allows the professional group to evaluate care, thus assigning members a role accountability beyond their own practice. The evaluation of peers is a component of professionals. Accountability to society by professionals can be accomplished through a peer review process (Passos, 1973).

Job description and performance appraisals. As the roles begin to evolve, the job descriptions and performance tools should be revised. They should reflect the changing roles, responsibilities, values, and expectations. Professional accountability and responsibility should be clearly delineated.

Clinical advancement. This program should also reflect the accountability regarding practice. It should emphasize the accountability for one's own practice, the practice of peers, the nursing division, and the profession at large. A clinical advancement program is a professional advancement program. It acknowledges the professional nurse for advanced professional skills. It provides a method for advancement within the clinical practice setting. Increased autonomy and accountability are provided by a clinical advancement program. It also impacts patient care through improvement of quality outcomes, and promotes retention through job satisfaction, recognition of advanced clinical skills, and expanded clinical roles.

Competency-based orientation. A competency-based orientation ensures attainment of a minimal standard of skill and knowledge level of the clinical practice nurse. It provides for quality care delivery. This method promotes professional accountability for the quality of the education. It further demonstrates autonomy of the profession.

Standards of practice. Standards provide a basis for measurement; they are a model by which to judge. They provide a direction and a foundation for quality care. A hallmark of a profession is its ability to define its own practice and standards. All professionals possess a unique body of knowledge and work within a conceptual framework.

Conceptual model. A conceptual model offers a unifying focus for practice decisions. A consistent approach is ensured. It serves as a tool that promotes holistic, in-depth patient care and practice decisions. A common reference point exists.

PHASE II—CHAOS, CONFUSION, AND UNCERTAINTY

This phase is the period of most resistance and conflict. "Noise" within the system may be present in varying degrees throughout the 3- to 5-year implementation process. This period will be the most difficult. There will be a struggle between the previous structure, roles, and expectations and the new emerging ones required by the shared governance model.

Opposition may be negligible at first but will become more noticeable as the structure and changes begin to unfold. Resistance will be seen at all levels. There are four reactions or behaviors that might be seen (Pinkerton and Schroeder, 1988): frustration and aggression, passive resistance, indifference, and acceptance. Conflict also frequently occurs.

Frustration and aggression. This active resistance may be overt at first but

will later become covert. Deliberate sabotage and manipulation may occur. Accusation and projection onto other groups is common in the unit manager group.

Passive resistance. Individuals may unite to resist the changes. They may be responding to real or perceived threats, and use information as their ammunition. Withholding and distortion of information, as well as covering of mistakes, may be seen. Opponents will actually contribute to errors to prove their points, and to make a case for not embracing the change.

Indifference. Individuals may ignore the situation by not taking part in the activities. They may attempt to divert the attention. They may rationalize why they are unable to get involved or implement the model on their unit at this time. Withholding resources of time and information may be evident in managers, as well as staff. Managers may also withhold assistance to staff for the development of the model or skills or may manipulate the staff to fail.

Participation of the staff can be frustrating in the implementation. As with any change, a small, committed group will be the high participators. Initially, it may be necessary to convince people that they want to be involved. As effects of the system become apparent, a new level of interest will develop. Choosing topics of significant importance to the staff can stimulate interest and involvement. In most cases, there will always be those who choose not to participate. It is important to design the structure so that expectations of involvement are evident. The structure should not reward nonparticipation; only participative behavior is to be rewarded. This may include peer pressure, evaluation standards, career ladder moves, etc.

Acceptance. There may be the appearance of acceptance, but this may not represent genuine acceptance. Only over time will the outcome of the acceptance and the level of participation be known.

Acceptance of change may be affected by many factors. As mentioned, previous experience with change will influence the response to new changes. Fears of perceived loss of control, power, or authority may be present. Fear of the unknown, an inability to conceptualize the change and new role, or fear regarding the ability to successfully function in the new system may constrain the acceptance of change. Lack of knowledge, understanding, or skills may also hinder acceptance. The inability to perceive the need or value of the change may exist. Philosophical differences should be examined. Change is difficult even for those who philosophically agree with the change. A sense of comfort with the familiar is replaced with a sense of loss and the uncertainty of the unknown.

A safe, supportive environment is necessary to facilitate acceptance. Opportunities to openly verbalize fears, concerns, and uncertainty should be provided. Educational resources and opportunities for skill development should be available. The ability to participate in the implementation of the change is helpful. The benefits derived from the change should be communicated. Information sharing concerning the change, as well as clarification of new roles and expectations, is necessary throughout the process. The hindrance to acceptance will vary with each individual. Multiple strategies to assist with acceptance will be needed.

Conflict. Problems and conflicts are a part of implementing any change. They should not be viewed negatively but should rather be seen as an inevitable part of the process. Not all conflicts or problems are bad. They can often assist in

the further refinement or clarification of the system. It is important, however, to view these conflicts objectively. The cause should be examined to determine a strategy to address them. It is important to analyze the conflict and address it but do not allow the conflicts to change the course or the direction of the change. There are many possible responses to objections within the system. The response depends on the type of objections, the severity, and amount, the impact on the change, and the timing. There are several types of responses to objections to change.

No response. At times simply allowing the objection to be voiced so that it can be resolved is all that is necessary. This response shows trust and that it is acceptable to question and challenge. Overreacting or reacting to an objection may cause it to escalate; it may be best to wait and ignore it.

Cooperation. Enlisting the involvement of the resisters gives them an opportunity to be involved and make choices. In this way, it becomes their change process.

Diplomacy. Individuals whom the resisters trust and respect can help persuade, sell, and convince.

Decrease the rate of change. It is important to moderate the change with the group's ability to absorb it and adjust to it. It may be necessary to decrease the rate of change to allow a deescalation of conflict. However, a forward momentum should be maintained. If objections completely halt the movement, a powerful reward for continued resistance is created.

Hold the line. This approach emphasizes reasserting the expectations, clarifying roles, and reviewing the vision.

Warning. The direction should be clearly set, and those who are unable to support the change must examine the appropriateness of their continued place within the organization.

Not all members of management or nursing staff will wish to or be able to effectively function in a shared governance system. However, it is important to assess the individual in-depth and allow ample time for acceptance and participation. Every effort should be made to ensure ample opportunity and resources for skill development.

Display support from upper level and other levels. Support of the changes can be displayed in a variety of ways. Verbal confirmation, as well as public positive praise for those who are involved and supportive of the change process, is important. Role modeling of the expected new behaviors can be influential.

As the structural changes begin, chaos, confusion, and uncertainty will occur. For a period of time, the organization will have portions of two systems, the old traditional structure and the new developing shared governance structure.

The system will experience some degree of chaos as everyone struggles with working within two systems. The transition process of the structure change cannot be instantaneous, but a short transition is desirable. As issues arise, particularly early in this period, it may be difficult to determine which process should be used. The groups' progress and exact stage in the change process will be unclear. In addition, the newly formed groups may not yet be ready developmentally to handle all issues. The nurse administrator's role at this time should be to assist in this

assessment. She should direct and moderate the systems. Delay in resolution of the problem and delayed decisions should be expected.

In the initial planning process, the council structure and areas of responsibility are loosely defined. As the groups begin to meet, there will be confusion regarding the structure, systems, and process. Role confusion will also be evident. Managers and staff will grapple with changing roles and new expectations. During the first 1 to 2 years, the structure will be undergoing continuous and dramatic change. The councils should begin by more clearly defining their work. They need to begin to develop their accountabilities.

There will be a lack of understanding regarding the shared governance system. Initially, the groups will be internally focused. They are interested only in what relates to their particular group. At this time, many misconceptions may emerge, which may hinder movement. Managers and staff may see no difference between a participatory structure and shared governance. Shared governance is *not* participatory management. In participatory management the manager invites staff involvement in decisions. The manager is not obligated to use the staff input. In addition, the manager retains the final authority and accountability of the outcome of the decision. By contrast, in a shared governance model the involvement in decisions is a right, a defined role in specified areas. Accountability and the authority rest with the staff.

