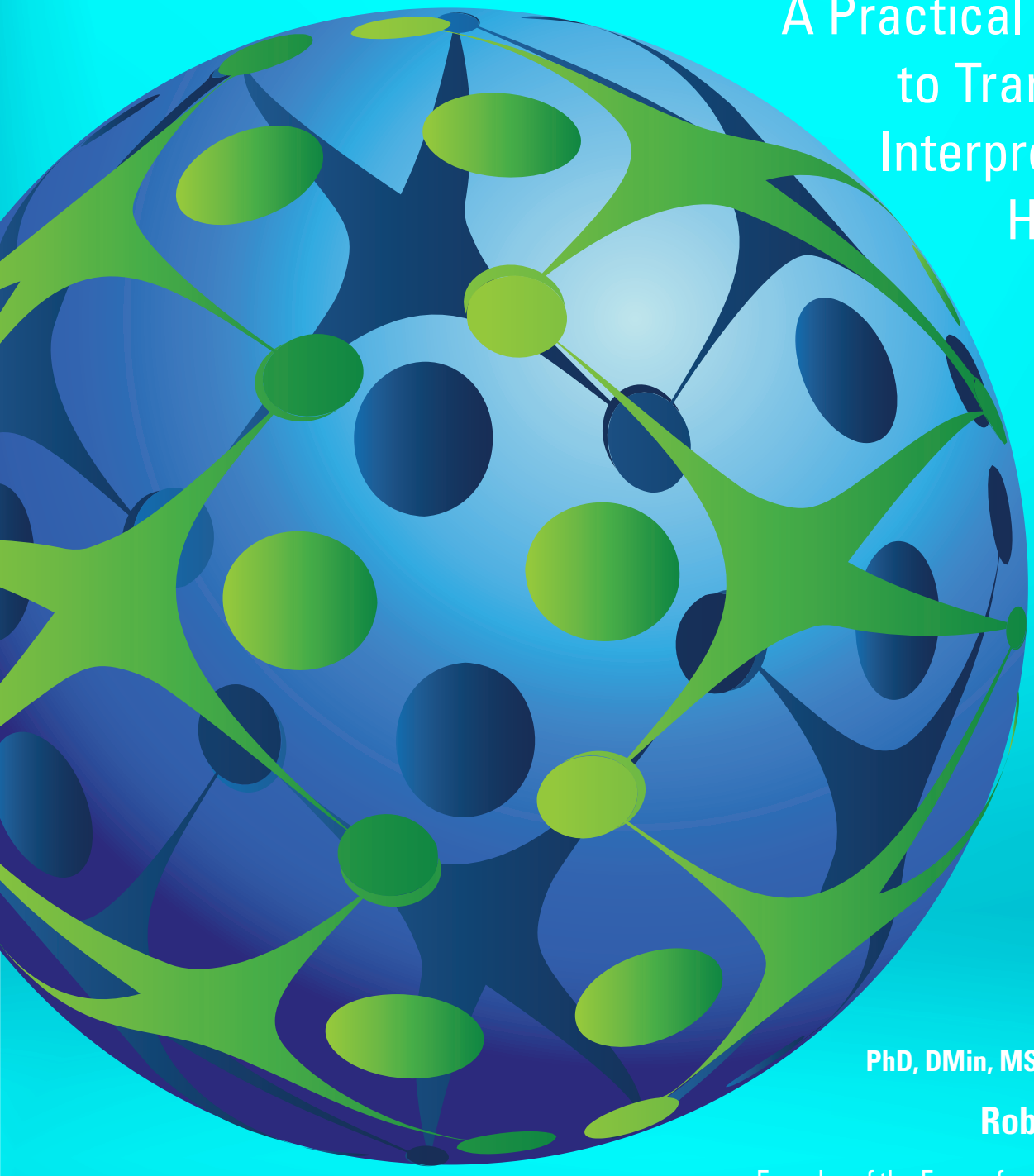
Third Edition

Shared Governance

A Practical Approach to Transforming Interprofessional Healthcare



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

Robert G. Hess, Jr.
RN, PhD, FAAN
Founder of the Forum for Shared Governance

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Dedication

To those who have the passion and willingness to give back to others; those who understand the importance of giving. Judie Bopp best expressed the specialty of preceptoring and its impact on those who give and receive within the context of such relationships: "The capacity to watch over and guard the well-being of others is an important gift, and one that is learned with great difficulty. For it is one thing to see the situation others are in, but it is quite another to care enough about them to want to help, and yet another to know what to do."

—Diana Swihart

To the staff, managers, and executives in all healthcare professions who passionately believe that the best possible professional, organizational, and patient outcomes can only be achieved by empowering everyone to share in decision-making about patient care. To staff for trying something new and risky, to managers for trading traditional roles for unknown new ones, and to executives for supporting staff and managers and showing the way.

—Robert G. Hess, Jr.

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, Dr. Stan, for his support and encouragement, his unwavering belief in me.

I would also like to acknowledge those many nurses and other healthcare providers, patients and community partners, speakers and teachers, and colleagues and friends who have contributed their ideas and thoughts through countless classes, seminars, lectures, and discussions 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 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 and continues to inspire my own work. 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 both of these extraordinary nurses have participated in writing what I hope to be another valuable addition to your own journey in helping reshape and transform professional practice in healthcare for this and the next generation.

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

I would first like to acknowledge the voice of reason in my life: my wife and partner of 40 years, Evamaria Eskin, MD. One night while going to bed, when I was perseverating about my dissertation ideas, Evi turned to me and said, "Why don't you propose something you know something about?" And that led me to defining and measuring shared governance.

