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Shared Governance During a Pandemic



Robert G. Hess Jr, PhD, RN, FAAN, Susan H. Weaver, PhD, RN, CRNI, NEA-BC, and Karen Gabel Speroni, PhD, MHSA, BSN, RN

When the COVID-19 pandemic struck US hospitals in early 2020, many nurse leaders went into crisis mode management. As the pandemic ensued, shared governance endured at hospitals with well-established models, even without council meetings. At other hospitals, clinical nurses began to wonder what happened to shared governance. This article offers advice and lessons learned from the interplay between the COVID-19 pandemic and shared governance at American hospitals.

Shared governance is ubiquitous in American hospital systems.¹ Other names, such as shared leadership, decision-making, or vision, may disguise it; shared governance may lurk in committee structures with varying degrees of effectiveness or purpose. But it is there, providing the infrastructure to do something important, especially in times of crisis.

Shared governance is a managerial innovation that gives clinical nurses control over their practice and extends their influence over the resources that it supports.² As clinical experts, professional nurses should have input into what they need to provide quality patient care. Shared governance structures and processes, whether unit-based or hospital-wide, afford opportunities for clinical nurses make decisions related to staffing, policy and procedure development, necessary resources, and even innovation and research that is needed. In the 21st century, it is hoped that nurse leaders continue to see the value of shared governance—and not just as a way to meet the American Nurses Credentialing Center's criteria for Magnet[®] or Pathway to Excellence[®] standards.^{3,4} When unexpected emergencies arise, clinical nurses and their managers should continue to steer clinical care together and not abdicate that responsibility to nonclinical experts alone.

PANDEMONIUM ENSUES

In December 2019, the causative agent of an outbreak of viral pneumonia in Wuhan, Hubei, China, emerged as a novel coronavirus, SARS-CoV-2. On January 21, 2020, the Centers for Disease Control and Prevention and Washington State Department of Health announced the United States' first case of COVID-19.⁵ On March 11, 2020, the World Health Organization declared the outbreak as a pandemic,⁶ and on March 13, 2020, US President Donald Trump declared a national emergency. As a result, some acute care hospitals quickly transitioned to primarily caring for

patients with COVID-19 or those persons under investigation (PUI) for the coronavirus.

With the onslaught of patients with COVID-19 and PUI needing care, many nurse leaders went into crisis management mode. As in other disaster situations, incident command centers were set up for decision making.⁷ The focus was on caring for the patients and staff, and dealing with staffing, personal protective equipment (PPE) and related supplies, as well as safety for all. Eventually, nurse leaders had time to make rounds and listen to the staff; however, there was no time for shared decision making.

As the pandemic struck, many clinical nurses were not really even thinking about shared governance as basic care of their patients while protecting themselves and not exposing their families at home dominated their attention. As supplies, demand, standards, and use of resources such as ventilators and PPE shifted weekly from the pre-COVID-19 environment, it sometimes seemed like panic, rather than reason and evidence, drove practice and the use of resources. The situation quickly became further complicated by practices dictated by availability of resources (e.g., whether or not to wear masks) and the need to limit staff exposure (e.g., adding extra intravenous tubing to manage the patient's IV pump outside the room) and not evidence-based practice.

KEY POINTS

- During the COVID-19 pandemic, shared governance endured at hospitals with well-established models even without council meetings.
- Suggestions are provided on how the structure of shared governance can be utilized during times of crisis.

In these unusual times, a hundred years removed from the last pandemic, to speak of shared governance seemed inappropriate or even silly. So, managers and participants cancelled council meetings and even stopped the work of shared governance, including research studies. In fact, some hospitals suspended council meetings, which were deemed “nonessential.”

Depending on their hospital’s location, bedside nurses continued their routines, waiting for something to happen, or engaged in a series of non-evidence-informed practice, as their customary work patterns descended into chaos, searching for a new normal that might preclude shared governance. Yet, some nurses began to wonder what happened to shared governance, as explained by a clinical nurse, “Nurses are not being allowed to do things that will make them feel safe caring for their patients. The premise is that our unit is a ‘clean’ unit, because we do not have patients who have officially tested positive for the coronavirus, but nurses are getting sick and testing positive for COVID-19. I think shared governance allows nurses to make decisions that affect them, and that is not being fully implemented during this pandemic.”

