

Shared Governance in a Clinic System

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Disclaimer: The authors report no conflict of interest. The authors were not compensated for the study.

Abstract

The purpose of this project was to describe and evaluate the process of shared governance implementation in a clinic system. Shared governance in healthcare empowers nurses to share in the decision making process, which results in decentralized management and collective accountability. Shared governance practices have been present in hospitals since the late 1970's; however, shared governance in ambulatory care clinics has not been well established.

The subjects of this project included staff and administrative nurses in a clinic system. The Stakeholder Committee chose what model of shared governance to implement and educated clinic staff. The Index of Professional Nursing Governance (IPNG) measured a shared governance score pre and post implementation of the Clinic Nursing Council (CNC). The CNC met bimonthly for three months during this project to discuss issues and make decisions related to nursing staff.

The IPNG scores indicated traditional governance pre and post implementation of the CNC, which is to be expected. The stakeholder committee was beneficial to the initial implementation process and facilitated staff nurse involvement. Shared governance is an evolutionary process that develops empowered nurses and nurse leaders.

Key Words (3-5): Clinical Governance, Ambulatory Care, Nurse Administrator, Shared Governance, Nurse Leadership

Shared Governance in a Clinic System

Shared governance models provide a structure for nurses to have a voice in decision making, policy development and an ability to manage their practice with high levels of autonomy (Styer, 2007). These characteristics provide a foundation for professional practice that results in positive outcomes involving improved patient and staff engagement, decreased turnover among nurses and managers (Swihart, 2011; Styer, 2007; Overcash, Petty, & Brown, 2012). Although evidence demonstrates positive outcomes, the prospective influence of shared governance is difficult to estimate as the percentage of health systems with shared governance is unknown. The development and growth of shared governance has been cited primarily within hospital systems, a significant gap in evidence exists regarding shared governance within ambulatory care systems.

Nursing administrators facilitate the development, formation, and sustainability of shared governance structures in their organizations. Organizations develop their shared governance structure based on three common models to include the councilor, congressional, and unit-based models. The councilor model is the most common and consists of a general coordinating council and topic-specific councils, such as education or quality improvement. The topic-specific councils function independently of the coordinating council and include representatives from multiple units of the organization. The congressional model is composed of an elected congress or senate that delegates to topic-specific councils that report back to the congress. Unit-based models are the least common and are confined to the individual unit, which has a shared governance council as well as topic-specific councils (Swihart, 2011).

Formation of shared governance requires administrators to give authority to nursing staff to make decisions, and requires staff to accept responsibility and accountability for outcomes

(Swihart, 2011). Managers empower staff to be informal leaders through mentoring and leading with a lateral approach rather than dictating decisions (McDowell et al., 2010). Nurses are mentored by their supervisors to take ownership through empowerment, autonomy, and competence (MacPhee et. al., 2012). Communication and decisions are fluid among staff and management to facilitate shared decision making for the benefit of patients and the organization. Mentoring includes reflection with staff nurses to facilitate evaluation of decisions in situations that resulted in both optimal outcomes and less than optimal outcomes.

Sustainability of shared governance is an evolutionary process that begins with the development of empowerment. The process begins with administrators making the majority of decisions while they mentor staff nurses. As nurses gain confidence and competence, the administrators make less of the staff nurse appropriate decisions. Eventually, the staff nurses become self-directed and have authority to make decisions that are specific to the various nursing councils (American Nurses Association, 2014). Shared governance councils may begin by focusing on nurse specific issues then transition to address patient-centered issues, incorporate evidence based practice into decisions, and direct policy and practice standards (Malleo & Fusilero, 2009). The continuum of the evolutionary process depends on continuous education regarding shared governance, CNE support, and openness to change (McDowell et al., 2010; Malleo & Fusilero, 2009). As nurses become empowered, the shared governance evolutionary process continues.

