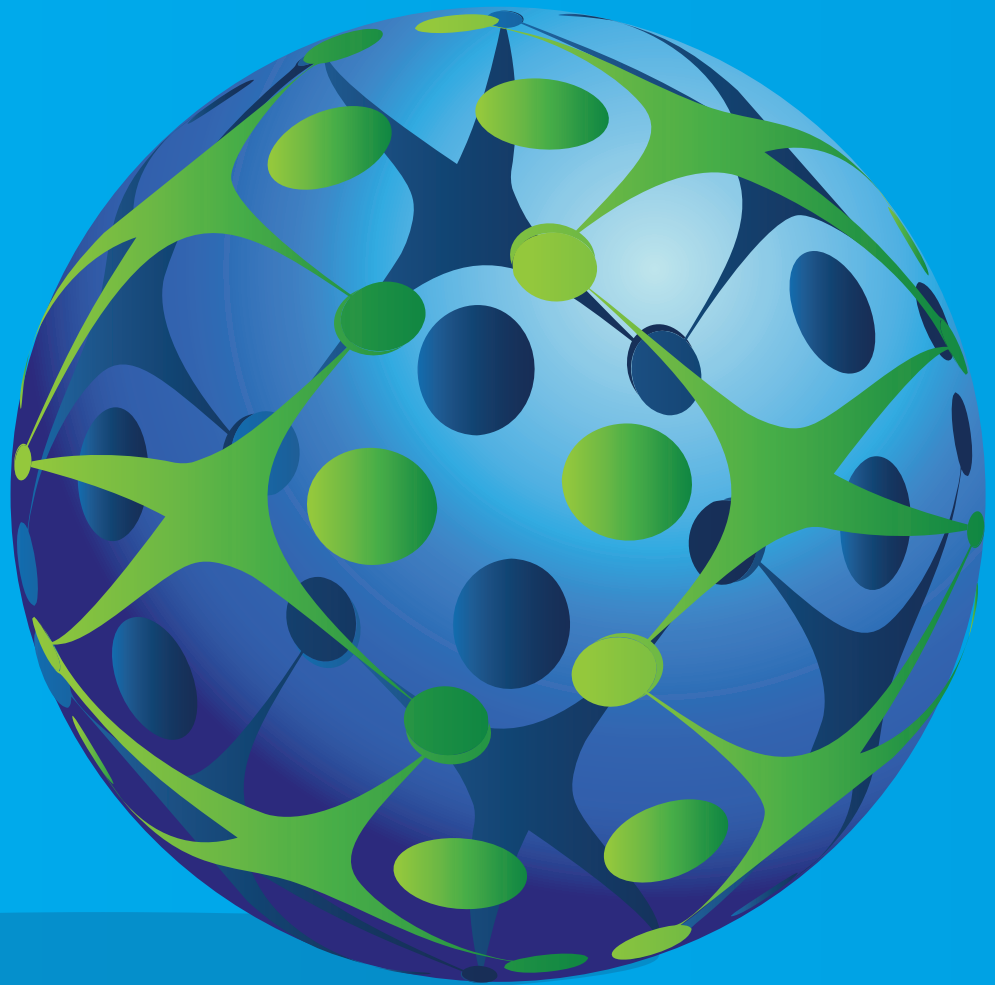# Shared Governance

A Practical Approach to Transforming Interprofessional Healthcare, Fourth Edition

Diana Swihart, PhD, DMin, MSN, APN CS, RN-BC, P-PCA, FAAN

Robert G. Hess, PhD, RN, FAAN

Fourth Edition

Shared Governance

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Founder of the Forum for Shared Governance

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Dedication

This work is dedicated to those courageous and giving healthcare providers and many other colleagues who continue to teach me about the extraordinary realities of lived shared governance. These profound heroes and heroines exemplify interprofessional partnerships at their best through their passion, integrity, and commitment to excellence at every opportunity of service and practice. Thank you.

—Diana Swihart

To the staff, managers, and executives in all healthcare professions who passionately believe that the best possible professional, organizational, and patient outcomes can only be achieved by empowering everyone to share in decision-making about patient care. To staff for trying something new and risky, to managers and supervisors for trading traditional roles for unknown new ones, and to executives for supporting staff, managers, and supervisors, and showing the way.

—Robert G. Hess, Jr.

Acknowledgments

Every work, regardless of scope and size, is completed only with the help and inspiration of others. My sincere thanks go to my beloved husband for his support and encouragement, and for his unwavering belief in me. I also want to thank my devoted son, who lent his own writing skills and gifts to the earlier reading and critiquing of the manuscript, helping me write in a way that would be more comfortable and interesting for readers.

I would also like to acknowledge those many other nurses and healthcare providers, patients and families, speakers and teachers, and colleagues and friends who have contributed their ideas and thoughts through countless classes, seminars, lectures, and discussions over the years. I write from their influence and want to recognize their contributions as well. Although their names are too numerous to list, many others can be found in this work and in the extended bibliography. To each and every one of you, thank you.

Finally, I would like to thank two innovative and courageous leaders in nursing today who have most transformed my own thinking about shared governance: Dr. Robert G. Hess, Jr., a friend and colleague who taught me how to measure shared governance and how to see more clearly the potential to truly lead change and advance healthcare on every level, and Dr. Tim Porter-O'Grady, whose work first drew me to the study of shared governance. After studying more than 180 articles, videos, and books, my ideas and writing most strongly reflect Dr. Porter-O'Grady's influence. For this reason, I am particularly pleased that he has again written the foreword for what I hope to be another valuable addition to your own journey in helping reshape and transform professional practice and service for this and the next generation of healthcare providers.