I am eternally grateful to Tim Porter-O'Grady, DM, EdD, ScD (h), FAAN, one of my sponsors into the American Academy of Nursing, a mentor, and a resonant soundboard for my incessant questions. It was Tim who first challenged me to solidify my conceptual thinking to quantify shared governance and share the data.

I also want to acknowledge my partner in shared governance, Diana Swihart, PhD, DMin, MSN, APN CS, RN-BC. We make quite a lively team, with my irreverence and her torrent of proper energy. As I sail around in a conceptual stratosphere, I can see Diana beckoning me to return to the weeds where the real work is done. And I thank her for that. She has taught me a lot.

Finally, I have been privileged to work with some of the most fascinating and empowering healthcare professionals on earth, both during my hospital career (read: before *Nursing Spectrum* magazine) and my more than 20 years with the Gannett Healthcare Group, my present day job. To every nurse and allied healthcare professional who has schooled me about real-life experiences with implementing shared governance, thank you for keeping me grounded.

I know this looks like a round robin to Diana's acknowledgements, but that's just the way it is.

—Robert Hess, RN, PhD, FAAN

About the Authors

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

Dr. Diana Swihart, the CEO for the American Academy for Preceptor Advancement, enjoys many roles in her professional career, practicing in widely diverse clinical and nonclinical settings. An author, speaker, researcher, educator, and consultant, she has published and spoken nationally and internationally on a number of topics related to preceptors, shared governance, competency assessment, professional development, servant leadership, Magnet Recognition Program®, research, and evidence-based practice. In 2008, her publication *Nurse Preceptor Program Builder: Tools for a Successful Preceptor Program* (2nd ed.) was selected as a foundational resource for the national VHA RN Residency Program.

Dr. Swihart has served as an ANCC Magnet Recognition Program® accreditation appraiser, as the treasurer for the National Nursing Staff Development Organization, and as adjunct faculty at South University and Trinity Theological Seminary and College of the Bible distance learning program.

Robert G. Hess, Jr., RN, PhD, FAAN

Robert G. Hess, Jr., RN, PhD, FAAN, is an educator, editor, author, consultant, and the founder of the Forum for Shared Governance. He currently serves as executive vice president of global programming for Gannett Education. An award-winning author, he has written more than 100 articles for numerous journals and books. He is the former vice chair of ANCC's Commission on Accreditation.