Empowerment as a Concept in Shared Governance

Empowerment theory and the underlying concepts of structural and psychological empowerment supported the premise of shared governance implementation within the

ambulatory care clinic system. Empowerment is facilitated through power and resources that are meaningful to complete work and is integrated into shared governance structures. Nurses and managers must have access to information, adequate resources, and support to function with empowerment. Empowered nurse managers facilitate an environment that direct care nurses feel empowered (Spence Laschinger, Gilbert, Smith, & Leslie, 2010). Structural empowerment influences the extent of psychological empowerment (MacPhee Skelton-Green, Bouthillette, & Suryaprakash, 2012). Psychological empowerment is the nurse's perception of how they interact with their work environment (Faulkner and Laschinger, 2008). Evidence has shown that structural empowerment significantly influences psychological empowerment and results in nurse loyalty to the organization, job satisfaction, and leadership qualities (MacPhee et al., 2012). The purpose of this project was to facilitate implementation of a shared governance structure in an ambulatory care clinic system. The project involved 1) formation of a stakeholders group with registered nurses, nurse supervisors, and the Chief Nurse Executive; 2) implementation of stakeholder and staff education; 3) development of a specific model for the clinic system; 4) a pre and post assessment of shared governance using the Index of Professional Nursing Governance (IPNG); and 5) evaluation of the implementation process.

Initial Stages of Shared Governance Implementation

The initial stages of shared governance implementation involved selection of a stakeholder committee, stakeholder committee education on shared governance and development of the shared governance process. The selection of the stakeholder committee was critical to the initial phase of the shared leadership implementation process which included the design of the model, as well as the selection and education of ambulatory clinic staff. Three direct care nurses

from different clinics, two nurse supervisors from different clinics, the Chief Nurse Executive, and the Doctor of Nursing Practice (DNP) student composed the stakeholder committee.

The stakeholder committee met six times over the course of two months. The initial meetings involved SG education by the DNP graduate student. The stakeholders then developed a model specific to the ambulatory clinic system and provided five education sessions over a two month period prior to formation of the Clinic Nursing Council (CNC). Formation of the CNC involved a process of self-nomination from the following clinics, Pediatrics, Ear, Nose, and Throat, Orthopedics, Internal Medicine, Asthma and Allergy, and Gastroenterology, and representatives were chosen by the stakeholder committee. Once the CNC was formed, the stakeholder committee dissolved.

The shared governance model consisted of clinic and management representation on the CNC to facilitate communication throughout the organization (Figure 1). The stakeholders chose to combine clinics that only had one or two nurses. Ophthalmology was grouped with Ear, Nose, and Throat; Neurology was grouped with Orthopedics; and Obstetrics was grouped with Internal Medicine. The number of representatives per area was based on the number of clinics in that specialty and established nurse communication between clinics. For example, six pediatric nurses sit on the council to represent the six different pediatric clinic locations.

Clinic Nursing Council

The CNC is composed of thirteen staff nurses, two nurse supervisors, and the CNE. The council voted in a staff nurse to the Chair of the council, who was responsible to lead the meetings and set the agenda with the assistance of the Co-chair. The two nurse supervisors decided amongst themselves who would be the Co-chair at the request of the CNE. The

representatives served as a resource to bring issues of staff nurses to the council and administration as well as disperse information and decisions to staff. The goal was to create a structure to share decision making authority between staff nurses and administration.

The CNC evolved in the first three months to fit the needs of the clinic system. The council decided to meet every two weeks over the lunch hour and establish video conferencing between two clinic sites on the East and West sides of town, approximately thirty minutes driving time apart. Nurses were able to choose which site they were present at depending on their clinic location and clinic schedule. The CNC also formalized a voting process and created a fluid document of ground rules that will be used to establish bylaws in the future and to facilitate resolution of clinical practice issues.

The CNC had an opportunity to engage in decision making regarding clinical practice issues. Clinical issues were brought forward by administration and direct care nursing staff included standardization of personal protective equipment cabinets, institution of patient juice and crackers that can be used if a patient is symptomatic during procedures, and Joint Commission issues of first patient contact and pharmacy mat. The members of the CNC worked together to ask questions and arrive at solutions with the input of staff nurses.

Measuring Shared Governance

Measuring organizational characteristics of shared governance at baseline and at established time periods post shared governance implementation is an important part of the established process. The Index of Professional Nursing Governance (IPNG) has been utilized to measure characteristics of shared governance among nurses since the 1990's (Swihart, 2011; Overcash, Petty, & Brown, 2012; Barden, Griffin, Donahue, & Fitzpatrick, 2011). The IPNG

