5 Nursing Staff Roles in Unfolding Shared Governance

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One of the hallmarks of a profession is control over its practice. To create an accountability-based professional practice model, a different environment and structure are required in the workplace. Nurses must be able to assert their place within the organization. They must be viewed as interdependent, not dependent, health care providers with equality of status, who are responsible for their practice and those areas that affect their practice. The practice of nursing encompasses a unique body of knowledge and a broad scope. The professional nurse is the only one capable of making decisions about the practice and the areas that affect it.

A systems approach must be used in the development of an accountability-based professional practice model. The model must address the needs of the professional nurse. It must provide support for the clinical practice and care delivery. A structure must be implemented that supports the role of the nurse and guarantees her the ability to make the decisions that affect her practice. Shared governance is a professional practice model that places accountability and authority for practice decisions at the level of the clinical nurse. Shared governance is a framework of concepts applied through a structure that ensures the application of the principles. The structure itself is not shared governance. Rather, the structure supports the application of the concepts.

The shared governance model will be unique in each institution, dependent on its culture, needs, and unique characteristics. Shared governance is an evolving model. The significance of the change requires careful planning and implementation. It is sometimes difficult to determine where to begin such a complex and dramatic change process.

"Would you please tell me, which way I ought to go from here?" (Alice)
"That depends a good deal on where you want to get to." (Cheshire Cat)
Alice's Adventures in Wonderland by Lewis Carroll

An understanding of the ultimate destination is basic to the change process. It assists in the development of the plan. It provides the direction. After the target or goal has been set, knowledge of the present state and the past will aid in the development of strategies. Evaluation and continuous assessment are necessary to ensure continuous progress to goal attainment. Therefore it is necessary to know

where you are going, where you are, and where you've been to determine the best way to attain your goals. Finally, you must be able to ascertain when you've arrived.

KNOWING WHERE YOU ARE AND WHERE YOU'VE BEEN

Before embarking on the implementation of a shared governance model, it is imperative that an in-depth assessment and analysis of the division of nursing and the organization be conducted. This part of the change process is too frequently minimized. The assessment and analysis provide valuable information to guide the planning and implementation process, as well as the development of strategies to ease the transition.

There are three possible targets of change: knowledge, attitude, and behavior. Hersey and Blanchard (1977) developed a model that conceptualized the type of change required and the length of time for the change to occur. Their model illustrates that change in knowledge may take a relatively short period for an individual and slightly longer for a group, whereas changes in attitude and behavior are respectively longer for the individual and longer still for a group. Identification of the target of the change will provide directions with regard to the areas of the change and the length of time required.

The movement to a shared governance model involves a change in all three areas. New knowledge will be needed concerning the concepts of shared governance. The staff and managers will need to acquire new knowledge and skills to successfully function in their changing roles. The requisite attitudes or values differ from those in a traditional model. Behaviors must be altered as the roles are transformed.

Examination of the key areas from both a historical and a current perspective will assist in the identification of potential areas of strengths and deficiencies within an organization. The historical perspective may indicate the reactions that may occur and the rationale for these reactions or perceptions. It may aid in the identification of potential areas of conflict. The appraisal of the current status of key areas will substantiate the areas of potential strength for continued development and support through the change process. It provides the foundation on which to build and support the system (Kanter, 1983).

The division of nursing is a dynamic system that operates within the larger hospital system. A change in one area affects the whole. As the assessment is made, the areas should be examined within the context of the system in its entirety. The areas of assessment should include not only the division of nursing but also the hospital at large.

ASSESSMENT AREAS
Culture

The norms and rules within any organization are indicators of the values and the beliefs held by that organization. An accountability-based professional practice model requires basic assumptions regarding the belief and value of the nurse as a

professional and her ability and right to exercise control over her environment and practice. The values and beliefs necessary in a shared governance model include concepts that relate to the professional nurse's commitment, ability, value of contributions, collaboration, and equality of status with other health care professionals (Peterson and Allen, 1986; Porter-O'Grady and Allen, 1986).

How is the division of nursing viewed within the organization?
How are employees viewed?
What value is placed on employee contributions?