—Diana Swihart, PhD, DMin, MSN, APN CS, RN-BC, P-PCA, FAAN

About the Authors

Diana Swihart, PhD, DMin, MSN, APN CS, RN-BC, P-PCA, FAAN

Diana Swihart, PhD, DMin, MSN, APN CS, RN-BC, FAAN the CEO & Managing Partner for the American Academy for Preceptor Advancement, enjoys many roles in her professional career, practicing in widely diverse clinical and nonclinical settings. An author, speaker, researcher, educator, mentor, and consultant, she holds graduate degrees in nursing and leadership and doctorates in theology and ministry. She continues to provide operational leadership for the shared governance processes of multiple national and international organizations and serves as a consultant and liaison to help facilitate the application of evidence-based practice and research.

She is a member of Sigma Theta Tau International, the Nurses Organization of Veterans Affairs, the Veterans Educators Integrated Network (VEIN), and several professional advisory boards. She has published and spoken on numerous topics related to nursing, shared governance, competency assessment, continuing nursing education, nursing and servant leadership, new employee orientation, professional nurse development, building effective preceptorships, and evidence-based practice in clinical settings locally, nationally, and internationally. During her career, she has served as a Consulting Partner with the Forum for Shared Governance, an American Nurses Credentialing Center (ANCC) Magnet Recognition Program® appraiser, a treasurer for the National Nursing Staff Development Organization (now Association for Nursing Professional Development, ANPD), and a commissioner on ANCC's Commission on Accreditation. In 2015, she was inducted into the American Academy of Nursing for her work in preceptor specialty practice and certification.

Robert G. Hess, Jr., PhD, RN, FAAN

Robert G. Hess, Jr., RN, PhD, FAAN, is an educator, editor, author, consultant, and the founder of the Forum for Shared Governance. He currently serves as executive vice president of global programming for Gannett Education. An award-winning author, he has written more than 100 articles for numerous journals and books. He is the former vice chair of ANCC's Commission on Accreditation.

In 2008, Dr. Hess was inducted as a fellow into the American Academy of Nursing for his work in shared governance.

Preface

Shared governance structures, with all their intrinsic complexities, responsibilities, and accountabilities, must be carefully designed and implemented to be sustained. This book takes some of the guesswork out of the various structures and processes behind shared governance and provides strategies, case examples, and best practices for making the daily operations of shared governance meaningful, successful, and sustainable. It is designed to provide a broad base on which to build planning and implementation of a successful shared governance infrastructure. To do that, you need guides, tips, and tools.

The purpose of this fourth edition of *Shared Governance* is to provide leaders, educators, and healthcare providers with many of the tools and ideas they need to implement practical approaches to designing—or redesigning—an effective and efficient interprofessional and multidisciplinary shared governance process model. They will help you embrace the changes required to mature your shared governance infrastructure towards sustainability. In this book, you will find a compilation of information and tools to help you develop your own models and processes.

As the demand for value, safety, effectiveness, and efficiency grow and expand, directed at achieving outcomes that measure and increase the value of processes (i.e., shared professional governance), quality, continual improvement, and excellence are becoming embedded in healthcare practices across disciplines and services. Therefore, this book also explores the relationship between shared governance and the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® (MRP) and Pathway to Excellence®. A case example also provides insight into how Lean Six Sigma demonstrates how quality is folded into shared governance and results in process improvements at points of care.

You will also find guides for identifying models and tools for designing and building a structure to support shared governance. Additional tools help you create or re-create your structures from the unit or practice level upward and mature your processes across disciplines and service lines.

You can explore ways to engage internal and external stakeholders, assess your processes and outcomes, and evaluate your infrastructure within six domains of measurement. This book helps you as you grow and develop your knowledge, skills, and abilities through research, evidence-based practice, and shared decisional processes. These tools can support your work as you participate in a partnership with your leadership, educators, interprofessional colleagues, and multidisciplinary team members to ensure safe, competent practice within your organization.

Let's take a closer look and see what's here.

Organization

This fourth edition of *Shared Governance* is organized into 12 chapters, with strategic and tactical processes for implementing your own organizational management system. It explores the evolving processes and decisions folded into shared governance. It contains a plethora of field-tested tools, measurement instruments, and strategies to help guide steering and operations groups for designing and redesigning unit, practice, and divisional councils. Each chapter begins with an encouraging quote and concludes with a brief summary.

- Chapter 1 explains the concept behind shared governance in today's complex work and healthcare environments. It looks at some of the language around shared professional governance, reviews four primary principles of shared governance (partnership, equity, accountability, and ownership), and compares several models.

- Chapter 2 identifies some of the characteristics of shared governance structures and structural process models. Basic guidelines for forming governance bodies provide further insight into designing a structure to support shared governance within the organization and across service lines.

- Chapter 3 explores four components of building a structure to support shared governance in diverse work settings. Part one focuses on implementing shared governance. Part two discusses leading strategic change. Part three considers shared governance systems' perspectives and formats in designing the structures. Part four guides you through the process for formalizing the shared governance structure with bylaws and articles and charters. This chapter also offers a brief look at redesigning shared governance after a breakdown in implementation has occurred.

