Research on hospital-based shared governance: a scoping review

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Purpose

To review research on hospital-based shared governance, focusing on its core elements.

Design

A scoping review was conducted by searching the Medline (Ovid), CINAHL (EBSCO), Medic, ABI/INFORM Collection (ProQuest), and SveMed+ databases using SG and related concepts in hospital settings as search terms (May 1998–February 2019). Only original research articles examining SG were included. The reference lists of the selected articles were reviewed. Data were extracted from the selected articles by charting and then subjected to thematic analysis.

Findings

The review included 13 original research articles that examined SG in hospital settings. The studied organizations had implemented SG in different ways, and many struggled to obtain satisfactory results. SG was executed within individual professions or multiple professions and was typically implemented at both unit- and organization-levels. Thematic analysis revealed six core elements of SG: professionalism, shared decision-making, evidence-based practice (EBP), continuous quality improvement (CQI), collaboration, and empowerment.

Practical implications

An SG framework for hospital settings was developed based on the core elements of SG, the participants, and the organizational levels involved. Hospitals considering SG should prepare for a time-consuming process that requires belief in the core elements of SG. The SG framework can be used as a tool to implement and strengthen SG in organizations.

Originality

The review resumes the tradition of systematically reviewing SG literature, which had not been done in the 21st century. General tendencies of the research scene and research gaps are pointed out.

Key words

Hospitals, Scoping review, Shared Governance, Nursing

1 BACKGROUND

Shared governance (SG) is a structural phenomenon (Porter-O'Grady, 2001) that supports nurses' professional autonomy, control of their practice environment, and communication (Church *et al.*, 2008). It originated in the USA in the late 1970s, when a nation-wide nursing shortage prompted healthcare organizations to reassess nurses' priorities (Porter-O'Grady, 2012). An organizational culture with an empowering approach to clinical and organizational decision making was considered central (Di Fiore *et al.*, 2018) because the framework emerging from this reassessment aspired to change the structural reality in which nurses worked within formal, bureaucratic, and hierarchical organizations (Hess, 2004).

SG contributed to the creation of The Magnet Recognition Program®, which aims to give hospitals tools to attract and retain qualified nurses. The program was initially available to American hospitals but was expanded internationally in 2000 (Morgan *et al.*, 2006). A key objective in magnet hospitals is to achieve structural empowerment, for which SG provides a framework (Clavule *et al.*, 2016).

In an SG organization, clinical practice decisions should be made by those who provide the care. The idea is that nurses own their practice environment and have a voice in decision-making (Winslow *et al.*, 2015). Nurse managers have an important role as supporters of nurses in SG activities. The resulting partnership supports reciprocal communication, which is essential to the functioning of SG (Ott & Ross, 2014).

Positive outcomes in nursing practice are achieved when nurses learn how to self-direct their work while aligning it with unit-level teams and nursing leadership (Joseph & Bogue, 2016). Professional autonomy and decision-making skills can be enhanced by incorporating EBP into the SG framework and by enhancing staff nurses' leadership skills. Mentoring is one way of helping staff nurses become

better clinical leaders (Dearmon *et al.*, 2015). These changes take time, but eventually, staff nurses grow personally and professionally as they engage in SG activities (Guanxi, 2018).

Besides leadership skills, nurses need guidance on how to use research and conduct quality improvement processes to resolve system-wide practice issues (Dearmon *et al.*, 2015). Many SG hospitals have engaged with this challenge by incorporating EBP into the SG councils' work methods (Fisher & Hubbard, 2015) or by establishing an organization-wide EBP council (Gallagher-Ford, 2015).

Porter-O'Grady (1987) described three models of SG, namely the councillor (1), congressional (2), and administrative (3) models. The councillor model (1) facilitates SG through nursing councils, which make system-wide decisions relating to specified areas. The councils are overseen by an executive group that manages issues relating to the whole organization, coordinates the council's work, and integrates the council's work into practice. The congressional model (2) resembles a constitutional government: staff elect an executive and representatives to a nursing cabinet, which usually includes both managers and staff nurses. Finally, the administrative model (3) divides organizational authority between management and clinical forums that are overseen by an executive committee and a nurse executive (Porter-O'Grady, 1987). A fourth unit-based SG model under which SG is only implemented within units and not at the system level was recognized in the 1990s (Yanko *et al.* 1995).

