

4 *Models of Shared Governance: Design and Implementation*

Beth E. Foster

This chapter focuses primarily on the forces driving nursing toward new management models, specifically shared governance, and the mechanisms necessary to establish and maintain these models. Included in the discussion are the environment from which shared governance has emerged and the primary models extant today.

It is important to remember there is no one "right" way to structure a shared governance model. Each organization has unique issues. The important factor is that the design be consistent with the purpose.

FORCES DRIVING CHANGE

The changes in today's society in general, particularly in health care, are propelling nursing to move in new directions. Social upheaval related to the women's movement has had a profound effect on nursing's struggle to create a meaningful place in health care. Institutions within the health care system have long been replicas of traditional male-oriented systems. As members of a predominantly female profession, until recently nurses have been socialized to accommodate the male-oriented system. They have learned to play the games necessary to survive by developing unspoken tactics (Stein, Howell, and Watts, 1990).

Because nursing education developed in hospitals and was financially supported by them, its structure and function became institutionalized in a form that still exists in many organizations. Hospital-based nursing schools existed to provide services that supported the values of the hospitals and to provide an unchanging supply of new nurses (Porter-O'Grady and Finnigan, 1984). The step from hospital-based nursing school to the hospital's nursing service, both often controlled by the same nursing director, was an easy one for new graduates. The familiarity of expectations between the two removed much of the anxiety ordinarily experienced in transitions and perpetuated the role of nursing as a source of service to the hospital.

The movement of nursing education from hospitals to institutions of higher learning was a major step in establishing an academic base for nursing practice. This triggered the beginning development of nursing as a profession (McNichols and Miller, 1988; Porter-O'Grady and Finnigan, 1984).

In addition to the women's movement and professionalization of nursing, other societal changes affect organizations. As job security has decreased in economically uncertain times, so has organizational loyalty. In addition, widespread skepticism of government, institutions, and industry has developed because of a loss of confidence in both organizations and their leaders. These changes are challenging the traditional bureaucratic organization that has been prevalent in industry (Heller, 1984; Peterson and Allen, 1986). Employees desire more control over the work environment. Participative management models have been successful in improving employee morale and perceptions. As Peterson and Allen point out, to view the need for change in management structure as limited only to enhancing professional practice in nursing does not fully appreciate the same need for change occurring in the rest of the industrial world. The control and decision-making issues related to these changes, however, have helped to shape the models of shared governance in nursing.

During this time of change, both managers and staff are experiencing dissonance in their work. The work is more complex, workers are better educated, and no single person can be relied on to provide all the information and answers.

Bureaucracy is defined as "government characterized by specialization of functions, adherence to fixed rules and a hierarchy of authority" (Webster, 1988). Most large organizations today would be referred to as bureaucratic in structure. The common perception is that little work is accomplished in a bureaucracy, al-

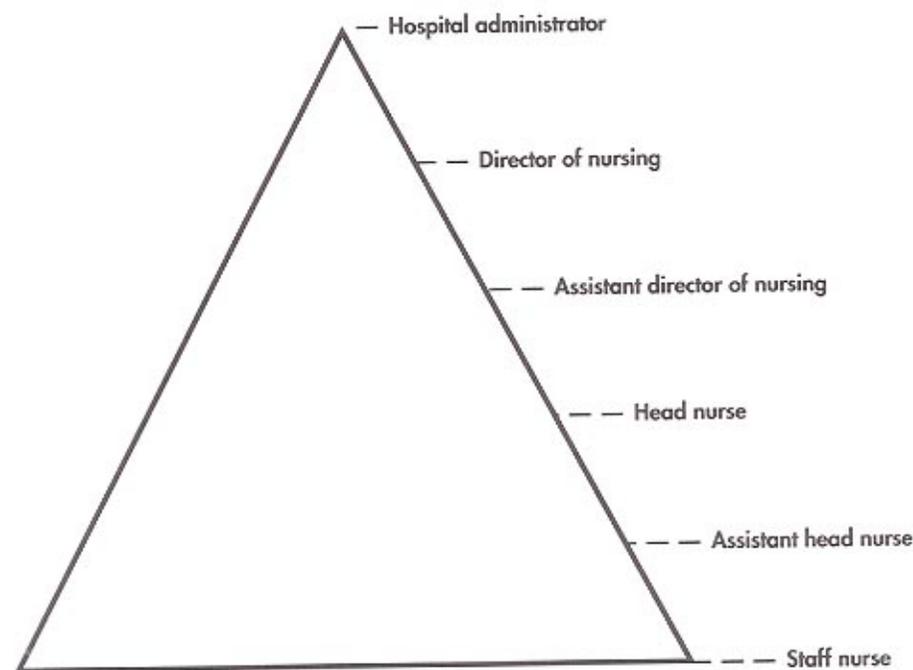


FIGURE 4-1. Bureaucratic model.

though this structure was designed to create efficiency and centralize control. The many hierarchical levels and an expanded scope of accountability as employees moved up in the organization resulted in layers of personnel between the staff and the highest level of management. Top-down communication and tight control characterize this model as shown in Figure 4-1.

Placement within the structure and reporting relationships become critical status issues. Decision making and policy development are kept at the highest levels and communicated down the line. The result of such structured systems is that managers at the top levels make decisions and are held accountable, while the work of the organization is performed by those who have had no input into the decisions. Although this may have addressed the need for improved production, little attention was paid to the higher-level human needs of the workers.

NURSING IN A BUREAUCRATIC STRUCTURE

The majority of nurses identify with the bureaucratic type of structure common in hospital settings. Most have become familiar with its workings. Unfortunately, this format often conflicts with the current roles for which professional nurses are educated (Ketefian, 1985).

Fiscal constraints have become a major concern of the health care community within the past 5 to 7 years. As an increasing percentage of the gross national product is consumed for health care (12% and increasing), the need for creative leadership to confront the problems of health care delivery in a cost-efficient manner was one of the findings of the Commission on Nursing (Lynaugh, 1989). Coupled with massive fiscal constraints is a demand-driven shortage of professional nurses. This supports the need for new methods of organizing nursing departments to enhance the professional component of the practice arena to recruit and retain nurses in the profession.

System structure reflects the values of the organization. When bureaucracy takes precedence over professional practice issues, care will be compromised and staff will be frustrated and unable to fully participate in the activities associated with their practice. Conflict between the profession and the institution results (Porter-O'Grady, 1985).

One approach that has been used to avoid this conflict is decentralization, a format frequently found in hospitals and other professional organizations. This approach maintains a hierarchical structure and thus may be referred to as a professional bureaucracy. It does decrease the layers of management by moving the authority for decisions to a lower level of the hierarchy, but accountability for decisions is retained at the management level. For example, in a decentralized structure, the nurse manager, rather than the director or administrator, has the responsibility for decisions regarding the practice environment on the unit, although it is not her role as a manager to perform those clinical activities. This places both the staff and manager in an untenable situation.

Because this structure does not effectively transfer accountability to the practicing clinician, it is not equal to the decentralized decision making required in promoting professional accountability. Only when both the authority and accountabil-

ity for an activity rest with the individual or group performing the function is true decentralization in place.

An organization's commitment to true decentralization is no stronger than its faith in the individual worker. Leaders in such organizations are responsible for sustaining this vision of the individual as professional and evolving policy and structure to support that vision.

Rather than attempting to control the organization, leaders serve as teachers by articulating these values and fostering the climate that develops and unites the individuals in the organization into a common purpose.

PRINCIPLES OF SHARED GOVERNANCE

It is important to remember that there is no one "right" way to structure a shared governance model and that the system and the work it facilitates are more important than the creation of a structure. However, the following basic principles and structures to support them will be present in a shared governance model:

1. Staff are elected by their peers to the positions they hold in the shared governance structure.
2. Clinical nursing staff are given accountability for all issues relating to nursing practice. This includes standards, quality assurance activities, and peer processes associated with clinical practice. Throughout the organization clinical nurses rather than managers are represented on all committees that affect nursing practice. Conversely, nursing management, rather than making clinical decisions, is accountable for the provision of necessary financial, human, and material resources for the nursing staff to do its work. Nurse managers are responsible for managing the budget, ensuring that adequate numbers of staff are hired, and ensuring that the interface between nursing and the departments that support nursing functions appropriately.
3. An acknowledgment of the role of the clinical nurse as central to the hospital's mission of patient care exists. The nurse executive no longer sees herself as the sole representative of the nursing department, and supports the representation of a clinical nurse at the highest level of the organization. A key difference between a bureaucratic organization and shared governance is that the potential exists for a staff nurse to represent nursing staff on the board of directors of the hospital. If the nurse executive is not a board member, other ways may need to be found to acknowledge the staff nurse in the organization's power structure.
4. Staff has a shared role with management in the issues of salary, budgeting, staffing, and working conditions. Such involvement may take various forms, but adequate information on these topics must be provided to staff for their input to be meaningful. Management no longer has absolute control of these processes.
5. Bylaws or rules define the operations and structure of the nursing organization. These provide a clear definition of roles and accountabilities within the department of nursing. To ensure that the processes undertaken cannot be