- Chapter 4 focuses on building councils at the unit and practice levels. Strategies and tools encourage providers to create a critical forum for participating in shared decision processes and outcomes specific to their needs and activities. It also explores leadership approaches critical to successful shared governance.

- Chapter 5 describes the process for implementing shared governance at organizational levels. Strong interprofessional and multidisciplinary relationships with key stakeholders (e.g., leadership, union representatives, community members, providers, staff, and patients) are critical to integrating shared governance into the organization. Several snapshots of organizations implementing shared governance in a union hospital provide insights and ideas for working with union partners in an environment of shared decision-making and leadership.

- Chapter 6 discusses how to build competencies in shared governance, and it provides some working definitions, goals, competency levels, and outcomes grounded in Wright's Competency Assessment Model: Ownership, Empowerment, and Accountability. Tools for identifying and measuring competencies are included with a case study looking at autonomous practice and competence through unit councils. Chapter 7 identifies research projects specific to the principles and newest instruments used to measure shared governance (i.e., the Index of Professional Governance 2.0 and 3.0 (IPG), the Index of Professional Nursing Governance 2.0 and 3.0 (IPNG), and the Council Health survey).

- Chapter 8 relates multiple case studies of organizations of various sizes, describing the strategic priorities, successes, rewards, and challenges of implementing an integrated interprofessional shared governance system across disciplines and services.

- Chapter 9 offers snapshots of shared governance in case studies contributed by organizations in two U.S. and global communities.

- Chapter 10 explores quality, safety, and value in quality management systems and service excellence through shared governance. Several case studies and best practices in quality, patient safety, and shared governance are included. Experts in the implementation of quality management and patient safety and in the ANCC's Magnet® and Pathway® programs provide insight into how these systems complement and are more fully realized through shared governance.

- Chapter 11 features an international clearinghouse for research and resources, with a selection of recent articles and both published and unpublished research on shared governance. It considers conclusions and recommendations for moving forward with shared governance. Lived shared governance is a dynamic, fluid, and ever-growing process that can transform healthcare.

- Chapter 12 offers tips for success, lessons learned, and best practices shared by healthcare leaders, direct-care providers, team leaders, and other organizations and communities of practice where shared governance thrives.

The information presented in *Shared Governance*, Fourth Edition, reflects the research and opinions of its authors, contributors, and advisors. Because of ongoing research and improvements in interprofessional and multidisciplinary team structures, information technology, and education, this information, these tools, and their applications are constantly shifting, changing, and evolving in healthcare, leadership, and other services and disciplines.

Because this book explores opportunities for folding shared governance into increasingly complex adaptive and uncertain work environments, we have provided you with definitions, a variety of models and tools, and multiple approaches to building stronger infrastructures within your own organization. It is the authors' sincere hope you will add this work to your library and consider how you, too, might contribute to this growing body of knowledge, research, and expertise through your own practice and organizational developments.

—Diana Swihart and Robert G. Hess, Jr.

Chapter 1

The Concept Behind Shared Governance

After reading this chapter, the participant will be able to:

- Define the four primary principles of shared governance: partnership, equity, accountability, and ownership
- Compare two shared governance models

With input from stakeholders inside and outside the organization, leaders are expected to shape agendas, not impose priorities; to allocate attention, not dictate results; and to define problems, not mandate solutions. These expectations we now have for leaders closely resemble conventional notions of governing.
—R. P. Chait, W. P. Ryan, and B. E. Taylor, Governance as Leadership

The increasingly complex changes in healthcare are leading a growing number of institutions to reexamine shared governance—a concept introduced into healthcare organizations in the 1970s—as an evidence-based method to support an empowering, integrated approach to healthcare services. This book takes some of the guesswork out of the various structures and processes behind shared governance and provides strategies, case examples, and best practices to make the daily operations of shared governance meaningful and successful.

As the demand for value, safety, effectiveness, and efficiency increases, with the aim of achieving outcomes that measure and increase the value of certain processes (i.e., shared governance), quality, continual improvement, and excellence are becoming more embedded in healthcare practices across disciplines and services. To address these changes, this book also explores the relationship between shared governance and the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® (MRP) and the International Organization of Standards (ISO), outlining the MRP and ISO expectations for shared governance practices.

What Is Shared Governance?

Before it can be solved, a problem must be clearly defined.
—William Feather

Shared governance has been referred to as a concept, a construct, a model, a system, a philosophy, and even a movement. In many organizations that have implemented it, it is most often called shared decision-making or shared leadership. Universal principles and approaches can support the relationships and interactions needed to plan and design, implement, measure, and sustain shared governance in healthcare through an overlapping and integrating infrastructure (Porter-O'Grady, 2009a; 2009b) that supports building competencies and achieving accreditation, such as the Forum for Shared Governance (*http://sharedgovernance.org/*).

Before we go any further, we need an operational definition to clarify this work and address the research and applications to practice we find in shared governance.

> ***Shared governance*** is an organizational innovation that legitimizes healthcare professionals' decision-making control over their practice while extending their influence to administrative areas previously controlled by managers (Hess, 1995). It provides a framework or structure for the process of shared decision-making and outcomes of shared leadership.

Because shared governance reflects the mission, vision, and values of those who embrace it, it adapts to each environment and practice setting. Over the years, many thought leaders such as Drs. Tim Porter-O'Grady, Robert Hess, and Diana Swihart have worked together to build autonomous interprofessional partners in healthcare through shared governance (see Appendix E for an expanded bibliography, which includes many classic resources as well as current research and thinking on shared governance and related concepts).

