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Shared Governance and Transition into Practice:

Impact on Work Engagement

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This Manuscript Partially Fulfills the Requirements for the


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Abstract

Practice Problem: High turnover rates, particularly in new graduate nurses, and poor organizational commitment and engagement negatively affect staffing, operational performance, and patient outcomes. A negative trend for nurse engagement indicators was noted in previous staff engagement surveys of this organization.

PICOT: The PICOT question that guided this project was: In transition-into-practice (TIP) nurses (P), how does the implementation of shared governance (I) compared with no shared governance participation (C), affect their engagement with the hospital (O) within eight weeks (T)?

Evidence: Literature has shown that nurse engagement is one of the nurse indicators positively affected by shared governance activities. The evidence supports the intervention and supplies a validated tool to assess the intended outcome.

Intervention: Guided by the Johns Hopkins Evidence-based Practice Model for Nursing and the ADKAR change model, this evidence-based practice project created a shared governance council as a resource for the TIP nurse population and a platform for multidisciplinary collaboration on TIP-specific issues. Engagement in TIP nurses was measured with the Utrecht Work Engagement Scale-9 (UWES-9) at pre-and post-implementation time points.

Outcome: The TIP Nurse Council was successfully implemented, with the council size increasing to eight members during the implementation period. Except for the lack of statistical significance in engagement scores and insufficient completion of pre- and post-implementation surveys by all TIP council members, all desired measures were met.

Conclusion: Shared governance can be a valuable adjunct to strategies used to support early career nurses in transitioning to practice and being engaged with the organization.

Shared Governance and Transition into Practice:

Impact on Engagement

One of the most crucial problems the healthcare industry faces nowadays is workforce issues, like lack of engagement, often exacerbated by factors associated with the COVID-19 pandemic (Woodward & Willgerodt, 2022). Turnover rates accelerating the nursing shortage have reached levels that imperil patient safety and quality of care and threaten healthcare organizations' financial survivability (Bae, 2022). The shock of transitioning to an unfamiliar work environment contributes to the high number of new graduate nurses leaving their job (Ho et al., 2021).

Leaders in healthcare and university settings recognize that turnover and organizational commitment are affected by many complex issues within the work environment and have examined strategies to overcome preventable barriers (McClain et al., 2022; Taylor-Clark et al., 2022). Shared governance (SG) in healthcare is a structural framework that positively influences the professional practice environment and those preventable factors causing negative work experience (Porter O'Grady et al., 2022). Nurse engagement is one of the nurse indicators positively affected by SG efforts (Olender et al., 2020; Weaver et al., 2018; Sohal, 2020). This project proposes implementing an SG council focusing on transition-into-practice (TIP) nurses to improve nurse engagement and thus reduce nurse turnover (Quek et al., 2021).

Significance of the Practice Problem

Increasing nursing turnover rates and poor engagement with the organization negatively affect staffing, operational performance, and patient outcomes (Bae, 2022). Several latent issues place a higher burden on the nursing staff and exacerbate the existing workforce crisis. These include the population's aging, increased chronic conditions of patients, impending retirements of baby-boomer generation nurses, exposure to workplace violence, nursing burnout, work-life balance demands, and new technological requirements (Haddad et al., 2020).

Annual turnover rates of nurses in the United States range from 19.1% (Taylor-Clark et al., 2022) to 27.65% (Nelson-Brantley et al., 2018). Globally, turnover rates vary along those numbers, with 15.1% in Australia or 23% in Israel (Bae, 2022). Also noteworthy is the intention to leave, which is predictive of actual turnover behavior (An et al., 2022). 23% of nurses indicated they intend to leave, and 29% are actively planning this soon (American Nurses Foundation, 2022). Due to transition shock, nurses in the first two years of practice are more likely than experienced nurses to leave their current job (Taylor-Clark et al., 2022). They often feel overwhelmed, unsupported, and without job embeddedness, community connections, or effective resilience strategies (Ho et al., 2021). Turnover rates in new nurses have increased threefold from 2006 to 2018, to 45.5% (An et al., 2022). Nurses born between 1980 and 2000 add 62% to the current US nursing workforce, though 30% express intent to leave within one year and 57% within two years (McClain et al., 2022). They intend to stay for an average job term of 2.8 years with frequent changes in roles and employers (McClain et al., 2022).

Low nurse retention is associated with work environment factors such as job satisfaction, engagement, and commitment (McClain et al., 2022). In this acute care community hospital, the annual employee engagement results for 2021 reported a negative trend for important nurse engagement indicators, like consistency with mission and values, the linkage of work to organizational goals, and the feeling of belonging to the workplace. The two most significant drops in the Press Ganey survey were an eight percent decline in intent to stay and a six percent decrease in sustainable engagement. The response to feeling a sense of belonging to the organization declined by 24% during the same period. Of the survey respondents, 41% felt disengaged, 18% detached, and 20% unsupported.

Evidence-based retention strategies for newer nurses include residency and mentorship programs (McClain et al., 2022). Due to a competitive position with other hospitals in town, recent graduates of this facility frequently change to other employers soon after completing their

residency programs. Consequently, the difficulty of retaining nurses impacts continuity in providing care under high-census situations, causing temporary department closures.

Additional costs of recruitment and training of temporary and permanent nurse replacements and loss of intellectual capital and productivity are economic outcomes of turnover, affecting healthcare organizations' financial sustainability (Bae, 2022). Nurse turnover costs can range from \$21,514 to \$88,000 (Bae, 2022). The inability to hold on to nurses and provide safe, quality care can further negatively affect a facility's reputation and disrupt cohesion and morale among the remaining staff (Tang et al., 2019). Higher costs for healthcare operations are likely to increase consumer expenses (Bae, 2022).

Modern complex healthcare systems and COVID-19 post-pandemic realities increase new nurses' vulnerabilities (An et al., 2022; Ho et al., 2021). In 2014, the professional practice environment was added as a fourth significant aim to the existing triple aim established by the Institute for Healthcare Improvement (Bowles et al., 2019). Nurse perceptions of work autonomy add to staff engagement (Hasselblad & Loan, 2022; Speroni et al., 2022). This facility's nursing operational agenda reflects the quadruple aim and targets stabilizing the workforce as a priority.

PICOT Question

In transition-into-practice nurses (P), does the implementation of shared governance (I) compared with no shared governance participation (C) affect their engagement with the hospital (O) within eight weeks (T)?

Population/Problem

Nurse turnover is increasingly affecting healthcare organizations' ability to provide safe, cost-effective care (Duru & Hammoud, 2022). Early career nurses are particularly at risk for turnover due to professional transition challenges (McClain et al., 2022). Individual, worksite, and organizational factors often influence the decision to leave (Jarden et al., 2021).

Intervention

Shared governance has positively impacted staff engagement, job satisfaction, and nurse retention (Dechairo-Marino et al., 2018; Quek et al., 2021; Kyytsönen et al., 2020). This project was intended to empower nurses to bring their personal experiences to a council designed to address their needs and effect change.

Comparison

The organization had few interventions in place to support novice nurses, and the existing SG structure did not include early career nursing needs.

Outcome

The desired outcome was increased staff engagement by TIP nurses, measured with the Utrecht Work Engagement Scale-9 (UWES-9), a validated tool (Schaufeli & Bakker, 2003), at pre-and post-implementation time points.

Timing

The project included the creation of a new SG council, recruiting TIP nurses as members, and their education on the shared governance model within eight weeks.