MORE THAN A COUNCIL

In mature models, shared governance has a way of enduring. It can be the best means to stay the course in emergencies; however, overwhelming or unique. Despite COVID-19, shared governance is still thriving and driving practice, only in ways not even considered before the present pandemonium. With an established means for communication, it can fast track practice changes in crisis situations, such as the current pandemic. It offers tools to plan and respond to hospital-wide emergencies. Accordingly, it is more than a collection of councils. When control and influence are shared among staff and managers, shared governance can be a powerful vehicle to effectively and immediately respond to emergent issues, facilitating the safety of not only nurses but all health care workers. It can also facilitate conducting business as usual. A good example of effective shared governance during this pandemic is when informatics council members labored virtually to streamline documentation for clinical nurses, and research council members worked remotely reviewing and approving research proposals.

Here are advice and lessons learned from the challenges raised by the COVID-19 pandemic and shared governance at American hospitals:

1. Evaluate in advance the potential for using your shared governance structure as a mechanism for dealing with the issues hospital-wide emergencies bring to an organization. Is there a better structure or process already in place? Is redundancy within the organization valuable in this case? For example, is there a parallel committee structure in place? If so,

you might think about combining these structures in the first place.

2. Review your bylaws or charter and determine how shared governance should continue during pandemic practice or emergencies (*Figure 1*). Consider those councils that might be essential and those that are not. Bylaws should provide a mechanism for convening an emergency council to be implemented in times of pandemic or other emergencies, with clear delineation of purpose, responsibilities, membership, and virtual meeting options.
3. If shared governance councils are to be used to deal with emergent issues, have resources ready to continue its customary, necessary work. Of course, emergencies, by their very nature, supersede business as usual, but that doesn’t mean that all other functions must stop. If the incident redirects the usual council members to other duties, have alternates in place to conduct the business at hand. Alternate council members should always be training in the wings anyway to ensure an effective succession.
4. Make sure a secure method of holding meetings is in place in advance of situations that preclude usual methods of participation. For example, if customary meeting rooms are being used for emergency-related meetings, have alternate facilities planned. If live participation is contraindicated as with the COVID-19 pandemic, have other methods for remote participation in place, such as web-based programs such as Zoom, Google Meet (Google Hangouts), GoToMeeting, or Microsoft Teams. Again, review your bylaws to determine when virtual meetings are allowed and establish a mechanism to facilitate virtual meetings whether in pandemic practice or not.
5. Have a strong communication system in place that can be used to facilitate vital processes and messages throughout the nursing group and other disciplines within the organization. For example, many mature shared governance models have unit-based phone or e-mail trees, where each individual council member is responsible for relaying communications to 3 or more people, and they, in turn, have a similar number of professionals and so on, until messages reach the

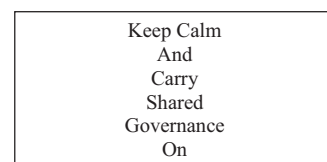


Figure 1. Keep Calm and Carry Shared Governance On.

entire staff of the nursing unit or division. The coordinating council members should have similar assignments to include other essential departments and disciplines within the organization. As the tree spreads, communications can effectively flow to the entire organization.

6. Use this opportunity to incorporate other disciplines within the nursing lines of communication. Besides, if up until now only nursing shared governance has been in place, it's only a matter of time before it becomes an interprofessional model.

In the past, shared governance's popularity and prevalence and utility have often hinged on external factors. For example, administrators have repeatedly discarded or defunded programs in the face of an oversupply of nurses only to resurrect it for recruitment when a nursing shortage re-emerges. This practice has been easily justified when there was little research or only anecdotal evidence to support its association with positive professional, patient, and organizational outcomes. However, that has changed.⁸ Nevertheless, emergencies, such as COVID-19, easily push shared governance aside as administrators and managers face down staffing and equipment crisis, and the warranted hysteria that accompanies a once-in-a-career disaster. But minimally shared governance can offer support that may be desperately needed by a stressed staff. For example, during the COVID-19 pandemic, one hospital used unit-based professional practice councils to send out messages of encouragement to frontline staff, keeping them connected, not only to unit coworkers, but to the organization's bigger perspective.

Shared governance purports to contribute to nursing excellence, and research continues to examine the relationship between shared governance and patient, organizational, and professional outcomes. Shared governance can continue to make a real-time difference—if only we use it.

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Robert G. Hess, Jr, PhD, RN, FAAN, is chief executive officer and founder of Forum for Shared Governance in Hobe Sound, Florida. Susan H. Weaver, PhD, RN, CRNI, NEA-BC, is nurse scientist at Hackensack Meridian Health, Ann May Center for Nursing, in Neptune, New Jersey and New Jersey Collaborating Center for Nursing, Rutgers, The State University of New Jersey, in Newark, New Jersey. He can be reached at bobhess@sharedgovernance.org. Karen Gabel Speroni, PhD, MHSA, BSN, RN, is nursing research consultant at Karen Gabel Speroni Consultant LLC in Leesburg, Virginia.

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