Continuous evaluation of SG is recommended for successful human resource management and improvement of healthcare service quality (Gerard *et al.*, 2016). The most widely used tool for assessing SG is "The Index of Professional Nursing Governance" (IPNG) (Hess, 1998; 2011), which measures six aspects of SG: professional control, organizational influence, organizational recognition, facilitating structures, liaison, and alignment. IPNG scores indicate which part of the SG

range an organization occupies. The range extends from nursing management or administration only to staff nurses only, with the middle part of the range corresponding to a situation in which SG is equally distributed between staff nurses, nursing managers, and administrators (Hess, 1998). IPNG is considered the gold standard for surveying SG (Di Fiore *et al.*, 2018).

Another way of evaluating SG is to measure structural empowerment in the organization (Joseph & Bogue, 2016). Kanter's theory of empowerment suggests that in working life, access to information, support and resources, as well as opportunities to learn and grow, enable the empowerment of employees, which helps them accomplish organizational goals (Laschinger & Wong, 1999). Structural empowerment is related to SG via elements such as autonomy, control over the practice environment, interprofessional collaboration, and access to information. It is also a contributing factor in enhancing magnet organizations and patient safety culture in healthcare (Armstrong & Laschinger, 2006).

Other concepts related to SG are clinical and professional governance. Clinical governance is an umbrella term associated with attributes such as quality, continual improvement, standards of care, system-orientation, and responsibility (Brennan & Flynn, 2013). It integrates activities targeting continuous quality improvement (Som, 2004). SG also shares this objective, although the SG literature places greater emphasis on empowering nurses than on SG's benefits to organizations (Porter-O'Grady, 2001; Hess, 2004). Professional governance refers to ideas of accountability, professional obligation, collateral relationships, and effective decision-making (Clavelle *et al.*, 2016). It overlaps with SG via elements such as partnership (Hess, 2004), equity, and a strong emphasis on clinical nurses' decision-making (Porter-O'Grady, 2001).

The last systematic review to evaluate SG was made by O'May & Buchan (1999). Since then, it has been stated that the gap between the concept of SG and its implementation requires study (Anthony,

2004; Gerard et al., 2016) and that management strategies for implementing SG have not been standardized (Church et al., 2008). A need for an operational definition of SG (Joseph & Bogue, 2016) and for robust assessments of the success of efforts to implement SG and their outcomes have also been noted (Anthony, 2004). Moreover, SG has evolved during its existence and continues to change. For example, in recent years, millennials have gained a strong footage in health care organisations, which has further accelerated the demands of renewing the structures and models that support professional nursing practice. (Porter-O'Grady, 2019.)

To conclude, this review is the first systematic review of SG written in the 21st century and is needed because the concept of SG is broad and because its premises have changed over time. Since SG has mainly been implemented and studied in magnet hospitals, this scoping review focuses on hospital-based SG. Its purpose is to provide an overview of research on hospital-based SG with a focus on core SG elements.

2 METHODS

A scoping review was conducted to explore and create an overview of the existing literature (Arksey & O'Malley, 2005). The methodological frameworks for conducting scoping reviews presented by Levac *et al.* (2010) and Arksey & O'Malley (2005) were adopted. To enhance the review's transparency and reporting quality, the "PRISMA Extension for Scoping Reviews" checklist was also used (Tricco *et al.*, 2018). A three-step search strategy involving an initial search, a database search, and screening of the initially selected articles' reference lists was used to increase reliability.

Searches were performed using the following keyword combinations: SG (title) OR clinical governance (title) OR professional governance (title) AND model (abstract). The database search was conducted with the same search strategy in the five databases selected for consideration, yielding the

following numbers of hits: Medline (Ovid) (100), CINAHL (EBSCO) (348), Medic (a Finnish database) (0), ABI/INFORM Collection (ProQuest) (360), and SveMed+ (a Swedish database) (0). The review included original research articles published in English, Finnish or Swedish. Because of the different ways in which SG can be implemented, only articles that described the applied SG model were eligible for inclusion. The beginning of the review's timespan (May 1998 - February 2019) corresponds to the end of the timespan of O'May & Buchan's (1999) review of SG. Articles for which the full text was unavailable were excluded. In accordance with the criteria for scoping reviews, articles included in the review were not subjected to quality assessment (Armstrong *et al.* 2011).

