SPECIAL REPORT | EXECUTIVE RESEARCH EDITION

When Leadership Fails to Deliver Results

What healthcare workers should demand when mission promises fail

Evidence-based synthesis, governance framework, and testable accountability protocol

A Thought Experiment

Is it realistic for healthcare workers to stop accepting empty promise mission language as evidence of leadership performance and demand **an outcome-based leadership model linked to the Leadership Accountability and a Compact that** governs patient care, staff engagement, proven performance models, safety, voice, compensation, structural wellbeing, executive incentives, and trust repair?

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Evidence-based analysis 2005

Prepared for executive, board, workforce governance, and scholarly discussion. This report is an evidence synthesis and proposed governance intervention, not a completed systematic review or legal opinion.

The Hypothesis Question

> *Is it realistic for healthcare workers to stop accepting empty promise mission language as evidence of leadership performance and demand an outcome-based leadership model linked to the Leadership Accountability and a Compact that governs patient care, staff engagement, proven performance models, safety, voice, compensation, structural wellbeing, executive incentives, and trust repair?*

18.5%	29.5%	$5.19M	35%
HOSPITAL TURNOVER	**FIRST-YEAR TURNOVER**	**AVERAGE RN TURNOVER LOSS**	**NO CONFIDENCE**
Calendar year 2025	All hospital employees	Per hospital estimate	Employees vs senior leaders

What the evidence does and does not support

The assertion that healthcare turnover is currently at its highest level is not supported across national indicators. NSI reported 2025 hospital turnover of 18.5% and RN staff turnover of 17.6%, both below the 2021 pandemic-era peaks of 25.9% and 27.1%, respectively. Bureau of Labor Statistics data likewise do not show a record current quit rate for the combined health care and social assistance sector. Nevertheless, the comforting interpretation is also wrong: hospital and RN turnover increased again in 2025, first-year turnover reached 29.5%, frontline support roles experienced rates above 30%, and the average hospital's estimated annual RN turnover loss was $5.19 million (BLS, 2026; NSI Nursing Solutions, 2026).

Leadership cannot reasonably be held causally responsible for retirement, relocation, family needs, educational advancement, or every labor-market shock. Leadership is accountable for the system it controls: workload design, staffing escalation, schedule control, physical and psychological safety, employee voice, compensation architecture, career access, operational burden, measurement, and governance. The research is strongest when it makes this attribution boundary explicit.

The Doctorate Level Synthesis of the Data

GOVERNANCE FAILURE

A promise has no accountability value unless it has an owner with authority, a funded intervention, a common metric, a deadline, worker decision rights, an escalation rule, and a consequence for repeated nonperformance.

Five practices should no longer be treated as adequate leadership responses:

1. Substituting resilience training for the correction of unsafe workload, avoidable administrative burden, or schedule instability.
2. Surveying employees without publishing a response covenant that names decisions, owners, dates, and declined requests.
3. Claiming safe staffing while withholding unit, shift, acuity, missed-care, and variance evidence.
4. Protecting executive incentive compensation from workforce stability, safety, trust, and first-year retention results.

5. Using confidentiality, branding, or aggregate reporting to conceal recurring nonperformance at the unit or leader level.

Executive action agenda

Table 1. Immediate executive and board action sequence

TIMING	REQUIRED ACTION	EXECUTIVE EVIDENCE OF COMPLETION
0 to 30 days	Publish the baseline, definitions, owners, and red-line thresholds; install anti-retaliation protections.	Signed data dictionary, unit dashboard, owner register, and protected reporting pathway.
31 to 60 days	Seat elected frontline representatives with voting rights; fund the first operating corrections.	Charter, voting record, budget, and documented response to workforce recommendations.
61 to 90 days	Launch unit pilots; place a material share of executive incentives at risk; publish the commitments register.	Pilot protocol, incentive weights, milestones, status, and escalation rules.
Quarterly	Review outcomes and implementation fidelity at the board level; intervene after repeated misses.	Minutes, variance review, remedies, consequences, and worker verification.
12 months	Commission independent evaluation and trust reassessment; renew, redesign, or replace failed leadership controls.	Audit opinion, effect estimates, equity review, and disposition decision.

Decision standard

The test is not whether leadership launches another initiative. The test is whether controllable working conditions improve, whether workers can verify the change, whether turnover and safety outcomes move without harm shifting to another group, and whether leaders experience consequences when avoidable failure persists.

Abstract

Background: Healthcare organizations routinely describe employees as their most valuable asset while tolerating unstable staffing, recurrent violence, weak schedule control, low confidence in senior leadership, and incomplete turnover governance.

Objective: To determine what healthcare workers should require when leadership has failed to deliver on its mission and workforce promises, and to translate the evidence into an enforceable governance intervention.

Methods: This special report used a structured evidence synthesis that prioritized current national workforce surveillance, transparent industry datasets, peer-reviewed systematic reviews and meta-analyses, large adjusted observational studies, and federal systems-level guidance.

Findings: Interpreted through the lens of psychological contract theory, organizational justice, perceived organizational support, and psychological safety.

Results: National evidence does not support a universal record-high turnover claim, but it documents a 2025 reversal in hospital and RN turnover, 29.5% first-year turnover, severe role-specific concentration, high financial exposure, and material distrust of senior leadership.

Observations: Evidence consistently associates emotional exhaustion, violence, unsafe practice environments, and weak organizational support with departure intention or turnover-related outcomes. Intervention reviews favor changing work conditions over relying on individual coping programs, although direct causal evidence on turnover remains limited.

Conclusion: Workers should demand a Workforce Accountability Compact built on audited transparency, safe staffing and workload controls, real decision rights, anti-retaliation, schedule control, violence prevention, fair pay and mobility, structural

wellbeing, executive consequences, and time-bound trust repair. The Compact should be evaluated using a stepped-wedge or difference-in-differences design, with pre-specified equity and safety guardrails.

Keywords: healthcare workforce; turnover; leadership accountability; psychological contract; organizational justice; psychological safety; staffing; governance; retention; burnout

Research question and hypotheses

Primary research question: What should healthcare workers demand of organizational leadership when leadership has repeatedly failed to fulfill its mission and explicit or implied promises to those workers?

Primary hypothesis (H1): Units implementing an audited, funded, and consequence-linked Workforce Accountability Compact will experience a greater reduction in risk-adjusted 12-month voluntary turnover than comparable units operating under advisory-only workforce programs.

Mechanism hypothesis (H2): The effect of the Compact on turnover will be mediated by improved staffing adequacy, schedule control, psychological safety, perceived organizational support, and confidence in leadership.

Governance hypothesis (H3): Implementation fidelity and outcome improvement will be stronger when workforce measures are tied to board oversight, executive incentive compensation, and mandatory escalation than when the same measures are disclosed without enforceable consequences.

Contents at a glance

PART	QUESTION ANSWERED
1. Methods and evidence discipline	What evidence was included, how it was weighted, and where causal claims stop.
2. The turnover reality	How large the problem is, where it is concentrated, and why the trend requires action.
3. Why broken promises matter	How psychological contract breach, justice, support, and safety connect leadership behavior to withdrawal.
4. The accountability boundary	Which departure drivers' leadership controls, influences, or cannot reasonably own.
5. Workforce Accountability Compact	The ten demands, proof standards, and consequences workers should require.
6. Board operating system	How governance, metrics, incentives, and implementation should work.
7. Evaluation protocol	How to test whether the intervention works rather than merely announcing it.

Definitions that prevent false agreement

TERM	MEANING IN THIS REPORT
Accountability	An assigned duty backed by authority, resources, measurement, worker verification, escalation, and consequence.
Leadership failure	Repeated avoidable nonperformance in a controllable domain, or failure to detect, correct, disclose, and learn from it.
Mission breach	A material gap between stated or reasonably implied reciprocal obligations and the organization's observed decisions or conditions.
Demand	A governance requirement with proof and consequence, not a request for leadership discretion.
Turnover	A rate whose numerator, denominator, population, period, and treatment of transfers must be stated before comparison.

1. Methods: evidence synthesis

1.1 Scope

This report examines hospital and health system leadership's accountability for workforce stability. It centers on employees and employed clinicians while recognizing that the available turnover literature is heavily weighted toward nursing. The decision question is governance-oriented: what requirements should workers place on leaders when mission and employment promises are not fulfilled? The analysis does not presume that every resignation is preventable or that turnover alone establishes wrongdoing.

1.2 Evidence identification and prioritization

Evidence was assembled from current national labor statistics, the 2026 NSI National Health Care Retention & RN Staffing Report, the 2026 Press Ganey employee experience report, peer-reviewed studies and reviews published principally from 2024 through 2025, seminal organizational theory, and the NIOSH Impact Wellbeing Guide. Priority was assigned in the following order: national surveillance or large workforce datasets with explicit denominators; systematic reviews and meta-analyses; large adjusted observational studies; intervention reviews; federal systems guidance; and theory used to explain mechanisms. Proprietary evidence was treated as useful but not independently definitive.