Evidence-Based Practice Framework & Change Theory

Evidence-Based Practice Framework

The Johns Hopkins Evidence-Based Practice Model (JHEBP), a linear problem-solving approach relevant to operational questions and responsive to internal and external factors, was applied to this project (Dang et al., 2022). This method follows the initial inquiry into the problem with the practice, evidence, and translation (PET) process to produce best practices and improvements. These three phases are iterative and dynamic, offering 20 steps and ten practice tools, refining the practice question, searching for the best evidence, and translating this knowledge to the practice setting (Dang et al., 2022). With this project, the problem step refined the question to include the application of SG and initiate stakeholder and team involvement. The evidence step sought literature evidence to analyze and decide on the best recommendations

about professional practice governance to support this project. The final step translated the findings into an action plan to implement a TIP nurse SG council.

ADKAR Change Management Model

Successful realization of evidence-based knowledge benefits from active change management with structured processes and tools to guide the development and implementation of an actionable framework (Roussel et al., 2018). The Prosci ADKAR® Model, with the five change outcomes of awareness, desire, knowledge, ability, and reinforcement, operates on the premise that individual change drives organizational transformation (Prosci, n.d.). Therefore, this theory is an excellent choice for any evidence-based, innovative project built on leader buy-in and employee empowerment (Mislan et al., 2021). Applied to this project, the actors and stakeholders became aware of the need to change with the resulting desire to improve the outcome of nurse retention. The plan involved all actors acquiring knowledge on changing and functioning in a novice-focused professional practice model and sustaining increased engagement.

Evidence Search Strategy

The PICOT elements guided the search for evidence. The keywords *engagement, nurse engagement, workplace engagement, shared governance, shared governance councils, unit councils, professional governance, nurs**, *nurses, and nursing*, were applied to the initial literature review. It explored the PubMed, OVID Emcare, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete, and ProQuest databases, yielding 7,430 papers. Applicable MeSH terms include *work engagement, nurses, nursing, nursing models, nursing shared governance, and professional governance*. Limiting publication dates to less than five years and publication type to scholarly journals further reduced the results to 796 studies. After removing duplicates, title and abstract reviews for exclusion criteria rejected 749 articles because of non-English language and lack of specific relevance to the population or practice issue, like patient instead of nursing engagement. Inclusion criteria integrated any discussion of

the impact of the implementation of a professional governance model or shared governance activity on nursing engagement or workplace environment. The remaining 47 articles were hand-screened to yield a final ten papers (Figure 1), selected for their usefulness in answering the PICOT question and critical appraisal results according to the JHEBP appraisal tool.

Evidence Search Results

Results

A Prisma flowchart (Figure 1) summarizes the search process and results. The identification process through database and snowball searching provided a rich aggregate of articles for closer screening. Given the volume of over 7,000 records, a narrow limit of recent publications within five years and in the English language was applied, which allowed a review for eligibility of non-duplicate citations by title and abstract screening. These 761 citations were examined for applicable content according to keywords indicating discussion of the population, intervention, and outcome elements of the PICOT question. The focus on shared or professional nursing governance excluded studies describing professional practice activities and SG implementation in non-practice settings, like colleges. Papers about multidisciplinary councils, specialty disciplines, and outpatient settings were retained when they discussed engagement or related staff impacts. Since this project is not concerned with patient consequences, citations concentrating on patient safety or quality were excluded.

A final 47 full-text articles were thoroughly reviewed for strength and quality according to the JHEBP appraisal tool. Despite the filter of peer-reviewed publications, several articles provided descriptions of a quality improvement process, expert opinions, case studies, or otherwise failed to discuss research designs or outcomes. A poorly described procedure also affected three papers that explained the experience of creating novice nurses or night shift councils. Two further quantitative studies were excluded for low subject numbers. Several studies conducted in Asia and the Middle East were removed in favor of primarily English-speaking practice areas.

Evidence

This process left a final ten studies representing consistently strong evidence supporting the PICOT question (Appendix A). The appraisal is based on the Johns Hopkins research appraisal tool (Dang et al., 2022). Primary research evidence consists of a mix of qualitative and quantitative papers: Five articles were graded as level II (Dechairo-Marino et al., 2018; Di Fiore et al., 2018; Hasselblad & Loan, 2022; Olender et al., 2020; Speroni et al., 2022), and three studies were found to be level III (Quek et al., 2021; Sohal, 2020; Weaver et al., 2018), with acceptable quality ratings of B for three studies and A or A/B grade for five papers (Appendix B). These analyses include a longitudinal quantitative study, three quasi-experimental studies, one mixed-methods paper, one mixed-methods study of explanatory sequential design, one secondary analysis of a subset of a cross-sectional survey, and a prospective two-group comparative study. Three papers describe the assessment of work engagement as an outcome, with the Utrecht Work Engagement Scale (UWES) utilized by two authors (Olender et al., 2020; Quek et al., 2021). Two review articles offer some relevance to the PICOT question (Appendix C). One Scandinavian scoping review (Kyytsönen et al., 2020), level V, Grade B, was included due to a lack of recent assessments of shared governance evidence from English-speaking countries. Another paper, a systematic review of quantitative research, level II (Jarden et al., 2021), adds background on the PICOT outcome but is graded at level C. Together, these papers offer evidence that SG implementation improves engagement.

Themes with Practice Recommendations

The literature search strategy focused on the PICOT elements of intervention and outcomes. All primary research articles and the scoping review by Kyytsönen et al. (2020) examine the impact of SG implementation on staff outcomes as the central idea (Dechairo-Marino et al., 2018; Di Fiore et al., 2018; Hasselblad & Loan, 2022; Olender et al., 2020; Quek et al., 2021; Sohal, 2020; Speroni et al., 2022; Weaver et al., 2018). Additional themes relate to

the PICOT outcome of nurse or work engagement and non-staff impact, namely turnover and patient outcomes (Appendix D).

Perception of Work Environment

The selected literature revealed improved outcomes of work perception, staff satisfaction, autonomy, and shared decision-making. Weaver et al. (2018) saw a change from traditional (168.62) to SG (103.84) ratings. Dechairo-Marino et al. (2018) showed a significant increase in shared decision-making overall in five of six domains along the SG level. Di Fiore et al. (2018) noted significant improvement in the Index of Professional Nursing Governance (IPNG) score ($p = .017$) overall and for three domain scores (p values between .005 and .031) after adjustment for nurse characteristics. Speroni et al. (2022) found that SG outperformed traditional governance (TG) by 25% ($p < .001$) in the measured outcomes (nurse-sensitive indicators, patient and staff satisfaction) and raised staff satisfaction by 51.7%. Sohal (2020) revealed an improved culture of teamwork, morale, and knowledge of the professional practice model. Hasselblad and Loan (2022) saw improved individual autonomy but found organizational change more challenging. Olender et al. (2020) demonstrated a sustainable, significant, and progressive rise in nurse empowerment, while Quek et al. (2021) found a statistically significant increase in staff satisfaction ($p < .0001$).

Engagement

Three quantitative papers (Quek et al., 2021; Sohal, 2020; Olender et al., 2020) investigated the relationships between SG and work, staff, or nursing engagement. Sohal (2020) assessed engagement with an unvalidated pre- and post-implementation survey and the Zammuto and Krakower Organization Culture Questionnaire and saw an increase of 6% to 15% in nurse engagement beyond the expected 2%. Quek and colleagues (2021) and Olender et al. (2020) measured employee engagement with the UWES-9 tool (Appendix A). Cronbach's α reliability scores for Olender et al. (2020) varied from 0.89 to 0.97. An initial increase in work engagement with interprofessional SG was reported by Olender et al. (2020), but levels

stabilized over time. Work engagement was statistically significantly related to nurse empowerment ($r = .668, p < .001$) and caring ($r = .295, p < .001$). The lack of sustainable increases in work engagement points to the need to set long-term goals after SG's initial implementation. Quek et al. (2021) found a statistically significant ($p < .001$) rise of 10% in nurse engagement after SG implementation.