The review process was conducted between February and March in 2019 by two independent researchers (MK, MH), first on the title and abstract level, then on the full-text level (Arksey & O'Malley, 2005). After the selection process, a manual search was conducted by screening the reference lists of the selected articles (Armstrong *et al.*, 2011). Refworks was used to facilitate the review process, including removal of duplicates. Eight original research articles were identified during the database search and five additional articles were identified by screening the reference lists of the initial eight articles (Figure 1).

The data were charted to identify common indicators of hospital-based SG and its core elements, as well as gaps in the literature (Armstrong *et al.* 2011). The charting categories correspond to extracted data relevant to the research objective. The categories are authors, year of publication, country, study design, participants, response rate, aims, methods used (instruments, statistical methods, and analytical methods), models, and key findings (Table 1).

Thematic analysis enables low-level interpretation and was therefore chosen to analyse the research articles (Vaismoradi *et al.*, 2013). The analysis was conducted by one researcher (MK), but another researcher (MH) was consulted in cases where the first researcher was uncertain. The analytical

process involved first compiling the data and then separating and grouping it (Castleberry & Nolen, 2018).

3 RESULTS

Study characteristics

All articles selected for inclusion in the review originated from the USA and were published between 2001 and 2018. The studies were mainly survey-based and used either longitudinal (Frith & Montgomery, 2006; Brull, 2015; Allen-Gilliam *et al.*, 2016; Ong *et al.*, 2017; Di Fiore *et al.*, 2018; Weaver *et al.*, 2018;) or cross-sectional designs (Howell *et al.*, 2001; Overcash *et al.*, 2012; Rheingans, 2012; Wilson *et al.*, 2014; Winslow *et al.*, 2015; Gerard *et al.*, 2016; Giambra *et al.*, 2018). One study employed a modified Delphi technique (Giambra *et al.*, 2018) and four studies utilized mixed methods (Frith & Montgomery, 2006; Winslow *et al.*, 2015; Ong *et al.*, 2017; Giambra *et al.*, 2018). The most widely used survey instrument was IPNG or its upgraded version (Howell *et al.*, 2001; Overcash *et al.*, 2012; Rheingans, 2012; Brull, 2015; Di Fiore *et al.*, 2018; Weaver *et al.*, 2018).

Hospital-based SG models

Three studies accepted participants other than nurses, such as nurse managers and patient care technicians (Frith & Montgomery, 2006; Wilson *et al.*, 2014; Giambra *et al.*, 2018). In all of the studied settings, SG had originally been established for nurses, but two of the articles examined interdisciplinary models (Allen-Gilliam *et al.*, 2016; Giambra *et al.*, 2018). Studies on organizations that served only the nursing profession strongly emphasized nurse managers' supporting role.

Most of the studies examined models implemented within the last 5 years (Howell *et al.*, 2001; Frith & Montgomery, 2006; Rheingans, 2012; Wilson *et al.*, 2014; Brull, 2015; Ong *et al.*, 2017; Di Fiore *et al.*, 2018) or recently redesigned models (Winslow *et al.*, 2015; Allen-Gilliam *et al.*, 2016; Gerard *et al.*, 2016; Giambra *et al.*, 2018; Weaver *et al.*, 2018). The models frequently had both a unit-level structure and an organization-wide structure (Frith & Montgomery 2006; Rheingans, 2012; Wilson *et al.*, 2014; Winslow *et al.*, 2015; Brull, 2015; Gerard *et al.*, 2016; Di Fiore *et al.*, 2018; Giambra *et al.*, 2018; Weaver *et al.*, 2018). Only two articles described models consistent with Porter-O'Grady's (1987) original classification (Overcash *et al.*, 2012; Rheingans, 2012). The articles described the SG models based on the levels at which SG was implemented (organization-wide, unit-based, or both) and the participants involved (single-profession or interdisciplinary).

