Shared leadership for nursing

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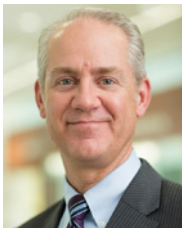

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Abstract What is 'shared leadership', how does it work and how did five Intermountain Healthcare hospitals use it to help their employees become more engaged and their managers more efficient? Shared leadership — an organisational model that is designed to engage front-line staff in traditional management functions, improve communication and help individuals advance their careers — was implemented in 75 nursing units in 5 of Intermountain Healthcare's hospitals in January 2014. The model involves three councils in each department: one focused on nursing practice issues, another on leadership issues and a third on patient and employee engagement. The goal of shared leadership is to increase involvement among front-line team members by giving them ownership for responsibilities

that traditionally belong to nurse managers, and to give managers more time to *lead* by spending less time *managing.* The model also addressed two consistent challenges:

- The region's nurse managers faced the constant need to do more with less.
- Employee surveys in the region showed that more employees wanted more control over their. Falling scores on one survey question — *At work, do my opinions seem to count?* — were a specific concern.

A year after shared leadership was implemented, the model has produced four major benefits:

1. It engages the front-line staff
2. It creates value for the organisation
3. It improves communication
4. It develops individuals

KEYWORDS: participatory management, shared governance, delegation, succession planning, engagement, communication

INTRODUCTION AND ORGANISATIONAL BACKGROUND

The 75 nursing units in five Intermountain Healthcare hospitals in Salt Lake City were facing problems that many American businesses were facing in 2013: their budgets were tight, many of their employees were restless, their workloads were increasing, their managers were overworked and a number of new competitors were seeking to take away their patients.

So nursing leaders at the hospitals joined with their human resources (HR) team to look at a new leadership model — called shared leadership — that would empower front-line workers to make more decisions about how they do their work and help them improve their work environments.

Background

The five hospitals that implemented shared leadership are part of Intermountain Healthcare's largest region — called the Central Region — which is based in Salt Lake City, Utah. The hospitals are Intermountain Medical Center (a major trauma and referral centre and the largest hospital in Utah, which serves as the flagship of the Intermountain Healthcare system), LDS Hospital, Alta View Hospital, Riverton Hospital (which are community hospitals that offer some highly specialised services) and TOSH — The Orthopedic Specialty Hospital (which provides orthopaedic and sports medicine services to patients from Utah and to high-level athletes from across the United States). The region has 8,000 employees, 2,300 physicians and annual gross revenues of roughly US$3bn. Intermountain Healthcare is a not-for-profit integrated health system that is known internationally for delivering high-quality clinical outcomes for costs that are dramatically lower than average. It has 37,000 employees and 22 hospitals.

WHAT IS SHARED LEADERSHIP?

Shared leadership is an organisational structure that is designed to engage the front-line staff in traditional management functions, improve communication and help individuals advance their careers. It involves three councils in each department: one focused on nursing practice

issues, another on leadership issues, and a third on patient and employee engagement. Each council's members are nurses or other clinicians who work on the unit; the council's leaders are bedside nurses who expressed an interest in — and the potential for — growing into formal management jobs.

The goal of shared leadership is for all council members to take ownership for responsibilities that traditionally belong to nurse managers. By sharing those responsibilities, the managers free themselves up to focus on other parts of their portfolio — including the daily rounds on patients and employees that take a huge amount of time, and yet have been shown to produce dramatic increases in patient and employee satisfaction. Shared leadership also gives managers more time to focus on problem-solving in their units and on the clinical and financial outcomes that determine the success of their units and their hospitals. Leaders have more time to *lead,* in other words, by spending less time *managing.*

As the five Intermountain Healthcare hospitals implemented shared leadership, each council on each nursing unit was given a collection of tools to help them work consistently, including communication templates, gap analysis and other measurement tools, agenda templates and individualised charters that outlined each council's scope, role and membership.

The 75 departments and 90 nurse managers in the region's five hospitals launched shared leadership in January 2014. Over 200 shared leaders were trained, and over 3,200 clinical and non-clinical employees were involved. The implementation was completed in July 2014.

