CHAPTER

7 Integrating Differentiated Practice into Shared Governance

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Society is changing from an industrial society to a less materialistic and more personally fulfilling, ecologically sound society. This important development in the Western world is influencing roles and relationships in deep and meaningful ways. Consumers are becoming more involved in their health, placing an increasing emphasis on wellness and the development of their full potential. The medically dominated and controlled health care system is evolving toward a primary care distributive model in which patients select care based on real or perceived needs. All these changes call for new roles and relationships among various health care providers.

Nurses have historically been educated and socialized to assist people with self-care needs, both in an institutional setting and at home. In addition to providing care at the bedside, the nurse can now assume a role that coordinates the medical and nursing plan of care to facilitate a timely, prepared discharge. The nurse can also serve as a case manager for the chronically ill, the indigent, and the elderly who lack personal or financial assistance in their lives. This role establishes a partnership with the client, providing information and assistance in reaching a fully informed decision about ongoing self-care needs. These differentiated nursing roles require varying levels of clinical and interpersonal competence. The nurse must also share in the governance of professional practice issues if a true business partnership is to be realized.

In this time of unprecedented change, all health care agencies and providers are experiencing structural, fiscal, and boundary challenges of great magnitude. Organizational life has become messy as traditional roles, relationships, functional patterns, and prevailing belief systems must be reexamined. This time of chaos also presents an opportunity for the emergence of a new paradigm that will be liberating for all of humankind.

A paradigm is a world view about the phenomena of concern to a specific discipline that guides the practitioners' inquiry and creates scientific development. Kuhn (1970) introduced the concept of a paradigm shift to describe a radical change in the fundamental framework or way of thinking through which people

view their world. This altered world view requires a new intuition or insight as well as the consideration of new information, so that the discipline can see old and new aspects of its world through an altered framework.

Nursing has moved from a vocation to a professional discipline whose science has become visible in the twentieth century (Parse, 1987). Perceiving nursing as a profession, different from yet complementary to medicine, is a new idea to many nurses. Viewing hospitals and human service organizations in a business context is another new notion for most practitioners. The framework for professional nursing practice must be expanded beyond clinical expertise to include relational, leadership, and management skills. Nurses will influence patient care decisions both clinically and economically as they become true business partners with other major players in the health care system. Based on social systems theory, a blueprint can be created to guide the reframing and further development of professional nursing practice through the implementation of innovation.

A SYSTEMATIC APPROACH TO REDESIGNING ORGANIZATIONS

A *system* is an orderly arrangement of components that are interrelated, interdependent, and semiautonomous. Systems theory focuses on relationships between the parts of the whole in order to understand and predict behavior. Organizations are comprised of interrelated systems; thus phenomena are viewed as parts of these nested systems that must be investigated and analyzed simultaneously to comprehend the "totality."

The traditional concept of "organization as machine" has been predominant for the past several decades. Based on the theory of behaviorism, it assumed that employee behavior could and should be controlled. Control was most efficiently accomplished by identifying and using predictable cause-and-effect relationships to reach one's goal. Such organizations preferred that people act in a predictable, routine manner, accepting direction from authority without question. Adherence to impersonal, universal rules was valued more than subjective, autonomous action.

The physical and social worlds are now viewed as much more complex. Rules that used to be stable change from one day to another. Events are seen as ambiguous rather than predictable, influenced by many sources. Many events do not take place in assembly-line fashion. As employees become more educated, organizations benefit in shared decision making, which in turn increases the number of persons who influence causes and effects. Clear, hierarchical patterns of organization are being replaced by flatter, parallel patterns. Thus as persons and forces interact they influence and modify the output so that the entire picture changes, creating a dynamic and fluid reality (Marsick, 1990).

A new metaphor of "organization as a holographic brain" is emerging in response to this rapidly changing universe. The organization is compared to a human brain as an information processor. Based on principles of cybernetics, the organization views employees as centers of intelligence that can scan the environment, learn from mistakes, and adjust goals or plans to meet changing conditions. Thus individuals are self-directed and creative in approaching situations as they

occur. In addition, the brain has a *holographic capacity* in which each portion of the brain contains information about the whole. The "whole" can be seen or sensed in any isolated segment of the organism. This makes the system both self-organizing and self-correcting. Table 2 compares the concepts of organizations as machines and organizations as brains.

