professional nurses helps establish a strong foundation that integrates beliefs and activities. A forum for discussion and decision making affirms the role and accountability of each member of the professional nursing staff for the way nursing is practiced. These activities are a demonstration of the department's commitment to participation and collaboration.

At least annually, officers of the body should be elected, bylaws reviewed, and reports on the activities and issues of the nursing body given. Although the specific purpose of the meeting is to provide opportunities to enact the business of the department, the opportunity for social interaction and education is also valuable.

CHECKS AND BALANCES

Although the emphasis is on transferring legitimate authority for decision making to nursing staff, checks and balances for the overall system do exist. This important issue may be lost on the participants as the program unfolds. Three basic controls exist:

1. Nurses at the administrative level are advisory members of councils to ensure decisions are consistent with overall organizational goals and objectives.
2. Rules, regulations, and bylaws that direct the work of each committee, council, or other formal group are clearly delineated.
3. A mechanism for resolution of differences between groups or between groups and the administrative role in the nursing organization exists.

Boyle (1984) provides valuable insights into the need for checks and balances that provide structure and coordinates activities in instituting participatory management in a large industry.

SHARED GOVERNANCE ACTIVITIES

The council accountable for nursing practice should establish the necessary criteria and accountabilities for each unit to establish a unit-based shared governance committee. These committees, which can be used with any shared governance model, are an extension of the system at the unit level. Those who are not participants in departmental governance activities will have an opportunity to see and participate in the principles of shared governance in their day-to-day work in a more visible fashion. These groups function as subsets of the practice council/committee and make decisions on practice issues at the unit level. If committees already exist on the unit, they may be able to continue functioning within the new guidelines.

The precise structure of the unit council is not critical provided the basic principles required to support its work are in place. The composition of the group is an issue that requires some insight. Some unit councils are composed of all professional staff members; some include nonvoting members who are not professional nurses (i.e., LPNs), and others include all members of the unit with a variety of categories of staff.

Care must be taken that registered nurses make decisions on issues pertaining

to their professional accountabilities, and that they do not isolate themselves from other members of the staff who also work as part of the unit team. The skill with which this is accomplished, regardless of the final format, will affect how professional nurses and shared governance are perceived by others. As a subset of the departmentwide practice group, how practice is managed on the unit will reflect already established standards.

When shared governance moves to the unit, the need for new skills in learning expected roles should be anticipated. Decision making and the use of power may be problematic, and conflicts can emerge. Craig (1989) mentions these two themes in her study of implementation and outcomes of shared governance. The interface between management and staff may not be well understood by the participants. Staff personnel may feel all decisions are theirs, or they may feel frustrated because the manager does not make the decisions and allows the group to flounder. The manager will have had experience in her new role in the management forum, but she may not feel comfortable or secure. The management group has the most difficult role change, and challenges to the nurse manager's authority by the staff may occur. If a mature steering committee exists, they can be helpful in guiding the unit-based committee. The need for a supporting relationship between management and staff and the role each plays as presented jointly by a staff nurse and a manager can enlighten groups struggling with the realities of implementation. Boyle (1984) describes the stabilizing role of the steering committee in implementing participative management in a non–health care setting.

Throughout the process, it will be important for the nurse executive to divest herself or himself of roles that belong to staff and managers. This will be difficult during the formation period because the functions and structure will not yet be developed and coordinated. In addition, the remainder of the institution is still functioning in a bureaucracy. The councils or forums that are actively forming will need much information from management and administration so they can understand why certain movements or decisions may be required. Collaboration with steering committee or council members will be critical. Otherwise, the fragile trust that exists will not be sustained.

BYLAWS

Bylaws to govern the department are important because they not only provide a framework for the work of the nursing organization, but they will also serve as a "snapshot" to describe the values and associated processes that can be expected to occur. It may be tempting to develop bylaws early in the process of shared governance to provide some structure. Organizations who have done this successfully have found that it takes 12 to 18 months of work. It is difficult to develop bylaws at the beginning because a clear picture of shared governance has not emerged, and the structure as viewed at the start may require a number of revisions. Otherwise, individual councils would not be able to make adjustments as the structure develops. Regardless of when the bylaws are developed, the professional nursing organization will need to approve them by at least a majority vote. It will be dif-

ficult for nurses to do this with clear understanding before the councils and forums have begun to function. Porter-O'Grady and Finnigan (1984) provide a detailed discussion and specific examples of bylaws.