can assist in identification of the specific characteristics evolving toward shared governance. The 86 question IPNG measures total shared governance and six subscales derived from a factor analysis which includes personnel, information, resources, participation, practice, and goals. Reliability for each factor ranged 0.84 to 0.96 (Hess, 2010). Personnel focuses on who controls hiring and termination, salaries, benefits, and budgets. Information relates to who has access to satisfaction or opinion surveys, budget information, department goals, and organizational strategic plans. Resources pertain to who has influence over what supplies are needed, consultation of services, and daily duties. Participation addresses who is involved on organizational or departmental committees that make decisions on policies, staffing, and goals. Practice involves who controls decisions regarding professional standards, policies, quality improvement, education, and utilization of evidence based research. Finally, goals pertain to who determines the goals and the conflict resolution process. Traditional governance is a total score between 86 and 172, which indicates that administration makes decisions. Shared governance scores are between 173 and 344, and administration shares decision making with nurses. Total scores 345 to 430 indicate self-governance and staff nurses alone are responsible for decisions in the organization (Hess, 2010).

The IPNG was distributed via email to all registered nurses prior to CNC implementation and at 3 months post CNC implementation using Survey Monkey. Participation was voluntary and anonymous. Baseline data was gathered for this clinic system using Hess's IPNG tool pre CNC implementation and three months post CNC implementation. An evaluation of the process was also distributed to nurses via email with Survey Monkey that included questions regarding the benefit of the stakeholder committee, empowerment, representation, and composition of the CNC at three months post implementation.

Results

Response rate for the pre-IPNG was 60.7% and the post-IPNG was 38.2%. For this project, Cronbach's alpha scores for the pre-assessment was 0.93 and the post-assessment was 0.96, indicating high reliability. The participants were women with the majority staff registered nurses who worked full-time (see Table 1). The independent t test was calculated for total governance and for each of the subscales. Baseline data revealed the organization had a traditional governance with a governance score of 140. Sub-scales, personnel, information, participation, practice, and goals indicated traditional governance as well pre and post CNC. Resources score was 29.33 in the pre CNC, which is in the range of shared governance (27-52) but was 26.17 and in the traditional governance range in the post CNC IPNG. However, the change of Resources score was not significant. No significant change was present in the total governance scores or the remaining five sub-scale governance scores pre and post CNC implementation, although participation approached significance (Table 2).

A paired t test was calculated by matching twenty-three surveys with demographic data, including age, degree, and years in nursing. The Participation score significantly changed toward shared governance ($p=0.0148$) (Figure 2).

The administrative and staff nurses who completed the open-ended evaluation communicated that the Stakeholder Committee was an effective approach to plan the implementation of the ambulatory clinic's shared governance structure and the nurses were well represented within the CNC. However, participants were divided when asked if they felt empowered by the CNC and if they had a voice in decision making. Nurses felt that administration had a too strong of a presence and too strong of influence over agenda at the CNC

meetings. Some nurses shared they could not openly voice their concerns or ideas due to administrative presence at the meetings.

Discussion

As expected, results showed traditional governance was established and supported with the evaluation. During the beginning stages of shared governance implementation, the ambulatory clinic system scores of total governance indicated that administrators were responsible for making decisions and were moving toward shared governance with the implementation of the CNC. The CNE and two nurse supervisors were present on the CNC to mentor and facilitate staff nurses to evolve into informal leaders in the organization. Administrators mentor staff nurses through education and shared decision making (Malleo & Fusilero, 2009). The stakeholder committee was useful to plan and provide education on the shared governance structure. Administrators and staff nurses were able to collectively plan the implementation process and educate staff about shared governance. In correlation with the initial stages of shared governance, nurses started to feel empowered by the CNC and that they had a voice in decision making (American Nurses Association, 2014). Results showed the participation score approached significance with the independent t test and significantly changed with the paired t test, which can be correlated with the implementation the CNC. Shared governance is new to ambulatory clinic systems and is an evolutionary process.

Over time, shared governance structures evolve and empower nursing staff. Healthcare organizations increase nurse-driven quality improvement efforts, nursing professionalism, and optimize nurse leaders. The nurses then influence the organization as shared governance core

concepts are ingrained into the overall organizational structure and goals (Bretschneider, Eckhardt, Glenn-West, Green-Smolenski, & Richardson, 2010).