Nursing as a system must be viewed as part of the greater social system as well as the health care delivery system (Brooten, Human, and Naylor, 1988). Social systems theory viewed through a holographic lens can be used to study human and organizational development in conjunction with social change. When applied to nursing, it can provide a provocative way to establish a clear professional identity. The profession is then free to organize new thinking about the components of nursing practice.

MANAGEMENT OF INNOVATION

Social and economic development depends on innovation and entrepreneurship. The stimulation and management of innovation has been identified as the central concern expressed by a group of chief executives (Van de Ven, 1982). They view innovation as the major solution to the inexorable pressures of balancing the demands from expanding technology through the specialization and proliferation of tasks, the escalating costs for achieving coordination, and the need for obtaining cooperation and conflict resolution in a rapidly changing environment.

TABLE 2
Comparison of the Organization as Machine to the Organization as Brain

Organization as Machine	Organizing Concept	Organization as Brain
• Predictable, stability is norm	Environmental conditions	• Ambiguous, change is norm
• Based on goal statements	Organizational ideology	• Based on an ideal philosophy
• Fixed with rigid boundaries	Organizational structure	• Tentative with fluid boundaries
• Assembly-line production	Organizational functioning	• Self-organizing, self-correcting
• Problem-oriented, transactional	Leadership traits	• Charismatic, transformational
• Controlling, directing	Leadership style	• Empowering, consulting
• Universal rules	Leadership directives	• Standards of competence
• Task- and reward-oriented	Individual motivation	• Values and ideals oriented
• Organizational hierarchy	Individual relationships	• Professional networks
• Prescriptive, mechanistic	Individual work style	• Innovative, creative

Contemporary nursing must cope with almost daily changes in organizational life as health care delivery systems respond to new developments in science, technology, and their client base. Institutions can no longer function with operational structures and processes based on conventional wisdom. Organizations must question many assumptions on which they have built past success. This situation demands fresh, innovative ways of using human resources and structuring workers' relationships with the internal and external environment (Mitroff, 1985).

The process of *innovation* is defined as "the development and implementation of new ideas by people who over time engage in transactions with others within an institutional context" (Van de Ven, 1986). The need to stimulate, understand, and manage innovation has been widely recognized (Ouchi, 1981; Peters and Waterman, 1982; Kanter, 1983; Lawrence and Dyer, 1983).

Creating A Conceptual Framework

Nursing administrators perform as general managers, dealing with issues that are different from, and more intangible than, those of functional unit managers. Lewin and Minton (1986) call for the nursing administrator to clearly identify the key components of their responsibility, noting the relationship of individual elements to the total operations.

Without a conceptual framework and theoretical base for understanding and addressing issues and barriers, problems in nursing recycle as symptomatic solutions fail. A conceptual framework can be designed to assist with visualization of the components of nursing practice and their relationship within the health care environment (Figure 7-1). Planning sessions with management and staff could identify the desired *outputs*, products of nursing service provided to clients within a hospital. The major *inputs*, the fiscal, material, and human resources necessary to provide those services, would then be enumerated. Components that create the most enriching and efficient structure and process for professional nursing practice were identified in the Magnet Hospital Study (McClure, 1983) conducted by the American Academy of Nursing. Four major factors were noted: participative management, a comprehensive patient care delivery system, collaborative relationships, and opportunities for personal and professional growth. These components comprise the process by which the inputs are converted to the goals of the nursing practice.

Creating A Vision

Based on the conceptual framework a *vision* would be created: The Department of Nursing will restructure the delivery of hospital nursing care by integrating nurses as professional business partners through interdependent relationships supported by a shared vision, open structure, and increased autonomy. A long-range strategic plan, complete with objectives and strategies, would then be created to assist the nursing department with innovations focused on true professional practice.

The glossary of terms in Box 7-1 clarifies the vision statement.

As the definitions indicate, the overall vision is created to combine the principles of empowerment, teamwork, and business acumen so that nurses are fully inte-

