CHAPTER 6

Unit-Based Shared Governance Activities

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Shared governance really does not take form until it is present in the places where the staff does its work. Unit-based activities in shared governance are important components of the shared governance process (see Chapter 4 in **Implementing Shared Governance**). Either the division-wide or department-wide approaches are essential for the shared governance process to be complete. The checks and balances necessary to ensure a balance between the two are important structural parameters. They ensure that each forum is not doing the work of the other and that expectations for the unit are not the same as those for the governance (divisional or departmental) councils.

All of the behaviors of shared governance actually emerge in the units or workplaces where the staff spend their clinical lives. All of the changes in shared governance should be directed to that end. Actual change in the approach emerges in the units. While there is certainly change in the council membership, broad-based changes in the staff occur in the work setting.

STRUCTURE

There is a lot of discussion regarding just how unit-based models should "look." Because of traditional thinking about organizational consistency, there is some feeling that unit models should match or reflect the governance councils. As most people are aware, each organizational system or work unit is designed ostensibly to respond to the service demand and work culture of the unit. Every unit of service is different from every other unit. There is no service consistency, nor should there be. If clinical departments are to be constructed to provide appropriate service within the context of demand and nature of service, they will necessarily reflect a unique set of organizational characteristics. Replicating the divisional or departmental governance model universally on multiservice, multilateral unit services would be inappropriate and ineffective. It is better to allow the units to create their own internal structures. The caveat to this should be the requirement that every work unit apply the prevailing principles of shared governance as articulated by the ExC to their own unit development. These principles can act as an overlay (template) to the units' shared governance efforts to validate their implementation strategies. This allows for consistency in principle and diversity in design.

READINESS

All work units will reflect a different level of readiness for implementation. A number of factors influence this:

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The knowledge of the unit with regard to the shared governance concept
The unit manager's understanding and readiness for the changes the shared governance approach may indicate
The nature and kind of staff that make up the unit from high per diem to long-term staff have a different impact on implementation
The degree of participation already present on the unit as facilitated by the nurse manager
The interest in the staff for maturity or adult relationships and behaviors
The service administrator's ability and willingness to risk the degree of change that will occur at the unit level
The ability of the system to allow the "noise" of change to occur with all the risks inherent in that process
The rate at which change is generally acceptable in the setting and the willingness to initiate the process in order to get things started
The willingness of staff and management to confront the fear of honesty, of directness, and of the more uncomfortable issues that will invariably emerge.

There is no such thing as readiness for change. People are rarely ready for change—change simply happens! Waiting for readiness simply means waiting. It usually indicates that the comfort level, information level, or risk level is not sufficient for undertaking the commitment that such a change requires. Focus on readiness most often means focus on fear. All of the above characteristics will never be sufficiently ready to implement change. The timing of change depends on many factors, the least of which is readiness. Choice of a change is strategic and depends on how much preparation, consideration, and willingness to risk have been anticipated and incorporated into the planning process. The model and format for the change are the vital elements that give any change process some structure. If well conceived and well planned, the degree of risk is reduced and the chances of success are accelerated. Readiness has very little to do with it.

Questions regarding the preparedness of individual units must be raised and answered by both staff and management:

What are the three most important factors inhibiting change to unit-shared governance?

1.

2.

3.

What are three factors that facilitate changing now to a shared governance format?

1.

2.

3.

Questions for the nurse manager:

What do I know about shared governance?

Is it enough? Do I need more? What do I need?

How do I feel about shared accountability?

What have I done to "free" my staff?

1.

2.

3.

4.

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Do I believe in collateral accountability (staff having equal authority, autonomy)?

Do I feel willing to risk a major change in this unit and staff at this time?

Have I reviewed all available literature on unit-based shared governance?

Do I have a notion of the event, crisis, or situation that will serve as a catalyst for getting started?

The following opportunities exist as a format for starting shared governance activities:

Self-scheduling

Standards development

Practice model changes

Work redesign

Unit location move

Change of manager

New unit

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Other:____

Is administration supportive of the move to shared governance?

Does this unit have good communication and relationship with the other units implementing shared governance in order to discuss opportunity and problems?

Unit size will often affect the degree of preparedness and the kind of model that will be selected or created by the individual unit. Smaller units may have one staff council that deals with all the clinical accountability and issues of the unit including those related to practice, quality assurance, education, and research. Other larger units will have all the above issues addressed in the appropriate unit councils. Other units may have a different set of forums or groups for expressing staff accountability. The requirement is the staff expression and formalization of their accountability. If they can give the governance councils evidence of such shared accountability, there should be no issue with regard to the "how" they have chosen.

A great deal of flexibility should be given to the units as they struggle with the most appropriate format for their shared governance activities. As much resource support should be available to them as possible in the process. There must be incorporation of the governance representative framework in the unit design so that there can be appropriate council connection at the unit level. If the individual governance councils have a difficult time determining their accountability relationship to each unit, it will be problematic for the system in determining whether its authority has connected with the unit and that the obligations for performance have been acted on by the unit staff.

The concept of clustering is used often to address this relationship between unit and governance councils. This concept creates a group of representatives from similar or like units (e.g., medical, critical care, specialty, and so on). This group meets to discuss issues of mutual concern or to problem solve or even support implementation activities. They also connect directly to the governance councils for referring issues or implementing decisions of the governance council(s). In some settings, the cluster selects their representatives to the governance councils. Those members connect the cluster directly to the larger governance bodies providing the direct linkage between the unit staff leadership and the councils, thus integrating all levels of the organization. The clusters then assume some authority for assuring

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the units' compliance with expectations or obligations. Also, this process strengthens the problem-solving process related to issues of conflict or concern. Again, this clustering notion depends on the kind of governance model chosen, the size of the hospital, and the connection between unit and governance bodies. Clearly, the smaller hospital would have unit representation to the councils where the larger institution would be precluded by size to accomplish the same kind of representation.

Units need to raise questions regarding their specific relationship to the governance councils by indicating how the various council accountabilities are to be manifested on their individual units:

What is the mechanism for staff ownership in making practice decisions on the unit?

Standards development

Job descriptions

Career ladder (clinical)

Performance standards

Clinical problems

Interdisciplinary concerns

Format for problem solving

Linkage to the Practice Council

How does staff ensure the connection of the unit to the assurance of quality nursing care?

Application of the quality assurance plan

Individual staff QA activities

Peer process in QA

Peer evaluation plan and process

Credentialing and privileging

Corrective measures and actions

Is the education requirement connected to the staff in a way that it can be met in the practice arena?

Unit education plan

Individual education plan

Patient-based education program

Unit orientation plan

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Unit-shared governance communication

New technology or practice education

Education for practice deficiency

Attendance at professional staff meetings

Is research a growing part of the units' activities involving the staff in research activities?

Compliance with the council research plan

Unit research priorities in conjunction with council plan

Format for disseminating research information

Accommodation of outside research

Application of research findings

Each unit must incorporate into its implementation plan at least the above considerations and their impact on the staff. Since these are assumed to be staff-driven processes in shared governance, it is important that they form the basis of the unit staff expression of their accountabilities in a shared governance framework. The following should be remembered: as much as possible shared governance activities should be done in the course of patient care in a shared gover-

nance format including the patient, where viable, in professional processes that affect care. As much as is possible, *shared governance activities at the unit level should not increase the workload or time commitment of the individual practitioner*. It is the expectation that the unit staff and management should attempt to incorporate much of the obligation for performance and participation in shared governance into their usual and normal workload and practice activities.

Initially, the manager may have to play a larger role in undertaking some of the first activities on the units related to shared governance. The tension here will relate to the contradiction between those activities the manager undertakes and the accountability for those actions that is supposed to emerge in the staff.

Like all change, often those who complete the change are not the ones who initiate it. A rule of implementation is to always use the rules in place at the time of initiation, not those hoped to replace the current structure. This will often mean that the more traditional approaches to getting things started might have to be used. When the contradiction becomes apparent to the staff and interferes with their ownership of the process, the manager will then know to pull back and simply facilitate the staff's development.

SPECIAL IMPLICATIONS FOR UNION ENVIRONMENTS

There is no reason why shared governance cannot be successful in union organized settings (see Chapter 9 in **Implementing Shared Governance**). There is a high level of compatibility between the values of shared governance and the elements of collective bargaining. Shared governance neither causes nor prevents the union organization of hospitals; it facilitates relationships within a work group and organizes the group based on the character of the relationship and the accountability for the work.

Much change is engendered in the workplace through the introduction of shared governance. Because it is a model that fundamentally alters the organization and roles in the workplace, it has an effect on all the players. Union members are not exempt from these changes. All relationships and structures are affected and will demand dialogue and negotiation to be successful. In many ways contract items and language will be affected by the design and function of shared governance. This should be no more threatening to the organization or the collective bargaining agents than any major social change occurring at this time. As organizations move toward the twenty-first century, all relationships will be affected as people retool their work structures and relationships to represent changing realities. A lack of flexibility in the face of these many social, economic, and technical changes diminishes the effectiveness and value of any group in getting ready for the future.

In union environments the following considerations must always form a part of the implementation process if the transformation to shared governance is to be successful:

> Union leadership must be involved in all phases of the development of shared governance from the outset.
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> All issues identified in the contract are subject to discussion as they affect implementing shared governance.
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> There are no hidden agendas in shared governance. Efforts to avoid generating them are encouraged.
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> If the contract is implicated in a shared governance change, discussion between organization and union leadership must occur before the change is completed.

N O T E S

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No change in economic or workplace issues as outlined in the contract should be affected without the agreement of the bargaining teams.

Shared governance as a structure should be supported within the language of the contract to indicate the strength of the commitment of the parties to the contract to shared governance.

Elements of the shared governance processes should not be included in contract language to provide as much flexibility in design and adjustments as necessary to assure effectiveness.

The Executive Council should have some relationship or representation to or from the union leadership to facilitate communication, relationship, and problem solving.

Shared governance changes the organization radically. If both parties to the collective bargaining process are either not aware of this factor or are unwilling to enter into this collective reorganization, it should not be attempted until they are in agreement with regard to initiating shared governance. Too much is at stake for the staff and management to enter into this degree of organizational restructuring without the support of all the players. Since unit level life of the worker is significantly altered by shared governance and empowerment changes many of the traditional characterizations of the roles of managers and staff, many of the "old" work delineators and values are not viable. Traditional master-servant and labor-management orientations are simply not adequate to the environment that shared governance engenders. Shared governance will create a new kind of relationship in the organization and will cause both union and management to rethink and restructure their interactions, roles, and relationships. All parties to the collective bargaining process should be prepared to understand this reality before implementing shared governance in their organizations (see also Chapter 9 in **Implementing Shared Governance**).