JONA
Volume 54, Number 2, pp 79-85


THE JOURNAL OF NURSING ADMINISTRATION

# A Road Map for the Development of a Decisional Authority Framework for Professional Governance Using Accountability Grids

Kirsten Wisner, PhD, RNC-OB, CNS, C-EFM, NE-BC
Aubree Collins, BSN, RNC-OB, C-EFM
Tim Porter-O'Grady, DM, EdD, APRN, FAAN, FACCWS

Although resources are available to guide structures and processes for professional governance, limited information exists about defining and legitimizing the decisional authority needed to support direct care nurses' ownership of clinical practice as well as the role of nursing leaders. This article presents a road map for creating and implementing clinical nurse, nurse leader, and nurse executive accountability grids with clearly delineated authority to provide a decisional authority framework for professional governance in one organization.

The framework supporting nursing professional governance is grounded in the understanding that nursing is a profession, and members of a profession require structures that enable professional ownership of practice and role accountability. Accountabilities have been broadly defined for the clinical or professional nursing role and for nurse leaders and should inform professional governance council work.[1] Professional accountabilities address the content of the nursing profession, are practice based, and include practice, quality, competence, and knowledge.[2] Aligned with professional governance values, these should be governed and demonstrated by nurses who perform the clinical work of the profession in direct care roles. Leader accountabilities include the *context* needed to support operations and the professional role, and are concerned with human, fiscal, material, support, and systems resources.[1] Professional governance provides the structure to operationalize direct care nurses' ownership and authority over decisions related to practice, quality, competence, and knowledge. The leaders' role in professional governance is essential because they are responsible for the resource and systems support needed for clinical nurses to exercise authority over the professional domains.[1,3] In professional governance, both leaders and direct care nurses have accountabilities to support the success of the model.

Although the lineage of this framework for professional governance and concepts surrounding professional accountabilities have been articulated in the literature[1,2,4–10] and in professional standards,[11–16] persistent challenges have been reported with successful professional governance enculturation and role accountability.[17–19] Despite its existence in healthcare for over 40 years, fully empowered, clinical nurse–led professional governance structures are uncommon, even in mature Magnet®-designated organizations.[19–21]

Successful enculturation of professional governance requires profound shifts in how clinical nurses, leaders, and organizational systems interact.[22,23] Nurses typically practice within entrenched hierarchical decision-making structures that must be renegotiated to actualize the decisional authority necessary for direct care nurses to legitimately exercise ownership of clinical practice.[8,22] Resources available to guide organizations as they develop

**Author Affiliations:** Magnet® Program Director (Dr Wisner), and Clinical Nurse (Collins), Labor and Delivery, Salinas Valley Health, California; Senior Partner (Dr Porter-O'Grady), Health Systems, TPOG Associates, LLC, Tucson, Arizona and Atlanta, Georgia, and Clinical Professor, Emory University, School of Nursing, Atlanta, Georgia.

The authors declare no conflicts of interest.

**Correspondence:** Dr Wisner, Salinas Valley Health, 450 E Romie Ln, Salinas, CA 93901 (klwisner@gmail.com).

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jonajournal.com).

**DOI:** 10.1097/NNA.0000000000001386

professional governance have thus far been focused on structures and processes. These include governance models and council infrastructure; organizational charts that depict council relationships and reporting structures; and bylaws containing guidance on council responsibilities and functions, membership selection, and council meeting supports and operations.[5,10] Although these structural and process elements are crucial, they exist to operationalize and legitimize professional role accountability,[24,25] which requires a clearly defined decisional authority framework. Conceptual models have been proposed for decisional authority in professional governance;[1,5] however, detailed examples of their translation and application are not available in the literature. To be fully understood and relevant, this authority should be translated into specific behaviors and outcomes. This gap may account for some of the persistent challenges with successful enculturation of professional governance.