THE ISSUE OF VETO

In some organizations the nurse executive may retain veto power over decisions. Veto power in any form of shared governance organization has major implications. Because the basis of the organization is shifting accountability from management to staff, this cannot be fully achieved if veto power is retained, which sends a message that a lack of confidence exists in the system itself or the professional staff cannot be fully trusted (Porter-O'Grady and Finnigan, 1984).

Conversely, because of the nurse executive's accountability to the board of trustees and the chief executive officer to support organizational initiatives and priorities, what type of interface should exist when conflict does occur? An important control mechanism in each decision-making group is the information and interpretation of the administrative representative. If this proves inadequate because of a rapidly changing situation or other gap in information, the nurse executive will generally meet with the group making the decision and provide the necessary additional information or interpretation. When resolution cannot be accomplished, the executive group, which includes staff nurses and a manager who are chairpersons of the councils, will take action on the issue. The leadership role of the nurse executive is critical in establishing credibility throughout the unfolding of the shared governance process, and the work that has been done before such conflicts arise will be realized here. Bylaws must fully address the process of conflict resolution.

MODELS

To provide a clearer visualization of the relationship of structure to process, the most common models of shared governance with a centralized coordinating function will be briefly described followed by shared governance as a unit-specific model. It should be understood that a model is simply *one* prototype that can be studied and modified to meet the needs of the organization. As many models exist as do institutions with shared governance.

COUNCILOR MODEL

The councilor model is structured to involve staff nurses in the widest possible range of activities related to clinical practice. Decision-making councils are established based on the functional areas of professional practice (see Fig. 4-2). Approval of staff council decisions by administration or other management groups is not required. All nursing managers and administrators will be involved in activities that support, facilitate, or integrate functions necessary to implement decisions made by clinical nurses in councils representative of the areas of practice. Except

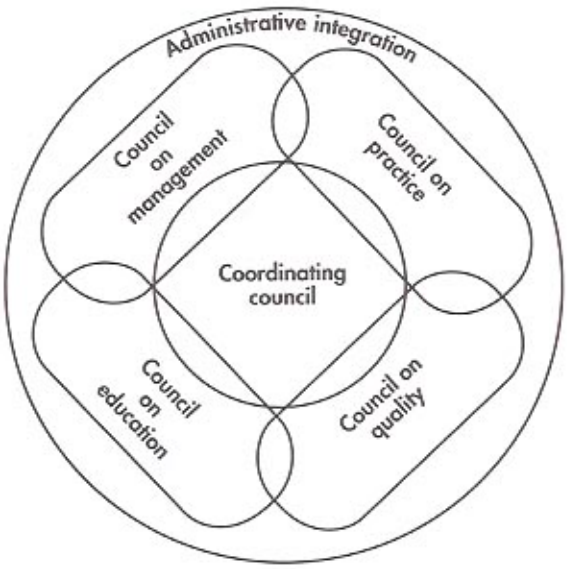

FIGURE 4-2. Councilor model. (From Porter-O'Grady, and Finnigan, S. Shared governance for nursing: a creative approach to professional accountability. With permission of Aspen Publishers, Inc., 1984, p. 105.)

for the management council, councils will be primarily composed of staff nurses. If the organization has clinical nurse specialists, one should be included in each clinical group. A single nurse manager will have the only nonclinical vote in each staff council. The nurse manager's role is to advise the council on management implications as issues are discussed. One administrative-level nurse without a vote advises each staff council regarding how various issues affect the goals and objectives of the department and institution at large. Effective communication of this information will assist the council to make appropriate decisions.

The size of the hospital may affect the actual number of staff members involved in any council, but no single area should dominate. Generally, all clinical areas should be represented. Large councils (more than 15 members) may become cumbersome to manage because effective decision making is difficult in larger groups.