Staff members will experience uncertainty regarding themselves and others; there will be a time of testing. They are unsure whether they will actually be allowed to make decisions instead of management. They may not yet trust management or the system. Skepticism will be projected. Reassurance and support will be necessary. As decisions perceived as important by the staff are made by the staff, the distrust should begin to dissipate.

Mistakes are unavoidable as the decisions are being made. An atmosphere that accepts errors must be created (Peters, 1987). Management must allow mistakes. They must help staff learn from mistakes, view them openly, and be able to talk about them without fear of punishment. Unit managers may find it difficult to allow staff members to make mistakes, or they may actually contribute to mistakes by not sharing information or assisting staff in the development of skills. The manager should not allow the staff to make blatant errors, but should assist them in examining the cause of the issues, developing alternatives, and evaluating the outcomes of the alternative. This is accomplished not by dictating answers, but by asking appropriate questions, thus allowing the staff to choose the answer.

Early in the decision-making stages, a reluctance to make difficult decisions may be noted. This may occur among both staff members and management and usually involves making decisions that will be unpopular with both peer groups. There is fear of rejection and anger. The groups may need to be challenged to make the difficult decisions. They will need support through the process. In the past it may have been easier to pass the difficult decisions to someone else. Assisting the staff through this stage will be aided by building their self-confidence. Talking through issues can be helpful. Those involved in the decisions need to support each other. Often having the opportunity to express the negative reactions aimed at them is helpful in dealing with the stress. After staff members have ex-

perienced this in a few situations, they are better able to handle the negative reactions of their peers and have the self-confidence to deal with the situation without personalizing it. Through the process they gain insight into the difficulty of decision making and acquire new understanding and respect for other decision makers.

Issues of nonsupport are evident in staff as well as management. There may be a lack of trust within the groups. Communication and information are important. Explaining the system and how it works may be helpful. An open invitation to observe the decision-making forums gives staff members who are not involved the opportunity to see the process firsthand. It also gives the message that the system is open and that there are no secrets.

It is expected that the major changes will be championed by a few leading innovators. They will be the change agents. As they lead their peers through the change process, they will experience conflict resistance and lack of understanding and support. Breaking new ground is never easy; they are paving the way for their successors. No one will be able to understand what they have had to accomplish. It is important not only that they receive support from their superiors but that there be opportunities for them to interact and set up supports among themselves.

The overall concept that staff make decisions that relate to practice and management makes decisions that relate to business issues and resources may sound clear, but it is not. There are many issues that seem to have components of both. It may not always be clear who should make what decision. As these issues arise it may be necessary to use the guideline that whoever is responsible for the outcome should have the accountability of the decision. In some instances it may be necessary to divide the decision into parts for different groups. If this is not possible because of the nature of the decision, one group may need to seek input from the other. Only one group can make the decision. When it is unclear who should make a decision, the executive council does not make the decision but rather decides who makes the decision.

In the beginning there is a lack of boundaries as the groups struggle for their identity. They are rapidly assuming responsibilities. They are initially timid but move quickly to challenge any boundaries. Boundaries must be placed; there needs to be clear definition or chaos will result. The resultant structure will become as unwieldy as the previous one with confusion of roles and overlapping responsibility. Reeducation of the principles and clarification of the direction will be needed. It will take time for the staff to understand the structures and the interrelationships within the hospital and the division.

