Components of Shared Governance:
Structures and Implementation Methods that Benefit Nurses

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Abstract

Introduced by Porter O’Grady in 1984 as an organizational model to put the control of nursing practice into the hands of bedside nurses, shared governance has been shown to increase job satisfaction, autonomy, control of nursing practice, commitment to the organization, and empowerment. While it is well studied that shared governance creates positive nursing outcomes, there exists a gap in the literature about what components of nursing shared governance create these positive nursing outcomes. This paper presents the results of an integrative literature review that was conducted to explore the components of shared governance that improve nursing outcomes, and to identify those shared governance components that are reported as being most beneficial to nurses. The resulting discussion based on the review indicates that shared governance is most successful at improving nursing outcomes when its structure promotes communication and collaboration. Evidence-based practice councils provide nurses with the evidence needed to support decision-making processes and ensure that changes implemented within shared governance structures are effective. Shared governance is most successful in improving nursing outcomes when it uses education to promote its development and incorporates professional advancement programs.
Introduction

The shared governance practice model is a participative, decentralized structure conceived as a method to promote decision making among certain employee sectors in organizations. Adapted by hospitals for nurses in the late 1970s and early 1980s, shared governance is a way for nurses to control their own practice (Porter-O’Grady & Finnigan, 1984). Control of nursing practice is defined as “the authority and freedom of nurses to engage in decision making related to the context of nursing practice including the organizational structures, governance, rules, policies, and operations” (Weston, 2008, p. 407). Shared governance allows nurses to control their practice by possessing both the accountability for determining operations as well as the responsibility for the outcomes they produce (Porter-O’Grady & Finnigan, 1984). This approach is intended to eliminate conflict between management and nurses by allowing nurses to control decisions that affect their practice. This paper presents the results of an integrative literature review that was conducted to explore the components of shared governance that improve nursing outcomes, and to identify those shared governance components that are reported as being most beneficial to nurses.

Background on Shared Governance

Historically, the settings where nurses practice have been governed via a bureaucratic structure. Under this kind of model, management determines hospital operations, so that nurses have limited control over operations, but responsibility for the outcomes of those operations (Porter-O’Grady & Finnigan, 1984). Structurally speaking, bureaucratic organizations may have nursing committees that review various practices or policies and make recommendations, but it is the managerial body that decides which recommendations are put into practice (Porter-O’Grady & Finnigan, 1984). While nurses in this kind of structure may be allowed to participate in the
identification of problems, the first step of the decision making process, they do not have control over the important step of making nursing practice decisions (Weston, 2008).

Shared governance, on the other hand, seeks to place the control of nursing practice into the hands of bedside nurses. It is both a structure and process that uses various nursing councils, which are given functional responsibility for various activities, and those councils are engaged in all three steps of the decision-making process, namely, problem identification, examination or development of evidence, and the selection of a decision or solution (Weston, 2008). This structure ensures that practicing nurses have the ability to make decisions about the standards of practice, policies, and structures that shape patient care based on core nursing values and clinically relevant evidence (Weston, 2008). This structure also upholds nurses’ preferences for greater involvement in decision-making than they have been offered historically (Mangold et al., 2006). By allowing nurses more control in shaping hospital policies that affect their practice, they are given the autonomy, or freedom, to make relevant patient care decisions, and potentially improve patient outcomes (Weston, 2008). Increasing nurses’ autonomy also improves their nursing job satisfaction (Anderson, 2011).

Nursing councils are the structural backbone of shared governance that allow nurses to control nursing practice. Porter-O’Grady and Finnigan (1984) initially recommended the following five councils in their model of shared governance: nursing practice, quality assurance, nursing education, nursing management, and a coordinating council to oversee operations. However, many different models of shared governance have evolved in U.S. hospitals. The four shared governance models identified in a literature review conducted by O’May and Buchan (1999) are counselor, congressional, unit-based, and administrative. In the counselor model, which most reflects Porter-O’Grady and Finnigan’s (1984) recommendations, sub-committees
work with department coordinating councils to create hospital wide practices reflecting nursing staff practice (O’May & Buchan, 1999). The typical sub-committees or sub-groups in a councilor model include research councils, leadership councils, education councils, quality control councils, and nursing practice councils. In a congressional model, the nursing staff belongs to a congress and committees submit work to a governance cabinet for administrative action (O’May & Buchan, 1999). The difference between councilor and congressional models is that a congressional model includes a congress that votes to make decisions based on requests for change submitted by councils or committees, whereas in a councilor model councils at every level are allowed to make decisions independently without a congress vote. In a unit-based council model, each unit establishes their own shared governance practice and there is no larger hospital or department-wide coordination of practice (O’May & Buchan, 1999). In an administrative model, councils submit requests up a hierarchical ladder to a governing executive body for decision-making. This latter model is a more bureaucratic structure than the others as councils are unable to work independently (O’May & Buchan, 1999).