An overemphasis on structure without actively translating its intent can be problematic.[6,25] Vulnerabilities in governance structures became apparent during the COVID-19 pandemic, when resources were scaled back, and normal meeting schedules were altered to accommodate staffing and other challenges.[26] Organizations with mature governance demonstrated agility and readily adapted their processes to support clinical nurses' role accountability in the absence of meetings.[27,28] However, many organizations reverted to hierarchical decision making, leaving nurses disenfranchised and mistrustful,[25] and revealing that the intent of professional governance is misunderstood and has not been widely enculturated.

## Local Context

Salinas Valley Health Medical Center, a 263-bed community hospital in California, earned its 1st Magnet designation in mid-2021. As part of its ongoing excellence journey, the interim chief nursing officer (CNO) and Magnet program director (MPD) sought consultation from a professional governance expert (TPOG) on next steps for professional governance development. A 2-day on-site consultation revealed a well-developed professional governance structure but significant role ambiguity and an opportunity for better clarity about the clinical nurse and nurse leader roles. These findings resonated with the clinical nurses and nurse leaders involved in professional governance. Clinical nurses encountered obstacles or misunderstandings from other stakeholders when exercising authority over clinical practice. Nurse leaders expressed uncertainty about their role in professional governance while continuing to own many decisions belonging to clinical nurses. The development of accountability grids was suggested as a strategy to address this role ambiguity and support professionally grounded decisional authority. After approval from the organization's professional governance coordinating council, a plan was established to pursue this recommendation.

## Accountability Grids

Written as a series of behavioral and outcome statements, accountability grids translate role-specific professional standards into expected behaviors and actions, and delineate decisional authority for key nursing roles, including clinical nurse, nurse leader, and nurse executive.[7] These are meant to be integrated into council charters, position descriptions, and performance evaluations providing a stronger linkage to the role accountabilities associated with professional practice. A logical next step would be to identify the structural and contextual barriers that exist within an organization that may impede full implementation of role-specific accountability and decisional authority.[9] To date, no reports have been published that capture such work. The authors posit that clearly articulated decisional authority and its associated locus of control is necessary for successful professional governance and may be the missing element that explains the persistent challenges with its enculturation. It is possible that, in future work, accountability grids may replace existing job descriptions that have historically focused on function and task instead of role-based accountability. This article outlines one organization's process of creating and implementing clinical nurse, nurse leader, and nurse executive accountability grids to serve as a decisional authority framework for their professional governance structure.

## Methods

### Forming and Preparing the Team

A workgroup of 19 clinical nurses and nurse leaders was formed in October 2021 to develop the grids for 3 roles: clinical nurse, nurse leader, and nurse executive. The clinical nurse chairs and co-chairs of the professional governance coordinating council and 4 of the 5 central councils (Practice, Quality, Research and Evidence-Based Practice, Professional Development) were included because they oversaw the clinical nurse accountabilities of practice, quality, competence, and knowledge. Key nursing directors were identified, and volunteers were sought from the nurse manager team. Because more managers volunteered than space allowed, the coordinating council created a scoring rubric to evaluate these leaders in 6 dimensions that were considered influential to effectively leading in professional governance (SDC 1, http://links.lww.com/JONA/B105). The final workgroup had representation from all clinical practice areas with a balance of clinical nurses and nurse leaders. It included the chairs and co-chairs of the central and coordinating

councils, selected nurse directors, 5 managers, the CNO, the MPD, and the Magnet clinical excellence specialist. Guided by TPOG, the workgroup was led by the MPD (K.W.) and the clinical nurse chair of the coordinating council (A.C.) (SDC 2, http://links.lww.com/JONA/B106).

### Meeting Structure and Team Preparation

Meeting structure and workgroup members' preparation were as follows:

- Two-hour monthly meetings were scheduled beginning in February 2022 with homework between meetings. Education from the consultant occurred throughout the process.
- Workgroup members were required to read foundational literature[1] and attend the virtual American Organization for Nursing Leadership 2-day course, "Dynamic Leadership for Professional Governance."
- Team agreements were established, which included attending regular meetings, participating in the implementation phase, and serving as a professional governance mentor for other stakeholders.
- At the end of the 1st meeting, homework was assigned for workgroup members to write clinical nurse accountability statements for the 4 domains: practice, quality, competence, and knowledge. Minimal instruction was given to encourage members to draw from their existing knowledge and nursing experience, and insights gained thus far from workgroup participation.