This was a synthesis rather than a registered systematic review. No claim is made that every eligible database, specialty, or setting was exhaustively searched. The method was designed for executive decision quality: triangulate current burden, identify convergent organizational mechanisms, state uncertainty, and convert findings into falsifiable governance requirements.

1.3 Inclusion logic

- Population: healthcare employees, nurses, physicians, and hospital-based workers in organizational settings.
- Exposure or intervention: leadership behavior, practice environment, staffing, organizational support, burnout, violence, safety, schedule conditions, or structural wellbeing intervention.
- Outcomes: actual turnover, planned departure, retention, burnout, psychological distress, safety, patient outcomes, or operating cost.
- Evidence use: current burden estimates were separated from causal explanation, and planned departure was treated as a leading indicator rather than equivalent to actual exit.

1.4 Appraisal and inferential rules

Four rules governed interpretation. First, cross-sectional association was not described as proof of causality. Second, industry and proprietary reports were checked against federal or peer-reviewed evidence where possible. Third, heterogeneity in turnover definitions, settings, and follow-up was treated as substantive rather than cosmetic. Fourth, an accountability recommendation was considered stronger when both empirical evidence and a plausible governance mechanism supported it.

Table 2. Evidence hierarchy and intended use

EVIDENCE STREAM	CONTRIBUTION	PRIMARY STRENGTH	PRIMARY LIMITATION	DECISION WEIGHT
BLS JOLTS	Current macro quit context	Federal recurring series	Health care combined with social assistance	Contextual

EVIDENCE STREAM	CONTRIBUTION	PRIMARY STRENGTH	PRIMARY LIMITATION	DECISION WEIGHT
NSI 2026	Hospital, RN, tenure, role, and cost estimates	527 hospitals; large denominators	Industry survey, not a national probability sample	High for burden, moderate for generalization
Press Ganey 2026	Engagement, trust, and turnover relationship	More than 2.6 million workers and physicians	Proprietary observational analysis	Moderate
Systematic reviews	Support, staffing, and intervention synthesis	Cross-study convergence	Heterogeneity; many cross-sectional studies	Moderate
Adjusted observational studies	Effect size and mechanism signals	Covariate-adjusted estimates	Residual confounding; often intentional outcomes	Moderate
NIOSH guidance	Systems intervention logic	Federal, operational, and participatory	Guidance, not a causal turnover trial	High for implementation design
Organizational theory	Psychological and governance mechanisms	Mature explanatory constructs	No specific proof of this Compact	Mechanistic

1.5 Claim discipline

CORRECTION TO THE OPENING PREMISE

The defensible statement is not that healthcare turnover is at an all-time high. It is that turnover remains strategically unacceptable, worsened again in 2025 for hospitals and RNs, is exceptionally high among early-career and frontline roles, and reflects organizational conditions that leaders are obligated to measure and improve.

2. The turnover reality: severe, uneven, and governable

2.1 Trend: improvement stalled

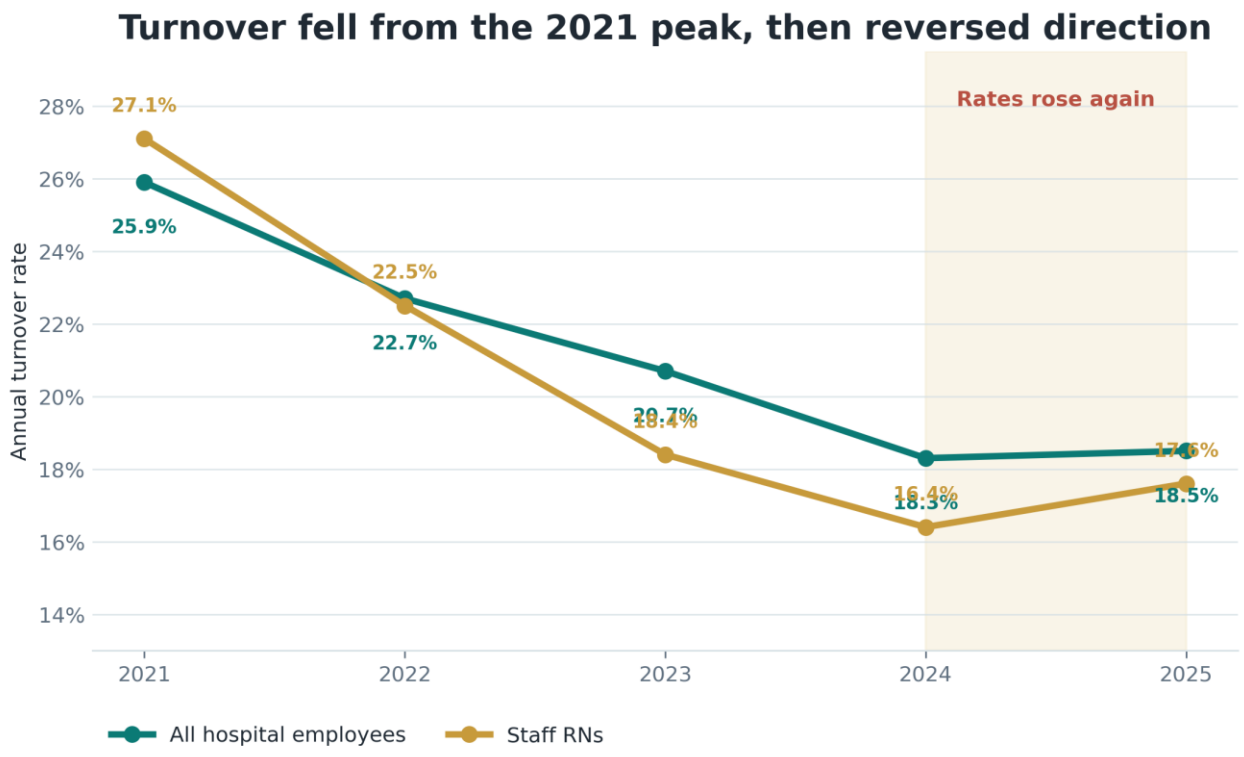

Figure 1. Hospital and staff RN turnover, 2021 to 2025

Source: NSI Nursing Solutions (2026). Rates are based on annual turnover, as defined by NSI.

Hospital turnover declined from 25.9% in 2021 to 18.3% in 2024, while staff RN turnover declined from 27.1% to 16.4%. That trajectory reversed in 2025: hospital turnover increased to 18.5%, and RN turnover increased to 17.6%. The increase does not recreate the 2021 peak, but it matters because it interrupts improvement and signals that post-pandemic normalization cannot be assumed to continue without management action (NSI Nursing Solutions, 2026).

The aggregate hides enormous variation. NSI reported hospital turnover ranging from 7.6% to 33.1% and RN turnover from 5.6% to 40.0%. Such dispersion is incompatible with an explanation based only on a single national labor market. Case mix, geography, and workforce supply matter, but wide organizational variation also indicates substantial room for operating practice and governance to influence outcomes.

2.2 The most acute risk is early and occupationally concentrated

First-year hospital employee turnover was 29.5%. Early tenure is where recruitment promises, onboarding reality, schedule expectations, workload exposure, and supervisory behavior collide. A system that treats a nearly one-in-three first-year exit rate as a recruiting problem is misclassifying a design and credibility problem. The role data are equally revealing: patient care technician turnover was 33.8%, certified nursing assistant turnover was 32.5%, and environmental services reached 27.6%. These roles are central to care flow, infection prevention, surveillance, and workload distribution, even though they often hold the least organizational power.

