Oncology Issues

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ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: Marsha Prater (1994) Leadership and Management in a Shared Governance System, Oncology Issues, 9:1, 17-21, DOI: 10.1080/10463356.1994.11904448

To link to this article: https://doi.org/10.1080/10463356.1994.11904448

Published online: 18 Oct 2017.

Leadership and Management in a Shared Governance System

by Marsha Prater, Ph.D., R.N.

Contemporary authors have found that successful organizations are moving from authoritarian organizational structures to more participatory structures.[1,2,3] Over the past 10 years, many nursing organizations have chosen to implement shared governance models as a means to promote employee participation in decision making, involve employees in governance issues, and provide autonomy in professional nursing practice. Although the concept of shared governance has not been explicitly defined thus far in the literature, the name implies the allocation of control, power, or authority (governance) among mutually (shared) interested and vested parties.[4]

In nursing, the vested parties include those who practice nursing by providing direct patient care (staff nurses) and those who manage settings in which clinical nursing care is provided (administration/management). The work or practice of nursing within a shared governance system is facilitated by a matrix of staff councils or representative bodies empowered with the authority and accountability of decision making for the profession (Figures 1 and 2). Management assumes accountability for issues within its control, whereas the professional staff is accountable for the definition, delivery, and evaluation of its practice.[4]

Descriptions of the various models of shared governance, as well as strategies for implementation of the new systems, are plentiful in the nursing literature. It is important to remember, however, that there is no one right way to structure a shared governance system within an organization.[5] Each organization must individualize the structure and processes to fit the climate, culture, and professional needs of the organization.

Implementing shared governance involves a system-wide shift, not only in organizational structure, but in the basic beliefs and management philosophy of the organization itself.[6] Due to the magnitude of this transformation, it has been reported that a complete transition from a traditional bureaucratic structure to a shared governance model requires approximately three to five years.[5]

ACHIEVING SUCCESS

There are at least seven components that are critical to a shared governance system.

- Staff are selected by their peers to leadership positions.
- Clinical nursing staff are given accountability for all issues relating to nursing practice (i.e., standards, quality assurance, peer processes, etc.)
- Nursing management is accountable for the provision of necessary financial, human, and material resources for the nursing staff to do its work.
- The role of the clinical nurse is acknowledged as central to the hospital's mission of providing excellence in patient care.
- Bylaws or rules define the operations and structure of the nursing organization. These provide a clear definition of roles and accountabilities within the department of nursing.
- Clinical staff are represented at the executive level of the department of nursing.
- There is a well-defined process for members of the department to meet to review pertinent issues in the work of the department.

Much of the success of shared governance depends on the perceptions and contributions of managers at all levels of the organization.[7] The nurse executive must be completely committed to the concept of shared governance and all that the term implies. He or she becomes an essential role model for the new leadership behaviors and must be willing and able to articulate to administrative peers the reasons and purposes for creating a different organizational system. The success of the nurse executive at doing so has implications for ongoing interdepartmental communications and problem resolution processes within the organization. The nurse executive must also be willing and able to undergo personal changes and provide a developmental program for others in the organization that will facilitate both

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personal and leadership change.

One key to successful implementation of a shared governance system is management support at the unit level.[8] The unit manager must have a thorough understanding of the concept and common principles on which shared governance is based. Before full implementation of the system, an adequate knowledge base of leadership behaviors, facilitation skills, conflict resolution, and team building processes should be in place. The unit manager must be able to give staff permission to make decisions and assist them in doing so.

The unit manager must provide an environment that emphasizes group/team values and process and be willing and able to undergo personal and professional change and to lead similar changes in the staff.[7] Without major shifts in the traditional way in which managers have managed, conflicts are sure to arise between staff and management regarding authority and decision-making realms.

Several key activities should be implemented to prepare managers in the organization for the essential shift in their role from one of management to one of leadership.[7] First, a database of shared governance literature should be established in an easily located area of the organization to facilitate managers' access to the latest information on shared governance processes. Second, each manager should be guided through a review of personal and professional values and how those values influence leadership behaviors. It is important to clarify those values that are necessary for success of a shared governance environment, for example, collaboration/teamwork, value of interpersonal relationships, and beliefs that employees want to make a difference. Finally, formal and informal discussions can help

Communication is the key to success within a shared governance system.

managers better understand how to transition to a new role and develop the competencies and confidence of a leader.