### Creating the Accountability Grids

#### *Identifying Professional Resources and Drafting the Accountability Grids*

The workgroup leads and consultant met regularly between meetings to plan the approach to creating the grids and determine the sources to use to inform the work. The grids were developed in a sequence from clinical nurse, nurse leader, to nurse executive because the nurse executive has oversight for nursing practice; therefore, the executive grid should reflect elements and language from the clinical nurse and nurse leader grids.

The coordinating council chair (A.C.) worked sequentially through resources including key professional standards and competencies (Table 1) to draft the clinical nurse accountability grid. Sources of evidence,[14] provisions,[11] and standards[13] were translated into behavioral or outcome statements that supported achievement of the source standard. These sources were documented/tracked within statements to facilitate the team's understanding of how the statements were grounded in professional standards (Figure 1). Finally, workgroup members' accountability statements were integrated to ensure that the team members' perspectives and the organization's nursing culture were captured. These edits were referenced as integrated team language.

### Reaching Consensus and Evaluating Readiness for Change

Between the 2nd and 3rd meetings, a draft clinical nurse accountability grid containing 33 statements was sent to workgroup members for independent evaluation. Instructions were to evaluate each grid statement on 2 levels. First was whether they agreed or disagreed with the statement. If they agreed, they were directed to rate each item on a scale of 1 to 3 representing their perception of organizational readiness to implement the accountability statement. A score of 1 indicated "ready to fully implement," 2 indicated "ready to implement with some support," and 3 indicated "major support needed." Results were compiled and a mean score for each statement was calculated. To explore whether there were differences in nurse leader and clinical nurse perceptions of readiness, we compared scores between the 2 groups. Statements that were rated as "disagree" and those with a mean greater than 2 were discussed in the next meeting. This was accomplished by dividing the group into small breakout sessions wherein each group evaluated several statements and identified barriers to implementation as well as strategies to overcome barriers. The group then discussed insights from the breakout sessions, with facilitation from the consultant.

This process furthered an understanding of current culture and identified strengths and barriers related to professional role accountability. This stage was formative for the group's shared understanding of professional role accountability. Translating professional standards into behavioral and outcome statements helped workgroup members to solidify the understanding that such accountability was nonnegotiable for members of a profession. The nature of dialogue and problem solving shifted from *whether* or *if* the team could implement the accountability grid statements to *how* to implement them. Information gathered from this phase was used to edit the draft clinical nurse grid. Preamble and domain introductory statements were added to emphasize the decisional authority of clinical nurses (Figure 2). To make the grid more readable and shorter, the sources associated with each statement were deleted, and a final version was approved by workgroup members. This process took approximately 5 months.

A similar stepwise process was followed for the nurse leader grid, adding leader-specific professional standards.[12,15,16] Some clinical nurse accountability statements were retained but edited to reflect the leader role.[1] Similarly, the team focused on the transformational leadership section of the 2023 Magnet Application Manual[14] and on the system and resource support