Time is an important issue throughout the process of shared governance. Staff members need time to participate in the decision-making process. They may feel pulled between the needs of their patients and their commitment to the duties on the forums. Other staff members may resent the time away from patient care and the extra burden it places on them. Managers feel the pressure to provide the resources to support both activities. This is clearly a challenge for the unit manager. There must be a balance between the direct patient care activities and the nondirect patient care activities. Both are important to quality care. Sufficient resources must be available to meet the patient care requirements so that quality is not affected. If time is not spent on development of the practice and the things that affect it, the quality of patient care will be negatively affected. The divisional bud-

gets and staffing must be designed to include adequate time for both activities. It may be necessary to prioritize the goals and projects of the division. Attempting to accomplish too many things at once may overextend the resources (energy, time, money). The resource of time is primarily the responsibility of the unit manager, but staff members have responsibility to negotiate their time needs with and for their peers.

The principal educational needs in this phase concern the concepts, principles, structure, and systems of shared governance. Skill development should focus on assertiveness, decision making, and consensus building. Support and much guidance and direction are essential.

PHASE III—DEVELOPMENT, REGROUPING, AND CLARIFICATION

The most skill development and process development occurs in the third phase. This phase can begin anywhere from month 6 to month 12. It lasts approximately 1 to 2 years. As the councils begin to more clearly define their work, guidelines for each council should be developed. The guidelines should define the accountabilities, the membership, the roles, the operating procedures, and the election process. These will take several months to generate. The council members will spend these first several months struggling to define their work and developing a process to accomplish it.

One area that affects group process is the size of its membership. The ideal group size for effective interactions is approximately eight to twelve members. Although this size may not be possible within every institution, a concerted effort should be made to limit the size to the minimum required. Some may argue that full representation is required initially. This should be avoided because the transition will be difficult and an effective group process cannot occur with large numbers. It will delay group development. The group should contain a representative number that adequately reflects the various types of areas. Initially, there will be much controversy over this issue. Many will think that every area should be represented. The responsibilities of the representatives are critical. Their role may need clarification, and problems with accountability for their role must be handled.

The membership is responsible for representing the interest, concerns, and ideas of the groups that they represent. A formal communication system between the representatives and the units should be established. There may be confusion regarding the decision process of shared governance. Representative decision making in shared governance is frequently confused with democratic rule.

Democratic rule is not used in a shared governance structure. The disadvantages of democratic rule include special interest groups, narrow focus of problem outcomes and decisions, and unequal representation of groups. A representative model is used in the decision-making forums of a shared governance model. This is often confused with democratic rule. The role of the representative in the decision-making forums is to represent the interest, ideas, and concerns of the staff who have chosen them. However, they are not there to represent only the majority opinions or a special interest group. The representatives participate with an open mind to weigh all the available information and ideas and to make the

best decision possible for the patient, the entire staff, and the hospital. They have an obligation to elicit input and to relay rationales for appropriate decisions. The staff members have the responsibility to keep informed and to give input when requested. In addition, they must support the decisions of the group regardless of their agreement or disagreement. The staff may need to be reminded that they were not present to hear all of the information and the discussion that may have influenced a decision. They must trust and support their peers that if they had been in similar circumstances with the same information, they would have made the same decision. The circumstances and information will vary at different times.

Although it is important to allow access to and involvement in the process, it is unrealistic to try to design the system so that no decisions are made without input. Some issues require a broad perspective. However, if there is proper representation, there are adequate and diverse viewpoints for most decisions. The groups need to be able to make decisions without surveying the staff. This is a "judgment call"; however, with advance circulation of the agenda, individuals will have the opportunity to provide input. As the trust level increases, the staff are supportive of the decisions made without their input. The representatives are able to determine the appropriate times when input is critical.

Group dynamics may cause problems with group interactions, group process, or decision-making abilities. Many members may have had limited experience in group problem solving. Some of the problem areas that may develop include "group think," inequality of membership, and lack of consensus.

Facilitating an atmosphere that promotes open disagreement and values individual diversity decreases the likelihood of "group think." Initially, some members may not be vocal or may shy away from disagreeing with a peer. The chair must foster an environment that promotes critical thinking. Group process must be structured to seek outside information and innovative ideas. Discussions and decision making should explore all alternatives. All members should be encouraged to actively participate.