Intent to Stay

A systematic review of new graduates' well- and ill-being predictors by Jarden et al. (2021) addressed turnover intention and showed that work engagement was a positive indicator of the intent to stay for new nurses. This study was included to provide additional background on PICOT outcomes and the focus on the target population, but the low-quality grade due to poor study standards limits the usability of the outcomes. The only quantitative study used that also investigated intent to stay demonstrated statistical significance for the association of SG implementation ($p = .001$), and the addition of distributed leadership agency produced a statistically significant raise ($p = .001$) (Quek et al., 2021).

Patient Outcomes

Sohal (2020) included a nurse-sensitive quality metric in the project aim and found a significant downward shift in patient fall rates with the initial implementation of SG. A refresh of the SG model produced another reduction from three to zero over the implementation period (Sohal, 2020). Speroni et al. (2022) examined patient satisfaction and observed that SG models outperformed TG significantly for 11.1% of the categories assessed. Separating the U.S. from international facilities generated no significant difference in nurse-sensitive indicators between SG and TG models, which led the authors to suggest shared governance as a strategy for leaders to improve select nurse-related benchmarks (Speroni et al., 2022).

Summary of Recommendation

Improved perceptions of shared decision-making, staff satisfaction, and autonomy related to SG were documented with quality grades of high (Di Fiore et al., 2018; Hasselblad &

Loan, 2022; Quek et al., 2021; Speroni et al., 2022), high/good (Dechairo-Marino et al., 2018), and good (Olender et al., 2020; Sohal, 2020; Weaver et al., 2018). Engagement outcomes were detailed with quality grades of high (Quek et al., 2021) and good (Olender et al., 2020; Sohal, 2020). The UWES assessment was presented as a validated tool to measure work engagement (Quek et al., 2021; Olender et al., 2020). While turnover intention and patient outcomes did not show consistent significant associations with SG practice, they were not the primary results investigated. As such, a case cannot fully be made about its usefulness in those situations.

Aside from the review by Jarden et al. (2021), the quality of the studies involved in these outcomes is good or high. The studies presenting the evidence reflect the intervention and the PICOT population. Some studies differed in assessing newly created (Di Fiore et al., 2018; Hasselblad & Loan, 2022; Sohal, 2020; Weaver et al., 2018) versus refreshed SG models. The UWES tool was used to measure work engagement outcomes (Olender et al., 2020; Quek et al., 2021), whereas the IPNG survey was the tool mainly used to assess council development (Dechairo Marino et al., 2018; Di Fiore et al., 2018; Speroni et al., 2022; Weaver et al., 2018). Despite variations, the research showed that the strength of the evidence presented is of good quality to support the intervention and supplied a validated tool to assess the intended outcome with the UWES-9 survey tool. Thus, it answered the PICOT question: In transition-to-practice nurses (P), does the implementation of shared governance (I) compared with no shared governance participation (C) affect their engagement with the hospital measured by UWES-9 (O) within eight weeks (T)?

Setting, Stakeholders, and Systems Change

Setting and Stakeholders

The project was implemented in a 278-bed acute care hospital with a 4-star rating in a faith-based healthcare system. The organization strives for high-reliability behaviors in its operations and culture. Its structure consists of chief executives at divisional and local levels accountable to a board of trustees. Its Catholic mission of steadfast service to all envisions

health for a better world and promises to know, care for and ease the way of all patients, families, and caregivers. Annual employee surveys have demonstrated poor employee engagement and worsening staff turnover. The organization prioritizes stabilizing the workforce, making the project timely and endorsed by leadership. This support was verified in several meetings with the chief nursing officer (CNO), managers, educational department specialists, and SG leaders, who constituted the major stakeholders. The other stakeholders were the transition-into-practice (TIP) nurses, active or recent graduates from the facility's residency program, invited to join this new council at the start of the implementation of the project.

The DNP student functioned as the project lead (PL) to develop the council structure with the TIP council and collaborate with all stakeholders. The PL facilitated the alignment of this council with the existing SG model and evidence-based knowledge on nursing governance. Unlike the overall SG structure, which includes peers from other disciplines, this council was designed for nurses. Including non-nursing partners as ad-hoc members at council meetings fostered interprofessional collaboration and familiarized the council members with the various professional partners in the facility. Integrating learnings from the first cohort and stakeholders with a clear succession plan aided sustainability.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

An organizational assessment revealed positive and negative issues caused by internal sources and external forces, represented in a SWOT analysis (Table 1). Significant factors backing this project included internal support and expertise by leadership to increase staff buy-in, engagement, and satisfaction and decrease turnover intention, especially by nurses not yet embedded in the organization. Strengths were endorsements by executive and core leaders, educators in charge of the hospital's residency program, and SG leaders. Other strengths were the existing SG model with proven successes, the organizational objective to stabilize the workforce, the system's promise to care for its staff, and improved dialogue with caregivers. Opportunities offered recruitment incentives, professional development, and enhanced staff

satisfaction, with attention to nursing needs. The opportunities to boost nursing engagement and decrease turnover as outcomes were of particular interest.

Weaknesses included the overall lack of staff engagement, ownership, and participation in councils, reduced financial resources, staffing shortages, resistance to change, and meeting restrictions. Poor morale, lack of employee participation, and resistance to change were possible impediments to successful outcomes. Threats were the nursing shortage overall, compounded by market competition, staff attrition, and a seasonal patient surge. Other threats came from implementing a new council with limited prior experience and recent negative media coverage of the system.

System Change

Socio-institutional theories in healthcare settings describe systems' micro, meso, and macro levels (Sawatzky et al., 2021). The micro level symbolizes the caregiving frontline units, the meso level embodies infrastructure and organizational decision-making areas, and the macro level represents the policy and regulatory environments (Sawatzky et al., 2021). This project presented the opportunity to create change at the micro, meso, and macro system levels. Creating a TIP council with nurses from different care areas or micro levels represented a meso level change. The council members acted as unit representatives to their peers in the various departments, creating micro and meso level changes in the facility. Further expansion across the healthcare system on the macro level is possible.

Implementation Plan with Timeline and Budget

Project Objectives

1. The PL facilitated a new SG council for the TIP nurses, as evidenced by two TIP council meetings held during implementation.
2. The PL and SG mentors educated the TIP council nurses in the first meeting on SG principles and structures.

3. The engagement of TIP nurses was expected to rise by 5%, assessed by pre- and post-council implementation survey results conducted by the PL.
4. The council's sustainability was improved through meeting structure and content development, as evidenced by a charter and a draft outline of the monthly meeting agendas within eight weeks of implementation.

Implementation Plan

The translation phase of the JHEBP framework guided the project management and application of the JHEBP action plan tool (Dang et al., 2022) for successful translation. The DNP student functioned as PL and identified change agents, implementation-related activities, timelines, resources, and barriers. The PL's leadership characteristics and skills rested on assuming accountability for the successful implementation of this project. This included content expertise, transparency, and respectfulness in frequent communications, supporting growth and team building in TIP nurses, and providing education and role modeling of distributed leadership skills. Mislán et al. (2021) suggest a resonant leadership style to create connections between leadership and the audience through sharing emotions and enthusiasm. The five outcomes of the ADKAR change model build on the understanding that organizational change is interwoven with individual change (Prosci, n.d.). Following these steps offered a logical structure for the project implementation activities and timeline (Appendix E).

Awareness

This milestone informs stakeholders of the need for change, creating awareness on the leadership level to ensure organizational support. Following executive endorsement, current SG and interprofessional leaders, managers, and C-suite were included in communications about this project. The PL connected with TIP nurses through educational leaders, conveying organizational support for change and enabling real-time dialogue with stakeholders. Attending unit meetings informed staff members of the micro-level system of this project.