In 2008, Dr. Hess was inducted as a fellow into the American Academy of Nursing for his work in shared governance.

Preface

Shared governance structures, with all of their intrinsic complexities, responsibilities, and accountabilities, must be carefully designed and implemented to be sustained. 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 is designed to provide a broad base on which to build planning and implementation of a successful shared governance infrastructure. To do that, you need guides, tips, and tools.

The purpose of the third edition of *Shared Governance* is to provide leaders, educators, and healthcare providers with many of the essential tools and ideas for practical approaches for designing—or redesigning—an effective and efficient interprofessional and multidisciplinary shared governance process model. They will facilitate your ability to embrace the evolving changes needed to mature your shared governance infrastructure towards sustainment. In this book you will find a compilation of information and tools to help you develop your own models and processes.

Quality, continual improvement, and excellence are embedded in healthcare practices across disciplines and services as the demand for value, safety, effectiveness, and efficiency grow and expand, directed at achieving outcomes that measure and increase the value of processes, i.e., shared governance. Therefore, this book also explores the relationship between shared governance and the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® (MRP) and the International Organization of Standards (ISO) outlining the MRP, as well as ISO expectations for shared governance practices.

You will also find guides for identifying models and tools for designing and building a structure to support shared governance. Additional tools help you create your structures from the unit or practice level upwards and mature your processes across disciplines and service lines.

You can explore ways to engage internal and external stakeholders, assess your processes and outcomes, and evaluate your infrastructure within six domains of measurement. This book helps you as you grow and develop your knowledge, skills, and abilities through research, evidence-based practice, and shared decisional processes. These tools can support your work as you participate in a partnership with your leadership, educators, interprofessional colleagues, and multidisciplinary team members to ensure safe, competent practice within your organization.

Let's take a closer look and see what's here.

Organization

This edition of *Shared Governance* is organized into 12 chapters with strategic and tactical processes for implementing your own organizational management system. This work explores the evolving processes and decisions folded into shared governance. The book contains a plethora of field-tested tools, measurement instruments, and strategies to help guide steering groups, for designing and redesigning unit and practice councils, and to support governing (or central) councils. Each chapter begins with an encouraging quote and concludes with a brief summary of content.

- Chapter 1 explains the concept behind shared governance in today's complex work and healthcare environments. It looks at four primary principles of shared governance (partnership, equity, accountability, and ownership) and compares several models.
- Chapter 2 identifies some of the characteristics of shared governance structures and structural process models. Basic guidelines for forming governance bodies provide further insight into designing a structure to support shared governance within the organization and across service lines.
- Chapter 3 explores four components for building a structure to support shared governance in diverse work settings. Part one speaks to implementing shared governance. Part two discusses leading strategic change. Part three considers shared governance systems' perspective and format in designing the structures. Part four guides you through the process for formalizing the shared governance structure with bylaws and articles. This chapter also offers a brief look at redesigning shared governance after a breakdown in implementation has occurred.