Recommendations for future clinic implementation of shared governance structures can be formed from this project. Stakeholder committees consisting of nurses and administrators were beneficial to review the literature and plan the implementation process (Bretschneider, et. al., 2010). Video conferencing was also useful as clinics may be dispersed throughout a region and would facilitate participation at meetings without significant driving time. Clinics would benefit from peer elections for representation on the CNC and having staff nurses in formal leadership. Administrators should also be present to support and act as resources to the nurses. IPNG is a useful tool to measure shared governance and provide direction for shared governance efforts. Anecdotally, nurses felt the demographic questions were too specific on the IPNG assessments and that they could be identified by their answers. Therefore, clinic systems may consider limitation of the demographic section or providing a “prefer not to disclose” option. Bylaws also need to be created after one to two years of shared governance implementation (Bretschneider, et. al., 2010; O’Grady, 1992).

Limitations of the DNP project include a convenience sample, and a non-experimental, descriptive design. The majority of the sample were female, full-time registered nurses, and findings may not be generalizable to other populations. The study is also performed at only one clinic system and may not be generalizable to regions outside the Midwest.

Conclusion

This project was to implement a shared governance structure in a clinic system. A Stakeholder Committee was established to review the education presented by the DNP student

are decide on specific implementation for the clinic system. The CNC was formed to address issues pertinent to nursing staff. Baseline data from the IPNG tool showed traditional governance, which was expected. Three months of the CNC was too short to see significant changes in the organization. Shared governance is an evolving process, and initial stages of implementation were completed with this project.

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Figures and Tables

Figure 1:

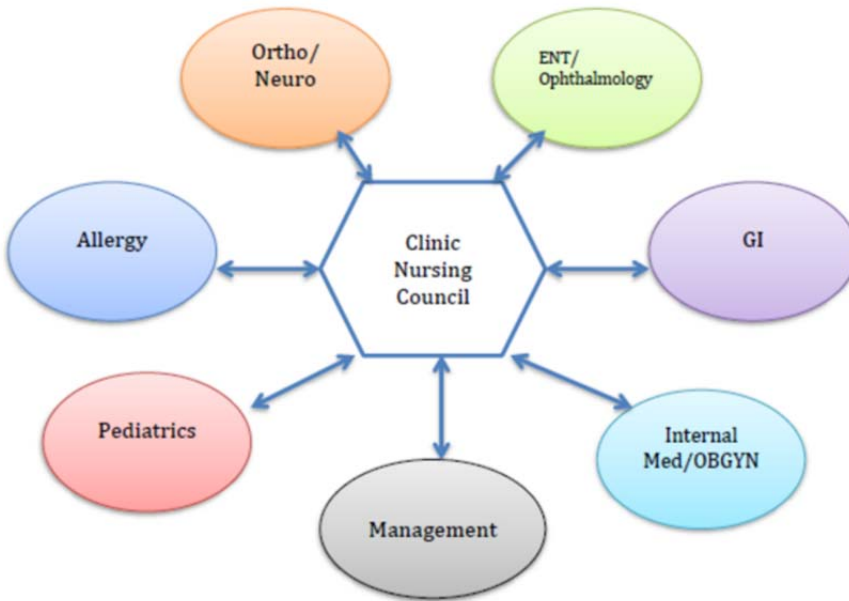


Table 1:

Demographics from IPNG Assessments

	Pre CNC		Post CNC	
	n	%	n	%
Gender				
Female	57	100	35	100
Male	0	0	0	0
Education				
Associate	24	42.1	14	40.0
Bachelors	29	50.9	17	48.6
Masters	4	7.0	4	11.4
Employment status				
Full-time	44	77.2	31	88.6
Part-time	13	22.8	4	11.4
Staff nurse	50	87.7	27	77.1
Administrator	7	12.3	8	22.9

Table 2:

IPNG Governance Scores

Governance Scale	Shared Governance Range	n	Mean	SD	t stat	p-value
Personnel	45-88					
Pre		56	28.27	1.51		
Post		35	29.80	2.53	0.52	0.6053
Information	31-60					
Pre		56	25.84	1.09		
Post		35	25.29	1.44	-0.31	0.7595
Resources	27-52					
Pre		57	29.33	1.46		
Post		35	26.17	1.58	-1.47	0.1452
Participation	25-48					
Pre		54	16.98	0.92		
Post		35	18.58	1.85	1.85	0.0692
Practice	33-64					
Pre		57	25.37	1.02		
Post		35	26.14	1.82	0.37	0.7117
Goals	17-32					
Pre		54	13.26	0.66		
Post		34	12.94	0.97	-0.27	0.7887
Total Governance	173-344					
Pre		54	140.3	5.78		
Post		34	140.2	9.15	-0.01	0.9928

Figure 2:

