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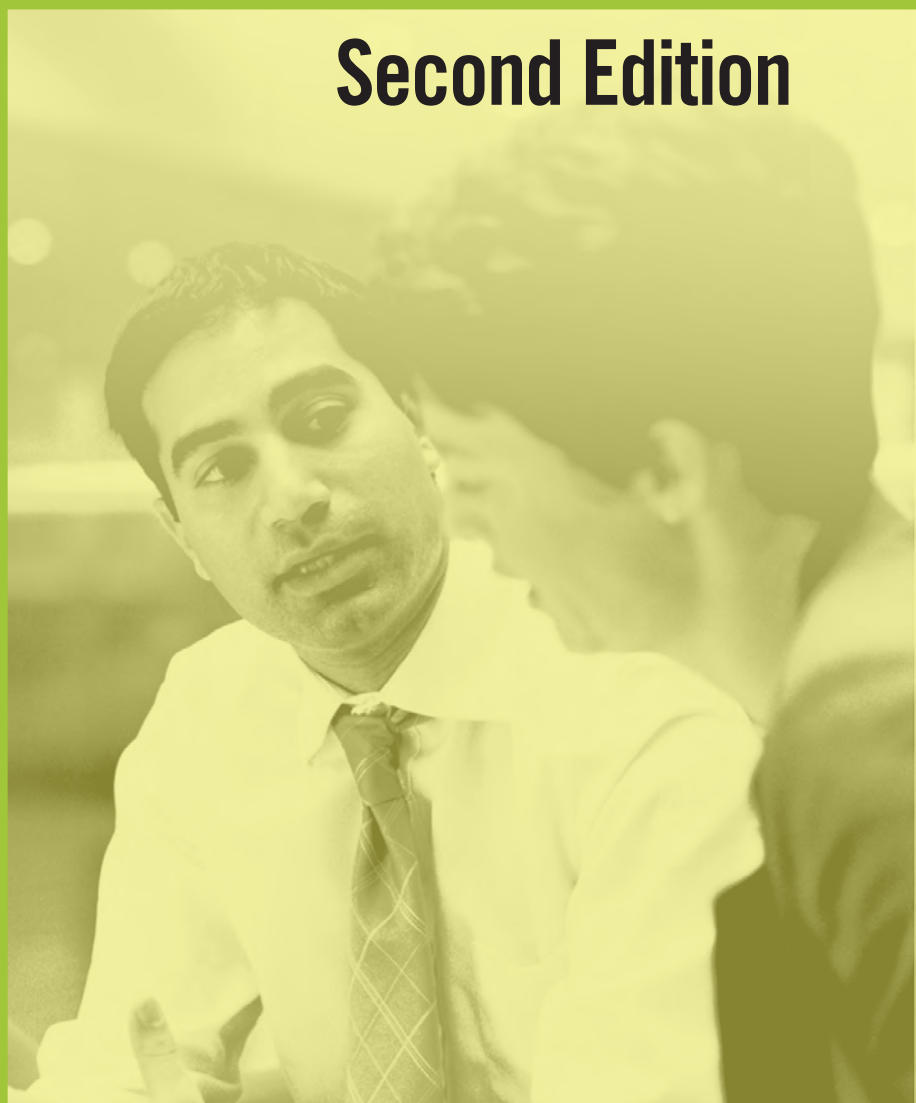
SHARED GOVERNANCE

A Practical Approach to Transform Professional Nursing Practice

Second Edition



DIANA SWIHART,
PhD, DMin, MSN, CS, RN-BC

Foreword by TIM PORTER-O'GRADY,
DM, EdD, ScD(h), APRN, FAAN

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LIST OF FIGURES AND TOOLS TO HELP BUILD AND MEASURE SHARED GOVERNANCE

The following figures are included in the book:

LIST OF FIGURES AND TOOLS

The following tools and resources relate to information contained in these chapters. The appendixes are available for download at *www.hcpro.com/downloads/9581.*

DEDICATION

This work is dedicated to those courageous and giving nurses who continue to teach me about the extraordinary realities of lived shared governance. These profound heroes and heroines exemplify professional nursing at its best through their passion, integrity, and commitment to excellence at every opportunity of service. Thank you.

ABOUT THE AUTHOR

Diana Swihart, PhD, DMin, MSN, CS, RN-BC

Diana Swihart, PhD, DMin, MSN, CS, RN-BC, enjoys many roles in her professional career, practicing in widely diverse clinical and nonclinical settings. She is currently a regional nurse at the Denver Office of Clinical Consultation and Compliance, Veterans Health Administration. An author, speaker, researcher, educator, mentor, and consultant, she holds graduate degrees in nursing and leadership and doctorates in theology and ministry. She provided operational leadership for the shared governance processes for the Bay Pines (FL) VA Healthcare System and served as a liaison to help facilitate the application of evidence-based practice and nursing research.