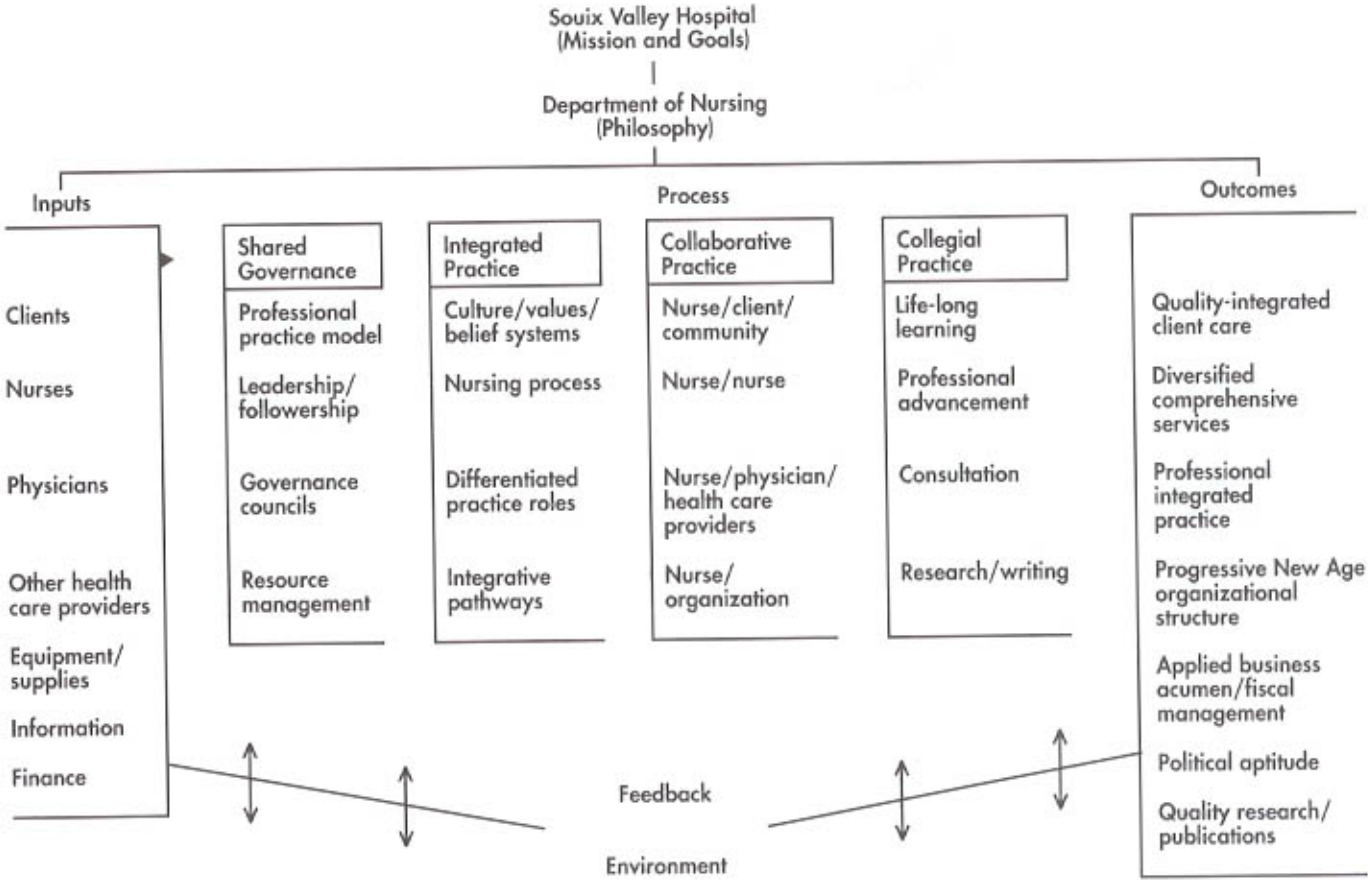

FIGURE 7-1. Conceptual framework for integrative nursing practice. (Used with permission from Sioux Valley Hospital, Sioux Falls, South Dakota.)

BOX 7-1
Glossary of Terms

Autonomy: Self-directing freedom and professional independence to influence the mobilization and allocation of resources on behalf of the patient.
Integration: The state of modifying individual goals to meet a broader objective through joining innovation and unity of effort within a given system or between related systems.
Interdependence: The state of attaining individual goals while being mutually influenced and benefited by another's contributions within a given system or between related systems.
Professional business partner: Nurses who have expanded their professional practice to include thought, behavior, and skills in business acumen. This fosters responsibility and accountability to the patient, the organization, and the society they serve.
Structure: A network of relationships among organizational positions that promotes equal opportunity and responsibility for information sharing and decision making.
Vision: A powerful mental image that clearly projects a future potential, inspiring the individuals to transform it into reality. Shared vision is the foundation for integration, unifying, and strengthening group process toward a mutual goal.

grated into an evolving health care industry as true professional partners to ensure their inclusion in the planning and execution of quality and cost-effective client care.