In 1990, the American Nurses Association incorporated shared governance into the Magnet Hospital Recognition Program for Excellence in Nursing Services®. This recognition program is based on a 1983 study that identified the qualities of hospitals that promoted better patient care and healthier work environments for higher nurse retention (American Nurses Credentialing Center, 2014). These hospital characteristics were identified as the Forces of Magnetism, used to determine Magnet Recognition for subsequent hospital applications. In 2008, the Commission of Magnet restructured the Magnet Program to include fourteen Forces of Magnetism divided into five components: Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovations, &
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Improvements; and Empirical Outcomes (American Nurses Credentialing Center, 2014). While shared governance is not explicitly included as a force of Magnetism, it is subsumed within the force of Structural Empowerment, as this force promotes giving nurses control over their own practice. In fact, many Magnet designated hospitals use shared governance as the structure through which Structural Empowerment is operationalized.

Promoting control over practice has been reported as beneficial for nurses. One identified benefit is an increased sense of empowerment (Kramer et al., 2008). In a descriptive correlational study conducted in one hospital, the investigators reported a positive correlation between perceptions of shared governance and staff nurse perceptions of empowerment (Barden, Griffin, Donahue, & Fitzpatrick, 2011). Empowerment reflects nurses belief about their ability to control their practice, which is consistent with the purpose of shared governance (Manojlovich, 2007). According to a literature review conducted by Twigg and McCullough (2014), empowered work environments typically have a shared governance structure enabling nursing and leadership collaboration along with a decentralized organization structure and participative management style.

In addition to providing nurses with a sense of empowerment, shared governance also provides nurses with a deeper understanding of hospital policies, which promotes organization involvement (Twigg & McCullough, 2014). Shared governance has a positive correlation with the nursing practice environment, as increases in preceptions of shared governance are linked to a better nursing work environment (Clavelle, Porter-O’Grady & Drenkard, 2013). In several studies, shared governance implementation resulted in an increase in employee satisfaction (Brody, Barnes, Rubel, & Sakowski, 2012; Poe, 2012; Sakowski, Hooper, Holton, & Brody, 2012). Additionally, shared governance has been shown to reduce turnover (Newman, 2011;
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Watters, 2009; Winslow et al., 2011). Thus, in terms of its benefits to nurses, shared governance has been shown to improve job satisfaction and reduce turnover by promoting employee empowerment and increasing organizational involvement.

When implementing a shared governance model, it is important to use measurement tools to assess its effectiveness. In one study conducted by Anderson (2011) the Index of Professional Nursing Governance (IPNG) was used to measure nurses’ perceptions of the degree to which shared governance existed in the organization. From 1999 to 2002, and on into 2006, nurses consistently rated shared governance as “primarily nursing management with some staff input” (Anderson, 2011, p. 199). Several interventions were recommended to improve the perceptions of shared governance including additional education on the philosophy of shared governance, staff nurse responsibilities, and involving nurses at the unit level in decision-making processes (Anderson, 2011). It is not enough to implement a structure of shared governance without constantly reevaluating its effectiveness and looking for areas of improvement. Shared governance must be implemented in such a way that nurses internalize a sense of accountability for their own practice.

While the benefits of shared governance for nurses are well known, the specific components of shared governance that create those benefits are less clear. Components of shared governance can be defined as the organizational structures and processes through which shared governance and its implementation influence its effectiveness. Therefore, the purposes of this project are twofold: to determine the components of shared governance that contribute to better outcomes for nurses; and of these components, to identify the ones that are the most beneficial to nurses. This purpose will be achieved by conducting a thorough integrative review of the literature.
Methods

Following a consultation with a health sciences librarian to determine appropriate search parameters, improve database searching knowledge, and define the research purpose, a literature review was conducted to select articles that addressed the study purpose. The main search term used was shared governance, followed by key terms related to the study purpose. These terms include empowerment, organization, nursing administration, program implementation, evaluation, nursing practice, clinical governance, quality improvement, work attitudes, decision making, work environment, professional autonomy, nursing management, nursing staff, shared leadership, and team management. The search was conducted across the databases of CINAHL, Pubmed, and Embase, as per librarian recommendation. The review was limited to studies conducted between 2004 and 2014 in the United States, to draw on relevant, current research, and to eliminate any potential biases and differences that might be introduced by examining the shared governance structures used in other countries, which reflect different policies and practices than those in the U.S.