Inequality of membership will surface early in the group's development. Managers, educators, and clinical nurse specialists who may be members of these groups will be initially influential. Staff members may tend to defer to the other members. Managers and specialists must be aware of their own influence. Staff should be allowed to present their opinions first. It may be necessary to preface their input with the statement that it is opinion and should not be regarded as the better approach. The non-staff members should use strategies that assist in the development of in-depth problem solving by questioning and allowing staff to examine all factors and components. In addition, chairpersons must be cognizant of their potential influence within the group. The staff may view such individuals as leaders and may also acquiesce to their ideas. Each chairperson's responsibility is to ensure and facilitate group process. The chair facilitates the discussion and decision making. Chairpersons need to resist setting their own agenda and control of the decisions. The chair should consider similar strategies as the non-staff member such as giving opinions last, giving no opinion in some instances, and encouraging other members' participation.

Decision by consensus implies open communication. Everyone has had the op-

portunity to state an opinion and influence the opinion of others. Members do not feel that they were not heard and understood (Arndt, 1988). They should not feel that if only they were understood, the group would not have made that decision. The environment is one of support. The decision chosen is the one that the most people support and those who oppose it are willing to support it because they were heard.

As in any group, it takes time for the group to develop a relationship and a team approach. The staff members and the staff chairpersons may be inexperienced in their new roles. They will need assistance from the facilitator in conducting an efficient meeting. The facilitator role is generally filled by a nurse administrator. The purpose of the role is to assist the chair and chair-elect in skill development. By meeting with the chair, the facilitator can assist in development and coordination of the council. Reviewing the group process and dynamics, the facilitator can assist in the development of strategies to improve group effectiveness and efficiency. The facilitator also serves as a resource on hospital, division, and regulatory policies and requirements. She provides a broad divisional and hospital perspective. It is important that chairpersons acquire an understanding of the politics and the structure of the other systems within the hospital. The interest, decisions, and concerns of the council are represented by the facilitator in other hospital forums.

The skill acquisition by staff members and the chairs will require both informal and formal education. Educational needs will include agenda development, minute writing, memo writing, conflict resolution, group leadership and facilitating skills, group problem-solving skills, and effective leadership of meetings.

When the councils first begin to meet, there will be a tendency to process work at the meetings. Items will be placed on the agenda and it will be apparent that insufficient information concerning the problem is available. Even when the problem is well described, additional gathering of information is required. Another problem that may arise is that actual program development may occur in the meetings. These problems will initially hinder the work and cause gross inefficiency and ineffectiveness at the meetings. Most work and the gathering of data should occur before these items are placed on the agenda. Issues should be fully investigated with some alternative solutions prepared before being discussed. New programs and policies should be presented in a final draft form. Thus meetings can be used for final decisions and approval with a decreased need for drastic development or revision. As the skills of the chairpersons and members increase, the frequency of issues that require more than one meeting for resolution will decrease.

After meeting efficiency and effectiveness improve, the shared governance structure may still delay the time it takes to make a decision. The overall process, however, remains efficient because those responsible for implementing decisions are also those who make them. Implementation time is shortened. However, in any organization, there must be an established, accepted, and understood method for making quick decisions when they are required. This method should include staff members. This is usually accomplished by empowering the chairperson to make decisions in lieu of the group. The chair, then, must report to the group the

decision and rationale for review and critique. There may be a tendency to revert to the previous manager decision process, but this approach should be avoided.

As decisions are made and policies and programs generated, the operations may become difficult and may warrant attention. The major responsibility for putting the decisions into operation lies with the staff. However, the manager also has a role. Managers may perceive that these issues no longer concern them and attempt to shirk this role. Clarification of both the manager's and the staff's role in this area may be necessary.

As the group gains skill and confidence, other issues may surface. In the early phases, some timid and reluctant behaviors may have been exhibited. With the newfound confidence, this may have yielded to the other extremes of wanting to make all decisions and a challenging of self-governance.

