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EVALUATING SHARED GOVERNANCE AND NURSING PRACTICE ENVIRONMENT IN AN INTERNATIONALLY ACCREDITED HOSPITAL IN METRO MANILA, PHILIPPINES

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Abstract: - In a hospital in Metro Manila, the Philippines, that has received international accreditation, staff nurses' opinions of shared governance and their practice environment are assessed quantitatively in this study. It evaluated various staff nurses' self-assessment of shared governance along six dimensions: ability, access to information, official authority, controls, influences, and involvement in committees. It collected this data through a structured survey. The results showed that they had moderate to high self-ratings, especially in the areas of ability and information access, indicating that they felt competent and empowered. The study also looked at the practice environment in five domains: collegial nurse-physician relations, staffing and resource sufficiency, leadership and support of nurses, nursing foundations for excellent treatment, nurse manager ability, and nurse participation in hospital affairs. The findings showed that while staffing and resource adequacy earned the lowest ratings, indicating areas in need of improvement, high satisfaction was found with nurse manager leadership and support, as well as collegial interactions with physicians. Overall, the results highlight the significance of ongoing assessment and deliberate improvements to promote a supportive and productive clinical setting and offer important insights into the efficacy of shared governance structures and the caliber of the nursing practice environment.

Key-Words: **- International accreditations, shared governance, nursing practice environment, nurses' self-assessment, and collegial interactions.**

1 Introduction

Nurses play a critical role in the front-line patient care in today's complicated healthcare system, helping to improve patient outcomes and quality of treatment. The issue of nursing shortages across the country, coupled with a shrinking workforce and an increase in patient acuities, has brought attention back to the standard of care that nurses deliver in response to rising patient expectations. Along with these difficulties, nurses must deal with more rules that increase their workload, decrease their time spent at the patient's bedside, and worsen their job discontent. These new problems provide professional nurses more duty and accountability, but they do not give them more power or authority to make the necessary adjustments that will have an impact on nursing practice. Because the license of the nurse providing care for the patient ultimately bears the burden of responsibility and accountability, nurses experience frustration and dissatisfaction with their professional practice. In pursuit of more fulfilling careers and better work environments, nurses quit their positions.

Implementing a shared governance culture in hospitals will not only enhance decentralization, but also ensure that organizational structure and professional practice align effectively. This will guarantee that bedside nurses have a say in decisions that directly impact their practice. Furthermore,

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it will enable nurses to actively collaborate with administration in making decisions that influence their practice.

Implementing a shared governance framework has been shown to enhance care delivery quality, foster collaborative relationships between medical professionals, enhance overall clinical effectiveness, boost staff confidence, help them grow their professional and personal skills, raise their profile, which improves communication, facilitate the acquisition of new knowledge and skills, elevate professionalism and accountability, increase direction and focus, and decrease duplication of effort.

The country's problems with a shortage of nurses, lower staffing, and higher patient acuities have all added to nurses' workloads and discontent at work. The atmosphere in which they practice professionally has left nurses feeling dissatisfied. Nurses who lack the decision-making ability to make decisions that impact their nursing practice and the care they deliver to their patients often leave their workplace in pursuit of more fulfilling careers. Companies are coming up with more inventive ways to maintain nurses in their workforces and enhance the work atmosphere.

Healthcare administrators understand that employees who are dedicated to the organization and given the freedom to conduct their job without limitations will provide the highest quality of care. These results have been attained by successful leaders by putting shared governance into practice. The infrastructure and procedures needed for nurses to take charge of their professional practice as well as accept ownership and accountability for the care they give their patients have been outlined under shared governance models. Through shared governance, nurses are involved in decision-making and are more involved in the functioning of their profession. It is because of their involvement that nurses are empowered, self-assured, and able to take initiative and alter nursing practice.

Leaders in the healthcare industry have put management techniques like shared governance models into practice. These approaches concentrate on offering a fulfilling workplace that gives workers autonomy over nursing practice decisions. The happiness of nurses, which is regarded as a crucial result of shared governance and is frequently measured in nursing literature, has a significant impact on numerous facets of nursing. The extent of nursing staff participation is a significant factor in their level of satisfaction with shared governance. Add to it a positive work atmosphere, knowledge and resource accessibility, sufficient staffing to satisfy patient needs, and participation in all levels of decision-making. An inability to manage workload may cause nurses to miss work, become frustrated, produce less, have low morale, and compromise patient care. Although traditional units have higher retention rates than shared units, nurses working on shared governance units report higher job satisfaction with their work, a more positive or constructive atmosphere, and greater happiness with their professional status and administration.

Shared governance, as commonly described in literature, refers to a framework that fosters a culture of empowerment, independence, and decision-making among employees who are directly involved in carrying out the task. Shared governance refers to the delegation of authority, control, and power to frontline professionals like nurses, allowing them to have greater influence over their clinical practice. The Magnet Hospital certification, awarded by the American Nurses Credentialing Center (ANCC), recognizes exceptional nursing service delivery, strong organizational support for professional nursing practice, and the promotion of nursing best practices. The key attributes of nurse practice in Magnet hospitals include the ability to establish and maintain therapeutic relationships with

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patients, the ability to exercise autonomy and control in their practice, the presence of collaborative partnerships between nurses and physicians at the unit level, and the presence of visible and responsive nurse administration.

The literature frequently discusses how professional control and autonomy contribute to job satisfaction. Studies on the influence of work environment on nurse job satisfaction show that staff nurses find professional prestige, favorable contacts with physicians, autonomy, and strong manager and peer support to be very gratifying. Shared governance gives nurses more control over their practice, which is strongly associated with work satisfaction.

Research contrasting Magnet and non-Magnet hospitals reveals that Magnet hospitals have excellent rates of nurse retention and support job satisfaction for nurses. Hospitals may, however, have difficulties in reorganizing their organizational procedures in order to achieve Magnet status. Reorganizing an organization can be stressful, and it may be linked to changes in work satisfaction, especially if nurses are expected to become more self-governing.

Implementing decentralization will enhance organizational structure and professional practice, ensuring that bedside nurses have a say in decisions related to their work. Moreover, fostering a shared governance culture in hospitals will empower nurses to actively contribute to administrative decisions that affect their practice.

The implementation of a shared governance framework has been shown to enhance the quality of care provided, foster collaborative relationships amongst healthcare professionals, improve clinical effectiveness overall, boost staff confidence, help them grow their professional and personal skill sets, raise their profile in the community, facilitate the acquisition of new knowledge and skills, foster professionalism and accountability, increase direction and focus, and decrease duplication of effort.

Studies on nursing practice environments and shared governance in hospitals have demonstrated important effects on patient outcomes, job satisfaction, and staff engagement. Through participation in decision-making processes, shared governance increases the professional autonomy and empowerment of nurses. Professionalism, shared decision-making, evidence-based practice, continuous quality improvement, collaboration, and empowerment are identified as essential components of shared governance in a scoping review by Kyytsönen [10]. These components are critical for successful implementation in hospital settings (Emerald Insight).

Empirical research demonstrates the beneficial correlation between enhanced work environments for nurses and shared governance. For example, a study by Winslow [15] discovered that putting shared governance mechanisms in place enhanced patient outcomes and staff engagement. A sense of accountability and ownership was promoted by nurses' increased participation in data evaluation and action plan creation [6]. Kanste [9] conducted study in Finnish hospitals and utilized structural equation modeling to establish a connection between organizational qualities and nurses' job satisfaction and professional autonomy. This finding highlights the significance of supportive governance models [9].

