Shared Governance and Rapid Response Teams Beyond Clinical Practice: *The Nurse Executive Advisory Cabinet*

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Nurses have continuously met challenges and adapted to change within an environment that is in constant flux. Given the need to transform care models and systems to respond to healthcare reform while balancing the quality and cost equation, nurses are working within a rule- and policy-imposing structure that profoundly affects their level of control over nursing practice (CONP) and engagement. Nurses are challenged to work in an environment in which the pressure to add value, optimize resources, and decrease expenses is moving at a faster pace than the work to transform the clinical delivery model and workflow. Consequently, this may result in a decreased sense of autonomy and overall CONP, augmenting the case for change. This sense of urgency, the need to find new solutions to old problems, presents an opportunity to creatively re-engage nurses in a greater breadth (i.e., type and level of involvement) of decision making and influence over practice and the context in which care is delivered.

The article aims to describe how a chief nursing officer (CNO) implemented a registered nurse participative governance model throughout an Integrated Delivery Network (IDN) to influence an administrative staff reallocation (float) policy beyond the traditional shared governance model. The model utilizes a rapid-response approach to provide accelerated problem solving throughout the organization.

INTEGRATED DELIVERY NETWORK

Traditionally, healthcare organizations have been primarily hospital focused, engaging in vertical integration through partnerships with physician groups and horizontal integration through multihospital mergers and acquisitions. Today's prevailing market conditions have been influenced by the comprehensive health insurance reform launched by the

Affordable Care Act of 2010[1]. These monumental changes paired with a renewed focus on clinical integration, consumerism, innovation, and high value, caused many organizations to transition from a primarily hospital-centric, vertically integrated design to a design with a higher focus on care models structured to deliver high-quality care at the lowest cost possible across the continuum of care. In addition, healthcare organizations are more focused on increasing patient access and focusing on disease management, population health, disease prevention, and wellness. Burns and Pauley[2] comment on past managerial innovation and hospital corporate structures and processes taken to address this need, including medical homes, accountable care organizations, and IDNs. These approaches are not new and, in fact, have been around for some time, although they are often poorly executed. However, by the very nature of an IDN, the successful integration of structures, processes, and practices can be a very effective means of delivering high-quality cost-effective care. This new IDN vision focuses on guiding consumers of healthcare seamlessly through the continuum of care with a focus on wellness, prevention, treatment, and recovery. In short, an effective IDN is set to provide the right care, at the right time, at the right place, with the right caregiver, no more and no less.

SHARED GOVERNANCE

As IDNs become more prevalent, successful implementation of this operating structure will be dependent on exceptional execution of the IDN principles and elements. This execution will require an engaged workforce across the organization to optimize efficiencies in both clinical and administrative process and practices. Traditionally, shared governance has served as a means of engaging nurses across an organization such as an IDN. The advent of nursing shared governance in the 1980s was an integral part of the acute care professional practice model. Shared governance was viewed as a managerial innovation that shifted control of nursing practice, once held only by managers, to the practicing nurse in collaboration with the manger. Hess[3] further explains how shared governance served as an introduction to participative management, harnessing the collective intelligence of nurses. These structures also supported nurse empowerment and shared decision making in clinical policies and practice, as well as increasing job satisfaction, CONP, and retention.[4,5]

Despite these benefits and positive outcomes, shared governance models have been described as poorly structured and badly implemented, making it difficult to sustain involvement and interest. In fact, Weston[6] shares her concerns that the concepts of empowerment and participatory management have historically been laden with a paternalistic tone, in which people in positions of authority allow staff to provide input and participate in some operations. In essence, the past structures that sought to empower and engage nurses from the bedside to participate in clinical decisions ultimately left power with the management team.[6] Consequently, just as in healthcare systems, the shared governance models have undergone many transformations throughout the last several decades as a result of nurses having expressed a desire for a greater voice in a wider range of activities. Hess[3] adds that other variables contributing to the case for change include complex multilevel structures, lack of accountability and "involvement-friendly environment" for nurse participation, minimal training and coaching for decision making, and cost effectiveness.

RAPID RESPONSE TEAMS MODELING THE WAY

One of the primary weaknesses of the traditional shared governance structure is the inability to make rapid decisions due to the complexity and interconnectedness of multiple teams related to the organizational structure. As nurse executives search for other models in which nurses have demonstrated effective and efficient critical thinking, teamwork, and collaboration; use of best practice; and clinical inquiry to improve outcomes within the complex healthcare environment, the current body of knowledge on the structure and value of rapid response teams (RRT) in hospital settings can provide valuable insights. Critical elements of an effective RRT, such as nurse empowerment, collective problem solving, and quick response can serve as a model for nurse executives to consider in the development of a rapid decision-making model within an IDN.

One of the key impetuses for the implementation of best practice RRTs within the hospital setting was the failure to rescue, which is described as delayed recognition of patients' deteriorating condition and subsequent lack of intervention resulting in an adverse outcome. According to Jones et al,[7] the aim of the RRT is to improve patient outcomes through identification of patients at risk, early notification of an identified set of responders, rapid intervention by the response team, and ongoing evaluation of the hospital-wide processes of care. These key components within the RRT model can be adapted to serve as a template for a rapid response approach to provide accelerated decision-making and problem solving throughout the organization. Moreover, nurse executives can learn from both the past and present shared governance and RRT structures to build a contemporary, efficient, and effective model for nurses to shape and influence both clinical and administrative policies and practices, affecting patient outcomes as well as the heart, minds, and wallets of the nurses.

THE NURSING QUEST FOR GREATER VOICE

The benefits of autonomy, shared decision making, and CONP contribute to increased nurse satisfaction and engagement.[8] Unfortunately, evidence suggests there is a moderate degree of dissonance between what the manager and staff nurses perceive to be the optimal type and level of involvement in decisions influencing the work environment and ideal CONP. In fact, Scherb et al[9] found nurses' actual level of shared decision making was less than their preferred level, with statistically significant differences in unit governance and leadership and quality of support staff practice. Additionally, Gormley[10] found a similar dissonance in staff nurses' and