, 2021). Brennan & Wendt (2021) postulated that leadership

qualities develop in each nurse within a shared governance model purely from the virtue of participation (p. 5). Nurses value professional growth and empowerment opportunities, which are critical drivers in increasing nurse engagement (Carthon et al., 2019).

Engaged nurses have a higher level of organizational commitment and are less likely to leave their position (Church et al., 2018). Leaders at the project facility perceived nurse engagement to be significantly declining following the COVID-19 pandemic and desired an intervention to improve nurse engagement and reduce turnover. Units with higher nurse tenure experience better patient outcomes (such as fewer hospital-acquired pressure injuries) and have stronger unit morale because nurses are more invested in the care they provide (Kim & Han, 2018). The project facility also had a large influx of new nurse graduates. Novice nurses benefit from working alongside more experienced nurses who can provide mentorship and foster leadership skill development in the next generation of nurses (Brennan & Wendt, 2021). Nursing shared governance councils are an excellent medium for multigenerational nursing collaborations to occur and result in more positive work environments, better financial performance, and overall higher quality of patient care within healthcare organizations (Dempsey & Reilly, 2016).

Chapter II: Literature and Theory Review

Shared governance is recognized as an effective structure for empowering nurses. Allowing nurses to have a voice in their practice can lead to higher nurse engagement, which can decrease nurse turnover rates. Shared governance structures rooted in theoretical frameworks have more favorable outcomes, specifically a more significant advancement of unit, department, and organizational level goals (Joseph & Bogue, 2016).

Literature Review

A literature review was conducted to review scholarly works on nurse engagement, retention, and shared governance models. Using the databases Medline, Cumulated Index to Nursing and Allied Health Literature, and Google Scholar, articles focusing on “shared governance,” “engagement,” and “nurse turnover” were collected. Articles published before 2016 were excluded from the review. Emerging themes from the literature support the concept that organizations with a nursing shared governance structure in place experienced higher levels of nurse engagement and lower turnover rates in comparison with healthcare systems that did not utilize a nursing shared governing hierarchy.

Engagement

Worker engagement is considered a top priority by many employers due to the numerous benefits that it offers to an organization. Ghazawy et al. (2021) defined engagement as "a positive affective, motivational work-related state of fulfillment, manifested by vigor (high commitment), dedication (motivated, strong involvement), and absorption (engrossed in work)" (p. 320). Companies that maintain high rates of worker engagement are more successful due to greater productivity and financial performance

(Dempsey & Reilly, 2016). Within healthcare, employee engagement has been identified as an essential strategy to improve patients' overall quality of care. Because nurses account for the largest group of workers within healthcare, nurse engagement must be a priority within healthcare facilities (Ghazawy et al., 2021).

Nurse engagement is nurses' commitment to their jobs (both to their unit and the organization), job satisfaction, and dedication to the nursing profession (Dempsey & Reilly, 2016). Facilities with high levels of nurse engagement have better patient outcomes (Li & Yamamoto-Mitani, 2021). Before project implementation, project facility leadership noticed a negative trend in nursing-related patient quality metrics. Leaders believed patient outcomes would improve following the integration of a nursing shared governance model. Nurses are critical drivers in clinical performance because they spend more time performing direct patient care than any other healthcare provider (Shah et al., 2021). Engaged nurses are linked to better nurse-sensitive quality metrics such as patient falls, hospital-acquired pressure injuries, catheter-associated urinary tract infections, and central line-associated bacterial stream infections (Ong et al., 2017). Healthcare organizations with highly engaged nurses also have better patient and nurse satisfaction rates (Oss et al., 2021).

Understandably, nurses prefer to work in settings prioritizing high-quality patient care. Nurses appreciate being valued for their skill set and extensive knowledge. These factors, along with adequate staffing and fair pay rates, influence the level of nurse engagement by increasing their sense of organizational commitment (Dempsey & Reilly, 2016; Church et al., 2018). Ghazawy et al. (2021) found that autonomy, or the ability to make decisions independently within one's scope of practice, is the most critical indicator

for nurse engagement (p. 325). An engaged nursing workforce often demonstrates higher professionalism and develops a sense of ownership for their practice. This type of work environment leads to enhanced clinical outcomes and positive patient satisfaction scores, resulting in optimal financial reimbursement rates (Oss et al., 2021; Ong et al., 2017). The project facility sought to utilize nursing shared governance to foster nurse engagement and support a work environment where nurses provide high-quality care. Focusing on nurse engagement is essential for healthcare organizations seeking to not only provide high-quality care but also to increase nurse retention and avoid the burden of high nurse turnover (Oss et al., 2021).

Turnover

Direct patient care is physically, emotionally, and mentally demanding, which places nurses at an increased risk of burnout and job dissatisfaction (Gebregziabher et al., 2020). Nurses at the project facility reported feeling overwhelmed, chronically fatigued, and burnout following the height of the COVID-19 pandemic. The leadership team feared nurses would be dissatisfied with their job and resign. Nurses who report poor job satisfaction and disengagement are at an increased risk of leaving their current position. Other factors influencing nurses' intention to leave positions include frequently caring for high-acuity patients, inadequate staffing ratios, poor leadership support, and less-than-desirable compensation and benefits (Li & Yamamoto-Mitani, 2021). Employee turnover is costly to any organization, but nurse turnover is particularly detrimental to the healthcare system due to its adverse effects on patient care. Poor nurse retention is directly associated with reduced quality of care, increased patient mortality, higher readmission rates, and increased lengths of stay (Li & Yamamoto-Mitani, 2021).

Facilities with low nurse retention rates also report higher rates of hospital-acquired pressure injuries, medication errors, and patient falls (Kim & Han, 2018; Ong et al., 2017).