Desire

Fostering the desire to be a part of change goes together with raising awareness. The PL explained the why for the change, was specific, and included the impact, opportunities, and potential concerns and barriers. The strengths and opportunities identified in the SWOT analysis were added. Individualizing arguments and information according to the audience and including the benefits of participation increased engagement and influence on the work environment and were used to appeal to stakeholders to support the project.

Knowledge

This milestone offers education and actionable skills. Stakeholders were educated in implementing this project, and TIP council members were oriented to SG processes, meeting management, and their role at an inaugural workshop. The PL facilitated the group's learning, with independence as the primary goal for the TIP council.

Ability

Making and maintaining a change is crucial for adoption at both the meso and micro levels. Waning leadership support and a lack of consistent structure are critical failure causes in SG efforts (Kyytsönen et al., 2020). Adding experienced SG mentors, education and leadership sponsors, and C-suite attendance to the TIP council enabled immediate and direct communication and change agency.

Reinforcement

Delegating accountability for refining meeting structures and content and creating a council charter added to the TIP council's commitment to this SG activity. Continued leadership support aided the sustainability of this council. Based on the literature findings, the UWES-9 tool was used to evaluate the project's impact on the PICOT outcome.

Project Schedule

The PL obtained institutional and facility review board approval before the beginning of the project and kept project sponsors and stakeholders informed throughout implementation.

- Week 1-2: The PL introduced the project at unit and residency program meetings to create staff awareness, recruit members, and obtain budget approval.
- Week 3: An introductory workshop provided SG education and updates for all interested stakeholders and the TIP council members. The PL collected the UWES-9 survey at the beginning of the workshop.
- Week 4: At the first TIP council meeting, members initiated the development of council documents and meeting strategies.
- Week 5-6: The PL supported council members and informed sponsors of the progress.
- Week 7: The members refined the succession plan and completed a post-implementation UWES-9 survey at the end of the second TIP council meeting.
- Week 8: The implementation was completed. The PL shared a report with stakeholders.

Budget

Administrative approval was granted to fund this project from the SG cost center. The main expenses arose from personnel costs for workshop and meeting attendance; training materials and mileage expenses added minor costs (Table 2).

Results

Data Collection

The PICOT question assessed the impact of SG implementation on work engagement in a TIP nursing council. Implementation began after approval by the evidence-based practice review committee (EPRC) from the University of St. Augustine for Health Sciences (USAHS) and the facility's institutional review board (IRB) was obtained. The initial data collection plan proposed paper surveys collected at in-person meetings. The council participants requested meetings to be held remotely, which necessitated the survey to be converted into an electronic version with a digital link offered to the participants. The university and institutional reviews approved the change in the data collection method before data collection began. All surveys

were completed anonymously, which maintained data integrity and security. To match pre-and post-intervention answers, the last three digits of the employee ID were used. Data was stored on the facility-owned files network and only accessible to the PL.

All TIP nurses participating in this council were included in the survey. At the beginning of the workshop meeting, the rationale for and the process of survey collection and data safety was explained, with the opportunity to complete the survey at that time. The post-intervention survey was offered at the end of the second council meeting. After the initial recruitment of seven potential council members, the council member size increased from seven to eight nurses during the implementation period. The three meetings saw varied attendance, which impacted survey completion.

Evaluation Tool and Design

The data was collected through a pre-and post-implementation assessment using a validated survey tool, the UWES-9 questionnaire, with established factorial validity, internal consistency, and test-retest reliability (Schaufeli et al., 2006). This self-reported 9-statement work and well-being survey measures the three work engagement dimensions of vigor, dedication, and absorption via a 7-item Likert scale from never to always (0 to 6) (Schaufeli & Bakker, 2003). Permission to use the tool was granted for non-commercial academic purposes, provided data were shared with the tool owner, including raw test scores, age, gender, and (if available) occupation, and the original order and format of questions were followed (Schaufeli, n.d.). To describe participants effectively and comply with the tool owner's permission conditions, demographic data by age brackets and gender was collected (Table 3).

Data Analysis

Seven participants completed the pre-intervention survey, six answered the post-intervention survey. Two pre-implementation responses and one post-intervention answer could not be matched to the corresponding identification code and were omitted from the analysis, leaving five participant data for inclusion in the analysis via the Intellectus Statistics software

program (Intellectus, 2022). A two-tailed paired samples *t*-test was conducted to examine the pre-and post-implementation engagement survey outcomes (Table 4). The pre-implementation mean ($\mu=4.31$) compared to the post-implementation mean ($\mu=4.36$) showed that the results were not statistically significantly different (Table 5). A Shapiro-Wilk test was conducted to test for the normal distribution of data, which indicated the normality assumption was met based on an alpha value of .05, $W = 0.94$, $p = .666$ (Figure 2). A two-tailed Wilcoxon signed rank test was added as a non-parametric alternative. Based on an alpha value of .05, $V = 2.00$, $z = -.53$, $p = .593$, it indicated that the differences in results (pre-intervention *Mdn* = 4.56, and post-intervention *Mdn* = 4.78) were explainable by random variation (Figure 3).

Outcomes

The sample size ($N=5$) and short implementation period limit the statistical significance and made inconclusive data outcomes likely. In addition, clinical significance is useful in practice when statistical significance is not present (Kim & Mallory, 2016), as is the case with this project. Of clinical significance is that the council was created, stayed active, and the member number increased during the implementation period. After the orientation workshop, the two initial council meetings were held despite the short implementation time and were aligned with the overall SG meeting schedule. During the meetings, the participants created a council charter and agenda based on the hospital's SG model and decided on goals to accomplish by the end of the year.

The outcome measures included the number of TIP nurses recruited, the creation of the new council, and the increase in engagement scores. Structural measures indicated the alignment with the existing SG model, the education delivery at an orientation workshop, and the number of support council members for this new council. Process measures consisted of the number of meetings held, the method of meeting, the number of council documents developed, and the number of pre-and post-implementation surveys completed. Balancing, financial and sustainability measures were added in Table 6. All measures were met except for the lack of

statistical significance in engagement scores and insufficient completion of pre- and post-implementation surveys by all TIP council members.

Impact

The project assessed the impact of SG participation on engagement in the TIP nurse population through the creation of an SG council. This hospital has experienced a repeated decline in staff engagement rates and increased turnover, especially among nurses at the beginning of their careers. The project successfully implemented a TIP nurse council using evidence-based practice for shared decision-making. The council presented a new and formal platform for TIP nurses to convene and collaborate on issues of particular importance to TIP nurses, in alignment with the existing SG model. Despite the lack of statistical change, clinical significance exists through the opportunity for active engagement as a TIP council member. The clinical impact of the project was confirmed by TIP council member statements. They indicated that this is a resource for all TIP nurses in the hospital for networking, support, a sense of community, belonging, and understanding of what the organization has to offer. The new practices created through this project involved the council's participation in the annual hospital week celebration and its collaboration in creating a council intranet site and onboarding presentations for TIP nurses. Council members repeatedly expressed satisfaction and an optimistic view of the opportunities, their role on the council, and their potential positive impact on other TIP nurses.

Barriers and Limitations

The main barriers to the initial implementation and future continuation of this project are related to the voluntary participation of staff who experience a stressful transition to practice, and the problem of timely connection with the target population. The recruitment of initial council members involved various and repeated methods of communication such as emails directed to clinical academy participants, announcements in unit meetings and at manager rounds, educators and SG leaders, and fliers posted in units. There were seven meetings offered to

introduce the project and subsequently find convenient meeting times for all interested participants on short notice. Another obstacle was the lack of familiarity of TIP nurses with the concept of shared governance. While the orientation workshop was helpful in introducing the model as practiced at this hospital, council members found the opportunities it presented for professional engagement for TIP nurses less obvious and somewhat abstract.