WHY THE REGION'S HOSPITALS IMPLEMENTED SHARED LEADERSHIP

Before the new leadership structure was implemented, the five hospitals had various forms of shared governance in their departments, lots of duplication in their work and varying degrees of accountability. Some units had front-line governance models that were very effective, and some used ineffective models — but either way, there was no regional structure that allowed the hospitals to standardise and share best practices, measure results and consistently produce the outcomes they desired.

The pressure on hospitals to increase efficiency and cut their costs was (and is) severe. Across America, the organisations that pay for care — including employers, private insurers and the government — cannot afford continued dramatic increases in health care costs. The government is ratcheting down the fees they pay hospitals and doctors, and private payers are following the government's lead. At the same time, competition in the healthcare marketplace is increasing: technology, telemedicine and healthcare exchanges are giving payers and patients new alternatives to traditional providers.

Two main factors were shaping the work environment in Intermountain Healthcare's Central Region:

- First, the region's nurse managers faced the constant need to do more with less.
- Second, employee surveys in the region showed that more employees wanted more control over their work. Falling scores on one question in the survey — *At work, do my opinions seem to count?* — were a specific concern.

Helping nurse managers work more efficiently and helping employees see that their opinions mattered were driving forces in the implementation of shared leadership.

HOW SHARED LEADERSHIP WORKS

The shared leadership model in Intermountain Healthcare's Central Region works as follows:

1. Each nursing department has three councils — a practice council, a leadership

council and an engagement council. Each council is led by a shared leader.
2. The leaders of each department council serve as members of their hospital's practice, leadership or engagement council.
3. One member of each hospital council serves on the regional practice, leadership or engagement council.

The result

The work of each council is integrated so that ideas, best practices, resources — and information about barriers and challenges — are shared, and each department council sees the big-picture issues their hospital, and the region, is facing. Once the model was established, nursing leaders and HR held a half-day training retreat for all shared leaders. Responsibilities and goals had already been set, so the agenda focused on specific skills that would make shared leaders successful: delegating responsibility, meeting management, conflict resolution, holding employees accountable, etc.

The integrated structure of the councils keeps them focused on making decisions that directly affect them, and as they do, creativity abounds, problem-solving is enhanced and engagement increases. To cite but one example of a problem facing the region's nursing units, the use of standardised nursing jobs was implemented inconsistently on different nursing units, which resulted in many nurses being classified in roles that did not reflect the work they were doing every day. During the creation of the shared leadership model, nursing and HR leaders reviewed the roles of the 2,000 nurses in the region and clearly defined the work each nursing role was responsible for doing. Roles were clarified and grouped into a leader track, a clinical track and an educator track. Leaders also decided that a shared leader needed to have a bachelor's degree in nursing to qualify for the role. This clear definition of work resulted in clear expectations about what was required and how nurses would be rewarded — and nurses felt a greater sense of fairness as the same people in the same role, doing the same work, were placed in the same pay grades.

One caveat

A number of department managers initially thought the creation of three new councils on their units — and having three council chairs to delegate responsibility to — was a takeaway. They worried that their role would be threatened or that working with the councils would create more work for them. Emphasising very specific roles for each shared leadership council helped the councils work — and brought unit managers on board. One HR manager says: 'Had we given these positions too much latitude, that would have caused more stress for our managers. Tight parameters of the roles of each unit's councils took that stress away. The councils freed our unit managers from some of the managerial tasks of their roles and allowed them to spend more time being leaders.'

FOUR PRIMARY BENEFITS OF THE SHARED LEADERSHIP MODEL

Nursing and HR managers who led the implementation of shared leadership saw four specific benefits of the model:

Benefit 1: Shared leadership engages the front-line staff

Higher employee engagement in a hospital pays a number of high-priority dividends: it improves patient care, clinical outcomes, patient satisfaction and employee satisfaction. A related benefit is that shared leaders and council members at the department level — who typically are bedside nurses with no previous experience in management — are introduced to the business side of health

care. Their focus expands beyond caring for the patients who are in their unit during their shift. For example, they get practical, hands-on experience interviewing job candidates, educating and motivating their peers and communicating. They are involved on an elementary level with budgeting, which previously belonged entirely to department managers. They contribute to the annual employee evaluations of their peers. One Intermountain Healthcare nursing leader says council members understand how change happens; they see what changes are necessary and the steps that lead to, or hinder, positive changes.