The Random House Unabridged Dictionary (2018) defines the verb "govern" as "to exercise in directing or restraining influence over; guide: the motives governing a decision; to have predominating influence. The term governance is about authority, control, influence, or power." It answers the simple question, "Who rules?" Hess developed a means for measuring governance by building on that context and on a classic analysis in which the sociologist Alvin Gouldner (1959) traced the conceptual lineage developed by several theorists who ultimately influenced how we view organizations (Blau & Scott, 1962; Hess, 2011a).

Professional governance—a multidimensional organizational characteristic that encompasses the structure and processes by which professionals direct, control, and regulate each others'

goal-oriented efforts (Hess, 2011a)—is critical to the success of organizations, especially high-reliability organizations. It encompasses the continuum from traditional governance (the bureaucracy that most of us have been brought up with) to shared governance to self-governance, which is a not-so-hypothetical situation wherein nurses might own a hospital and employ managers to help them run it (Swihart & Hess, 2014).

Hess' focused research resulted in the only current reliable and valid instrument specifically designed to assess the six domains of shared governance in an organization and in the profession of nursing: control, influence, authority, participation, access, and ability. Most instruments measure characteristics and only some outcomes related to shared governance; however, the Index for Professional Governance and the Index for Professional Nursing Governance have been researched and used to measure progress in developing and establishing shared governance in growing numbers of organizations. (See Chapter 7 for further details on the Index for Professional Governance and the Index for Professional Nursing Governance; copies of these tools are found in Appendices C and D.)

The management process model of shared governance—shared decision-making—is based on the principles of partnership, equity, accountability, and ownership at the point of service and practice. It empowers all members of the healthcare workforce to have a voice in decision-making. This facilitates diverse and creative input to advance the business and healthcare missions of the organization. In essence, this makes every employee feel like he or she is "part manager" with a personal stake in the success of the organization, which leads to the following outcomes:

- Longevity of employment
- Increased employee satisfaction
- Better safety and healthcare
- Greater patient satisfaction
- Shorter lengths of stay

Those who are happy in their jobs take greater ownership of their decisions and are more invested in patient outcomes. Thus, employees, patients, the organization, and the surrounding communities benefit from shared governance

> **STRUCTURE:** shared governance
> **PROCESS:** shared decision–making
> **OUTCOME:** shared leadership

In effective shared governance, decision-making must be shared at the point of service to allow for cost-effective service delivery and staff empowerment. Such decision-making is only possible with a decentralized management structure. In this context, employee partnership, equity, accountability, and ownership occur at the point of service (i.e., on the patient care units)—at least 90% of the decisions need to be made there, and only 10% of the decisions at the service or unit level belong to management. Thus, the locus of control in the professional practice environment shifts to practitioners in matters of practice, quality, and competence (Porter-O'Grady & Hitchings, 2005). The following terms describe the principles of shared governance.

Partnerships

The concept of *partnership* links healthcare providers and patients at all points of service in the system; it is a collaborative relationship among all stakeholders and disciplines required for professional empowerment. Partnership is essential to building relationships, involves all staff members in decisions and processes, implies that each member has a key role in fulfilling the mission and purpose of the organization, and is critical to the effectiveness of the healthcare system (Porter-O'Grady & Hitchings, 2005).

Equity

Equity refers to the best method for integrating staff roles and relationships into structures and processes to achieve positive patient outcomes. Equity maintains a focus on services, patients, and staff; is the foundation and measure of value; and says that no role is more important than another. Although equity is not the same as equality in scope of practice, knowledge, authority, or responsibility, treating team members justly and fairly, or equitably, communicates that each person is essential in providing safe and effective care (Porter-O'Grady & Hitchings, 2005; Porter-O'Grady, Hawkins, & Parker, 1997).

Accountability

Accountability is a willingness to invest in decision-making and to express ownership in decisions. This concept is the core of shared governance, and the term is often used interchangeably with responsibility. Accountability allows role performance to be evaluated, facilitates partnerships in decision-making, and is secured when staff produce positive outcomes (Porter-O'Grady & Hitchings, 2005). Figure 1.1 provides more information on these principles of shared governance.

Ownership

Ownership is the recognition and acceptance that everyone's work is important and that an organization's success is based on how well individual staff members perform their jobs. Ownership designates where work is done and by whom to enable participation of all team members. Implementing the principle of ownership requires a commitment by each staff member to what is to be contributed, establishes a level of authority with an obligation to own what is done, and includes

FIGURE 1.1	Characteristics of principles of shared governance

PARTNERSHIP	EQUITY
- Role expectations negotiated - Equality between players - Relationship grounded in shared risk - Clear expectations and contributions - Solid measure of contribution to outcomes established - Defined horizontal linkages	- Each one's contributions are understood - Payment reflects value of contribution to outcomes - Role based on relationship, not status - Team defines service roles, relationship, outcomes - Team conflict and service issues defined by methodology - Evaluation assesses team's outcomes and contributions
ACCOUNTABILITY	OWNERSHIP
- Based on outcomes, not process - Defined internally by person in role; embedded in roles - Defines roles, not jobs; cannot be delegated - Determined in advance of performance - Performance validated by results - Focus is on collective activities - Self-described; depends on and directly inter-sects with partnerships - Shares evaluation - Contributions-driven value - Processes generally loud and noisy	- All workers invested - Every role and person has a stake in outcomes - Rewards directly related to outcomes - Every member associated with a team - Relationships supported by processes - Opportunity based on competence