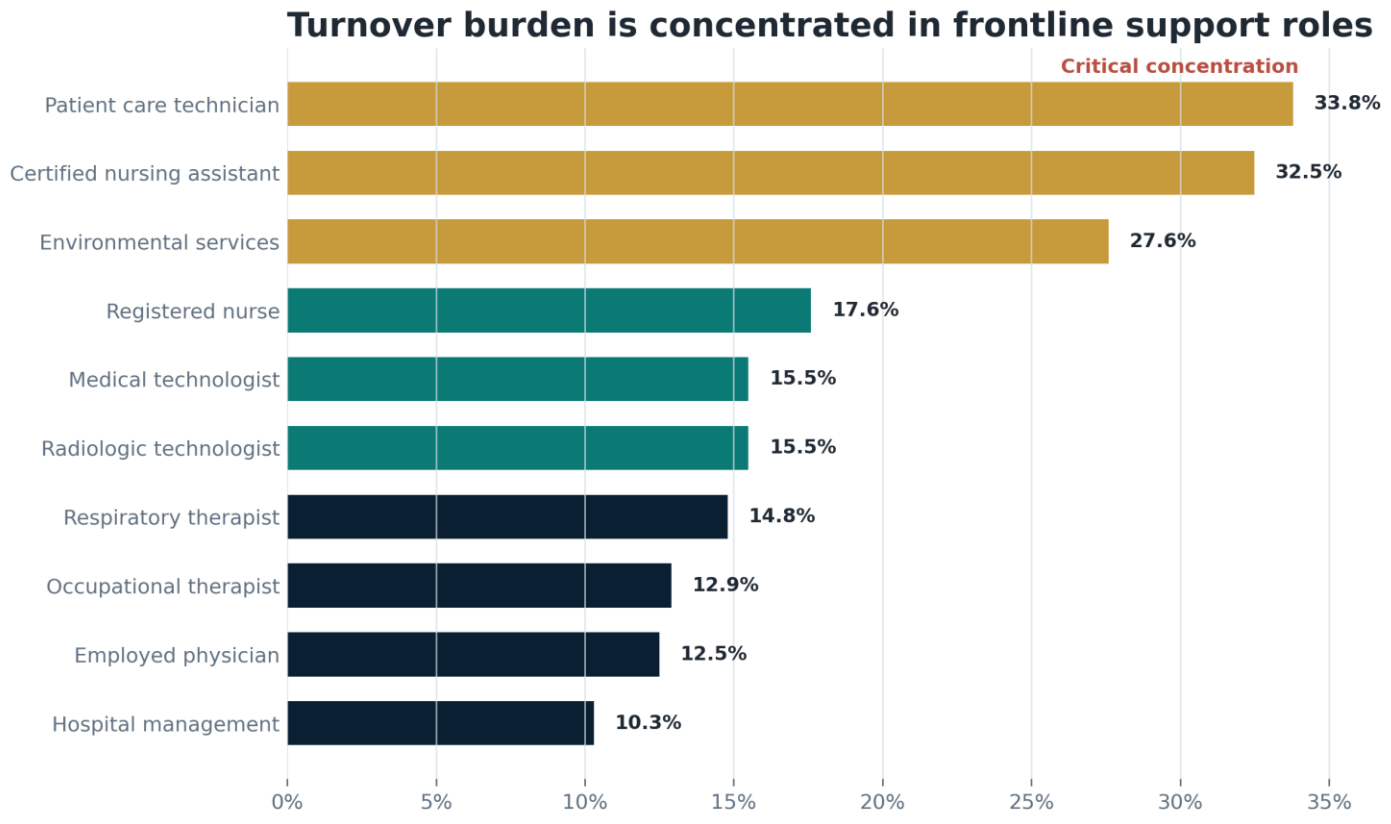

Figure 2. Turnover by selected hospital role, 2025

Source: NSI Nursing Solutions (2026). Selected occupations shown; values reflect reported annual turnover.

2.3 The financial burden is material and incompletely governed

NSI estimated the average cost of turnover for one bedside RN at $60,090 and the average annual RN turnover loss per hospital at $5.19 million. Each percentage-point change in RN turnover was valued at approximately $295,000. On that basis,

the 1.2-point increase from 2024 to 2025 corresponds to roughly $354,000 for an average hospital before rounding and local adjustment. Nevertheless, only 46.1% of surveyed hospitals tracked RN turnover cost, and 27.6% had no measurable hospital turnover-reduction goal. The governance defect is not simply that turnover costs money. It is known that multimillion-dollar exposures are often not measured or assigned a target.

Vacancy compounds the exposure. NSI reported an RN vacancy rate of 8.6%, with one-third of hospitals at or above 10%, and an average time-to-fill of 78 days. During vacancy, organizations may incur premium labor, overtime, closed capacity, management distraction, and reduced continuity. A valid internal cost model should therefore measure actual vacancy days, agency and overtime premiums, recruitment and onboarding costs, preceptor time, productivity ramp, and avoidable lost capacity rather than relying solely on a national average.

BOARD QUESTION

Why does the organization review operating margin every month but tolerate annual, aggregated, or definitionally unstable reporting of first-year turnover, unsafe staffing shifts, and leadership trust?

2.4 Trust is an operating variable

Press Ganey's 2026 analysis reported that 35% of employees and 37% of providers lacked confidence in senior leadership. Disengaged caregivers were reported as 2.6 times more likely to leave, with observed turnover of 24% in disengaged environments compared with 15% in high-engagement systems. Because the analysis is proprietary and observational, it should not be treated as an independent causal estimate. Its scale and direction, however, align with peer-reviewed evidence on organizational support, practice environment, and psychological safety.

Trust should not be reduced to a sentiment score. It changes whether employees disclose hazards, interpret leadership messages as credible, invest discretionary effort, recommend the organization, remain through a difficult period, or leave before another promise is broken. Confidence in leadership is therefore both a relational outcome and a leading operational indicator.

The burden is not confined to nursing. In a national physician survey, 45.2% reported at least one burnout symptom in 2023, an improvement from 62.8% in 2021, but still a higher adjusted risk than other US workers. The change illustrates a crucial interpretive rule: recovery from an extreme peak does not establish an acceptable operating state, and a favorable comparison year should not be used to normalize persistent harm (Shanafelt et al., 2025).

Table 2A. Governing upstream conditions instead of waiting for exits

LAGGING OUTCOME	LEADING CONDITION TO GOVERN	WHY IT MATTERS
Voluntary turnover	Leadership confidence and organizational support	Detects withdrawal before separation is recorded.
First-year exit	Expectation accuracy, preceptor load, and schedule reality	Tests whether recruitment promises hold up under operational contact.
Vacancy and agency use	Staffing-plan attainment and capacity escalation	Shows whether demand is being covered safely or deferred to premium labor.
Safety event	Psychological safety, violence exposure, and missed-care signals	Makes it more likely that risk is visible before patient or worker harm.

3. From mission promise to workforce withdrawal

3.1 Psychological contract breach

A psychological contract is the employee's belief about reciprocal obligations between the worker and the organization. In healthcare, the contract is unusually dense: sacrifice will be met with protection; speaking up will not trigger retaliation; patient safety will outrank avoidable throughput pressure; extraordinary effort will not become the permanent staffing model; and mission language will be reflected in budget decisions. Morrison and Robinson's model distinguishes cognitive recognition that an obligation was unmet from the stronger affective experience of violation. The latter is experienced as betrayal, anger, or moral injury when the breach is serious, repeated, and poorly repaired (Morrison & Robinson, 1997).

A missed promise does not automatically produce an exit. Employees assess magnitude, attribution, fairness, and repair. Leaders intensify violations when they deny observable conditions, redefine metrics after failure, ask workers to absorb the consequences, suppress voice, or continue to reward executives. Leaders reduce it by acknowledging the breach, disclosing constraints, making restitution where possible, sharing decision authority, and verifying the correction.

Figure 3. Theory-informed pathway linking broken promises to withdrawal

Source: Author synthesis informed by Morrison and Robinson (1997), Colquitt et al. (2001), Rhoades and Eisenberger (2002), and Edmondson (1999).

3.2 Organizational justice and support

Organizational justice clarifies why the same difficult condition can produce different reactions. Distributive justice concerns who bears the workload, the risks, and the rewards. Procedural justice concerns whether decisions are made with consistent rules, accurate information, correction mechanisms, and a legitimate voice. Interpersonal justice concerns dignity and respect. Informational justice concerns whether explanations are timely, candid, and complete. Meta-analytic evidence shows that these dimensions relate to work attitudes and behavior, making justice a practical design requirement rather than a public-relations concept (Colquitt et al., 2001).

Perceived organizational support concerns whether employees believe the organization values their contribution and cares about their well-being. A 2024 meta-analysis of eight cross-sectional studies involving 5,754 nurses estimated a pooled correlation of -0.32 between organizational support and turnover intention. The association was moderate and consistent, but all included studies were cross-sectional, so the result cannot establish that raising support alone will cause retention. It does establish that support is not peripheral to the turnover problem (Galanis et al., 2024; Rhoades & Eisenberger, 2002).

3.3 Psychological safety and leader inclusiveness

Psychological safety is a shared belief that interpersonal risk-taking is safe. In healthcare, it affects whether staff question an order, report deterioration, disclose near misses, or challenge a staffing decision. Edmondson demonstrated its relationship to team learning, and Nembhard and Edmondson showed that leader inclusiveness can mitigate professional status differences in healthcare improvement teams. An anti-retaliation policy is necessary but not sufficient. Workers need independent reporting, observable protection after speaking up, transparent case closure, and discipline when leaders suppress safety concerns (Edmondson, 1999; Nembhard & Edmondson, 2006).

3.4 Betrayal is not a metaphor when institutions violate protection duties

In a 2024 study of 1,066 healthcare and hospital workers, approximately one-third reported betrayal by institutional leaders and/or people outside healthcare during the pandemic. Reported betrayal was associated with about 2.9 times the odds of mental distress and 3.3 times the odds of post-traumatic stress symptoms. The study was cross-sectional, involved a single health system, and arose from an extraordinary period; it should not be generalized as a prevalence estimate for all organizations. It does show that perceived institutional betrayal can be clinically and operationally consequential (Park et al., 2024).

