Empowering frontline nurses to transform shared governance

By Cheryl D. Jacobs, RN-BC, and Cynthia W. Ward, MSN, ACNS-BC, CMSRN, RN-BC

AS WE STARTED our Magnet® journey over 7 years ago, shared governance had a genuine appeal. The nurses at our organization were excited about having a voice in their workplace to impact patient care, patient safety, practice issues, and research. We wanted to set the world on fire with the latest and greatest shared governance ever seen within a Magnet organization!

This article describes how we first evaluated our system of shared governance and then improved it by simplifying the organizational structure and improving the flow of communication.

Where we came from

Our original shared governance model was based on a congressional model with departmental, divisional, and unit councils. All RNs and LPNs were part of the nursing congress with voting privileges. The nursing congress nominated and voted for a chair of the nursing governance board (NGB), as well as one unit manager and one director. The NGB also included one RN from each nursing division, the vice president of nursing, and the senior vice president/CNO, and other ad hoc members as needed.

Nurses and members of other disciplines began attending meetings, participating in discussions, and presenting ideas that would lead to solutions to benefit patients, staff, our organization, and community. We were the driving force behind getting the job done.

Four councils were set up on each nursing unit: education, professional practice, quality, and resource management. Every direct care nurse was expected to participate on a council. (See Our original communication flow: Round and round.)

Just when we thought things were going well, our departmental level council was eliminated due to budget concerns. After several months passed, we came to believe that the elimination of this council hadn’t been in our best interest. We developed a plan to reintroduce the departmental level council as a quarterly meeting instead of as a monthly meeting.

We then began to see our multi-layered shared governance was bogging down communication, resulting in delayed decision making. Attendance began to dwindle, and a sense of dissatisfaction lingered across the organization. Realizing a change was needed, we took the following steps to transform our shared governance.

Gathering information

The NGB discussed the existing problems of our current shared governance model, and all members agreed that changes were needed. We carefully planned a timeline and started our process with a strengths, weaknesses, opportunities, and threats (SWOT) analysis facilitated by a process engineer. We identified three top priorities:

- streamline the shared governance councils
- attempt to provide home e-mail access for employees
- provide mentoring for new council chairs.

To gather more information about the topics identified in the SWOT analysis, we surveyed all nurses participating in shared governance in June 2009. The NGB developed a survey relating to the shared governance model. Although responding to the survey
was voluntary, we received 683 responses from requests sent to 1,200 nurses, or a 57% response rate. (See Results of our survey.)

The survey results were unexpected, except for the response to the statement, “A unit representative to the NGB would enhance communication.” This statement was overwhelmingly validated, with a combined agree and strongly agree score of 89%. The statements about measurable outcomes produced by the unit, divisional, and departmental councils received more favorable responses than expected. However, the response to the survey questions and the comments made by survey participants were incongruent.

Comments revolved around several themes related to the shared governance program, including communication, outcomes, effectiveness, time, structure, and staff interest. Here are examples of some of the comments:

• “There’s been a disconnect in shared governance since we did away with the departmental level council.”
• “Communication, I believe, is the biggest detriment to the shared governance process.”
• “Outcomes may be measurable but not in a timely manner. Accuracy might be compromised by lack of enthusiasm in the lengthy process.”
• “I don't believe shared governance has been effective.”
• “Unit-based councils are most effective.”
• “We have limited staff to attend all the council meetings and to schedule them with work time is difficult.”
• “I strongly feel we need representative from our unit to the council.”
• “Every unit is different and a person should be available as a spokesperson.”

Comments such as these led the NGB members to believe that their assumption about dissatisfaction with the shared governance process was correct, that respondents didn’t understand the statement, or that only those people who responded in the disagree or strongly disagree categories wrote comments.

Because of the incongruent survey results, the task force decided to hold focus-group meetings to discuss the issue further. Items that the staff felt were important to change were to eliminate the departmental and divisional councils and staff meetings that weren’t value-added, to use direct care nurses as change agents, to improve ways in which individual direct care nurses could be more engaged and involved in the governance process, to continue collaboration with leadership, and most important, to focus on patient outcomes.