*Table 1. Resources Used*

| Source | Grid | Rationale for Use | Application |
|---|---|---|---|
| *2023 Magnet® Application Manual*[14] | Clinical nurse<br>Nurse leader<br>Nurse executive | Translates professional standards into source of evidence exemplars that demonstrate nursing excellence. | The respective standards, provisions, or competencies were translated to role-specific behavioral or outcome statements. |
| *Nursing Scope and Standards of Practice*[13] | Clinical nurse<br>Nurse leader<br>Nurse executive | Defines the scope of practice statement and standards of professional practice for RNs. | |
| *Code of Ethics for Nurses With Interpretive Statements*[11] | Clinical nurse<br>Nurse leader<br>Nurse executive | Defines the ethical standard for the nursing profession providing guidance for ethical decision making. Articulates nursing's duty to society. | |
| *Nursing Administration Scope and Standards of Practice*[12] | Nurse leader<br>Nurse executive | Defines the role accountabilities for nursing administration practice based on the span of influence. Suggests educational and specialty practice preparation and defines ethical considerations[11] for the role. Defines practice standards and associated competencies for nursing administration. | |
| *AONL Nurse Manager Competencies*[16] | Nurse leader | Defines the expertise required for the nurse manager role in 3 categories: the science, the leader within, and the art. Offers guidance to facilitate reflective practice about individual leadership practice. | |
| *AONL Nurse Executive Competencies*[15] | Nurse leader<br>Nurse executive | Establishes the expertise required for nurse executives to effectively lead and manage healthcare delivery. Communication and relationship management, knowledge of healthcare environment, leadership, professionalism, and business skills and principles comprise the 5 domains of healthcare leadership. | |
| Workgroup members' accountability statements and edits | Clinical nurse<br>Nurse leader<br>Nurse executive | Provided local context and interpretation and captured workgroup members' unique language. | Used to edit grids for relatability. |

needed to successfully achieve standards in the structural empowerment; exemplary professional practice; and new knowledge, innovations, and improvements components.[1,14] The nurse executive grid was drafted focusing on executive competencies[15] and by considering the vision and strategic support needed to achieve the accountability articulated in the clinical nurse and nurse leader grids. The creation and approval of the 3 grids occurred over 18 months, from February 2022 to August 2023. About half of the meetings during this time were facilitated by the consultant, and group discussion was used to work through questions and promote learning.

***Practice Domain***
Nurses provide ethical care, promote diversity, equity, inclusion, and practice cultural humility. They incorporate the patient's preferences and values into care. (ANCC, 2021: OO8, TL2, EP15; ANA, 2015: Provision 1; ANA, 2021, Standards 7, 8, and 9; Integrated team language)

***Quality Domain***
Nurses collect, examine and report clinical quality indicators for their unit. They set unit specific quality goals and use and respond to data to improve patient outcomes and experience (ANCC, 2021: EP18, EP19EO, EP20EO, EP21EO, EP22EO; ANA, 2021, Standards 1 and 6; Integrated team language)

***Competence Domain***
Nurses encourage professional and clinical growth of self and peers and use peer feedback. (ANCC, 2021: EP13; ANA, 2015: Provisions 3 and 5; ANA, 2021, Standard 10; Integrated team language)

***Knowledge Domain***
Nurses conduct research and share their results with internal and external audiences (ANCC, 2021: NK2, NK3a, NK3b, N4; ANA, 2015: Provision 7; ANA, 2021, Standard 14)



Figure 1. Sample clinical nurse accountability statements with sources tracked.

## Results

### Implementation of the Clinical Nurse, Nurse Leader, and Nurse Executive Accountability Grids

Project leaders planned to use this newly developed decisional authority framework based on the clinical nurse (Figure 2), nurse leader (SDC 3, http://links.lww.com/JONA/B129), and nurse executive (SDC 4, http://links.lww.com/JONA/B130) grids to improve clarity about role-based professional authority and accountability and to inform the scope of responsibilities of professional governance councils. The implementation phase included 5 elements: measurement; name change; appending the nurse leader and CNO grids to position descriptions and including them in the hiring and