KEY PRINCIPLES

- Build on decisions and structure on a point-of-service foundation
- Always involve stakeholders in their own decisions
- Shared governance: an accountability-based approach, not a participative management model
- Team-based strategies are basic to structural design
- Locus of control placed wherever needed for decisions required
- Shared governance has no approval structures; it reflects relatedness between people and systems, not status within structures and systems
- Managers focus on context, staff on content
- Partnership, equity, accountability, ownership: undergirding principles of shared governance

SOURCES: Adapted from Edmonstone, J. (2003). *Shared governance: Making it work*. Chichester, West Sussex, United Kingdom: Kingsham Press; and Porter-O'Grady, T. (2009b). *Interdisciplinary Shared Governance: Structuring for 21st Century Practice*. Sudbury, MA: Jones & Bartlett Publishers.

participation in devising purposes for the work (Koloroutis, 2004; Page, 2004; Porter-O'Grady & Hitchings, 2005). Shared governance activities may include participatory or self scheduling, joint staffing decisions, and shared service or unit responsibilities (e.g., every RN is trained to be "in charge" of his or her unit or area and shares that role with other professional team members, perhaps on a rotating schedule) to achieve the best patient care outcomes.

The old centralized command-and-control management structures are ineffective in today's health-care market; they frequently inhibit effective change and growth within the organization and limit future market possibilities in recruitment and retention of qualified providers. Summative, hier-archical decision-making creates barriers to employee autonomy and empowerment. It can also undermine service and quality of care, in part because today's patients are no longer satisfied with directive care. They, too, want partnership, equity, accountability, and mutual ownership in their own healthcare decisions and those of their family members (Institute of Medicine, 2011).

Many organizations are now exploring and integrating an interprofessional approach to shared gover-nance, from clinical decisions at points of service to strategic priorities placed on complex issues by senior leadership (see Chapter 5 for details; Porter-O'Grady, 2009d; Alrwaihi, Kehyayan, & Johnson, 2017). This approach often engages patients and families as partners. Keys to successful implemen-tation of this approach to shared governance include active participation of all team members who contribute to mutually respectful, trusting, collaborative, openly communicative, safe, and effective learning environments of care and practice across disciplines and departments. Interprofessional shared governance provides a unique structure for shared decision-making that reflects the current and evolving demands of an increasingly diverse and integrated care delivery system (see case stud-ies in Chapter 8; Porter-O'Grady, 2009b).

History and Development of Shared Governance

The concepts of shared governance and shared decision-making are not new. Philosophy, education, religion, politics, business and management, and healthcare have all benefited from a variety of shared governance process models implemented in many diverse and creative ways across genera-tions and cultures.

- Socrates (470–399 BC), an ancient Greek philosopher, integrated shared governance concepts into his philosophies of education. The Socratic Method (answering a question with a ques-tion) calls for the teacher to facilitate the student's autonomous learning as the teacher guides him or her through a series of questions. The Socratic Method encourages students to use reason rather than appeal to authority.

- The government model for the United States was established on the concepts of shared gov-ernance—"of the people, by the people, for the people" (from Lincoln's Gettysburg Address, 1863)—wherein the very citizenry is directly responsible for the government on both the

state and federal levels. Political variations of this model of shared governance can also be seen in the European Union and the United Nations, where individual countries share in the decision-making on joint international matters.

- Eventually, shared governance found its way into the business and management literature (Laschinger, 1996; O'May & Buchan, 1999; Peters & Waterman, 1982). Organizations began to design formal structures and relationships around their leaders and employees. Positive outcomes emphasized movement from point of service outward. This differed from the more traditional, hierarchical method of moving from the "top" leadership of the organization downward to staff.

- In the late 1970s and early '80s, shared governance found its way into the healthcare arenas as a form of participative management. It engaged self-managed work teams and grew out of the dissatisfaction that nurses and other healthcare providers were experiencing with the institutions in which they practiced (McDonagh, Rhodes, Sharkey, & Goodroe, 1989; O'May & Buchan, 1999; Porter-O'Grady, 1995).

The professional practice environment of healthcare has shifted dramatically over the past generation (American Association of Colleges of Nurses [AACN], 2002; American Organization of Nurse Executives, 2000; Institutes of Medicine, 2011). Rapid advances are occurring in the following areas:

- Biotechnology and cyberscience
- Disease prevention, patient safety, and management
- Relationship-based care
- Patients' roles in their own healthcare (i.e., they are active partners and not just passive recipients)

Economic constraints related to service reimbursement and corporatism have forced healthcare systems to cost save by doing the following:

- Downsizing the professional workforce
- Changing staffing mixes
- Restructuring and reorganizing services
- Reducing support services for patient care
- Moving patients more rapidly to alternative care settings or discharge

Poor collaboration and ineffective communication among healthcare providers can lead to sometimes devastating medical errors. The struggle to provide safe, quality care in today's highly stressful— and sometimes highly charged—work environment has resulted in limited success in recruitment and retention of qualified providers nationwide (AACN, 2002; Kohn, Corrigan, & Donaldson, 1999; Weinberg, 2003).