3.5 Burnout and safety are linked consequences of work design

A 2024 meta-analysis of 85 studies and 288,581 nurses found that nurse burnout was associated with worse safety and quality outcomes, including medication errors, falls, infections, and adverse events. The literature does not justify treating every adverse event as caused by burnout, but it rejects the notion that workforce wellbeing is separate from clinical performance. When leaders frame exhaustion as an individual resilience deficit while preserving the work design that produces it, they transfer organizational risk back onto workers and patients (Li et al., 2024).

4. What conditions predict departure, and what changes appear to help?

4.1 Adjusted evidence from nurses

Friese and colleagues analyzed Michigan nurse survey data from 2022 and 2023. In 2023, 39.1% planned to leave their position, compared with 32.0% in 2022. Emotional exhaustion was associated with higher adjusted odds of planned departure (OR 3.05, 95% CI 2.38 to 3.91), as was workplace abuse or violence (OR 1.39, 95% CI 1.05 to 1.82). A favorable practice environment (OR 0.37, 95% CI 0.22 to 0.62) and an excellent clinical safety rating (OR 0.28, 95% CI 0.14 to 0.56) were associated with lower odds. Workload was the most frequently cited reason among nurses planning to leave. The response rates were low, and the outcome was intention rather than actual exit, so the estimates should be treated as strong warning signals rather than causal turnover multipliers (Friese et al., 2024).

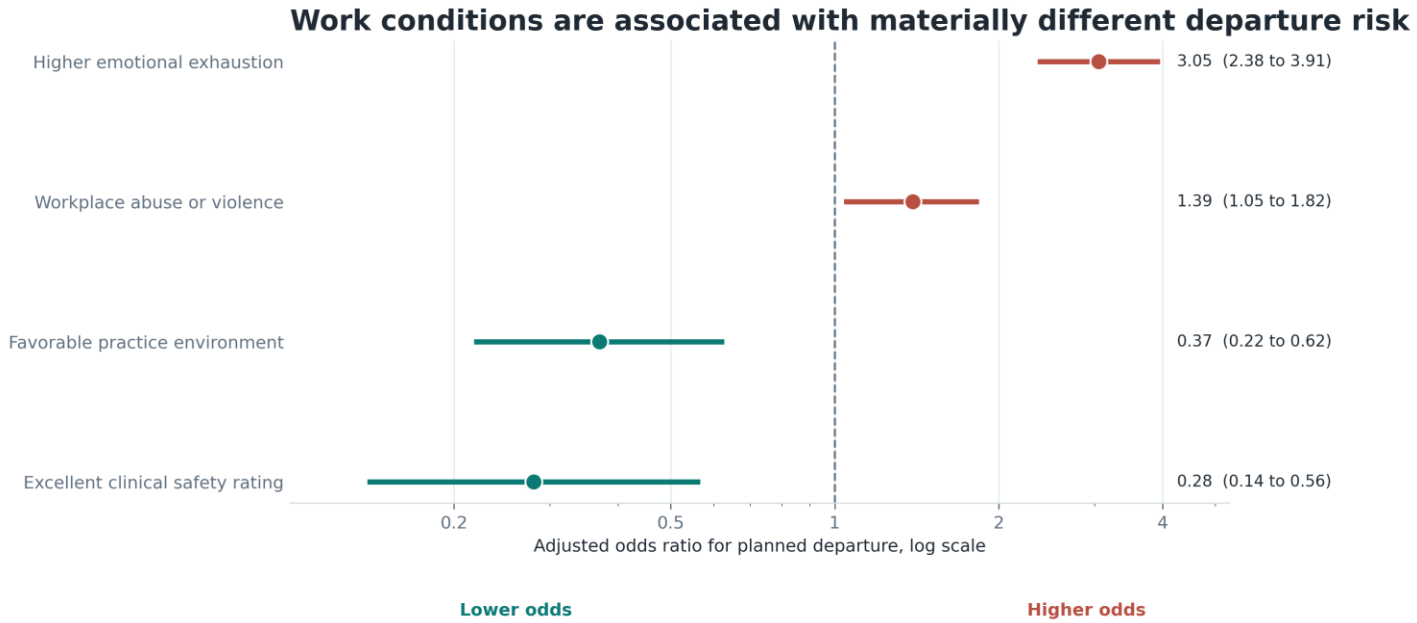

Figure 4. Adjusted associations with planned departure among Michigan nurses, 2023

Source: Friese et al. (2024). Points are adjusted odds ratios; lines are 95% confidence intervals.

The symmetry of the findings matters. Exhaustion and violence are not merely employee vulnerabilities, and practice environment and safety are not amenities. They are organizational exposures and protections that can be monitored at the unit and shift level. A leadership dashboard that reports turnover without these antecedents arrives after the harm and cannot guide prevention.

4.2 Staffing and retention

Bae's systematic review found that inadequate or unsafe nurse staffing was associated with actual turnover across the included literature, while evidence on scheduling was less developed. Buckley and colleagues' 2025 scoping review synthesized 130 studies but found only nine intervention studies, underscoring a central problem in healthcare retention science: the field knows far more about correlates than about implemented, rigorously evaluated organizational remedies. Their synthesis organized retention strategies around safe and flexible staffing, work environment, psychological support, leadership and communication, career development and mentorship, and compensation (Bae, 2024; Buckley et al., 2025).

4.3 Structural intervention outperforms symbolic wellbeing

Aust and colleagues reviewed organizational interventions to reduce burnout. Sixty-eight percent of included studies improved at least one primary outcome; evidence was strongest for job and task modification and moderate for flexible scheduling and physical work-environment changes. The heterogeneity of interventions and outcomes prevents a universal effect estimate, but the directional lesson is clear: change the work. NIOSH reaches the same operational conclusion in its Impact Wellbeing Guide, which emphasizes systems-level improvement, two-way communication, trust, worker participation, and a 12-month quality-improvement process (Aust et al., 2024; NIOSH, 2024).

NON-NEGOTIABLE INTERPRETATION

Resilience resources may be useful as an optional support. They are not an adequate primary intervention when the principal exposure is unsafe workload, unstable scheduling, violence, administrative burden, or absent decision-making power.

4.4 Evidence synthesis matrix

Table 3. Evidence strength and the boundary of inference

FINDING	BEST SUPPORTING EVIDENCE	CONFIDENCE	GOVERNANCE IMPLICATION
Turnover remains severe and reversed direction in 2025	Large 2026 hospital industry survey; federal quit context	Moderate	Treat trend reversal and first-year concentration as board risks, not a temporary HR variance.
Exhaustion, violence, practice environment, and safety track departure risk	Adjusted observational nurse study	Moderate	Govern leading indicators at the unit and shift level.
Organizational support relates to lower turnover intention	Meta-analysis of eight cross-sectional studies	Low to moderate	Measure support and test it as a mediator, not as proof of causality.
Unsafe staffing relates to actual turnover.	Systematic review	Moderate	Require acuity, competency, variance, and capacity controls.
Work-environment interventions can reduce burnout.	Systematic review of organizational interventions	Moderate	Fund operational redesign before individual coping programs.
Betrayal can accompany significant distress.	Cross-sectional single-system study	Emerging	Install explicit breach acknowledgment and trust-repair processes.
The proposed Compact will reduce turnover.	Theory-informed intervention, not yet trialed	Unknown	Implement with a rigorous comparative evaluation and stop rules.

5 | THE ACCOUNTABILITY BOUNDARY

5. Leadership accountability without causal overreach

5.1 What leadership owns

Accountability is not the same as blame. Blame asks who deserves condemnation after an outcome. Accountability asks who had authority, resources, and a duty to prevent, detect, correct, and learn. A chief executive does not control every resignation. The executive team and board do control whether the organization has reliable workforce definitions, invests in sufficient capacity, protects voice, designs incentives, funds remedies, and removes leaders who repeatedly fail.

Table 4. A disciplined attribution framework

CONTROL ZONE	EXAMPLES	LEADERSHIP DUTY	INTERPRETATION
Direct control	Staffing model, schedule rules, span of control, reporting pathway, incentive design, pay architecture, onboarding, security resources	Set standards, resources, monitor, correct, and impose consequences	Failure is directly governable.
Material influence	Team climate, workload, local labor supply response, commute mitigation, career access, supervisor quality, technology burden	Use available levers, test alternatives, and disclose constraints	Outcome is shared, but inaction is not neutral.
Limited control	Retirement, family relocation, spouse employment, illness, licensure pipeline, macroeconomic shock	Forecast, accommodate where feasible, and avoid false attribution	Departure may be unavoidable; system response remains governable.
Unknown or mixed	Exit reason recorded as personal, better opportunity, or culture	Use a confidential qualitative review and multiple indicators	Do not use a vague code to close the inquiry.

5.2 The minimum anatomy of accountability

A workforce commitment becomes governable only when eight elements are present:

1. A named owner whose authority matches the obligation.
2. A funded intervention and explicit operating capacity.
3. A metric with a stable definition, denominator, and equity stratification.
4. A baseline, target, deadline, and red-line threshold.
5. Frontline decision rights, not merely consultation after the decision.
6. A public commitments register showing accepted, declined, and delayed actions.
7. A pre-specified escalation rule and material consequence for repeated avoidable failure.
8. A repair process that acknowledges the breach and verifies correction with workers.