Early in the process it is not unusual for the staff to challenge management that all decisions should be made by them. This is an expected developmental reaction caused by lack of sophistication, maturity, and understanding. Not all decisions within the division should be made by the shared governance structure. The system is an evolving system. As it is developed and refined, more of the decisions may become the responsibility of the shared governance model. It is the responsibility of the nursing administrator to evaluate the staff and system readiness and appropriateness of the decisions. Initially it will be important to start in the more simple and concrete areas of practice and to expand the areas as the staff members develop the skills and an understanding of the structure and its relationship to the division and the interrelationship with the rest of the hospital. Determining when and which issues are appropriate will require staff insight. Allowing certain areas to assume responsibility before they are ready may prove troublesome, yet it is important not to withhold them.

Some may misinterpret that *all* activities and responsibilities within the division are determined with the shared governance structure; literally, this would be management by committee. Kanter (1983) identifies the need for parallel organizations. Two parallel organizations should exist. One is the traditional management or maintenance organization that is defined by lines, job descriptions, and reporting relationships. The other is a highly participatory structure like the shared governance structure that is defined by bylaws. It is the means by which the division manages change and attains its goals. It allows staff members to determine their practice and the areas that affect care delivery. These two structures need to be integrated within the system. There are a complementary relationship and a flow of information, decisions, and programs between the two structures. Participation should be balanced. It is not a replacement of leadership or the management structure. It is the method by which the division chooses to accomplish its work.

In some literature reports, the terms *shared governance* and *self-governance* are used interchangeably. There is an important distinction between these two terms. *Shared* refers to an equality of positions. It is a requirement of all of the professionals in the division. It sets a tone of collegiality and collaboration. In a shared governance model the staff members have control over practice decisions, but management also is involved and has a perspective and an expertise. Similarly, the management decisions are made by the managers, but staff involvement is also

sought. There are a sharing of authority and accountability and a collaboration on the development and attainment of goals. *Self-governance* implies a total separation of areas of responsibility. It may establish a "we-they" atmosphere. There needs to be a close collaborative relationship and atmosphere. They are interrelated and cannot properly be developed separately. Synergism is vital. Synergism is the combination of the parts greater than the sum of the individual pieces.

Early in the development of the groups there will be confusion and a lack of cohesiveness and integration among the decision-making forums. Each group will struggle to define its work and its accountabilities. There may be group conflict. Challenging of each other's decisions or their right to make the decision may exist. Communication among the chairpersons is critical. The nursing administrator also must assist the staff in understanding the process, as well as integrating the groups. As the accountabilities become more well defined and as the relationships are developed, a more cohesive approach should emerge.

As the system changes, the need for accurate, timely, and efficient communication grows. This need is more complex in a shared governance model because the number of participants and the amount of information are significantly higher. The system needs to be multidirectional.

One of the accountabilities of the councils is the development of a comprehensive communication system. This is generally assigned to the education council. It will become apparent early in the implementation that the previous communication system is woefully inadequate for the shared governance structure. Constant monitoring and refinement of the communication system are necessary. There can never be too much communication. The goal should be to make being knowledgeable and informed inevitable.

PHASE IV—INTEGRATION, REFINEMENT, AND CONTINUED EVOLUTION

Toward the end of the final phase, the council chairpersons have initiated the movement toward coordination and integration. That step involves the negotiation and synthesizing of the guidelines of all the councils. The accountabilities must not be in conflict and the operating procedures must be consistent. Election processes, membership, roles, and so on should be similar. These guidelines will form the basis of the bylaws. The formal development of the bylaws should not be undertaken until the second or third year of the implementation process. During the first 2 years, the structure will undergo continuous and dramatic change.

The members of the executive group (vice president, staff council chairs) should evolve into a cohesive leadership team for the division. They are responsible for the integration and interdependence of the divisional councils. In the beginning, their group process was comprised predominately of communication and information with little understanding of the executive council role. At this point in the process, the group dynamics and skill ability should be emerging to facilitate the continued development of the model.

Staff members may have also processed little understanding of the purpose of the executive council. There may be fear of too much power being placed with too

few people. Reassurance that the executive council does not overrule the other councils may be required. Reeducation concerning the function and purpose will be necessary.