She is a member of Sigma Theta Tau International, the Nurses Organization of Veterans Affairs, the Veterans Educators Integrated Network, and several professional advisory boards. She has published and spoken on a number of topics related to nursing, shared governance, competency assessment, continuing nursing education, nursing and servant leadership, the American Nurses Credentialing Center (ANCC) Magnet Recognition Program®, professional nurse development, building effective preceptorships, and evidence-based practice in clinical settings locally, nationally, and internationally. She published the first edition of *Shared Governance: A Practical Guide for Reshaping Professional Nursing Practice* in 2006. She served as an ANCC Magnet Recognition Program® appraiser for six years and as the treasurer for the National Nursing Staff Development Organization for four years. She currently serves as a commissioner on ANCC's Commission on Accreditation.

Dr. Swihart believes deeply in partnerships in healing and professional practice. Her training and multidimensional experiences give her a broad and balanced perspective of nursing that influences and colors all she does as she creatively challenges and encourages others in professional practice and environments of care.

ACKNOWLEDGMENTS

Every work, regardless of scope and size, is completed only with the help and inspiration of others. My sincere thanks go to my beloved husband for his support and encouragement, his unwavering belief in me. I also want to thank my devoted son, who lent his own writing skills and gifts to the earlier reading and critiquing of the manuscript, helping me write in a way that would be more comfortable and interesting for readers.

I would also like to acknowledge those many other nurses and patients, speakers and teachers, and colleagues and friends who have contributed their ideas and thoughts through countless classes, seminars, lectures, and discussions I have experienced over the years. I write from their influence and want to recognize their contributions as well. Though their names are too numerous to list, many others can be found in this work and in the extended bibliography. To each and every one of you, thank you.

Finally, I would like to thank two innovative and courageous leaders in nursing today who have most transformed my own thinking about shared governance: Dr. Robert Hess, a friend and colleague who taught me to measure shared governance and how to see more clearly the potential for nurses to truly lead change and advance healthcare on every level; and Dr. Tim Porter-O'Grady, whose work first drew me to the study of shared governance. After studying more than 180 articles, videos, and books, my ideas and writing most strongly reflect Dr. Porter-O'Grady's influence. For this reason, I am particularly pleased that he has again written the foreword for what I hope to be another valuable addition to your own journey in helping reshape and transform professional nursing practice for this and the next generation.

Diana Swihart, PhD, DMin, MSN, CS, RN-BC
April 2011

FOREWORD

The concept of shared governance continues to be a centerpiece of developing the collaborative environment for patient care. It continues to reflect the need to engage and empower people, and is the centerpiece of shared governance. Shared governance has been associated with good management for some 60 years. It seems to many that such concepts are new and innovative simply because so few leaders actually implement these concepts into the exercise of their own management. The prevailing model for management has historically been one that represents parent-child relationships, because it is the predominant model of leadership that most people can identify in the absence of real leadership education.

In nursing, much of management represents a parental and maternal influence that extends into the staff management interaction at every level of nursing practice. From the orientation program to policy, procedure, protocols, and practices, the nurse is constantly reminded of how much his or her life is scripted and controlled by external parameters and directives. It is no wonder that, given enough time, most nurses lose interest in controlling their own practice and influencing the practice lives of others. Ultimately, a nurse's locus of control becomes so narrow that he or she ceases to do anything but the most functional and routine activities and quickly becomes addicted to the predictable and ritualistic activities of nursing.

It is a challenge to get nurses out of their rut and fully engage them in their practice lives. Even when it is clearly in the best interest of the nurse to become more fully involved, the vagaries of work, the demands of patient care, and any other excuse becomes the barrier to fully engaging with those things that are necessary to advance and change practice. The leaders, for their part, have created such a vertical orientation and relationship that staff ultimately feel as though anything significant, important, or valuable can only be done by managers or by management mandate. They feel that any effort on the part of the staff infringes on their time and therefore is not legitimate. In this age of reform and interdisciplinary

integration around an evidence-driven patient care model, the engaged and mature partnership role of the nurse is the essential centerpiece.