GOVERNANCE EQUATION

Accountability = owner + authority + funding + metric + deadline + worker decision rights + consequence + verified repair.

5.3 What workers should no longer concede

Workers should not concede that aggregate reporting is transparent when it conceals high-risk units, shifts, occupations, or demographic groups. They should not concede that a listening session is shared governance when management retains every vote. They should not concede that an employee assistance program is a staffing intervention, that a bonus is compensation justice, or that a new dashboard is accountability when missing targets produce no action.

The ethical basis is straightforward. Healthcare workers accept exposure to suffering, time pressure, and high-consequence work, but these exposures do not absolve leadership of its reciprocal duty to organize work safely. Mission cannot operate as a demand for unlimited sacrifice. It must bind the institution as strongly as it binds the worker.

Table 4A. Four tests for a credible accountability claim

BOARD TEST	PASSING EVIDENCE
Controllability	The owner can identify which levers were available, which were used, and which constraints were independently verified.
Specificity	The promise, metric, denominator, affected group, deadline, and expected change are explicit.
Reciprocity	Workers receive protection, decision rights, and repair proportionate to the risk and sacrifice expected of them.
Consequence	Repeated avoidable failures change incentive pay, authority, performance status, or leadership assignment.

6 | WORKFORCE ACCOUNTABILITY COMPACT

6. The ten demands

The Workforce Accountability Compact is a proposed governance intervention. It is deliberately more demanding than an engagement plan. Each requirement specifies a minimum standard, observable proof, and a consequence. Local collective-bargaining agreements, professional standards, regulatory requirements, and state law may require stronger protections.

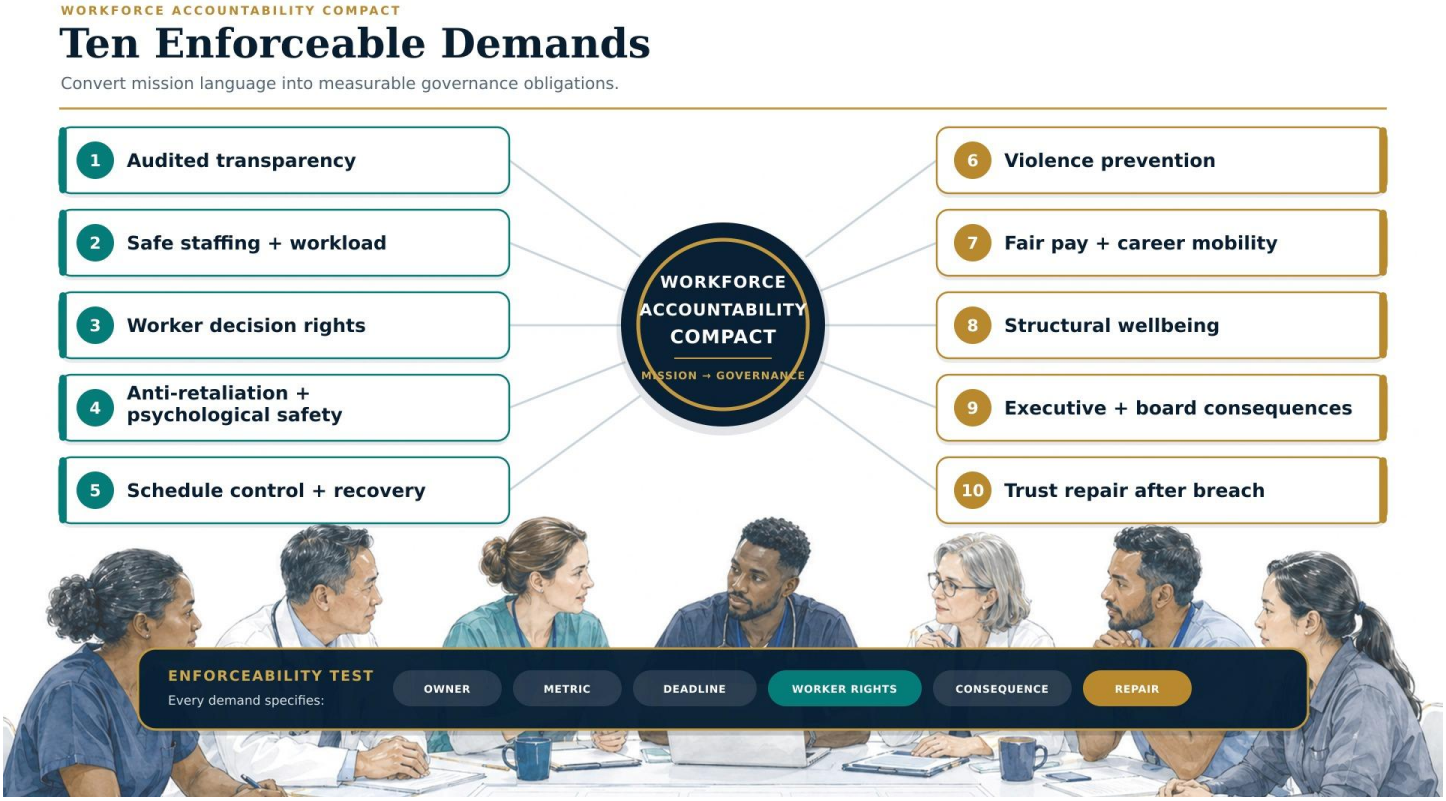

Figure 5. The Workforce Accountability Compact

Source: Author synthesis. The sequence indicates implementation logic, not an empirical ranking.

6 | COMPACT REQUIREMENTS IN DETAIL

Table 5a. Compact requirements 1 through 5

DEMAND	MINIMUM STANDARD	PROOF AND CONSEQUENCE
1. Audited workforce transparency	Monthly unit-level turnover, first-year exits, vacancies, overtime, agency use, injuries, violence, burnout, trust, and pay-compression indicators with common definitions.	Proof: Board-reviewed dashboard, data dictionary, denominators, trend, targets, and named owner. Consequence: Corrective plan within 30 days for missing data or adverse outliers; audit committee escalation after two missed cycles.
2. Safe staffing and workload controls	Acuity- and competency-based staffing plan, shift escalation rules, relief coverage, and authority to limit capacity when safe care cannot be supported.	Proof: Percent of shifts meeting plan, workload variance, missed breaks, missed care, overtime, closure or diversion events. Consequence: Mandatory operating review and capacity action when red-line thresholds are breached.
3. Meaningful worker decision rights	Elected frontline representation with voting authority on staffing, workflow, scheduling, safety, technology, and wellbeing priorities.	Proof: Charter, voting record, documented management response, and implementation log. Consequence: Board review of rejected recommendations and written rationale within 30 days.
4. Psychological safety and anti-retaliation	Independent reporting, just culture review, confidentiality protections, and an explicit prohibition on retaliation for raising safety or staffing concerns.	Proof: Case closure time, substantiation patterns, retaliation allegations, culture measures, and remedy completion. Consequence: Independent investigation and leadership discipline for retaliation or suppression.
5. Schedule control and recovery	Predictable schedules, limits on mandatory overtime, protected breaks, usable paid leave, and participatory scheduling where operations permit.	Proof: Schedule-change notice, mandatory overtime, missed breaks, denied leave, fatigue events, and schedule-control scores. Consequence: Unit redesign and supervisor correction when thresholds are repeatedly missed.

6 | WORKFORCE ACCOUNTABILITY COMPACT CONTINUED

Table 5b. Compact requirements 6 through 10

DEMAND	MINIMUM STANDARD	PROOF AND CONSEQUENCE
6. Violence prevention and physical safety	Staffed security plan, hazard assessment, rapid response, post-event support, prosecution policy where appropriate, and environmental controls.	Proof: Assault rate, injury severity, response time, lost workdays, reporting completeness, and corrective actions. Consequence: Executive safety review after sentinel workforce events and capital remediation when hazards persist.
7. Fair compensation and career mobility	Transparent market review, compression analysis, differentials, internal mobility, paid development, clinical ladders, and equitable access to advancement.	Proof: Market position, compression gaps, promotion rates, internal fill rates, tuition use, and exit reasons. Consequence: Funded adjustment plan with deadlines when material inequities are documented.
8. Structural well-being intervention	Operational redesign of workload, administrative burden, staffing, workflow, and team conditions before relying on individual resilience programs.	Proof: Funded intervention portfolio, baseline, process measures, outcome measures, and stopped low-value work. Consequence: Reallocate wellbeing spending away from ineffective programs and redesign the work.
9. Executive and board consequences	Workforce stability, safety, trust, and first-year retention are included in executive evaluation and incentive compensation.	Proof: Published scorecard weights, thresholds, board minutes, and action after misses. Consequence: Reduced incentive pay, narrowed authority, a formal improvement plan, or leadership replacement after repeated avoidable failure.
10. Trust repair after breach	Specific acknowledgment of what failed, disclosure of decisions and constraints, restitution where possible, co-designed correction, and scheduled follow-up.	Proof: Written breach review, commitments register, completion status, worker verification, and independent reassessment. Consequence: Escalation to the board and an external review if leaders deny, minimize, or repeat the breach.