Nine articles described the subjects addressed by the studied organizations' SG councils. Thematic analysis of these subjects revealed five council themes: education and research (Howell *et al.* 2001; Frith & Montgomery 2006; Wilson *et al.* 2014; Brull 2015; Allen-Gilliam *et al.* 2016; Weaver *et al.* 2018), professional growth and development (Howell *et al.* 2001; Frith & Montgomery 2006; Brull 2015; Winslow *et al.* 2015; Allen-Gilliam *et al.* 2016; Weaver *et al.* 2018), coordination and leadership (Howell *et al.* 2001; Frith & Montgomery 2006; Winslow *et al.* 2015; Allen-Gilliam *et al.* 2016; Gerard *et al.* 2016; Di Fiore *et al.* 2018), safety and quality (Frith & Montgomery 2006; Brull 2015; Allen-Gilliam *et al.* 2016; Weaver *et al.* 2018), and professional practice (Brull 2015; Winslow *et al.* 2015; Allen-Gilliam *et al.* 2016).

Core elements

Thematic analysis was used to identify the core elements of SG by first analysing the research themes of the articles and then categorizing these themes and using them to identify the core elements of SG. The first phase revealed five research themes – in order of decreasing frequency, the level of SG (1),

barriers and facilitators of SG (2), the effect of demographic characteristics on nurses' views of SG (3), SG outcomes (4), and shared decision-making (5).

Most of the articles assessed the level of SG (1) using the IPNG, which emphasizes professionalism as a driver of SG. Few of the studied organizations' IPNG scores were in the SG range, indicating that most of the SG implementations were unsuccessful. Of the six organizations assessed using IPNG, only one exhibited a satisfactory level of SG without improving their SG model (Rheingans, 2012). Two other organizations achieved scores in the SG range in the third measurement round after redesigning their SG model (Brull, 2015; Weaver *et al.*, 2018).

One of these organizations redesigned its SG model based on the wishes of staff, which included more education on SG, better communication and unit-based council meetings, involvement of night shift nurses, and increased participation of nurses in SG activities (Weaver *et al.*, 2018). The second organization also aimed to increase nurses' participation in decision-making at the organization level and added more councils (Brull, 2015). The other studied organizations were perceived to be traditionally governed or led mainly by nursing management (Howell *et al.*, 2001; Overcash *et al.*, 2012; Di Fiore *et al.*, 2018). Some studies found that active involvement in SG predicts more positive views of SG across organizational levels (Frith & Montgomery, 2006; Overcash *et al.*, 2012; Rheingans, 2012).

Three studies investigated the barriers and facilitators of SG (2). Barriers included disruption of patient care (Wilson *et al.*, 2014) and an information deficit (Giambra *et al.*, 2018). Facilitators included manager support and time to participate in SG activities (Frith & Montgomery, 2006; Wilson *et al.*, 2014; Giambra *et al.*, 2018). Some studies also investigated the effects of nurses' demographic characteristics (e.g. work experience and education) on their view of SG (3) (Howell *et al.* 2001; Frith & Montgomery 2006; Overcash *et al.* 2012; Rheingans 2012; Brull 2015). However, the observed

correlations between demographic characteristics and views on SG were either non-significant or inconsistent.

Three articles assessed outcomes of SG (4) including self-perceived caring, the safety climate, and job satisfaction (Rheingans, 2012); the professional practice environment, empowerment, teamwork, risk of practice errors, and EBP (Allen-Gilliam *et al.*, 2016); and engagement and turnover (Ong *et al.* 2017). Rheingans (2012) examined a councillor model that achieved positive outcomes, but the organization-wide model studied by Allen-Gilliam *et al.* (2016) and the unit-based model studied by Ong *et al.* (2017) both had inconclusive outcomes.

Shared decision-making (5) was analysed in three studies and addressed in four (Brull 2015; Allen-Gilliam *et al.*, 2016; Giambra *et al.*, 2018; Weaver *et al.*, 2018). Winslow *et al.* (2015) found that once an SG model was implemented and became part of the organizational culture, shared decision-making grew stronger. Gerard *et al.* (2016) found that nurses in the organization desired more decision-making capacity. Similarly, Di Fiore *et al.* (2018) concluded that nurses' assessments of organizational decision-making were less positive than would be desirable.