Shared governance reflects a completely different mental model for relationship and for leadership within and between disciplines. It recognizes that nursing as a profession coordinates, integrates, and facilitates the interface between the disciplines and around the patient. In fact, shared governance is predominantly about building a particular infrastructure or framework for building an effective interprofessional interaction between nursing and its care partners. It reorients the decision-making construct to require a broader distribution of decisions across the professions and allocates decisions based on accountability and role contributions to the collective work of patient care. This reconfiguration of the health system is intended to define staff-based decisions, accountability, roles, and ownership of all clinical staff in those activities that directly affect the care of the patient.

Success with shared governance requires a powerful reorientation of the organization. It requires leadership to understand that a significant retooling of leadership capacity and skill is required to successfully implement shared governance and sustain it as a way of life in the professional organization. Implementing shared governance means retraining managers, engaging staff, reallocating accountability, and building a truly staff-driven model of decision and action. Because behavior cannot be changed or sustained without a supporting infrastructure, it means redesigning and structuring the organization to eliminate rewards for passive behavior and enumerating and inculcating rewards for engagement within the very fabric of the organization.

Staff-driven decision-making is a strong indicator of excellence. It is no surprise that the American Nurses Credentialing Center Magnet Recognition Program® bases its major themes in a way that reflects the values and system of shared governance and staff-based accountability. Also, the work is not easy, and it cannot be done overnight. It means building an entire new culture that clearly and unambiguously reflects the characteristics of a truly collaborative, professional organization. From the highest levels of organizational leadership to the patient relationship, there must be strong evidence of practice driving the organization's work. In all professions, power is grounded in practice. Excellence in practice can only be obtained and sustained if the practitioners hold and exercise the power that only practice can drive in achieving excellence and satisfaction. Without it, the power to influence, change, challenge, and "push the walls" toward innovation and creativity is simply vacated, and others end up playing that role, whether their doing so is legitimate or not.

FOREWORD

Sharon Finnigan and I wrote the first definitive book on shared governance in 1985. Although we and others have continued to add to that body of knowledge over the years, no substantial foundational text on implementing the basics of an effective shared governance system has been forthcoming since that time, until this current work (written first in 2006, now expanded in 2011). Here, the author has clearly enumerated the foundations of shared governance and the practical elements necessary to construct a shared governance structure (including the interdisciplinary requisites) and to make it successful. This is perhaps one of the clearest explications of the principles, design, and processes associated with a viable and successful shared governance model that exists in the literature today.

If the reader carefully works through this text and thoughtfully reasons and applies the principles set out herein, he or she can advance the opportunity to create a successful approach to broad-based shared governance. Each stage of development, every design element, components of the decision process, and evaluation of effectiveness outlined here provides the tools necessary to make implementation successful. Although the work will be focused and sometimes difficult, the rewards have proven to be substantial to those who have been willing to risk the effort and initiate the dynamic of creating a truly professional patient-centered organization. There is no greater indicator of a viable and sustainable potential for nurses and the clinical team—as well as those we serve—than a fully empowered and engaged professional community that creates the foundations and conditions for excellence for the foreseeable future.

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PREFACE

Why a second edition of a shared governance book devoted to the "how to" approach to implementing this particular model? When the first edition was written, it was specifically to fill an identified need. As a new American Nurses Credentialing Center Magnet Recognition Program® (MRP) director, I was asked to design a shared governance structure for a growing multifacility healthcare system as part of its journey to excellence and MRP designation. Direct-care nurses and leaders described the concept as "shared decision-making" or "shared leadership" without being able to identify specifics of what that might look like as part of shared governance in practice or how to get there.

As I investigated how best to proceed, I found that even the most learned experts and consultants seemed to disagree on what shared governance was, much less how to apply it to the nursing meso- and micro-systems within the organization. Yet, nurse leaders such as Dr. Tim Porter-O'Grady had been developing and teaching the benefits and structures of shared governance for many years, while his friend and colleague Dr. Robert Hess had designed and validated instruments to measure it.

So why was shared governance not part of the lived experience of professional nurses at the point of service?

- Leaders believed shared governance was necessary and possible
- Direct-care nurses believed it was necessary but not possible

Therefore, in beginning the work in my own organization and carefully considering the evidence, I found that the theory, concept, and constructs for shared governance were all sound. The key lay in defining, describing, and applying them in practice settings. To do this, direct-care nurses needed clearly delineated guidance, templates, and tools.

Since that first publication, I have received a plethora of ideas, descriptions of repeated challenges across diverse organizations (e.g., nurses holding to legacy systems; insistence on micromanagement of professional nurses around practice, quality, and competency; leaders who manage but do not lead; direct-care nurses who disengage or even sabotage the efforts of engaged nurses at all levels; lack of resources and/or commitment to sustained shared governance), and contributions of best practices from nurses who work in organizations where shared governance is the lived experience—the business-as-usual approach to professional nursing practice in partnership with interprofessional and interdisciplinary team members.

