
Shared
Governance

SHARED GOVERNANCE IN THE HEALTH CARE ORGANIZATION: UNITED WE STAND—DIVIDED WE FALL

GOALS

1. Promote the understanding, appreciation, and definition of "Shared Governance."
2. Promote the understanding that unity promotes organizational strength and survival.
3. Reiterate the difference between leadership and management.
4. Present the role of the healthcare organization in shared governance.
4. Present the development of organizational councils/groups.
5. Present the meaning of standards and how they assist in maintaining shared governance.

KEYWORDS FOR APPLICATION

1. Shared Governance
2. Organizational Principles
3. Standards
4. Philosophy, Mission, Goal(s), Purpose, Objectives
5. Leadership
6. Management
7. Job Description(s)
8. Benjamin Bloom's Taxonomy – Cognitive, Psychomotor, Affective
9. Council(s)
10. Patient Care Coordination Council (PCC)
11. Shared Leadership Council (SLC)
12. Coordinating Council (CC)
13. Research and Innovation Council (RIC)
14. Executive Council (EC)
15. Clinical Education Council (CEC)
16. Nurses
17. Nurse Preceptors
18. Physicians
19. Interdisciplinary Staff
20. Leader/Administrator
21. The Law
22. Rule of Three
23. Personal Determination in Establishing Councils/Groups

United We Stand—Divided We Fall is one of the most used phrases to promote unity and strength! The words encourage and inspire, and being alone is harder and encourages failure. From Greek history, in the 6th century BC century, we are introduced to two of Aesop's fables—The Bundle of Sticks and the Four Oxen and the Lion. My favorite—the lion pursued the oxen without success in overtaking an ox. But then, when the pack of oxen dispersed and went their own way—well, you guessed it—the lion caught his ox! United We Stand—Divided We Fall has also been heard in the Liberty Song by John Dickinson

(1768) and George Pope Morris's words in 1853. It all supports that we are more likely to succeed when we work together—UNITY IS STRENGTH!

DEFINITION OF SHARED GOVERNANCE

The definition of a healthcare organization's shared governance program involves the ongoing experience of unified sharing of council/group members to improve quality healthcare.

PROCESS OF SHARED GOVERNANCE

Quality healthcare processes are established through shared governance. The process involves sharing ideas, concerns, and recommendations for improving healthcare processes.

Shared governance is a process used universally in many endeavors, from marriages to the most magnificent and complicated businesses and educational efforts. It is a significant part of leadership/administration for the survival of the fittest. For example, the Stanford Health Care and Magnet Recognition Award processes were developed by the American Nurses Credentialing Center (ANCC). Both systems (Stanford Health Care and Magnet Recognition Award) are known for their extensive shared governance culture, including collaboration and teamwork.

THE ORGANIZATION'S BASIC LEADER/ADMINISTRATOR SHARED GOVERNANCE STANDARDS

No one claims that sharing and unity in an organization are easy, and it is somewhat difficult, as many health care professionals have strong personalities and opinions. However, the effort to communicate collectively on behalf of every patient/resident or the organization has its rewards!

Shared governance councils/groups have documented *standards* to measure expected and competent outcomes.

The standards include:

Council/Group Title--- The representing of a general category of concern---Identified as a council, group, or committee.

Philosophy--- The belief system related to the need---Paragraph starting with, "We believe."

Goals--- The ultimate and intended end-point(s) to be attained---Each goal starts with a Bloom's Taxonomy action verb related to the cognitive, psychomotor, or affective domain.

Purpose/Mission--- The intended "good" to be accomplished—Each purpose or mission statement starting with the word "To."

Objectives--- The success incremental "markers" along the way to the ultimate end-points or goal(s)---Each objective starts with an action verb.

Policies--- The "rules" of the council keep entropy (the movement of all universal things and happenings toward randomness and deterioration) under control.

ADMINISTRATIVE EXPECTATIONS RELATED TO SHARED GOVERNANCE (Random placement of expectations as to order of importance.)

* Knows the difference between leadership and management. Leadership involves others in the problem-solving process, and management tells others what to do. The use of shared governance in an organization is LEADERSHIP.

* Knows the concept of entropy and how this natural universal movement toward deterioration and change can alter councils/groups' intended standards (the expectations by which a council's/group's success is measured).

* Determines, documents, and updates overall/all standards related to the entire organization--- philosophy, goals/mission, purpose, objectives, policies, shared governance recommendations, and organizational job descriptions according to Benjamin Bloom's Taxonomy. It provides the basis of all council/group expectations as an extension of the healthcare organization's supportive endeavors.

* Determines, documents and updates shared governance standards of councils/groups, involves healthcare employees by name and title, and assigned counsel/group leader.

* Understands that shared governance councils/groups are developed and assigned to meet an organization's specific and unique needs according to their stated standards.

* Incorporates and maintains shared governance principles into the everyday employee activities of a healthcare corporation.

* Performs (or at least reviews) all organizational employee and council/group member evaluations related to their job descriptions.

* Understands the potential good, problems, challenges, and concerns related to implementing and maintaining shared governance.

* Performs to be legally accountable for organizational and council/group standards.

***** Knows where the "BUCK STOPS"—It stops with the leader/administrator and the LAW! The organization's job descriptions' expectations and maintenance, council/group job descriptions, and associated job description evaluations will help prevent litigation, and it is evidence of leadership prowess.

BENEFITS OF SHARED GOVERNANCE

There is no question that professional health care staff's involvement improves patient/resident healthcare outcomes and safety. It encourages professional health care employee partnership, equity, accountability, and ownership of results. Leaders/Administrators claim that it optimizes efficiency and

potential for meeting the organization's established standards. There is an improvement in the retention of nurses. Teamwork also is improved through council/group "rounding" (bedside conferencing) on patient/resident care areas.

Determination of significant patient/resident health care decisions is accomplished by health care and administrative councils/groups. Because of involvement for the good of patients/residents and the healthcare environment in which healthcare occurs, employees become positively energized. There is shared energy as staff see and feel the evidence of making a positive difference due to their involvement.

Using the Rule of Three provides an uneven number on every council/group to determine major decisions. There is no magic in the number three. However, a majority determination of a varying number of council members democratically determines the best options for an organization and patient/residential health promotion. Suppose there must be/needs to be an even number of health care providers on a council, thereby an uneven number of council members making a council decision. In that case, there is a possibility of a voting tie, and the uninvolved leader/administrator of the organization breaks the tie. Therefore, there is always a final council/group decision. The benefits of a majority decision positively impact the desire to have shared governance decisions. It determines professional practice and strategic plans through multiple and collaborative efforts.

With the guidance and determination of the astute health care leader/administrator who understands the legal and ethical implications of shared governance, positive healthcare administration and application escalates. Leader/administrative support says that professional input is valued.

Leaders/administrators can change the complex health care world for the better. Who else would recognize that entropy (universal automatic deterioration of everything in the universe) occurs without positive administrative and watchful collaborative leadership? The strength, ability, and fortitude to "tie" the sharing of healthcare shared governance into a consistent working and ongoing healthcare endeavor *truly* belongs to the health care leader/administrator. Such effort makes the organization an integrative system that is *something to behold*! *And—the benefits are covertly too many to identify!*

This concept applies--To know the *good/benefits of* shared governance, we have experienced the *not-so-good* (no shared governance)—like to understand light, you must also know dark.

EXAMPLES OF POSSIBLE COUNCILS/GROUPS REPRESENTING SHARED GOVERNANCE

1. NURSING CARE COUNCIL (NCC) --- (Building and Implementing a Nursing Care Plan)

PHILOSOPHY: We believe that every patient/resident deserves a unique/individualized nursing care plan that results from professional nursing health care input.

GOAL/MISSION/PURPOSE: Determine and review individualized nursing care plans that meet each patient/resident's unique healthcare needs.

OBJECTIVE: To meet regularly or as needed as professional nurses to identify and support nursing behaviors that enhance nursing health care for individual patients/residents.

A Nursing Patient Care Council/group is responsible for the professional sharing, review, adjustments, implementation, and coordination of individual patient/resident health care plans. Selected health care standards for particular patients/residents become the documented patient's/resident's care plan, nursing diagnosis, realistic healthcare goals, and intended nursing interventions to meet the healthcare goals.

Let us not forget the human variable that says every patient's goals and needs (due to individual uniqueness) are somewhat different. Thereby, we have a basic guideline (standard of care) to commence with patients/residents' treatment. Yet, as a council/group commissioned to determine professional health care, we do so humanely and individually. It means that the ultimate patient care council's/group's responsibility is to determine individual care plans according to proven standards of care. It also enhances the care plan to include a more individualized plan representing a patient's uniqueness and several additional healthcare disciplines that help reach patient/resident healthcare goals.

*Members are professional nurses.

2. ***SHARED MULTI-DISCIPLINARY COUNCIL (SMC) --- (Building and Implementing an Interdisciplinary Care Plan)***

PHILOSOPHY: We believe that every patient/resident deserves a unique/individualized care plan with an interdisciplinary health care input outcome.

GOAL/MISSION/PURPOSE: Determine and review individualized interdisciplinary care plan that meets each patient/resident's unique healthcare needs.

OBJECTIVE: To meet regularly or as needed as multidisciplinary healthcare providers to identify and support the specific interdisciplinary health care needs of individual patients/residents.

A Shared Multi-Disciplinary Council is responsible for assessing, implementing, and maintaining current practice standards related to appropriate interdisciplinary care plans. The council supports and enhances the vision and identifies strategic and individualized care plans set forth by professional nurses. Suppose the SMC identifies a professional concern or a needed individualized multidisciplinary health care in addition to the nursing care plan. In that case, a representative of this council meets with the NCC to clarify or adjust the care plan.

*Interdisciplinary healthcare members are a combination of nurses, physicians, and multidisciplinary health care specialists.

3. COORDINATING COUNCIL (CC) --- (Patient/Resident Safety and Quality Check)

PHILOSOPHY: We believe that every patient/resident deserves a unique/individualized care plan with medical oversite.

GOAL/MISSION/PURPOSE: Determine and review individualized care plans for correct medical protocols that meet each patient/resident's healthcare needs.

OBJECTIVE: To meet regularly or as needed as medical healthcare providers to identify, support, and medically monitor the specific interdisciplinary health care needs of individual patients/residents.

A Coordinating Council monitors other councils/groups and unsolved medical issues within or between councils. Care plans are strategically reviewed from a medical perspective for efficacy. Documentation is checked to ensure that care plans are implemented and appropriately documented. Council members are considered a necessary resource for understanding potential medical (positive or negative) effects and unresolved issues regarding implementation and varied disciplinary practice(s) as stated on the care plan developed by the NCC and SMC.

*Members are medical staff.

4. RESEARCH AND INNOVATION COUNCIL (RIC) --- (Research and Application of Identified Patient Care Research)

PHILOSOPHY: We believe that every patient/resident deserves the use of the most current and researched quality healthcare evidence.

GOAL/MISSION/PURPOSE: Review relevant literature and apply the researched findings to individual care plans for patients/residents' most effective healthcare management of patients/residents.

OBJECTIVE: To meet regularly or as needed as multidisciplinary healthcare providers to review research findings for appropriate recommendations and applications to individual patients/residents' care plans.

A Research and Innovation Council is responsible for researching evidence-based healthcare practices. It helps to assure current and effective healthcare practices. Communication with other councils/groups provides researched and updated information to all healthcare disciplines to ensure safety and quality care decisions. It assures that healthcare practice is evidenced-based using quality healthcare practice.

*Members are healthcare-supportive disciplines, such as nurses, physicians, and multidisciplinary healthcare specialists.