CQI and EBP were not major research themes of any of the studies. However, EBP served as a framework in one study that evaluated the implementation of SG (Ong *et al.*, 2017). It was also an explicit factor of the SG models considered in four articles (Brull, 2015; Winslow *et al.*, 2015; Allen-Gilliam *et al.*, 2016; Di Fiore *et al.*, 2018). CQI was identified as an objective of the organization's SG model in five articles (Howell *et al.*, 2001; Rheingans, 2012; Wilson *et al.*, 2014; Allen-Gilliam *et al.*, 2016; Ong *et al.*, 2017). It was also a council theme in four organizations (Frith & Montgomery, 2006; Brull, 2015; Di Fiore *et al.*, 2018; Weaver *et al.*, 2018).

Collaboration was another element that was not used as a research theme. However, many of the articles highlighted collaboration between professionals (Howell *et al.*, 2001; Wilson *et al.*, 2014), between management and staff (Wilson *et al.*, 2014; Gerard *et al.*, 2016; Ong *et al.*, 2017), and between organizational levels (Rheingans 2012; Ong *et al.*, 2017) as core elements of successful SG.

Empowerment was mentioned as a main interest in one study (Allen-Gilliam *et al.*, 2016). However, when the articles were analysed through Kanter's theory of empowerment, the council themes clearly included aspects of empowerment such as professional growth and development as well as professional practice, which highlight professionalism and the work force's opportunities for growth (Howell *et al.* 2001; Frith & Montgomery 2006; Brull 2015; Winslow *et al.* 2015; Allen-Gilliam *et al.* 2016; Weaver *et al.* 2018). Other overlapping themes included education, research, and EBP, which can all be linked to empowerment through access to information and learning.

The analysis thus revealed six core elements of SG: professionalism, shared decision-making, EBP, CQI, collaboration, and empowerment. Of these elements, professionalism is a string that ties everything together. Shared decision-making is an element that allows SG to manifest itself, while EBP provides a tool for decision-making. CQI is the objective of SG. The element of collaboration then represents the values embedded in the SG phenomenon – the idea of working together towards shared goals. Empowerment is thus an underlying element that gives momentum to SG.

To help organizations establish SG, a framework based on the main findings of this review was created by combining the structural choices and core elements identified above to provide an overview of SG in hospital settings. The framework is presented in the form of a map of outcomes showing the frequency at which each SG factor was discussed in the reviewed articles (Figure 2).

4 DISCUSSION

This scoping review resumes the tradition of systematically reviewing SG literature, which had not been done in the 21st century (O'May & Buchan 1999). The aim was to review research on hospital-based shared governance, focusing on its core elements. Thematic analysis of the reviewed articles suggests that the core elements of SG in hospital settings are professionalism, shared decision-making, EBP, CQI, collaboration, and empowerment. These core elements are equivalent to those recognized by previous researchers (O'May & Buchan, 1999; Porter-O'Grady, 2001; Anthony, 2004; Hess, 2011), except that CQI and EBP have not previously been linked so directly to SG. The two new elements reflect the changing healthcare environment, which has placed a greater emphasis on patients' rights to first-rate care.

SG is executed in varying ways, as noted previously by Church *et al.* (2008) and Joseph & Bogue (2016). Based on the results obtained here, organizations do not seem to strive for a standardized way of implementing SG because only two articles described models consistent with Porter-O'Grady's (1987) classification. It is thus possible that this classification does not serve the current needs of the healthcare arena. Since this first classification, healthcare organizations and disciplines have evolved, and especially in the nursing field, professional development has changed the way in which the borders of competences, decision-making, and autonomy are defined (Fisher & Hubbard, 2015; Gallagher-Ford, 2015).

This review endorses the research articles' approach of classifying SG models more simply, as being either organization-wide or unit-based, and as being executed within a single profession or an interdisciplinary group. This classification augments organizations' ability to define themselves in relation to other SG organizations while leaving space for innovation. SG can be implemented at different levels depending on organizational priorities (Gallagher-Ford, 2015; Gerard *et al.*, 2016).

Team characteristics are also important; for example, the implementation of SG in a highly experienced ICU nursing team may differ from that in a team consisting mainly of novice nurses.