I have been amazed and humbled at how well the first edition was received and the willingness of readers to share their thoughts, concerns, and recommendations for improving it as more organizations are formally devoting funds and other resources to shared governance. This second edition retains everything readers need from the first edition but with more clarity in defining terms, describing processes, and advancing professional nursing practice. It also contains suggestions for building unit-level councils and nursing governance councils in step-by-step format with tools and information addressing every need identified by direct-care nurses and nurse leaders over the past five years. Additionally, this work includes important information regarding the future of nursing (Institute of Medicine, 2011) and the critical need for nurses to engage in shared governance at the point of service to more successfully participate in building that future.

Diana Swihart, PhD, DMin, MSN, CS, RN-BC
June 2011

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Chapter 1

INTRODUCTION: THE CONSTRUCT OF SHARED GOVERNANCE

LEARNING OBJECTIVES

After reading this chapter, the participant should be able to:

- Define the four primary principles of shared governance: partnership, equity, accountability, and ownership
- Compare two professional nursing practice models

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

– *American Nurses Association (2003)*

The increasing criticality of the professional nurse shortage is a recurrent and dangerous theme in healthcare. A growing number of institutions are reexamining shared governance—a concept introduced into healthcare organizations in the 1970s—as an evidence-based method to curb the damaging effects of the shortage (e.g., negative patient outcomes, high cost of agency staff, and RN sign-on bonuses). This book takes some of the guesswork out of the various structures and processes behind shared governance and provides strategies, case examples, and best practices to make the daily operations of shared governance meaningful and successful. It also explores the relationship between shared governance and the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® (MRP), outlining the MRP expectations for shared governance practices.

CHAPTER 1

What Is Shared Governance?

> Before it can be solved, a problem must be clearly defined.
>
> – *William Feather*

Shared governance has been referred to as a concept, a construct, a model, a system, a philosophy, and even as a movement. It is most often called shared decision-making and/or shared leadership in many organizations that have implemented it. Before going any further, then, an operational definition is needed to clarify this work and address the research and applications to practice we find in shared governance.

> *Shared governance* is an innovative organizational management model; it is the structure for the process of shared decision-making and outcomes of shared leadership.

Because shared governance reflects the mission, vision, and values of those who embrace it, it appears to be a fluid presence in each environment and practice setting. In 1975, Dr. Luther Christman, a highly honored but controversial leader and provocative advocate for nursing (Pittman, 2006), spoke about an autonomous nursing organization at the American Nurses Association convention in Atlantic City, NJ. Other great nurses caught his vision and continue to build nursing as a profession through shared governance, such as Dr. Tim Porter-O'Grady and Dr. Robert Hess (see expanded bibliography, which for space reasons is included only online with the rest of the downloadable resources).

The *Random House Unabridged Dictionary* defines the verb *govern* as to exercise a directing or restraining influence over; guide: *the motives governing a decision*; to have predominating influence. Building on that context, Hess' research in measuring shared governance developed and validated an 86-item instrument specifically designed to assess the six domains of shared governance in an organization and in the profession of nursing related to control, influence, authority, participation, access, and ability. Most instruments measure characteristics and some outcomes related to shared governance. However, the Index for Professional Governance and the Index for Professional Nursing Governance have been researched and used to measure progress in developing and/or establishing shared governance in growing numbers of organizations.

See Chapter 6 for further details on the Index for Professional Governance and the Index for Professional Nursing Governance. You can find both these documents with the rest of the appendixes on the downloadable resources page at *www.hcpro.com/downloads/9581*. Look for App1 and App2 in the list of resources. In addition, see the expanded bibliography for more details on this topic.

STRUCTURE: shared governance
PROCESS: shared decision-making
OUTCOME: shared leadership

The management process model of shared governance, *shared decision-making*, is based on the principles of partnership, equity, accountability, and ownership at the point of service. It empowers all members of the healthcare workforce to have a voice in decision-making. This facilitates diverse and creative input to advance the business and healthcare missions of the organization. In essence, this makes every employee feel like he or she is "part manager" with a personal stake in the success of the organization, which leads to:

- Longevity of employment
- Increased employee satisfaction
- Better safety and healthcare
- Greater patient satisfaction
- Shorter lengths of stay

Those who are happy in their jobs take greater ownership of their decisions and are more vested in patient outcomes. Employees, patients, the organization, and the surrounding communities benefit from shared governance.