Benefit 2: Shared leadership creates value

Employee engagement for nursing in Intermountain's Central Region was at a concerning low in 2014. The shared leadership model was a joint effort between nursing and HR to increase engagement with our front-line nurses. Engagement jumped from 3.91 on a five-point scale in 2014, before the model was implemented, to 4.11 in 2015 and 4.18 in 2016, which is a statistically significant jump. In 2015, we began monitoring the engagement of the shared leader group and found it to be significantly higher than that of their larger group of nursing peers. In 2015, shared leadership engagement was 4.34 at our largest hospital in the region, and as the model matured and became more effective, engagement continued to rise in 2016 with a score of 4.41.

Another example of increased value in the region's five hospitals: when a unit's practice council addresses a problem and identifies a solution, the members of the leadership council hold people accountable for implementing it, and the engagement council highlights successes and keeps them engaged. The result is a continual cycle of engagement and improvement. The participatory shared leadership model has the potential to enhance not just nursing, but all employees' roles and all functions in the hospital.

The councils offer specific benefits to 'Millennials', or employees who were born between 1980 and 2001, who have different expectations and priorities about work than other generations. Research shows Millennials want leaders who inspire and challenge them; they want to contribute not just to their company, but to their industry; and they love working together to create innovative solutions to problems at work. Shared leadership gives them those opportunities, which is important, because by 2025, they will make up 75 per cent of the global workforce.

Benefit 3: Shared leadership improves communication

Shared leaders and council members communicate better in and outside of their units. They collaborate more effectively with their counterparts from other departments and hospitals because they have the same responsibilities. The fact that the councils fill standardised roles and work on similar problems means they are speaking the same language, which increases teamwork and reduces redundancy within the region's hospitals and the region itself.

Communication has dramatically improved in clinical areas and between front-line nurses and nursing leaders. The councils develop and use similar tools — such as bulletin boards to convey the information that is shared in daily unit and hospital-wide safety huddles. Many councils produce and share standard talking points to address important action items and summarise issues that need to be communicated to staff or discussed in council meetings.

Benefit 4: Shared leadership develops individuals

The 90 nurse managers who work in the Central Region have three new leaders on

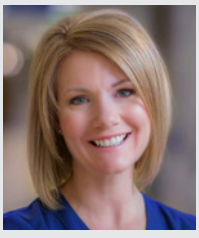
their units they can delegate work to — and as chairs of the practice, leadership and engagement councils fill their roles, they are also filling a pipeline of potential new nurse leaders who are interested in and qualified to serve in management roles. Nurse managers' roles have traditionally been a difficult role to recruit for and retain, and serving as a council chair gives nurses a virtual apprenticeship in that role. Succession planning in the Intermountain Central Region has become dramatically easier since shared leadership was launched. Since July 2014 the region has moved 21 shared leaders into nurse manager roles. This has had a dramatic impact on our ability to develop and groom future leaders.

One nurse administrator said: 'Before shared leadership, it was difficult to find new department leaders. Nurse managers don't have glamorous jobs, and front-line nurses see that. But shared leadership helps them grow and learn leadership techniques, and it helps them experience not only the responsibilities of leadership but the rewards, and thus it's strengthened our succession planning effort. We are filling open nurse manager positions faster, and we're filling them with more qualified candidates who've been exposed in a well-structured way to different aspects of the leadership role. They have more skills, they're more prepared to lead, and the learning curve once they assume their new roles is appreciably shorter.'

One example is profiled in Box 1.

Shared leadership provides professional development opportunities for the 200 individuals who serve on unit councils — it takes them away from their clinical work and introduces them to the business part of health care, often for the first time. One nurse administrator says: 'They gain greater appreciation for what their manager does, and they see that complaining — which is a trap I think every person in the American workforce falls into at one time or another — isn't productive. They see they can't take feedback from every person and make it a reality; they have to consider everyone's point of view and make decisions that serve the greater good. That's a large leap for a lot of bedside nurses.'