Structure

Structure is the composition of the organization. It refers to the arrangement of the system. It includes not only the reporting relationships but also the committee and meeting structure. The transition process of the structure will be affected by the current organization. The new structure will be based on the requirements and needs of the organization.

What are the formal and informal lines of power and authority?
To what degree is the organization decentralized?
What is the level of staff participation in decision making?
Define the purpose, membership, and responsibilities of all committees, task forces, and groups within the division.
Define the purpose, membership, and responsibility of other hospital committees in which nursing is involved.

Knowledge and Skill Level

Knowledge is a structure of ideas, facts, and concepts used in a particular endeavor. Skill is the functional ability to perform a set of characteristics or actions required for an activity. To produce a specific outcome, the ability to combine knowledge and skill in an effective manner must exist. To make the role transition and successfully function in a shared governance model, special knowledge and skills are required of the staff nurse and the manager. Although it is true that the implementation process of shared governance does assist in the development of staff and management, a basic level of competency is required in certain areas for success of the change process. These areas include, but are not limited to, assertiveness, change process, group decision making, team building, conflict management, leadership, communication, group process, facilitating, and interpersonal skills.

What are the developmental levels of the staff and unit managers?
What are their strengths and areas for further development?
What are the assets of each group?
Who are the key leaders of change within each group?

Intergroup and Intragroup Relationships

The movement to a shared governance model affects all members of the nursing division. As the structure unfolds, the expectations, relationships, and roles

change. It is a difficult period characterized with fear, uncertainty, and conflict. A basis of trust and team cohesiveness is an important foundation. Role clarity is essential. An understanding of the current roles helps in the transition. Some role uncertainty is unavoidable during the implementation process, which may be heightened with greater conflict if there are preexisting role ambiguity, role conflict, and territory issues. These areas also need to be evaluated in the context of the whole organization.

How would you characterize the relationship of nursing with other departments?

Does a collaborative relationship exist with other members of the health care team?

Are there unresolved territory issues?

Who and where are your supports?

What is the level of trust within the division (between and among levels)?

Are roles clearly understood and valued?

Resources

A change of this magnitude requires a sizable commitment of resources. The highest resource usage will occur during the planning and implementation phase. Resource utilization will be ongoing and requires planning and budgeting. Resources include people, time, money, energy, and expertise. Early in the process much time will be devoted to planning. After the initial planning, resources will be spent on participation and learning of skills and concepts. These two areas will be greatest during the implementation phase, but they will be a constant requirement for system maintenance caused by turnover.

What are the available resources?

How can you maximize the resources?

Do you require external resources?

Communication

Communication is vital in the change process and key to the attainment of a shared governance model. In a traditional model, poor communication has a negative impact on the effectiveness of the organization but does not prevent its functioning. In a shared governance model, an ineffective communication system interferes with the ability of the structure to function. The communication system will evolve as the structure unfolds. The structure will drive the needs of the communication system. However, open, multidirectional communication lines are needed during the development of the shared governance system to decrease confusion, conflict, and to provide feedback so that the system can be modified.

What are the formal and informal lines of communication?

How efficient, effective, and accurate is the current system?

Is information freely shared?

Is there free communication across departments?

Response to Change

Many factors influence an individual's response to change. Previous experience with change can positively or negatively affect feelings regarding change. Knowledge of the organization's previous response and experiences with change can provide information that may be useful in predicting future responses. Individuals' perception of the effect of the change on them or misperceptions regarding the change may cause some fears. Lack of knowledge about the change may lead to confusion and misinterpretation.

Does the organization promote risk taking and change?

What are the past experiences with change?

Review past successes and failures in implementation of change. What were the influencing factors?

Analysis

All hospitals are unique and each implementation plan must be individualized. As the assessment areas are reviewed, and analysis of the strengths, deficiencies, and their importance and effect in the change process must be examined. The identified strengths can be further developed and capitalized. A plan for development of the problem areas and a time frame for resolution can be generated. Areas of deficiency must be viewed in terms of their degree and level of importance. Depending on the area and the degree of deficiency, it may be necessary to develop the area before initiating the planning process for the structural changes. Thus the beginning of the change process may start before introduction of the shared governance concepts and theoretical framework.