Integration of the shared governance model is important in three areas. First, there must be integration among the division councils. As previously stated, the councils are interdependent. The direction and the goals must be coordinated. Initially, there is a lack of understanding of how the councils' work is interrelated. Issues and new programs will frequently affect more than one council. The groups initially will work in isolation. When the accountabilities and the intergroup process have been developed, intragroup process should formulate. The shared governance structure has a unit component and a divisional component. Integration of the unit-based shared governance structure and the divisional structure is the second level of integration. These two components are interrelated. The divisional council sets the broad standards and guidelines, and the unit council determines the implementation plan and the program specifics. Issues, problems, and decisions need to flow between the division and the unit. The third level of integration occurs at the hospital level. The shared governance structure is a systems model that must fit within the larger hospital system. Ultimately the values, goals, and direction for the division of nursing flow from that of the hospital.

All members of the nursing division are responsible for integration. The staff members are responsible for the integration between the unit councils and divisional councils. At the unit level the unit manager should assist with the department's integration with other hospital departments. The nursing administrators should focus on ensuring integration of the divisional councils with the hospital management, committees, and systems.

KNOWING WHEN YOU'VE ARRIVED

The planning process should include the development of an evaluation plan. The implementation process occurs over a 3- to 5-year period. It is an evolving systems model that is affected by the environment. Periodic evaluation assists in refinement of the model as it evolves and adjusts to the changing needs of the organization. Development of pretesting of selected areas before the implementation process begins may be desirable for a comparison study on the effects of the model.

The evaluation of the shared governance model should focus on the intended purpose of the change. What was the reason for the reorganization of the structure? What were the problems with the previous structure that the shared governance structure will improve? From these questions, the objectives of the model can be determined. The objectives of the implementation should be formalized. The objectives then serve as the basis of the evaluation from which criteria can be developed. The evaluation system is designed by the objectives. Well-delineated objectives and criteria direct the selection methods and the development of the evaluation system. The evaluation system must coordinate and integrate the several kinds of objectives. A summary evaluation should be conducted while evalu-

ating the component parts. The evaluation must draw conclusions and make recommendations.

There will most likely be several reasons for implementing the model. The program evaluation criteria may focus on several areas. The components of program evaluation should include structure, process, and outcome. The relationships of the components should be explored (Clemenhagen and Champagne, 1986).

Structure criteria relate to the organization of the system and the resources that are necessary for that system to function. The resources used include human, time, equipment, training, and education. All have an impact on finances. The quality of the resources should also be assessed. Although some of these costs relate to the start-up of the process, there are ongoing maintenance costs that should be quantified. The financial impact should be compared to the previous organizational structure. It is important, therefore, to quantify the resources of the existing structure before the changes begin. This may include quantifying the current committee and meeting structures in which all nursing staff are involved within the division and the hospital. This includes the number of hours and dollars for these activities. This area may require close monitoring throughout the implementation process. Careful resource assessment is necessary so that needs can be budgeted and allocated. In addition, periodic assessment is helpful so that adjustment and streamlining of the structure occur. In many institutions a cost reduction has been realized after the full implementation of the model.

Process criteria focus on how the system functions to accomplish its work. They assess the interactions within the system itself and among other systems. The efficiency and the effectiveness of the system are evaluated. Decision making, communication, integration of divisional councils, integration with the unit councils, and integration with the rest of the hospital systems are a few of the possible areas for evaluation.

Outcome criteria evaluate the effect of the system. The effects are examined as they relate to the program objectives. The objectives may describe characteristics, behaviors, or the state of the nursing organization. Examples of effects include improved nurse satisfaction, staff accountability and control of practice, increased staff professional development, and improved trust and teamwork.

The evaluation of the components must include the examination of the integration and relationship among them. The analysis provides information that examines the program design, the resource utilization, and the achievement of the program objectives (Clemenhagen and Champagne, 1986). Analysis of the relationships of the components is the only way to evaluate the overall efficiency and effectiveness of the system. It guides and directs the complex decisions for the system's evolution and refinement.