A total of 747 articles were identified after using the database search parameters. The abstract of each articles was reviewed for inclusion in the literature review, based on two selection criteria that intended to identify articles that addressed the study purpose: articles that identified and described components of shared governance models; and articles that used qualitative or quantitative approaches. These approaches help to ensure that the study has appropriately answered its research question. Many articles were not scientific studies or did not include information about the shared governance structure or implementation process, and as such were eliminated from this review. Following the elimination of these articles, 165 remained. These articles were read fully to determine if they met the selection criteria and addressed the
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study purpose. From the 165 articles, fifteen were deemed appropriate to address this study’s purpose. The reference lists of the selected articles were also reviewed for additional articles that related to the research question, and from this review two additional articles were selected, for a total of seventeen articles included in this review.

**Key Components of Nursing Shared Governance Models**

Table 1. Article Review Summaries

<table>
<thead>
<tr>
<th>Title, Author, Year of Publication</th>
<th>Shared Governance Structure</th>
<th>Paper Purpose</th>
<th>Sample</th>
<th>Measurement Tools</th>
<th>Findings</th>
</tr>
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<tbody>
<tr>
<td>Shaping future nurse leaders through shared governance Beglinger et al. 2011</td>
<td>N/A</td>
<td>Demonstrate that SG produces nursing leaders</td>
<td>Council chairs advanced to unit directors and clinical nurse specialists</td>
<td>N/A</td>
<td>Shared governance encourages nurses to assume higher positions as nurse leaders</td>
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<td>Decisional involvement Bina et al. 2014</td>
<td>Councilor model: Unit councils, operational councils, coordinating council with staff leaders and CNO</td>
<td>Measure impact SG has on actual and preferred involvement in decision-making</td>
<td>Nurses at one hospital Pretest 2004 n=290 posttest 2010 n=111</td>
<td>DIS decisional involvement scale measures actual and preferred involvement</td>
<td>Decrease in preferred and actual involvement after SG implementation</td>
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<td>Strengthening the voice of the clinical nurse Bretschneider et al. 2010</td>
<td>Councilor model: Unit councils 4 department councils: stewardship, quality, practice and translational research, and</td>
<td>Measure effects of councilor SG implementation with NDNQI indicators</td>
<td>N/A</td>
<td>NDNQI national database of nursing quality indicators measures turnover and employee satisfaction</td>
<td>Increase in decision making, autonomy, professional status</td>
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<tr>
<td>Method</td>
<td>Model/Structure</td>
<td>Measure/Outcomes</td>
<td>Study/Implementation Details</td>
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<td>Evidence-based practice councils:</td>
<td>Councilor model: Evidence based practice councils</td>
<td>Use qualitative measurements to assess impact of EBP councils on nursing outcomes</td>
<td>6 hospitals, interviews n=76 survey response n=39</td>
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<td>potential path to staff nurse empowerment and leadership growth</td>
<td>Brody et al. 2012</td>
<td></td>
<td>Interviews and survey</td>
<td>Increase in leadership growth, staff nurse empowerment,</td>
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<tr>
<td>Nursing peer review:</td>
<td>Councilor model: Evidence based practice councils</td>
<td>Evaluate effects of incorporating nursing peer review into SG structure by giving nursing practice review power to the nursing practice council</td>
<td>N/A</td>
<td>Increased staff autonomy, decision making, decreased vacancy rates, increased staff engagement</td>
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<tr>
<td>Integrating a model in a shared governance environment</td>
<td>Fujita et al. 2009</td>
<td></td>
<td>NDNQI national database of nursing quality indicators</td>
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<tr>
<td>Structures and practices enabling staff nurses to control their practice</td>
<td>Kramer et al. 2008</td>
<td>Determine which characteristics of SG structures enable nurses to control practice</td>
<td>8 hospitals, 101 units, n=244</td>
<td>CWEQII measures perceived empowerment, CNP control of nursing practice, interviews, participant observation</td>
<td>SG and career ladders identified by interviewees as enabling control of nursing practice. Access to power, participation, recognition, accomplishment s, and EBP intitiatives,</td>
</tr>
<tr>
<td>Staff nurses lead the way for improvement to shared governance structure</td>
<td>Moore &amp; Wells 2010</td>
<td>Measure nursing outcomes from congressional shared governance implementation</td>
<td>One hospital Pre and post test n=204</td>
<td>CWEQ Conditions of Work Effectiveness Questionnaire measuring workplace empowerment and OCQ Organizational</td>
<td>No changes in structural empowerment and organizational commitment, higher informal power scale for those in councils</td>
</tr>
<tr>