Study limitations

The scoping review has several limitations. Firstly, only the most relevant databases were selected as information retrieval sources. Two databases in languages other than English were also included to obtain an overview of SG research outside English-speaking countries. Secondly, the review only included articles that examined SG in hospital settings. Thirdly, the review included only original research articles. Other types of articles were excluded because of their variable quality. The review's validity was strengthened by consulting a librarian when planning the search strategy. Additionally, the search was conducted by two independent researchers, first on the title and abstract level and then on the full-text-level. The analysis was then discussed between researchers to add validity.

All the included research articles deal with SG even though professional and clinical governance were also used as search terms, which might be due to differences in execution. It should also be noted that the actual database screening identified eight relevant articles, whereas screening of the included articles' reference lists revealed five relevant articles. All the studies included in the review were conducted in the USA, possibly due to a language bias. The Finnish and the Swedish databases yielded no relevant articles. Additionally, the magnet hospital movement, which has favoured SG, has been largely restricted to the USA.

5 CONCLUSIONS

Six core elements of SG were identified in this review: professionalism, shared decision-making, EBP, CQI, collaboration and empowerment. The findings of this review are summarized in a new SG framework consisting of these core elements as well as the participants in the SG process and the organizational levels at which SG is implemented. Additionally, our analysis endorses a classification of SG in hospital settings that is simpler than that of Porter-O'Grady (1987), with SG organizations being classified based on the professionals included in SG activities (single profession and managers only or interdisciplinary) and the level at which SG activities are conducted (unit-based, organization-wide, or both).

The core elements should be monitored to keep up with changes in the healthcare arena. Further systematic reviews should be performed periodically to accumulate data on SG, which continues to inspire organizations, professionals, and researchers despite the challenges they face. Since many organizations found it difficult to achieve a satisfactory level of SG, continued assessment of SG levels is recommended, along with further exploration of barriers and facilitators of SG. There is also a notable lack of research on the effects of SG on patients, which should be addressed.

6 PRACTICAL IMPLICATIONS

Based on the findings of this review, an updated SG framework has been developed. This framework could be used to guide and strengthen the implementation of SG and the updated core elements should be considered in SG organizations. Additionally, the benefits of SG to organizations and patients as well as professionals should be emphasized. By combining EBP and SG, knowledge and knowhow can be transferred from professionals to the whole organization through the SG structure, ensuring that improvements are not dependent on the presence of specific individuals.

The implementation of SG is not always as straightforward as first thought because even more mature SG organizations face challenges in meeting the expectations of the workforce. This review shows that SG can be achieved, but not without meaningful effort from the facility and its workforce. In other words, SG is not for the impatient looking for an easy fix, but for those who truly want to be part of an organization that gives a voice to its professionals.