Shared Governance and Professional Practice Models

As economic realities continue to shift and change, so does practice. Tim Porter-O'Grady (1987) observed the following: "Reorganization in healthcare institutions is currently the rule rather than the exception. All healthcare participants are attempting to strategically position themselves in the marketplace" (p. 281). This observation is still relevant, and developing an effective professional practice model for an economically constrained healthcare system to achieve positive outcomes, build workplace advocacy, and provide needed resources and support to improve recruitment and retention of a shrinking healthcare workforce is an even greater challenge today than it was in 1987 (Barden, 2009; Institutes of Medicine, 2011; Monaghan & Swihart, 2010; Porter-O'Grady & Malloch, 2010a; Swihart, 2011).

Anthony (2004) describes some of the models that have evolved to provide structure and context for care delivery in the reshaping of professional practice:

- Those based on patient care assignment (i.e., working in teams)
- Accountability systems (i.e., primary care practice)
- Managed care (i.e., case management)
- Shared governance, based on professional autonomy and participatory—or shared—decision-making (i.e., relationship-based care)

Koloroutis (2004) presents the integrated work of nurse leaders, researchers, and authors who have worked with a global community of healthcare organizations over the past 25 years. The result is a model for transforming practice that lends itself effectively to shared governance versus self-governance (see Figure 1.2 for an explanation of self-governance vs. shared governance) in today's complex healthcare systems: relationship-based care (RBC).

FIGURE 1.2	Self-governance vs. shared governance

Centralized Interactions (Self-Governance)

DECISION-MAKING

Decentralized Interactions (Shared Governance)

- Position-based
- Distant from point of care or service
- Hierarchical communication
- Limited staff input
- Separates responsibility; managers or supervisors are accountable
- We/they work environment
- Divided goals or purpose
- Independent activities and tasks

- Knowledge-based
- Occurs at point of care/service
- Direct communication
- High staff input
- Integrates equity, accountability, and authority for staff and managers
- Synergistic work environment
- Cohesive goals and purpose, ownership
- Collegiality, collaboration, partnership

The RBC model embraces a philosophical foundation and operational framework for providing health services through relationships in a caring and healing environment that embodies the concepts of partnership, equity, accountability, and ownership in shared governance.

Reflected in this model, shared decision-making occurs most effectively in a decentralized organizational structure where those at the point of service are granted the autonomy and authority to make and determine the appropriateness of their own decisions. "When staff members are clear about their roles, responsibilities, authority, and accountability, they have greater confidence in their own judgments and are more willing to take ownership for decision making at the point of care" (Koloroutis, 2004, p. 72). Decentralized decision-making is most successful when responsibility, authority, and accountability (R + A + A) are clearly delineated and assigned (Wright, 2002a) in shared governance.

Responsibility

Responsibility is the clear and specific allocation of duties to achieve desired results. Assignment of responsibility is a two-way process: Responsibility must be visibly given and visibly accepted. Acceptance is the essence of responsibility. However, note that individuals cannot accept responsibility without a level of authority.

Authority

Authority is the right to act and make decisions in the areas where one is given and accepts responsibility. When people are asked to share in the work, they must know the level of authority they have to carry out that work. Levels of authority are the right to act in areas where one is given and accepts authority based on the situation, and they must be given to those asked to take on responsibility. There are four levels of authority (i.e., ways to be clear in communication and delegation of that authority; Wright, 2002a):

- **Data gathering:** "Get information, bring it back to me, and I will decide what to do with it."
  - o Example, "Please go down and see whether Mr. Jones has a headache, and come back and tell me what he says."
- **Data gathering + recommendations:** "Get the information (collect the data), look at the situation and make some recommendations, and I will pick from one of those recommendations what we will do next. I still decide."
  - o **Example,** "Please go down and see whether Mr. Jones has a headache, and come back and tell me what you would recommend that I give him."
- **Data gathering + recommendations [pause] + act:** "Get the information (collect the data), look at the situation and make some recommendations, and pick one that you will do. But before you carry it out, I want you to stop (pause) and check with me before you do it." The pause is not necessarily for approval. It is more of a double check to make sure that everything was considered before proceeding.
  - o **Example,** "Please go down and see whether Mr. Jones has a headache, come back and tell me what you would recommend for him, and then take care of him for me."
- **Act and inform or update:** "Do what needs to be done, and tell me what happened or update me later." There is no pause before the action.
  - o **Example,** "Please take care of Mr. Jones for me."

Accountability

Accountability begins when one reviews and reflects on his or her own actions and decisions, and culminates with a personal assessment that helps determine the best actions to take in the future.

For example, in shared governance, a manager or supervisor is accountable for patient care delivery in his or her area of responsibility. The manager or supervisor does not complete all of the tasks but does provide the resources that employees need and ensures that all staff members deliver patient care effectively. In that patient care area, the manager or supervisor is accountable for setting the direction, looking at past decisions, and evaluating outcomes. Bedside providers and nurses, for example, are accountable for the overall care outcomes of assigned groups of patients for the time when they are there and for overseeing the big picture; however, other people (dieticians, therapists, pharmacists, laboratory technicians, and other healthcare providers) share in the responsibility for the subsequent tasks in meeting patients' needs.