It is important to conduct an analysis that encompasses the "total picture." The overall stability of the division and the organization is an important factor. Because of the magnitude of the change and the length of time required for implementation, a stable environment is required. This type of change will cause conflict and some instability. The organization must be able to withstand the process. After a certain point is reached, it will be impossible to return to the previous structure without serious consequences. Although it has been reported that a shared governance model is an effective deterrent to unionization, it should not be undertaken during a time of union threat because this is usually a time of great and long-standing instability. The shared governance model may an effective deterrent to unionization, but it should be instituted only as a proactive strategy.

With a thorough analysis, some responses, behaviors, and areas of conflict can be predicted, which assists in the development of strategies and a phased planning process.

HOW TO GET THERE
The Evolving Model

The shared governance model is an evolving model. As the structure evolves, so to do the roles, skills, educational needs, and problems.

After an initial planning phase, the implementation and the transition of the structure occur. This phase is marked by chaos, confusion, and uncertainty. The next phase is one of development, regrouping, and clarification. The final phase is the refinement phase of integration. These phases should be viewed as a continuum. Overlapping areas and blurring between phases will occur.

Before developing the plan for implementation it is important to first determine the destination. A vision must be developed; without knowing the destination, it is impossible to develop the route.

VISION

A vision is an ideal, unique image of the future (Kouzes and Posner, 1987). A vision sets the direction for development and change. It provides the standard to which to aspire. The vision must first be defined, and then be shared, marketed, and sold.

The vision should be broadly communicated. The nursing staff of the division as a whole needs to know the direction that is being set. They need to understand what to expect and what is expected of them.

Marketing the vision involves relaying the positive impact that this change will have on individuals, helping them to view the change as necessary and desirable.

Selling the individuals means that they accept and support the vision. The vision becomes their vision. They accept the responsibility for the attainment of the vision.

The idea for pursuing the implementation of the shared governance model may come from several sources. For it to be developed into a vision, however, requires the senior nurse executive's support and commitment to its development. She must be willing to accept the key leadership role in the process. Change cannot occur without this commitment or involvement. The senior nurse administrator is the only one who has the authority and power to restructure the organization. She is the one who will pass the authority to the staff. The nurse executive is charged with creating an environment that fosters staff nurse accountability. She assists in the development of structures, systems, and expectations that promote the development of staff accountability. She must model the management role changes.

PHASE I—PLAN DEVELOPMENT

As the vision takes shape, a planning group should be formed that is representative of the division. Staff members should be included early and in the process be well represented. Small representation from the other categories should be included. The group should contain approximately eight members who form a broad representation. They may be selected or volunteer. They are usually considered the leaders and innovators within their peer group. The planning process should be led by a change agent who possesses an overall understanding of the theoretical framework of the model. This person must be highly skilled in the change process and should be at the administrative level in the nursing organization. The planning group will develop the initial implementation plan. This group should be viewed

as a task force with a defined goal. Its only purpose should be the development of the initial implementation plan. After this has been accomplished, the group should be disbanded. The continued implementation and developmental process should be facilitated by the change agent in conjunction with multiple key staff and managers. As the process unfolds, more individuals become involved with the implementation and development. Over time, the role of the change agent is phased out as the shared governance structure and participants assume its continued refinement and development.

Before members of the group begin their work, it is important that they process a solid foundation of knowledge about shared governance. Educational resources and programs should be made available to the members. The plan will focus on three major categories: education, structure, and support programs.

Education

Education is an ongoing, continuous process. It is required before, during, and after implementation. There are two major areas of education. One area involves the knowledge of the concepts of shared governance. The other concerns the skill and knowledge necessary for the staff and management to function in the shared governance organization.

The plan for education of the concepts of shared governance should develop strategies to address four needs. One is the basic knowledge of concepts for all members of the nursing division. Second is a more in-depth knowledge base for the members who are involved in the implementation. A third area is a method for orientation of new employees. The fourth area is an ongoing re-education, a clarification of concepts, and a more in-depth knowledge of concepts for staff that will be necessary throughout the process.