THE HUMAN CHALLENGE OF MANAGING ATTENTION

Nursing administrators occupy a unique position within the organization to identify problems and influence their resolution. They must also examine how the effects of organizational problems impact the implementation of an innovation. If the nursing administrator understands the process of innovation, she or he will understand the factors that facilitate and inhibit the progression of those innovations. Thus the administrator's management of ideas, people, transactions, and context throughout implementation of an innovation will ensure its success.

People and organizations are largely conditioned to focus on, cultivate, and protect existing practices rather than pay attention to the development of new ideas. The more successful an organization is, the more difficult it is to trigger people's attention toward new ideas, needs, and opportunities.

An innovation is a new idea that may be the recombination of old ideas, or something new and different. Although many ideas are presented in an organization, only a few receive serious consideration. If the idea is perceived as useful, it is an innovation. Ideas perceived as not useful are labeled mistakes and are auto-

matically resisted—people prefer to invest their energies and careers in a "sure thing."

Selling The Vision

Architectural firms that design building projects create a miniature model of the finished structure. Located in a place of prominence within an organization, employees view the model and visualize the finished project, creating a common definition of the new structure's appearance as well as its relationship to the existing structure.

Creation of a conceptual model of the various elements of professional practice that are to be developed will assist staff members in conceptualizing the vision established for nursing. By identifying the various components of nursing practice and their relationship to each other, a common vision for the entire department could be created (Figure 7-2).

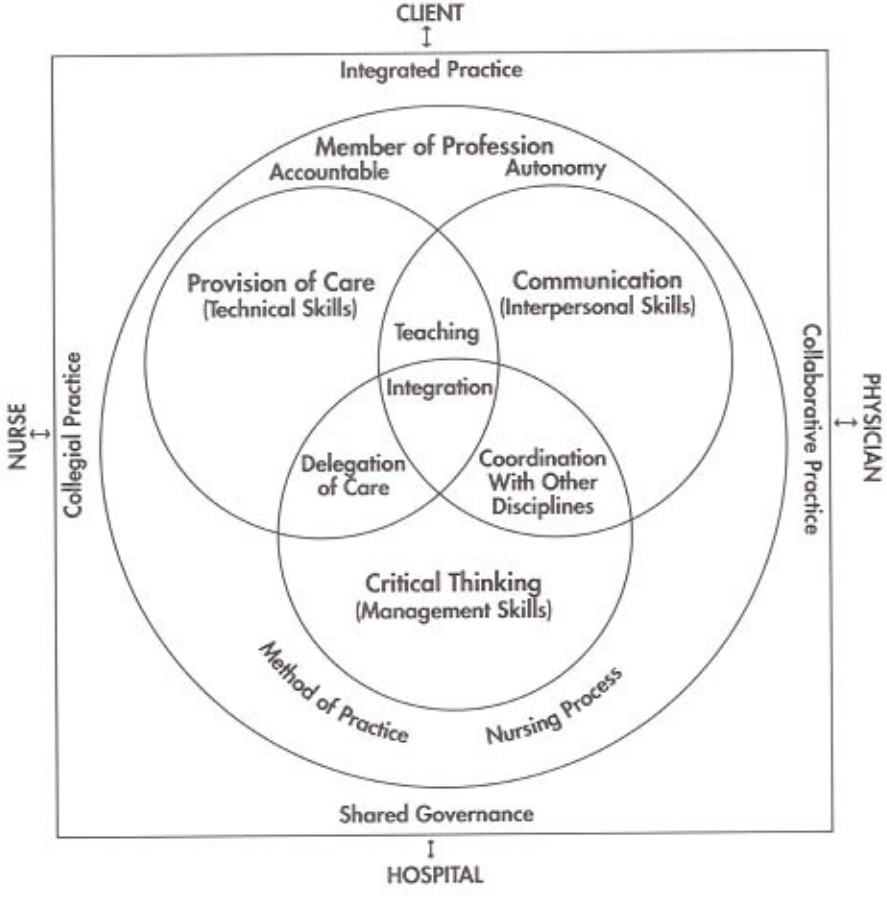

FIGURE 7-2. Professional practice model for nursing. (Used with permission from Sioux Valley Hospital, Sioux Falls, South Dakota.)