MOVING TOWARD MENTORING

The essence of a manager's new role is mentoring. A mentor coaches, inspires, and supports the growth and development of individuals. The role of a mentor is to foster employee development through socialization and skill development.[8] The behaviors of a good mentor include stimulating enthusiasm, maintaining high expectations, being approachable, encouraging risk taking, and helping people learn from mistakes.

Motivated, committed clinical staff are no less essential than committed executives and managers to the success of shared governance. In a shared governance system, the clinical staff are leaders in the full essence of the word, and thus must have assistance in developing the leadership behaviors to make them successful. Clinical staff must have access to as much information as possible about the shared governance process. The required formal and informal education should initially be targeted at the individuals who are actively involved in the council structures. However, this education and information should be disseminated in a timely manner to all care givers who will be affected by the value and philosophy changes of the organization.

The ongoing role of management in a shared governance system is focused on providing and managing the resources necessary to support patient care, mentoring competent

Figure 1: Staff councils within the shared governance system

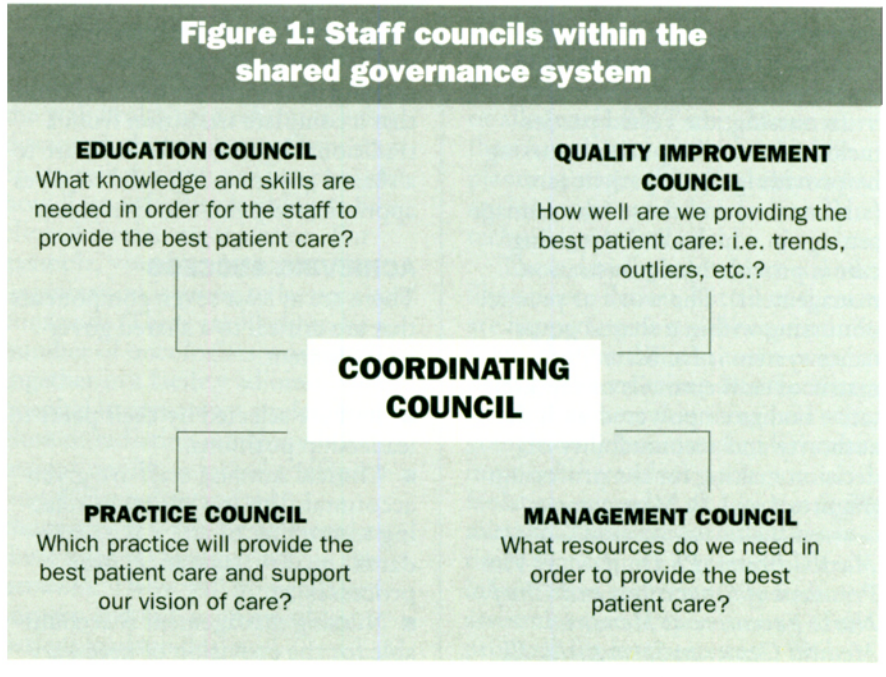
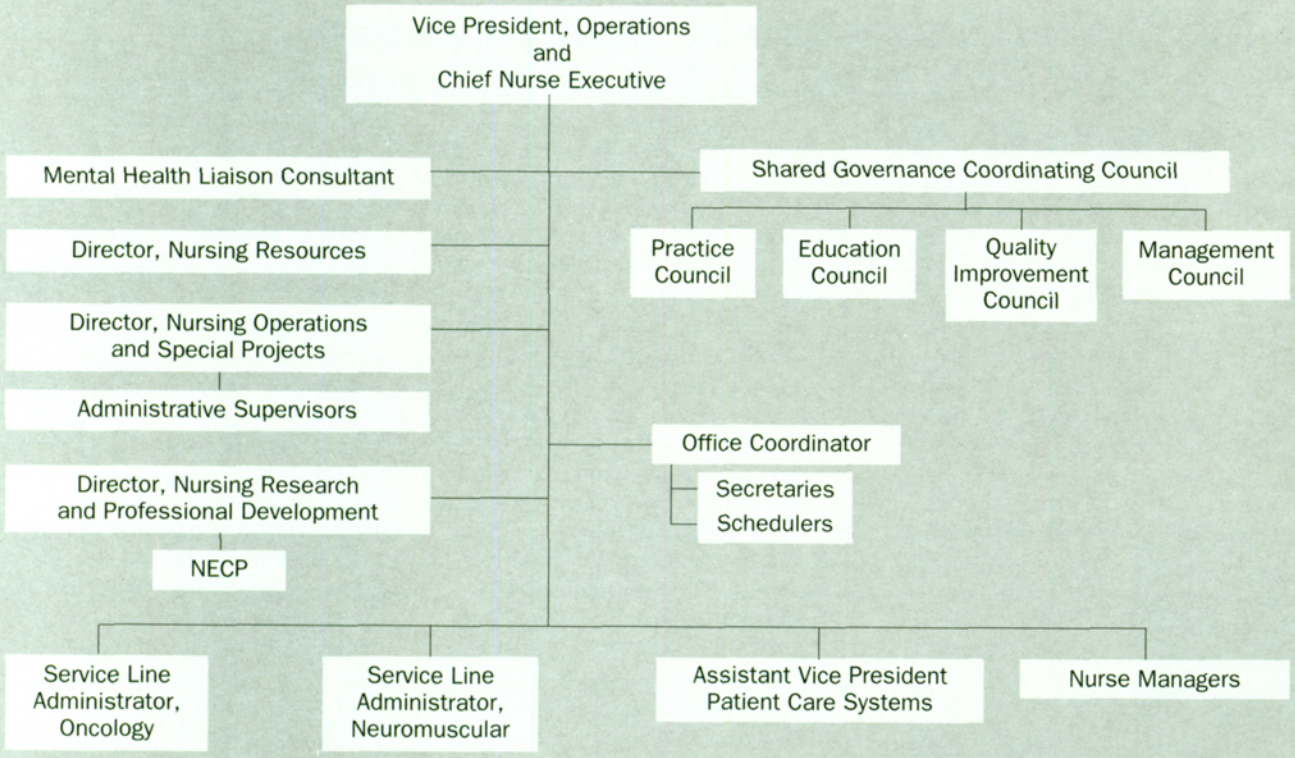


