Yes, We Can and Did: *Engaging and Empowering Nurses Through Shared Governance in a Rural Health Care Setting*

Linda McClarigan, MS, BSN, RN, NE-BC, David Mader, BSN, RN, CCRN, CCDS, and Carrie Skiff, RN

The ever-increasing demands on health care systems to improve patient satisfaction, manage costs, improve the quality of care, and promote a healthy work environment known as the Triple Aim Plus One, has forced many organizations to reorganize, merge, affiliate, or close their doors entirely. At the center of any organization that hopes to be successful in achieving the Triple Aim Plus One, is an engaged nursing workforce.[1] According to the Press Ganey employee engagement database, 15 of every 100 nurses are considered disengaged (thus lacking commitment and/or satisfaction with their work). Conservative estimates suggest that each disengaged nurse costs an organization $22,200 in lost revenue due to a lack in productivity.[2] There have been many studies that have shown the impact nurses have on both patient satisfaction and quality of care outcomes.[1,3] The challenges have been how to keep nurses in the rapid-fire, tumultuous health care environment from burning out and how to promote a high level of engagement. One method of achieving a high level of nurse engagement is the implementation of shared governance.[4] The purpose of this article is to share the story of how one rural health care system ignited nurse engagement through the implementation of shared governance.

SETTING

Located in northern New York, Adirondack Health is a health system comprising a 95-bed acute care hospital, 4 primary care clinics, multiple specialty clinics, and a long-term care facility. It is the only health care system within the 6 million–acre Adirondack Park. Our nursing staff were largely recruited from our local community college with greater that 75% of staff achieving the associate degree in nursing (ADN) as their terminal degree.

Three years ago, we, the nursing leadership team, recognized that we were challenged by a long-term union environment, where salary increases were automatic within the language of the contract based on seniority, rather than merit. Additionally, continuing education apathy and longevity entitlement were rampant. Along with these unique challenges within our small rural hospital, we were also faced with meeting regulatory requirements that all health care facilities are faced with such as meaningful use, computerized provider order entry, value-based purchasing (VBP), and

Figure 1. Adirondack Health Councilor Model

electronic health records, to name a few. Direct care staff's attempts to respond to these numerous challenges can lead to stress, disengagement, and ultimately, burnout of nurses due to an unstable work environment. Through research, a direct correlation has been found that nurse engagement, patient safety, satisfaction, and quality outcomes are interconnected.[3] Further research has shown that practice environments that incorporate shared governance improve all the above.[4] On the basis of this knowledge, we embarked on the shared governance journey utilizing the work of Tim Porter O'Grady.[5] O'Grady's principles of partnership, equity, accountability, and ownership are the foundational components of shared governance at Adirondack Health.[5]

BUILDING THE ESSENTIALS FOR SUCCESSFUL IMPLEMENTATION

For shared governance to be successful, there are essentials that need to be in place. These include leadership support, the education of staff, and creation of practice councils.

LEADERSHIP SUPPORT

A committed nurse officer or chief nursing officer (CNO) is the key to a successful implementation. He/she needs to create, communicate, and sell the vision across the organization, from the C-suite to the direct care staff. He/she must build an environment of mutual respect and trust. This creates a culture of "excellence everyday." He/she needs to be a change-hardy, innovative, and futuristic thinker. Education, facilitation, and resource coordination is a large piece of the nurse executive's role in shared governance.

The C-suite must accept and understand the value of shared governance and allocate appropriate resources for successful implementation. This falls largely on the CNO who must continually educate and update other members of the C-suite of the gains that the organization is realizing through shared governance. In our organization, the CNO used data and evidence related to value-based purchasing and nurse-sensitive indicators to make the financial case for tying outcomes to reimbursement through an engaged workforce.