Additionally, nurse turnover places a heavy financial burden on healthcare organizations. According to Ong et al. (2017), the national average cost to replace one nurse is approximately $64,000, which does not include the additional costs of orientation and other training requirements once the nurse is hired. Increased nurse turnover negatively impacts productivity levels and increases the number of overtime hours that the remaining nurses must work. Many facilities also face the additional challenge of low applicants, which results in expensive agency costs to fill open positions temporarily (Ong et al., 2017). Due to the detrimental effects of nurse turnover on patient outcomes and the financial performance of healthcare organizations, it is essential to directly address factors that increase nurses' intentions to leave.

While the intention to leave does not necessarily reflect turnover rates, it does provide insight into current employee levels of stress and disengagement (Li & Yamamoto-Mitani, 2021). Understanding the current state of a nursing team provides leadership an opportunity to promptly address the factors influencing turnover. The most common factors for nurse turnover include job dissatisfaction and low levels of perceived autonomy (Gebregziabher et al., 2020). Nurses dissatisfied with their autonomy level were approximately 2.5 times more likely to leave their current position than those who reported being satisfied (Gebregziabher et al., 2020). A shared governance model is a strategy found highly effective in providing nurses with more autonomy (Ong et al., 2017).

Shared Governance

A nursing shared governance model allows for a shared decision-making process among the leaders in a healthcare organization and the bedside nurses who provide direct patient care. As operational experts, nurses should be included in discussions that involve their daily practice (Orton, 2021). Empowering frontline nurses to impact facility decisions provides nurses with a sense of responsibility and accountability (Ong et al., 2017). Shared governance is also a cornerstone of the prestigious Magnet Recognition Program awarded by the American Nurses Credentialing Center (Cai et al., 2021). Li & Yamamoto-Mitani (2021) elucidated that shared governance offers nurses more opportunities to become involved in their units. It also creates an attractive workplace for current and potential employees by allowing nurses to directly influence their practice (Li & Yamamoto-Mitani, 2021).

Utilizing a nursing shared governance model has been shown to increase nurses' sense of autonomy. In a study by Oss et al. (2021), the implementation of shared governance resulted in 48% of units having increased satisfaction with autonomy because nurses felt more capable of working to their full scope of practice. The study also found that nurses' satisfaction with involvement in decision-making and feeling that they made a difference in their units increased by 53% and 36%, respectively (Oss et al., 2021). Nurses participating in shared governance are more likely to be satisfied with their careers and maintain an optimistic outlook on impacting change at their facility. Nurses in shared governance also demonstrate that it enhances collaborative skills and report more comfort in addressing sensitive issues with leaders (Cai et al., 2021; Oss et al., 2021).

Patient outcomes are also positively impacted through a shared governance model. Because nurses are more satisfied in their role, they are more willing to go above and beyond in the care they provide. Patients benefit by having shorter hospitalizations, lower rates of readmissions, and fewer hospital-acquired infections or injuries when nurses are engaged in their role (Reich et al., 2018). Patient satisfaction rates are also positively impacted by shared governance. Literature supports the assertion that as nurses gain a sense of empowerment and become more satisfied with the care they can provide, their intention to leave declines, allowing facilities to benefit from lower turnover rates (Ong et al., 2017; Oss et al., 2021). Project facility leadership recognized the critical impact nurse satisfaction has on improving nurse engagement and reducing turnover and desired to see these areas positively impacted by a nursing shared governance model.

Review of Theory

Upon review of the shared governance literature, varying definitions of the model were identified. An underlying theme of all nursing shared governances included the development of unit-level councils to advance nursing practice while simultaneously elevating engagement and autonomy for nurses. The most effective shared governance models were those founded in evidence-based theoretical frameworks, such as the first theory of nursing shared governance entitled the general theory for effective multilevel shared governance (GEMS) (Joseph & Bogue, 2016).

Joseph & Bogue (2016) developed the GEMS theory to aid teams in implementing a nursing shared governance model. They defined nursing shared governance as “self-directed goal attainment that aligns unit-level and nursing leadership to enable the achievement of personal, unit/team, department, and organizational goals

for nursing practice" (p. 341). This theory highlights the connections between a nursing shared governance structure's inputs, processes, and outputs. Inputs refer to the empowerment and autonomous actions of the nursing unit work teams in collaboration with the nursing leadership team. The processes encompass the actual implementation of works by the councils to impact nursing practice positively. Lastly, outputs are the outcomes for which the effectiveness of the nursing shared governance structure is measured across four levels: the individual, unit, department, and organization (Joseph & Bogue, 2016).

Alignment of Theory

The GEMS was the foundational theoretical framework for this project. The author provided education on the GEMS theory to the newly formed shared governance to understand the model's implementation outline. Nursing members and leadership were informed of their perspective roles. The importance of balancing nurse empowerment with support and collaboration by the leadership team was also highlighted as outlined in the GEMS framework. The project manager encouraged the nursing shared governance council to identify one initial process to focus on that aligned with the unit and organizational goals. The nurses recognized response time to patient call lights was a pressing issue in their unit and discussed interventions for improvement. Strategies to monitor the progress of the output were also discussed, which included charge nurses rounding on patients and reviewing monthly patient satisfaction surveys. Joseph and Bogue (2016) postulated that ongoing evaluation of the shared governance structure is essential for maintaining its effectiveness and ensuring that the council remains aligned with the unit and organizational values (p. 349). The project manager guided the council

and leadership team in implementing quarterly self-evaluations by ensuring their goals maintained alignment with the overarching objectives of the hospital and the organization's mission, vision, and values.