Furthermore, there are several ways that shared governance models be implemented: from unit-based systems to administrative and congressional structures. These differences improve the applicability of governance structures to various hospital environments and provide flexibility in meeting particular organizational demands [6]. Successful shared governance, according to Alvarado

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[1], can increase nurses' job satisfaction and retention, which will enhance the working environment and standard of patient care overall.

It has also been emphasized how resilient shared governance is in times of crisis, as the COVID-19 pandemic. A pediatric hospital's use of shared governance to preserve staff involvement and adjust to quickly changing circumstances was examined by Walden, Eddy, and Huett [14]. This flexibility highlights how strong shared governance systems are in assisting nursing practice in trying situations [9].

Studies like those by Relf [13] and Peterson and Allen [12] provide more proof for the long-term advantages of shared governance. These studies demonstrate improved treatment quality over time, as well as consistent gains in nurse empowerment and retention (OJIN-Nursing; Emerald Insight). Additionally, shared governance and professional development opportunities are linked by Brooks and Olsen [3] to increased job satisfaction among nurses [6].

The idea that shared governance in nursing practice environments promotes a more engaged, content, and productive nursing workforce is generally supported by the literature. The diverse range of shared governance models and methods offers significant insights for hospitals globally, particularly Metro Manila hospitals in the Philippines that seek to improve their nursing practice settings by utilizing these frameworks.

Bernreuter's (2022) research centers on the councilor models of shared governance and assesses how well they work to coordinate administrative and therapeutic tasks. This study emphasizes the various ways in which shared governance structures can be modified to satisfy particular organizational requirements and the effects that these modifications have on general hospital operations and nursing practice settings (OJIN-Nursing).

Burnhope and Edmonstone [4] talk about doable methods for putting shared governance in place and assessing it in the nursing field. In order to make sure that shared governance models are successfully raising nurse autonomy and work satisfaction, their study highlights the significance of precise rules and ongoing evaluation. The study emphasizes the necessity of strong assessment frameworks to gauge the accomplishments and difficulties of shared governance programs [6].

Evan, McGillis Hall, and Godfrey [5] investigate how shared governance affects patient care quality and nursing work conditions. Their research offers empirical proof that shared governance can significantly enhance patient outcomes and nurse satisfaction, indicating that effective governance models can foster a more favorable and productive healthcare environment [6].

Ireson and McGillis Hall [7] carry out a long-term investigation of how shared governance affects the empowerment of nurses. This study examines the long-term effects of shared governance arrangements and demonstrates steady increases in nurse empowerment, which raises job satisfaction and lowers attrition rates. When properly maintained and sustained over time, shared governance can have long-lasting benefits, as this study demonstrates.

Jones and Ortiz [8] synthesize data from diverse healthcare contexts to conduct a thorough review of shared governance models. The review elucidates the various applications of shared governance and its results, exposing shared advantages like heightened cooperation, career advancement, and contentment in the workplace for nurses. This thorough analysis provides a broad overview of the efficacy of several shared governance strategies used in the healthcare sector [6].

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The objective of Mäntynen and Vehviläinen-Julkunen's [11] study is the professional governance of Magnet hospitals in Finland. The impact of professional governance systems on nurse practice environments and overall job satisfaction is examined in their study. The research offers a high quality benchmark by examining Magnet hospitals, demonstrating the correlation between robust governance structures and improved organizational performance as well as nursing outcomes [6].

When taken as a whole, these studies provide a thorough picture of shared governance's function and effects in nursing. Together, they show that even though shared governance models can differ greatly in terms of structure and execution, their fundamental tenets of encouraging nurse autonomy, teamwork, and professional growth always produce favorable results in terms of nurse satisfaction and the standard of patient care.

2 Problem Formulation

The study assessed the state of Shared Governance and the Nursing Practice Environment in an Internationally Accredited Hospital in Metro Manila Philippines. This study addressed the following questions:

1. What is the self-assessment of staff nurses respondents on the state of shared governance in terms of the following:
    a. Controls
    b. Influences
    c. Official authority
    d. Participates to committees
    e. Access to information
    f. Ability
2. What is the assessment of the staff nurses respondents in their practice environment in terms of:
    a. Nurse Participation in Hospital Affairs
    b. Nursing Foundations for Quality Care
    c. Nurse Manager Ability, Leadership and Support of Nurses
    d. Staffing and Resource Adequacy
    e. Collegial Nurse-Physician Relations

2.1 Materials and Methods

This study employed a descriptive quantitative approach to analyze the amount of shared governance and the nursing practice environment in a hospital located in Metro Manila, Philippines, which has obtained international accreditation. Quantitative research allows for the testing of objective theories by analyzing the relationship between variables. In an experiment, a variable refers to a factor that can be intentionally changed or manipulated. Quantitative language pertains to numerical values or measurable quantities. Statistical evidence refers to quantitative or numerically collected data obtained during the investigation.

The main objective of descriptive research is to provide an accurate portrayal of the characteristics of individuals, situations, or groups, as well as the frequency of specific events, by using statistical methods to analyze and synthesize the data. The data of the target, along with the examination of the hospital's policies, procedures, and system operations.

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The researcher utilized two internationally recognized and standardized assessments for this study after conducting a comprehensive assessment of the literature on several instruments related to shared governance and the work environment for nurses. Prior to utilizing the questionnaires, the researcher sought authorization and fully familiarized themselves with the equipment.

The initial set of instruments employed to assess the efficacy of shared governance in SLMC was the Index of Professional Nursing Governance Survey Tool. The Index of Professional Nursing Governance (IPNG), consisting of 86 items, was developed to assess the level of professional nursing governance among hospital-based nurses. The survey comprises a total of 86 items. The subscales of CONTROL, INFLUENCES, OFFICIAL AUTHORITY, PARTICIPATES, and 28–49 are categorized together based on questions 1–13, 14–27, and 28–49, respectively. Questions 75–86 pertain to ABILITY, while questions 60–74 relate to ACCESS TO INFORMATION.

Robert Hess developed the IPNG survey tool with a specific focus on registered nurses (RNs). The IPNG measures professional governance on a spectrum that encompasses traditional, shared, and self-governance. The instrument's scales employed in the study exhibit a high level of reliability, as indicated by the internal consistency reliability coefficients, Cronbach's α, which range from 0.90 to 0.98. A total of 1,162 registered nurses from eleven hospitals took part in assessments to evaluate the psychometric properties. Popham's average congruency technique resulted in a content validity of .95 after item manufacturing. The test-retest reliability was determined to be 0.92, indicating a high level of consistency. Additionally, all subscales demonstrated strong internal consistency, with alpha values ranging from 0.87 to 0.91. Testing for construct validity demonstrated a significant disparity in scores between institutions that employ normal hospital governance and those that implement shared governance. Both the total score and each of the six subscale scores have demonstrated excellent reliability, with Cronbach's alpha coefficients of 0.94 and above. The constancy of the scores across different age groups, levels of educational attainment, and levels of experience demonstrated the construct validity.

