Chapter 1

Introduction: The concept behind shared governance

Learning objectives

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

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

"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 increasingly critical shortage of professional nurses is a dangerous theme in healthcare. In response to it, more and more institutions are turning to shared governance—a concept

introduced into healthcare organizations in the 1970s—as an evidence-based method to curb the shortage's damaging effects (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 Magnet Recognition Program® by outlining the Magnet program expectations for shared governance practices.

What is shared governance?

Before it can be solved, a problem must be clearly defined.
—William Feather

In its simplest form, shared governance is shared decision-making based on the principles of partnership, equity, accountability, and ownership at the point of service. This management process model empowers all members of the healthcare workforce to have a voice in decision-making, thus encouraging diverse and creative input that will help advance the business and healthcare missions of the organization. In essence, it makes every employee feel like he or she is "part manager" with a personal stake in the success of the organization. This feeling 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. Therefore, employees, patients, the organization, and the surrounding communities benefit from shared governance.

Four principles of shared governance

If shared governance is to allow for cost-effective service delivery and nurse empowerment, decision-making must be shared at point of service—which means that the management structure must be decentralized. To make that happen, employee partnership, equity, accountability, and ownership must occur at the point of service (e.g., on the patient care units). At least 90% of the decisions need to be made there. Indeed, in matters of practice, quality, and competence, the locus of control in the professional practice environment must shift to practitioners. Only 10% of the unit-level decisions should belong to management (Porter-O'Grady and Hinshaw 2005).

- *Partnership*——links healthcare providers and patients along all points in the system; 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 healthcare system's effectiveness (Porter-O'Grady and Hinshaw 2005; Batson 2004).

- *Equity*——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 one role is more important than any other. 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 to providing safe and effective care (Porter-O'Grady and Hinshaw 2005; Batson 2004; Porter-O'Grady, Hawkins, and Parker 1997).

- *Accountability*——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 for evaluation of role performance (see Figure 1.1 for characteristics of accountability and responsibility). It supports partnerships and is secured as staff produce positive outcomes (Porter-O'Grady and Hinshaw 2005; Batson 2004).

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 T. Porter-O'Grady and K. S. Hinshaw 2005.

• *Ownership*——recognition and acceptance of the importance of everyone's work and of the fact that an organization's success is bound to how well individual staff members perform their jobs. To enable all team members to participate, ownership designates where work is done and by whom. It requires all staff members to commit to contributing something, to own what they contribute, and to participate in devising purposes for the work (Porter-O'Grady and Hinshaw 2005; Batson 2004; Koloroutis 2004; Page 2004). 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. They frequently inhibit effective change and growth within the organization and limit future market possibilities in recruitment and retention of qualified nurses. Summative, hierarchical decision-making creates barriers to employee autonomy and empowerment and 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 healthcare decisions and those of their family members.

History and development of shared governance

The concept of shared governance, or shared decision-making, is not new. Philosophy, education, religion, politics, business and management, and healthcare have all benefited from various shared governance process models implemented in many diverse and creative ways across generations and cultures. For example:

- In the 19XXs, shared governance found its way into the business and management literature (O'May and Buchan 1999; Laschinger 1996; Peters 1991; Walton 1986; Peters and Waterman 1982). Organizations began to design structures and relationships among their leaders and employees. They emphasized making decisions from the point of service on instead of from the organization downward.

- In the late 1970s and early 1980s, shared governance formally found its way into the healthcare and nursing arenas, growing out of nurses' dissatisfaction with the institutions in which they practiced (O'May and Buchan 1999; Porter-O'Grady 1995; McDonagh et al 1989; Cleland 1978). They started to use it as a form of participative management, using self-managed work teams.

The professional practice environment of nursing care has shifted dramatically over the past generation (AONE 2000; AACN 2002). Rapid advances are occurring in

- biotechnology and cyberscience
- disease prevention, patient safety, and management
- relationship-based care
- patients' roles in their healthcare (i.e., they are active partners, not just passive recipients)

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

- downsizing the professional workforce
- changing staffing mixes

- restructuring/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 can result in devastating medical errors. The struggle to provide 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 (Kohn, Corrigan and Donaldson 1999; AACN 2002; 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, "Reorganization in health care institutions is currently the rule rather than the exception. All health care participants are attempting to strategically position themselves in the marketplace. What do these changes mean for nursing? How can nursing best respond?" (p. 281). It is an even greater challenge today to develop an effective professional nursing practice model for an economically constrained healthcare system to achieve positive outcomes, build work place advocacy, and provide needed resources and support to improve recruitment and retention of a shrinking nurse workforce.