Chapter III: Method

The nursing team at a small Midwest rehabilitation hospital faced a high volume of nurse turnover, resulting in decreased nurse engagement and low retention rates. This project aimed to improve these areas by introducing a nursing shared governance model. Ong et al. (2017) found that a shared governance structure provides a sense of empowerment to nurses that can positively influence them to remain in their positions (p. 31).

Design of the Project

The project utilized a quantitative quasi-experimental pre and post-survey design to explore the effects of nursing shared governance on nurse engagement and retention. Approval was granted for this project by the Indiana Wesleyan University (IWU) Institutional Review Board (IRB) per a Notice of Exemption (Appendix A). The project facility accepted IWU's IRB Notice of Exemption and did not require further review per the IRB Authorization Agreement (Appendix B) to initiate the project. The presurvey collected demographic information and baseline data on nurse engagement levels using the Utrecht Work Engagement Scale (UWES) (Appendix C). This valid and reliable survey measures levels of engagement by focusing on the three variables of vigor, dedication, and absorption (Schaufeli et al., 2006). The UWES was free for use for non-commercial scientific research, and written permission was not required. Nurse retention rates were collected from the administration team. At the culmination of the study, the UWES was reissued, and retention rates were collected for analysis.

The project facility's chief nursing officer (CNO) holds monthly forums where she discusses updates on staffing, upcoming training, and current unit performance trends. The meetings are offered on two-three different days and times to accommodate the staff's varying schedules. The CNO invited the project manager to attend the CNO forums in October 2022. Before the meetings, the project manager created a PowerPoint presentation to educate the participants. At each meeting, the project manager spent approximately 20 minutes informing the 18 participants about the relationship between nurse engagement and retention. Participants were also introduced to shared governance and educated on the professional and practice benefits that shared governance could provide to their team. The project manager guided the nurses through the implementation process and detailed the projected timeline of the project based on each step in the GEMS framework, which was used as a visual guide (Joseph & Bogue, 2016). The education (Appendix D) was recorded and emailed to the team so that any absent members could still participate and view the meeting.

Following the education, participants were invited to complete the presurvey by scanning a Quick Response (QR) code with their electronic device, which led them to the questionnaire. After reading and agreeing to the electronic informed consent (Appendix E), participants answered a brief demographic questionnaire (Appendix F). Nurses who met the eligibility criteria (having a current and unencumbered registered nurse license and being a current employee of the facility) then completed the UWES survey (Appendix C). Participants were assured that there would be no impact on employment regardless of their choice to participate. Participants could withdraw from

the study at any time. The CNO provided the unit's nurse retention rates based on the data reported by the human resources team.

The potential risks to participation in the study were minimal. Answering personal questions about engagement could cause discomfort or emotional distress. Participants were asked to consider issues they may have been uncomfortable discussing with strangers. Participants were encouraged to contact the primary investigator or call or text the National Alliance on Mental Illness at 1-800-950-6264 for assistance if they experienced emotional distress. Other than the cost of the participant's time, there were no additional costs to participants in the project.

There were no direct benefits for the subject's participation in the project, except for possible increased empowerment and engagement. Participants may appreciate the opportunity to share their feelings and to have their knowledge and experiences benefit others in the future. The project's results could provide a better understanding of a nursing shared governance model's impact on nurses. As a token of appreciation, nurses participating in the first shared governance meeting could enter their names into a drawing to win a gift card provided by the CNO.

An initial unit council was formed from volunteers interested in a leadership role. Following the GEMS framework, the project manager provided the inaugural committee with a description and expectations of their respective positions as outlined in the GEMS framework. Monthly council meetings were initiated and scheduled for the last Wednesday of each month. The CNO served as a mentor and facilitator as nurses learned their new roles within the unit council. The project manager facilitated

the nurses and the leadership team as a nursing shared governance structure was implemented (Joseph & Bogue, 2016).

During the shared governance meetings, participants collaborated on unit initiatives to help improve bedside practice and patient care utilizing evidence-based practices. As the shared governance structure becomes established and the council members are familiar with their roles, more complex and robust initiatives may be addressed. The project manager initially supported the council in identifying and strategizing for one achievable short-term goal. The unit recognized that response time to patient call lights was an area of concern, and formulated interventions to improve this metric. The project manager guided the leadership team in helping the nurses develop a detailed plan with specific, measurable, achievable, and realistic goals within a set timeframe. A plan for monitoring the team's progress was also created and discussed at each consecutive meeting.

After approximately three months of shared governance meetings, the nursing staff completed the post-survey containing the same demographic questionnaire and UWES survey as they did in the presurvey to determine the new level of nurse engagement. Nurse retention rates were again collected from the administration team. The results were compared with those from the baseline data to determine nursing shared governance's impact on the team's nurse engagement and retention rates.

Setting

The setting was a Joint Commission-accredited 36-bed inpatient rehabilitation hospital in the Midwest. The hospital specializes in physical medicine and rehabilitation for patients 14 years of age and older who have suffered conditions such as brain injury,

spinal cord injury, and amputation. The hospital is a freestanding facility on the campus of a more extensive healthcare system. Due to the facility's size, the hospital is a single unit with an independent administration team separate from the parent healthcare system.

Population

The population was a convenience sample of approximately 30-40 licensed nurses employed at a Midwest inpatient rehabilitation hospital with either an associate's or bachelor's degree in nursing. Criteria to be eligible for participation in the study included a current and unencumbered registered nurse license and a current facility employee. Exclusion criteria included those in the licensed practical nurse role, having an expired or revoked registered nurse license, and employment in a temporary or agency position. The nursing administration team included a CNO, the nurse manager role was vacant during project implementation. Demographic data, such as age, years of experience, and years in the role, were collected within the presurvey (Appendix E).

