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Introduction

The World Health Organization [2019] defined burnout as a syndrome caused by chronic job stressors that are not successfully managed, characterized by exhaustion, depersonalization, job

detachment, and feelings of inadequacy (WHO, 2019). According to Murthy [2022], the nursing burnout crisis was underway before COVID-19. Nurse burnout recognized pre-COVID-19 was due to systemic organizational problems such as inadequate organizational support and underinvestment in public health (Murthy, 2022).

A 2022 survey of 2500 nurses exhibited increased rates of burnout during the pandemic, with 75% of respondents experiencing burnout, while 65% of those surveyed expressed their desire to leave the healthcare field (Johnson, 2022). Additional research demonstrated that nearly one-third of nurses surveyed claimed they would leave their jobs by the end of 2022, 44% of which cited burnout and high stress as the primary reason for leaving employment (Landi, 2022).

Literature Overview

According to the 2022 Nurse Salary Research Report, nurses stated that factors other than salary had contributed to nursing burnout. Despite nurse salary increases, healthcare providers need help recruiting and retaining nurses (Kreimer, 2022). The literature review revealed that symptoms and clinical diagnoses such as depression, burnout, and fatigue were common for nursing staff. Nurses had depression rates more than double that of employees in any other field (Thew, 2018). Additional research suggested that healthcare workers' intention to leave healthcare doubled from 2020-2021 (Almendral, 2022). The data indicated that burnout was the most significant controllable reason for nurses quitting healthcare, emphasizing the importance of organizational interventions (Fontaine, 2021).

Bakhamis et al. [2019] defined factors associated with nurse burnout as personal, management, and organizational factors, such as excessive workload, staff shortages, and low nurse-to-patient ratio. As nurses experiencing burnout left their positions, peer nurses experienced increased stress (Bakhamis, Paul, Smith, & Coustasse, 2019). Consequently, hospitals aim to prevent increased patient injuries, medical errors, and mortality rates by decreasing burnout among nursing staff (Bakhamis et al., 2019).

An additional literature review of 20 studies that examined nurses from 14 countries, including the United States, suggested that a high dimension of emotional exhaustion in nurses was associated with increased patient mortality. In contrast, depersonalization was associated with increased adverse events such as medication errors (Jun et al., 2021). The authors also found that high levels of nurse burnout were associated with reduced commitment to organizations and reduced job productivity. Furthermore, nurses who regularly worked 12-hour or longer shifts experienced burnout and were likelier to experience lower job satisfaction (Dall'Ora et al., 2015).

With nurse burnout acknowledged as a system-wide concern, the U.S. Surgeon General recommended interventions to combat nurse burnout that included adequate pay, increased mental health services, improved access to health insurance and personal protective equipment, investment in public health services, and a reduction in administrative burdens (Murthy, 2022). Additional research demonstrated that most healthcare organizational interventions in 2022 had focused on addressing nurse burnout (Pijpker et al., 2019). The organizational interventions included improving job control, social support, working well in the proper environment, and effort-reward balance (Giga et al., 2018).

An additional review of the literature considered the structure of Magnet-designated hospitals and the likelihood that the requirements of this designation might affect nursing burnout. Magnet hospitals were designated as such by the American Nurses Credentialing Center (ANCC) for meeting the requirements of its Magnet Recognition Program (ANCC, n.d.). The Magnet Recognition Program has several standards for excellence, including transformational leadership, structural empowerment, innovations and improvements, exemplary professional practice, and empirical quality results (ANCC, n.d.) One of the aspects of the structural empowerment requirement for Magnet recognition was shared governance, defined as a governance model where nurses share power, input, and decision-making with hospital administration, usually via committees and councils (Collins, 2017).

Methodology

The purpose of this research was to examine Magnet-designation status in U.S. hospitals, specifically shared governance and structural empowerment, and its effects on the rates of nurse burnout, nurse turnover, and job satisfaction of nurses. This study utilized mixed methodologies with a literature review complemented by semi-structured interviews to gain perspectives about burnout with relevant answers used in the discussion. The literature reviewed consisted primarily of peer-reviewed journals, news articles, and data analyses from within the last 12 years. Interviews were recorded with the nurses' consent, and the answers were transcribed. Interviews were approved by the Marshall University Institutional Review Board (IRB).

Results

An analysis of cross-sectional data from 425 U.S. hospitals examined the involvement that nurses had in shared governance ranging from the least engaged, where nurses did not serve on hospital committees, to the most engaged, where nurses had the opportunity to participate in policy decisions (Kutney-Lee et al., 2016). Magnet Hospitals accounted for 46 of the 425 hospitals in the study; of these, 36 were found to have nurses highly engaged in shared governance, and 10 had nurses that were moderately engaged, with no Magnet hospitals being rated as having minor engaged nurses (Kutney-Lee et al., 2016). Nurses who were highly engaged in shared governance reported significantly better job outcomes than less engaged nurses, with 13% of most engaged nurses having reported being dissatisfied with their jobs compared to 43% of the minor engaged nurses (Kutney-Lee et al., 2016). In addition, 23% of highly engaged nurses said they experienced burnout, compared with 52% of the least engaged nurses and 8% of the most engaged nurses stating their intentions to leave, compared to 13% of minor engaged nurses (Kutney-Lee et al., 2016).