The slow process of recruiting council members, the time constraints for this project, and the varying attendance and membership at the initial meetings affected the evaluation methods and survey completion. The pre-and post-intervention survey conducted at this time was restricted by small participation numbers, leading to a small number of surveys included for analysis (N=5). This limited the ability to interpret evaluation data for outcomes.

A concern for sustainability is the transitioning of council leadership. This was addressed through the addition of experienced colleagues, champions in mentorship, professional practice, and shared governance who will continue to support the council members. One TIP nurse has committed to assuming the council chair role and is mentored by the PL.

Future Implications for Practice

Repeating the UWES-9 survey, and adding an established council health assessment instrument, like the one by Hess and colleagues (2020), will further validate the clinical and possibly also add statistical significance to the outcomes. Based on the clinical impact, SG will be a valuable addition to the strategies used to support early career nurses transitioning into practice. SG participation will encourage engagement with the organization given ongoing support and adjustments. If further assessments demonstrate more value, then this SG activity can be expanded to more hospitals in the system, and include other disciplines as supported by leadership.

Dissemination Plan

The dissemination plan includes internal and external sharing of results. Within the facility, in-person or virtual presentations using PowerPoint demonstrations with video and

voice-over were well received. The project was presented at the facility-wide shared governance council, the TIP council, and professional development and leadership meetings within three months after implementation was completed since the facility lacks an evidence-based practice committee.

External dissemination includes an oral poster presentation to faculty at USAHS and the paper submission to SOAR@USA, the university repository for scholarly student works. The PL has submitted an abstract to the hospital organization's South division nursing research conference for poster and PowerPoint presentation and was accepted for a podium presentation later this year.

Conclusion

This project sought to address current workforce problems related to nursing turnover and poor work satisfaction. The facility's leadership endorsed this project, and possible stakeholders were identified. The project intended to raise the engagement of the nursing group most vulnerable to turnover, nurses transitioning into practice (TIP). By creating a professional practice platform for SG activity, these nurses have been provided the ability to connect as a group and access significant stakeholders and leaders of the organization. An eight-week implementation was planned after IRB approval was granted and led to the creation of a hospital-wide SG council for TIP nurses. The project applied evidence-based knowledge about SG practice and its impact on workplace experience and staff engagement. The PET process of the JHEBP model as an evidence-based practice framework and the ADKAR change management model offered the conceptual foundations to support the change. This experience enabled the embedding of TIP nurses into the culture of this facility through a dialogue and decision-making venue and the formal appreciation of their professional insights and needs. While the small survey sample size and short implementation period limited statistical results, TIP nurses' participation in this council demonstrated shared governance activities as a valuable

adjunct to support early career nurses in transitioning to practice and being engaged with the organization.

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Table 1

Strengths – Weaknesses – Opportunities – Threats (SWOT) Analysis

Strengths	Weaknesses	Opportunities	Threats
Executive leadership buy-in and support	Poor staff engagement	Professional development of nurses	Seasonal patient surge impacting staff demands
Support from experienced shared governance leaders	Pandemic-related meeting restrictions	Incentives for committee participation (clinical ladder program)	Market competition in the community for staff
Existing residency program	Lack of staff participation in councils	Unique in community	Registered Nurses shortage
Existing shared governance structure	Staff turnover and shortage	Option to customize council to nurses' needs	Staff attrition
Published content expert in the organization	Concern about sustainability	Increased staff satisfaction	New council with limited prior experience
Consistent with organizational promise	Change resistance	Improved nursing engagement	Negative media coverage
Support from educational department leaders	Low staff participation	Improved patient outcomes	
Consistent with the priorities of the nursing agenda by the Chief Nursing Officer	Lack of ownership	Successful implementation spreads through the system	
Endorsed by core leaders and managers	Financial restraints	Recruitment incentive	
Promotes communication to frontline nursing		Decreased nursing turnover	
Ministry history of achievements and successes in council work			

Table 2

Implementation of TIP Council Budget

Expenses			
Indirect-			
Salary and benefits x 4 hours for workshop, variable staff.	\$80/hr x 20 n staff	Funds provided by the organization	\$6,400
Salary and benefits x 2 hours for 2 monthly meetings, variable staff.	\$80/hr x 20 n staff	Funds provided by the organization	\$6,400
Overhead	\$0		
Gas	\$ 50	Funds provided by the PL	
Supplies – office	\$<50	Funds provided by the organization	\$<50
Estimate Total Expenses	\$		\$12,800
Net Balance			0.00

Note: All budget entries are estimates. Expenses are based on means. The organization is expected to provide funding for staff hours, office supplies, printed materials, etc. associated with the project. PL will cover her own gas mileage.

Table 3*Demographic Data*

Variable	<i>n</i>	%
Sex		
Female	4	80.00
Male	1	20.00
Other	0	0.00
Age		
20-25	0	0.00
26-30	1	20.00
31-35	1	20.00
36-40	0	0.00
41-45	1	20.00
46-50	1	20.00
> 50	1	20.00

Table 4

UWES-9 Survey Questions and Before and After Survey Answers

Question #	Question Mean Pre- Implementation	Question Mean Post-Implementation
1	3.80	4.00
2	3.60	4.00
3	4.40	4.60
4	5.00	4.60
5	3.60	3.60
6	4.00	4.20
7	5.20	5.40
8	5.40	5.00
9	3.80	3.80

Table 5

Two-Tailed Paired Samples t-Test for the Difference Between Pre-Implementation (Engagement Pretest) and Post-Implementation (Engagement Posttest)

Engagement Pretest		Engagement Posttest		<i>t</i>	<i>p</i>	<i>d</i>
<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
4.31	1.21	4.36	1.18	-0.28	.794	0.12

Note. N = 5. Degrees of Freedom for the *t*-statistic = 4. *d* represents Cohen's *d*.