6.1 Demand architecture

The ten demands work as a system. Transparency without staffing authority exposes harm but may not reduce it. Worker voice without anti-retaliation invites risk. Compensation without schedule control may buy short-term tolerance at the expense of worsening fatigue. Wellbeing funding without task redesign individualizes a structural problem. Executive incentives without reliable denominators create gaming. Trust repair without consequences becomes another cycle of apologies.

6.2 Worker decision rights

Meaningful participation requires a formal charter, elected frontline representation, access to the same operating data used by management, protected time, independent facilitation where needed, and a recorded vote on staffing, scheduling, safety, workflow, technology, and wellbeing priorities. Management may retain statutory authority, but rejected workforce recommendations should trigger a written rationale and board visibility. A consultation that cannot alter the decision is not shared governance.

6.3 Consequence proportionality

Consequences should distinguish unforeseeable misses from repeated avoidable failures. Repetition warrants reduced incentive pay, narrowed authority, or a performance plan. Retaliation, concealment, data suppression, or refusal to implement controls warrants independent investigation and possible leadership removal.

7. From compact to operating system

7.1 Accountability maturity

Organizations often confuse measurement with accountability. Measurement is only the third of five maturity stages. Stage one denies or normalizes the problem. Stage two publishes promises without deadlines. Stage three installs dashboards but leaves decision power and incentives unchanged. Stage four gives workers consequential governance rights and funds corrective work. Stage five links outcomes and implementation fidelity to executive consequences and verifies repair.

Figure 6. Five-stage workforce accountability maturity model

Source: Author-developed framework.

Table 6A. Maturity-stage diagnostic

STAGE	DIAGNOSTIC QUESTION	REQUIRED MOVE
1. Denial	Can leadership state the rate, the denominator, the concentration, and the named owner?	Establish the factual baseline and stop normalizing the variance.
2. Promise	Does every commitment have funding, a deadline, and an escalation rule?	Convert statements into a commitments register.
3. Measurement	Can workers alter decisions, and do misses change management action?	Transfer defined decision rights and prescribe responses.
4. Shared governance	Are authority, resources, and worker power sufficient to correct the exposure?	Close implementation gaps and audit fidelity.
5. Consequence	Are outcomes, repair, and leadership consequences independently verifiable?	Maintain external review and recalibrate incentives.

7.2 Board scorecard

The board should receive a small set of decision-grade measures monthly or quarterly. Each measure requires a named executive owner, a stable definition, a baseline, a target, a red line, equity stratification, and a prescribed response. Rates should be presented with denominators, trends, and control limits where volume permits. Heatmaps should direct attention, not substitute for the underlying data.

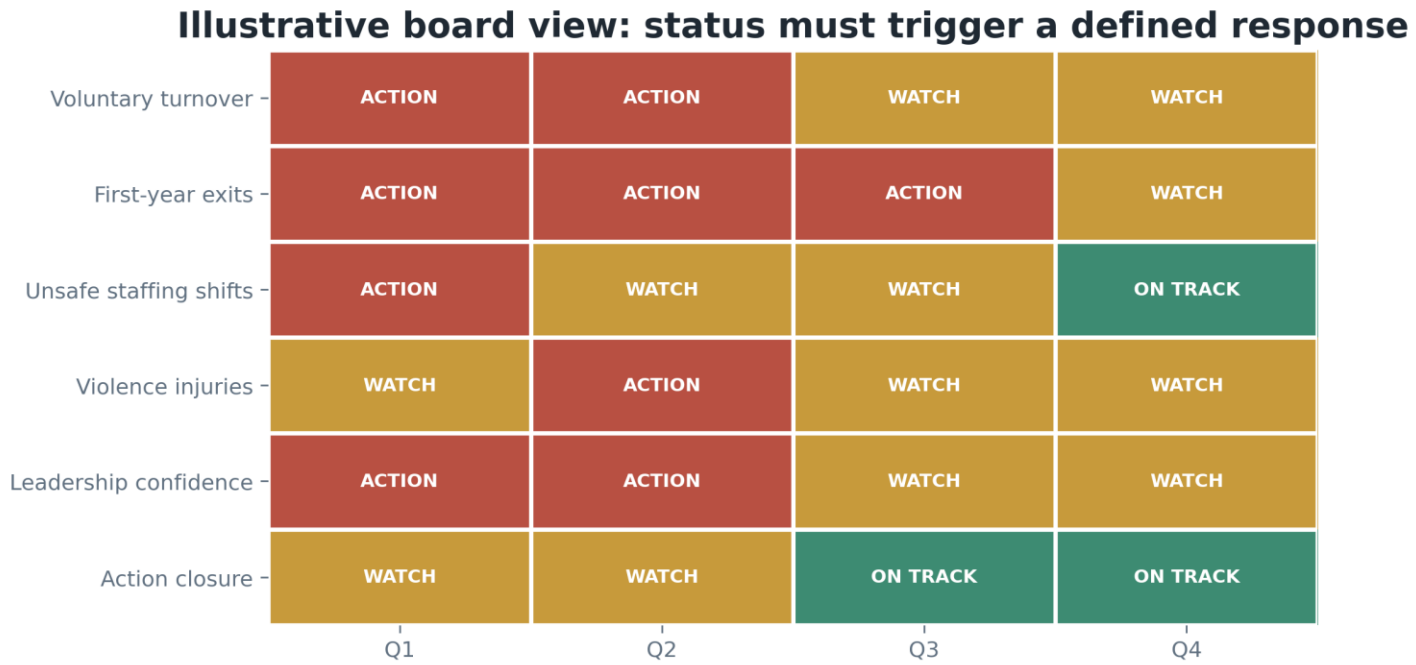

Figure 7. Illustrative workforce accountability heatmap

Source: Author illustration. Status values are fictional and serve only to display logic.

Table 6. Minimum board scorecard specification

MEASURE	MINIMUM DEFINITION	STRATIFICATION	RED-LINE RESPONSE
Voluntary turnover	Voluntary separations / average headcount; report rolling 12-month and quarterly flow	Unit, role, shift, status, tenure, demographic equity	Corrective review after an adverse special-cause signal or two target misses.
First-year exits	Separations among employees within 365 days, with hires and risk-set definition disclosed	Hiring cohort, recruiter, unit, supervisor, role	Root-cause review and onboarding or job-design correction within 30 days.
Staffing plan attainment	Shifts meeting acuity- and competency-adjusted plan / eligible shifts	Unit, shift, weekday, service line	Capacity, diversion, or staffing escalation when the safety threshold is crossed.
Workplace violence	Reported assaults, injury severity, lost days, and response time	Location, shift, role, source of violence	Sentinel workforce event review and capital or security remedy.
Schedule control	Notice, changes, mandatory overtime, missed breaks, and denied leave	Unit, shift, employment status, caregiver status	Supervisor and scheduling redesign after repeated breaches.
Leadership confidence	Validated survey item with response rate and nonresponse analysis	Unit, role, tenure, and key equity groups	Listening plus published response covenant; independent review if decline persists.
Commitment closure	Verified commitments completed by deadline/commitments due	Owner and demand category	Board escalation after two missed cycles; consequence per charter.

Thresholds should be calibrated to local baseline, statistical variation, regulatory standards, and patient acuity. A target is not permission to tolerate preventable harm below the threshold.

7.3 Incentive design

A material share of executive incentive compensation should depend on workforce outcomes and implementation fidelity. Pure outcome incentives can encourage risk selection, coding changes, or suppression. Pure process incentives can reward activity without improvement. A balanced design should combine outcomes such as voluntary and first-year turnover, leading

indicators such as staffing-plan attainment and leadership confidence, implementation measures such as action closure, and guardrails such as safety events, retaliation allegations, and equity gaps. The board compensation committee should approve definitions before the performance year and prohibit retroactive denominator changes.

7.4 Data integrity and worker verification

Workforce data should be auditable. The data dictionary must define the inclusion of internal transfers, retirements, involuntary separations, per diem workers, contractors, and leave. Dashboard owners should reconcile HR information systems, scheduling, payroll, incident reporting, and survey data. Worker representatives should be able to challenge definitions and append a dissent statement. An independent audit should focus on missingness, denominator drift, suppressed small cells, repeated reclassification, and whether recorded completion matches frontline experience.

QUARTERLY BOARD CHALLENGE

Show the three largest adverse workforce variances, the workers who experience them, the corrective actions already funded, the commitments past due, and the executive consequences that will follow another missed cycle.

8. Implementation sequence

Implementation must move fast enough to establish credibility and slowly enough to preserve measurement quality. The first 30 days should establish disclosure, protection, and ownership. The next 60 days should convert worker voice into decision rights and fund initial corrections. Quarterly governance should verify outcomes and impose escalation. At 12 months, an independent evaluation should determine whether the Compact is producing meaningful change.