Along with the CNO, the nursing leadership team must be strong and committed to the success of shared governance. Our CNO again used much of the same evidence that she used with the C-suite to garner director support. We were fortunate that most of our leadership already possessed similar values and beliefs, as well as a vision, for where our organization was headed. Our nursing leadership firmly believed that the best staff is an engaged staff. The directors assist with running meetings, teaching computer skills, taking minutes, and performing other tasks that the direct care nurses struggle with initially. In our experience, the leadership team had to continually remind themselves to take a step back and let the direct care staff take control of the councils. They must serve as mentors, coaches, and facilitators to the various councils, not directors.

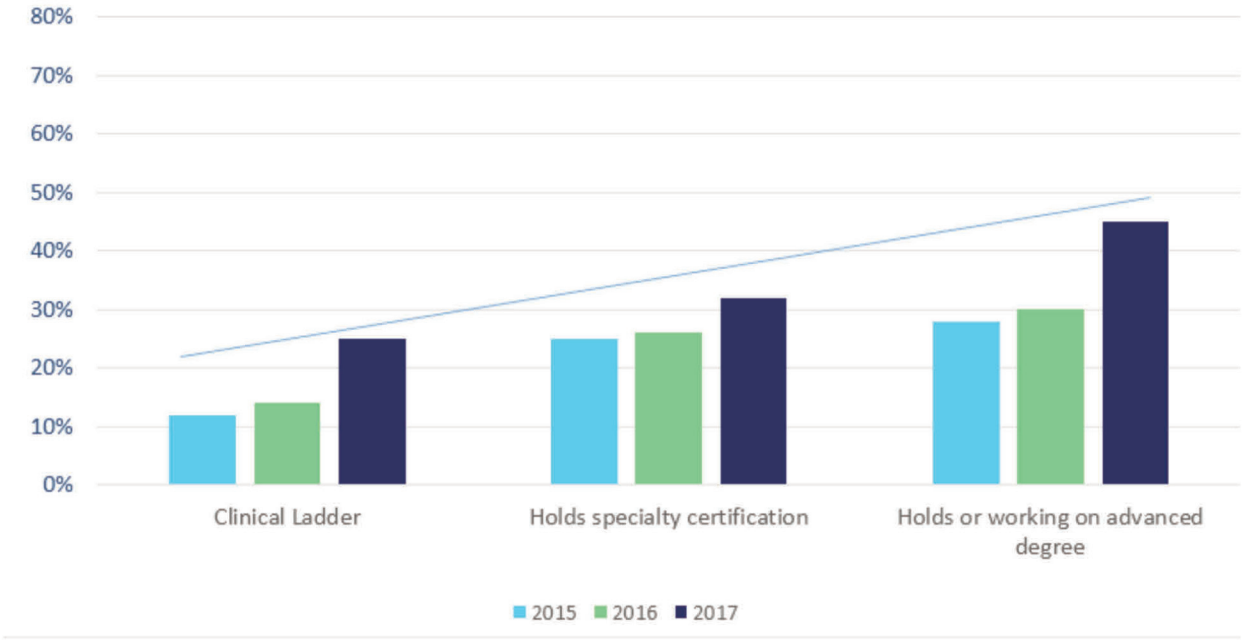
STAFF EDUCATION

Early education of the direct care nurses is crucial for them to gain confidence and trust in the shared governance model. This will ensure the model chosen is a good fit for your organization. It must include education regarding the foundational components and concepts of all shared governance models to promote nurse buy-in and acceptance of the model that is ultimately chosen by them. Re-education is imperative to successful embedding of new council membership as the council grows and changes. In our organization, we initially rolled out a mandatory educational session detailing the principles, structures, and various models of shared governance. Approximately a year later, we held multiple open forums over the course of a week to foster discussion with staff about which model of shared governance would be most practical in our small organization and to determine whether the staff thought it was feasible and of interest to them. Ultimately, there was enough interest to form 5 councils (*Figure 1*).

BUILDING PRACTICE COUNCILS

As any engineer will tell you, one of the prime aspects to building any structure is creating a solid foundation. If this step is neglected, one can plan on the need to rebuild the entire structure in the future because there is a high potential for collapse. Taking the time to develop the professional practice model, charters, bylaws, philosophies, a logo, and standardized forms and tools is imperative to the future success and sustainability of your shared governance model. This is by far one of the most difficult and time-consuming tasks to complete, but well worth the effort. In our organization, we used the main governing council, which comprised the chair, cochair, and mentor from each of the 5 councils, as well as the CNO, to disseminate samples of charters, bylaws, rules of order, logos, mission, vision, and value statements, etc. to bring back to their councils for discussion. Feedback was obtained from all the councils, and multiple revisions ensued for well over a year. This was by far the most frustrating and discouraging time, leading to the loss of some membership.

Figure 2. Registered Nurses at Adirondack Health Professional Growth and Development



Although this was a discouraging period, we now realize it was vital to creating a solid foundation upon which all councils felt that they were instrumental in creating. This was essentially our very first shared governance success.

COUNCIL SUCCESSES

After the initial lengthy period of laying the foundation, the councils began to choose projects with enthusiasm and pride as they worked toward and completed their goals. For example, many nurses were grappling with the dilemma of personal cell phone usage while attempting to communicate with physicians. Out of this dilemma, the Technology and Informatics Council researched and implemented a HIPAA (Health Insurance Portability and Accountability Act)-complaint secure texting platform for improved communication. This is now utilized across the organization. The Nurse Practice Council implemented monthly nursing grand rounds as a result of a recognized need for more educational opportunities. The topics that were chosen were cutting edge and timely such as: medical marijuana use, caring for transgender patients, and the opioid crisis. "Grow as a Professional Day" was developed by the Education and Professional Development Council due to our high number of long-term ADN nurses as well as the Institute of Medicine's report *The Future of Nursing: Leading Change, Advancing Health*.[6] The goal of this day was to provide the nursing staff in our organization with the education and tools necessary to obtain an advanced degree, specialty certification, or clinical ladder status. As demonstrated in Figures 2 and 3, this has been a successful program. The Recruitment and Retention Council built a very successful mentorship program that has increased our graduate nurse retention rate (*Figure 4*). The Quality Council, based on declining use of the Rapid Response Team (RRT), researched, developed and implemented a revised rapid response policy, algorithm, protocol, and debriefing tool. This initiative has led to increased usage of the RRT leading to decreased need for cardiopulmonary resuscitation (code blue) (*Figure 5*).

ORGANIZATIONAL OUTCOMES

Many of these council successes thus far have led to tremendous organizational success. As mentioned above, positive trends have been seen in the professional growth of staff (*Figure 2*), nurse satisfaction, decreased staff turnover (*Figures 6 and 7*), new graduate retention (*Figure 4*), patient outcomes, and laying the groundwork for the ANCC Pathway to Excellence® designation. Evidence shows that nurses with higher levels of education, engagement, job satisfaction, and longevity lead to better patient care and outcomes.[7] In today's health care environment, these positive outcomes lead to reduced health care–acquired conditions, improved nurse-sensitive indicator metrics, improved payer incentives via VBP ultimately optimizing reimbursement, while keeping the exorbitant costs of nurse turnover at a minimum.

LESSONS LEARNED

Throughout our journey, we gained insight into several components for successful implementation and learned a number of valuable lessons. The first lesson learned was to *assess where you are before you begin*. It is important to ask yourself, "What is our professional practice model?" "Do we even have one?" "Can the direct care staff communicate the model?" "Is it based on the work of a theorist?" "What is working well in our organization?" and "What is not working well for us?" It is imperative to know where you are before you embark on any journey.

Figure 3. NYS Educational Level of Nurses
HANYS, Healthcare Association of New York State; NYS, New York State.[8]

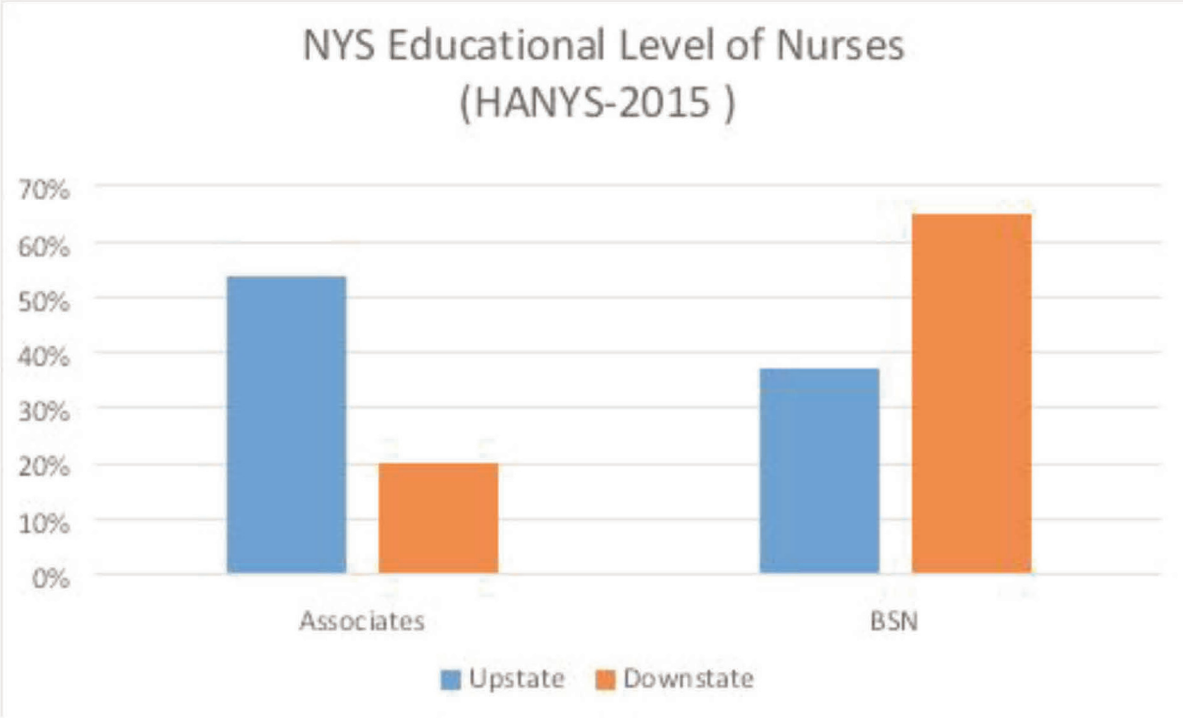
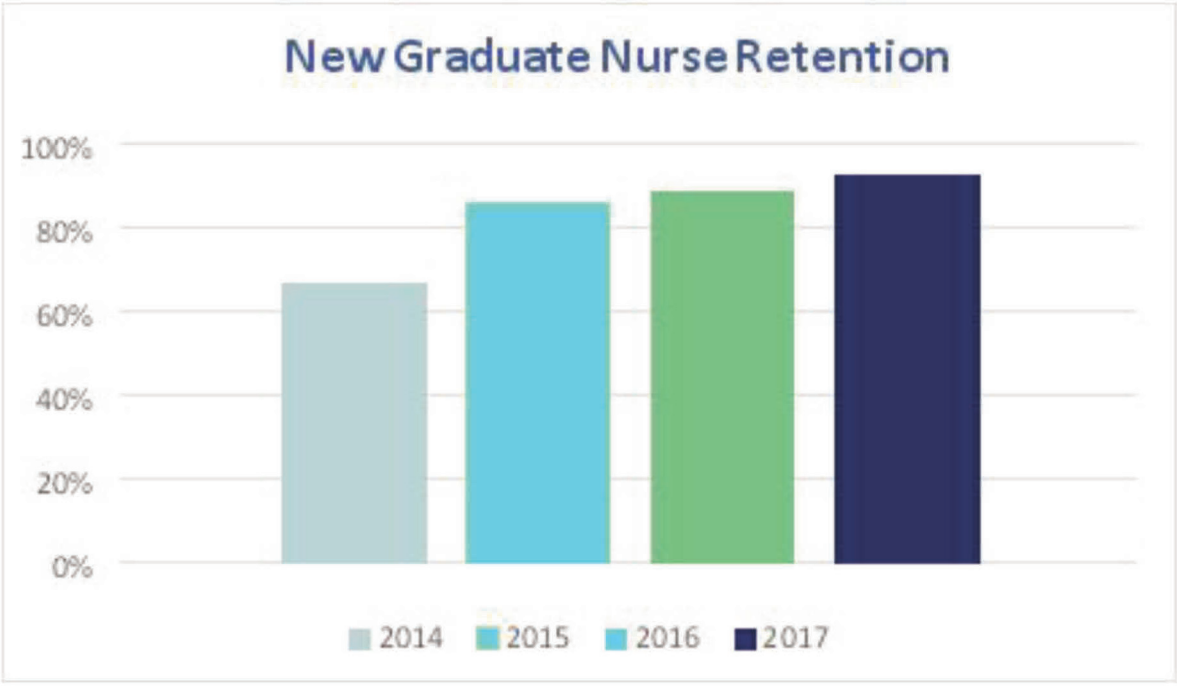


Figure 4. Adirondack Health New Graduate Nurse Retention

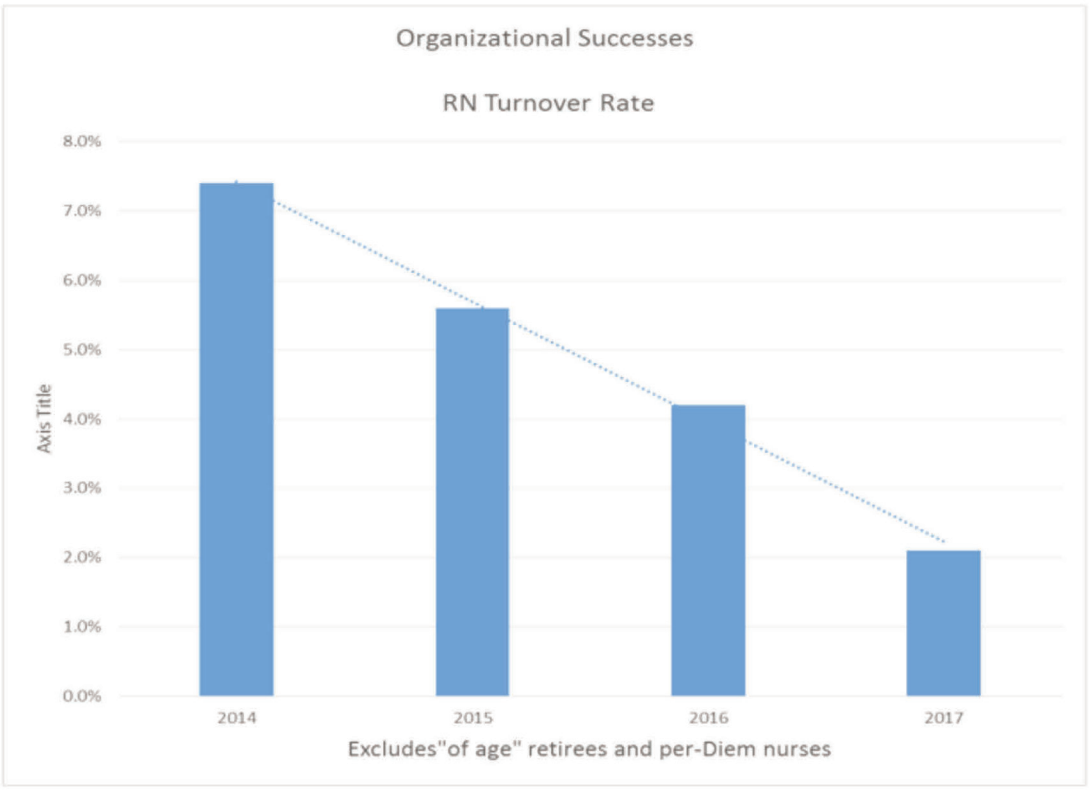


Another lesson we learned is to *be patient*. There will be setbacks—prepare for them. It is important to have a timeline for any initiative but maintain flexibility as the councils grow and mature. Some projects initially chosen may require more time and resources than expected.

Similarly, we learned that *consensus can be painful*. Although nurses share many key similarities, they are also as diverse as our society as a whole. Like any group, they come from a variety of backgrounds, generations, cultures, and political parties, holding vastly different opinions at times. Making decisions by consensus allows for a group to create a solution that is greater than any one person can make alone. In order to build consensus within any council, there must be tolerance, sensitivity, and mutual respect. Everyone's voice must be

Figure 5. Rapid Response and Code Blue Events

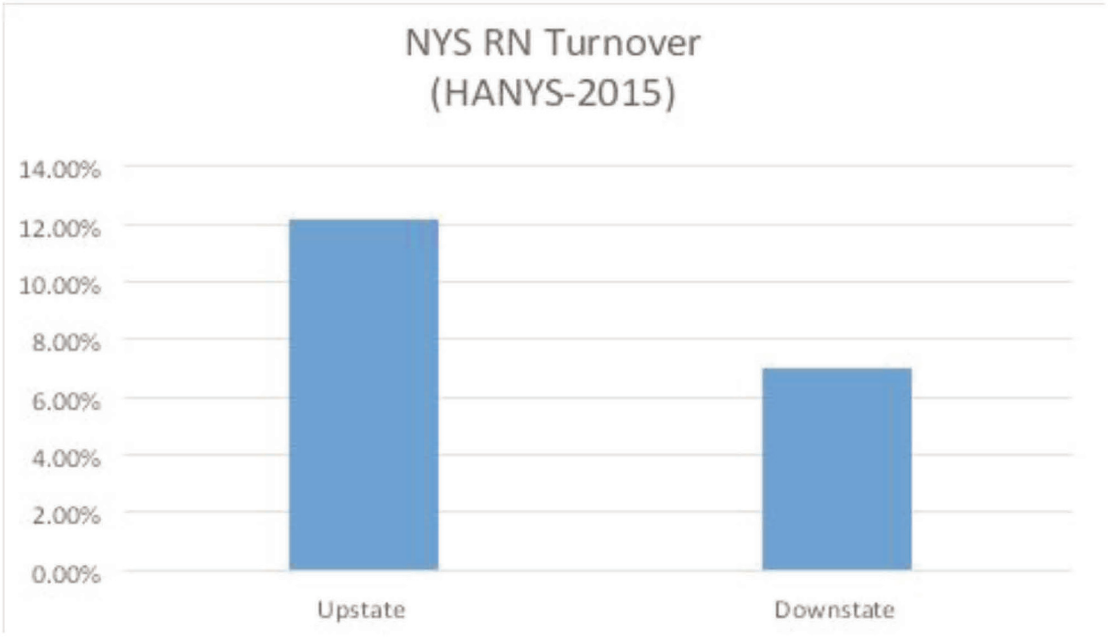
Figure 6. Adirondack Health RN Turnover Rate



heard to create a solution that best serves everyone's vision and meets the goal of the project.

