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Shared governance and nurse engagement

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Staff turnover has far-reaching implications: Exiting RNs cause productivity losses and organizational inefficiencies due to instability within the nursing staff, leading to additional costs.[1] Productivity diminishes when more experienced RNs precept new hires and take time to thoroughly orient them to the required competency level.[2] Other costly ramifications include overtime, temporary agency costs, and recruitment expenses.[1]

Even more alarming, care quality decreases with inadequate RN staffing and high turnover.[3] Increased medication errors, patient falls, and other adverse events are linked to RN turnover.[4,5] And, as turnover increases, the percentage of patients satisfied with their care decreases.[6] With value-based purchasing, the decrease in these quality metrics consequently results in a reduction of reimbursement and the ability of a health system to sustain services for many patient populations.[7]

In this article, we discuss an evidence-based quality improvement project to evaluate the outcome of a newly implemented shared governance environment

on RN engagement and turnover. Our setting is the medical intensive care unit (MICU) at an academic health center in southern California. As a frame of reference, RN turnover here in 2016 was approximately 17%, and the turnover rate on the MICU in 2013 was 21%. (The national average for clinical nurse turnover is 17%.[8]) When you consider the national average replacement cost of $64,000 per RN, our facility's RN turnover translated to a $17.7 million expense.[9]

Work engagement is defined as a positive, fulfilling, work-related state of mind characterized by the attributes of high vigor, strong dedication to work, and positive absorption or interest in work.[17] RN engagement is a predictor of job satisfaction and turnover intention.[18-20] Improving RN engagement positively impacts financial metrics and nurse-sensitive quality metrics, such as patient falls, pressure injury prevention, catheter-associated urinary tract infections, and central line-associated bloodstream infection.[21] To stay engaged, RNs seek an environment with little stress, feelings of empowerment, developmental opportunities, and the ability to achieve a good work-life balance.[22,23]

To measure RN engagement, we focused on vigor, dedication, and absorption. *Vigor* refers to high levels of energy and resilience, the willingness to invest effort, not being easily fatigued, and persistence in the face of difficulties. *Dedication* refers to deriving a sense of significance from one's work, feeling enthusiastic and proud of one's job, and feeling inspired and challenged by it. *Absorption* is characterized by being fully concentrated and happily engrossed in one's work whereby time passes quickly as one has difficulties with detaching oneself from work.[17] The project aim was to have statistically significant improvement in vigor, dedication, and absorption score means for acute care RNs 3 months after the implementation of shared governance.

Shared governance is based on the premise that staff members should have access to information, resources, and growth opportunities by being involved in the decisions that affect their practice.[24-26] Historically, management at our facility has been hierarchical and implemented change that impacts RN practice without bedside staff involvement. Shared governance engenders a sense of empowerment along with responsibility and accountability for RNs, and allows active participation in the decision-making process, particularly in administrative areas from which they were previously excluded.[12] Involvement in decision-making allows staff to develop and implement the best processes for workflow and improved outcomes. The role of managers

The role of managers in a shared governance environment is to serve as subject matter experts for regulatory requirements.

On what terms?

The shared governance model of nursing practice encourages RNs and administrative leaders to collaborate to determine internal policies controlling nursing clinical practice and quality of care delivery.[10] The concepts of shared governance models were introduced to improve RNs' work environment, satisfaction with work, and retention.[11,12] *Turnover* is identified as a costly by-product of lack of staff engagement and/or job satisfaction; causative factors associated with turnover are role ambiguity, role conflict, poor RN to supervisor communication, work stressors, issues with management, and burnout.[13-16]

in a shared governance environment is to serve as subject matter experts for regulatory requirements and ensure that RN teams' projects and activities stay within legal and regulatory bounds. With the implementation of shared governance, RNs can positively influence their work environment through active involvement in the decisions that affect their practice. This empowerment can influence RNs' intent to remain employed.[19,24]

Methods

Our evidence-based improvement project had a pre/postsurvey intervention design. Data from the pretest served as a baseline for RN engagement and RN perceptions of the work environment. Variables measured were vigor, dedication, absorption, perception of management support, and barriers to success.

The setting was the 25-bed MICU in a nonunionized, academic health center in southern California. The average daily census is 22, with an average length of stay of 7 days. The hospital is a level 1 trauma center that supports four counties. At the time of implementation, 5 of 21 inpatient units had adopted a shared governance model.

The sample population was 50 RNs employed to provide care for patients on the MICU. The turnover rate for this unit was 21.3% (N = 22) in 2013. Over the last 3 years, the unit had three different directors and four different managers. During the study period, there was a change in first-line managers of the department. The MICU's director (second-line leader) has been with the team since January 2016.

Our shared governance implementation process rolled out in this manner: The initial council formed with RN staff members who showed interest and voluntarily completed an application. This council consisted of RNs from each unit who represented their peers and participated in the decision-making process. Then, education material was distributed to all new council members and followed up with the first council meeting. Simultaneously, noncouncil staff members received education material on shared governance, how it impacts them, and how they can interact with the council. Education content was created by the original design team and validated by an outside consultant working with different hospitals in southern California that achieved Magnet® recognition multiple times. The education material, which takes approximately 30 minutes to complete, was distributed via the organization's online learning management system.

Following a review of applications, 10 clinical nurses from the MICU became part of the unit's first shared governance council. Invitees ranged from 2 to 23 years of experience and represented both day and night shift. The only qualifier to be part of the council was that no written disciplinary action was present for the last 12 months.