Shared governance is a complex conceptual model. A full understanding of the concepts and principles will initially be difficult to grasp. It will be helpful to simplify the terms, concepts, and principles. Concrete examples assist in the comprehension. Resources such as articles, books, and video tapes should be made available. Conferences and networking with other institutions are useful. Education of shared governance should be made available to all personnel. Requiring some mandatory education concerning the concepts may be desirable. It gives a message of the importance of the model. More extensive education should be targeted at those most involved in the change process. As the model develops and the system changes, it will create a new level and need for knowledge concerning shared governance. A re-education may be requested and will be required; during employees' first exposure, a frame of reference for the information did not exist. New questions will arise, and there will be a need for more specific and detailed information. As they begin to work in the system they are better able to understand the concepts, the effects, and the application. There may also have been an initial lack of interest or resistance to the subject. It is impossible to teach someone who does not want to learn. Whereas formal and informal education provides a basis or background of knowledge, true understanding occurs only with involvement in the development of, or participation in, the shared governance structure. As new people enter the system, it is necessary to provide education. It may be helpful to

initiate shared governance education into the orientation program early in the implementation process.

In addition to educating the members of the division of nursing concerning the concepts of shared governance, there is a need to provide information to others in the organization. When the decision is being made to implement a model, the senior nurse administrator should begin discussions with her superior and peers. It is important for them to understand what is being undertaken and why. Senior management support will assist in dealing with the negative reactions that may occur within the hospital. Periodic updates and more in-depth information should be shared throughout the process. When the implementation begins, a brief description of shared governance should be shared with the rest of the organization. It will be too early in development to provide many specific details of the model. It would be confusing to explain the structure because it will be evolving and changing throughout the implementation. There will be fears from other departments within the organization. Some will be expressed, others will not. Most concerns will be in regard to the effect of the change on them. They may fear loss of control or that nursing is isolating itself and will not make collaborative decisions. It is best to address these concerns as they are expressed. Reassurance will be needed, with emphasis that they should continue their interactions with nursing as before. As the structure changes, management will be responsible for assisting them through the shared governance system. Other departments should use the same contacts as before the shared governance structure was initiated. This contact is generally from management. The nursing manager is responsible for introducing and assisting other department managers through the new process of the shared governance model. This decreases the likelihood of a negative first experience for nonnursing departments. It prevents confusion and frustration, particularly early in the model development when it is changing and evolving. The manager can facilitate smooth interaction and follow-through. After the structure is fully developed, staff will learn over time how and whom to access in the structure. A common reaction to the concept of shared governance is that it is, or will lead to, a union. Clarifying the concept and sharing the literature can alleviate this concern.

The largest need for education exists in the area of the skills and knowledge required by the staff and management to make the role transition and to function successfully in the new system. Both formal and informal education and development are required. The assessment and analysis will provide the information regarding focus areas. As previously mentioned, some skill development may be necessary before the process is started. Other skills will need refinement as implementation occurs. The informal and formal education should coincide with the developing model. As the various changes occur in the structure and the roles change, different educational needs will surface. An understanding of the role transition and the model's development will provide direction to the educational plan. The education should initially be targeted at the individuals who are actively involved. Continuous education will be essential because of turnover and increased participation will create an ongoing need.

Role Transition

Staff. The authority and responsibility for the professional practice of nursing are invested at the staff nurse level in a shared governance model. By definition responsibility is the obligation to perform an assigned task to the best of one's ability. Authority is the right of decision concerning the responsibility. Accountability is answering to someone for what has been done. Responsibility cannot be delegated. Only an individual can be accountable. In a traditional model, there was incongruence in assignment of accountability, responsibility, and authority. The staff nurse was given responsibility for her practice but lacked the authority. This made it impossible to fulfill the expectation of accountability. As the staff role develops and expands, the staff members become responsible and accountable for their own practice. The organizational structure supports this movement and is developed so that failure to function in a responsible and accountable manner is not rewarded. The initial role transition begins with the acceptance of responsibility by the professional nurse for her practice. It then moves to involve the areas that affect that practice. The final expansion is the acceptance of responsibility and accountability for the entire nursing professional practice at the organization. Thus the staff nurse is not only responsible for her own practice delivery, but also that of her peers and the division of nursing at large. This requires a change in the perception of the work from a job to a profession. Some may view this change with fear and resistance. It does place greater requirements on the staff nurse. These requirements include time, skill, knowledge, commitment, and effort. Personal obligations increase. Staff members become responsible not only for their direct care delivery but for all things that relate to that care. They also have an obligation to the care delivered by their peers. They are responsible not only for the positive outcomes, but also the negative outcomes. They must rectify the problems that relate to practice issues.

The role transition of the staff occurs over time as the organization changes. At any given time, the staff will be at varying levels of development. The effect of the organizational changes will be seen in the behavior and personal growth of the staff. Argyris (1962) contends that in the traditional organization the workers are kept in a state of immaturity because they lack control of their work and their environment. This encourages behavior that is passive, dependent, and submissive. Argyris identifies seven stages or changes that take place as an individual moves from immaturity to maturity. Each change is viewed on a continuum within each stage.

The first stage is the passive state, characterized by little involvement in activities that affect the individual, the organization, or the profession. Feelings of powerlessness and a victim mentality may exist; these yield to increasingly greater involvement in activities and decisions. Support and reassurance are important at this stage. Expectations should be set and role modeling should occur.

Second is the highly dependent stage. In this stage staff members may be uncertain of their capabilities. They may lack self-confidence and fear errors or mistakes. They may not trust that they actually have the authority to make decisions or control their practice. They seek support and reassurance. They may wait to

voice ideas and opinions until those of the manager are known. There may be a tendency to rely on or refer to the manager. As the individuals gain more confidence, they will move toward progressively higher levels of independence. The need for the manager's assistance, although always necessary, will diminish. The manager needs to be attuned to these feelings. A safe environment that fosters acceptance for errors and mistakes is important. Acknowledging past mistakes of managers may decrease anxiety. Positive reinforcement and development of skills should be the focus. The manager must avoid the temptation to rescue the staff and should moderate their participation in decision making.

In the third stage, staff members are capable of behaving in only a few ways. The staff will be involved in many issues and situations to which they have not been previously exposed. They will vary from the simple to the complex and will require a variety of responses. In the beginning the staff will draw on a limited pool of skill, knowledge, experience, and expertise. Their ability to match the approach required in a given situation may be limited. As they acquire new skills and knowledge, they will be better able to function in many complex situations by use of a variety of approaches. In addition to acquiring new interactive skills, the staff will need to gain an understanding of the politics and complex structure of the hospital. Information and an understanding of a broader prospective should be provided. They will need an understanding of the integration within the division and within the hospital.

During the fourth stage, there is a tendency for the staff to have shallow, casual interests. When staff involvement begins, it may be on a superficial level. Members may tend to focus on the things that directly affect them. Their understanding of the extent of the new organization and the responsibility and impact may not be recognized. Their understanding will increase as they become more involved and as the model continues to unfold and develop. The feeling that this is only a temporary fad that will eventually disappear and that its impact on them is minimal, particularly if ignored, will change. A new level of interest will emerge as they begin to feel the effects of the changes. A deeper interest and a stronger commitment will grow.

In the fifth stage, the time perspective is short and narrowly focused, encompassing only the present. Tunnel vision may be evident, with a lack of understanding of the system as a whole and integration required. Staff members may only be aware of their own perspective. As the implementation process begins, there will be a tendency to deal with issues in the context of the present; the focus of the various groups will be in the "here and now." The ability to solve problems may be limited. They will require assistance in assessment of the problem and the analysis of solutions. Initial problem solving may deal only with the surface issues. The issue may not be viewed in its entirety or in regard to the impact of the decision on others. The need for others to be involved in the decision may not be considered. This is partially because of the lack of knowledge and understanding of the intricacies and complexity of the division and the organization. As the groups begin to understand their roles, define their work, and comprehend the complexity and integration within the division and the hospital, there will be a shift to more in-depth problem-solving abilities. The need for long-range planning and integra-

tion will be apparent. The focus will shift to viewing the picture in its entirety. Active involvement in development and direction of the goals will occur. There will be a realization of the need to consider all the factors: financial, regulatory agencies, hospital goals, etc.

The sixth change that occurs is in the concept that the employee is subordinate to others. In nursing, because of the position of the profession and the effects of the women's movement, staff members may exhibit suppressed group behaviors. They may not view themselves as equal to others within the organization. They may exhibit behaviors of horizontal violence. They may be reluctant to assertively interact with other professional members of the health care team. Until nurses view themselves as equal to others and assert control over their own practice, they cannot expect to receive respect or acceptance of authority for making practice decisions.

Finally, there is a lack of awareness of self that moves toward awareness of and control of the "self." Staff members initially may not have the ability to view themselves objectively. They may be unable to identify areas of strength and areas that require assistance or development. Understanding the concept of interdependence with others may be difficult. They may shy away from objectively viewing themselves and their peers. A strong sense of self-identity must develop. Nurses should become aware of the perceptions of others but learn not to build their self-concept totally on those perceptions. As a greater understanding of themselves and others emerge, their ability to function within the structure will be enhanced.

Management.   The unit manager's role is the position that is most profoundly affected by the move to a shared governance model. It is also the key to the successful implementation and the position that exhibits the most resistance to the changes. This unique set of circumstances creates a challenge to the move to a professional accountability-based practice model. Those experiencing the greatest impact and who are the most resistive are the ones who can influence the success of the outcome.

Unit managers may fear that their positions are in jeopardy because of the implementation of a shared governance model. There is no easy response to this fear. Most institutions that have implemented a shared governance model have not eliminated management levels but may have been able to reduce the number of positions within a management category. The purpose of shared governance is to implement an accountability-based professional practice model that places control over practice at the clinical nurse level. The ability to decrease the number of managers should be viewed in the context of the economic health care climate and the recent management literature on organizational structures and layers. It has been suggested that there should be a maximum of five levels within an organization and that three levels should be adequate for most (Peters, 1987). The decision to decrease or eliminate management levels should be made during the assessment phase and will be institution-specific, depending on the needs, complexity, and size of the organization. A change in the maintenance organization or a decision to change should be made before implementation of the shared governance structure is begun. If the intent is to remove levels or decrease the number of managers, it

should be made clear how, when, and why. Hidden agendas and plans will only interfere with the change process.

The traditional role of the unit manager has been that of controller, director, supervisor, and decision maker (Porter-O'Grady, 1986). The unit manager was responsible and accountable for the activities of the department. Even if she was highly participatory, the final responsibility, decision, and outcome rested with her. As the authority for professional practice and those areas that affect it is shifted to the staff, and the staff become accountable, the unit manager's role must change to that of facilitator, coordinator, integrator, and supporter (Porter-O'Grady, 1986).

The new environment requires different management skills. The unit manager not only must be proficient in the traditional management skills but also must possess leadership abilities. Leadership and management are distinct, complementary, and necessary (Kotter, 1990). Management is systems, control, order, quality effectiveness, and productivity. Leadership is the facilitating of change. Management plans and budgets; it is the process of tasks. Leadership sets a direction and the strategies to achieve the vision. Management achieves the plan by organizing and staffing. Leadership unites people and creates commitment and understanding of the vision. Management attains the outcome by controlling and problem solving. Leadership achieves through inspiring, motivating, and maintaining the movement toward the vision.

In traditional models, a strong manager could successfully function and achieve the outcomes because it was possible to rely on the authority of the position. In a shared governance model, the authority has been shifted to the staff. Strong management skills are still required, but they are focused on systems management and fiscal, material, and staff resources. Strong leadership skills are necessary to assist the staff in the change process, the development of the skills and the model. Management in a shared governance model focuses on systems support and resources—to ensure that staff nurses have the necessary resources to perform their work. The clinical nurse should not waste time dealing with inadequate systems or resources. Staff nurse hours should not be spent on securing resources (equipment or supplies) or in dealing with inadequate systems. Inefficient systems will devour nursing time that is taken from direct patient care. Management's role is to assist the caregiver to deliver quality care.

Leadership of change is an active, demanding, and continuous role. It involves five practices: (1) challenging the process, (2) inspiring a shared vision, (3) enabling others to act, (4) modeling the way, and (5) encouraging the heart (Kouzes and Posner, 1987). A leader challenges the status quo and seeks ways to continually improve. Leadership requires the ability to take risks and an openness to mistakes. Inspiring a shared vision is accomplished by helping others envision the future, by encouraging them to become enthusiastic and committed, and by assisting in seeing the value and the benefits of the vision. Leaders must be able to enlist involvement and ownership in that future. A leader enables others to act by support and collaboration. They form a team. Leadership must have the ability to access the strengths and areas of development of the staff, to find the unique areas of interest and motivation for individual staff members. The leader strengthens the team with skills, knowledge, communication, and information.

The manager must model the pathway for change by setting the example and living the value and the belief. Managers set high standards and expectations and must meet them and expect others to do the same. It is important to make the vision concrete and a reality. One way is to start with small achievable wins that can be built upon—encourage the heart. A change of such magnitude is draining. Frequent encouragement is necessary. Accomplishments should be recognized, and everyone must feel part of the success. Positive behaviors must be rewarded. Those who are not contributing should be neither punished nor rewarded.

Structure

Before the structure changes are implemented, careful consideration should be given to the type of model to be used. There are three basic types of models: the councilor, the administrative, and the congressional models. The models should be fully investigated and matched to the organizational culture, environment, and needs. Although there are three basic types, no model is developed exactly the same in every organization. Although it is helpful to study other models in other institutions, they should be used as a guide only. The model should be adapted to the particular institution and meet the unique needs of that system.

After the model type has been chosen, a vision of the model should be developed. The vision of the model will be modified as the model unfolds, but it will provide direction to the change process. The structure should be loosely defined, followed by definition of the groups and broad outlining of accountabilities. These will become more specific, detailed, and refined as the process evolves. Minimally, the structure should provide forums to deal with issues that relate to practice, education, quality assurance, and management. Other areas may be defined, for example, research, personnel, or recruitment. The current structure should be reviewed next, with a list of the committees, task forces, and meetings that currently exist. Their purpose, work, and membership should be defined and compared to the future structure. The steps to transform the groups should be determined. It is desirable to limit the disruption of the various groups' work. In some instances there may be a need to make dramatic changes. Others will make a slow transformation. Each group's accountability in the new structure must be ascertained. Can its work be included at this time? If not, the group's work and a timeline to incorporate it should be determined and reported to the group responsible. Some groups may need to be disbanded; others may not be part of the shared governance structure but may be part of the management structure. However, their purpose and function may need to be redefined. The transformation or disbanding of groups will be resisted. It is important to objectively review the purpose and justify its continued existence.

The current groups' membership and chair positions should be compared with the new structure. If they contain predominantly management personnel, it may ease the transition to slowly replace the membership with staff. Co-chairing a manager and a staff nurse briefly will allow for some skill development, ease the transition, and prevent disruption of the group's work.

At the divisional level, the council or forum that should be first initiated will depend on the current structure. It may be possible to use an existing group structure and, with modification, easily make the transition. The strengths and devel-

opmental level of the groups should be assessed. Although the development of the councils or forums will not occur simultaneously, there should not be a lengthy time lag until group development. It is important that the groups be developed in a relatively similar time period. The shared governance model is a systems model and the councils or forums are interdependent. Integration will be difficult and may ultimately affect the success of the new structure.

The level of the development of the structure requires consideration. There are three possible approaches. One is to begin development at the unit level on some trial areas. This approach may be perceived as "safer" because it allows those who have concerns or fears regarding the changes to test the system. Unit-based structures also allow more participation. Staff members have the opportunity to be exposed earlier and more directly to the shared governance system. Skill development will begin and be better developed for the divisional council. A drawback to initiating change at the unit level is that the units who have begun may be perceived as elite or privileged. Isolation from the division and hospital, particularly in terms of goals and direction, is a danger. As the unit structure develops it will quickly reach a point beyond which it will not be able to progress. It requires a divisional structure for guidance, support, and direction. Frustration over the inability to influence practice decisions at the divisional level may emerge.