| |
|---|
| **Practice:** Informed by professional standards and evidence, Clinical Nurses oversee nursing practice. They demonstrate expertise regarding their practice, and exercise authority over decisions related to the care they provide. |
| Nurses exercise autonomy and practice within the full scope of their nursing practice. |
| Nurses align their practice with the Salinas Valley Health organization mission, vision, strategic plan, and the STAR and PRIDE values. |
| Nurses provide ethical care, promote diversity, equity, inclusion, and practice cultural humility. They incorporate the patient's preferences and values into care. |
| Nurses collaborate with families and interprofessionally to provide relationship-based, family-centered (or person-centered) care. |
| Nurses advocate for resources to support patient care and organizational goals. |
| Nurses support the well-being of patients, themselves, the Salinas Valley Health workforce, and the community. |
| Nurses communicate effectively and professionally with patients, leadership, and staff. |
| *Nurses serve and lead on councils, committees, and organization-level interprofessional groups and use shared decision-making. |
| Nurses derive inspiration from the professional practice model (PPM) and practice in alignment with its principles. |
| Nurses advocate for working environments that promote nursing satisfaction, engagement, and retention. They support unit- and organization-level work plans to improve engagement. |
| Nurses focus on the patient and protect the rights, health, and safety of the patient. |
| *Nurses advocate for the health of the public, protect human rights, promote social justice and health diplomacy, and reduce health disparities. |
| Nurses teach and promote health and wellness. |
| Nurses utilize appropriate resources judiciously. |
| Nurses utilize expert knowledge and research to improve patient outcomes. |
| **Quality:** Clinical Nurses determine the quality metrics that define nursing excellence for their patient population. They systematically measure the quality of care, report their findings, evaluate their own and others' practice, and design initiatives to create excellent outcomes and improve care. Clinical Nurses exercise authority over decisions related to quality and quality improvement in their specialty. |
| Nurses create the safest environment for patients, staff, visitors, and other nurses and use the We Care system to identify events that affect safety. |
| *Nurses collect, examine, and report clinical quality indicators for their unit. They set unit-specific quality goals and respond to data by changing their practice to improve patient outcomes and experience. |
| *Nurses provide critical review and evaluation of policies, procedures, and guidelines to improve the quality of health care. |
| *Nurses engage in formal and informal peer review. |
| Nurses develop and/or participate in quality improvement initiatives. |
| Nurses collaborate with the interprofessional team to implement quality improvement plans and interventions. |
| Nurses collaborate with physicians to provide evidence-based, compassionate and timely care to patients. |
| **Competence:** Clinical Nurses determine the education, training, certification requirements, and competencies required for practice in their specialty and exercise authority over decisions related to competence. |
| Nurses act as clinical leaders, mentors, preceptors, and role models for colleagues and the community. |
| Nurses utilize standards and guidelines from the professional group(s) that pertain to their specialty areas to improve practice. |
| *The majority of nurses are certified in their specialty area. |
| Nurses utilize the clinical ladder and progress to achieve expert status as described by Patricia Benner. The majority of nurses practice with a bachelor's degree in nursing or higher. |
| Nurses engage in professional development to maintain current knowledge and skills relative to the role, population, specialty, setting, and local or global health situation. |
| Nurses encourage professional and clinical growth of self and peers and use peer feedback. |
| Nurses engage in self-reflection and self-evaluation of nursing practice on a regular basis, identifying areas of strength as well as areas in which professional growth would be beneficial. |
| **Knowledge:** Clinical Nurses appraise current nursing knowledge (science, evidence); evaluate the knowledge that informs standards- and evidence-based practice; and where applicable, develop new knowledge through research. Clinical Nurses exercise authority over decisions related to evidence-based practice and research in the organization and identify the resources needed to support knowledge appraisal and knowledge generation. |
| Nurses use creativity and innovation to enhance nursing care. |
| *Nurses conduct research and share their results with internal and external audiences. |
| Nurses utilize technology to improve patient care. |
| *Nurses engage in the design or redesign of the care environment. |
| Nurses implement evidenced-based practice changes in response to research. |

Note. *Salinas Valley Health nurses accomplish these goals as a collective group; for example, through work done by professional governance councils or other committees on behalf of nursing, or by individual nurses engaged in the work.



Figure 2. Salinas Valley Health clinical nurse accountability grid. Preamble: Nursing is a profession, and members of a profession are accountable for the practice, competence, quality, and knowledge of that profession. These domains are the content accountabilities that define the foundations of professional work. As such, authority over decisions in these domains belongs to members of the profession practicing in direct care roles. This accountability grid outlines an evidence- and standards-based framework for clinical nurses to exercise ownership and accountability for practice, competence, quality, and knowledge. © 2023 Salinas Valley Memorial Healthcare System.

onboarding process; integration of the content, and intent of the grids into the professional governance bylaws; and an education plan. Workgroup members were assigned to implementation groups based on skills and interest. Leads for each group were role based; for example, the education plan was led by the director of education, the position descriptions and hiring group by the CNO and human resources (HR), and the bylaws revision by the chair and advisor of the coordinating council. The implementation was planned to take place from January to December 2023.