- Chapter 4 focuses on building the practice and unit councils at points of service. Strategies and tools encourage providers to create a critical forum for participating in shared decisional processes and outcomes specific to their needs and activities.
- Chapter 5 describes the process for implementing shared governance at organizational levels. Building strong interprofessional and multidisciplinary relationships with key stakeholders, e.g., leadership, union representatives, community members, providers, staff, and patients, are critical to integrating shared governance into the organization.
- Chapter 6 identifies research projects specific to the principles and newest instruments used to measure shared governance, i.e., the Index of Professional Governance 2.0 (IPG) and the Index of Professional Nursing Governance 2.0 (IPNG).
- Chapter 7 relates one healthcare organization's strategic priorities, successes, rewards, and challenges of implementing an integrated interprofessional shared governance system across disciplines and services.
- Chapter 8 offers snapshots of shared governance in case studies contributed by organizations in two U.S. and global communities.
- Chapter 9 explores quality, safety, and value in quality management systems and service excellence through shared governance. Experts in the implementation of ISO 9001:2008 quality management and in the ANCC's MRP provide insight into how these systems complement and are more fully realized through shared governance.
- Chapter 10 offers tips for success, lessons learned, and best practices shared by healthcare leaders, direct-care providers, team leaders, and other organizations and communities of practice where shared governance thrives.
- Chapter 11 features an international clearinghouse for research and resources with examples of recent published and unpublished research on shared governance.
- Chapter 12 considers conclusions and recommendations for going forward with shared governance. Lived shared governance is a dynamic, fluid, and ever-growing process that can transform healthcare. You have the book, the tools, and a foundation built by many of your colleagues, peers, and thought leaders. All that remains is to determine how you will answer the question, "Where do we go from here?"

The information presented in *Shared Governance, Third Edition,* reflects the research and opinions of the authors, contributors, and advisors. Because of ongoing research and improvements in interprofessional and multidisciplinary team structures, information technology, and education, this information, these tools, and their applications are constantly shifting, changing, and evolving in healthcare, leadership, and other services and disciplines.

Because this book explores opportunities for folding shared governance into increasingly complex adaptive and uncertain work environments, we have provided you with definitions, a variety of models and tools, and multiple approaches to building stronger infrastructures within your own organization. It is the authors' sincere hope you will add this work to your library and consider how you, too, might contribute to this growing body of knowledge, research, and expertise through your own practice and organizational development.

—Diana Swihart and Robert G. Hess, Jr.

Foreword

The concept of shared governance continues to be a centerpiece of developing the collaborative environment for patient care. It continues to address the need to engage and empower people, which 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.

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, expanded in 2011 and 2014). 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, each component of the decision process, and each 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.

Tim Porter-O'Grady, DM, EdD, ScD (h), APRN, FAAN
Senior Partner, Tim Porter-O'Grady Associates, Inc.
Atlanta, Georgia

Chapter 1

Introduction

The Concept Behind Shared Governance

With input from stakeholders inside and outside the organization, leaders are expected to shape agendas, not impose priorities; to allocate attention, not dictate results; and to define problems, not mandate solutions. These expectations we now have for leaders closely resemble conventional notions of governing.

—R. P. Chait, W. P. Ryan, and B. E. Taylor,
Governance as Leadership

The increasing complexities of changes in healthcare have a growing number of institutions reexamining shared governance—a concept introduced into healthcare organizations in the 1970s—as an evidence-based method to support an empowering, integrated approach to healthcare services. Although there is no one "right" process model, the basic principles of shared governance are generic, viable, and measurable. This book takes some of the guesswork out of the various structures and processes behind shared governance. It provides strategies, case examples, and best practices to make the daily operations of shared governance meaningful and successful.

Quality, continual improvement, and excellence are embedded in healthcare practices across disciplines and services as the demand for value, safety, effectiveness, and efficiency grow and expand, directed at achieving outcomes that measure and increase the value of processes (i.e., shared governance). Therefore, this book also explores the relationship between shared governance and the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® (MRP) as well as the International Organization for Standardization (ISO), and outlines the MRP and ISO expectations for shared governance practices.

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 or shared leadership in organizations that have implemented it. Universal principles and approaches engage the relationships and interactions needed to plan and design, implement, measure, and sustain shared governance in healthcare through an overlapping and integrating infrastructure (Porter-O'Grady, 2009).

Before going any further, then, an operational definition is needed to clarify this work and address the research and applications to practice that we find in shared governance.

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. Over the years, many thought leaders, including Drs. Tim Porter-O'Grady and Robert Hess (coauthor of this book), have worked together to build autonomous interprofessional partners in healthcare through shared governance (see Appendix B for an extensive bibliography).