Data Collection

Due to its high validity and reliability, the UWES survey is used across multiple professions to measure occupational engagement. The UWES has an internal consistency of Cronbach's alpha between 0.8 and 0.9, which meets and exceeds the standard 0.8 traditionally used today in research (Schaufeli et al., 2006). The UWES measures worker engagement by evaluating three areas: vigor, dedication, and absorption (Appendix C). Vigor refers to one's energy and level of drive within the workplace. Dedication describes an employee's commitment and loyalty to their work. Lastly, employees who score high in absorption are passionate and become deeply invested in their work

(Schaufeli et al., 2006). Through 17 Likert-type scale questions, the UWES measures the worker's level of engagement based on the combination of vigor, dedication, and absorption into a final score.

Via Qualtrics, participants completed an electronic seven-question demographic questionnaire (Appendix E) followed by the UWES survey. Participants' responses remained anonymous to ensure privacy and confidentiality. All identifiers were removed, and participants' responses were assigned a number to maintain confidentiality. Nurses who agreed to participate electronically signed an informed consent before participating in the project (Appendix E).

After implementing a nursing shared governance, participants were asked to complete a questionnaire containing the same demographic and UWES survey as the previously administered questionnaire. A correlational analysis was then conducted to determine if the intervention significantly impacted engagement. Nurse retention rates were recorded at the beginning and end of the project. The facility's administrate team provided retention rate data to the project manager.

Chapter IV: Results

The UWES survey was administered to nurses before and after implementation of a shared governance structure. Nurse retention was tracked before and after the intervention. The project intended to determine whether there were significant increases in UWES scores and retention rates after the intervention compared to before the intervention. A significance level of $\alpha = 0.05$ was used throughout to assess statistical significance, and Statistical Analysis System (SAS) version 9.4 was used for all analyses.

Results of Data Collection/Analysis

A score for the UWES was calculated for each respondent by finding the mean of all their responses. A total of 13 responses were collected for the pre-survey and eight responses for the post-survey. Inclusion criteria for the project was that participants should be registered nurses and employees of the facility. Five responses were excluded from the pre-survey and six were excluded from the post-survey for failing to meet the inclusion criteria. The nurses who completed the UWES before the intervention differed from those who completed the UWES post-intervention. This discrepancy occurred because the pre-survey was completed during the in-person CNO forums, and the post-survey was conducted via email. Many nurses who completed the pre-survey resigned before the post-survey was collected.

The initial plan was to analyze data utilizing a paired *t*-test by matching the participants' pre and post-survey responses. This was not possible because the nurses who completed the pre-survey differed from those who completed the post-survey. Therefore, an independent samples *t*-test was completed to determine whether a significant mean difference existed for UWES scores between the two points. The

response variable was the UWES score, and the independent variable was the time point (pre-intervention or post-intervention).

Based on a *p*-value of 0.51, there was insufficient evidence to suggest a significant difference in mean UWES scores before the intervention compared to after the intervention. It would have been more statistically robust (i.e., more likely to correctly detect a significant difference) if it had been the same nurses who filled out the UWES before and after the survey. The statistical power was likely inherently low due to only eight qualifying responses before the intervention and two qualifying responses after the intervention. Descriptive statistics for the two time points are provided in Table 1.

Table 1: *Descriptive Statistics for UWES Scores by Time*

Time	*n*	Mean	Std Dev	Minimum	Maximum
Pre	8	3.85	1.06	2.12	5.12
Post	2	3.29	0.5	2.94	3.65

This project used a baseline retention rate of 98.28%, which was the average monthly retention rate between January 2022 and September 2022 (pre-intervention). Data analysis was completed via a series of binomial tests of proportions, where a separate test was completed each month. Table 2 shows the retention rates for October 2022 - December 2022 (post-intervention) compared to the baseline retention rate of 98.28%.

Table 2: *Retention Results*

Month	Retained	*p*-value	95% CI
October	98.18%	0.96	(90.39%, 99.68%)
November	96.36%	0.27	(87.68%, 99.00%)
December	94.44%	0.0302	(84.89%, 98.09%)

The October results, based on a *p*-value of 0.96, identified insufficient evidence to suggest that the retention rate for October differs from the mean retention rate of January through September. The November retention rates, based on a *p*-value of 0.27, lack evidence to suggest that the retention rate for November differs from the mean retention rate of January through September. As opposed to October and November results, the December numbers, with a *p*-value of 0.0302, show strong evidence to suggest that the retention rate for December differs from the mean retention rate of January through September.

Discussion

The study evaluated whether implementing a nursing shared governance model would impact nurse engagement and retention. Responses to the UWES survey suggested that nurses were less engaged following the intervention than before implementing a shared governance model. However, a significant relationship between nurse engagement and shared governance could not be established due to the small sample sizes in the pre-survey (n=8) and the post-survey (n=2). Similarly, nurse retention declined following the start of nursing shared governance. While there was no significant relationship between retention rates in October (98.18%) or November (93.36%), December's retention rate of 94.44% (*p*-value = 0.0302) did suggest a significant relationship.

The limited period of the study, extenuating circumstances, and seasonal turnover patterns impacted the results. In the months leading up to the project, the facility had significant staffing shortages and requiring the use of travel nurses to temporarily fill positions. In September 2022, the contracts for the travel nurses ended and the unit leadership was not approved to refill those positions. Simultaneously, the incentive pay

offered throughout the COVID-19 pandemic concluded, meaning nurses would only receive their base pay for working extra hours. The now critical staffing levels and lack of incentive pay influenced many nurses to transfer to other units or resign from the organization. Many nurses who resigned during the project cited in their exit interviews that their reason for termination was lower than their desired income, unsafe working conditions, and relocation.

Implications for Practice

With nursing turnover at an all-time high, healthcare organizations must recognize the importance and urgency of creating cultures promoting nurse engagement and retention (Nursing Solutions Inc., 2022). Nurses are more likely to feel engaged in their roles when their voices are heard, valued, and included in the decision-making process. The more nurses are engaged, the more satisfaction they will have in their role and the less likely they are to resign from their position (Wan et al., 2018).

Leadership should provide development opportunities for nurses to gain the leadership skills necessary to influence practice changes (Joseph & Bogue, 2016). Without empowering the nursing workforce, nurses may lose the incentive to improve their practice and may become disengaged (Brennan & Wendt, 2021). While the results of this project did not show a significant relationship between nurse engagement and retention after the implementation of a nursing shared governance structure, other studies with larger sample sizes did demonstrate a positive relationship between the variables (Kutney-Lee et al., 2016; Ong et al., 2017; Reich et al., 2018; Oss et al., 2021). Therefore, it is still strongly recommended that healthcare organizations consider implementing a nursing shared governance structure.

Limitations

Several limitations to the project must be considered when interpreting the results. First, the number of participants was small. Therefore, the sample of nurses present in the project may not reflect the nursing profession as a whole. Due to time constraints, only a limited amount of data was collected. Additionally, there was no control group included in the project. A seasonal effect on retention or extenuating circumstances during the project might have affected the results.

Recommendations

Future projects should seek to replicate the process with larger sample sizes and a control group to strengthen result quality. Allowing the team more time to acclimate to the new governance structure and lengthening the time between the pre-survey and the post-survey would also minimize the effects of seasonal trends. Additionally, participation in this project may have been improved by first understanding the team's readiness for change.

To effectively manage the transition to a shared governance structure, nurse leaders must understand how their nursing team responds and adapts to change. Many assessment tools that measure readiness for change exist and have been successfully utilized in healthcare, such as the Acceptance of Change Scale or the Resistance to Change Scale (Beasley et al., 2021). Understanding where each individual is on the change continuum provides leaders with the necessary insight to support and encourage them through the transition to a nursing shared governance structure.

Once teams have successfully adopted nursing shared governance into their professional practice model, it is essential to monitor the progress and outcomes of the

council to ensure continuous growth and appropriate use. The success of nursing shared governance should be measured by the quality and quantity of the activities produced by the council (Joseph & Bogue, 2016). Healthcare organizations should also seek to expand shared governance across all disciplines to achieve optimal patient outcomes and interprofessional collaboration (Joseph & Bogue, 2016).

Conclusion

The escalating rates of nurse turnover and staffing shortages have been identified as a national and global crisis following the COVID-19 pandemic. As the largest body of professionals within the healthcare field, nurses have a significant role in impacting and advocating for the population's health and well-being. Although this project did not identify a significant correlation between nursing shared governance and nurse engagement or retention, healthcare organizations should continue to foster environments of nurse autonomy and include nurses in the decision-making process to experience a higher quality of nursing care and better patient outcomes. Through constructs such as nursing shared governance models, nurses can utilize their expertise to transform and positively influence practices and policies related to patient care.

References

American Hospital Association. (2022). *Data brief: Workforce issues remain at the forefront of pandemic-related challenges for hospitals.* https://www.aha.org/issue-brief/2022-01-25-data-brief-workforce-issues-remain-forefront-pandemic-related-challenges

Beasley, L., Grace, S., & Horstmanshof, L. (2021). Assessing individual readiness for change in healthcare: A review of measurement scales. *Journal of Health Organization and Management, 35*(8), 1062-1079. https://doi.org/10.1108/JHOM-10-2020-0414

Brennan, D., & Wendt, L. (2021). Increasing quality and patient outcomes with staff engagement and shared governance. *The Online Journal of Issues in Nursing, 26*(2), 1-9. https://doi.org/10.3912/OJIN.Vol26No02PPT23

Cai, E. D., Hall, A. D., & Siedlecki, S. L. (2021). A descriptive study of factors that facilitate nurses' participation in shared governance and attendance at unit meetings. *Journal of Nursing Management, 29*(7), 2243-2249. https://doi.org/10.1111/jonm.13385

Carthon, J. M. B., Davis, L., Dierkes, A., Hatfield, L., Hedgeland, T., Holland, S., Plover, C., Sanders, A. M., Visco, F., Ballinghoff, J., Del Guidice, M., & Aiken, L. H. (2019). Association of nurse engagement and nurse staffing on patient safety. *Journal of Nursing Care Quality, 34*(1), 40–46. https://doi.org/10.1097/NCQ.0000000000000334

Church, C. D., He, Z., & Yarbrough, S. (2018). Factors influencing organizational commitment and turnover in nurse residents. *Journal of Continuing Education in Nursing, 49*(10), 482–488. https://doi.org/10.3928/00220124-20180918-09

Dall'Ora, C., Ball, J., Reinius, M., & Griffiths, P. (2020). Burnout in nursing: A theoretical review. *Human Resources for Health, 18*(1). https://doi.org/10.1186/s12960-020-00469-9

Dempsey, C., & Reilly, B. A. (2016). Nurse engagement: What are the contributing factors for success? *Online Journal of Issues in Nursing, 21*(1). https://doi.org/10.3912/OJIN.Vol21No01Man02

Gebregziabher, D., Berhanie, E., Berihu, H., Belstie, A., & Teklay, G. (2020). The relationship between job satisfaction and turnover intention among nurses in Axum comprehensive and specialized hospital Tigray, Ethiopia. *BioMed Central Nursing*, *19*(1). https://doi.org/10.1186/s12912-020-00468-0

Ghazawy, E. R., Mahfouz, E. M., Mohammed, E. S., & Refaei, S. A. (2021). Nurses' work engagement and its impact on the job outcomes. *International Journal of Healthcare Management, 14*(2), 320–327. https://doi.org/10.1080/20479700.2019.1644725

Hisel, M. E. (2020). Measuring work engagement in a multigenerational nursing workforce. *Journal of Nursing Management*, *28*(2), 294–305. https://doi.org/10.1111/jonm.12921

Joseph, M. L., & Bogue, R. J. (2016). A theory-based approach to nursing shared governance. *Nursing Outlook, 64*(4), 339–351. https://doi.org/10.1016/j.outlook.2016.01.004

Kim, Y., & Han, K. (2018). Longitudinal associations of nursing staff turnover with patient outcomes in long-term care hospitals in Korea. *Journal of Nursing Management, 26*(5), 518-524. https://doi.org/10.1111/jonm.12576

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. *Journal of Nursing Administration, 46*(11), 605–612. https://doi.org/10.1097/NNA.0000000000000412

Li, C. C., & Yamamoto-Mitani, N. (2021). Ward-level nurse turnover and related workplace factors in long-term care hospitals: A cross-sectional survey. *Journal of Nursing Management, 29*(6), 1587-1595. https://doi.org/10.1111/jonm.13293

Nursing Solutions Inc. (2022). *2022 NSI national health care retention and RN staffing report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

Ong, A., Short, N., Radovich, P., & Kroetz, J. (2017). Ripple effect: Shared governance and nurse engagement. *Nursing Management, 48*(10), 28-34. https://doi.org/10.1097/01.NUMA.0000524811.11040.05

Orton, A. (2021). Supporting nursing autonomy through shared governance. *Nursing Management, 52*(12), 44–46. https://doi.org/10.1097/01.NUMA.0000800404.94545.fb

Oss, J. A., Schad, E. A., Drenth, A. R., Johnson, L. M., Olson, J. M., & Bursiek, A. A. (2021). Driving nurse satisfaction through shared governance. *Nurse Leader, 19*(1), 47-52. https://doi.org/10.1016/j.mnl.2020.03.019

Reich, J., Ruggiero, J., & Triantos, L. (2018). Engaging nursing ancillary staff through shared governance. *Nurse Leader, 16*(4), 224-228. https://doi.org/10.1016/j.mnl.2017.11.004

Schaufeli, W. B., & Bakker, A. B. (2004). Utrecht work engagement scale: Preliminary Manual. *Utrecht University.* https://www.wilmarschaufeli.nl/publications/Schaufeli/Test%20Manuals/Test_manual_UWES_English.pdf

Schaufeli, W. B., Bakker, A. B., & Salanova, M. (2006). The measurement of work engagement with a short questionnaire: A cross-national study. *Educational and Psychological Measurement, 66*(4), 701-716. https://doi.org/10.1177/0013164405282471

Shah, M. K., Gandrakota, N., Cimiotti, J. P., Ghose, N., Moore, M., & Ali, M. K. (2021). Prevalence of and factors associated with nurse burnout in the US. *Journal of American Medicine Association, 4*(2). https://doi.org/10.1001/jamanetworkopen.2020.36469

Wan, Q., Li, Z., Zhou, W., & Shang, S. (2018). Effects of work environment and job characteristics on the turnover intention of experienced nurses: The mediating role of nurse engagement. *Journal of Advanced Nursing, 74*(6), 1332–1341. https://doi.org/10.1111/jan.13528

Zaheer, S., Ginsburg, L., Wong, H. J., Thomson, K., Bain, L., & Wulffhart, Z. (2021). Acute care nurses' perceptions of leadership, teamwork, turnover intention and patient safety: A mixed methods study. *BioMed Central Nursing 20*(134), 1–14. https://doi.org/10.1186/s12912-021-00652-w

Appendices

Appendix A

Notice of Exemption

Institutional Review Board
4201 South Washington Street
Marion, IN 46953

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

Notice of Exemption

The Effect of Shared Governance on Nurse Engagement and Retention
Title of Research Topic

Lanae McAllister, Beth Bailey
Investigator(s)

1781.22
IRB ID Number

The IWU Institutional Review Board has reviewed your proposal and has determined that your proposal is exempt from further review by the IRB under Exemption Rule 2iii:

> (2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
> (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §ll.111(a)(7).

The limited review associated with this exemption accompanies this exemption letter. This exemption is valid for one year from the date of this notice. If there are any changes in the project during the year or if the project extends beyond the one-year period, the IRB must be notified.

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

October 17, 2022
Date

Appendix B

IRB Authorization Agreement

Institutional Review Board (IRB) Authorization Agreement (the "Agreement")

Name of Institution or Organization Providing IRB Review ("Institution A"): Indiana Wesleyan University
Institution A's FWA #, if applicable: **FWA00019738**
Registration # of Institution A's IRB ("the Designated IRB"): **IRB00005244** *Note: This registration is required if the Designated IRB will be reviewing FDA-regulated research or federally-supported research.*
Name of CHS[1] Affiliate Relying on the Designated IRB ("Institution B"): Rehab Hospital of Fort Wayne, General Partnership, dba Rehabilitation Hospital of Fort Wayne
Institution B's FWA #, if applicable: Click here to enter text.

1. Scope of Review: The Officials signing below agree that Institution B may rely on the Designated IRB for IRB determinations of exemption and waivers, and for review and continuing oversight of the following categories of human subjects research (called "Covered Research") *(check only one)*:

☐ This agreement applies to any research study conducted by or at Institution B, for which Institution B requests review by the Designated IRB, and to which Institution A agrees to provide such review in writing.

☒ This agreement is limited to the following specific protocol(s):

Name of Research Project: The Effect of Shared Governance on Nurse Engagement and Retention
Name of Principal Investigator: Lanae' McAllister MSN, RN, CMSRN, CNE
Sponsor or Funding Agency: N/A
Award Number, if any: Click here to enter text.

☐ This agreement applies to the following category or categories of research (describe):
Click here to enter text.

2. Institution A agrees as follows:

- The review performed by the Designated IRB will satisfy the requirements of the federal regulations for the protection of human subjects at 45 CFR Part 46 and 21 CFR Parts 50 and 56, as well as all other applicable federal and state law.
- The Designated IRB will take minutes of its meetings in which Covered Research is reviewed, copies of which will be provided to Institution B upon request by Institution B.
- The Designated IRB will document all findings and actions regarding Covered Research taken outside of convened meetings, and will provide copies of such documentation upon request by Institution B.
- The Designated IRB will provide notice of the IRB's suspension or termination of Covered Research, and of any serious adverse event that occurs at Institution B during Covered Research that is reported to the Designated IRB, to Institution B's contact listed in Section 4(e) below, within two (2) business days of when the Designated IRB learns of the event.
- The Designated IRB will ensure that its review accounts for local institutional, population, legal and cultural influences that may be relevant to subjects participating in Covered Research at Institution B.

[1] CHS and Community Health Systems are registered trade names of CHSPSC, LLC, which provides management services on behalf of affiliated entities.

Institutional Review Board (IRB) Authorization Agreement (the "Agreement")

- The Designated IRB will implement procedures to ensure that no IRB member participating in review of Covered Research has a conflict of interest, as defined in the Designated IRB policies.
- The Designated IRB will comply with the requirements for retention and accessibility of records under 45 CFR 46.115.
- The Designated IRB will provide to Institution B copies of the Designated IRB's policies and procedures upon request by Institution B.
- The Designated IRB will permit Institution B to audit the IRB's operations, during regular business hours and upon reasonable advance request by Institution B.
- To report to Institution B any request for audit, investigation or external review of Covered Research, including by a government regulatory agency.

3. Institution B agrees as follows:

- Institution B will maintain responsibility for the conduct of the Covered Research and for ensuring compliance with the determinations of the Designated IRB, as applicable to the conduct of Covered Research at Institution B.
- Institution B will require reporting to the Designated IRB of proposed changes in Covered Research activity, and that such changes in Covered Research may not be initiated without IRB review and approval except when necessary to eliminate apparent immediate hazards to research subjects.
- Institution B will require prompt reporting to the Designated IRB of any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with the requirements or determinations of the IRB.
- To report to Institution A any request for audit, investigation or external review of Covered Research, including by a government regulatory agency.

4. Miscellaneous Provisions:

a. Relationship of the Parties: The parties are independent contractors and not partners, agents, employees, or representatives of the other.

b. Termination: The parties may terminate this Agreement under the following circumstances:

- Upon material breach by a party, the other party may terminate this Agreement if the breaching party fails to cure the breach within 15 days after notice of the breach is provided by the non-breaching party.
- Either party may terminate without cause, upon 30 days' prior notice.

c. Governing Law: The laws of the state where Institution B is located will govern this Agreement. The courts of this same state have jurisdiction, without regard to its conflict-of-law provisions.

d. Alternative Dispute Resolution: The parties desire to resolve all disputes arising hereunder without resort to litigation. Accordingly, the parties will attempt in good faith to resolve any controversy or claim arising out of or relating to this Agreement through voluntary mediation with a mutually acceptable mediator.

e. Notice: Any notice, authorization, approval, consent or other communication will be in writing and deemed given to the contact noted below: (a) upon delivery in person; (b) upon delivery by courier; (c) upon promised delivery date by a nationally-recognized overnight delivery service such as FedEx; or (d) three days after USPS registered or certified mailing with postage prepaid and return receipt requested.

Institutional Review Board (IRB) Authorization Agreement (the "Agreement")

Contact information for notice to Institution A under Agreement:
Name & Title: Don Sprowl, Director of Research Integrity
Address: 4201 South Washington Street Marion, IN 46953
Email address: don.sprowl@indwes.edu
Phone: 765-677-1002

Contact information for notice to Institution B under Agreement:
Name & Title: Robbin Seago, Senior Director, Clinical Research Operations
Address: 4000 Meridian Blvd Franklin, TN 37067
Email address: Robbin_Seago@chs.net
Phone: 615-465-7262

With a copy to:
CHS Clinical Research Operations
CHS Clinical Operations
4000 Meridian Blvd
Franklin, TN 37067

With a copy to:
CHS Legal Department
Legal Department
4000 Meridian Blvd.
Franklin, TN 37067
Attention: General Counsel

f. Payment: N/A

g. Compliance *[Note: Insert this section only if the CHS affiliate will pay Institution A for IRB review.]* The parties to this Agreement certify they shall not violate the Anti-Kickback Statute and/or the Stark Law with respect to the performance of the Agreement. Each party to this Agreement is subject to and required to abide by its Code of Conduct and other compliance policies including Stark and Anti-Kickback Statute policies. A copy of relevant policies may be made available to the other upon request. Except as set forth above, all other terms and conditions of the Agreement shall remain in full force and effect.

Institutional Review Board (IRB) Authorization Agreement (the "Agreement")

Signatures:
The parties, each by a duly authorized representative, have executed this Agreement, which is effective as of the date of the last signature.

Institution A:

Signature: 

Print Full Name: Don Sprowl

Institutional Title: Director of Research Integrity

Date: 10/24/2022

Institution B:

Signature: Miguel S Benet
Miguel S Benet (Oct 25, 2022 11:50 CDT)

Print Full Name: Miguel Benet

Institutional Title: Senior VP of Operations

Date: Click here to enter a date.
Oct 25, 2022

Appendix C

Utrecht Work Engagement Scale (UWES)

Work & Well-being Survey (UWES) ©

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, cross the "0" (zero) in the space after the statement. If you have had this feeling, indicate how often you feel it by crossing the number (from 1 to 6) that best describes how frequently you feel that way.

	Almost never	Rarely	Sometimes	Often	Very often	Always
0	1	2	3	4	5	6
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

1. _____ At my work, I feel bursting with energy
2. _____ I find the work that I do full of meaning and purpose
3. _____ Time flies when I'm working
4. _____ At my job, I feel strong and vigorous
5. _____ I am enthusiastic about my job
6. _____ When I am working, I forget everything else around me
7. _____ My job inspires me
8. _____ When I get up in the morning, I feel like going to work
9. _____ I feel happy when I am working intensely
10. _____ I am proud of the work that I do
11. _____ I am immersed in my work
12. _____ I can continue working for very long periods at a time
13. _____ To me, my job is challenging
14. _____ I get carried away when I'm working
15. _____ At my job, I am very resilient, mentally
16. _____ It is difficult to detach myself from my job
17. _____ At my work I always persevere, even when things do not go well

Appendix D

Educational Outline

I. Greetings & Introductions

II. Definition of Shared Governance Model

III. Benefits of Shared Governance to Nursing Practice

    a. Provide Overview of Shared Governance Implementation Plan

    b. Introduce the General Theory for Effective Multilevel Shared Governance (GEMS)

IV. Address Potential Barriers to Implementation and Provide Solutions

V. Allow Time for Questions

VI. Provide QR Code to Collect Survey Responses

    a. Explain Response via Email is Available if the QR Code is Inaccessible

VII. Closing Remarks and Vote of Thanks

Appendix E

Electronic Consent for Participation

Hello, we are conducting research about the effect of shared governance on nurse engagement and retention. If you want to participate, please read the following consent document.

I certify that I am over the age of 18 and am participating in this survey of my own free will. I recognize that some or all of the questions contained in this survey may be of a sensitive nature and may cause discomfort. I understand all survey answers will be held in strict confidence and may be used by the researchers for future publications.

I understand that the purpose of the research is to explore my perception of engagement before and after being involved in a nursing shared governance structure.

I authorize Lanae' McAllister of the Indiana Wesleyan University Division of Doctoral Nursing program to gather information regarding my responses to questions asked on this survey. This survey will ask about perceptions of engagement and will take approximately 5-10 minutes to complete. If I agree to take part in this study, I understand that I will be asked to complete the survey questions listed on the following pages. I understand that my responses will be utilized for research and may become part of a published journal article or scholarly presentation.

I recognize that I will not receive monetary compensation for participating in this survey. Conversely, there are no monetary costs to me for participating.

I certify that my participation in this survey is wholly voluntary and recognize that I may withdraw at any time. I understand that I am free to skip any question I do not feel comfortable answering. There is no obligation for my participation and I may withdraw at any time.

I understand that Lanae' McAllister will be available for consultation should I have any additional questions regarding the research being conducted.

I understand that the answers given to this survey will be maintained by the researcher for a period of no less than three years after the close of the study. The researcher will store all survey responses on a password-protected and encrypted laptop.

I release any claim to the collected data, research results, publication of or commercial use of such information or products resulting from the collected information.

If I have any questions or comments about this research project, I can contact:

- Primary Investigator: Lanae' McAllister
  lanae.mcallister@myemail.indwes.edu

- Research Advisor: Dr. Beth Bailey
  beth.bailey@indwes.edu

If I have concerns about the treatment of research participants, I can contact the Institutional Review Board (IRB) at Indiana Wesleyan University, 4201 South Washington Street, Marion, IN 46953. (765) 677-2090.

The survey is designed not to collect email addresses or Internet protocol (IP) addresses. To further maintain confidentiality of the survey, please do not include your name or any other information by which you can be identified in any comment boxes that may be included in the survey.

BY CLICKING ON "CONTINUE," I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO CONSENT TO MY PARTICIPATION IN THIS SURVEY.

Appendix F

Demographic Questionnaire

1. Age
    a. Under 25 years old
    b. 25-34 years old
    c. 35-44 years old
    d. 45-54 years old
    e. 55-64 years old
    f. 65 and older
    g. I prefer not to say

2. Gender
    a. Male
    b. Female
    c. Non-binary/third gender
    d. I prefer not to say

3. Ethnicity (Select all that apply)
    a. African American
    b. Asian
    c. Hispanic/Latino
    d. Native American/Alaskan Native
    e. Native Hawaiian
    f. Pacific Islander
    g. White
    h. Other (please specify) _____
    i. I prefer not to say

4. Discipline
    a. Registered Nurse
    b. Licensed Practical Nurse
    c. Patient Care Assistant
    d. Other (please specify) _____

5. Education Level
    a. Certification (LPN/LVN)
    b. Associate degree
    c. Bachelor's degree
    d. Master's degree
    e. Doctorate degree
    f. Other (please specify) _____

6. Years of experience as a nurse
    a. Less than 1 year

   b. 1-3 years
   c. 4-5 years
   d. 6-10 years
   e. 11-15 years
   f. 16-20 years
   g. 20+ years
   h. I am not a nurse

7. Current Employment Status
   a. Full-time (36+ hours per week)
   b. Part-time (less than 36 hours per week)
   c. PRN
   d. Travel/Agency