An initiative by a Magnet-designated U.S. hospital sought to improve shared governance and decision-making to improve nurse job satisfaction (Oss et al., 2020). Interventions included distributing literature about shared governance to nurses and meetings to enhance relationships between nurses and management. A follow-up survey of the nursing department found that 53% of nursing units demonstrated improvement in registered nurse (RN) satisfaction with involvement in decision-making, and 48% of units noted improvement regarding RN job satisfaction about autonomy and job duties (Oss et al., 2020).

A survey regarding work environment and nursing outcomes was given to nurses from 567 hospitals in Pennsylvania, California, Florida, and New Jersey, with 46 of these being Magnet hospitals (Kelly et al., 2011). The work environment aspects studied included nurse participation in hospital affairs, nurse manager ability, and organizational support, and outcomes measured included burnout, job satisfaction, and intent to leave their jobs (Kelly et al., 2011). The results of the survey found that nurses in Magnet hospitals were 18% less likely to report job dissatisfaction and 13% less likely to have high levels of burnout as compared to nurses from non-Magnet hospitals, as well as being less likely to leave their positions (Kelly et al., 2011).

Additional research was performed on cross-sectional data, which included over 20,000 nurses in 523 U.S. hospitals, of which 83 had a Magnet designation. The analysis results found that Magnet hospital status reduced burnout, with 40% of the Magnet hospitals studied being in the lowest quartile of burnout scores (Schlak et al., 2021).

A correlational study that examined a sample of 2,958 nursing units in 497 U.S. hospitals analyzed reasons for turnover and compared Magnet and non-Magnet hospitals (Park et al., 2016). The results indicated that turnover due to work environment factors was significantly less in Magnet hospitals than non-Magnet hospitals, with 14.21% of separated Magnet hospital nurses indicating that work environment was the reason for separation versus 17.09% for non-Magnet nurses (Park et al., 2016). Additionally, a cross-sectional study of longitudinal data from 1,884 nursing units in 306 U.S. hospitals found evidence that Magnet hospitals had 16% lower RN turnover than non-Magnet hospitals (Staggs & Dutton, 2012).

Another study examined in the literature review sought to compare the performance of military hospitals to civilian Magnet hospitals and non-Magnet civilian hospitals. Performance indicators analyzed included job satisfaction and the intent of nurses to leave their jobs (Patrician et al., 2022). Results indicated that job satisfaction scores were higher in Magnet hospitals than non-Magnet hospitals, with a median score of 68.24 vs. 65; this was statistically insignificant (Patrician et al., 2022). The study also found that intent to leave was not statistically significantly different in Magnet Hospitals vs. non-Magnet hospitals. However, that nurse participation in hospital affairs, a proxy measure for shared governance, was significantly higher in Magnet hospitals at p=0.0014 (Patrician et al., 2022).

Additional research included data analysis from 157 non-Magnet and 14 Magnet hospitals with 675 and 162 nurse respondents, respectively, to define the differences in nurse satisfaction and work environment between the two types of hospitals (Trinkoff et al., 2010). There were no statistically significant differences in job satisfaction, 79% for Magnet hospitals vs. 71.9% for non-Magnet hospitals (Trinkoff et al., 2010). The results also indicated no significant difference in practice environment scores between Magnet and non-Magnet hospitals, with a score on this measure of 51.0 for Magnet and 50.0 for non-Magnet hospitals (Trinkoff et al., 2010).

One study that surveyed new RNs examined the differences in job satisfaction and reports of workplace hostility between nurses in Magnet and non-Magnet hospitals (Hickson, 2015). This analysis also found no significant difference between Magnet and non-Magnet hospitals regarding job satisfaction, with a mean score of 80.9 for nurses in Magnet hospitals and 74.3 for non-Magnet

hospitals (Hickson, 2015). Finally, some nurses claimed that they were still expected to work 12-hour shifts and take on documentation tasks in Magnet hospitals, which could have led to burnout (Bachert, 2017).

Conclusion

The literature review found evidence that Magnet hospitals had better nurse burnout, turnover, and job satisfaction outcomes than non-Magnet hospitals. Several reviewed articles showed no significant difference between Magnet and non-Magnet hospitals for these performance metrics. However, findings were only consistent across some studies.

Other studies found no significant difference in work environment factors between Magnet and non-Magnet hospitals. These studies noted that despite earning a designation as a Magnet hospital, these organizations function similarly to non-Magnet hospitals in practice (Trinkoff et al., 2010).

The practical implications of this study demonstrate that although Magnet hospitals have generally shown better outcomes regarding nurse satisfaction, retention, and lower levels of burnout, more research is needed to determine what specific aspects of the Magnet program are the most significant contributors to this success. Results generally indicate that engaged nurses, regardless of Magnet or non-Magnet status, typically demonstrate more favorable performance indicators related to job satisfaction. Successful aspects of the Magnet program, such as shared governance, could be more widely adopted to combat nurse burnout in U.S. hospitals.

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