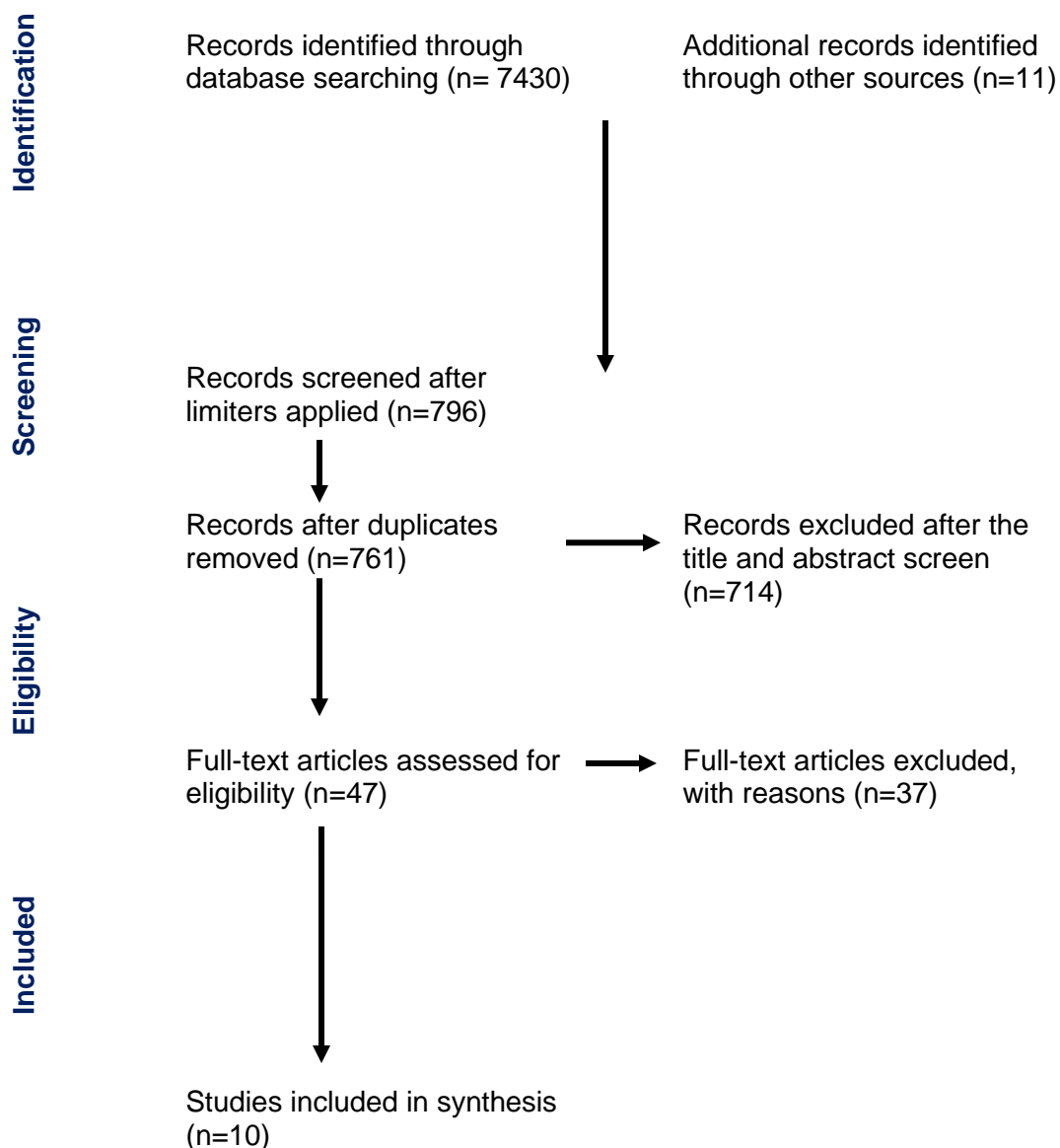
Table 6

Variable Measures

Outcome	Process	Structural	Balancing	Financial	Sustainability
TIP nurse council created	Number of meetings held	Number of support council members	Members who leave the council during implementation	Percentage of costs within budget	Number of annual agendas created
Number of TIP nurses recruited as members	Meeting documents developed	Orientation workshop done			Council charter completed
Percentage rise in engagement scores	Number of members completed survey pre-implementation	Aligned with existing SG model			
	Number of members who completed survey post-implementation				

Figure 1

PRISMA Flowchart



Note. Prisma flow chart diagram from "Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement," by D. Moher, A. Liberati, J. Tetzlaff, & D.G. Altman, 2009, *Annals of Internal Medicine*, 151(4), p.267 (<http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00135>). Copyright 2009 by The American College of Physicians.

Figure 2

The means of Pre-Implementation (Engagement Pretest) and Post-Implementation (Engagement Posttest) with 95.00% CI Error Bars

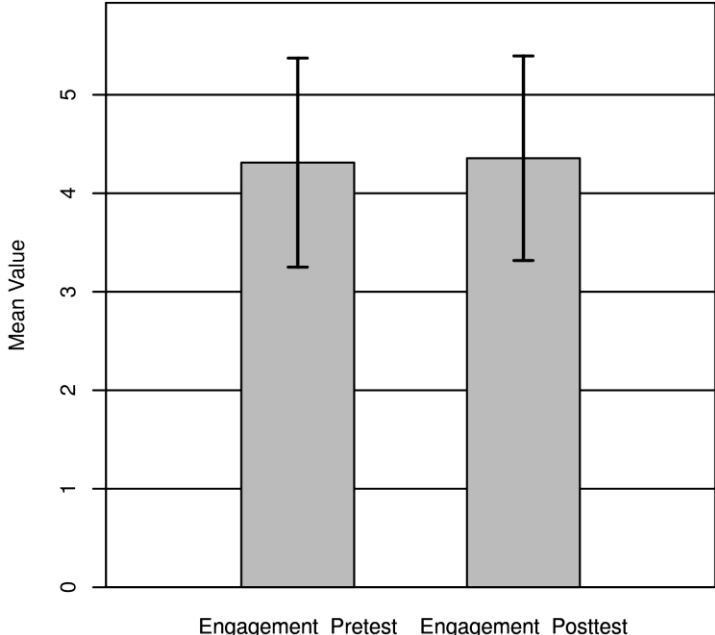
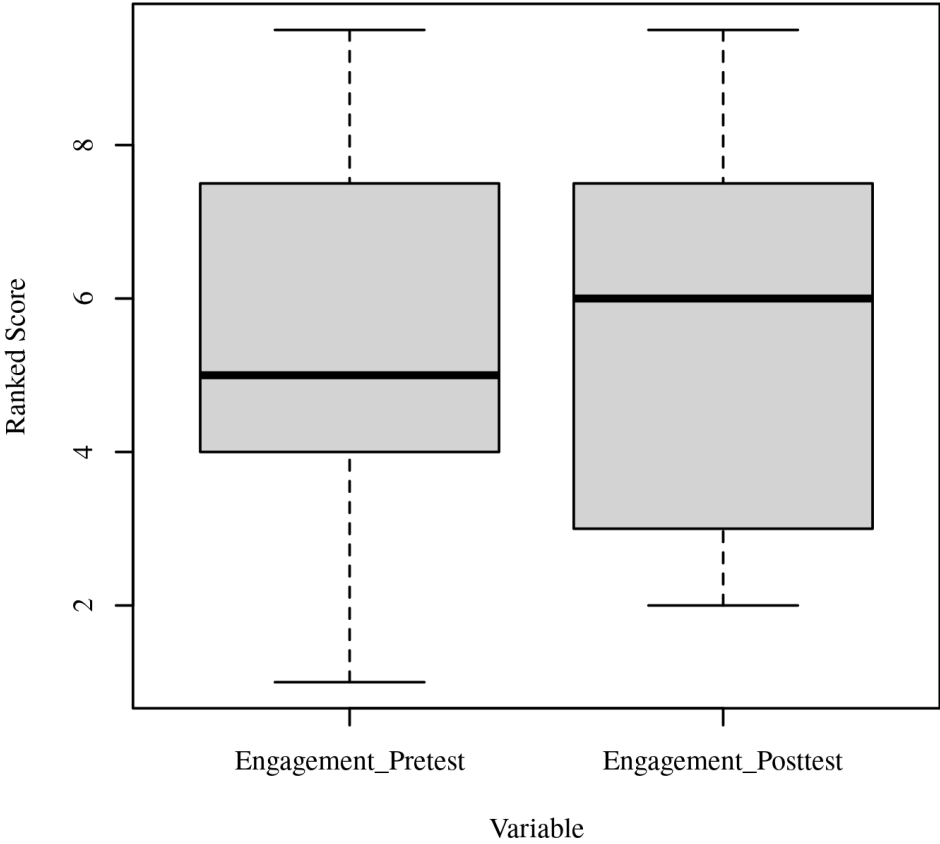


Figure 3

Ranked values of Engagement_Pretest and Engagement_Posttest



Appendix A

Levels and Types of Evidence

	Olender et al., 2020	Weaver et al., 2018	Sohal, 2020	Quek et al., 2021	Hasselblad & Loan, 2022	Speroni et al., 2022	Dechairo-Marino et al., 2018	Di Fiore et al., 2018	Jarden et al., 2021	Kyytsönen et al., 2020
Level I: Experimental study, randomized controlled trial (RCT), or systematic review (SR) of RCTs, with or without meta-analysis										
Level II: Quasi-experimental study or SR of quasi-experimental studies	B				A	A	A/B	A	C	
Level III: Non-experimental study; SR of a combination of RCTs, quasi-experimental and non-experimental studies		B	B	A						
Level IV: Clinical practice guidelines or consensus panels/position statements										
Level V: Scoping reviews, integrative reviews, literature reviews, case reports										B

Note. Hierarchy of Evidence Guide from Dang, D., Dearholt, S., Bissett, K., Ascenzi, J., & Whalen, M. (2022). *Johns Hopkins evidence-based practice for nurses and healthcare professionals: Model and guidelines* (4th ed). Sigma Theta Tau International.