The impact of shared governance on the unit was measured using a Work and Well-being Survey, as well as pre- and postimplementation focus groups. To identify whether the observed outcomes were due to shared governance, the focus group was asked the same questions at pre- and postimplementation. The survey in English, which measures work engagement on the Utrecht Work Engagement Scale (UWES), was completed by MICU staff pre- and postimplementation of shared governance on the unit. The UWES survey was analyzed using descriptive statistics and a paired *t* test. The focus groups were conducted using a semistructured question, audiotaped, transcribed verbatim, and analyzed by using a free textual analysis. Focus groups were conducted pre- and postimplementation. The focus group questions were:

1. What are your thoughts on a unit-based shared governance council?
2. How do you feel about management support for shared governance? What evidence have you seen?
3. What do you think are the top three things you need for shared governance to be successful?

The review identified themes from the participant responses. A researcher independent of the focus group process reviewed the transcripts. The project lead and the researcher agreed on final themes.

Results

MICU RNs received the UWES preimplementation survey via e-mail in July 2016 and the postintervention survey via e-mail 4 months later in November. Nineteen of the 110 MICU RNs completed the survey before and

after implementation of shared governance. The average vigor, dedication, and absorption scores all increased, but didn't show statistical significance. (See *Table 1*.)

The preinitiation focus group revealed common themes surrounding a passion for improving unit quality, making policies and procedures more relevant to frontline staff, dissatisfaction with past communication, and having an avenue where staff could have a voice and feel heard. There were hopeful comments about shared governance, such as "...if we could be a voice, that would be helpful to our patients' care and our sanity" (Participant 4).

The focus groups also revealed RN frustration. There were comments that managers were out of touch with the realities of frontline staff, and although managers asked for input, they didn't use it in decision making. The amount of time required to make institutional change also frustrated focus group members, as did physician interactions, although no participants requested management support to help foster a more collaborative relationship between nurses and physicians.

Some members of the focus group pointed out the positive recent change in management. They felt supported by no longer having a punitive work environment. One focus group participant (Participant 1) mentioned, "...they [management] were anticipating that we would be helping the unit...and I think that management is really supporting us." Others, on the other hand, mentioned that when they bring concerns to managers, the response they receive is, "I can't do anything about that" rather than moving it up the chain of command (Participant 3). The focus group responses enabled the management team to identify improvement areas. Extra efforts to enhance communication clarity and guidance on how to best address council needs were initiated.

The first MICU shared governance council met in August 2016. Members intently listened to a verbal presentation about shared governance, which reiterated the information they learned in the education material sent via the online learning system. Council members were forthcoming in their skepticism, as they believed that as frontline staff, they wouldn't be able to make a difference on their unit. Even after repeated reassurance, many council members voiced that they didn't think the ideas would work, but that they'd try them. The council's goals during this first meeting were to educate staff regarding the newly revised float policy, find a better urinary catheter securement device, and find a better disposable wipe product.

Council meetings were scheduled 1 month apart. Between meetings, members connected with their peers to solicit feedback. During council meetings, members would then discuss all the feedback they had received during the month and identify the best solution.

The following month, the second council meeting took place and included vendors and leaders from other areas to help accomplish unit improvement goals. By the end of the meeting, council members were still doubtful about having any power to make change, but had a better understanding of the shared governance vision.

During the third council meeting, spirits were high. They had successfully completed three projects identified as goals during their first meeting. The council seemed to have a good momentum and kept asking what else could be improved. They identified what was within their scope of influence and when to ask for support from leadership.

The postinitiation focus group held after the third meeting showed evidence of council member engagement. Feedback themes included the ability to make a difference in challenges they faced every day, management support, collaboration with other departments toward a common goal, and collaboration with managers to initiate change.

Measurements of vigor, dedication, and absorption all increased, although there was no statistical significance. A

Table 1: Pre- and postintervention means

Attributes	Preintervention mean	Postintervention mean
Vigor	4.87	5.45
Dedication	5.40	5.80
Absorption	4.48	4.80

qualitative change identified in the focus group was evident. Participants indicated an improved level of engagement 3 months after the implementation of shared governance on the MICU.

Interpretation

Through the transcriptions of the focus groups, we discovered an association between shared governance and the level of engagement. The difference of engagement throughout the entire department is unclear. The focus group responses revealed increased engagement postintervention as compared with preintervention. However, the survey didn't indicate a statistically significant improvement, possibly due to the small sample. Additionally, the lack of responses from the unit could be an indicator of engagement levels. The turnover of both the MICUs first- and second-line leadership, along with a short period in which the project occurred, may have contributed to the lack of statistical significance in improvement on the survey.

The outcomes of this project may be helpful for other managers to understand the potential impact of shared governance on their units. Additionally, it can provide evidence for the MICU that involving frontline staff is valuable and can produce better outcomes for staff engagement and patient quality indicators.

Limitations and recommendations

This project was conducted on one specialized unit in an academic health center for a short time. The sample was small. There were numerous efforts made to elicit a higher response rate. The low rate of participation in the survey may reflect a culture of staff seldom checking their institutional e-mail accounts.

Recommendations for similar projects include employ the 9-question Work and Well-being Survey as opposed to the 17-question version used for this study, use paper surveys for staff to complete as opposed to an online survey tool sent by e-mail, and conduct the survey at a time when there are no other institutional surveys being fielded. Exploration of other types of units and other types of hospitals is necessary for the generalizability of the work.

Branching out

The implementation of shared governance on the MICU has enhanced nurse engagement. This project offers an opportunity to assess the effect of resources allocated toward improving nurse engagement. Sustainability of shared governance hinges on managers' commitment to valuing frontline staff expertise. Leadership styles of managers can either promote the success of shared governance and nurse engagement or become a barrier to both. In addition, there's potential to expand shared governance to disciplines outside of nursing and beyond healthcare. Next steps include continuing to monitor nurse engagement through surveys and focus groups on the MICU, as we refine internal shared governance processes and team cohesiveness. NM

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