Nurse managers also get a chance to expand their leadership skills under the shared leadership model. The model defines some of the delegation that needs to happen and outlines what each unit's council chairs will oversee. That helps the managers, by freeing up their schedules, to concentrate on tasks they are best suited to do: developing their people, coaching and rounding with their staff members, and rounding with their unit's patients. For some nurse leaders, shared leadership gives them an opportunity to help enhance their employees' leadership skills for the first time — and it extends the leader's reach and influence in their departments.



Box 1: CARIE SAETRUM IS A SHARED LEADER IN A MEDICAL/SURGICAL UNIT AT LDS HOSPITAL. She chairs her unit's leadership council; she also chairs the leadership councils for her hospital and for the Central Region. Carie got a running start in shared leadership, having previously served as a leader in the region's shared governance nursing leadership structure. She is an enthusiastic champion for shared leadership and credits the model's well-defined responsibilities with her enhanced ability to produce the outcomes her teams desire. One of the hospital's administrators says: 'Carie is a strong leader who's taken the opportunity to learn and grow in the shared leadership structure. Her goal is to become a nurse manager, and I'm confident she'll get that opportunity. She's a great example of how shared leadership helps us develop new nursing leaders.'

A FEW PRACTICAL EXAMPLES OF THE SUCCESS OF SHARED LEADERSHIP

First, one nursing unit had a problem making sure the immunisations of their patients were recorded in each patient's chart. The practice council reviewed the unit's process and found they did not have a standard practice that outlined how immunisations should be administered and documented. The council's leader brainstormed the process with her team and defined a new process to improve documentation. Then they handed the issue off to their unit's leadership council, which took responsibility for implementing it and holding people accountable to follow up. The result: documentation rates went from 83 to 100 per cent — problem solved.

Another unit had an increase in patient falls during 2015. The manager engaged her practice council, which examined potential causes of the increase. They spent several weeks reviewing the data that showed what kind of patients were at risk for falls, how often they fell, and what circumstances increased their risks. They decided to take two steps to solve the problem: (1) they created new signs for patient doors that alerted the staff about which patients faced increased risks of falling and (2) they developed scripts to help the staff educate patients about how to reduce their risk of falling. Those steps were tested, more data was collected, and when it proved to be effective, the solutions were shared with other units throughout the region.

One hospital was challenged with rising rates of C-difficile, a bacterium, transmitted in caregiving settings, that causes gastrointestinal problems. The problem was taken to the practice council to investigate whether best practices were in place to reduce the occurrence of C-difficile. Through continuous improvement techniques, and with the collaboration of all departments, the team organised an effort to improve care. The hospital's rates dropped by 31 per cent over a two-year period as a result of the combined efforts of the team.

WHAT CHALLENGES DID THE CENTRAL REGION'S TEAM FACE AS THEY IMPLEMENTED SHARED LEADERSHIP?

1. Being consistent in all of the region's 75 nursing units and its five hospitals. That is why each council makes an effort to document what they do and how it impacts their work. Documentation makes problems and solutions easier to share with other units.
2. Selecting the right people to lead and staff the councils on each unit, in the hospital and in the region. There was some angst among front-line staff when the model was introduced, and the right leaders helped their colleagues understand the vision and feel comfortable about its implementation. Effective leadership also helped non-nursing disciplines — such as respiratory therapy, pharmacy, food services and environmental services — know where to take multidisciplinary issues to be resolved.
3. Being tempted to implement shared leadership too quickly. The region's leaders originally thought implementation would go much faster, but when it did not, they did not rush it — they took the time for the new culture to be adopted, which enhanced buy-in and, ultimately, effectiveness.

Intermountain Healthcare is now launching the shared leadership model system-wide to all 22 hospitals and its homecare organisation. Expanding shared leadership will broaden the reach of its benefits — increased engagement, value, communication and leadership development. The entire system will be connected through common work in a unified model.

And the bottom line? If your organisation is looking to increase employee engagement or revamp your shared governance model, shared leadership could be your guiding star. The system has worked extremely well for Intermountain Healthcare's Central Region. The journey to implement it was challenging, but the impact it has had on employee engagement, efficiency and value, communication and leadership development has been worth the effort.