Appendix B

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
<p>Olender, L., Capitolo, K., & Nelson, J. (2020). The impact of interprofessional shared governance and a caring professional practice model on staff's self-report of caring, workplace engagement, and workplace empowerment over time. <i>JONA: The Journal of Nursing Administration</i>, 50(1), 52. https://doi.org/10.1097/NNA.0000000000000839</p>	<p>Longitudinal quantitative study Level II Quality Grade: Good</p>	<p>Respondents increased over time N=103 to N=301 in 2015)</p>	<p>Pre-/post- Interprofessional SG implementation in work environments, measurement through AES on workplace engagement and caring for four years</p> <p>CFSCP, established content and criterion validity 0.80, Cronbach's α .81, reliability .80 or greater</p> <p>UWES, Cronbach α reliability .89 to .97</p> <p>Conditions of Work Effectiveness Questionnaire II, Cronbach α reliability .81 to .91, .92 for the total score</p>	<p>Watson's Theory of Human Caring, Appreciative Inquiry</p>	<p>Impact of interprofessional SG and caring professional practice model on caring, work engagement, and empowerment</p>	<p>Relevant to PICO question (outcome)</p> <p>Work empowerment increased progressively and significantly over time Caring remained stable</p> <p>Statistically significant relationship between work engagement and empowerment ($r= 0.668$, $p<.001$)</p> <p>Respondents increased over time</p> <p>Significant relationships for all variables. Transitioning major cultural change, requires time and support from key stakeholders and leaders</p>
<p>Weaver, S. H., Hess, R. G., Williams, B., Guinta, L., & Paliwal, M. (2018). Measuring shared governance: One healthcare system's experience.</p>	<p>Quality improvement project, mixed</p>	<p>N (2017) = 599</p>	<p>Newly implemented shared governance environment after two assessments 2013 and 2015 rate IPNG 3.0 – after years of SG, in the traditional range.</p>	<p>ANCC</p>	<p>The outcome of SG on RN engagement and turnover</p>	<p>Relevant to the PICO question (intervention, outcome)</p>

<p><i>Nursing Management</i>, 49(10), 11–14. https://doi.org/10.1097/01.NUMA.0000546208.70574.</p>	<p>methods study Level: III Quality Grade: Good</p>		<p>Retains validity and reliability after shortening (from IPNG 2.0)</p>		<p>2017 results IPNG in SG range</p>	<p>New structure nurtured, adjusted until following survey 2019 Concern about survey overload</p>
<p>Sohal, L. (2020). Implementing a nursing professional model to improve staff nurse engagement and teamwork. <i>The Journal of Continuing Education in Nursing</i>, 51(3), 124. https://doi.org/10.3928/00220124-20200216-07</p>	<p>Quality Improvement project Level III Quality Grade: Good</p>	<p>Not mentioned Nursing staff: N=100</p>	<p>Implement a professional practice model Pre-and post-intervention: staff engagement survey Zammuto and Krakower Organization Culture Questionnaire</p>	<p>Organizational professional practice model – six core nursing values Koloroutis' Relationship-Based Care model Felgen's Change Theory</p>	<p>To improve quality outcomes and foster teamwork -increase nurse knowledge about professional practice model -improve staff engagement -Improve culture of teamwork - decrease patient falls</p>	<p>Relevant to the PICO question (Population, intervention, outcome) Improved engagement, culture of teamwork, and staff satisfaction (6% to 33%). Reduced falls (from 3 to 0) Important for staff to know "why"</p>
<p>Quek, S. J., Thomson, L., Houghton, R., Bramley, L., Davis, S., & Cooper, J. (2021). Distributed leadership as a predictor of employee engagement, job satisfaction and turnover intention in UK nursing staff. <i>Journal of Nursing Management</i>, 29(6), 1544. https://doi.org/10.1111/jonm.13321</p>	<p>Mixed methods explanatory sequential design Level III Quality Grade: High</p>	<p>Quantitative survey: N=116 direct care providers Qualitative semi-structured interviews: N=15 direct care providers</p>	<p>Impact of 8-year SG program, measured through: DLA, validated in hospital setting, Cronbach α 0.91 to 0.93 UWES, adequate reliability, Cronbach α 0.80 to 0.90 MSQ-SF, good reliability, discriminant validity TIS-6, good criterion-predictive validity, differential validity, reliability, Cronbach α 0.80</p>	<p>Tashi's distribution leadership as a shared decision framework</p>	<p>Effect of distributed leadership through SG on employee engagement, job satisfaction, and turnover</p>	<p>Relevant to the PICO question (Intervention, outcome) Engagement results: DLA associated with statistically significant increase (14,670, $p < .0001$) DL increased employee engagement by 10% Should facilitate a meaningful exchange Identified challenges</p>
<p>Hasselblad, M. M., & Loan, L. A. (2022). Implementing shared governance to</p>	<p>Quasi-experimental pre-</p>	<p>N = 82 (2018)</p>	<p>Change to SG structure</p>	<p>ANCC</p>	<p>Nurses' perceptions regarding</p>	<p>Relevant to the PICO question (Intervention, outcome)</p>

<p>improve ambulatory care nurse perceptions of practice autonomy. <i>AAACN Viewpoint</i>, 44(3), 4–8. https://prx-usa.lirn.net/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=157469752&site=eds-live</p>	<p>test, post-test study Level II Quality Grade: High</p>	<p>N = 81 (2020)</p>	<p>Measured after six months with the PES-NWI, used only subscale Nurse Participation in Hospital Affairs</p>	<p>Shared decision-making Kanter's structural empowerment</p>	<p>improved autonomy (organizational support of nursing practice and nurses' ability to deliver quality care) after implementation of SG.</p>	<p>Nurse Participation in Hospital Affairs: Autonomy Domaine improved, statistically significant ($p=0.028$, SD 0.20); question on involvement with statistically significant change ($p = 0.036$, SD 0.30) Executive leadership support, trust-building required</p>
<p>Speroni, K. G., Budhathoki, C., Walters, C., Dutton, S., Mackay, P., & Oguariri, R. M. (2022). Survey research: Do all RN types have the same perceptions regarding professional nursing governance? <i>The Journal of Nursing Administration</i>, 52(5), 258–265. https://doi.org/10.1097/NNA.0000000000001145</p>	<p>Secondary analysis of subset of a cross-sectional survey Level II Quality Grade: High</p>	<p>N = 502 RNs</p>	<p>Professional Governance Scale (no published studies) Measured with IPNG tool and DIS</p>	<p>Kanter's theory of structural empowerment</p>	<p>Compare differences in mean IPNG governance scores by RN type and compare differences by RN type for unit-based nurse-related outcomes</p>	<p>Relevant to the PICO question (Population, outcome) No statistically significant differences in overall IPNG scores or the six subscale scores Recommend similar strategies for different nurse subgroups</p>
<p>Dechairo-Marino, A. E., Collins Raggi, M. E., Mendelson, S. G., Highfield, M. E. F., & Hess, R. G. (2018). Enhancing and advancing shared governance through a targeted decision-making redesign. <i>JONA: The Journal of Nursing Administration</i>, 48(9), 445–451.</p>	<p>Quasi-experimental Study Level II Quality Grade: High/Good</p>	<p>N= 240 nurses (pre-intervention) N=222 (post-intervention)</p>	<p>Redesign of shared decision-making based on pre-intervention scores Post-intervention data collected within one year Measured with IPNG tool, validity and reliability are well established, α .94 or higher, midrange scores (173-344) indicate SG level</p>	<p>Shared decision-making model: ANCC</p>	<p>Level of SG. (1) Customized redesign will improve SG. (2) Personal and work-related characteristics will affect SG.</p>	<p>Relevant to the PICO question (intervention) Scores moved from the traditional to SG level Reinforce the relationship between SG and satisfaction with professional practice</p>