Figure 8. Compact implementation roadmap

Source: Author-developed implementation sequence.

8.1 First 30 days: acknowledge and disclose

- Issue a specific breach statement: what was promised, what failed, who was affected, and which decisions or constraints contributed.
- Publish the baseline dashboard with definitions, denominators, missingness, targets, and owner names.
- Freeze retaliation risk by installing independent reporting, preservation of relevant records, and rapid protection review.
- Identify immediate hazards requiring capacity limits, security action, relief coverage, or schedule correction.

8.2 Days 31 to 90: transfer power and fund correction

- Seat the workforce council through a transparent election or selection process and provide protected time and technical support.
- Approve staffing, schedule, safety, and workflow red lines with automatic escalation.
- Redirect wellbeing resources toward work redesign where baseline data identify structural exposures.
- Publish executive incentive weights, commitments, and deadlines before claiming the Compact is operational.

8.3 Quarterly and annual governance

Quarterly review should pair outcomes with fidelity. A turnover reduction cannot validate the program if it resulted from a hiring freeze, changed eligibility, or involuntary exits. A missed target cannot invalidate a well-implemented control during an external labor shock. The board needs both the result and the causal context. At 12 months, an independent review should estimate effects, test equity, identify unintended consequences, and recommend renewal, redesign, scale, or discontinuation.

8.4 Communication covenant

Every workforce survey or listening exercise should begin with a response covenant. Leadership should state in advance when results will be published, which decisions workers can influence, how declined recommendations will be explained, how confidentiality will be protected, and when progress will be revisited. The covenant prevents listening from becoming extraction: workers should not repeatedly disclose harm while leaders retain the information and the discretion to do nothing.

Table 8A. Implementation failure modes and controls

IMPLEMENTATION RISK	EARLY SIGNAL	REQUIRED CONTROL
Symbolic adoption	Compact signed, but no budget, red lines, or incentive exposure	Do not declare launch until the minimum fidelity criteria are met.
Data gaming	Definitions, exclusions, or denominators change after a miss	Freeze definitions prospectively and require audit approval for change.
Voice without protection	Participation rises while retaliation allegations or transfers increase	Independent investigation, interim protection, and board escalation.
Burden shifting	One group improves while overtime, violence, or vacancies rise elsewhere	Equity and spillover analysis across occupations, shifts, and units.
Initiative overload	Milestones accumulate while frontline capacity deteriorates	Stop low-value work and fund implementation time.

9 | EVALUATION PROTOCOL

9. A research-grade test of the Compact

9.1 Preferred design

The preferred pragmatic design is a stepped-wedge rollout across comparable units or facilities. Every participating unit eventually receives the Compact, but the transition is staggered, allowing contemporaneous comparison between units operating under usual governance and units under the intervention. Where staggered rollout is infeasible, use difference-in-differences with matched comparison units and at least 12 months of baseline data. Follow-up should extend 18 to 24 months because turnover, hiring cohorts, and trust repair evolve more slowly than implementation activity.

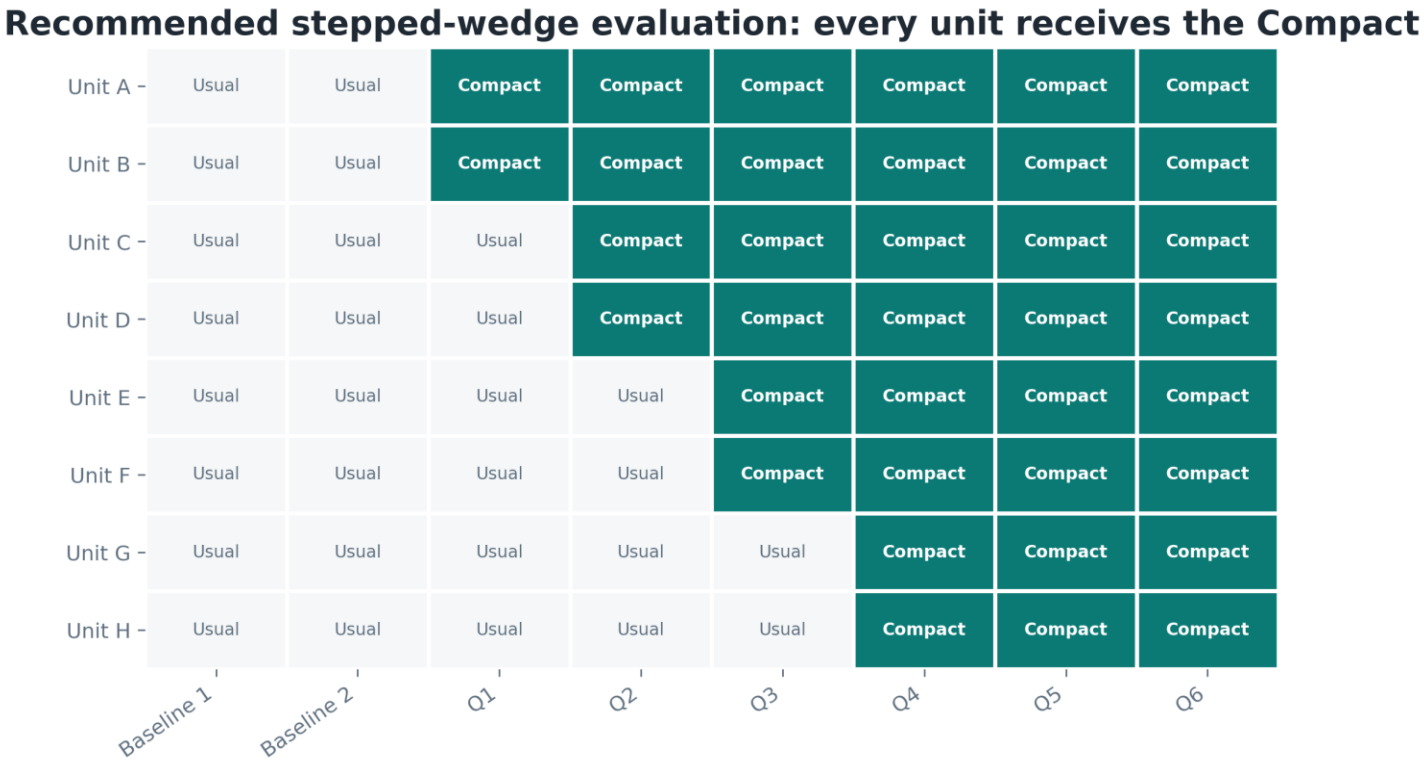

Figure 9. Illustrative stepped-wedge implementation

Source: Author illustration. Transition timing should be randomized where operationally and ethically feasible.

9.2 Intervention definition and fidelity

The intervention is not the presence of a written Compact. A unit is exposed only when the required elements are operational: baseline disclosure, worker voting rights, red-line controls, a funded corrective portfolio, executive and board review, consequence rules, and a live trust-repair register. Fidelity should be scored independently, with evidence for each component. This prevents a null result caused by partial implementation from being misinterpreted as evidence that accountability does not work.

9.3 Outcomes and estimands

The primary estimand is the intention-to-treat effect of assignment to Compact implementation on risk-adjusted voluntary turnover over 12 months. A complementary per-protocol analysis should estimate outcomes among units that meet a prespecified fidelity threshold, but it must be labeled as vulnerable to selection bias. Person-level time-to-exit analysis is preferred where de-identified dates are available. Competing events such as internal transfers, retirements, involuntary separations, and promotions should be distinguished.

Table 7. Core evaluation protocol

ELEMENT	SPECIFICATION
Design	Stepped-wedge implementation or difference-in-differences comparison across matched units or hospitals, with at least 12 months of baseline and 18 to 24 months of follow-up.
Primary outcome	Risk-adjusted 12-month voluntary turnover by unit, occupation, shift, employment status, and tenure; analyze time to exit when person-level de-identified data are available.
Secondary workforce outcomes	First-year turnover, vacancy, internal transfer, overtime, agency hours, schedule control, emotional exhaustion, psychological safety, organizational support, and confidence in leadership.
Patient and operating outcomes	Safety events, missed-care indicators, patient experience, closed capacity, time-to-fill, labor cost, orientation cost, and turnover cost.
Mechanism test	Estimate whether changes in staffing adequacy, organizational support, safety, voice, and trust mediate changes in turnover.
Adjustment	Occupation, wage changes, patient acuity, service-line mix, regional unemployment and labor supply, retirement eligibility, seasonality, and baseline trend.
Governance contrast	Compare advisory-only implementation with implementation tied to board oversight, executive incentives, deadlines, and documented consequences.
Decision rule	Pre-specify minimum clinically and operationally meaningful change, confidence intervals, equity checks, and stop or redesign criteria before launch.

9.4 Statistical model

For unit-period turnover rates, estimate a generalized linear mixed model with unit random effects, time-fixed effects, intervention exposure, and prespecified covariates. For person-level data, use a survival model with robust standard errors clustered by unit. The stepped-wedge model can be expressed conceptually as:

PRIMARY MODEL

g(E[Y_it]) = alpha + beta(Compact_it) + gamma_t + u_i + thetaX_it, where beta estimates the intervention effect, gamma_t captures common period shocks, u_i captures stable unit differences, and X_it contains pre-specified time-varying confounders.