This conceptual model for professional nursing practice is based on social systems theory with a holographic focus. The center of the model depicts the role of nurse. It reflects a merging of the components of nursing practice: provision of care, management of care, and communication. The interactive roles of nursing are identified along with the public addressed: collegial practice with nurse colleagues, integrated practice with the client, collaborative practice with physicians (and other allied health personnel), and a relationship of shared governance with the hospital. Development and implementation of the components of this conceptual model would place nursing in a strategic position of business partnership and provide a framework for future research and theory development in nursing practice.

It takes a champion to move an innovative idea into action. People apply varying levels of skills, energy, and frames of reference to an idea as a result of their background, experience, and the activities that require their attention. Nursing management must be intimately involved in the generation and selling of the vision. Thus managers could be given access to a set of transparencies and a script, complete with anticipated questions and answers, to present the model at unit meetings. The vision would then be presented as an innovation within the organization.

THE PROCESS CHALLENGE OF MANAGING REDESIGN

People develop, carry, react to, and modify the ideas found in an innovation. Schon (1971) has identified that people become attached to ideas over time through a social-political process of pushing and activating their ideas into good currency.

Change is initiated by a disruptive event that threatens the social system. As the problem is recognized, ideas begin to surface to the mainstream as the result of efforts of people on the fringe (champions) who supply the energy necessary to raise the ideas into the threshold of public consciousness. Networks of individuals and interest groups galvanize around the ideas and exert their own influence on them through further development of the innovation. As the ideas are considered by people of power, legitimacy is gained to promote the change. Ideas that are acceptable become implemented and institutionalized, becoming part of the conceptual and social structure of the system. The ideas remain viable only as long as they continue to address the critical issues, or as long as the regime remains in power (Schon, 1971).

Establishing the Teams for Redesign

A model that creates and governs the practice of nursing must be designed by the individuals who are expert in the field: nurses within the institution. Thus components of the model would be assigned to various teams that work autonomously as well as collaboratively. A charter would be established for each team to outline the tasks to be accomplished, membership composition, length of time allotted, and expectations of individual team members.

Team positions could be posted, inviting staff members to apply with a statement of intent as to why they want to serve. Membership selections would be

based on talent and expertise germane to the task assigned. The organization must make a commitment to value the time and expertise of individual practitioners by paying them for committee work. Team members must make a reciprocal commitment for communication with colleagues to obtain input on issues under discussion and report findings back to the team.

Nurses who participate in decision-making activities must be assisted with the development of skills in systems thinking, group process, leadership, and political acumen. Thus initial group leadership is best assumed by a nursing manager with a staff nurse serving as co-chair. The agenda and current articles pertinent to the task at hand would be sent to all team members before the initial meeting to focus awareness. Formative activities completed at early meetings could include education on the concept to be developed, creating a common understanding; establishment of group norms to clearly articulate suitable group behaviors and group decision-making processes; and the development of assumptions to clarify group beliefs regarding the component under development. As the team members become more familiar with each other and the task at hand, the ongoing leadership would be selected by the group from among the members.

Managing Attention

Empirical evidence suggests that most individuals lack the capability and inclination to deal with complexity (Tversky and Kahneman, 1974; Johnson, 1983). Allowing for individual differences, most people have a short-term memory for raw data that lasts only a few seconds. Most individuals are very efficient at processing routine tasks. Skills for these tasks are stored in subconscious memory. People do not concentrate on the repetitive tasks once they are mastered, thus freeing time and attention for unfamiliar things.

The average person begins to create stereotypes as a defense mechanism to deal with complexity when seven (plus or minus two) objects or concepts are involved in the decision (Miller, 1956). As decision complexity increases, people become more conservative and apply more subjective criteria, which are further removed from reality (Filley, House, and Kerr, 1976). Because the correctness of outcomes from innovative ideas can rarely be judged, the perceived legitimacy of the decision process becomes the dominant evaluation criteria. Thus as decision complexity increases, solutions become increasingly error prone, means become more important than ends, and rationalization replaces rational thought (March, 1981; Janis, 1982). For an innovation to receive proper attention and understanding, it must be presented in a sequenced manner that staff can assimilate.

Differentiating the Practice Roles of Nurses

The project to implement change must begin with an evaluation of nursing roles within the organization because nursing is a clinical discipline. To trigger the action threshold of the nursing staff, it is essential for management to identify and address the most significant source of dissatisfaction to nurses within the institution as well as within the total profession. Historically, nurses with different levels of education have been used interchangeably in most health care settings. Nursing practice is not systematically differentiated on the basis of basic education, prior

experience, or additional contribution to the practice. Informally, the "expert" nurse has been relied on by patients, physicians, other nurses, and hospital management to a greater degree than the "novice," with little formal recognition or compensation. Professional advancement into a new role category required movement into a management role.