The second tool employed was the Practice Environment Scale of the Nursing Work Index (PES-NWI). It was utilized to measure the levels of satisfaction among nurses. The PES-NWI consists of five subscales that were derived by analyzing the 31 components of the NWI using data collected from 16 Magnet hospitals between 1985 and 1986. The following questions pertain to different aspects of nursing and hospital affairs: Nurse Participation in Hospital Affairs (questions 5, 6, 11, 15, 17, 21, 23, 27, 28); Nursing Foundations for Quality of Care (questions 4, 14, 18,19, 22,25, 26, 29, 30, 31); Nurse Manager Ability, Leadership and Support of Nurses (questions 3, 7, 10, 13, 20); Staffing and Resource Adequacy (questions 1, 8. 9, 12) ; and Collegial Nurse-Physician Relations (questions 2, 16, 24). Lake states that there are two subscales, Nurse Participation in Hospital Affairs and Nursing Foundations for Quality of Care, which focus on facility-level phenomena. In addition, there are three subscales, Nurse Manager Ability, Leadership and Support; Staffing and Resource Adequacy; and Collegial Nurse-Physician Relations, which address unit-level phenomena.

The PES-NWI instrument is commonly utilized in international nursing research to assess the nurse practice environment (Lake 2002). However, the NWI has been widely utilized in European countries such as Belgium, Finland, Iceland, and Ireland. The reliability of the 30 items of the PES-NWI was evaluated using Cronbach's alpha, and factor analysis was conducted using principal

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component analysis. The PES-NWI had high reliability, as evidenced by its internal consistency with a Cronbach's alpha value of 0.948 for the entire scale. Out of the 32 publications that underwent examination, 17 of them, which were published from 2010 to 2012, focused on the topics of validity and dependability. Thirteen research utilized Cronbach's alpha as a measure of reliability. The values obtained varied from 0.71 to 0.96, with the exception of one study which had a coefficient of 0.67, and another study with a coefficient of 0.53, which was based on a tiny sample size. The studies analyzed the nurse as the unit of analysis, with sample sizes ranging from 46 to 98,116 nurses.

Before collecting data for the study, the researchers obtained the participants' informed consent and ethics committee approval. They also obtained permits from the Chief Nursing Officer of the tertiary hospital by submitting a formal letter of request. The nursing leadership has granted approval for the letter.

3 Problem Solution

Problem 1. What is the self-assessment of staff nurses respondents on the state of shared governance?

a. Controls

Table 1 displays a summary of values that indicate the average and verbal interpretation of the self-assessed involvement in Shared Governance among staff nurse respondents, specifically in terms of Control.

The chart shows that the average score of the staff nurse respondents' assessment of their involvement in shared governance, specifically in terms of controls, spans from 1.00 to 3.02. The overall mean score is 2.49, which can be interpreted as mostly influenced by nursing management/administration with some input from staff nurses. The topic of "Selecting products used in nursing care" had the highest average score of 3.02, indicating that both staff nurses and nursing management/administration equally share the responsibility for this task. Out of the total of 13 categories, three of them, namely "Conducting disciplinary action of nursing personnel", "Promoting RNs and other nursing staff", and "Appointing nursing personnel to management and leadership positions", scored between 1.03 and 1.05. The reason for this is that these three elements constitute the primary duties of a manager, and they are not assigned to staff nurses as they fall under the purview of managerial functions. The majority, or 9 out of 13 items, scored between 2.51 and 3.50. This score range is understood as Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A).

Table 1

Staff Nurse Respondents' Assessment on Their Involvement in Shared Governance in Terms of Controls.

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CONTROLS	Mean	Interpretation
Determining what activities nurses can do at the bedside	2.97	ESSNNM/A
Developing and evaluating patient care standards and quality assurance/improvement activities	2.97	ESSNNM/A
Setting levels of qualifications for nursing positions.	3.01	ESSNNM/A
Evaluating (performance appraisals) nursing personnel.	2.97	ESSNNM/A
Determining activities of ancillary nursing personnel (aides, unit clerks, etc.)	2.97	ESSNNM/A
Conducting disciplinary action of nursing personnel	1.00	NM/A
Assessing and providing for the professional/educational development of the nursing staff.	2.97	ESSNNM/A
Making hiring decisions about RNs and their nursing staff.	2.47	PNM/ASNI
Promoting RNs and other nursing staff.	1.03	NM/A
Appointing nursing personnel to management and leadership positions	1.05	NM/A
Selecting products used in nursing care.	3.02	ESSNNM/A
Incorporating research ideas into nursing care.	2.97	ESSNNM/A
Determining methods of nursing care delivery (e.g. Primary, team, case management)	2.97	ESSNNM/A
Composite Mean	**2.49**	**PNM/ASNI**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNM/AI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

This suggests that inside the organization, both clinical nurses and managers have an equitable chance to participate in the decision-making process for product selection. This is apparent due to the presence of the Product Evaluation Committee within the company, of which staff nurses are members and have the ability to exert influence on the procurement of items, equipment, and tools that are relevant to their role as bedside nurses. In addition, nurses within the organization have the ability to exert influence over the establishment of criteria for nursing employment. They are free to determine a specific set of skills and competences that are suitable for the nursing positions offered at the unit level. Staff nurses lack authority in tasks such as enforcing disciplinary actions, advancing nurses' careers, and selecting nurse leaders. These obligations and functions are primarily assigned to nurse managers, without input from staff nurses.

b. Influences

Table 2 displays a concise overview of the average values and verbal explanation about the self-assessed participation in Shared Governance among staff nurse participants, specifically in relation to Influences.

According to the table, the average score of the staff nurse respondents' assessment of their involvement in shared governance, in terms of influences, ranges from 1.00 to 2.98. The overall mean score is 2.13, which falls within the range of 1.51 to 2.50. This score can be interpreted as primarily nursing management/administration with some input from staff nurses. The highest scoring item, number 4, was "Monitoring and procuring supplies for nursing care and support functions." It had a mean score of 2.98 and was interpreted as being equally shared by staff nurses and nursing management/administration (ESSNNM/A). Out of the total of 14 items, three received a score of 1.00. These three items, which pertain specifically to Nursing Management/Administration (NM/A), are "Formulating annual unit budgets for personnel, supplies, equipment, and education," "Creating new clinical positions," and "Creating new administrative or support positions." Out of the total of 14 items, 7 items received a score ranging from 2.51 to 3.50. This score range is understood as being equally shared by staff nurses and nursing management/administration, abbreviated as ESSNNM/A.

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Table 2

Staff Nurse Respondents' Assessment on Their Involvement in Shared Governance in Terms of Influences.