Report absolute risk differences as well as relative effects, 95% confidence intervals, and the number of exits potentially avoided. Examine pre-trends before the difference-in-differences analysis. Use interrupted time-series diagnostics where rollout occurs simultaneously. Do not declare success from statistical significance alone; pre-specify a minimum operationally meaningful reduction and the cost required to achieve it.

9.5 Mechanism, equity, and safety analyses

Mechanism analysis should test whether improvements in staffing adequacy, schedule control, psychological safety, perceived organizational support, and leadership confidence mediate turnover change. Because mediation under time-varying confounding is complex, these analyses should be framed as explanatory unless stronger assumptions are met. Equity analysis should estimate differential effects by occupation, shift, employment status, tenure, race and ethnicity, sex, age, and disability where lawful and sufficiently powered. Small-cell suppression must protect confidentiality without hiding persistent disparities.

Patient and workforce guardrails should include missed care, adverse events, workplace injuries, violence severity, sick leave, closed capacity, and patient experience. A retention improvement that depends on involuntary conversion, suppressed reporting, unsustainable overtime, or disproportionate burden on a lower-power group is not successful.

9.6 Economic evaluation

Estimate cost from the health-system perspective. Include implementation staff, protected worker time, technology, staffing additions, security, schedule premiums, compensation correction, and an independent audit. Benefits should include avoided vacancy and recruitment costs, reduced labor costs, retained productivity, reduced closed capacity, and measurable safety savings. Present budget impact separately from cost-effectiveness, and include sensitivity analyses rather than treating national turnover cost estimates as local truth.

9.7 Decision rule

Before launch, the board and workforce council should define four possible dispositions: scale, continue with modification, pause and redesign, or stop. Scale requires meaningful improvement in the primary outcome, acceptable fidelity, no serious harm to guards, and equitable benefit. A null outcome with high fidelity argues against the current intervention theory. A null outcome with low fidelity argues against the implementation. Harm, retaliation, or data suppression requires immediate investigation, regardless of the outcome of the turnover.

Table 7A. Minimum pre-registration checklist

PRE-REGISTRATION ITEM	MINIMUM DECISION
Primary estimand	Population, exposure definition, outcome window, and comparison condition
Meaningful effect	Absolute turnover reduction and confidence interval are considered operationally important.
Fidelity threshold	Components and evidence required to classify the Compact as implemented
Confounding plan	Covariates, pre-trend assessment, matching, and handling of time-varying shocks
Missing data	Mechanism, imputation or weighting plan, and sensitivity analyses
Equity and guardrails	Subgroups, minimum cell sizes, harm thresholds, and protected reporting rules
Disposition	Scale rules, modify, pause, redesign, or stop.

10. Limitations

This report has six important limitations. First, it is a rapid evidence synthesis, not a registered systematic review, and may omit relevant studies. Second, NSI is a large-industry survey rather than a probability sample of all US healthcare organizations; participating hospitals may differ from non-participating hospitals. Third, BLS combines health care with social assistance, so it provides a macro context rather than a precise hospital turnover measure. Fourth, Press Ganey analyses are proprietary and observational. Fifth, much of the peer-reviewed literature on nurses relies on cross-sectional surveys and uses intention to leave rather than verified turnover. Sixth, the Workforce Accountability Compact and maturity model are author-developed constructs that have not yet been validated as a package.

These limitations narrow the claims but do not erase the convergent pattern. Current burden data indicate significant instability and high costs. Systematic reviews and adjusted studies link organizational conditions to withdrawal risk. Intervention evidence and federal guidance favor structural work redesign. Organizational theory explains why unfulfilled reciprocal obligations, unfair procedures, low support, and unsafe voice can damage trust. The appropriate conclusion is therefore not that leadership causes every exit. It is that leadership has sufficient control over consequential antecedents to justify enforceable governance and rigorous evaluation.

11. Discussion

Healthcare organizations have often responded to workforce distress with a sequence of surveys, wellbeing campaigns, recruitment incentives, and mission reaffirmation. Those actions can be useful, but they do not answer the central governance question: what happens when leadership fails again? If the answer is another listening session, a revised slogan, or an action plan without consequence, the organization has not established accountability. It has established discretion.

The Compact reframes the workforce relationship. Employees do not ask leaders to guarantee that no one will leave. They require leaders to prove that controllable conditions are measured, resourced, and corrected; that workers have decision rights where they bear the risk; and that repeated avoidable failures change executive consequences. This standard is both ethically stronger and empirically more defensible than assigning leaders blanket blame for every resignation.

The report also shifts board attention from lagging turnover to a causal operating system. Turnover is an endpoint. Boards need the upstream conditions: staffing-plan attainment, workload variance, schedule control, violence, psychological safety, organizational support, first-year experience, and trust. They also need implementation fidelity. Otherwise, leaders can report a favorable annual rate while unsafe conditions remain concentrated in particular units or while denominator changes drive improvement.

12. Conclusion

Healthcare workers should demand proof, power, and consequences. Proof means audited unit-level evidence with stable definitions. Power means meaningful decision-making rights, a protected voice, and the authority to trigger safety escalation. Consequences mean that executive incentives, authority, and tenure are exposed when avoidable failures persist or when leaders retaliate, conceal, or refuse to accept correction. Trust repair then becomes an operating process rather than an apology.

> *The blunt conclusion is warranted: mission statements do not retain workers, absorb violence, cover unsafe workloads, or restore credibility. Leadership accountability begins when promises are converted into funded controls, deadlines, worker verification, and consequences. Anything less leaves the moral burden on employees while preserving discretion for those in power.*

APPENDIX A | COMPACT ADOPTION INSTRUMENT

Appendix A. Model Workforce Accountability Compact

Purpose: To establish enforceable organizational duties when workforce commitments have been missed and to govern future workforce stability, safety, and trust.

Adoption statement: The board, executive leadership, and elected workforce representatives adopt the ten Compact requirements in this report. Each requirement will receive an executive owner, worker co-owner, funded action, metric, target, deadline, escalation rule, and consequence. No definition, denominator, or target may be changed retroactively without written approval and disclosure.

Table A1. Compact adoption fields

COMPACT FIELD	REQUIRED ENTRY
Breach acknowledged	Promise or duty, observed failure, affected workforce, period, and available evidence.
Executive owner	Name, title, authority, and resources controlled.
Workforce co-owner	Elected or formally designated representative and protected time
Baseline	Metric value, definition, denominator, stratification, missingness, and data owner
Target and red line	Expected change, deadline, safety threshold, and statistical rule
Funded action	Intervention, budget, staffing, dependencies, and implementation milestones
Decision rights	Votes, veto, or escalation rights, and subjects reserved to management or the board
Verification	Data audit, worker validation, independent review, and publication schedule
Consequence	Response to first miss, repeated miss, retaliation, concealment, or refusal
Repair	Acknowledgment, restitution where feasible, co-designed correction, and reassessment date

Appendix B. Accountability questions

1. Which mission or workforce promises were made, and what evidence shows they were fulfilled or breached?
2. Who owned each promise, and did that person control the necessary budget, staffing, and policy authority?
3. Which unit, shift, occupation, tenure cohort, and demographic groups bear the highest turnover, workload, and safety burden?
4. How are voluntary turnover, internal transfer, retirement, involuntary separation, and first-year exit defined?
5. What percentage of shifts met the acuity- and competency-based staffing plan, and what happened when the plan was missed?
6. Which workforce recommendations were declined, by whom, for what reason, and with what board visibility?
7. What evidence shows that speaking up is safe, including retaliation allegations, case closure, remedies, and leader discipline?
8. How much executive incentive compensation is truly at risk for workforce stability, safety, trust, and action closure?
9. Which wellbeing investments change work conditions, and which place the intervention burden on individual workers?
10. What restitution or repair followed a documented breach, and did affected workers verify that the correction was real?
11. What would cause the board to narrow a leader's authority, reduce incentive pay, require a performance plan, or replace the leader?
12. How will the organization determine whether the Compact reduced turnover without shifting harm or suppressing reporting?

Appendix C. Suggested worker resolution.

RESOLUTION

We request adoption of the Workforce Accountability Compact within 90 days, beginning with audited unit-level disclosure, protected worker decision rights, safe staffing and workload red lines, executive incentive exposure, and a board-approved consequence framework. We further request an independent evaluation of outcomes, equity, implementation fidelity, and trust repair at 12 months.

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Data and figure note

All charts and infographics in this report are original. Figures 1 and 2 use values transcribed from the 2026 NSI report. Figure 4 reproduces reported adjusted odds ratios and 95% confidence intervals from Friese et al. (2024). Figures 3 and 5 through 9 are author-developed conceptual or illustrative graphics and are labeled accordingly. The illustrative dashboard does not represent a real organization.