Figure 2: Matrix of staff councils within the organizational framework



and adequate staff, and representing and connecting corporate goals to clinical staff. The decision-making realms of the management team continue to be strategic planning, fiscal management and accountability, areas that can be considered within the collective bargaining realm (i.e., hours, wages, benefits), and disciplinary action and processes. While the manager maintains final decision-making responsibility and accountability for these particular areas within the shared governance system, it is appropriate that staff are asked for input. After all, they will be affected by the decisions that are made.

OVERCOMING THE OBSTACLES

There are several possible obstacles to implementing a shared governance system within traditionally bureaucratic health care organizations.[9] Shared governance demands a willingness to build on trust and to create trust when it is not present. Inconsistencies in the management team regarding management/leadership concepts and behaviors can be extremely problematic because clinical staff may hear managers espouse the values of shared decision-making processes and yet observe the continuation of the autocratic behaviors of the past. In addition, staff may be divided in their willingness to be involved in decision making. Critics and skeptics seem to be numerous. It is often easy to procrastinate, waiting for the right time for implementation due to the magnitude of the transformation change process involved. Moreover, there is a prevalence of generally negative reactions to "mistakes" that are made at the start of any new venture.

Communication is the key to success within a shared governance system. Information must be abundantly shared with all levels of care givers and managers. It is essential that everyone understand the magnitude of the transformation process. The development of staff and managers up front is time-consuming, but essential. And finally, extreme patience is demanded from all involved to let the change process run its course. Change of this kind will result in a significantly altered work place and culture. The outcome is a much broader orientation to accountability and corporate/professional responsibility.[7]

REFERENCES

[1]Peters TJ, Waterman RH: In *Search of Excellence*. New York: Harper and Row, 1982.

[2]Naisbitt J, Aburdene P: *Megatrends 2000*. New York: William Morris and Company, 1990.