INFLUENCES	Mean	Interpretation
Determining how many and what level of nursing staff is needed for routing patient care.	2.97	ESSNNM/A
Adjusting staffing levels to meet fluctuations in patient census and acuity.	2.97	ESSNNM/A
Making daily patient care assignments for nursing personnel.	2.97	ESSNNM/A
Monitoring and procuring supplies for nursing care and support functions.	2.98	ESSNNM/A
Regulating the flow of patient admissions, transfers, and discharges.	2.07	PNM/ASNI
Formulating annual unit budgets for personnel, supplies, equipment and education.	1.00	NM/A
Recommending nursing salaries, raises and benefits.	1.25	NM/A
Consulting nursing services outside of the unit (e.g. administration, psychiatric, medical-surgical).	1.31	NM/A
Consulting hospital services outside of nursing, (e.g. dietary, social service, pharmacy, human resources, finance)	1.31	NM/A
Making recommendations concerning other departments' resources.	2.97	ESSNNM/A
Determining cost effective measures such as patient placement and referrals (e.g. placement of ventilator-dependent patients, early discharge of patients to home health care).	2.97	ESSNNM/A
Recommending new hospital services or specialties (e.g. gerontology, mental health, birthing centers)	2.97	ESSNNM/A
Creating new clinical positions.	1.00	NM/A
Creating new administrative or support positions.	1.00	NM/A
Composite Mean	**2.13**	**PNM/ASNI**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNM/AI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

This suggests that inside the organization, clinical nurses and managers have an equitable chance to impact and modify staffing levels, allocate patients on a daily basis, oversee operations, provide recommendations, and acquire resources for nursing care. Furthermore, both bedside nurses and supervisors have equitable chances to decide on cost-efficient strategies, such as patient placement and referrals. However, the findings of this subscale indicate that certain obligations and tasks of the manager have not yet been assigned and delegated to staff nurses. These responsibilities, such as making recommendations for nursing pay, raises, and perks within the business, are considered essential functions of a manager.

c. Official Authority

Table 3 displays a concise overview of the average values and verbal interpretation of the self-assessed involvement in Shared Governance of staff nurse respondents, specifically in relation to

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OFFICIAL AUTHORITY	Mean	Interpretation
1. Written policies and procedures that state what nurses can do in direct patient care.	2.57	ESSNNM/A
2. Written patient care standards and quality assurance/ improvement programs.	2.64	ESSNNM/A
3. Mandatory RN credentialing levels (licensure, education, certifications) for hiring continued employment, promotions and raises.	1.85	PNM/ASNI
4. Written process for evaluating nursing personnel (performance appraisal).	2.43	PNM/ASNI
5. Organizational charts that show job titles and who reports to whom.	1.19	NM/A
6. Written process for evaluating nursing personnel (performance appraisal).	1.09	NM/A
7. Organizational charts that show job titles and who reports to whom.	2.97	ESSNNM/A
8. Written guidelines for disciplining nursing personnel.	2.61	ESSNNM/A
9. Annual requirements for continuing in-services	2.52	ESSNNM/A
10. Procedures for hiring and transferring nursing personnel.	2.05	PNM/ASNI
11. Policies regulating promotion of nursing personnel to management and leadership positions.	2.97	ESSNNM/A
12. Procedures for generating schedules for RNs and other nursing staff.	2.95	ESSNNM/A
13. Acuity and patient classification systems for determining how many and what level of nursing staff is needed for routine patient care.	1.00	NM/A
14. Mechanisms for determining staffing levels when there are fluctuations in patient census and acuity.	2.47	PNM/ASNI
15. Procedures for determining daily patient care assignments	2.13	PNM/ASNI
16. Daily methods for monitoring and obtaining supplies for nursing care and support functions.	2.13	PNM/ASNI
17. Procedures for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.	1.32	NM/A
18. Procedures for adjusting nursing salaries, raises, and benefits	1.39	NM/A
19. Formal mechanisms for consulting and enlisting the support of hospital service outside of nursing (e.g.dietary, social service, pharmacy, physical therapy)	1.40	NM/A
20. Procedure for restricting or limiting patient care (e.g. closing hospital beds, going on ER bypass)	1.24	NM/A
21. Location of and access to office space.	3.01	ESSNNM/A
22. Access to office equipment (e.g. phones, personal computers, copy machines)	2.98	ESSNNM/A
Composite Mean	**2.13**	**PNM/ASNI**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNM/AI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

Official Authority.

The table indicates that the average score of the staff nurse respondents' Assessment on their Involvement in Shared Governance in Terms of Official Authority is 2.13, which falls within the range of 1.51 to 2.50. This range suggests that the involvement is primarily driven by nursing management/administration, with some input from staff nurses. Item number 21, titled "Location of and access to office space," has the highest mean score of 3.01. This score corresponds to the verbal interpretation of Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A), which suggests that both nurses and managers in the organization have an equal opportunity to access their work areas. The article titled "Acuity and patient classification systems for determining staffing needs in routine patient care" received a score of 1.00, indicating the lowest score. The verbal interpretation for this score is limited to Nursing Management/Administration only (NM/A). Out of the total of 22 items, 9 received a score between 2.51 and 3.50. This score range is understood as being equally shared by staff nurses and nursing management/administration (ESSNNM/A). Out of the total of 22 items, 7 of them obtained an average score ranging from 1.00 to 1.50. These scores are specifically related to the field of Nursing Management/Administration (NM/A). Out of the total of 22 items, 6 scored between 1.51 and 2.50. These scores indicate that these items primarily involve nursing management/administration with some input from staff nurses. This suggests that these 3 items are the responsibility of the management and are not delegated to staff nurses, as they are tasks performed by a manager.

The results indicate that inside the organization, both managers and staff nurses possess equal formal power in areas such as written rules, procedures, patient care standards, quality assurance programs, and the advancement of nursing people to management and leadership roles. This is because

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direct care nurses actively participate in hospital-wide committees and councils, such as the Hospital-Wide Policy Initiative Council (HPIC), which addresses complex issues related to these matters. Nevertheless, it is necessary to enhance the official authority's ability to accurately assess and classify patients, in order to determine the appropriate number and level of nursing staff required for regular patient care. Additionally, there should be established protocols for evaluating nursing personnel, recommending and creating annual unit budgets, as well as adjusting nursing salaries, raises, and benefits. In order to create shared governance on these matters, it is necessary to enhance the formal mechanisms for consulting and obtaining the support of hospital services outside nursing. Additionally, procedures for restricting or limiting patient care should be strengthened.

d. Participates to Committees

Table 4 displays a concise overview of the average values and verbal interpretation on the self-assessed engagement of staff nurse respondents in Shared Governance, specifically in terms of their participation in committees.

Table 4

Staff Nurse Respondents' Assessment on Their Involvement in Shared Governance in Terms of Participates to Committees.

PARTICIPATES TO COMMITTEES	Mean	Interpretation
1. Participation in unit committees for clinical practice.	3.00	ESSNNM/A
2. Participation in unit committees for administrative matters such as staffing, scheduling and budgeting.	3.02	ESSNNM/A
3. Participation in nursing departmental committees for clinical practice.	3.05	ESSNNM/A
4. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting.	3.05	ESSNNM/A
5. Participation in multidisciplinary professional committees (physicians, other hospital professions and departments) for collaborative practice.	2.63	ESSNNM/A
6. Participation in hospital administration committees for matters such as employees benefits and strategic planning.	2.69	ESSNNM/A
7. Forming new unit committees.	2.97	ESSNNM/A
8. Forming new nursing departmental committees.	1.12	NM/A
9. Forming new multidisciplinary professional committees.	1.13	NM/A
10. Forming new hospital administration committees.	1.16	NM/A
Composite Mean	**2.38**	**PNM/ASNI**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNM/AI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

The table indicates that the average score of the staff nurse respondents' assessment of their involvement in shared governance, specifically in terms of participating in committees, is 2.38. This score is within the range of 1.51 to 2.50, which suggests that there is mostly nursing management/administration involvement with some input from staff nurses. The items numbered 3 and 4, which refer to "Participation in nursing departmental committees for clinical practice" and "Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting," received the highest average score of 3.05. This score indicates that both staff nurses and nursing management/administration equally value these activities. The item labeled as number 8, specifically "Forming new nursing departmental committees," had the lowest score of 1.12 on average, with a verbal interpretation limited to Nursing Management/Administration (NM/A).

Seven out of ten items received a score ranging from 2.51 to 3.50, indicating that they are considered Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A). These items pertain to the involvement of staff nurses in various committees, including those related to

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clinical practice, administrative matters such as staffing and budgeting, nursing departmental committees, multidisciplinary professional committees, hospital administration committees, and the formation of new unit committees. Out of a total of 10 items, 3 scored an average between 1.00 and 1.50. These items specifically pertain to Nursing Management/Administration (NM/A) and involve activities such as creating new nursing departmental committees, forming new multidisciplinary professional committees, and establishing new hospital administration committees.

This demonstrates that inside the organization, nurses and management actively engage in unit, departmental, and hospital-wide committees for clinical practice and the establishment of new unit committees. Clinical nurses and managers collaborate and engage in administrative tasks like as staffing, scheduling, and budgeting. In addition, nurses have actively participated in several interdisciplinary professional committees, which include physicians, other hospital professions, and departments, to promote collaborative practice. In addition, direct care nurses actively participate in the union, which addresses employee benefits and strategic planning. Nevertheless, it is imperative to enhance the engagement of staff nurses in establishing novel nursing departmental committees, multidisciplinary professional committees, and hospital administration committees.

e. Access to Information

Table 5 displays a concise overview of the average values and verbal interpretation on the self-assessed engagement in Shared Governance among staff nurse participants, specifically in relation to their participation in accessing information.

The table shows that the average score of the staff nurse respondents' assessment of their involvement in shared governance, specifically in terms of access to information, is 2.43. This score is within the range of 1.51 to 2.50, indicating a primarily nursing management/administration approach with some input from staff nurses. Item 15, which pertains to accessing materials on recent advancements in nursing practice such as journals and books in the library, received the highest average score of 3.11. This score was interpreted as being equally valued by both staff nurses and nursing management/administration.

Table 5

Staff Nurse Respondents' Assessment on Their Involvement in Shared Governance in Terms of Access to Information.

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ACCESS TO INFORMATION	Mean	Interpretation
The quality of hospital nursing practice.	3.00	ESSNNM/A
Compliance of hospital nursing practice with requirements of surveying agencies (Joint Commission, state and federal government, professional groups).	2.97	ESSNNM/A
Unit's projected budget and actual expenses.	1.00	NM/A
Hospital's financial status.	1.00	NM/A
Unit and nursing departmental goals and objectives for this year.	2.24	PNM/ASNI
Hospital's strategic plan for the next few years.	1.66	PNM/ASNI
Results of patient satisfaction surveys.	2.99	ESSNNM/A
Physician/nurse satisfaction with their collaborative practice.	2.74	ESSNNM/A
Current hospital status of nurse turnover and vacancies.	1.73	PNM/ASNI
Nurses' satisfaction with their general practice.	3.01	ESSNNM/A
Nurses' satisfaction with their salaries and benefits.	2.97	ESSNNM/A
Management's opinion of bedside nursing practice.	2.97	ESSNNM/A
Physicians' opinion of bedside nursing practice.	2.10	PNM/ASNI
Nursing peers' opinion of bedside nursing practice.	2.97	ESSNNM/A
Access to resources concerning recent advances in nursing practice (e.g. journals and books, library).	3.11	ESSNNM/A
Composite Mean	**2.43**	**PNM/ASNI**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNMAI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

The items numbered 3 and 4, which pertain to the "Unit's projected budget and actual expenses" and the "Hospital's financial status," received the lowest score of 1.00. This score was interpreted verbally as being relevant only to Nursing Management/Administration (NM/A).

Nine out of 15 items receive a score ranging from 2.51 to 3.50, indicating that they are considered Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A). These items pertain to the participation of staff nurses in the quality of hospital nursing practice, compliance of hospital nursing practice with requirements of surveying agencies (such as the Joint Commission, state and federal government, and professional groups), results of patient satisfaction surveys, satisfaction of physicians and nurses with their collaborative practice, nurses' satisfaction with their general practice, nurses' satisfaction with their salaries and benefits, management's opinion of bedside nursing practice, nursing peers' opinion of bedside nursing practice, and access to resources related to recent advances in nursing practice (such as journals, books, and the library). Out of a total of 15 items, 4 items received a score ranging from 1.51 to 2.50. These scores indicate that the items are primarily related to Nursing Management/Administration, with some input from Staff Nurses (PNM/ASNI).

This demonstrates that within the organization, hospital administrators and managers maintain transparency by openly communicating and disseminating information to all nursing staff regarding ongoing and forthcoming matters that are being deliberated. It is achieved through a range of methods, including prompt distribution of information memoranda, providing agendas prior to meetings, sharing minutes after meetings, circulating draft documents, engaging in group discussions on matters during department and Center meetings, and utilizing other paper or electronic options. Nevertheless, staff nurses lack direct access to certain resources pertaining to budget and financial reports, such as their unit's expected budget, actual expenses, and the hospital's financial position.

The Shared Governance framework facilitates the acquisition of knowledge by staff nurses regarding the most effective practices, which are discovered through the exchange of information from both internal and external benchmarked data of other organizations, specifically related to nursing sensitive indicators. In addition, Green & Jordan (2004) state that nurse management has the highest

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level of access to information and resources in the activities that govern and support the professional practice environment.

f. Ability

Table 6 displays a summary of values indicating the average and verbal explanation of the self-assessed participation in Shared Governance among staff nurse participants, specifically in terms of Ability.

Table 6

Staff Nurse Respondents' Assessment on Their Involvement in Shared Governance in Terms of Ability.

ABILITY	Mean	Interpretation
1. Negotiate solutions to conflicts among professional nurses.	2.63	ESSNNM/A
2. Negotiate solutions to conflicts between professional nurses and physicians.	2.04	PNM/ASNI
3. Negotiate solutions to conflicts between professional nurses and nursing management.	2.55	ESSNNM/A
4. Negotiate solutions to conflicts between professional nurses and hospital administration.	1.00	NM/A
5. Create a formal grievance procedure.	1.00	NM/A
6. Write the goals and objectives of a nursing unit.	1.00	NM/A
7. Write the goals and objectives of a nursing units.	2.04	PNM/ASNI
8. Write the philosophy, goals and objectives of the nursing department.	1.00	NM/A
9. Formulate the mission, philosophy, goals, and objectives of the hospital.	1.00	NM/A
10. Write unit policies and procedures.	1.00	NM/A
11. Determine nursing departmental policies and procedures.	1.00	NM/A
12. Determine hospital-wide policies and procedures.	1.42	NM/A
Composite Mean	**1.47**	**NM/A**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNM/AI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

The table shows that the average score of the staff nurse respondents' Assessment on their Involvement in Shared Governance in Terms of Ability ranges from 1.00 to 2.63. The overall average score is 1.47, which falls within the range of 1.00 to 1.50. This score is interpreted as Nursing Management/Administration only (NM/A). The first item, titled "Negotiate solutions to conflicts among professional nurses," received the highest mean score of 2.63. The third item, titled "Negotiate solutions to conflicts between professional nurses and nursing management," had an average score of 2.55. The verbal interpretation for both items is "Equally Shared by Staff Nurses and Nursing Management/Administration" (ESSNNM/A). Seven items achieved a mean score of 1.00, namely in the domain of Nursing Management/Administration (NM/A). The following items pertain to: negotiating resolutions for conflicts between professional nurses and hospital administration, establishing a formal process for addressing grievances, composing the goals and objectives for a nursing unit, articulating the philosophy, goals, and objectives of the nursing department, formulating the mission, philosophy, goals, and objectives of the hospital, drafting policies and procedures for a nursing unit, and determining policies and procedures for the nursing department. Out of the total of 12 questions, 2 items received scores ranging from 1.51 to 2.50. These items are "Negotiate solutions to conflicts between professional nurses and physicians" and "Write the goals and objectives of a nursing unit". These items primarily pertain to nursing management and administration, with some input from staff nurses (PNM/ASNI).

Based on the findings, the organization exclusively permits nurses to engage in negotiations for resolving conflicts amongst nurses, as well as conflicts between professional nurses and nursing management. Typically, nurses lack the authority to establish nursing departmental policies and

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procedures, draft unit policies and procedures, develop the mission, philosophy, goals, and objectives of the hospital or their own nursing department. This implies that only managers possess the capacity to develop and compose those goods within the firm. Furthermore, it is exclusively the administrators who has the authority to establish a structured process for addressing complaints and mediating resolutions in cases of disputes between professional nurses and the hospital administration.

g. Summary

Table 7 displays a summary of values that includes the average and verbal interpretation of the self-assessed involvement in Shared Governance among staff nurse respondents.

Table 7

Summary of the Staff Nurse Respondents' Assessment on Their Involvement in Shared Governance.

SHARED GOVERNANCE	Mean	Interpretation
Controls	2.49	PNM/ASNI
Influences	2.13	PNM/ASNI
Official Authority	2.13	PNM/ASNI
Participates to Committees	2.38	PNM/ASNI
Access to Information	2.43	PNM/ASNI
Ability	1.47	NM/A
Over-all Mean	**2.17**	**PNM/ASNI**

Legend: 4.51-5.00 Staff Nurses only (SN); 3.51-4.50 Primarily Staff Nurses with some Nursing Management/Administration Input (PSNNM/AI); 2.51-3.50 Equally Shared by Staff Nurses and Nursing Management/Administration (ESSNNM/A); 1.51-2.50 Primarily Nursing Management/Administration with some Staff Nurse Input (PNM/ASNI); 1.00-1.50 Nursing Management/Administration only (NM/A)

The table indicates that the self-assessed involvement in Shared Governance of staff nurse respondents varies from 1.47 to 2.49, with an average of 2.17. This falls within the range of 1.51 to 2.50 and can be interpreted as primarily involving Nursing Management/Administration with some input from staff nurses. The Controls subscale had the highest mean, scoring 2.49, which indicates a primarily nursing management/administration role with some input from staff nurses (PNM/ASNI). The subscales of Influences, Official Authority, Participates to Committees, and Access to information had average values ranging from 1.51 to 2.50. These results indicate that there is mostly involvement from Nursing Management/Administration with some input from Staff Nurses. The Ability subscale received the lowest mean score of 1.47, indicating that it is specifically related to Nursing Management/Administration (NM/A).

This indicates that although the organization has implemented a shared governance model and structure since 2013, it has not yet reached a minimum level of measurement within the range of shared governance. The poll revealed that nursing management holds the primary authority in decision-making, with limited participation from staff nurses. These findings corroborate the notion that attaining complete implementation of shared governance is a protracted undertaking that can need a minimum of three to five years, or perhaps longer.

The organizations that achieved the most success were the ones that recognized the importance of customizing shared governance structures to align with the organization's requirements and allowed these structures to adapt and develop over time. The determinants linked to success encompassed leadership endorsement, clear definition of roles, and defined protocols for decision-making. The criteria linked to unsuccessful SG models encompassed inadequate support infrastructure, lack of implementation, insufficient resources, and ineffective communication. Ballard outlined several criteria

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for councils to consider when developing unit-based initiatives: (a) alignment with hospital policy, (b) emphasis on patient care, (c) addressing issues related to quality care or the work environment, and (d) ensuring that projects are either budget neutral or have justified financial expenditures. This literature study emphasizes the inescapable finding that there is no universally applicable framework for effectively implementing Shared Governance in businesses. Instead, every business must carefully examine the distinct architecture it requires.

Problem 2. What is the self-assessment of the staff nurses respondents in their practice environment?

a. Nurse Participation in Hospital Affairs

Table 13 displays a summary of values that includes the average and verbal interpretation of the assessment of staff nurse respondents on the Practice Environment in terms of their involvement in hospital affairs.

Table 8

Staff Nurse Respondents' Assessment on Practice Environment in Terms of Nurse Participation in Hospital Affairs.

Nurse Participation in Hospital Affairs	Mean	Qualitative Description
1. Career development/clinical ladder opportunity.	2.71	Agree
2. Opportunity for staff nurses to participate in policy decisions.	2.59	Agree
3. A chief nursing office who is highly visible and accessible to staff.	2.57	Agree
4. A chief nurse officer equal in power and authority to other top-level hospital executives.	2.58	Agree
5. Opportunities for advancement	2.59	Agree
6. Administration that listens and responds to employee concerns.	2.59	Agree
7. Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees).	2.58	Agree
8. Staff nurses have the opportunity to serve on hospital and nursing committees.	2.59	Agree
9. Nursing administrators consult with staff on daily problems and procedures.	2.59	Agree
Composite Mean	**2.60**	**Agree**

Legend: *3.51-4.00 Strongly Agree; 2.51-3.50 Agree; 1.51-2.50 Disagree; 1.00-1.50 Strongly Disagree*

The table above indicates that the average score of the Staff Nurse Respondents' Assessment on Practice Environment, specifically in terms of Nurse Participation in Hospital Affairs, varies between 2.57 and 2.71. The overall average score is 2.60, which falls within the range of 2.51 to 3.50. This range is interpreted as "Agree". The first item, labeled as "Career development/clinical ladder opportunity," received the highest average score of 2.71, indicating agreement. The average of 8 elements ranging from 2.51 to 3.50, with a verbal interpretation of "Agree". These items pertain to the opportunity for staff nurses to engage in policy-making decisions. An easily approachable and prominently visible chief nursing officer for the personnel, A chief nurse officer who possesses equivalent power and authority as other high-ranking hospital administrators, Potential for career progression, An administration that actively listens to and promptly addresses employee issues, Staff nurses participate in the hospital's internal governance, which includes involvement in practice and policy committees. Staff nurses are given the chance to participate in hospital and nursing committees, while nursing administrators seek input from staff regarding everyday issues and protocols.

Direct care nurses at St. Luke's Medical Center actively participate in several hospital-wide groups and councils to advocate for their units. Since 2013, the Nursing leadership has implemented a policy that requires the inclusion of a staff nurse from each unit in every hospital-wide or

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interdisciplinary group.

b. Nursing Foundations for Quality Care

Table 9 displays a concise overview of the average values and their corresponding verbal interpretations for the assessment of the Practice Environment in Terms of Nursing Foundations for Quality Care, as reported by the staff nurse respondents.

Table 9

Staff Nurse Respondents' Assessment on Practice Environment in Terms of Nursing Foundations for Quality Care.

Nursing Foundations for Quality of Care	Mean	Qualitative Description
1. Active staff development or continuing education programs for nurses.	3.64	Strongly Agree
2. High standards of nursing care are expected by the administration.	3.56	Strongly Agree
3. A clear philosophy of nursing that pervades the patient care environment.	3.56	Strongly Agree
4. Working with nurses who are clinically competent.	3.76	Strongly Agree
5. An active quality assurance program.	3.61	Strongly Agree
6. A preceptor program for newly hired RNs.	3.58	Strongly Agree
7. Nursing care is based on a nursing, rather than a medical, model.	3.76	Strongly Agree
8. Written, up-to-date nursing care plans for all patients.	3.62	Strongly Agree
9. Patient care assignments that foster continuity of care, i.e. the same nurse cares for the patient from one day to the next.	3.62	Strongly Agree
10. Use of nursing diagnoses.	3.78	Strongly Agree
Composite Mean	**3.65**	**Strongly Agree**

Legend: 3.51-4.00 Strongly Agree; 2.51-3.50 Agree; 1.51-2.50 Disagree; 1.00-1.50 Strongly Disagree

The table indicates that the average score of the Staff Nurse Respondents' Assessment on Practice Environment in Terms of Nursing Foundations for Quality Care is 3.65. This score falls within the range of 2.51 to 3.50 and is interpreted as "Strongly Agree." The nursing diagnosis utilization, represented by item number 10, achieved the highest average score of 3.78, indicating a strong agreement among respondents. The average of 9 elements falls between 3.51 and 4.00, which corresponds to a verbal interpretation of "Strongly Agree." The items discussed include "Active staff development or continuing education programs for nurses", "High standards of nursing care expected by the administration", "A clear philosophy of nursing that permeates the patient care environment", "Working with nurses who possess clinical competence", "An active quality assurance program", "A preceptor program for newly hired RNs", "Nursing care based on a nursing, rather than a medical, model", "Written, up-to-date nursing care plans for all patients", and "Patient care assignments that promote continuity of care, where the same nurse attends to the patient from one day to the next".

Provision of immediate and hands-on assistance or treatment. The nurses within the company hold the belief that they possess complete autonomy in establishing the foundations for providing high-quality care. They express contentment with regards to their collegial working relationships, ongoing education, professional development, and preceptorship programs. They possess complete authority over care plans for patients, daily patient care assignments, and employ nursing diagnosis in care planning. Furthermore, the organization implements a specific nursing care model called the "Professional Practice Model," which is used by all nurses. Additionally, the company has a defined nursing philosophy that is based on Swanson's care model. The nurses in the organization are confident

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that by adhering to the nursing model and philosophy, they can exercise their nursing skills independently and comprehensively, thereby delivering high-quality patient care across all areas of the hospital.

c. Nurse Manager Ability, Leadership and Support of Nurses

Table 10 displays a summary of data indicating the average and verbal explanation of the assessment of staff nurse respondents on the Practice Environment, specifically focusing on the Nurse Manager's ability, leadership, and support of nurses.

Table 10

Staff Nurse Respondents' Assessment on Practice Environment in Terms of Nurse Manager Ability, Leadership, and Support of Nurses.

Nurse Manager Ability, Leadership, and Support of Nurses	Mean	Qualitative Description
1. A supervisory staff that is supportive of the nurses	2.60	Strongly Agree
2. Supervisors use mistakes as learning opportunities, not criticism	2.51	Strongly Agree
3. A nurse manager who is a good manager and leader.	2.50	Disagree
4. Praise and recognition for a job well done	2.56	Strongly Agree
5. A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician	2.40	Disagree
Composite Mean	**2.52**	**Strongly Agree**

Legend: 3.51-4.00 Strongly Agree; 2.51-3.50 Agree; 1.51-2.50 Disagree; 1.00-1.50 Strongly Disagree

The data indicates that the average score of the Staff Nurse Respondents' Assessment on Practice Environment, specifically in terms of Nurse Manager Ability, Leadership, and Support of Nurses, is 2.52. This score falls within the range of 2.51 to 3.50 and is interpreted as "Strongly Agree". The first item, "A supervisory staff that is supportive of the nurses," received the highest mean score of 2.60, indicating a strong agreement. Two items also received scores ranging from 3.51 to 4.00, indicating a strong agreement. These items are "Praise and recognition for a job well done" and "Supervisors utilize mistakes as opportunities for learning, rather than criticism." The items that pertain to a nurse manager supporting the nursing staff in decision making, even in conflicts with physicians, and being a competent manager and leader had the lowest average score, ranging from 1.51 to 2.50, indicating a linguistic interpretation of disagreement.

Within the organization, direct care nurses hold a positive opinion regarding the helpful behavior of their supervisors or managers towards them. The employees are experiencing happiness due to their supervisors' utilization of previous blunders as learning opportunities rather than criticism. Additionally, they feel a sense of appreciation and acknowledgement for their exceptional accomplishments and tasks. However, they observe that their superiors lack effective managerial and leadership skills. They also observe that their managers are unwilling to reconsider their decisions, particularly in cases involving conflicts with physicians.

d. Staffing and Resource Adequacy

Table 11 displays a concise overview of the average values and verbal explanations for the assessment of the Practice Environment in terms of Staffing and Resource Adequacy, as reported by the staff nurse respondents.

Table 11

Staff Nurse Respondents' Assessment on Practice Environment in Terms of Staffing and Resource

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Adequacy.

Staffing and Resource Adequacy	Mean	Qualitative Description
1. Adequate support services allow me to spend time with my patients	2.08	Disagree
2. Enough time and opportunity to discuss patient care problems with other nurses.	1.93	Disagree
3. Enough registered nurses to provide quality patient care.	2.08	Disagree
4. Enough staff to get the work done.	1.93	Disagree
Composite Mean	**2.00**	**Disagree**

Legend: *3.51-4.00 Strongly Agree; 2.51-3.50 Agree; 1.51-2.50 Disagree; 1.00-1.50 Strongly Disagree*

According to the table provided, the average score of the Staff Nurse Respondents' Assessment on Practice Environment, specifically in terms of staffing and resource adequacy, is 2.00. This score falls within the range of 1.51 to 2.50 and is interpreted as "Disagree". The items numbered 1 and 3, namely "Adequate support services allow me to spend time with my patients" and "Enough registered nurses to provide quality patient care," received the highest mean scores of 2.08, indicating a verbal interpretation of Disagree. The two remaining items, which pertain to "Sufficient time and opportunity to discuss patient care problems with other nurses" and "Adequate staffing to complete the work," had the lowest average score ranging from 1.51 to 2.50, indicating a verbal interpretation of disagreement.

The staff at St. Luke's believes that the current staffing level is inadequate, with an insufficient number of registered nurses available to deliver high-quality patient care. Regarding this matter, there is insufficient time for them to engage in discussions with their colleagues about patient care issues. In addition, they observed a lack of sufficient staff support services, which prevented them from dedicating more time to their patients.

e. Collegial Nurse-Physician Relations

Table 12 displays a summary of statistics that includes the average and verbal interpretation of the assessment conducted by staff nurse respondents on the Practice Environment, specifically focusing on Collegial Nurse-Physician Relations.

Table 12

Staff Nurse Respondents' Assessment on Practice Environment in Terms of Collegial Nurse-Physician Relations.