The current system of nursing education and licensure, which fails to differentiate the competencies and responsibilities of nurses educated in associate, diploma, and baccalaureate programs, has confused the public and the employer, while creating deep divisions within nursing (Boston, 1990). Three compelling reasons to differentiate the practice role of nurse include:

- Fragmentation of client care as a result of increasing physician subspecialization and the emergence of a decentralized, distributive health care delivery system
- Changing career expectations of graduates who seek career advancement opportunities based on education and competence
- Changing reimbursement options that demand coordinated care, thus eliminating redundancy and gaps in service

Differentiating practice roles provides the nursing profession with a vehicle to create a nursing care delivery system, based on client needs, across the health care continuum. This will position nursing as a powerful integrating force in the changing health care industry.

A pilot project invites staff members to participate in the testing and refinement of alternate care delivery systems and the inherent role changes for nursing practice. To ensure staff support and investment, units involved in a demonstration project should be self-selected through an 80% vote to participate from the membership on the unit. It is essential to attain this level of commitment from the staff to minimize the internal group pressures to maintain status quo.

Janis (1982) has suggested that innovation can only occur under conditions of moderate stress. There must also be sufficient time and an abundance of resources to help make decisions. Under conditions of tight resources or short time horizons (which produce stress), the decisions made regarding innovation will have a crisis orientation, resulting in significant implementation errors. A unit with a history of innovation, a nursing manager who has demonstrated leadership and experiences the trust of her staff, or a staff that has demonstrated involvement in professional practice activities will maximize the potential inherent in a change project of this magnitude.

Argus and Schon (1983) have identified that double-loop learning models, rather than single-loop learning, may improve the innovation process. Single-loop learning represents conventional monitoring activity, with action taken based on the findings of the monitoring system. This process may lead the organization to inertia. Double-loop learning includes the option of changing the evaluation criteria. Past performance is questioned, new assumptions are raised, and significant changes in operations can occur on an ongoing, dynamic basis.

On the basis of pilot project outcomes and the experiences of the demonstration units, a recommendation to adopt the innovation can be forwarded to the practice

(Koerner and others, 1989a). A set of guidelines and recommendations for implementation would be generated by the pilot units to be evaluated in second-generation activities regarding this concept. These recommendations and guidelines would be categorized and submitted to various committees for addition, deletion, and further refinement.

THE STRUCTURAL CHALLENGE OF MANAGING WHOLE-PART RELATIONSHIPS

A little-understood but pervasive characteristic of the innovation process is the proliferation of ideas, people, and transactions over time. With these phenomena come complexity and interdependence as well as the basic structural problem of managing good ideas into currency.

Successful implementation of innovation is not an individual activity, but rather a collective achievement. Therefore over time there is a proliferation of people (bringing diverse skills, resources, and interests) who become involved in the innovation process. The differing perceptions and frames of reference are magnified through the increase of transactions or relationships among people and organizational units that occur as the innovation unfolds. Thus the management of the innovation process can be seen as managing increasing numbers of transactions over time.

Integrating the Diverse Components of Innovation

Innovations thrive or perish depending on their acceptance or rejection by people who are affected by them. Human transactions are exchanges that tie people together within a common context. The more novel and complex the innovation, the more often trial-and-error cycles of renegotiation, recommitment, and readministration of transactions must occur. People demonstrate a conservative bias, entering into transactions with people they trust through previous successful experiences. Therefore building trust within and among groups is a key activity to foster in team-building activities.

The most effective approach to handling the complexity and interdependence is to divide the labor among specialists best qualified to perform unique tasks. The reintegration of these specialized parts will recreate the whole. The innovation could be divided among four major committees: clinical ladder committee, integrated care committee, collaborative practice committee, and collegial practice committee. Committee membership would be participative, with a staff nurse selected by each unit to be their representative. A unit manager from each division (medical-surgical, critical care, and maternal-child), a supervisor, a clinical nurse specialist, and representation from staff development would complete the committee. A clinical director and the vice president of patient services would serve in an ad hoc advisory capacity to all committees.