The methodology for evaluation can be determined after the objectives and criteria have been established. Several approaches may be necessary. Prioritizing the essential versus the desirable outcomes may be necessary (Rezler and Stevens, 1978). Also, unexpected outcomes may occur that may need evaluation.

Assessment and measurement are used in the evaluation process. Assessment is the collection of quantitative and qualitative data to define behavior. Measurement

assigns numeric values to objects and observations (Rezler and Stevens, 1978). There are a variety of types and numbers of tools that can be used to evaluate the shared governance model. The formats may include observations, surveys, and questionnaires.

The evaluation tool chosen will partially depend on the criteria being evaluated. However, there may be a range of choices for any given criteria. An established tool may be used for evaluation. Another alternative is the construction of a tool.

An established tool has the advantage of providing well-established reliability and validity indexes. For example, there are a variety of tools that evaluate nurse satisfaction, effectiveness of communication, or decision making. There are also tools specifically designed to evaluate a shared governance model. Although these tools have not yet been fully developed or established, they may provide valuable data and the opportunity to compare results with other institutions. A disadvantage may be that the tool does not fully meet the criteria. However, an alternative of adapting the model to the needs should be considered.

The construction of an evaluation tool offers the appeal of tailoring the tool to the unique needs of the institution. One disadvantage is the time and complexity of the undertaking. The feasibility and usefulness of utilizing an existing tool or the adaptation of a tool must be weighed against the time and expense required in the development of a new tool.

The evaluation system itself must be reviewed and revised throughout the process. The quality assurance group should assist in the development of the plan. The overall responsibility for the efficiency and effectiveness of the shared governance system rests with the coordinating or executive group. They define the objectives and use the evaluation results in the refinement, growth, and the development of the model.

SUMMARY

The implementation of shared governance is a significant undertaking in any organization. The change in structure involves a change in the culture of the organization. The culture is defined by values. The values are expressed in how members interact to accomplish the work. Structures and systems within an organization support and influence behaviors and values. Figure 5-1 depicts this interaction.

As an accountability-based professional practice model, shared governance is based on concepts and principles that promote a new set of values. With changing values, behaviors must also undergo transformation.

Behaviors are the expression of the values held. They are also influenced by life experiences, experience in the organization with others, as well as observation of behaviors within the workplace (norms, rules, rituals, etc.). Role expectations also impact behavior. However, the formal written or spoken expectation may be different from those encouraged or implied. Skill and knowledge affect behavior. Increasing knowledge and skill to impact changing values and behavior is helpful. It may be an unsuccessful strategy if the role expectations and the behavior experiences of others, particularly of management, continue unchanged or incongruent.

The organization systems and structures assist in supporting the values and be-

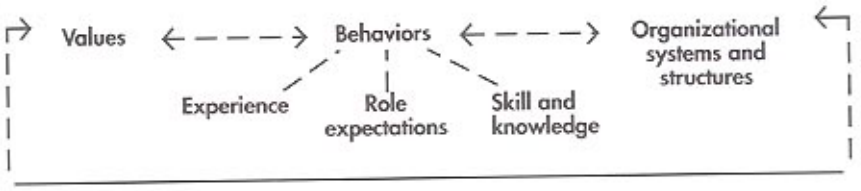

FIGURE 5-1. Culture.

haviors. Concurrently, structure and systems development are shaped by values and behaviors. As the organization moves toward changing values, the structure and support systems must be redesigned to meet the values. For example, the system and structures include committee structure, organizational chart, communication system, performance appraisals, job description, etc.

Transformation of the culture involves diligence, careful planning, and time. The following steps summarizes this complex process:

1. Confirm and commit to the new values.
2. Create a vision and enlist others.
3. Role model management changes first.
4. Promote and set expectations.
5. Build skill along the way.
6. Change structure and systems to support the new values.

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