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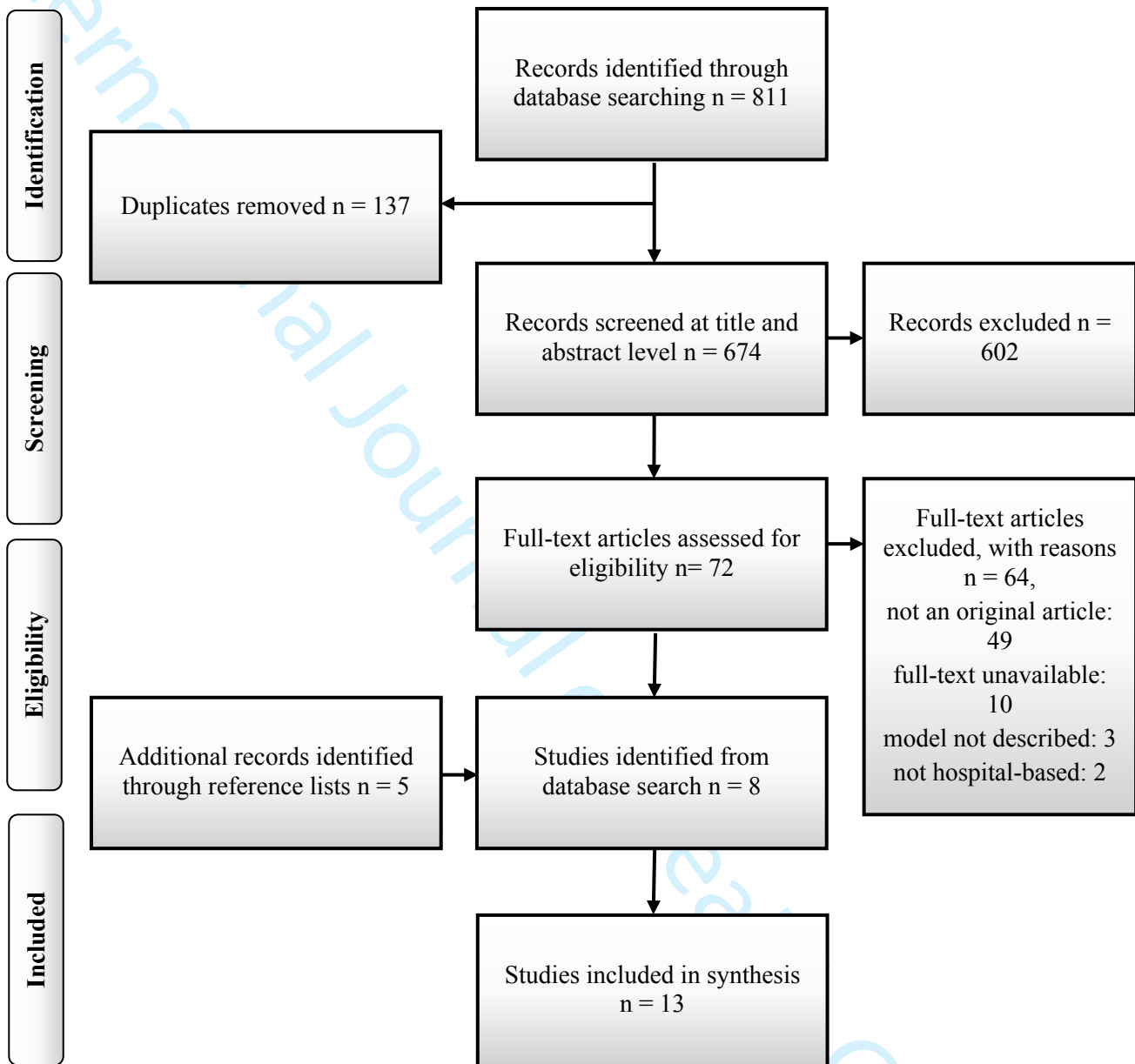
Figure 1. Flowchart of the article selection process. Adapted from Moher et al. (2009).

Table 1. Data extracted from the research articles.

Author(s), year of publication, country	Design, participants, response rate (rr)	Aims	Methods (instruments, statistical methods, methods of analysis)	SG model	Key findings
Howell et al. 2001 USA	a cross-sectional study, n=183 RNs*, rr=67 %	to measure perceptions of SG** two years after its implementation and to determine whether nurse characteristics affect the perceived level of SG	a survey utilizing IPNG*** and statistical analysis, including descriptive statistics and measures of central tendency	organization-wide councils	the organization is perceived to be traditionally governed; nurse demographics do not significantly correlate with IPNG scores
Frith & Montgomery 2006 USA	a longitudinal study, n=687 RNs, licensed practical nurses, care technicians, and medical receptionists, rr=33 % second round: n=961, rr=48% focus group interviews, n=68 clinical and managerial staff	to explore perceptions and knowledge of SG as well as commitment to SG before and after its implementation	a survey utilizing the Shared Governance Survey adapted from Minors et al., statistical analysis, including descriptive statistics	unit level and organization-wide councils	implementation of SG is time-consuming, but staff remain committed to it; facilitating factors of SG include management support, providing time for council work and educating council members about SG; monthly council meetings and greater than 50 % attendance predict more positive views
Rheingans 2012 USA	a cross-sectional study, n=140 nurses	to determine whether SG is present in the organization five years after its implementation and to investigate if SG resulted in improvements	a survey utilizing IPNG, the Caring Nurse-Patient Interactions Scale, the Measure of Job Satisfaction and the Safety Climate Survey as instruments, statistical analysis, including regression analyses	"a councillor model": unit level and organization-wide councils	IPNG score is in the SG range; work status, hospital unit, participation in hospital-wide councils, and professional certification affect nurses' evaluations
Overcash et al. 2012 USA	a cross-sectional study, n=100 RNs	to determine whether demographic variables affect nurses' level of perceived SG	a survey utilizing IPNG and statistical analysis, including analysis of	"a councillor model" with organization-wide councils	the governance model is perceived to be primarily led by nursing management /administration