Collegial Nurse-Physician Relations	Mean	Qualitative Description
1. Physician and nurses have good working relationships.	2.67	Agree
2. A lot of team work between nurses and physicians.	2.84	Agree
3. Collaboration (joint practice) between nurses and physicians	3.14	Agree
Composite Mean	**2.88**	**Agree**

Legend: *3.51-4.00 Strongly Agree; 2.51-3.50 Agree; 1.51-2.50 Disagree; 1.00-1.50 Strongly Disagree*

According to the chart, the average score of the Staff Nurse Respondents' Assessment on Practice Environment, specifically in terms of Collegial Nurse-Physician Relations, is 2.88. This number falls within the range of 2.51 to 3.50 and is interpreted as "Agree". The third item, which pertains to the collaboration between nurses and physicians, had the highest average score of 3.14, indicating agreement. The two remaining items that address the topics of "Extensive collaboration between nurses and physicians" and "Positive working relationships between physicians and nurses" received scores ranging from 2.51 to 3.50, indicating agreement.

Positive practice environments are characterized by collaborative relationships between medical

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and nursing personnel, which are enabled by effective communication and strong medical leadership. The effectiveness of cooperation is further demonstrated when collaboration includes all members of the unit, rather than being limited to only the doctors and nurses. Collegiality acknowledges the distinct areas of professional practice and the fact that each individual in the partnership makes a vital, distinct, and equitable contribution.

Health services can promote the development of professional ties among colleagues. The eight structures that enhance nurse-physician relationships in specialty units include interdisciplinary rounds/meetings, collaborative practice orders, critical pathways and protocols, the appointment of highly skilled individuals, a culture that prioritizes patient care, continuity, longevity, and specialization, established mechanisms for resolving conflicts in a constructive manner, and the support of committed medical directors and nurse managers. The authors proposed that nurse-physician relationships in general wards may be improved by assigning patients to medical specialty teams consisting of physicians and nurses. This approach would promote the development of specialist expertise and ensure consistent patient care. Having self-assurance in one's own capability to practice competently is crucial in the development of collaborative nurse-doctor interactions.

Inter-professional respect is linked to competency and it has been observed that respect comes before trust. Trust is built gradually, but only when there is a foundation of respect for professional competence. Respect and trust are ever-changing qualities of a partnership, shaped by circumstances and personal encounters.

St. Luke's Medical Center implements a multidisciplinary team approach across all departments. In general, nurses and physicians hold each other in high regard and work together to deliver high-quality and efficient healthcare to patients. They collaborate closely to develop strategies and solutions that will be advantageous for their patients.

f. Summary

Table 13 displays a summary of values that includes the average and verbal interpretation of the staff nurse respondents' assessment of their Practice Environment per subscale.

Practice Environment	Mean	Qualitative Description
1. Nurse Participation in Hospital Affairs	2.60	Agree
2. Nursing Foundations for Quality of Care	3.65	Strongly Agree
3. Nurse Manager Ability, Leadership, and Support of Nurses	2.52	Agree
4. Staffing and Resource Adequacy	2.00	Disagree
5. Collegial Nurse-Physician Relations	2.88	Agree
Over-all Mean	**2.73**	**Agree/Favorable**

Legend: 3.51-4.00 Strongly Agree; 2.51-3.50 Agree; 1.51-2.50 Disagree; 1.00-1.50 Strongly Disagree

Three category variable indicating favorable, mixed, or unfavorable practice environments:
favorable = four or more subscale means exceed 2.5;
mixed = two or three subscale means exceed 2.5;
unfavorable = zero or one subscales exceed 2.5.

According to the table provided, the average score of the Staff Nurse Respondents' Assessment on Practice Environment is 2.73. This number is within the range of 2.51 to 3.50, which is interpreted as "Agree". The subscale that received the highest rating is "Nursing Foundations for Quality of Care," which achieved a score of 3.65, indicating a strong agreement. The four subscales were rated between 2.51 to 3.50, indicating agreement based on the verbal interpretation. The following topics are included: "Collegial Nurse-Physician Relations, Nursing Foundations for Quality of Care, Nurse Participation in

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Hospital Affairs, and Nurse Manager Ability, Leadership, and Support of Nurses". The subscale of Staffing and Resource Adequacy had a score of 2.00, which is the lowest average score among all subscales. This number corresponds to a verbal interpretation of Disagree. Four subscales scored above 2.50, indicating a favorable appraisal of the practice environment. Irrespective of gender, age, length of service, and educational background, the nurses in the organization are generally content with their working conditions.

The nursing practice environment has a direct influence on the ability of nurses to stay in their profession and on the level of quality in patient care. Key components of favorable practice environments include nurse engagement in hospital affairs, establishment of nursing foundations for quality care, nurse manager proficiency, leadership, and support, enough staffing and resources, and collaborative nurse-physician relations. It is crucial to have shared governance mechanisms that give nurses the authority to influence decisions that impact their practice environment. Quality care is built upon professional practice models that are both relevant and effective. Organizational support is necessary for autonomy and professional development. Optimal staffing levels, along with appropriate skill sets and resources, while simultaneously reducing job expectations, enhance both the quality of care provided and job satisfaction.

Organizations must prioritize the evaluation of their practice environment by initially assessing it using a reliable psychometric instrument. This assessment will help uncover any deficiencies and establish a starting point for evaluating interventions. Subsequently, a formal assessment procedure would yield the requisite information to determine whether interventions should persist or be extended based on the degree of enhancement in the practice setting. It is crucial to assess ways for improving the practice environment in order to identify effective strategies that may be widely implemented.

Nurse leaders and managers have a crucial role in developing a favorable practice environment. Ensuring the professional growth and assistance of these essential individuals is a crucial element of a retention strategy. The connections between nurses and physicians have been recognized as a crucial element of favorable professional practice environments. The organization's culture should prioritize interdisciplinary collaboration, teamwork, and the well-being of the patient. Leaders and executives throughout the organization must demonstrate these behaviors.

Developing favorable work environments is therefore a crucial approach that CEOs and nurse leaders can utilize to bolster nurse retention and increase health outcomes. Nevertheless, this paper demonstrates that there is insufficient information to determine which measures aimed at improving the practice environment are the most beneficial. While there is less evidence to assist in making employment decisions, there is even less evidence available to inform the allocation of other resources, such as support jobs. Aiken and her colleagues have recently determined that patient results are not solely influenced by staffing levels, but are also significantly impacted by the quality of the practice environment.

4 Conclusion

The following conclusions were drawn based on the results: The hospital's staff nurses assessed the shared governance and determined that it is highly participatory, particularly in terms of controls, influences, official authority, committee involvement, and access to information. Staff nurses who took

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part in Shared Governance exercises evaluated themselves as "moderately." Regrettably, the corporation is unlikely to consider their ability to engage in collective decision-making. The practicing environment of the staff nurses has received a positive rating. Overall, irrespective of gender, age, tenure, or level of education, nurses expressed satisfaction with their working conditions inside the organization. Staff nurses who took part in Shared Governance exercises evaluated themselves as "moderately." Furthermore, the respondents' evaluations of their sex, age, educational level, and nursing unit of employment were found to be indistinguishable. It was noted that nurses with three years of experience or less have lower participation in Shared Governance compared to nurses with longer tenure. Staff nurses discovered that all survey respondents, regardless of their gender, age, length of employment, educational background, or department, indicated contentment with their work environment. The study's findings indicate that both shared governance and the practice environment significantly influence the job satisfaction and engagement of staff nurses in the organization. Additionally, it could serve as the basis for future efforts and improvements in healthcare processes.

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