We also learned that *project selection is important*. It is vital that each of the councils choose a project that is in alignment with the strategic plan of the organization or department and within the council's circle of influence. With everyone's plate so full, why not have the council choose a project that aligns with the organization's goals? To ensure successful completion of a coun-

Figure 7. NYS RN Turnover
HANYS, Healthcare Association of New York State; NYS, New York State.[8]



cil's initial project, it is best to select a project that nursing has complete control over. For example, it is risky to choose a project that requires assistance from the information technology department because they may have different goals to meet in that time frame and cannot dedicate time to help the council. However, as the shared governance model becomes solidified, it should expand to include other disciplines in the organization. This will facilitate future multidisciplinary projects.

The most important take away was to *communicate and celebrate often*. It is essential that the direct care staff hear about the shared governance activities. This is done using a variety of methods which include CNO rounding, CNO round-the-clock meetings, newsletters, staff meetings, bulletin boards, e-mail, and the organization's intranet. This multimodal communication keeps shared governance and the councils' successes in the forefront of the staff's minds. Shared celebrations garner enthusiasm, support, and interest in shared governance. Our organization celebrates twice a year with a summer garden party and a December holiday party for all staff that are involved in any aspect of shared governance or anyone advancing their professional education. Celebrating successes, achievements, and milestones gives the members of shared governance an opportunity to reflect on the positive changes they have made and give them confidence and motivation to continue to strive for "excellence everyday."

CONCLUSION

Implementing shared governance is possible, even in a small rural health care system, with limited resources and a challenging union environment, by creating partnerships and building bridges between direct care nurses from across the continuum with nursing leadership. That partnership reignited and engaged the workforce. An engaged nursing workforce is essential for any organization to not only survive, but thrive, in today's turbulent health care environment. NL

References

1. Kerfoot K. Four measures that are key to retaining nurses. *Hosp Health Netw.* 2015. Available at: https://www.hhnmag.com/articles/3253-four-measures-that-are-key-to-retaining-nurses. Accessed September 16, 2017.
2. Schaufenbuel K. Powering Your Bottom Line Through Employee Engagement. 2013. UNC Kenan-Flagler Business School. Available at: http://execdev.kenan-flagler.unc.edu/powering-your-bottom-line-through-employee-engagement. Accessed September 16, 2017.
3. Press Ganey. *Nursing Special Report: The Influence of Nurse Work Environment on Patient, Payment, and Nurse Outcomes in Acute Care Settings.* South Bend, IN: Press Ganey; 2015:2-23.
4. Kutney-Lee A, Germack H, Hatfield L, et al. Nurse engagement in shared governance and patient and nurse outcomes. *J Nurs Adm.* 2016;46(11):605–612.
5. Swihart D, Hess R. *Shared Governance: A Practical Approach to Transforming Interprofessional Healthcare.* 3rd ed. Danvers, MA: HCPro; 2014.
6. IOM (Institute of Medicine). *The Future of Nursing: Leading Change, Advancing Health.* Washington, DC: The National Academies Press; 2011.
7. Aiken LH, Clarke SP, Cheung RB, Sloane DM, Silber JH. Educational levels of hospital nurses and surgical patient mortality. *JAMA.* 2003;290(12):1617-1623.
8. Healthcare Association of New York State. *2015 Nursing and Allied Professionals Workforce Survey Report: Exploring Emergent Healthcare Workforce Titles and Functions.* Rensselear, NY: Healthcare Association of New York State; 2015.

Linda McClarigan, MS, BSN, RN, NE-BC, is chief nursing officer and vice president patient care services at Adirondack Health in Saranac Lake, New York. David Mader, BSN, RN, CCRN, CCDS, is assistant vice president patient care services at Adirondack Health. He can be reached at dmader@adirondackhealth.org. *Carrie Skiff, RN, is patient care director, critical care, at Adirondack Health.*

1541-4612/2019/ $ See front matter

http://dx.doi.org/10.1016/j.mnl.2018.04.004