changed casually by present or new management, the bylaws or rules should be approved by the board of trustees.

6. Clinical staff are represented at the executive level of the department of nursing. The structure selected to accomplish this is often a coordinating or executive group composed of staff and management. This executive group would generally address those issues affecting the entire department (for example, approving the departmental budget or developing the bylaws). They may also assume a role in determining or assigning accountabilities to appropriate groups within the structure.
7. There is a well-defined process for all members of the department to meet to review pertinent issues and the work of the department. Minimally, an annual meeting should occur at which the leadership may be elected.

INITIATING THE MODEL

Considerable work and creativity are involved in establishing an organization that supports shared governance. The implementation process involves a period of at least 3 to 5 years. It is a lengthy process because of the extended preparation period necessary for both management and staff as each phase of the new model is unfolded.

The change from a bureaucratic structure to shared governance is not a matter of rearranging a few structures and lines. As the underlying principles are examined, it becomes clear that it is a systemwide shift not only in organizational structure but in basic beliefs (Krejci and Malin, 1989). The clinical nurse, rather than the nursing administrator, has the pivotal and critical role in the department. Ferguson (1980) describes a distinctly new way of thinking about old issues as a paradigm shift. When the practice of nursing in a bureaucratic structure is compared with the practice of nursing in a shared governance structure, the concept of paradigm shift is helpful in analyzing the process.

Elements of a new paradigm must grow in a culture that will support them. Determining the cultural norms of an organization helps ensure selecting a program that can succeed over time. Allen and Kraft (1984) describe the organizational culture as containing "two organizations—one with visible, articulated, expressed, and stated goals, policy statements, and procedure manuals; the other invisible and unconscious, lying quietly under the surface, but actually determining what will happen in the long run." It is critical that both "organizations" be assessed.

When the decision has been made to redesign an organization, a number of questions must be asked. Among the first are "What is the work of the organization?" and "What structure would facilitate the accomplishment of this work?" These are critical questions that cannot be answered in isolation from the current organizational culture.

The structure that is created is not simply a mechanical drawing with labeled positions but the framework that will integrate the functions and work. It will necessarily be open to communication and information flow required to facilitate decision making and timely activity. Mechanisms must be present to respond not

only to the work of the department but also to the needs of the employees as human beings and as a professional staff.

The cardinal rule is that shared governance cannot be implemented by management fiat. However, nursing leadership often will begin the process by informally exploring with individuals and groups their concerns, thoughts, and beliefs of how nursing is and could be practiced at their institution. In some instances the impetus to change occurs because of overt staff dissatisfaction and in others because of the desire of the nurse executive to develop a more professional model of practice.

Regardless of the primary impetus to change the nursing organization, changes so profound necessarily must be led by the nurse executive. The concept of leadership in shared governance is changed dramatically, so the nurse executive must be comfortable with the relocation of much decision making. This needs to be carefully considered because shared governance will not succeed without this support. The current bureaucratic structure has been supported through design of the nursing organization (role descriptions, rules and regulations, reporting relationships) and nursing also has the power to redesign it. However, no one functions in a vacuum. The interrelationships between departments also need to be considered in the design. Naisbitt (1982) states that change occurs when changing values and economic necessity meet. This is clearly the situation in nursing and health care today.

To assist in the necessary redesign, Porter-O'Grady and Finnigan (1984) suggest a series of questions that should be asked relating to the role and work of nursing as a service, how nursing's work is viewed and valued within the institution. The fact that the structure must include the functional aspect of practice makes this task more complex.

1. What are the essential activities of nursing that require organizational and structural support?
2. What role does nursing currently play in the organization and does this meet the organization's expectations?
3. What are the goals of nursing and what roadblocks must be overcome to accomplish them?
4. What linkages will coordinate activities within the department and in the hospital as a whole?
5. How can a professional practice model for nursing best "fit" the current structure and culture of the institution?
6. How can nursing most effectively support the vision and goals of the organization?

Why is the change to shared governance so difficult? Shared governance is not an easy concept to understand, and developing departmental consensus on its meaning is more difficult. This is especially true when the required changes in behaviors are not fully understood by the individuals involved. In addition, breaking away from traditional roles that have provided meaning and status will be resisted.

STRATEGIZING THE MOVE TO SHARED GOVERNANCE

Both nursing and general administrative leadership must be committed to the changes that must occur. The concept of shared governance will not be totally understood by the Chief Executive Officer (CEO). However, the CEO must agree to generally support the necessary process required to implement shared governance.

The CEO/COO's beliefs about nursing and how he or she interacts with the nursing department will be key factors in the nurse executive's approach to shared governance with him or her. It is important to remember that the hospital administrator will probably come from the traditional management background found in most hospitals today. The process and effects of shared governance will be viewed in that context. Nevertheless, the executive or operating officer may come from a broad spectrum of styles within the traditional framework, from autocratic to participatory. Knowing this style will guide the nurse executive in presenting the issue.

The hospital administrator regards his or her leadership as institutional but recognizes nursing as a large and important part of the system. Particularly in today's health care environment, the CEO will try to balance clinical and budgetary concerns. Most administrators are concerned about quality patient care but must approach it from a nonclinical point of view. The administrator is therefore dependent on the nursing executive's interpretation of how any changes in the department will affect quality of care. Because quality is primarily a matter of individual perception, the response that quality of care will be affected can be unsettling by its lack of definition. The ability of the nurse executive and hospital administrator to communicate with confidence on issues such as this when the administrator is essentially dependent on the nurse executive's clinical interpretation, in combination with the CEO's experience with nursing, will be important factors in assessing how this history will facilitate or constrain the introduction and acceptance of shared governance.

Knowing the administrator's preferred style and value system will be important in planning the strategy to move to an open and participatory system. Developing the plan with emphasis on those aspects that will best reflect the values of the administrator and working to enhance the institution's goals will facilitate acceptance and support.

Because the outcome unfolds over time, apprising the administrator of the early phases is appropriate, emphasizing areas that may be of particular interest that the nurse administrator can support. Regular follow-up, as successes occur, or when noise in the system is expected, should maintain confidence and support. As changes occur that are important to the administrator's value system, they can be emphasized (Porter-O'Grady and Finnigan, 1984).

Other officers of the corporation, especially in the human resources department, will need to be informed of activities. Because the vice president for human resources is concerned about all employees and their working situation, the changes that occur in the nursing department will be of great interest. Because nursing is a large department and affects nearly every department in the hospital, the human resource officer's views of nursing as a department and its role within

the institution will be factors to consider in presenting shared governance as a concept. Nursing has not always been understood by human resources personnel; thus it is not uncommon that animosity or a certain level of wariness exists between these two departments. As recruitment and retention issues have become more critical in nursing, a general appreciation of human resources in making changes in the work environment has occurred. This should help to facilitate the integration of new concepts related to shared governance.

Activities traditionally considered as the human resources department's responsibilities (developing job descriptions and evaluations) will eventually become part of the new governance process; therefore collaboration with the human resources officer will be an important strategy. Inability to complete the process once implementation has begun will create a feeling of betrayal in the nursing organization with long-term effects on morale.

Having the knowledge and skills of the experienced human resource expert who understands and supports the needs of the professional can be valuable to the nurse executive. Because resources from management, education, and development are often within the domain of the human resources department, implementing strategy to meet the developmental needs of the nursing department in the transition to a new form of governance can be a joint collaboration. If this project is undertaken without adequate support, the changes that occur will be limited.

Peer leadership in the institution also should be informed of the changes and strategies that will be undertaken. Time demands to implement and sustain the program will be substantial, and the nurse executive's role will change. As accountabilities are transferred, the executive will be less involved with traditional day-to-day activities related to nursing practice. This will decrease the level of detail to which she ordinarily has ready access because many decisions will be moved to other members of the department. Other administrators will need to be informed of progress, although the difficulties encountered in departmental activities related to the changes that are occurring will not be easy for them to appreciate.

MOVING AHEAD

When support for change has been determined, the next step is to explore with nursing management and staff how the process should unfold. Literature review, attendance at presentations, use of consultants, and, when possible, site visits of models of interest have been used to discover usable models.

The particular model selected is not as critical as how well it fits the organization. This fact will be emphasized by any nursing leader who has implemented shared governance. No process of this magnitude should be introduced without an assessment of the organization and a plan for preparing individuals and groups for the change ahead. Much will be learned in the process of development. The reasons for shared governance become clearer for staff and management as the concepts and models are explored.

In discussing early implementation, Wilson (1989) points out the need for consensus regarding what shared governance means since each position in the organi-

zation will experience a different role change. For example, the role changes of the manager will be expressed differently from those of the staff nurse. In addition, there are varying levels of skill and maturity as well as trust issues and personal agendas within the nursing department.

STEERING FUNCTION

A steering committee is helpful to oversee the shared governance process. The committee should be limited to 10 or 12 members and be composed of staff and management. The exact number of each is not critical, but it must be understood that the process is a collaborative effort between staff and management. Two satisfactory approaches are: (1) an equal number of staff and management; (2) a proportional number, with more staff representation because the major focus will be in the area of staff expertise, patient care. In this early phase of development, a mix of half staff and half management is probably appropriate. The group will often be selected rather than elected, with elections subsequently occurring as the new structure begins to function. The level of sophistication and professional maturity in the group will influence its progress and format. An additional administrative representative who is not associated with nursing can lend credibility to the necessary activities.

The same questions related to changes necessary to move to a professional practice model asked during the nursing administrator's assessment should be asked of this group. The questions provide a focus to the discussions that have the potential to move the group from individual and unit-based issues to a broader outlook of the department and institution.

This larger view is important because nurses tend to view their work environment in terms of the interaction between themselves and their patients and the units on which they work. One strength of group work is uniting nurses from various areas of the hospital whose perspectives may differ significantly.

The structure is the framework through which the department will perform its work. How this occurs may be easier to visualize when the models are reviewed. The values and beliefs of both the organization and department will be demonstrated as the roles of staff and management are described.

Because this group will help the nursing administrator lead the department through the change associated with shared governance, it is of primary importance to support an education process for them. Shared governance will require a systemwide effort to reach a mutual understanding of the term *shared governance*; thus the steering committee will need to attain some level of comfort with the concept. This process will not be easy because it will represent a reversal of many well-established patterns of thinking and behavior.

A good starting point is a discussion of nursing's place in the current health care field and how it was reached. Information on the health care setting and the continued expected changes will help to clarify why the bureaucratic structures under which most nurses function are no longer appropriate. A focused review of nursing as practiced at the institution will help put the current organizational structures in perspective.

Information on shared governance in nursing and similar structures in the business world is readily available. Videos, educational programs, use of consultants, and site visits offer additional opportunities to understand the concept. Unfortunately, there is little information on the actual implementation available in print. Most hospitals that have implemented, or are in the process of implementing, shared governance have personnel who are eager to discuss their work over the telephone.

Group discussion about the information within the committee will be necessary for continued development of a shared meaning of the concept. Because each role will be affected differently, the interface of the various perceptions is important (Wilson, 1989). The first obligation will be to select the model that most closely fits the needs of the organization and establish a timetable for implementation. The model may be altered as necessary, provided the basic criteria for shared governance are met. Until members of the steering committee are fairly comfortable with the newly acquired information, they will be understandably reluctant to try to explain it to others. Skepticism both within and outside the group is to be expected. Animosity by peers may occur because of the time required away from the unit for such a poorly understood concept.

Assistance in supporting the steering committee members in their communication efforts is warranted because this is generally a new role for them. This is especially true for staff members who may be uncomfortable with the prospect of giving information when they still lack confidence in its content. Because the management role will change significantly, committee members who are managers may find themselves in a position of relaying information that will not be well received.

Opportunities to discuss anticipated questions and explore responses to these questions can decrease some of the associated anxiety. In addition, managing information can be facilitated by structuring the process and monitoring information flow so that clear expectations are established. For example, it should be determined who will have basic responsibility to communicate information about the steering council activities to the staff on each patient care unit. During the early phases, complaints regarding lack of general institutional knowledge about the process are not uncommon.

INITIAL ACTIVITIES

Part of the educational process will evolve from the primary activities of the group. As beliefs about and hopes for nursing are examined, the philosophy and purpose of the nursing organization will need to be reviewed. It is unlikely that these two documents will reflect the new thinking about nursing and its role in the institution. Many philosophies are sufficiently vague that almost any concept will fit in them. In such cases, a more specific definition should be written. Developing a clear statement of beliefs is a challenge for most nursing departments. It will be necessary, however, if it is to be translated into meaningful objectives. It should provide a framework for later development of bylaws.

The purpose of the nursing department should also be developed by this group.

Identifying and validating the nursing department's reason for being will continue to clarify the new role for nursing. Necessary elements to address will include services provided to the organization and the authority for such services, the organization's commitment to education and research, and how it will be utilized in patient care, as well as how the environment will be structured to support nursing's growth and continued development (Porter-O'Grady and Finnigan, 1984, p. 171).

After the philosophy and purpose are determined, the critical objectives of the department will be developed. These objectives should be quite specific but applicable to the department at large. Department objectives should include the development of the patient-nurse relationship, nursing's participation in supporting the departmental and institutional goals, how work will be organized to support the practice environment, and standards for assessing results. Specific examples of objectives can be found in the appendix of Porter-O'Grady and Finnigan's book on shared governance (1984, Appendix A). A time frame of 4 to 6 months will be needed to complete this beginning work.

As staff and management personnel are informed of progress, anger may be expressed that only a few people are involved in the decisions. Even when groups have elected their representatives, nonparticipants may not have fully understood what responsibilities would be assigned to the steering group. This will be especially true when long-held values are threatened.

For managers, anxiety related to role change can be expected. Because power and authority are vested in management in bureaucratic systems, the change to a shared governance structure can be expected to evoke feelings of uncertainty and resistance. Staff may feel uncomfortable as they realize the security of bureaucracy, wherein someone else had the final accountability and responsibility for decision making, is being changed. There may have been significant effort to communicate, but the concept was not clearly understood (Gramenz and Jameson, 1982).

The work of the group continues to clarify the process for members. When the core functions have been completed, a mechanism to develop councils or other working groups will be needed.

At this point the group should be functioning well together. The initial lack of trust between management and staff will have been overcome generally, although it may resurface in times of stress. During such times it will be important to remind the group to view the broader professional issues common to all members and that roles, although different, will be structured to support each other. The initial activities will have clarified many of the early uncertainties. Several members will likely develop a leadership role in the organization. Members volunteer to attend staff meetings when issues needing clarification surface, or they plan educational forums to keep enthusiasm and interest high.

THE ROLE OF MANAGEMENT IN THE EARLY PHASE

In most hospitals nursing management has one or more meeting forums. Because the magnitude of change in the organization required for shared governance cannot occur without management support, the group already in place should begin to

work on the management role early in the implementation process. Generally, this will be the first council or forum functioning. The management members of the steering committee will be able to communicate with the council on their activities, which can facilitate movement. Because many managers may perceive negative consequences in this new governance process, management steering group members will need support (Eckes, Marcoullier, and McNicholas, 1989; Wilson, 1989).

COUNCILS

In this chapter the term "council" denotes a decision-making group. Regardless of the exact group structure, existing committees that generally fit the identified areas of accountability should be used. This creates less turmoil and gives value to the previous work of the committee. The leadership, title, and responsibilities can be changed through designation by the steering committee (Porter-O'Grady and Finnigan, 1984). If no such committees exist, then the role of the steering group is to create the format and design a process for selection of members. In the latter case, as long as 12 to 18 months may be necessary to establish the groups. This will depend largely on the level of maturity and sophistication of both the steering committee and the nursing staff.

SELECTION OF CHAIRPERSONS

Chairpersons serve a highly visible and important role in the councils. Most chairpersons have had no preparation for this activity and need support to learn the new skills required. Craig's (1989) study indicated that the staff involved wanted help to learn the new role and more formal training about shared governance as a model. Providing educational opportunities on group process and decision making yields benefits, enhancing the speed and effectiveness of council activities.

One effective way to select leaders of the forming governance groups is to select a staff member from the steering committee to be chairperson. This allows the forming group to have a leader who understands the fundamental process. If the steering committee does not have appropriate or available staff members for the chairperson position for all newly forming groups, a management or administrative member can be selected from the steering committee to serve as a representative in his or her capacity as manager or administrative representative. In this fashion, the steering committee, as it coordinates and controls the process, can become the executive or coordinating council or forum. Any additional members will gradually be replaced as chairpersons are chosen. Throughout the duration of the steering committee stage, the ratio of management to staff should generally remain constant.

Because council members are also inexperienced, they may not always choose effective chairpersons. If reasonable opportunities for education and counseling do not effect change that permits the council to function effectively, the chairperson will need to be replaced. This can occur through counseling and resignation or the executive committee can act to remove the chairperson. The structure of the group should require a chair-elect to serve as an understudy for the year before assuming

the chair position. Thus role rehearsal occurs as an ongoing process and prepares the chair-elect for the chairperson's activities.

ESTABLISHING A TIMETABLE

Some members of the steering committee may find themselves unable to continue to serve. If the group is well underway, it may choose not to replace members because of the time required for a new person to "catch up" to the other members. Throughout the process the steering committee works on the timetable established at its outset. This helps the group recognize success when projects are completed and to know when deadlines are not being met. Because projects such as developing philosophies and a statement of purpose are less concrete than the usual nursing activity, it is easy for work to fall behind schedule. Monitoring progress becomes critical because the implementation timetable will depend on regular movement.

As each council or forum is formed, activity related to its accountabilities should be communicated to the steering group. How the accountabilities are addressed will not be prescribed—that is the work of the council or forum. When the guidelines have been established, they are submitted to the steering committee for review and approval or clarification if necessary. This ensures the appropriate framework is being followed in the transfer of decision making. The major projects for the coming year should be identified and a timetable established.

All forms of shared governance will address in some fashion five major areas of emphasis: practice, quality, education, peer relations, and governance.

How will the five areas of accountability be supported? In bureaucratic structures, management assumes accountability for all the nursing activity and the staff does not actually assume accountability for their work. Outcomes of care, therefore, become the responsibility of someone other than the caregiver. In shared governance models, assignment of accountability for patient care is to the staff nurse, and the integrating structures to support this change must be in place.

A strong value statement about the clinical nurse is made in allocating accountabilities. The message is clear that clinical nurses have accountability and authority for clinical practice in the institution. Because this role has usually been assigned to management, the structure must be designed to avoid this. The activities of practice and quality groups are at the core of professional practice. Work in these areas convinces others of the seriousness with which nurses view their practice and professional responsibilities (Knowlton, 1982). This is an example of structure supporting the desired process and outcome.

IMPLEMENTING A STRUCTURE FOR PROFESSIONAL PRACTICE

Nurses in bureaucratic structures have been alienated from the type of supportive network that moves them beyond focusing on tasks to a focus on nursing as a whole. In a bureaucracy, the roles of management and staff are essentially isolated and decisions are made for staff by managers who have been granted that authority

by the position they hold. The design of shared governance creates the necessary linkage for networking and integration of all elements of nursing practice. This is done by establishing mechanisms that ensure that professional nursing staff are accountable for the practice of nursing and managers are accountable for appropriate support of the practicing nurse. The allocation of accountability for various work roles is established in the mandates of the various councils or forums.

No "required" format exists for shared governance, but the underlying principles must be reflected in the structure design. A design to support principles may be difficult to visualize. It is helpful to organize the structure around the five major areas of accountability, indicating the mechanisms of support. The general controls to monitor the work of the group are common to all five areas and include keeping minutes of all meetings, setting group expectations for individual participation and the specific work of the group, and establishing guidelines to monitor progress.

PRACTICE STRUCTURE

Nursing practice is at the center of any shared governance system and will generally be the first structure formed in relation to staff accountability. Whereas other councils will address issues vital to practice, this group will establish the authority of the staff nurse in all areas of clinical practice. Because of the accountabilities addressed, the composition of this body should be primarily staff nurses, a manager and a nursing administrator for input to staff on their areas of expertise, and any additional information that will assist the staff in decision making. A clinical nurse specialist should be also be a voting member of the council in organizations with this role.

The following list of key elements to be addressed may be used to begin the determination of nursing accountabilities:

1. Develop standards of practice
2. Establish job descriptions for all clinical nurses
3. Review and reaffirm the nursing care delivery system or select and implement a new system
4. Appoint nursing representatives on all hospitalwide committees and task forces affecting patient care
5. Establish criteria for unit-based shared governance committees

QUALITY STRUCTURE

The focus of work in this body is the quality-control aspect of nursing practice. Often this function has been performed by nursing management even though the measurement is usually related to staff practice. In the shared governance format, staff nurses not only identify the appropriate monitors and criteria, they also determine the need for corrective action or opportunity for improvement. Finally, as a quality issue, the credentialing of nursing staff must be established to help ensure nurses are qualified to practice. This council will have a similar composition as the practice council. The program will need to be integrated with the hospital quality

assurance plan. The person responsible for the overall hospital plan should sit as a nonvoting member of the council to facilitate this process.

The following key activities should be undertaken to fulfill the quality obligation of the department:

1. Assess and review data sources, and establish department priorities
2. Develop measurable monitoring criteria and instruments
3. Assess standards on a regular basis to ensure they are current and being met
4. Evaluate deficiencies and recommend action to eliminate the deficiencies
5. Establish credentialing mechanisms and a peer review format for all clinical nurses
6. Approve all nursing research activities

EDUCATION STRUCTURE

The education program for the department is designed and initiated by this council or forum. Education is the cornerstone of keeping the practicing nurse informed and able to meet the standards established by the practice and quality councils. Because of the diverse needs that will probably be presented, there should be a staff representative from each unit as well as a nurse manager, nurse administrator, and clinical nurse specialist. This may cause some difficulty with group dynamics because of the number of people involved. The council will essentially provide overall direction of the resources, both human (through the nursing education division) and financial (through education funds available) for the department to meet its educational requirements. Primary accountabilities will include:

1. Identification of short- and long-term educational needs of nurses within the department
2. Ensuring that a program with adequate flexibility to meet the learning needs of experienced and beginning practitioners is available
3. Incorporation of new standards and nursing research
4. Development of specific and consistent evaluation processes for nursing education programs
5. Review and approval of the budget for nursing education activities

NURSING MANAGEMENT STRUCTURE

Nursing management is often the first active council group because it generally already exists in some form, and initiation of shared governance cannot begin at the unit level without the support of the managers. As noted earlier, the narrowing of focus in the management role will be a major change. The role of the manager moves from controlling and directing to facilitating and integrating the functions of the unit. This council will address the accountabilities of management in shared governance through the following activities:

1. Allocation of resources for staff, budgeting, and supplies. Staff input is sought in determining these allocations

2. Provision of support in clerical and other nonnursing areas so nursing care can be delivered appropriately
3. Implementation of the decisions of the nursing councils on the nursing unit
4. Facilitation of interdepartmental problem solving
5. Establishment of mechanisms to develop skills necessary for problem solving, decision making, and patient care management
6. Creation of consistent methods to monitor the level of staff accountability. Council activities are structured to enhance leadership skills appropriate to the manager in a shared governance setting
7. Shift in clinical decision making to staff personnel.

EXECUTIVE OR COORDINATING GROUP

Regardless of format, the work of the members is to ensure that there is overall coordination of activities and that departmentwide decisions are made in a timely fashion. The coordinating group is composed of the chairpersons of each council or committee and the nurse executive. Through this format staff nurses develop a role at the executive level and a forum for the nurse executive is provided directly to the leadership of the governance system. The group functions as the central point for the coordination of the activities of the individual councils and is accountable for decisions that affect the entire nursing department.

1. Mechanisms for communication related to decisions of the councils, resolution of conflict, and facilitation of decision making between councils are established. For example, is an issue being addressed in the appropriate council? Has a decision been made that will negate the outcomes of another? This becomes important as decision making becomes spread over a wider base than in the traditional model.
2. Decisions that affect the entire department are implemented. An example is final approval of the department's annual budget.
3. The work of all the governing groups is reviewed and the efficiency of the overall nursing department is evaluated.
4. Bylaws for governing the established groups and all members of the department of nursing are developed and revised as necessary.
5. General guidance to the nurse executive on issues of concern to the department is provided.

CORPORATE BODY

Another aspect of governance is the work of the corporate body of nursing. All nonprovisional members of the professional nursing staff make up this body. At intervals specified in the bylaws, the members meet to ensure that the business of the department is being appropriately enacted. In this manner, members of the nursing staff retain the overall final authority for departmental activities even though the majority of the work is done in nursing councils or forums.

Participating in the collective body of nursing to approve actions affecting all