In effective shared governance, decision-making must be shared at the point of service to allow cost-effective service delivery and nurse empowerment. This requires a decentralized management structure. Employee partnership, equity, accountability, and ownership occur at the point of service (e.g., on the patient care units) where at least 90% of the decisions need to be made. The locus of control in the professional practice environment shifts to practitioners in matters of practice, quality, and competence. Only 10% of the decisions at the unit level belong to management (Porter-O'Grady & Hitchings, 2005).

Partnerships

Partnership links healthcare providers and patients along all points in the system; it is a collaborative relationship among all stakeholders and nursing required for professional empowerment. Partnership is essential to building relationships, involves all staff members in decisions and processes, implies that each member has a key role in fulfilling the mission and purpose of the organization, and is critical to the effectiveness of the healthcare system (Porter-O'Grady & Hitchings, 2005).

Equity

Equity is the best method for integrating staff roles and relationships into structures and processes to achieve positive patient outcomes. Equity maintains a focus on services, patients, and staff; is the foundation and measure of value; and says that no role is more important than another. Although equity does *not* equal equality in terms of scope of practice, knowledge, authority, or responsibility, it does mean that each team member is essential in providing safe and effective care (Porter-O'Grady & Hitchings, 2005; Porter-O'Grady, Hawkins, & Parker, 1997).

Accountability

Accountability is a willingness to invest in decision-making and express ownership in those decisions. Accountability is the core of shared governance. It is often used interchangeably with responsibility and allows evaluation of role performance. It facilitates partnerships for sharing decisions and is secured in the roles by staff producing positive outcomes (Porter-O'Grady & Hitchings, 2005). Figure 1.1 shows characteristics of accountability and responsibility.

Figure 1.1

CHARACTERISTICS OF ACCOUNTABILITY AND RESPONSIBILITY

Accountability	Responsibility
Defined by outcomes	Defined by functions
Self-described	Delegated
Embedded in roles	Specific tasks/routines dictated
Dependent on partnerships	Isolative
Shares evaluation	Supervisor evaluation
Contributions-driven value	Tasks-driven value

Adapted from Porter-O'Grady and Hitchings (2005).

Ownership

Ownership is recognition and acceptance of the importance of everyone's work and that an organization's success is bound to how well individual staff members perform their jobs. Ownership designates where work is done and by whom to enable participation of all team members. It requires a commitment by each staff member for what is to be contributed, establishes a level of authority with an obligation to own what is done, and includes participation in devising purposes for the work (Koloroutis, 2004; Page, 2004; Porter-O'Grady & Hitchings, 2005). Shared governance activities may include participatory scheduling, joint staffing decisions, and/or shared unit responsibilities (e.g., every RN is trained to be "in charge" of his or her unit or area and shares that role with other professional team members, perhaps on a rotating schedule) to achieve the best patient care outcomes.

The old centralized management structures for command and control are ineffective for today's healthcare market, frequently inhibiting effective change and growth within the organization and limiting future market possibilities in recruitment and retention of qualified nurses. Summative, hierarchical decision-making creates barriers to employee autonomy and empowerment. It can undermine service and quality of care. Today's patients are no longer satisfied with directive care. They, too, want partnership, equity, accountability, and mutual ownership in their own healthcare decisions and those of their family members (Institute of Medicine, 2011).

History and Development of Shared Governance

The concepts of shared governance and shared decision-making are not new ones. Philosophy, education, religion, politics, business and management, and healthcare have all benefited from a variety of shared governance process models implemented in many diverse and creative ways across generations and cultures.

- Socrates (470–399 BC), an ancient Greek philosopher, integrated shared governance concepts into his philosophies of education. The Socratic Method (answering a question with a question) calls for the teacher to facilitate the student's autonomous learning as the teacher guides him or her through a series of questions. The Socratic Method encourages students to use reason rather than appeal to authority.

- The government model for the United States was established on the concepts of shared governance—"of the people, by the people, for the people" (from Lincoln's *Gettysburg Address*, 1863)—wherein the very citizenry is directly responsible for the government on both state and federal levels. Political variations of this model of shared governance can also be seen in the European Union and the United Nations, where individual countries share in the decision-making on joint international matters.

- Eventually, shared governance found its way into the business and management literature (Laschinger, 1996; O'May & Buchan, 1999; Peters & Waterman, 1982). Organizations began to design formal structures and relationships around their leaders and employees. Positive outcomes emphasized movement from point of service outward. This differed from the more traditional, hierarchical method of moving from the organization downward approach previously used.
- In the late 1970s and early '80s, shared governance found its way into the healthcare and nursing arenas as a form of participative management. It engaged self-managed work teams and grew out of the dissatisfaction nurses were experiencing with the institutions in which they practiced (McDonagh, Rhodes, Sharkey, & Goodroe, 1989; O'May & Buchan, 1999; Porter-O'Grady, 1995).

The professional practice environment of nursing care has shifted dramatically over the past generation (American Association of Colleges of Nurses [AACN], 2002; American Organization of Nurse Executives, 2000; Institutes of Medicine, 2011). Rapid advances are occurring in:

- Biotechnology and cyberscience
- Disease prevention, patient safety, and management
- Relationship-based care
- Patients' roles in their healthcare (i.e., active partners and not just passive recipients)

Economic constraints related to service reimbursement and corporatism have forced healthcare systems to cost save by:

- Downsizing the professional workforce
- Changing staffing mixes
- Restructuring and/or reorganizing services
- Reducing support services for patient care
- Moving patients more rapidly to alternative care settings or discharge

Poor collaboration and ineffective communication among healthcare providers eventuate in sometimes devastating medical errors. The struggle to provide safe, quality care in the highly stressful—and sometimes highly charged—work environment today has resulted in limited success in recruitment and retention of qualified nurses nationwide (AACN, 2002; Kohn, Corrigan, & Donaldson, 1999; Weinberg, 2003).

Shared Governance and Professional Nursing Practice Models

As economic realities shift and change, so does nursing practice. Tim Porter-O'Grady (1987) observed the following: "Reorganization in healthcare institutions is currently the rule rather than the exception. All healthcare participants are attempting to strategically position themselves in the marketplace. What do these changes mean for nursing? How can nursing best respond?" (p. 281). The relevance of developing an effective professional nursing practice model for an economically constrained healthcare system to achieve positive outcomes, build workplace advocacy, and provide needed resources and support to improve recruitment and retention of a shrinking nurse workforce continues to be an even greater challenge today (Barden, 2009; Institutes of Medicine, 2011; Monaghan & Swihart, 2010; Porter-O'Grady & Malloch, 2010a; Swihart, 2006).

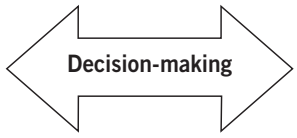
Anthony (2004) describes some of the nursing models that have evolved to provide structure and context for care delivery in the reshaping of professional nursing practice:

- Those based on patient care assignment (i.e., team nursing)
- Accountability systems (i.e., primary care nursing)
- Managed care (i.e., case management)
- Shared governance, based on professional autonomy and participatory, or shared, decision-making (i.e., relationship-based care)

Koloroutis (2004) presents the integrated work of nurse leaders, researchers, and authors who have worked with a global community of healthcare organizations over the past 25 years. The result is a nursing model for transforming practice that lends itself effectively to shared governance versus self-governance (see Figure 1.2 for self-governance vs. shared governance) in today's complex healthcare systems: relationship-based care (RBC).

Figure 1.2

SELF-GOVERNANCE VS. SHARED GOVERNANCE



Centralized Interactions
(Self-Governance)
Position-based
Distant from point of care/service
Hierarchical communication
Limited staff input
Separates responsibility/managers are accountable
We/they work environment
Divided goals/purpose
Independent activities/tasks

Decentralized Interactions
(Shared Governance)
Knowledge-based
Occurs at point of care/service
Direct communication
High staff input
Integrates equity, accountability, and authority for staff and managers
Synergistic work environment
Cohesive goals/purpose, ownership
Collegiality, collaboration, partnership

The RBC model embraces a philosophical foundation and operational framework for providing nursing services through relationships in a caring and healing environment that embodies the concepts of partnership, equity, accountability, and ownership in shared governance.

Shared decision-making occurs best in a decentralized organizational structure where those at the point of service are granted the autonomy and authority to make and determine the appropriateness of their own decisions. "When staff members are clear about their roles, responsibilities, authority, and accountability, they have greater confidence in their own judgments and are more willing to take ownership for decision making at the point of care" (Koloroutis, 2004, p. 72). Decentralized decision-making is most successful when *responsibility*, *authority*, and *accountability* (R+A+A) are clearly delineated and assigned (Wright, 2002) in shared governance.

Responsibility

Responsibility is the clear and specific allocation of duties to achieve desired results. Assignment of responsibility is a two-way process. Responsibility is visibly given and visibly accepted. Acceptance is the essence of responsibility. However, individuals cannot accept responsibility without a level of authority.

Authority

Authority is the right to act and make decisions in the areas where one is given and accepts responsibility. When people are asked to share in the work, they must know their level of authority in which to carry out that work. *Levels of authority* are the right to act in areas one is given and accept authority based on the situation and must be given to those asked to take on responsibility. There are four levels of authority (ways to be clear in communication and delegation of that authority; Wright, 2002):

- Data gathering: "Get information, bring it back to me, and I will decide what to do with it." Example, *Please go down and see if Mr. Jones has a headache and come back and tell me what he says.*

- Data gathering + recommendations: "Get the information (collect the data), look at the situation and make some recommendations, and I will pick from one of those recommendations what we will do next. I still decide." Example, *Please go down and see if Mr. Jones has a headache and come back and tell me what you would recommend that I give him.*

- Data gathering + recommendations [pause] + act: "Get the information (collect the data), look at the situation and make some recommendations, and pick one that you will do. But before you carry it out, I want you to stop (pause) and check with me before you do it." The pause is not necessarily for approval. It is more of a double-check to make sure everything was considered before proceeding. Example, *Please go down and see if Mr. Jones has a headache, come back and tell me what you would recommend for him, and then take care of him for me.*

- Act and inform/update: "Do what needs to be done and tell me what happened or update me later." There is no pause before the action. Example, *Please take care of Mr. Jones for me.*

Accountability

Accountability begins when one reviews and reflects on his or her own actions and decisions, and culminates with a personal assessment that helps determine the best actions to take in the future.

For example, in shared governance, a nurse manager is accountable for patient care delivery in his or her area of responsibility. The manager does not do all the tasks but does provide the resources direct-care nurses need and ensures that patient care delivery is done effectively by all staff members. In that patient care area, the nurse manager is accountable for setting the direction, looking at past decisions, and evaluating outcomes. Bedside nurses are accountable for the overall care outcomes of assigned groups

of patients for the time period they are there and for overseeing the big picture; however, other people (dieticians, therapists, pharmacists, laboratory technicians, and other healthcare providers) share in the responsibility for the subsequent tasks in meeting patients' needs.

Although definitions, models, structures, and principles of shared governance (sometimes called *collaborative governance*, *participatory governance*, *shared or participatory leadership*, *staff empowerment*, or *clinical governance*) vary, the outcomes are consistent. The evidence suggests implementation of shared governance and shared decision-making processes result in:

- Increased nurse satisfaction with shared decision-making related to increased responsibility combined with appropriate authority and accountability
- Increased professional autonomy with higher staff and nurse manager retention
- Greater patient and staff satisfaction
- Improved patient care outcomes
- Better financial states due to cost savings and cost reductions

Shared Governance and Relational Partnerships

> The best [leader] is the one who has sense enough to pick good [people] to do what he/she wants done, and self-restraint enough to keep from meddling with them while they do it.
>
> – *Theodore Roosevelt*

Professional nurses long ago identified shared governance as a key indicator of excellence in nursing practice (McDonagh, Rhodes, Sharkey, & Goodroe, 1989; Metcalf & Tate, 1995; Porter-O'Grady, 1987, 2001, 2004, 2009a, 2009b, 2009c). Porter-O'Grady (2001) described shared governance as a management process model for providing a structure for organizing nursing work within organizational settings. It allows strategies for empowering nurses to express and manage their practice with a greater degree of professional autonomy. Personal and professional accountability are respected and supported within the organization. Leadership support for point-of-care nurses enables them to maintain quality nursing practice, job satisfaction, and financial viability when partnership, equity, accountability, and ownership

are in place (Anthony, 2004; Green & Jordan, 2002; Koloroutis, 2004; Page, 2004; Porter-O'Grady, 2003a, 2003b; Porter-O'Grady & Malloch, 2010a, 2010b, 2010c).

Today's transformational relationship-based healthcare creates a new paradigm with different goals and objectives in organizational learning environments driven by technology. Leaders, administrators, and employees are learning and implementing new ways of providing care, new technologies, and new ways of thinking and working. In the process, they recognize more and more that the nurse at the point of service is key to organizational success associated with changing the environments of care.

Nurses, managers, interprofessional partners (i.e., physicians, professional nurses, pharmacists), and organizational leaders must be prepared for new roles, new relationships, and new ways of managing. Shared governance is about moving from a traditional hierarchical model to a relational partnership model of nursing practice (see Figure 1.3).