[3]Porter-O'Grady T, Finnigan S: *Shared Governance for Nursing: A Creative Approach to Professional Accountability*. Rockville, MD: Aspen Publishers, 1984.

[4]Stichler JF: A conceptual basis for shared governance. In *Implementing Shared Governance: Creating a Professional Organization*. T. Porter-O'Grady. St. Louis, MO: *Mosby Year Book*, 1992, p. 1-24.

[5]Foster BE: Models of shared governance: design and implementation. In *Implementing Shared Governance: Creating a Professional Organization*. T. Porter-O'Grady. St. Louis, MO: *Mosby Year Book*, 1992, p. 79-110.

[6]Krejci JW, Malin S: A paradigm shift to the new age of nursing. *Nursing Administration Quarterly* 13(4):40-47, 1989.

[7]Porter-O'Grady T: *Shared Governance Implementation Manual*. St. Louis, MO: *Mosby Year Book*. 1992.

[8]Smith S: Nursing staff roles in unfolding shared governance. In *Implementing Shared Governance: Creating a Professional Organization*. T. Porter-O'Grady. St. Louis, MO: *Mosby Year Book*, 1992, p. 111-140.

[9]Campbell CC: Redesigning the nursing organization. In *Implementing Shared Governance: Creating a Professional Organization*. T. Porter-O'Grady. St. Louis, MO: *Mosby Year Book*, 1992, p. 53-78.

What Shared Governance Really Means: Interviews with Staff at Memorial Medical Center in Springfield, Ill.

Cathy Schwartz, *R.N., M.S., Professional Nursing Practice Coordinator, acts as liaison with all units in Memorial Medical Center that are participating in shared governance.*

"The principle behind shared governance is that those who provide a service are the ones who are the experts as to what that service needs to look like. Because nursing staff are the ones who know how nursing care should best appear, they should be involved in the decisions that shape that practice.

Shared governance is not self-governance. Staff can make decisions about practice issues—issues that concern patient care. They cannot decide administrative or corporate goal setting, fiscal management, allocation of resources, discipline, or wage issues. They may provide input into these issues, but the accountability for the final decision lies with management or administration.

We have learned much about the shared governance system over the last three years. Initially, some staff were not willing to participate because they feared the system was not here to stay and consequently not worth the time nor the energy. Turnaround time for decisions to be made were taking many months. Some staff believed if they were not on a council then they were not a part of shared governance.

Starting in January 1993, we decided to put a new emphasis on unit councils because that is where practice takes place. Now 28 units are participating in our shared governance councils. To foster open communication and an environment in which everyone's voice is heard, each council member meets with four or five unit colleagues to discuss issues before and after council meetings. Decisions are starting to be made quicker.

There is staff accountability for decisions. Before, if the nurses did not like a practice decision they could point fingers to somebody outside. Now, they are the ones making decisions. Some find this difficult and uncomfortable.

Decisions, of course, are not made in a vacuum. Few practice issues affect only nursing. Although nurses may be coordinators of patient care, they need to identify who else—including physicians—will be affected and get them involved in the decision-making process.

What is needed for successful implementation of a shared governance system? An up-front, honest commitment from the administration and an openness in the management team. Those who believe in an autocratic bureaucracy will not do well. Flexibility is important. For example, before shared governance, visiting hours in intensive care were severely restricted. Some nurses saw this as a violation of holistic care. Under shared governance, they now had the authority to establish open visiting hours and they did.

Finances are a factor, too. It costs money to pay for meeting times. These costs, however, may be recouped. For example, since the initiation of our shared governance system our nurse turnover and vacancy rates have dropped drastically. Recruitment and replacement can cost $15-30,000 per nurse, depending on the specialty. Thus, by impacting our turnover, we have recouped costs. And, by the way, not only do surveys show increased nurse job satisfaction, they also show increased patient satisfaction."

Teresa Foster, *R.N., is a staff nurse in admissions.*

"Finally, nurses on the floor are taking more control. They have a greater role in deciding what's happening with patients, with themselves, and with nursing as a profession. In this admissions unit, for example, we decide as a group the type of patients that are best suited to come through this area. Instead of being told what we must monitor, we discuss and decide which patient care issues to monitor.

I don't see much resistance to implementing shared governance. That may be because we are a small unit of only eight individuals. We have probably been doing shared governance even before the term existed. In a small unit, everyone has

to participate in decision making.

Shared governance has given me more confidence. I know that I can affect decisions. Not only can I express my opinions more readily, but someone will listen. Although my suggestions may not be totally embraced, I am more accepting of decisions, knowing I had the opportunity to voice my opinions."

Celeste Wiley, *R.N.C., O.C.N., is a staff nurse in the oncology unit.*

"Shared governance means more responsibility, more accountability, and more personal input. When I began my nursing career in the 1970s, there was a vertical chain of command. Now we use a lateral model and gain support and guidance from several areas—without administration dictating our practice.

For example, one recent issue that our Practice Council has discussed is whether to wear a special gown during IV push chemotherapy. Instead of my nurse manager making the decision herself, our Practice Council did a literature search, which indicated that OSHA and the Oncology Nursing Society recommend wearing a gown with chemo. We will present this information to the staff through our unit Coordinating Council and suggest having gowns available for use in such situations.

Another topic under discussion has been central lines and 24-hour continuous chemotherapy. From our literature search, direct connect of the IV tubing to the open hub of the central line is the preferred practice. Our actual practice has involved a male adapter attached to the hub and a needle on the end of IV tubing. The literature indicated some instances of spills, as well as the potential for leaks, with this approach. Our own unit did experience such a situation, so many believed the direct connect method would be safer. Since this change would affect the nursing practice, we want the staff to try it for a specific period and give the council written feedback on this change.

In the old days, the Staff Education Department had major responsibility for keeping the nursing staff up to date on skills, new technology, and new drugs. Now, our unit Education Council has that responsibility. In other words, the responsibility for nursing education has moved from a house-wide department (Staff Education) to a unit-based group. The benefit is that the training is more unit-specific and unit-oriented. I need to know about new chemotherapy drugs, for example, more than I need updates on cardiology medications. We still have the Nursing Education and Clinical Practice Department as resources, as well as our oncology nurse specialist.

Not all staff will eagerly support the system of shared governance. Clearly, there is resistance from some staff who favor the traditional and institutional way of nursing. They are likely more task driven in delivering their care. The shift is to a more holistic approach, looking at the needs of the patient and the family.

There is definitely more work now, but it is gratifying to know that I have a voice. Being involved with shared governance pushes me to learn and know more."

Karen Claycomb *is a clinical staff nurse and chairperson for the Nursing Practice Council.*

"Things are somewhat different since the implementation of shared governance. We have lost a little of the 'we vs. they' concept. Bedside nurses always thought of themselves as 'we,' the person who cares for the patient and looks for the positive outcomes. 'They' were thought of as the dollar sign person, who sometimes stood in the way of the positive outcomes. All 'they' cared about, we thought, was productivity and the dollar balance.

Now, we have learned that productivity has a real effect on patient care and consumer satisfaction. When we are more productive, we see a benefit to the patient outcomes. Before shared governance, we didn't always understand what all the numbers meant and never knew how numbers affected consumer satisfaction and outcomes. Although we are not perfect at it yet, we are learning to respect those numbers as just another factor in health maintenance.

The acuity system of rating patients' treatment needs is a concrete example of how things are changing for the better. Before shared governance, bedside nurses thought acuity was their enemy because it structured their time too much. After working with managers and clinical and computer specialists, we completed work studies allowing us to appreciate the amount of time patient care takes under various circumstances. We are working to restructure our acuity system to reflect what we found. We developed more respect for each other and stopped blaming others. After all, we are part of the decision-making process now. It can be a win/win situation for the bedside nurse, the administrator, and the patient."

Wilfred Lam, *M.D., is Program Director of Cardiology*

"It's difficult to tell what the influence of shared governance is, because so many other factors have intervened over the last two years in which the system has been in place. For instance, one of our cardiac floors has had problems. Although things are much better now, I wouldn't be able to say whether the improvements are due to shared governance or to hiring a better nurse manager. Another unit, the open heart unit, works very well, but it was working well before shared governance.

I don't know of any drawbacks to shared governance. A lot of the administration at our hospital has come through the nursing realm. The chief operating officer was head of nursing and a nurse herself. That makes nursing and administration all in one."