Clinical Ladder Committee

The concept of "differentiated practice" is currently being used in several ways. Some institutions view it as a care delivery model for primary nursing. Others use

it as a staff deployment mechanism that ascribes job categories based on education and/or competence. A third approach is the use of the concept as a philosophy. The Governing Board of the National Commission on Nursing Implementation Project (NCNIP) completed 3 years of activity dedicated to creating strategies for redesign of the nursing profession. The goal for differentiated practice within the organization is stated in the NCNIP (1989) definition:

> **Differentiated practice:** In order to improve patient care, effectively utilize health care resources, and create a more satisfying work environment, roles and functions of nursing personnel should be based on education, experience, and competence, and nurses should be compensated accordingly.

Many organizations currently have some form of a clinical ladder. Based on the Benner model of novice to expert (1984), most organizations reward increasing competence in the basic role of nurse. Differentiated practice proposes two distinct career pathways, each offering a continuum of novice to expert within the role. The organizational clinical ladder committee would take the recommendations from the demonstration units, along with the job descriptions tested during the project, to refine career opportunities for the nursing practice (Primm, 1987). Their charge would be to create two distinct clinical tracks for nurses at the bedside: the associate nurse role, which provides direct care at the bedside, and the primary nurse role, which integrates the nursing and medical plan of care to facilitate a timely, well-prepared discharge. A plan for placement into the role, evaluation, and reward criteria for the practitioners plus educational plans to ensure success in the newly developed role are also needed. Although the roles are mutually valued, the competencies and salary would expand with each role (Koerner, 1990).

As discussions evolve, the staff will identify that the emerging importance of critical thinking and timely communication of information is equal to that of technical skills. The term *career pathways* may be viewed as more reflective of the totality of nursing practice than clinical ladders. At this point the committee may change its name to "career pathway committee," and broaden its charge by expanding on the best components from the previous clinical ladders concept.

As the innovation unfolds, the committee may identify that the practice role of MSN-prepared nurses must be restructured to support the evolving practice roles of nursing at the bedside (Nicholai, 1990), creating three levels of career opportunities for nurses within the organization and the community (Figure 7-3).

Dialogue may also reveal that nurses have varying needs during their professional career. Most nurses begin their career with a great deal of time and energy for their profession. Staff members will express concern that the challenge of raising children, caring for elderly parents, and managing the pressures of combining school and work may deter some of the energy previously available for their career. A pilot project on differentiated practice revealed that 40% of the nurses with BSN degrees chose to maintain their current RN position when offered expanded career opportunities (Koerner, 1989).

Thus an equitable transitional model for career advancement may best be based on *competencies* and *choice*. A nurse with the requisite competencies (as demonstrated through a factoring process) could work in the primary nurse role. In addi-

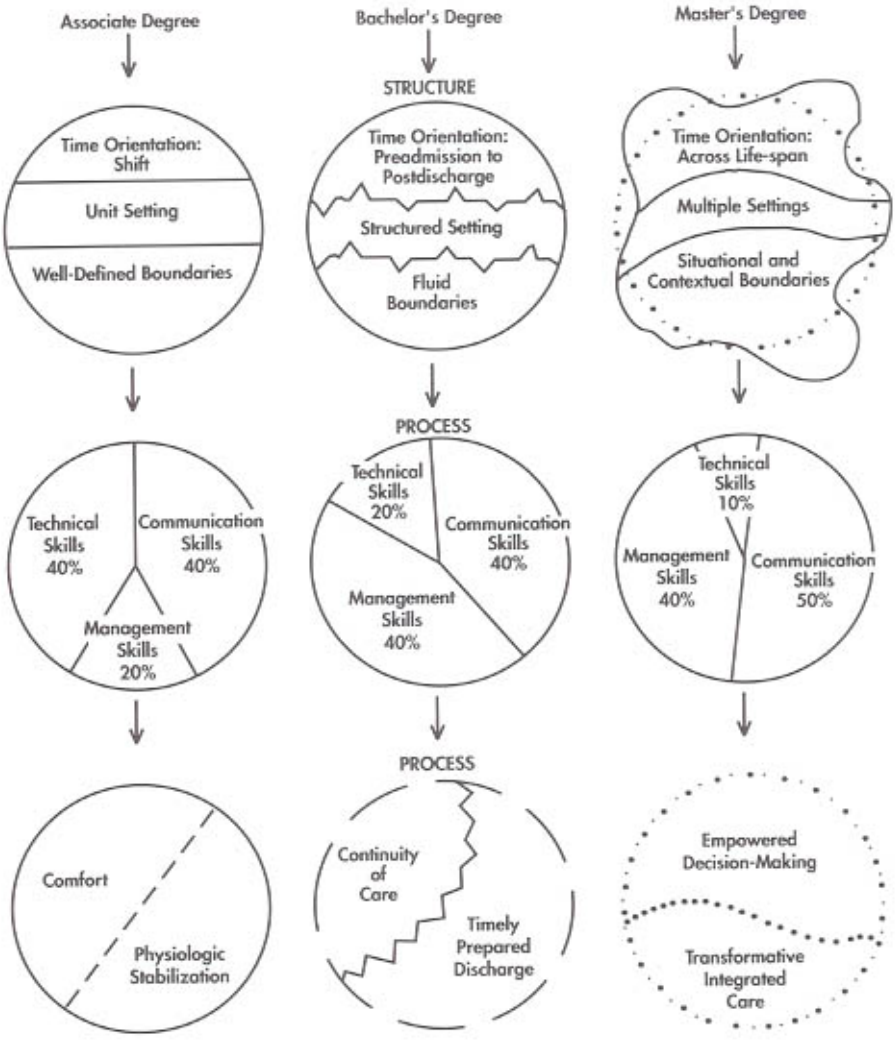

FIGURE 7-3. Framework for differentiating practice roles of nursing. (From American Academy of Nursing: Differentiating Nursing Practice: Toward the Twenty-First Century. Kansas City, Mo. American Academy of Nursing, 1991. Reprinted with permission.)

tion, that nurse may choose to return the traditional RN role and salary if life circumstances so dictate.

There is an important connection between the transactions of a group and the total organization. Transactions are the micro-elements of macro-organizational arrangements. Each month the committee members must report on progress of the group at the unit meeting. All work of the committee should be posted in an information book strategically located on the unit so that individual nurses can review and comment on the item under consideration by the committee at that time. When competencies and guidelines are adopted, the work of the committee would be ready for implementation by the nursing practice throughout the organization.

Integrated Care Committee

Demographic and economic forces are demanding changes in the structure and organization of the health care delivery system. Thus the nursing profession must establish an integrative nursing care delivery system with the following goal: nursing will integrate the care of patients to maintain quality while maximizing efficiency in resource allocation and utilization.

> **Integrated care:** A system of patient care delivery that integrates the allocation of resources (human and material) over a variety of settings and appropriate time frames through differentiation of nursing practice. Differentiation implies expansion of patient care management beyond physiologic stabilization to the entire episode of illness.

When the roles of nursing have been differentiated, the delivery of nursing care should be evaluated to clearly unite the roles into an integrated whole on behalf of the client, the professionals themselves, and the total organization.

Each unit would establish a unit-based integrated care committee to redesign the unit's care delivery system based on the revised role competencies according to established guidelines. A hospitalwide integrated care committee would also be established as a monitoring, problem-solving arena for the individual units to share innovations and concerns. Often one unit may find another moving smoothly in an area of difficulty for them. An increase in consultation by nurses (staff and management) from one unit with another will be noted, facilitating a growing sense of teamwork and professionalism.

Currently, no formal health care delivery system exists within our country. Thus "each individual or family puts together an informal set of services and facilities to meet their own needs" (Torrens, 1978). Financing is provided by personal and employer contributions or governmental funds. Services currently available include the following:

- **Environmental protection** (en masse protection; water, sewage, etc.) from the public health department.
- **Biogenetic engineering** (monoclonal antibodies, gene splicing, etc.) from geneticists and scientists.
- **Wellness promotion** activities (discretionary care) from health educators, nutritionists, exercise physiologists, and lay advisors.
- **Ambulatory care** (prevention and maintenance care) from a private physician, nurse practitioner, dentist, or psychologist.
- **Acute care** (profit or nonprofit) from a hospital setting using advanced technology, multispecialty services, and practitioners.
- **Rehabilitative care** (restorative care) from a physiatrist and multidisciplinary team.
- **Home health care** (individual support services) from case managers, visiting nurses, home care aides, and congregate living centers.
- **Extended care** (continuous care) from skilled care facilities and nursing homes.
- **Hospice care** (terminal care) from a multidisciplinary team of caregivers.

The presence of primary nursing within one agency resulted in a 150% increase in discharge referrals for some client populations (Koerner, 1989a). A need for