<td>Transforming organizational culture through nursing shared governance Newman 2011</td>
<td>Councilor model: Unit councils 3 department councils Quality and research, practice, education and professional development Coordinating council (chair, cochair, nursing leaders), senior nursing leadership council</td>
<td>Measure nursing outcomes from councilor SG implementation</td>
<td>1200 nurses total, one hospital, RN response rate of 58-80%</td>
<td>NDNQI, PES practice environment scale measuring work environment</td>
<td>Reduced turnover, increased nursing engagement, improved work environment</td>
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<td>Capacity building for magnetism at multiple levels Parsons 2004</td>
<td>N/A</td>
<td>Unit-based capacity-building intervention to promote collaboration and create a healthy work environment</td>
<td>Nurses in one ED department Pre and post test n=15</td>
<td>COPS control over practice scale, IWS index of work satisfaction, OCQ organizational commitment questionnaire</td>
<td>Reduction in nurse vacancies, increase in organizational commitment and communication between employees</td>
</tr>
<tr>
<td>Leading a culture change to nursing and patient excellence Poe 2012</td>
<td>Councilor model: 4 department councils: professional practice, development, research, quality</td>
<td>Improve patient and nursing satisfaction with a SG structure</td>
<td>N/A</td>
<td>N/A</td>
<td>Employee satisfaction rate increases</td>
</tr>
<tr>
<td>Partners advancing clinical excellence Sakowski et al. 2012</td>
<td>Councilor model: Staff led nursing quality improvement council (EBP councils)</td>
<td>EBP councils with clinical transformation directors to improve practice</td>
<td>Nurse council members, n=35</td>
<td>N/A</td>
<td>Improved job satisfaction, increased sense of meaningfulness from work, increased satisfaction</td>
</tr>
</tbody>
</table>
| Improving work environment | N/A | SG structure implemented with additional | One hospital Pretest Day shift: n=16 | IWPS Individual Workload Perception Scale | No increases in IWPS, but results non-
<table>
<thead>
<tr>
<th>Research Question</th>
<th>Governance Structure</th>
<th>Methodology</th>
<th>Outcomes</th>
<th>Summary</th>
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<tbody>
<tr>
<td>Perceptions of nurses employed in a rural setting</td>
<td>Night staff administrative support</td>
<td>Night: n=15 Posttest Day shift: n=25 Night: n=11</td>
<td>measuring work environment support and intent to stay</td>
<td>Conclusive for shared governance because additional changes were implemented</td>
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<tr>
<td>Shared leadership: taking flight</td>
<td>Councilor model: 4 department councils evidence-based practice, professional practice, quality, operations</td>
<td>Implement councilor SG structure</td>
<td>92% response rate</td>
<td>NDNQI national database of nursing quality indicators</td>
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<td>Decrease in nursing turnover, NDNQI nursing satisfaction measurements increased</td>
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<td>Tracking decisions with shared governance</td>
<td>Congressional model: Unit councils nursing executive operations council, patient care leadership council Patient care governing congress votes on council requests</td>
<td>Congressional model with congress voting and Congressional Decision Implementation Team implementing decisions</td>
<td>Staff nurses at 3 hospitals n = N/A</td>
<td>NDNQI, national database of nursing quality indicators, Decision-Making T-Scores</td>
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<td>Increase in decision making and job satisfaction</td>
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<tr>
<td>Evaluating shared governance for nursing excellence</td>
<td>Councilor model: Unit councils 4 department councils: Patient care team, professional practice team, leadership development, executive team</td>
<td>Evaluate SG effectiveness at hospitals claiming SG structure</td>
<td>Nurses at three hospital system n = 207</td>
<td>IPNG index of professional nursing governance</td>
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<td></td>
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<td>Shared governance structures in place are not enough to create shared governance</td>
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<tr>
<td>Staff nurses revitalize a clinical ladder program through shared governance</td>
<td>Councilor model: 4 department councils leadership, practice excellence, education and professional development, and work design</td>
<td>Revision of clinical ladder program within councilor SG structure</td>
<td>Nurses from one hospital n = N/A</td>
<td>NWI-R nursing workforce index revised</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Higher satisfaction rates and lower turnover for nurses higher on clinical ladder</td>
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After determining the articles for review, it was necessary to identify the components of nursing shared governance models that were reported to affect nursing outcomes. Shared governance articles were categorized into structural components, which determined how shared governance was organized and utilized in a particular hospital, and the additional components, which encompassed strategies used to initiate and maintain shared governance function.

The articles were first reviewed by structural types of shared governance. Ten articles had a counselor shared governance model, and two articles had a congressional shared governance model. Five articles did not state a shared governance model. No unit-based or administrative models were identified. Details about the outcomes of shared governance structural components, including congressional models, counselor models, and unit and evidence-based practice councils within those structures are included below. Following this review of the structural components of shared governance, the articles were reviewed for additional components that shaped nursing outcomes. Professional advancement and education were identified as components that, when used within shared governance, improve nursing outcomes. Additional studies demonstrated that programs implemented using shared governance structures such as clinical ladder programs, annual shared governance conferences, and nursing peer review programs benefited nurses.

**Structural Components**

**Integrated or Silo Model**

Hospitals with shared governance either utilize an integrated model or a silo model. An integrated shared governance model is incorporated into the structure of the entire hospital with communication between levels of governance. A silo model of shared governance functions within individual departments without communication between different levels of governance (Kramer et al., 2008). Hospitals with an integrated model have been reported to demonstrate
higher levels of empowerment, indicating that integrating a shared governance structure encourages nurses to interact and collaborate with administration to exert greater control over nursing practice (Kramer et al., 2008). This is supported by evidence indicating that unit-level councils need to be integrated into the overall shared governance structure to foster control over practice at the level of practicing nurses (Newman, 2011; Whitt et al., 2011). Hospitals with shared governance models that promote collaboration between different levels allow nurses to work together to create change within the hospital. This structural concept can be applied to both councilor and congressional models.

**Councilor Models**

In the councilor model, councils and committees work together to determine nursing practice. The councilor model features hospital level councils, with some models including additional unit-level councils or an additional coordinating council overseeing operations. The articles reviewed reported the use of different councils as part of the shared governance implementation.

Implementation of a councilor model was reported to positively affect nursing outcomes in six studies, and negatively affect nursing outcomes in two studies. Four of the six studies that reported positive nursing outcomes, such as increased empowerment and job satisfaction, had only hospital level councils, without a coordinating council or unit-based councils. The other studies had both unit-based councils and a coordinating council. For the two studies with negative outcomes, such as a decrease in decision-making ability, one had all three levels of councils, and the other had unit level and department level councils. From the variety of structures presented in both positive and negative outcome studies, it cannot be concluded that a certain structure of councilor shared governance consistently generates positive results.
Integrated unit councils, evidence based practice councils, and integrated models instead of silo models were identified as structural components of councilor model shared governance that generated positive results. Although unit councils and evidence based practice councils exist in both councilor and congressional models of shared governance, they are included under the councilor model portion of the review because only within the councilor model are these councils able to make decisions and implement changes in nursing practice. The ways in which these structures affect shared governance are detailed below.

**Unit Councils.** Unit councils bring shared governance to bedside nurses by giving them control over nursing practice via councils established on their units. In one councilor model study, unit based councils were incorporated into the hospital-wide shared governance structure and encouraged staff participation, resulting in increased employee engagement, satisfaction, and decreased turnover (Newman, 2011). This hospital educated nurses about the model’s implementation before and during the implementation process (Newman, 2011). It was a priority to ensure that the nurses participating in shared governance understood how the model worked, and were able to utilize the structure for control over nursing practice. Bretschneider et al. (2010) incorporated unit councils into the hospital-wide shared governance structure by including unit council chairs as members of the coordinating council, thereby integrating the different council levels. Both studies ensured that unit level councils were incorporated into the shared governance structure and able to collaborate with administrators.

In other studies unit-based councils were less well incorporated into the overall shared governance structure, or nurses were given inadequate decision-making power, which resulted in negative outcomes (Bina et al., 2014; Wilson, 2013). In one study that reported the results of implementing unit team councils within departments, the councils were described as active, but
many department level councils stopped meeting following implementation (Wilson, 2013). Nurses in this study reported on the Index of Professional Nursing Governance (IPNG), scores that indicated the organization was governed by only the administration without staff input (Wilson, 2013). Nurses reported that they only had the ability to control their practice at the unit level instead of the hospital level because unit councils were operating independently of each other.

Another study examining shared governance reported that the hospital changed its structure from three councils to a tiered system of unit level councils, division wide councils, and chairs from division councils participating in a coordinating council (Bina et al., 2014). Using the Decisional Involvement Scale tool to measure nurses’ perceptions of involvement in making decisions, the study concluded that the implementation of shared governance decreased both actual decisional involvement and preferred decisional involvement (Bina et al., 2014). The paper speculated that this was due to the organizational administrative leaders not allowing nurses to have an adequate role in controlling their practice (Bina et al., 2014).

As the purpose of shared governance is to put the control of nursing practice into the hands of bedside nurses, it is important to avoid creating a hierarchical structure that limits bedside nurses’ access to nursing practice decisions. Unit councils that are detached from central shared governance structures, or that operate without central structures, are unable to exert adequate control over nursing practice because they lack access. When comparing successful unit-level councils to unsuccessful, the key to success is a well-integrated shared governance structure with communication between council levels, as well as education at initiation so nurses can best utilize the structure.

**Evidence Based Practice Council.** Evidence based practice (EBP) uses scientific
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evidence to determine nursing practice. The use of EBP provides nurses with the research needed to guide nursing practice, and allows nurses to use the results of research to guide and direct nursing practice. Two councilor model studies implemented EBP councils to give nurses autonomy in shaping nursing practice (Brody et al., 2012; Sakowski et al., 2012). One study established EBP councils in 2007 composed of five to twelve bedside nurses, with nurse directors to guide the initial formation and organization of the councils (Brody et al., 2012). Qualitative evaluation following implementation revealed “council members believed that the ability to change standards of practice and improve quality of care presented them with an opportunity for workplace empowerment” (Brody et al., 2012, p. 30). The other study implemented EBP councils to initiate quality improvement measures across nursing controlled practices (Sakowski et al., 2012). Council members in both studies reported that they experienced increased meaningfulness, improved job satisfaction and leadership growth in an EBP councilor model of shared governance (Brody et al., 2012; Sakowski et al., 2012).

In both of these studies focusing on EBP councils as a means to promote nursing control of practice, nurses perceived that EBP councils gave them the data needed to substantiate changes they wished to make in their practice or workplace environments. With scientifically proven support, the changes are likely to be more effective than they might be otherwise, and nurses are likely to gain a sense of meaningfulness and empowerment from implementing effective changes and taking control of their practice. EBP councils are an important part of shared governance because they give nurses the tools to assume control over nursing practice.

Congressional Models

Two studies evaluated a congressional model of shared governance, in which the nursing staff belonged to a congress and committees submitted work to a governance cabinet for
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行政行为（O’May & Buchan, 1999）。一项由 Moore 和 Wells（2010）进行的研究实施了一种共享治理结构，其中包括四个部门级委员会和一个由护理委员会成员和护理执行官组成的护理员工委员会。在实施这种类型的模型后，护士对结构授权或组织承诺的感知没有变化，表明共享治理结构没有改善护理结果（Moore & Wells, 2010）。他们将这些发现归因于实施不善，或结构问题。然而，这些作者不确定这些发现的原因，因为没有计划或进行后续调查（Moore & Wells, 2010）。

另一项由 Whitt 等人（2011）进行的研究实施了以单元为基础的委员会、三个部门委员会和一个护理管理大会作为他们的共享治理模型。大会主席来自每个护理单元委员会，以及跨学科参与者作为他们共享治理模型的一部分（Whitt et al., 2011）。为了在医院中做出改变，护士会请求委员会改变，然后投票提交请求的改变到大会（Whitt et al., 2011）。大会投票，如果改变请求被通过，它就会交给国会决策实施团队（CDIT）包括沟通官，临床信息科学家，执行赞助商，和一个临床教育成员（Whitt et al., 2011）。CDIT每月为所有护士更新所有行动项目的状态（Whitt et al., 2011）。实施后，作者观察到护士的工作满意度和决策能力的提高（Whitt et al., 2011）。正如之前所述，实施一个忽视将单元委员会整合到医院级别的共享治理模型限制了护士的决策能力（Bina et al., 2014）。有趣的是，这种结构提高了护士的决策能力。
considering they only presented requests to the councils for consideration and were not involved in deciding which practice changes would be implemented. It is possible that because CDIT posted monthly updates about changes to nursing practice, and the requested changes were implemented on a hospital-wide level, nurses perceived a greater decision-making ability.

**No Model Stated**

One study implemented shared governance along with enhancing roles for licensed practical nurses (LPNs), augmenting administrative support on nights and weekends, and introducing wireless communication devices (Teasley et al., 2007). Night shift registered nurses reported an increase in workplace satisfaction following the implementation of shared governance, while day shift registered nurses reported a decrease (Teasley et al., 2007). This study does not provide conclusions about shared governance structures, because its results are confounded with the implementation of LPN roles, administrative support, and wireless communication device interventions.

**Additional Components**

Two components that enhanced the effectiveness of shared governance models were identified in the literature. These components include professional development and education. Each of these components will be discussed in greater detail below.

**Professional Advancement.** Professional advancement, for the purposes of this review, is described as any process or structure that promotes nursing responsibility, be that through increasing leadership roles or attaining higher levels of clinical education. At a time when nurses are striving to develop their national image as professionals, professional advancement emerged from this review as an important component of nursing practice. In many ways, shared governance and professional advancement go hand in hand. Shared governance requires nurses
to take control of their own practice by assuming positions of leadership, but to reach those positions nurses must advance themselves professionally through continuing education, obtaining certifications, obtaining advanced degrees, or other formal and informal learning experiences. Through professional advancement, nurses can be better prepared to assume leadership over their own nursing practice, just as nurses take control of their own practice through the management structures created by shared governance models.

Participation in shared governance increases nurses’ leadership skills and their professional advancement (Beglinger et al., 2010; Brody et al., 2012). Following eighteen years of shared governance, one hospital reported that five nurses advanced from council chairs to unit directors, and three nurses advanced from council chairs to clinical nurse specialist roles (Beglinger et al., 2010). Another hospital reported that 21% of shared governance council members applied for promotion after joining, and 76% assumed additional responsibilities such as “committee work, education initiatives, and charge nurse duties” (Brody et al., 2012, p. 31). These studies suggest that shared governance inspires nurses to pursue advancement as they come to understand the benefits of taking control over their own practice.

An alternate approach for leadership development within shared governance was to use education programs for encouragement. One hospital utilized a Frontline Nursing Leadership Program to promote leadership development among its council members, along with communication skills training to assist in effective management of council activities (Bretschneider et al., 2010). Shared governance implementation at this hospital resulted in increases in decision-making, autonomy, and professional status (Bretschneider et al., 2010).

**Education.** Education before and during shared governance implementation assists nurses in understanding the purpose for and process of shared governance. It also provides the
knowledge nurses and hospital leaders need to implement shared governance in a manner that fosters nursing autonomy.

One study, which concluded that shared governance drives nurses to pursue leadership roles, used education throughout their shared governance structure to groom clinical nurses for future leadership roles (Beglinger et al., 2011). The hospital, based on the belief that shared governance promoted professional development, created forums where staff nurses could learn about management, mentoring and education programs for nurses interested in pursuing management positions, and classes were provided that focused on opportunities for leadership and advanced practice (Beglinger et al., 2011). The hospital anticipated that with these programs they would promote professional advancement into leadership positions and advanced practice through the empowerment opportunities offered by a shared governance structure.

Three studies demonstrated that having an experienced authority assist with educating new council members throughout the implementation process resulted in many positive nursing outcomes, including increased job satisfaction, autonomy, professional status, and empowerment (Bretschneider et al., 2010; Brody et al., 2012; Newman, 2011). The first study used nurse managers to precept clinical nurses during their first year as a chair of unit-based councils (Bretschneider et al., 2010). This precepting relationship gave clinical nurses a resource from whom they could learn their role as a nurse leader working on the council. In addition to the preceptor, clinical nurses were offered a four hour standardized education curriculum to learn about their shared governance role (Bretschneider et al., 2010). The second study reported a hospital’s experience using education on shared governance theory for nurse managers and senior nurse leaders to facilitate the transition to shared governance (Newman, 2011). The nurses participating on councils attended a conference led by shared governance proponent, Dr.
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Timothy Porter O’Grady, and an educational seminar kickoff event was convened for council members with additional education sessions provided throughout the first year (Newman, 2011). Nurses at both of these hospitals demonstrated decreased nurse turnover, improvements in their perceptions of the practice environment, and increased job satisfaction (Bretschneider et al., 2010; Newman, 2011).

The third study used nurse directors as mentor to groups of bedside nurses participating in evidence-based practice councils until they had the knowledge to independently manage the councils (Brody et al., 2012). Council members participated in the study through interviews and surveys, and reported that these councils lent meaningfulness to their work, “presented them with an opportunity for workplace empowerment” and paved the way for leadership growth (Brody et al., 2012, p. 30). These studies indicate that using qualified leaders to educate new members about the shared governance process provides guidance and support. This support allows staff nurses to develop knowledge, confidence, and eventually autonomy in running the councils. The confidence these nurses develop results in positive nursing outcomes such as empowerment, meaningfulness, and job satisfaction.

Alternately, a lack of education about shared governance can result in negative outcomes. Wilson (2013) found that three hospitals that claimed to have a shared governance structure actually provided no formal education for new council members, but instead provided them with a resource manual. The study reported that several department level councils at this hospital were no longer functioning, which the authors interpreted to mean that inadequate education about and a theoretical understanding of shared governance would prevent the structure from being sustainable (Wilson, 2013). Without supportive, continuous education for nurses involved in and outside of shared governance, the structure may not be effective. Nurses cannot benefit from the
positive outcomes of shared governance if they are lacking education about how the model can be used to shape nursing practice.

**Structures within Shared Governance.**

Other studies used the structure of shared governance to implement changes that positively affected nursing practice such as increased job satisfaction and decreased turnover (Fujita, Harris, Johnson, Irvine, & Latimer, 2009; Parsons, 2004; Winslow et al., 2011).

Clinical ladder programs implemented within a shared governance structure provide impetus for professional advancement. Kramer et al. (2008) interviewed nurses on 101 separate units at eight hospitals and reported that shared governance and clinical ladders were repeatedly identified by nurses as a component that enabled control of nursing practice. Nurses working at these hospitals reported a higher level of control over nursing practice than the national magnet average, as well as a moderate to high level of empowerment (Kramer et al., 2008).

Another study reported the implementation of a clinical ladder program through shared governance, which resulted in increased satisfaction and decreased turnover for those individuals on higher levels (Winslow et al., 2011). Conducted at Martha Jefferson Hospital, a clinical ladder program was implemented through a newly created Clinical Ladder Committee and Shared Governance Education Committee formed by nurses participating in shared governance (Winslow et al., 2011). Nurses who were higher on the clinical ladder reported increased job satisfaction and demonstrated lower turnover rates (Winslow et al., 2011).

Within the shared governance structure, another study reported the results of a new nursing peer review structure implemented within a shared governance structure to promote staff participation, nursing accountability, and process transparency (Fujita et al., 2009). The hospital created a nursing peer review committee with two advanced practice nurse co-chairs and staff
nurses to review and vote on cases (Fujita et al., 2009). The positive results from this study were increased levels of satisfaction, autonomy, decision-making, and staff engagement, as well as decreased vacancy rates (Fujita et al., 2009). Using shared governance, nurses were able to institute positive organizational changes that allowed them to take control over nursing practice, which led to positive staff outcomes.

The final study used a conference to bring together staff for shared governance collaboration (Parsons, 2004). The annual conference was used to brainstorm strategies to unite hospital-wide shared governance with unit-level nursing staff (Parsons, 2004). The pilot study, conducted with 27 staff from their Emergency Department, involved a conference to establish unit action plans for change through voting (Parsons, 2004). The unit reviewed progress monthly, and participated in an additional two conferences every six months to maintain progress (Parsons, 2004). There were no changes in control over practice or work satisfaction after implementing the use of this conference. However, nurses’ perceptions of organizational commitment, or their identification with and involvement in the organization, did increase, and nursing turnover and vacancy rates declined. However, given that only 22% of the nurses from the unit participated in the study, it is difficult to draw any conclusions about the effects of the conference implementation per se on the reported outcomes.

In these three studies, a shared governance structure in the hospital paved the way for nurse leaders to implement changes that promoted greater control over practice among nurses. The results were positive, such as increasing satisfaction levels, decreasing vacancy rates, and increasing staff engagement (Fujita et al., 2009; Parsons, 2004; Winslow et al., 2011).

**Discussion**

To implement a shared governance model that promotes control over nursing practice,
and results in positive nursing outcomes, hospital leaders must consider both the structure of the model as well as additional components like professional advancement and education that improve shared governance effectiveness. Once implemented, additional activities, such as clinical ladders, nursing peer review, and conferences can be used to supplement shared governance structures that promote control of nursing practice.

The studies in this review indicated that the structure selected did not determine the effectiveness of shared governance as there were a variety of structural combinations in both successful and unsuccessful shared governance models. Instead of focusing on what structure to use, hospitals should focus on ensuring that the structure is integrated. Collaboration among different levels of councils must exist, and nurses must be able to implement hospital wide changes to nursing practice using the shared governance structure (Newman, 2011; Whitt et al., 2011). EBP councils promote positive nursing outcomes because they give nurses the scientific tools to select appropriate, effective interventions, which promoted nursing autonomy and increased job satisfaction (Brody et al., 2012; Sakowski et al., 2012). Unit-based councils produce positive outcomes when they are well incorporated into the overall shared governance structure using an integrated model approach (Newman, 2011; Whitt et al., 2011). Without a well-organized, supported shared governance structure, nurses are unable to utilize shared governance to control nursing practice and improve outcomes. It is also important to measure the effects of shared governance at regular intervals to ensure that the selected structure is effective (Anderson et al, 2011).

Additional components of shared governance that best promoted nursing control of practice and created positive outcomes for nurses were education and professional advancement. Educational curricula offered in tandem with shared governance implementation was reported to
increase job satisfaction, autonomy, professional status, and empowerment (Bretschneider et al., 2010; Brody et al., 2011; Newman, 2011). Professional advancement, whether it emphasized assuming leadership positions or promotion via clinical ladder programs, emerged as a component of shared governance that increased nursing empowerment and satisfaction (Brody et al., 2012; Kramer et al., 2008; Winslow et al., 2011). Education and professional advancement are both components that should be used within shared governance to promote positive nursing outcomes.

Introduced by Porter O’Grady in 1984 as an organizational model to put the control of nursing practice into the hands of bedside nurses, shared governance has been shown to increase job satisfaction, autonomy, control of nursing practice, commitment to the organization, and empowerment. Structurally, shared governance is most successful at improving nursing outcomes when its structure promotes communication and collaboration, and when it uses evidence-based practice councils, in addition to other councils, to support decision-making. Evidence-based practice councils provide nurses with the evidence needed to support decision-making processes and ensure that changes implemented within shared governance structures are effective.

Shared governance is most successful in improving nursing outcomes when it uses education to promote its development and incorporates professional advancement programs. Education in tandem with implementation gives nurses the knowledge necessary to use the shared governance structure in a way to make decisions about policy, nursing practice, and structure. Professional advancement goes hand in hand with shared governance, as it gives nurses the leadership positions required to assume control over nursing practice. Properly implemented shared governance can be used to create programs that benefit nurses, such as
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clinical ladder programs, nursing peer review programs, and shared governance conferences.
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