The management council will include all nurse managers, directors, and the nurse executive. The council's primary shared governance functions are to manage the fiscal, human, and material resources for the institution in concert with decisions made in the clinical councils. The management team becomes the agent to ensure that decisions of the councils are implemented on the units, within the available resources. Because this role is much different than the role previously assigned to the management team, the council provides an opportunity, through its work as a group, to identify needed developmental activities. The management council provides a forum for discussing and assigning management accountabili-

ties and roles. For example, when a department project or incident is identified, management accountabilities can be assigned based on the role developed by the council members.

The coordinating or executive council is composed of the chairs of each council and the nurse executive. As noted earlier, this council presents the staff nurse with the opportunity for a significant role at the executive level. The primary purposes of this council are to coordinate the activities of all the councils and, as necessary, to make decisions that affect all areas of the nursing department. The coordinating function is vital because decision making is now spread throughout the organization rather than solely at the management level. There will be debate throughout the implementation process regarding who should make certain decisions. Often, involvement by more than one council is necessary. For example, when unit-based shared governance committees are established, they will deal with practice, quality, and education issues. Decisions involving more than one council will be reviewed to be certain they are congruent and have been addressed by the appropriate groups. It is expected that ambiguity will continue in any shared governance organization, but comfort should develop with experience.

The role of the council chairpersons is important because their position affords them an opportunity to expand their view of the nursing organization within the institution. This expanded knowledge base should enhance their decision-making skills. Conversely, the nurse executive has direct access to the leadership of the governance representatives on a regular basis, which expands her knowledge of current staff concerns. The resulting collaborative relationship will serve the department and institution well. With only five members, this group can be convened, should it become necessary, to make critical decisions that cannot wait for regularly scheduled meetings. Communication is integrated and decisions are made in a timely fashion.

Constraints of this model are its complexity, particularly when moving issues through the system. As noted earlier, there is a broad decision-making base, and the ability to integrate activities becomes a crucial factor. Cost and time involvement also need to be considered. It will be necessary to build the cost of staff participation into the nursing budget. Small groups, few in number, with clear accountabilities and goals will minimize confusion and help to focus governance activities. As previously noted, the coordinating council plays a key role in integrating department activities.

CONGRESSIONAL MODEL

In the congressional model, all members of the nursing department (RNs, LPNs, nurses' aides) belong to the nursing congress. The overall structure is similar in format to the federal government with elected representatives, a cabinet or executive council, and committees. Figure 4-3 depicts the structure of the congressional model.

The president and a cabinet of officers are elected by the congress from a slate of nominees. Nominees may be both staff members and managers, but at least

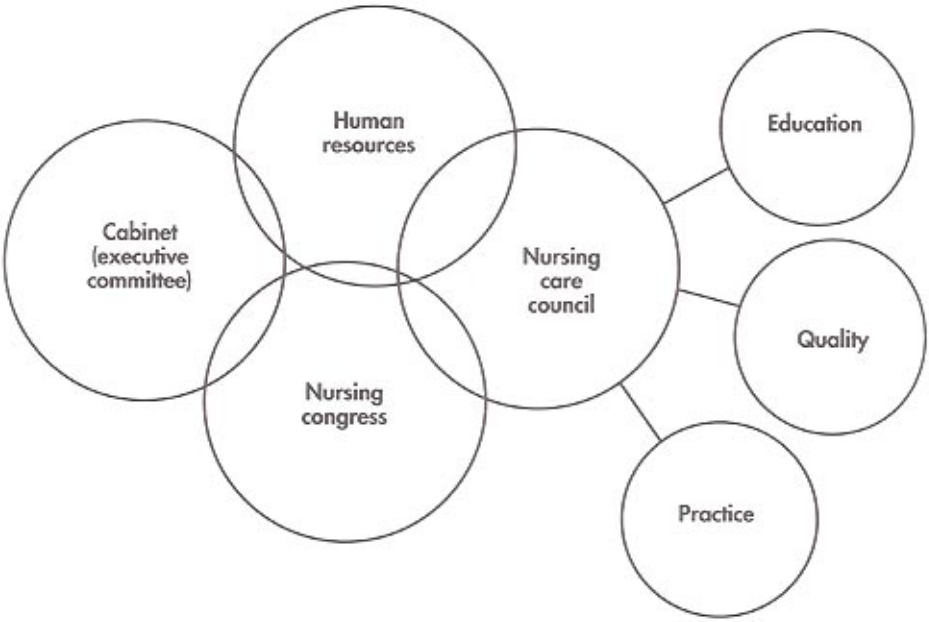

FIGURE 4-3. Congressional model. (Adapted from Rose Medical Center, Nursing Congress Bylaws, 1983. Used with permission.)

50% are staff. Committees or councils are formed to represent the five areas of nursing accountability and are responsible for specific activities that are defined in rules or bylaws. As committee work is completed, it is presented to the cabinet for action. The cabinet becomes the coordinator of shared governance activities, monitoring the effectiveness with which committees perform their work, and advising the nurse executive on matters of concern to the nursing congress.

The nursing care council monitors and coordinates the activities that relate to the practice of nursing, including all functional areas of clinical practice in the general categories of practice, education, and quality assurance. Subcommittees are formed to provide direction in all areas of practice, and these subcommittees present reports and recommendations to the council for action.

If issues require further consideration or intervention after review by the council, they may be referred by this council to the cabinet. The nurse executive and the chairpersons or a representative of each subcommittee form the nursing care council.

A unique characteristic of this model is that a council dealing with human resources is created. It is composed of representatives from all clinical areas and an administrative human resources representative. The council advises hospital administration on issues of concern to the nursing department such as staffing, recruitment and retention, and other employment-related activities. Participation in institutional planning and development around human resources activities may be offered.

In a general sense, a parallel organization is formed by nursing within the institution at large. This is a constraint that needs to be considered before implementation of a congressional model. The ability for the format to be replicated in other parts of the organization should be assessed. In addition, opportunities to create linkages with other hospital departments such as establishing a professional relationship committee to enhance collaboration between nursing staff and other personnel who work with patients can help to decrease the isolation of nursing from its support areas.

ADMINISTRATIVE MODEL

The administrative model follows more traditional lines of separation between management and practice. A practice structure and a management structure are established. Management and staff have separate groups that focus on their specific functions and accountabilities. The areas of accountability for staff may be defined in various ways but should address the categories defined earlier—practice, quality, education and development, peer relations, and governance. Figure 4-4 depicts the structure of the administrative model.

In this structure, the clinical group work is done by staff committees. All practice issue recommendations from the various staff committees are referred to an umbrella group or council composed of both managers and staff. This group makes decisions on the recommendations it receives. In some models a separate integrating forum for all clinical issues and all management issues may exist between the committees and the executive group because many concerns may relate to more than one committee. This format can streamline the work of the executive committee to some extent since it may prevent the need to refer the work to another committee that will need input. The group composition may vary but will be most representative if a majority are staff nurses. The nurse executive role, whether through the vice president or director level, is represented in the clinical forum to provide a departmental and institutional view of the issues brought before it. It is also a source of important information for administrative nurses to learn staff concerns. When there is a management component, the issue will be referred to the appropriate management structure. In all shared governance models, there will be many instances when decisions between management and the clinical staff will overlap. This will not change as the model matures, but the comfort level of those involved should increase. Each committee should have a specific purpose with developed goals and objectives, and the bylaws should reflect the membership, responsibilities, and roles of all groups established as part of the system.

A key characteristic of the administrative model is the structural familiarity in discussing, recommending, and moving decisions upward. The decision-making body, however, will be composed of both staff and management. This group should be composed of at least 50% staff or a representative proportion in the institution of staff to management. It can be assumed that the decision on composition will reflect the degree of commitment to staff nurse participation within the nursing organization.

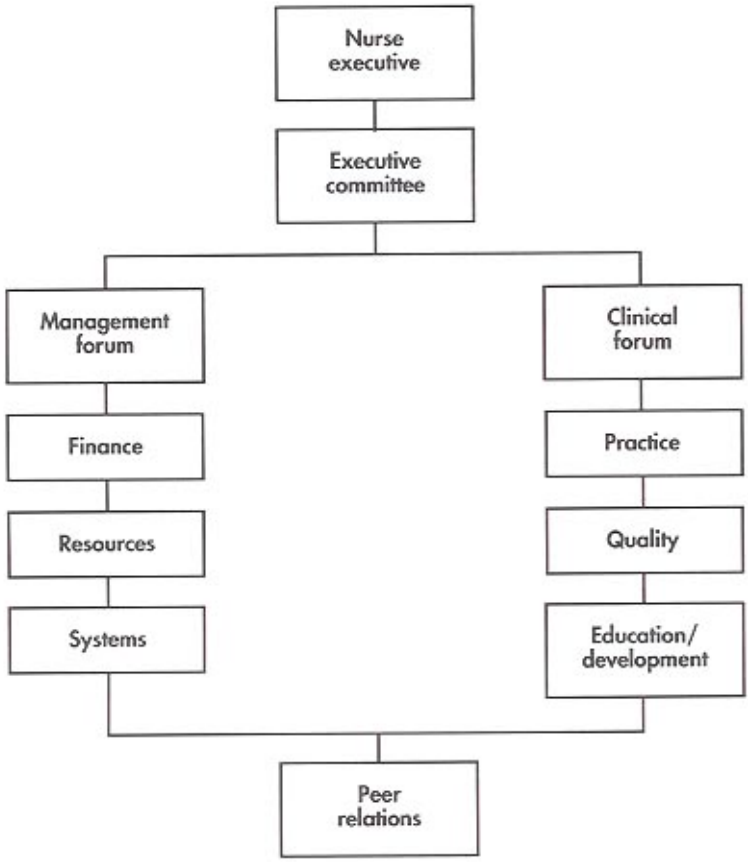

FIGURE 4-4. Administrative model. (From Porter-O'Grady, T: Shared governance and new organizational models. Nursing Economics 5[6]:286, 1987.)

As noted earlier, this model is familiar in format and may be the model of choice in organizations that are more traditional. It may also be practical in the use of existing committees, because less reorganization may be necessary.

However, the potential exists in this traditional format to revert to old management-centered processes. This is especially true when the staff is not proportionately represented on staff and management committees. When there is equal representation between the two groups, it may be expeditious for the nurse executive to assume the role of tiebreaker. To prevent this situation, staff representation should be greater than 50%. Clear mechanisms for resolution of conflicts involving staff decisions and nursing administration should be developed. Most organizations now use the councilor, congressional, or unit-based structure. Pinkerton and Schroeder (1989) provide in-depth information of the administrative model.

UNIT-BASED MODELS

Several institutions have established models that are unique to each nursing unit. Unit-based models, as depicted in Figure 4-5, differ from the more traditional format because there is no central integrating function with staff input at the executive and coordinating levels. Each unit is authorized to establish its own governance system. There is considerable latitude so that each unit can establish a format that seems to best meet its needs. The functional areas of accountability are addressed on a unit-by-unit level. Some institutions have one or more units that have chosen to eliminate established managers, dividing the management function among the group's members.

In providing control, each unit submits its plan to the nurse executive to ensure there is no conflict with other policies and standards in the department. Generally, the members of the administrative team with overall responsibility for the unit will have advised unit staff of possible conflicts while developing their model. Regardless of the flexibility of the nurse executive and administrative staff, administration still approves decisions related to practice in this format. This remains a central issue even if *all* plans are approved as submitted.

Perceived benefits of this approach are that the process is faster than waiting for the entire department to organize itself, and units can form groups at their own

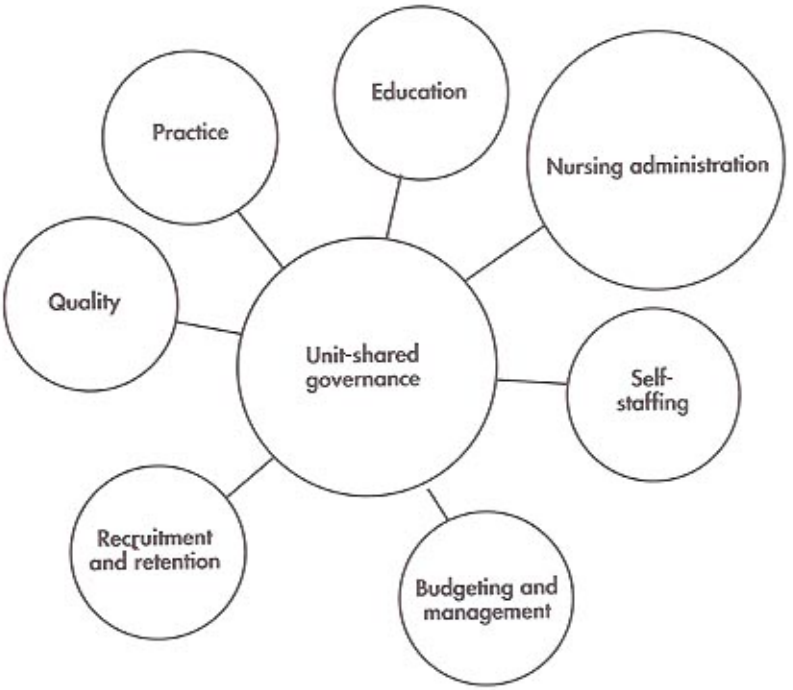

FIGURE 4-5. Unit-based model.

pace. Innovation can be encouraged and groups learn from each other. Conversely, no unit would be required to form a shared governance model. A high value in this format is given to recognizing the individuality of groups.

One of the constraints of unit-based models are that the coordinating function and a role at the executive level for staff nurses are not part of the design. Therefore, there must be executive approval for the format that defines the practice of nursing on any particular unit. Rather than staff nurses making decisions with the nurse executive on departmentwide decisions and integrating issues relating to accountability, nursing administration fulfills this function.

Some organizations have started with the unit-based model and later developed a departmental integrating and control function that gives staff full decision-making authority over practice issues. Until central integration and control are present, shared governance cannot be said to be fully implemented.

COLLECTIVE BARGAINING

Establishing effective shared governance models in unionized hospitals has begun. Several unionized hospitals are currently in that process of adopting shared governance models. The challenge of integrating the contract and the governance structure in a fashion that continues to promote decision making at the staff level is a major undertaking. Obviously this can be accomplished only in an environment where change beneficial to all involved can occur.

Unfortunately, there is a dearth of literature on implementation of shared governance within a union environment. In general, those issues that exist when trust is lacking will exist in this setting. Active effort to keep communication open will be critical because relationships, especially in the beginning, are likely to be tenuous.

A suggested approach is to begin exploratory meetings jointly with union and management negotiating teams so that all members feel invested in the process. During the early phase the participants must agree to be open to all conditions of change that may need to be explored. This presents a major commitment for both union and management and is likely to cause some anxiety. Because it is uncertain which issues will arise, concerns are apt to surface surrounding long-standing issues or areas of current stress. The union wants to protect the contract, and the process may be seen as "caving in" to management, undermining union authority, or trying to eliminate the union. Management may expect the union to not be fully cooperative to maintain their control or to place bargaining conditions in the contract that interfere with the full implementation of shared governance. Some management members of the group might also be concerned about giving staff, who are union members, so much decision-making authority. In addition, there may be concern about giving management information to the union or appearing to be supportive of the union. The concerns of both parties are quite similar. Acknowledging these concerns can be helpful if it is understood these issues will only be resolved over time as the working relationship develops. If it is possible to involve

a consultant, it will generally be easier to be more objective and to defuse difficult situations.

If both parties agree to proceed with the project, specific mechanisms must be in place to ensure ongoing involvement of the negotiating teams, staff, and corporate officers of both the union and the hospital. Although the corporate officers are less directly involved, lack of their support at critical junctures can make the task more arduous. If they are regularly informed of issues and progress, difficulties are less likely to arise. To bring them to the table to resolve an impasse or inform them of a major change they did not anticipate disadvantages the process.