The *Random House Unabridged Dictionary* offers several definitions of the term *govern,* including: "to exercise in 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 (IPG) and the Index for Professional Nursing Governance (IPNG) have been researched and used to measure progress in developing and establishing shared governance in growing numbers of organizations. (See Chapter 6 for further details on the IPG and IPNG, and refer to Appendix A for the tools themselves.)

The management process model of shared governance and 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 all 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 staff 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 service or unit level belong to management (Porter-O'Grady and Hitchings, 2005).

Partnerships

Partnership links healthcare providers and patients along all points of service in the system; it is a collaborative relationship among all stakeholders and disciplines 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 and 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 mean 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 and Hitchings, 2005; Porter-O'Grady, Hawkins, and 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 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 and Hitchings, 2005). Shared governance activities may include participatory scheduling, joint staffing decisions, and shared service or 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 providers. 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 [IOM], 2011).Refer to Figure 1.1 for a look at the role of shared governance in these four points of service: partnership, equity, accountability, and ownership.

Interprofessional Shared Governance

Organizations are beginning to explore and integrate an interprofessional approach to shared governance, from clinical decisions at points of service to strategic priorities placed on complex issues by senior leadership (see Chapter 7). This approach often engages patients and families as partners. Keys to successful implementation of this approach to shared governance include active participation of all team members contributing to mutually respectful, trusting, collaborative, openly communicative, safe, and effective learning environments of care and practice across disciplines and departments. Interprofessional shared governance provides a unique structure for shared decision-making reflective of the current and evolving demands of an increasingly diverse and integrated care delivery system.

FIGURE 1.1 Four characteristics of the principles of shared governance

PARTNERSHIP

- Role expectations negotiated
- Equality between players
- Relationship grounded in shared risk
- Clear expectations and contributions
- Establish solid measure of contribution to outcomes
- Defined horizontal linkages

EQUITY

- Each one's contributions are understood
- Payment reflects value of contribution to outcomes
- Role based on relationship, not status
- Team defines service roles, relationship, outcomes
- Team conflict and service issues defined by methodology
- Evaluation assesses team's outcomes and contributions

ACCOUNTABILITY

- Based on outcomes, not process
- Defined internally by person in role; embedded in roles
- Defines roles, not jobs; cannot be delegated
- Determined in advance of performance
- Performance validated by results
- Focus is on collective activities
- Self-described; dependent on and directly intersects with partnerships
- Shares evaluation
- Contributions-driven value
- Processes generally loud and noisy

OWNERSHIP

- All workers invested
- Every role and person has a stake in outcomes
- Rewards directly related to outcomes
- Every member associated with a team
- Relationships supported by processes
- Opportunity based on competence

KEY PRINCIPLES

- Build on decisions and structure on a point-of-service foundation
- Always involve stakeholders in their own decisions
- Shared governance: an accountability-based approach, not a participative management model
- Team-based strategies are basic to structural design
- Locus of control placed wherever needed for decisions required
- Shared governance has no approval structures; it reflects relatedness between people and systems, not status within structures and systems
- Managers focus on context, staff on content
- Partnership, equity, accountability, ownership: undergirding principles of shared governance

Source: Porter-O'Grady, T. (2009c)

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. For example:

- 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 and Buchan, 1999; Peters and 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 in the previously used approach.
- In the late 1970s and early 1980s, shared governance found its way into the healthcare arenas as a form of participative management. It engaged self-managed work teams and grew out of the dissatisfaction nurses and other healthcare providers were experiencing with the institutions in which they practiced (McDonagh et al, 1989; O'May and Buchan, 1999; Porter-O'Grady, 1995).

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

- Biotechnology and cyberscience
- Disease prevention, patient safety, and management
- Relationship-based care
- Patients' roles in their own 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 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 providers nationwide (AACN, 2002; Kohn, Corrigan, and Donaldson, 1999; Weinberg, 2003).

Shared Governance and Professional Practice Models

As economic realities continue to shift and change, so does practice. Tim Porter-O'Grady 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" (1987, p. 281).