Development at the divisional level also has some benefits and some negative aspects. The initiation at the divisional level can aid in the development of the unit-based structure. It can serve as a model and assist in coordination and sharing between the units. Beginning at the divisional level may also give more credibility, legitimacy, and momentum to the change process. One problem with only divisionwide councils is that the new structure becomes just another hierarchy. There is too much centralization with little opportunity or few forums for unit-based decisions.

Simultaneous or closely developed systems may be the best alternative. This approach to change has the benefits of the other two approaches and minimizes the drawbacks. Skills are developed at both levels. There is better understanding of the model because of increased participation and more exposure. Improved integration between the unit and divisional structure can occur. Staff members have forums at the unit and divisional level in which to assume accountability for their practice.

Regardless of the level of the approach of the structure, the unit-based structure is vital. There must be a structure that allows unit-specific decisions.

One of the requirements of a shared governance model is the need for centralization and decentralization. The system needs to be centralized in its goals and directions. There is a need for some unity and overall standardization and guidance. The divisional councils provide that unifying focus and direction. The service delivery is decentralized. It is important to maintain a degree of decentralization so the unique needs of the departments can be met. Practice, education, and quality assurance issues arise on a unit that are individualized to that area. To address these needs, a structure must also exist at the unit level that empowers the staff to assume responsibility and accountability. Without a structure in place, the previous incongruence exists and management maintains authority and control. It

also sends a confusing message in terms of commitment to the concepts of shared governance. In some systems, elaborate decision trees have been developed that outline the route to be taken when a decision is required. Essentially, this process assigns urgent practice decisions to the manager with confirmation by staff at a later time. It assigns nonurgent practice decisions to staff groups. This can be a dangerous practice: it suggests that only a manager is capable of urgent, and therefore important, decisions. The need for a decision tree can be eliminated by empowering staff chairs and co-chairs to act in lieu of the staff groups.

There is a delicate balance between too much centralization, in which the divisional decision-making forums become another hierarchy, and too much decentralization, when there is lack of integration and each department becomes isolated and out-of-step with the needs, direction, vision, and goals of the institution.

In many instances there will be decisions or policies that only outline the direction. The specifics and the implementation may vary among units, thus requiring the units to further define the policy as it uniquely relates to them. The development of a unit structure also assists in the integration of the model between the division and the various departments. There is a system by which needs, issues, policies, and information can flow and be addressed at the appropriate level. Multidirectional communication is aided. The unit structure supports the premise that a shared governance model is a "bottom-to-top" structure for information, communication, and decisions, as compared with a traditional hierarchy where all decisions flow down from management to the staff.

The unit structure need not exactly mirror the divisional structure. The unit structure should be developed to meet the unique needs of the unit. The structure should allow responsibility and accountability for issues that relate to practice, education, and quality assurance. This can be accomplished in a variety of structures. Some units have developed multiple groups to accomplish these areas, whereas other units use one group for all. The possible types of structures may be as varied as the number of units.

Support Programs

As the plan is developed, it is important to examine the programs that support and facilitate staff nurse accountability for nursing practice. In addition to the structure, these support programs assist in creating an environment that fosters accountability. Although these are not essential in implementing the structure, they are important to the development of a professional practice model.

Primary nursing or case management.   The delivery of nursing care model is the foundation for control of practice. A model should exist that provides a vehicle for individual accountability for patient care delivered and its outcome. It allows decentralized decision making and invests responsibility in an individual. The professional nurse has autonomy for her practice delivered to her clients. It is the first level of practice accountability. It is incongruent to have a shared governance model in place without a delivery of care model that is also accountability based.

Peer review/peer input.   As professionals, the assessment of the quality of care delivered by peers further demonstrates control over all aspects of practice. It