5. ***EXECUTIVE COUNCIL (EC) –- (Leadership Recommendations and Coordination for Organizational Behaviors, Educational Services, Lectures, and On-Hand Practice of Healthcare Providers.)***

PHILOSOPHY: We believe that leadership is enhanced by sharing creative administrative ideas. Education/services/lectures/on-hand practice of health care providers increases professional healthcare competence.

GOAL/MISSION/PURPOSE: Contribute to the healthcare organization's positive administrative efforts and functions.

OBJECTIVE: To meet regularly or as needed as a multidisciplinary healthcare team to identify potential new and supportive administrative happenings to support or improve the healthcare organization.

Conducts problem-solving groups with follow-up meetings/forums to assure continued compliance or appropriate modifications of group decisions. Decisions require leader/administrative approval before implementation.

*Members are "second-line" leaders, at least one member from all shared governance councils, and the organizational leader/administrator.

6. CLINICAL EDUCATION COUNCIL (CEC)---(Collaborative recommendations between a nursing education program and a clinical facility used for clinical nursing education)

PHILOSOPHY: We believe that nursing education and clinical nursing practice are mutually enhanced by collaboration between nursing education programs and clinical healthcare facilities. It encourages the nursing practice expertise of the nurse preceptor and effectively teaches student nurses. Student nurses are more inclined to be employed in a healthcare facility where they receive a preceptor nursing experience.

GOAL/MISSION/PURPOSE: Contribute to nursing students' clinical practice as collaborative healthcare educators and clinical nursing providers.

OBJECTIVE: To meet regularly or as needed as a multidisciplinary healthcare team to determine educational opportunities and requirements that support nursing education and ultimately retain graduating nurses to work in the associated healthcare organization.

Nursing faculty often assign student nurses to clinical nurses employed in a specific healthcare area. There, at times, is no criteria established for being the nurse preceptor. Careful selection of a practicing nurse preceptor for a nursing student provides the nursing role model immolated by the student nurse. It is important to require the nurse preceptor to review techniques expected to supervise or demonstrate to nursing students. There is a correct carry-over of principles from the classroom to the clinical setting. Positive reinforcement (reward) is given to approved nurse preceptors by wearing a name tag with the school's name and name, indicating they are currently a "Student Nurse Preceptor" for the day. Preceptor identification establishes nursing prowess on a nurse's resume. A plaque on the hall wall with the engraved names of clinical nurses who meet the preceptor criteria is recognized and increases the nurse preceptor's professional image. This positive reinforcement increases more positive nursing outcomes! Nursing students who receive quality nurse preceptor support are more inclined to apply for employment at the same clinical area post-graduation—decreasing the possible need for so many "traveling nurses."

*Members are nursing faculty who teach clinical nursing skills at the academic level and nursing healthcare administrator(s) of a clinical healthcare facility used by nursing students for direct patient/resident application of clinical skills.

PERSONALIZATION OF SELF-GOVERNANCE

NOW—With all the previous examples of the possible use of shared governance councils/groups--- let us be "real." Think carefully and creatively about how your healthcare staff/team can share knowledge and experiences to better the healthcare organization and the patients/residents.

What has been presented in this document might not mean what your organization needs as you pursue your shared governance quest. You might want to have committees instead of counsels/groups—even though they can mean the same. Make up your own council/group/committee titles, standards, and participants that best suit you and your administrative needs. Perhaps selected organizational or academic members could determine each council/group/committee's labels and standards. You will benefit by using your personally designed shared governance counsels/groups as a powerful means of collecting previously unspoken and changing healthcare information. Then, you will truly understand the meaning of **TOGETHER WE STAND!**

RECOMMENDED READING

Shared Governance (concepts available online)
Entropy by this author
Job Descriptions by this author
Benjamin Bloom's Taxonomy (concepts of the domains cognitive, psychomotor, and affective (attitude) in the document on Job Descriptions by this author and variations of the concepts online)
Magnet Hospital Journey (access online)
Stanford Health Care (access online)

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