A suggested format will provide support at several levels. In addition to meetings with the negotiating teams, the union negotiator and selected officers of the bargaining unit should meet with nursing administration, preferably the nurse executive and one or two other nurse directors. Meetings should occur at least monthly to review progress, discuss changes, and begin to study contract content and language once the process is underway. Items of conflict or concern that have surfaced between meetings should be discussed so they can be referred for resolution to the appropriate individuals or put on the agenda for further discussion. The work of this group is excellent preparation for negotiations because members will have discovered that even the most difficult issues can be discussed without animosity. Successes develop trust and a willingness to continue the commitment.

An additional informal meeting with union officers and nursing administration should also include a manager and two or three staff members from the same unit. If there is tension regarding an issue on a particular unit, it is good to invite the manager and staff from that area. These meetings allow discussion and clarification of information related to the concern. A monthly luncheon or other regularly scheduled meeting in a relaxed setting works well. This provides an opportunity for members of the nursing staff to observe union and management leaders solving problems together and to be comfortable participating in that activity. This is an important factor in the overall process, since trust issues will surface often. This is especially true during times of stress.

The number of meetings may seem complicated and cumbersome, but the various groups provide a solid foundation for problem solving and enhance the possibility of success in this sometimes arduous undertaking.

The need for a steering committee is not eliminated by the work of the groups described above. These groups support the work of the steering committee. Staff nurses on the steering committee are union members. They should be given the opportunity to choose whether they are to be elected by bargaining unit members or appointed by union officers. Satisfaction of the membership with the choice of their representatives may become an issue, and it is important that members feel comfortable with how their representatives were selected. The steering committee will be more focused on how practice should be structured to accomplish the goals of shared governance, and the negotiating team will need to discuss broader issues related to collective bargaining and how the contract may be affected. There is an opportunity for the negotiating team to deal with current health care issues and the

concept of shared governance in the early phases while the steering committee undergoes its own educational process. Once the program is underway, quarterly meetings of the negotiating teams are probably adequate, whereas the steering committee should meet at least monthly.

The question of whether shared governance should be included in the contract will arise. Because most contracts are of shorter duration than the implementation of shared governance, the concern is almost certain to occur. Two factors are of particular importance: Professional practice cannot be negotiated and contract language, by intent, tends to be restrictive. Contracts are usually negotiated for 1- to 3-year periods, and it is important that items not preclude activity of the councils that are forming. Careful review will be necessary so these activities are not defined by the contract rather than by council members. Sensitivity should be exercised so that the language of the contract and the ongoing shared governance process are not in conflict. The effort is not to unduly restrict the work of the staff in developing their model.

It is helpful to acknowledge in the contract the work being undertaken and language indicating the mechanism to be used when changes are needed in the contract. A single article in one major hospital contract recognizes that shared governance is being implemented and indicates how contract changes will occur, the role of the contract during the interim phase, and what mechanism intervenes should the process cease to exist. No further mention of shared governance appears in the contract. The article was written by the steering committee and submitted to the negotiating teams before the start of negotiations.

Development of an article in the contract is an initial process. Meetings between union and management leadership should help to prepare for negotiations in which contract language will be changed. Meeting and identifying specific areas for cooperative change present a challenge. Conversely, the opportunity to jointly work out language without the added pressure to complete negotiations is beneficial. Some of the concerns surrounding traditional areas of confrontation such as grievance and disciplinary action can be defused if a trusting relationship was developed during the implementation phase. Nevertheless, language that is mutually satisfactory will be needed. It should be as nonrestrictive as possible so the need of staff to develop formats and structures that promote professional practice is not impaired. For example, by limiting language to phraseology such as . . . "mechanisms shall exist for settlement of disagreements" . . . rather than a detailed procedure to be followed for specific grievances allows the appropriate councils to determine how these issues will be handled. In this manner an activity such as peer review is not precluded. It is also important to acknowledge that under this format management will also relinquish its traditional role in the grievance procedure.

Just as using the bureaucratic structure to begin implementation of shared governance seems incongruent, so does the resistance of the union in giving their members decision-making authority in the workplace. However, the historical perspective of each must be considered, with sensitivity shown as concern is expressed and resistance encountered. Because neither party will be experienced in addressing contract issues in the context of shared governance, a sense of perspec-

tive in working through the difficulties of doing what has not been done before can add some excitement and perhaps a sense of humor to the challenge.

Steering committee members will be important leaders in establishing shared governance. Because of the work in which they have been involved, they will be more knowledgeable and informed than their peers. Major changes in established relationships between management and staff are needed, and committee members will require support to deal with reactions of their peers to these changes. Reactions will be related to both staff nurse accountability and a lack of understanding of the need for controls and a defined management role. As previously noted, staff may resist accepting accountability because an activity has always "belonged" to management. Conversely, they may feel they no longer need any management input and can make rules as the need arises. This can be resolved effectively in the steering committee because the knowledge base has been expanded during the preparation phase. A staff nurse and manager from the steering committee are an excellent team to work with groups experiencing difficulty in adjusting to the changes.

TRENDS IN SHARED GOVERNANCE MODELS

It is difficult to describe shared governance models because many modifications have been made. It is unclear how to categorize some models. As a result, the concept remains somewhat hazy. Because no single model exists, it is difficult to envision it precisely. The principles on which it should be based are much easier to state.

Some institutions have developed models in which other members of the organization join with nursing in an integrated or collaborative model. In some cases, this emerged as an accommodation to particular circumstances in the institution. For example, some unions have claimed the model represented a collective bargaining unit for nursing so other staff were integrated. Finding ways to integrate others into shared governance is of interest because of nursing's tendency to become isolated from the rest of the organization. In Mershon's interview with Bocchino (1990) the tendency of nurses to isolate themselves from the larger health care system is discussed. Pinkerton and others (1989) also address this issue in relation to the difficulty of having a progressive group working with personnel in other departments who have not developed as fully. As noted earlier, the literature of other disciplines indicates employee needs of more responsive and humanistic work environments. Finding organizationwide models that help members work more effectively together may be the next step in shared governance.

SUMMARY

The selection of a professional practice model that meets institutional and departmental needs requires careful analysis. In addition, knowledge that adequate support within the institution exists is a prerequisite to begin the process.

There are as many models for shared governance as there are hospitals where it

has been implemented. The models described in this chapter should serve only as guides in the development of structures most appropriate to the culture and work of an organization.

Because uncertainty is a normal part of change, anxiety and even some chaos are to be expected in a project of this magnitude. Providing adequate information about the project and fully involving both staff and management are critical to success. This is especially true as traditional roles change and old identities are challenged.

A formal group of staff and management should be established to oversee the project and help the nurse executive lead the department through the necessary changes. Establishing clear goals and timetables will prevent a loss of momentum, especially when broader issues such as philosophy, purpose, and mission are being defined.

The steering committee plays an important role in integrating the work of various forums and councils. Throughout the process communication is a key factor in decreasing resistance to change. There will be a knowledge gap between council members, who are formally involved, and other unit staff. When unit governance committees are established the staff members who are not involved with council work will have an opportunity to apply the principles of shared governance to their day-to-day activities. The need for new skills in learning expected roles should be anticipated because conflicts can be expected, particularly in the area of interface between staff and management.

Union and management are beginning to find ways to integrate professional practice models with collective bargaining agreements. Although the issues are complex, full participation between the two groups and an openness of all parties involved will be necessary to succeed.

New management structures that challenge the traditional bureaucratic organization have evolved throughout the work force. This has been the result of employee dissatisfaction with models that fail to recognize basic human needs and an increasingly complex and changing work environment. Nowhere has this been more true than in health care. New models of shared governance will continue to evolve, such as organizationwide models that facilitate cooperation. Shared governance is the process that moves nursing to the future and should not serve as an end point or constraint to resolving new challenges that will inevitably develop.

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