Inspiration for change

Once the need for a change was determined, we formed a task force of staff nurses to review the literature and discuss ways to revitalize the governance structure. The goal was to keep shared governance vibrant, with value for the staff. This task force gathered ideas and inspiration from the literature, which were incorporated into the revisions.

Several factors are essential to the success of a shared governance program, including support from managers and leadership, clear role delineation, and support for the time needed to participate. Participants also need ongoing education about how to prepare an agenda, how to lead a meeting or discussion, and how to read reports.1

One method of organizing agenda items and activities is to base them around the organization's pillars of success. This provides focus for the reporting of outcomes and maintains emphasis on strategic goals.2,3 The task force decided to use our hospital’s five critical success factors—people, service, efficiency, quality, and finance—to provide guidance and direction to the unit councils.

Successful shared governance programs are those in which participants are expected to make changes or take action to control outcomes. The flexibility for nurses to participate in different ways leads to increased participation and strength of the shared governance structure.

<table>
<thead>
<tr>
<th>Results of our survey</th>
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<tbody>
<tr>
<td><strong>Question</strong></td>
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<tr>
<td>The current shared governance structure is effective (N = 683)</td>
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<tr>
<td>Unit-based councils produce measurable outcomes (N = 678)</td>
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<tr>
<td>Division-based councils produce measurable outcomes (N = 674)</td>
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<tr>
<td>Department-based councils produce measurable outcomes (N = 676)</td>
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<tr>
<td>A unit representative to the NGB would enhance communication (N = 672)</td>
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Due to rounding, not all results add up to 100%.
Success is also influenced by recognition of contributions, accomplishments, and outcomes. The most important thing we learned is that shared governance is a journey, and that changes are to be expected as a program progresses. The task force felt that the traditional shared governance structures didn’t meet the needs of our staff and believed that the recognition of the need for change was a sign of maturity. We were inspired by B.E. Foster (an expert on shared governance) who said, “There are as many shared governance models as institutions that practice shared governance,” and decided not to try to make our shared governance program fit a mold but to make our own mold.

Making the change

The shared governance structure was completely revised by the staff based on the input from the staff survey, the focus groups, and the literature. Unit councils changed to one council per unit focusing on the hospital’s critical success factors. The divisional and departmental councils were eliminated. Additionally, staff were no longer required to participate in shared governance meetings, instead, they’re expected to work on short-term projects or task forces as needed. Due to human resources concerns, we weren’t able to arrange for home e-mail access.

The unit council is led by an elected unit president. The unit president and unit manager collaborate to select a cabinet member who’s responsible for each critical success factor. Each unit president is a member of the NGB. (See Our revised communication flow: Simpler is better.) Orientation was held for all unit presidents with information about the roles and responsibilities of the unit presidents and cabinet members, the critical success factors, the use of the outcomes reporting database, leading effective meetings, and keeping meeting minutes.

The NGB focuses on sharing outcomes and best practices and identifying innovations across all clinical areas that influence excellence in patient care and safety. To help archive outcomes data and stories, a method of reporting outcomes was developed called Centra Outcomes in Nursing Excellence (COINE). The COINE form was derived from the Magnet instructions on developing an empirical outcome. Besides providing a way to share information, the COINE will help us keep track of projects and innovations in preparation for our Magnet redesignation in 2014.

Initially, the COINE was a paper form, but with the help of the hospital’s performance improvement and information technology departments, it was developed into an online database. Unit presidents enter the information about their projects into the database and update them as projects advance. Reports from the units are presented at the NGB meetings throughout the year so that each unit has reported by the end of the year.

The staff’s response to the revisions has been positive. Staff report that communication is enhanced by having all unit presidents attend NGB meetings. The unit presidents are excited and energized by the sharing of information at NGB meetings. Future plans include a formal evaluation of the effectiveness of the revision.

REFERENCES

Cheryl D. Jacobs is a staff nurse and Cynthia W. Ward is an RN IV at Centra Lynchburg General Hospital in Lynchburg, Va.

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