Although definitions, models, structures, and principles of shared governance (sometimes called collaborative governance, participatory governance, shared or participatory leadership, staff empowerment, or clinical governance) vary, the outcomes are consistent. The evidence suggests that the benefits (see Tab 1.1 for more on the benefits and challenges) of implementation of shared governance and shared decision-making processes can result in the following:

- Increased employee satisfaction with shared decision-making related to increased responsibility combined with appropriate authority and accountability
- Increased professional autonomy with higher staff and manager or supervisor retention
- Greater patient and staff satisfaction
- Improved patient care outcomes
- Better financial states due to cost savings and cost reductions

TABLE 1.1	Benefits and challenges of shared governance	
Targets	Benefits	Challenges
For the patients, clients		
• Reduced mortality • Reduced morbidity • Increased patient and client satisfaction • Increased safety • Decreased "failure to rescue"	• Increased confidence in health-care providers • Reduced confusion or concern about care due to increased collaboration among providers • Decreased lengths of stay	• Appropriate delegation of authority, roles, and responsibilities for care • Willingness by providers and managers to share authority for decision-making at points of service
For organizations		
• Decreased length of stay • Decreased cost of staff replacement • Increased opportunity to market institution • Variable costs of implementation	• Increased retention of experienced care providers • Anticipatory change • Broad-based horizontal relationships among systems • Balance between service accountability and system accountability • Fewer levels of management • Involved stakeholders (e.g., for resource-based decisions) • Decisions reflect organizational mission, priorities, and goals	• Resources (fiscal, human, and material) for sustained shared governance • Resistance of managers to support staff through shared leadership (i.e., shared authority) • Obstacles to autonomous point-of-service decision-making that may exist within the organization • Transfer of influence and control away from senior and middle managers alone to include point-of-service staff
For healthcare providers		
• Lower turnover • Lower vacancy rates • Lower "burnout" rates • Lower emotional exhaustion • Decreased work-related injuries • Better interprofessional relationships • Higher employee satisfaction • Higher healthcare provider-to-patient ratio • Decreased medical errors	• Increased professionalism and accountability • Interdependent relationships among healthcare providers • Shared accountability, ownership, equity, and engaged partnerships • Increased collaboration and collegiality related to mutual trust, respect, and shared decision-making • Increased control over practice and decision-making related to competence, quality, safety, service, and practice	• Training and development of councils and council participants • Release from routine duties to participate in councils • Seeing shared governance as a "nurses-only" process that does not impact fiscal or clinical activities or outcomes for other providers • Confusion about roles and responsibilities associated with shared governance

Shared Governance and Relational Partnerships

The best [leader] is the one who has sense enough to pick good [people] to do what he wants done, and self-restraint enough to keep from meddling with them while they do it.
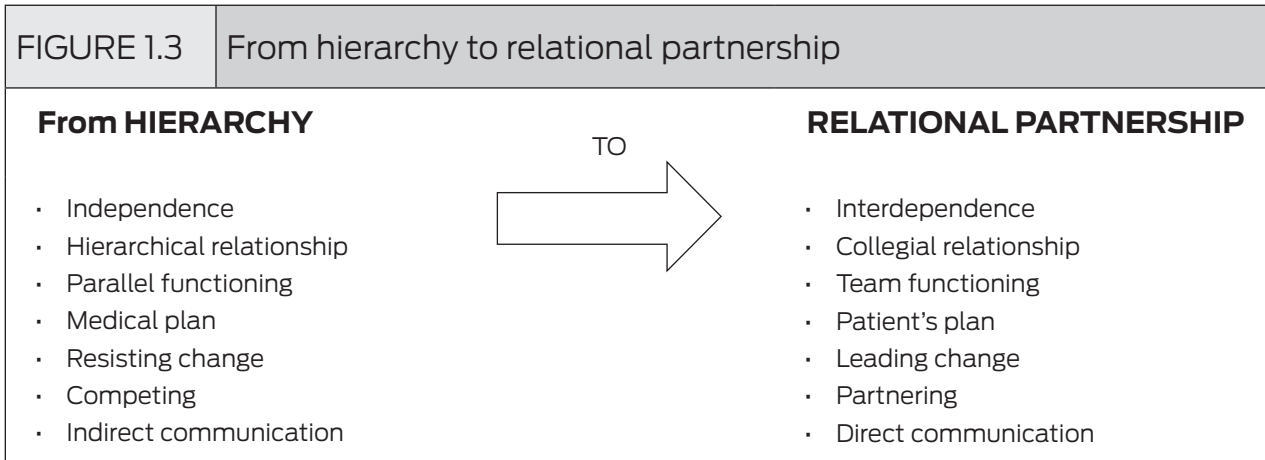*—Theodore Roosevelt*

Professional nurses long ago identified shared governance as a key indicator of excellence in professional practice (McDonagh, Rhodes, Sharkey, & Goodroe, 1989; Metcalf & Tate, 1995; Porter-O'Grady, 1987, 2001, 2004, 2009a, 2009b, 2009c). Porter-O'Grady (2001; 2018) described shared governance as a management process model for providing a structure for organizing work within organizational settings. It allows for strategies that empower providers to express and manage their practice with a greater degree of professional autonomy. Personal and professional accountability are respected and supported within the organization.

Leadership support for point-of-service staff enables them to maintain quality practice, job satisfaction, and financial viability when partnership, equity, accountability, and ownership are in place (Anthony, 2004; Green & Jordan, 2002; Koloroutis, 2004; Page, 2004; Porter-O'Grady, 2003a, 2003b; Porter-O'Grady & Malloch, 2010a, 2010b, 2010c).

Today's transformational relationship-based healthcare creates a new paradigm with different goals and objectives in organizational learning environments, driven by technology. Leaders, administrators, and employees are learning and implementing new ways of providing care, new technologies, and new ways of thinking and working. In the process, they recognize more and more that the healthcare provider at the point of service is key to organizational success associated with changing the environments of care.

Health providers, managers and supervisors, interprofessional partners, and organizational leaders must be prepared for new roles, new relationships, and new ways of managing. Shared governance is about moving from a traditional hierarchical model to a relational partnership model of practice (see Figure 1.3).

FIGURE 1.3	From hierarchy to relational partnership

From HIERARCHY   TO   **RELATIONAL PARTNERSHIP**

- Independence
- Hierarchical relationship
- Parallel functioning
- Medical plan
- Resisting change
- Competing
- Indirect communication

- Interdependence
- Collegial relationship
- Team functioning
- Patient's plan
- Leading change
- Partnering
- Direct communication

Successful relational partnerships in collaborative interprofessional and multidisciplinary team practice require understanding the roles of each partner. If the partners are not aware of what each brings to the relationship, then they will have considerable problems collaborating, acting responsibly, and being accountable for decisions and care. Therefore, relational partnerships can be a complex and challenging framework for the shared governance professional practice model (Green & Jordan, 2017; Porter-O'Grady & Hitchings, 2005; Porter-O'Grady & Malloch, 2010a).

The key provider at point of service moves from the bottom to the center of the organization, becoming the only one who matters in a service-based organization: the one providing the care. Frontline employees who do the work connect the organization to the recipient of its service at the point of service. An entirely different sense and set of variables now affect the organization's design. The paradigm at point of service has shifted to a relationship-based, staff-centered, patient-focused professional practice model of service in which managers or supervisors assume the role of servant leaders managing resources and outcomes within the context of relational partnerships (Nightingale, 1992).

Patient-centered care differs from patient-focused care. The Institute for Healthcare Improvement (IHI) describes patient-centered care in the following way:

> Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their loved ones integral parts of the care team who collaborate with healthcare professionals in making clinical decisions. Patient-centered care puts responsibility for important aspects of self-care and monitoring in patients' hands—along with the tools and support they need to carry out that responsibility. Patient-centered care ensures that transitions between providers, departments, and healthcare settings are respectful, coordinated, and efficient. When care is patient centered, unneeded and unwanted services can be reduced. (IHI, 2011)

IHI supports shared governance in recognizing the multifaceted challenges in advancing patient-centered care and encouraging organizations to identify best practices and systems changes in three areas:

1. Involving patients and families in the design of care

2. Reliably meeting patient's needs and preferences

3. Participating in informed shared decision-making

Healthcare research is guiding the development of initiatives for "reorganizing the delivery of healthcare services around what makes the most sense for patients" (Institute for Medicine, 2001; 2010; 2011, p. 51). A few examples of patient-centered care initiatives include the following:

- Patient-centered medical homes (Swihart, 2016)

- Transforming care at the bedside (TCAB)

- Primary care (rather than specialty physician care)

- Midwives and birth centers

- Parish nursing

- Forensic nursing

- Telehealth

- Community outreach (e.g., Program for All-Inclusive Care for Elders; *www.npaonline.org*)

- The transitional care model (Institute of Medicine, 2011)

Patient-focused care refers to the caregiver's ability to focus his or her education, experience, and expertise on caring for the patient at the point of service and to facilitate organizational and community patient-centered care. To do so, caregivers must have managers or supervisors who are servant leaders functioning differently in newly delineated roles (as agent or representative, advocate, ambassador, executor, intermediary, negotiator, proctor, promoter, steward, deputy, and emissary) and transforming practice settings in which patient-focused care occurs. Relational partnerships are built with equity, and in such relationships, the value of each participant is based on their contributions to the relationship rather than on their positions within the healthcare system.

Although frontline staff members are key to recruiting other employees, managers and supervisors are key to retaining them. Collateral and equity-based process models of shared governance define employees by the work they support rather than by their location or position in the system. For example, the manager or supervisor in the servant—or transformational—leader role provides human and material resources, support, encouragement, and boundaries for the employee in the service-provider role. Health providers, then, are accountable for key roles, decisions, and critical patient care outcomes around practice, quality, and competency.

Summary

Strong interprofessional collaborations with diverse professional perspectives based on variances in education, experience, and philosophy are essential to be successful in providing point of care services, as in the following cases:

- RNs bring a holistic (whole-istic) approach to care, managing diseases and disorders while considering psychosocial, spiritual, family, and community perspectives
- Pharmacists bring expertise in pharmacodynamics
- Physicians bring a more focused approach to diagnostically managing diseases and disorders with expertise in physiology, disease pathways, and treatments (Institute of Medicine, 2011)

Shared governance as an organizational management process model for reshaping practice and decision-making requires a transformational shift with strategic change in organizational culture and leadership through collaboration with interprofessional partners and multidisciplinary team members. Implementation demands a significant realignment in how leaders, employees, and systems transition into new relationships, responsibilities, and accountabilities. It begins with operationalizing the definitions and objectives, building relationships, and creating the design.

Shared Governance

A Practical Approach to Transforming Interprofessional Healthcare, Fourth Edition

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Robert G. Hess, PhD, RN, FAAN

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