Successful relational partnerships in collaborative interprofessional and interdisciplinary practice require understanding the roles of each partner. If the partners are not aware of what each brings to that relationship, they will have considerable problems collaborating, acting responsibly, and being accountable for decisions and care. Therefore, relational partnerships can be a complex and challenging framework for the shared governance professional nursing practice model (Green & Jordan, 2004; Koloroutis, 2004; Porter-O'Grady, 2002; Porter-O'Grady & Hitchings, 2005; Porter-O'Grady & Malloch, 2010a).

Figure 1.3

FROM HIERARCHY TO RELATIONAL PARTNERSHIP

From HIERARCHY	to	RELATIONAL PARTNERSHIP
Independence	→	Interdependence
Hierarchical relationship		Collegial relationship
Parallel functioning		Team functioning
Medical plan		Patient's plan
Resisting change		Leading change
Competing		Partnering
Indirect communication		Direct communication

The key provider at point of service, the direct-care nurse, moves from the bottom to the center of the organization, becoming the only one who matters in a service-based organization, the one providing the care. Nurses are the frontline employees who do the work and connect the organization to the recipient of its service at the point of care. An entirely different sense and set of variables now affect the design of the organization. The paradigm at point of care has shifted to a relationship-based, staff-centered, patient-focused professional nursing practice model of care in which nurse managers or supervisors assume the role of servant leaders managing resources and outcomes within the context of relational partnerships (Nightingale, 1992).

Patient-centered care differs from patient-focused care. The Institute for Healthcare Improvement (IHI) describes patient-centered care in the following way:

> Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their loved ones an integral part of the care team who collaborate with healthcare professionals in making clinical decisions. Patient-centered care puts responsibility for important aspects of self-care and monitoring in patients' hands—along with the tools and support they need to carry out that responsibility. Patient-centered care ensures that transitions between providers, departments, and healthcare settings are respectful, coordinated, and efficient. When care is patient centered, unneeded and unwanted services can be reduced. (IHI, 2011)

IHI supports shared governance in recognizing the multifaceted challenge in advancing patient-centered care, encouraging organizations to identify best practices and systems changes in three areas:

1. Involve patients and families in the design of care
2. Reliably meet patient's needs and preferences
3. Participation in informed shared decision-making

Healthcare research is guiding the development of initiatives for "reorganizing the delivery of healthcare services around what makes the most sense for patients" (Institute for Medicine, 2001, 2011, p. 51). A few examples of patient-centered care initiatives include:

- Patient-centered medical homes
- Transforming care at the bedside
- Primary care (rather than specialty physician care)

- Nurse midwives and birth centers
- Parish nursing
- Telehealth
- Community outreach (e.g., Program for All-Inclusive Care for Elders; *www.npaonline.org*)
- The transitional care model (Institute of Medicine, 2011)

Patient-focused care refers to the caregiver's ability to focus his or her education, experience, and expertise on caring for the patient at the point of service and facilitate organizational and community patient-centered care. To do this, caregivers must have managers who are servant leaders, functioning differently in newly delineated roles (as agent or representative, advocate, ambassador, executor, intermediary, negotiator, proctor, promoter, steward, deputy, and emissary) and transforming practice settings in which patient-focused care occurs. Relational partnerships are built with equity, wherein the value of each of the participants is based on contributions to the relationship rather than on positions within the healthcare system.

Although direct-care nurses and staff are key to *recruiting* other nurses, managers are key to *retaining* them. Collateral and equity-based process models of shared governance define employees by the work they support in regard to each other rather than by their location or position in the system. For example, the manager in the servant, or transformational, leader role provides human and material resources, support, encouragement, and boundaries for the direct-care nurse in the service-provider role. Direct-care nurses, then, are accountable for key roles, decisions, and critical patient care outcomes around practice, quality, and competency. Strong interprofessional collaborations with diverse professional perspectives based on variances in education, experience, and philosophy are essential to be successful in providing point of care services. For example,

- RNs bring a holistic (whole-istic) approach to care, managing diseases and disorders while considering psychosocial, spiritual, family, and community perspectives
- Pharmacists bring expertise in pharmacodynamics
- Physicians bring a more focused approach to diagnostically managing diseases and disorders with expertise in physiology, disease pathways, and treatments (Institute of Medicine, 2011)

CHAPTER 1

Shared governance as an organizational management process model for reshaping nursing practice and decision-making requires a transformational shift with strategic change in organizational culture and leadership through collaboration with interprofessional partners and interdisciplinary team members. Implementation demands a significant realignment in how leaders, employees, and systems transition into new relationships, responsibilities, and accountabilities. It begins with operationalizing the definitions and objectives, building relationships, and creating the design.