Developing an effective professional practice model for the economically constrained U.S. healthcare system is more important than ever. In the post–Affordable Care Act era, healthcare organizations are increasingly challenged to achieve positive outcomes, build workplace advocacy, and support recruitment as well as retention of the industry's shrinking workforce (Barden, 2009; IOM, 2011; Monaghan and Swihart, 2010; Porter-O'Grady and Malloch, 2010a; Swihart, 2011).

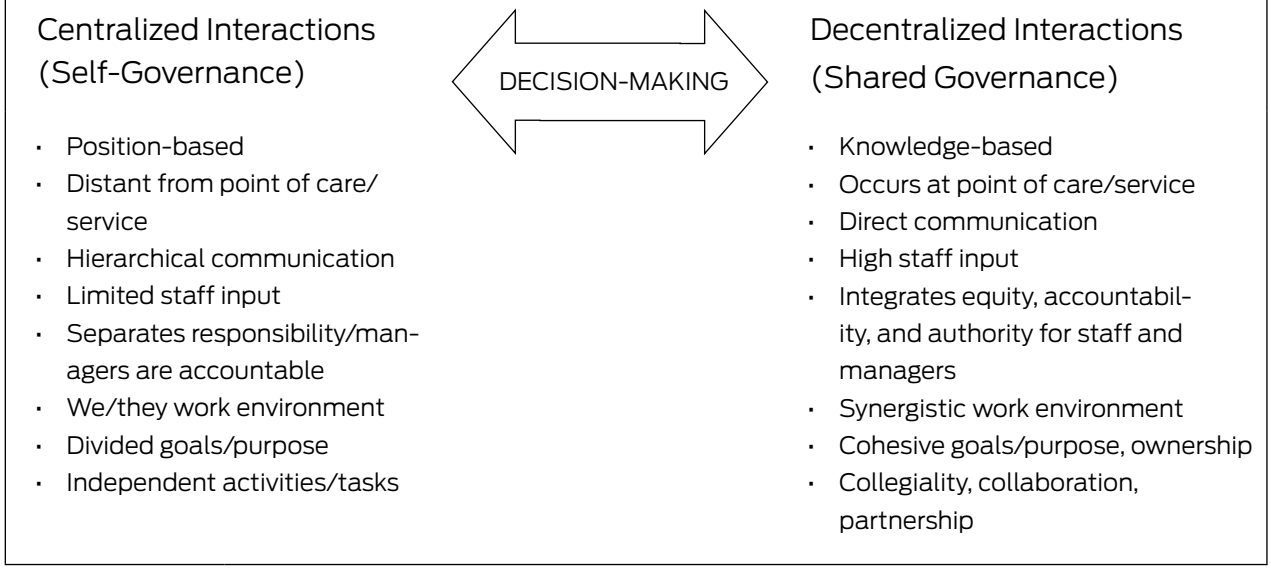
Mary K. Anthony (2004) describes some of the models that have evolved to provide structure and context for care delivery in the reshaping of professional practice:

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

Mary 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 model for transforming practice that lends itself effectively to shared governance versus self-governance) in today's complex healthcare systems: relationship-based care (RBC). (See Figure 1.2 for a comparison of self-governance to shared governance.)

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

FIGURE 1.2 Self-governance vs. 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 must be given to those asked to take on responsibility. There are four levels of authority, or 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 or 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 and update me on his status at the end of the shift.*

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 manager or supervisor is accountable for patient care delivery in his or her area of responsibility. The manager or supervisor does not do all the tasks but does provide the resources employees need and ensures patient care delivery is done effectively by all staff members. In that patient care area, the manager or supervisor is accountable for setting the direction, looking at past decisions, and evaluating outcomes. Bedside providers and nurses, for example, 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 (dietitians, 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 that the benefits of implementation of shared governance and shared decision-making processes (detailed in Figure 1.3) can result in:

- Increased employee satisfaction with shared decision-making, related to increased responsibility combined with appropriate authority and accountability
- Increased professional autonomy with higher staff and manager or supervisor 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 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 professional practice (McDonagh et al., 1989; Metcalf and Tate, 1995; Porter-O'Grady, 1987, 2001, 2004, 2009a, 2009b, 2009c). Tim Porter-O'Grady (2001) described shared governance as a management process model for providing a structure for organizing work within organizational settings. It allows strategies for empowering providers 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-service staff enables them to maintain quality practice, job satisfaction, and financial viability when partnership, equity, accountability, and ownership are in place (Anthony, 2004; Green and Jordan, 2002; Koloroutis, 2004; Page, 2004; Porter-O'Grady, 2003a, 2003b; Porter-O'Grady and Malloch, 2010a, 2010b, 2010c).

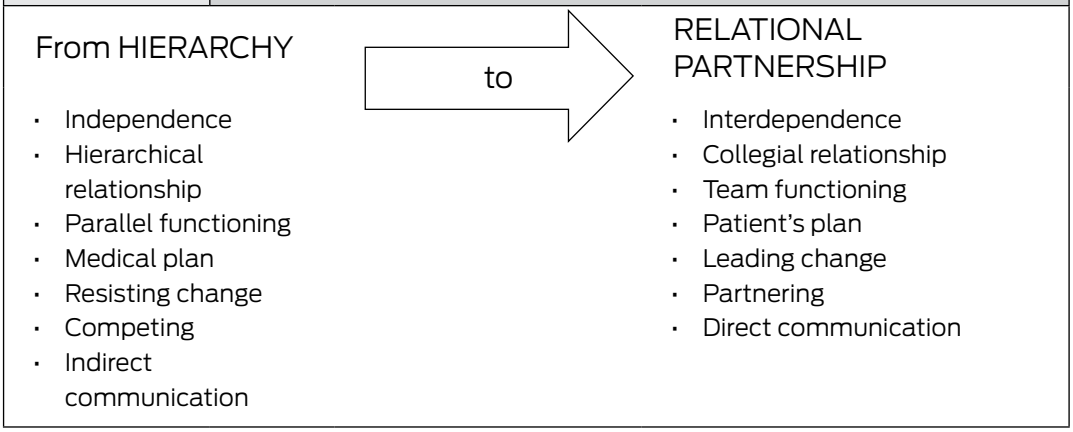
Today's transformational relationship-based healthcare creates a new paradigm with different goals and objectives in organizational learning environments driven by technology. Leaders, administrators, and employees are learning and implementing new ways of providing care, new technologies, and new ways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

healthcare provider at the point of service is key to organizational success associated with changing the environments of care.

FIGURE 1.3	Benefits and challenges of shared governance	
Targets	Benefits	Challenges
For the patients, clients		
• Reduced mortality • Reduced morbidity • Increased patient and client satisfaction • Increased safety • Decreased "failure to rescue"	• Increased confidence in healthcare providers • Reduced confusion or concern about care due to increased collaboration among providers • Decreased lengths of stay	• Appropriate delegation of authority, roles, and responsibilities for care • Willingness by providers and managers to share authority for decision-making at points of service
For organizations		
• Decreased length of stay • Decreased cost of staff replacement • Increased opportunity to market institution • Variable costs of implementation	• Increased retention of experienced care providers • Anticipatory change • Broad-based horizontal relationships among systems • Balance between service accountability and system accountability • Fewer levels of management • Involved stakeholders, e.g., for resource-based decisions • Decisions reflect organizational mission, priorities, and goals	• Resources (fiscal, human, and material) for sustained shared governance • Resistance of managers to support staff through shared leadership (i.e., shared authority) • Obstacles to autonomous point-of-service decision-making that may exist within the organization • Transfer of influence and control away from senior and middle managers alone to include point-of-service staff
For healthcare providers		
• Lower turnover • Lower vacancy rates • Lower burnout rates • Lower emotional exhaustion • Decreased work-related injuries • Better interprofessional relationships • Higher employee satisfaction • Higher healthcare provider-to-patient ratio • Decreased medical errors	• Increased professionalism and accountability • Interdependent relationships among healthcare providers • Shared accountability, ownership, equity, and engaged partnerships • Increased collaboration and collegiality related to mutual trust, respect, and shared decision-making • Increased control over practice and decision-making related to competence, quality, safety, service, and practice	• Training and development of councils and council participants • Release from routine duties to participate in councils • Seeing shared governance as a "nurses only" process that does not impact fiscal or clinical activities or outcomes for other providers • Confusion about roles and responsibilities associated with shared governance

Health providers, managers and supervisors, interprofessional partners, and organizational leaders must be prepared for new roles, relationships, and ways of managing. Shared governance is about moving from a traditional hierarchical model to a relational partnership model of practice, as shown in Figure 1.4.

FIGURE 1.4 Moving from a hierarchy to a relational partnership



Successful relational partnerships in collaborative interprofessional practice (e.g., nurses, physicians, pharmacists, social workers, therapists) and multidisciplinary team members (e.g., administration, support services, environmental services and housekeeping) 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 practice model (Green and Jordan, 2004; Porter-O'Grady and Hitchings, 2005; Porter-O'Grady and Malloch, 2010a).

The key provider at points of service 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. Frontline employees who do the work connect the organization to the recipient of its service at the point of service. With this shift of focus, an entirely different sense and set of variables now affect the design of the organization. The paradigm at point of service has shifted to a relationship-based, staff-centered, patient-focused professional practice model of service in which managers or supervisors assume the role of servant leaders by managing resources and outcomes within the context of relational partnerships (Nightingale, 1992).

Patient-centered care

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 (2011).*

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

1. Involving patients and families in the design of care
2. Reliably meeting patients' needs and preferences
3. Participating 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" (IOM, 2001, 2011, p. 51). A few examples of patient-centered care initiatives include:

- Patient-centered medical homes
- Transforming care at the bedside (TCAB)
- Primary care (rather than specialty physician care)
- 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 (IOM, 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 to facilitate organizational and community patient-centered care. To do this, caregivers must have managers or supervisors 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.

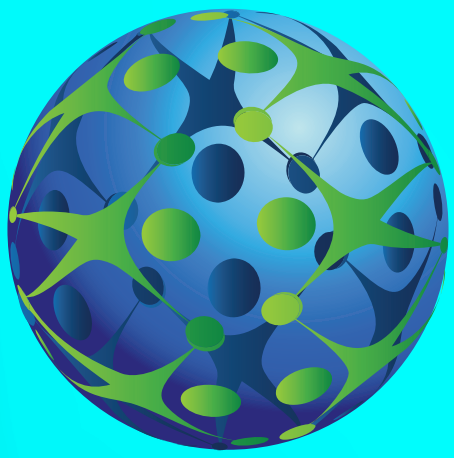
Organizations must move to relational partnerships to be effective and sustain levels of excellence in service. Although frontline staff members are key to recruiting other employees, managers and supervisors are key to retaining them. Collateral and equity-based process models of shared governance define 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 or supervisor in the servant, or transformational, leader role provides human and material resources, support, encouragement, and boundaries for the employee in the service-provider role. Health providers, then, are accountable for key roles, decisions, and critical patient care outcomes around practice, quality, and competency.

Catalysts of change

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 (IOM, 2011)

Shared governance as an organizational management process model for reshaping practice and decision-making requires a transformative shift. The resulting strategic change in organizational culture and leadership comes about through collaboration with interprofessional partners and multidisciplinary 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.



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Shared Governance

A Practical Approach to Transforming Interprofessional Healthcare

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PhD, DMin, MSN, APN CS, RN-BC

Robert G. Hess, Jr.
RN, PhD, FAAN
Founder of the Forum for Shared Governance

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