<p>https://doi.org/10.1097/NNA.0000000000000647</p>						
<p>Di Fiore, T., Zito, A., Berardinelli, A., Bena, J. F., Morrison, S. L., Keck, D. E., Kennedy, K., Stibich, A., & Albert, N. M. (2018). Staff perceptions of decision-making in a shared governance culture. <i>JONA: The Journal of Nursing Administration, 48</i>(11), 561–566. https://doi.org/10.1097/NNA.0000000000000680</p>	<p>Prospective, 2-group comparative design Level II Quality Grade: High</p>	<p>N = 303 nurses, n= 106 (2012) n= 197 (2015)</p>	<p>Implementation of council SG model Measured with IPNG tool, strong internal consistency reliability, Cronbach α .94 or higher, validity supported</p>	<p>Shared decision-making model</p>	<p>Effect of SG on decision-making perceptions of clinical nurses after three years: (1) Perceptions of involvement in hospital and clinical decision-making (2) Differences in decision-making after adjusting for nurse characteristics</p>	<p>Relevant to the PICO question (outcome) The overall score ($p=.017$) and 3 of 6 domain scores improved: professional control of work, structures for decisions, and access to information (p-values between .005 and .031) Later comparison (7 years): some sites improved decision involvement variable: sustainment needs foundational structures, leader support and time</p>

Legend:
 N – Number SG – Shared Governance PES-NWI - Practice Environment Scale of the Nursing Week Index
 ANCC - American Nurses Credentialing Center (ANCC®) Magnet® model PICO – Population, intervention, comparison, outcome question
 RN – Registered Nurse IPNG - Index of Professional Nursing Governance DIS - Decisional Involvement Scale
 NSI – Nurse Sensitive Indicator DLA – Distributed Leadership Agency UWES - Utrecht Work Engagement Scale
 MSQ-SF - Minnesota Satisfaction Questionnaire – Short Form (MSQ-SF) TIS-6 – Turnover Intention Scale
 AES – All Employee Survey CFSCPv - Caring Factor Survey Care provider version

Appendix C

Summary of Systematic Reviews

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness Recommendation Implications
Jarden, R. J., Jarden, A., Weiland, T. J., Taylor, G., Bujalka, H., Brockenshire, N., & Gerdtz, M. F. (2021). New graduate nurse well-being, work well-being and mental health: A quantitative systematic review. <i>International Journal of Nursing Studies</i> , 121. https://doi.org/10.1016/j.ijnurstu.2021.103997	Systematic review of quantitative research Level II Quality Grade: Low	Determine published prevalence, predictors, barriers, and enablers of new graduate registered nurse well-being, work well-being, and mental health	Initial limited search (CINAHL, Medline) for potentially relevant articles, systematic identification, screening and appraisal, snowball search of references	Inclusion: Sample (new nurses), phenomena of interest (barriers, predictors, enablers), broad unspecified context, study design (2009-2019, English), databases (CINAHL, EMBASE, Medline, PsycINFO), study selection Exclusion: Population not identifiable, participants not in first year of practice	Review-specific fields: Populations, study methods (survey instruments, analytic data methods), interventions, outcomes (prevalence, predictors, barriers, enablers). Two reviewers, by consensus. Psychometric instruments to organize, and analytical methods from each study	Suboptimal quality standards for research or study design Prevalence: well-being, resilience, optimism, hope Work well-being: increased job satisfaction after one year Work ill-being: burnout, emotional exhaustion, stress; decreased over time	Relevance to PICO (Population, outcome) Work engagement positive predictor of intent to stay. Stress as a positive predictor to leave A gap in robust evidence of effective interventions Include predictors in SG intervention
Kyytsönen M, Tomietto M, Huhtakangas M, Kanste, O. (2020). Research on	Scoping review Level V	Identify common indicators of hospital-based SG	Scoping review: existing literature, & methodological frameworks (Levac et al., 2010; Arksey &	Inclusion: original research articles (English, Finnish, Swedish) only articles that	Categories: authors, year of publication, country, study design,	Similar study designs, most widely used survey instrument IPNG	Relevance to PICO question (intervention) Few of the studied organizations' IPNG

Citation	Quality Grade	Question	Search Strategy	Inclusion/Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness Recommendation Implications
hospital-based shared governance: A scoping review. <i>International Journal of Health Governance</i> , 25(4), 371–386. https://doi.org/10.1108/IJHG-04-2020-0032	Quality Grade: Good	and its core elements, as well as gaps in the literature	O'Malley, 2005) "PRISMA Extension for Scoping Reviews" checklist. Three-step search strategy (initial search, database search, and snowball screening of the initially selected articles Medline (Ovid) (100), CINAHL (EBSCO) (348), Medic (a Finnish database) (0), ABI/INFORM Collection (ProQuest) (360), and SveMed+ (a Swedish database)	described the SG model; 05/1998 – 02/2019, Exclusion: Articles for which the full text was unavailable	participants, response rate, aims, methods used (instruments, statistical methods, and analytical methods), models, and key findings Thematic analysis (two researchers)	five council themes (education and research, professional growth and development, safety and quality, professional practice coordination and leadership) and	scores were in the SG range Six core elements of SG: professionalism, shared decision-making, EBP, CQI, collaboration, and empowerment Created framework based on findings to guide and strengthen implementation of SG.

Legend:

CINAHL, EBSCO, Medline (Ovid), EMBASE, Medline, PsycINFO – literature databases

SG – Shared Governance, EBP – Evidence-Based Practice, CQI – Continuous Quality Improvement

PICO – Population, intervention, comparison, outcome question

Appendix D

Summary of the Strength of the Body of Evidence for Recommendation for Practice

	Work Perception	Grade	Engagement	Grade	Turnover Intent	Grade	Patient Outcomes	Grade
Level I	Experimental Studies							
Level II	Dechairo Marino, 2018	A/B	Olender et al., 2020	B	Jordan et al., 2022	C	Speroni et al., 2022	A
Quasi-Experimental Studies	Di Fiore et al., 2018	A						
	Speroni et al., 2022	A						
	Hasselblad & Loan, 2022	A						
	Olender et al., 2020	B						
Level III	Weaver et al., 2018	B	Sohal, 2020	B	Quek et al., 2021	A	Sohal, 2020	B
Non-experimental studies, qualitative studies	Sohal, 2020	B	Quek et al., 2021	A				
	Quek et al., 2021	A						
Level IV	Clinical practice guidelines or consensus panels							
Level V	Literature reviews, QI, case reports, expert opinion	B	Kyytsönen et al., 2021					

Note. Levels of Evidence from Dang, D., & Dearholt, S. (2017). Evidence synthesis and recommendation tool. In Johns Hopkins, *Nursing evidence-based practice: Model and guidelines* (3rd ed.). Copyright© 2019 by Sigma Theta Tau International.

	NUR7801								NUR7802								NUR7803								
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	
revision of bylaws, and annual meeting agenda with TIP-C team																									
Review of statistics results																x									
Complete evaluation and analysis of results																	x	x	x						
Develop the dissemination plan, and disseminate results internally and externally																	x	x	x	x	x	x	x	x	x

Legend:

SG – Shared Governance, TIP – Transition-into-practice, TIP-C – Transition-into-practice Council

IEB – Institutional Review Board, CNO – Chief Nursing Officer