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

- Those based on patient 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 relationship-based care (RBC), a nursing model that lends itself to

shared governance in today's complex healthcare systems (see Figure 1.2 for self governance vs. shared governance).

In the RBC model, nursing services are provided through relationships in a caring and healing environment that embodies the concepts of partnership, equity, accountability, and ownership.

Figure 1.2: Self governance vs. shared governance

Centralized interactions (Self governance)	Decision-Making	Decentralized interactions (Shared governance)

Centralized interactions (Self governance)

1. Position-based
2. Distant from point of care/service
3. Hierarchical communication
4. Limited staff input
5. Separates responsibility/managers are accountable
6. We-they work environment
7. Divided goals/purpose
8. Independent activities/tasks

Decentralized interactions (Shared governance)

1. Knowledge-based
2. Occurs at point of care/service
3. Direct communication
4. High staff input
5. Integrates equity, accountability, and authority for staff and managers
6. Synergistic work environment
7. Cohesive goals/purpose, ownership
8. Collegiality, collaboration, partnership

Shared decision-making works best in a decentralized organizational structure where those at the point of service make their own decisions and determine whether they are appropriate. "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). Decentralized decision-making is most successful when *responsibility, authority, and accountability* (R+A+A) are clearly delineated and assigned (Wright, 2002).

- *Responsibility:* the clear and specific allocation of duties to achieve desired results.
  Assignment of responsibility is a two-way process: It is visibly given and visibly

accepted. This acceptance is the essence of responsibility. Note, however, that individuals cannot accept responsibility without a level of authority.

• *Authority:* 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 with regard to that work. Levels of authority determine a person's right to act in the areas he or she is given. There are four levels of authority (Wright 2002):

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

2. **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 whether Mr. Jones has a headache. Then come back and tell me what you would recommend that I give him.*

3. **Data gathering + recommendations [pause] + act**—"Get the information (collect the data), look at the situation, 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 that everything was considered before proceeding. Example, *Please go down and see whether Mr. Jones has a headache. Then come back and tell me what you would recommend for him; then take care of him for me.*

4. **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:* begins when one reviews and reflects upon 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 of the tasks but does provide the resources that staff nurses need and ensures that patient care delivery is effective. In that patient care area, the nurse manager/leader 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 (or *collaborative governance, participatory governance, shared or participatory leadership, staff empowerment,* or *clinical governance*) vary, the outcomes are consistent. The evidences suggest that shared governance processes result in the following:

- Increased nurse satisfaction with shared decision-making, related to increased responsibility that is combined with appropriate authority and accountability
- Increased professional autonomy, as well as higher staff and nurse manager retention
- Greater patient and staff satisfaction
- Improved patient care outcomes
- Better financial states due to cost savings/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 et al. 1989; Metcalf and Tate 1995; Porter-O'Grady 1987, 2001, 2005). Porter-O'Grady (2001) described shared governance as a process model that provides a structure for organizing nursing work within organizational settings. It empowers 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. In addition, 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 (Page 2004; Anthony 2004; Koloroutis 2004; Porter-O'Grady 2003a, 2003b; Green and Jordan 2002).

Today's transformational relationship-based healthcare, which is driven by technology, creates a new paradigm with different goals and objectives in an organizational learning environment. 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.

Nurses and managers 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).

Figure 1.3: Hierarchy vs. 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

Successful relational partnerships in collaborative 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 (Porter-O'Grady and Hinshaw 2005; Green and Jordan 2004; Koloroutis 2004; Porter-O'Grady 2002).

The key provider at point of service—the staff nurse—moves from the bottom to the center of the organization. Nurses are the primary employees who do the work and connect the organization to the recipient of its service. An entirely different sense and set of variables now affect the design of the organization—the only one who matters in a service-based organization is the one who provides its service. All other roles become servant to that role. In this way, the paradigm shifts 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 (Nightingale, 1859).

When managers become servant leaders, they function differently in newly delineated roles (e.g., agent or representative, an advocate, ambassador, executor, intermediary, negotiator, proctor, promoter, steward, deputy, emissary). Relational partnerships are built with equity, wherein the value of each participant is based on contributions to the relationship, rather than on positions within the healthcare system. That is, although staff nurses are key to recruiting other nurses, nurse managers are key to retaining them.

Collateral and equity-based process models of shared governance define employees by the work they support rather than by their location or position in the system. For example, the manager in the servant leader role provides human and material resources, support, encouragement, and boundaries for the staff nurse in the service-provider role. Staff nurses, then, are accountable for key roles and critical patient care outcomes around practice, quality, and competency.

Shared governance requires strategic change in organizational culture and leadership. It demands a significant realignment in how leaders, employees, and systems transition into new relationships and responsibilities. It begins with the definitions and objectives and flows from the design.