### Measurement/Evaluation

A research protocol was developed and approved by the hospital institutional review board to measure nurses' perceptions of professional governance before and after implementation of the grids. The Verran Professional Governance Scale © was selected to measure nurses' perceptions because it focuses on professional governance behaviors.[29] The preimplementation survey was administered from January to April 2023. The postimplementation survey is planned for early 2024. The other implementation elements began after the preimplementation data collection for this study was completed.

### Name Change and Integration of Grids Into Position Descriptions and Hiring

Reflecting the evolution of the group's understanding of professional role accountability, team members changed the name of the governance structure from shared governance to professional governance. All related intranet sites, documents, and support structures were updated to reflect the new name. The nurse leader grid was added to the nurse manager and director position descriptions, and the nurse executive grid was added to the CNO position description. Because clinical nurses are part of a union, adding the clinical nurse grid to the related position descriptions requires collective bargaining, which is currently being discussed. A future goal is to work with HR to amend interview guides and hiring, and onboarding processes to reflect the grids.

### Professional Governance Bylaws Revision

The professional governance bylaws, which had been in place for nearly 6 years, underwent a major revision

Unit Practice Council Charter

Purpose

The purpose of the Unit Practice Councils (UPCs) is to identify and implement standards of care and evidence-based practice specific to clinical area(s), and identify and resolve clinical and systems issues impacting or affecting care coordination, a healthy work environment, the delivery of patient-family centered care, patient safety and clinical outcomes.

Accountability Statement for the UPCs

Members of a profession are accountable for the practice, competence, quality, and knowledge of that profession. These domains are the *content* accountabilities that define the foundations of professional work and should be overseen by members of the profession practicing in direct-care. The UPCs provide the structure for clinical nurses and other professional groups to exercise authority and accountability for practice, competence, quality, and knowledge and to own decision-making in these domains. Because the UPCs govern specialty practice, relevant accountability statements in the Practice, Quality, Professional Development, and Research & EBP Council Charters extend to the UPCs.

Figure 3. Unit Practice Council charter: example of added accountability statement.

to reflect the grids. The grid preamble and introductory statements (Figure 2) were added to the charters of the appropriate councils to emphasize both council and role decisional authority, and scope of responsibility. For example, the preambles from the clinical nurse and nurse leader accountability grids were added to the Unit Practice Council and Nurse Leadership Council, respectively (Figure 3). The domain introductory statements from the clinical nurse grid were added to the related council as follows: practice domain to the Practice Council, quality domain to the Quality Council, competence domain to the Professional Development Council, and knowledge domain to the Research and Evidence-Based Practice Council charter. The council responsibilities section in all charters was edited to align with the grids.

### Education Plan

Education was planned and included several phases: an introductory module assigned via e-learning about the name change; a letter from the workgroup sent to all nurses' homes introducing the grids; in-person education provided during annual competency camps, and leader lunch and learns; a video featuring workgroup members sharing detail about the grids; and communication from the CNO to nurse leaders about changes to position descriptions. Throughout the education process, information was posted on the organization's intranet site and included contests and raffles.

## Discussion

This article outlines a road map for the development of a decisional authority framework for professional governance using accountability grids. Accountability grids use role-specific statements to translate professional standards into expected behaviors. Such a granular interpretation of professional role accountability and its translation into behavioral and outcome expectations provides the detail needed to support professional authority and autonomy. The use of accountability grids may be the missing link needed for the successful enculturation of nursing professional governance. Building a governance structure and establishing the framework for its operation take considerable time and work, and often numerous iterations. Mature professional governance is reflected in the behaviors of its members in response to routine and emergent situations. Nurses in thriving governance systems reflexively ensure that appropriate stakeholders are at the table when problem solving occurs and decisions are made, under any conditions. This requires having clarity and a shared mental model of how professional work is carried out and where authority and accountability lie. Accountability grids provide formal language for clinical nurses and nurse leaders to define the boundaries of their practice and navigate the hierarchical and other shifts needed to support professional role accountability. The process of developing accountability grids for the 3 key nursing roles as a team is formative and may expedite arriving at an updated shared mental model for professional governance.

### Implications for Nurse Leaders

Although this article maps the process used by 1 organization and involved a consultant, this work can likely be carried out in other settings without external support using the proposed strategies. Table 1 presents the professional standards that should serve as the framework to define accountabilities for each nursing role. Because every organization has a unique nursing culture, accountability grids produced by other organizations will be different than those presented here. The consultant assessed the professional governance structure, provided education about role accountability, helped to translate standards into behavioral statements, and supported workgroup members to vision beyond challenges. Having a knowledgeable and influential internal leader to serve these functions would be important to ensure success if the work is undertaken independently.

## Acknowledgments

We thank the nurses who were part of the workgroup that developed and implemented the accountability grids (listed alphabetically): Abigail Acosta, MSN, RN, CPAN, CAPA; Norma Coyazo, MSN, RNC-OB, C-EFM; Frances Espino, BSN, RN, CCRN; Arnold Failano, MSN, MBA, RN, CNML; Stephanie Frizzell, MSN, RN, NPD-BC, CMSRN; Catherine Gomez, MSN, RN, CMSRN; Jeremy Hadland, BSN, RN, CEN; Vanessa Irwin-Nieto, DNP, RN, NPD-BC, NE-BC, CNML, CNE, CLC; Karina Kessler, MBA, BSN, RNC-NIC; Agnes Lalata, MSN, RN, CMSRN, CNML; Anna Linn, MSN, RN, CNML; Megan Lopez, MSN, RN, CNL, VA-BC; Anna Mercado, BSN, RN, ONC; Lisa Paulo, MSN/MPA, RN, CENP; Sheilah Quentin, BSN, RN, CAPA; Rebecca Rodriguez, MSN, RN, CEN, CPHQ; Carla Spencer, MSN, RN, NEA-BC; and Pamela Yates, RN.

## References

1. O'Grady TP, Clavelle JT. Transforming shared governance: toward professional governance for nursing. *J Nurs Adm*. 2021; 51(4):206-211. doi:10.1097/NNA.0000000000000999.
2. Porter-O'Grady T, Finnigan S. *Shared Governance for Nursing: A Creative Approach to Professional Accountability*. Vol. 84. Burlington, MA: Aspen Systems Publishers; 1984:1487.
3. Porter-O'Grady T. Council accountabilities. *Nurse Lead*. 2023; 21(2):127. doi:10.1016/j.mnl.2023.01.003.

4. Clavelle JT, Porter O'Grady T, Weston MJ, Verran JA. Evolution of structural empowerment: moving from shared to professional governance. *J Nurs Adm*. 2016;46(6):308-312. doi:10.1097/NNA.0000000000000350.
5. Haag-Heitman B, George V. *Guide for Establishing Shared Governance: A Starter's Toolkit*. Silver Spring, MD: American Nurses Credentialing Center; 2010.
6. Hess RG Jr. From bedside to boardroom—nursing shared governance. *Online J Issues Nurs*. 2004;9(1):2.
7. Porter-O'Grady T. *Implementing Shared Governance: Creating a Professional Organization*. St. Louis, MO: Mosby; 1992.
8. Porter O'Grady T. *Interdisciplinary Shared Governance: Integrating Practice, Transforming Health Care*. 2nd ed. Sadbury, MA Jones & Bartlett Learning; 2009.
9. Porter-O'Grady T, Clavelle JT. The structural framework for nursing professional governance: foundation for empowerment. *Nurse Lead*. 2020;18(2):181-189. doi:10.1016/j.mnl.2019.08.004.
10. Swihart D, Hess RG. *Shared Governance: A Practical Approach to Transforming Interprofessional Healthcare*. 4th ed. Marblehead, MA: HCPro; 2018.
11. American Nurses Association. *Code of Ethics for Nurses With Interpretive Statements*. Silver Spring, MD: Author; 2015.
12. American Nurses Association. *Nursing Administration Scope and Standards of Practice*. 4th ed. Silver Spring, MD; Author; 2016.
13. American Nurses Association. *Nursing Scope and Standards of Practice*. 4th ed. Silver Spring, MD: Author; 2021.
14. American Nurses Credentialing Center. *2023 Magnet® Application Manual*. Silver Spring, MD: Author; 2021.
15. American Organization of Nurse Executives, American Organization for Nursing Leadership. *AONL Nurse Executive Competencies*. Chicago, IL: Author; 2015.
16. American Organization of Nurse Executives, American Organization for Nursing Leadership. *AONL Nurse Manager Competencies*. Chicago, IL; Author; 2015.
17. Ballard N. Factors associated with success and breakdown of shared governance. *J Nurs Adm*. 2010;40(10):411-416. doi:10.1097/NNA.0b013e3181f2eb14.
18. Dechairo-Marino AE, Collins Raggi ME, Mendelson SG, Highfield MEF, Hess RG. Enhancing and advancing shared governance through a targeted decision-making redesign. *J Nurs Adm*. 2018;48(9):445-451. doi:10.1097/NNA.0000000000000647.
19. Weaver SH, Hess RG, Williams B, Guinta L, Paliwal M. Measuring shared governance: one healthcare system's experience. *Nurs Manage*. 2018;49(10):11-14. doi:10.1097/01.NUMA.0000546208.70574.27.
20. Clavelle JT, O'Grady TP, Drenkard K. Structural empowerment and the nursing practice environment in Magnet® organizations. *J Nurs Adm*. 2013;43(11):566-573. doi:10.1097/01.NNA.0000434512.81997.3f.
21. Moreno JV, Girard AS, Foad W. Realigning shared governance with Magnet® and the organization's operating system to achieve clinical excellence. *J Nurs Adm*. 2018;48(3):160-167. doi:10.1097/NNA.0000000000000591.
22. Porter-O'Grady T. Principles for sustaining shared/professional governance in nursing. *Nurs Manage*. 2019;50(1):36-41. doi:10.1097/01.NUMA.0000550448.17375.28.
23. Randolph WA. Re-thinking empowerment: why is it so hard to achieve? *Organ Dyn*. 2000;29(2):94-107.
24. Caramanica L. Shared governance: Hartford Hospital's experience. *Online J Issues Nurs*. 2004;9(1):5. doi:10.3912/OJIN.Vol9No01Man02.
25. Porter-O'Grady T, Pappas S. Affirming nurses' value. *Nurs Outlook*. 2022;70(3):361-364. doi:10.1016/j.outlook.2022.03.006.
26. Hess RG Jr., Weaver SH, Speroni KG. Shared governance during a pandemic. *Nurse Lead*. 2020;18(5):497-499. doi:10.1016/j.mnl.2020.05.008.
27. Baron K, LaBella E, Parkosewich JA, Hahn JM. Keeping nurses engaged in nursing professional governance during the COVID-19 pandemic: nursing professional governance structure at Yale New Haven Hospital. *Nurse Lead*. 2021;19(2):194-197. doi:10.1016/j.mnl.2020.10.007.
28. Hancock B, Catrambone C, Mayer KM, Hoskins JL, Chierici C, Start RE. Leveraging professional governance during the COVID-19 pandemic. *J Nurs Adm*. 2021;51(3):117-119. doi:10.1097/NNA.0000000000000990.
29. Weston MJ, Meek P, Verran JA, et al. The Verran Professional Governance Scale: confirmatory and exploratory analysis. *J Nurs Adm*. 2022;52(5):273-279. doi:10.1097/NNA.0000000000001147.