			variance and regression models as well as general linear models		with some staff nurse input; having a role in SG and working in in-patient settings affects evaluation
Wilson et al. 2014 USA	a cross-sectional study, n=144 RNs and nurse managers, rr=44%	to determine which factors affect SG participation and whether there are differences between staff nurses' and nurse managers' perceptions	a survey utilizing a 26-item instrument created for the study, statistical analysis, including frequency distributions, Chi-square analysis and Fisher's exact tests	unit level and organizatio n-wide councils	staff nurses' participation in SG is increased when they work as a team, are supported by nurse managers, get compensation for participating, and participation does not disrupt patient care
Winslow et al. 2015 USA	a cross-sectional study, n=113 RNs, rr=25%	to determine whether the SG model meets the needs of shared decision-making after organizational changes and to measure nurses' understanding of SG	a survey utilizing an instrument developed for the study, thematic and statistical analysis, including calculation of means and the Mann-Whitney U test	unit level and organizatio n-wide councils	77 % believed SG gives nurses a voice in decision-making, 80 % agreed they had adequate resources and encouragement to make council work meaningful; qualitative themes: SG is a pathway for nurses to have a strong voice, it is based on ownership of the practice environment and various disciplines identifying issues and collaborating to identify solutions
Brull 2015 USA	a longitudinal study, n=88 nurses, rr=34% second round: n=140, rr=50% third round: n=107, rr=41%	to determine whether an education plan strengthened SG by assessing changes in the level of SG, and to evaluate the impact of demographic variables on SG scores	a survey utilizing IPNG and statistical analysis, including frequency distributions and variance analysis	unit level and organizatio n-wide councils	a strategic approach to SG implementation had a significant effect; the baseline IPNG score indicated a traditionally governed organization but the score increased marginally after one year and entered the SG range after two years

Allen-Gilliam et al. 2016 USA	a longitudinal study, n=52-142 RNs and licenced practical nurses, rr=24-65%	to measure the impact of a redesigned SG model on the professional nursing practice environment (nursing leadership, nurse empowerment, nurse satisfaction, risk of practice errors, and comfort with EBP) at baseline and in subsequent years	a survey using the Nursing Work Index-Revised, Shared Governance Survey, Index of Work Satisfaction, Work Practice Breakdown Survey and Developing Evidence-Based Practice as survey instruments, statistical analysis, including descriptive statistics, a correlation matrix and multiple linear regressions	organization-wide councils that are partially interdisciplinary	all instruments indicated improvement except in the final survey year
Gerard et al. 2016 USA	a cross-sectional study, n=162 staff nurses, rr= 21%	to describe how measuring the perceived and desired decision-making capacity of nurses working in a SG organization can be beneficial	a survey using the Decisional Involvement Scale and statistical analysis (calculation of dissonance levels)	unit level and organization-wide councils	nurses would have preferred more control over decision-making
Ong et al. 2017 USA	a longitudinal study, n=19 RNs, rr=17 % two focus groups	to evaluate the newly implemented SG model's impact on RNs' engagement and turnover	a survey using the Work and Wellbeing Survey and the Utrecht Work Engagement Scale, a semi-structured interview, a free textual and statistical analysis, including a paired t-test and descriptive statistics	a medical intensive care unit with unit-level SG	the survey showed no statistically significant improvements; the focus groups revealed an increase in engagement postintervention, but there was no statistically significant increase in vigour, dedication, or absorption
Giambra et al. 2018 USA	a cross-sectional study, n=237 patient service staff, round two: n=76, rr=56%	to identify the preferred ways of spreading information and meaningful ways to participate in SG	a modified Delphi technique with two rounds of structured surveys, content and statistical analysis, including descriptive statistics	an interdisciplinary SG model with councils at multiple levels	manager support, scheduled time and adequate coverage for patient care were considered important facilitators of SG participation; communication of ideas from

					clinicians to council representatives was considered important
Weaver et al. 2018 USA	a longitudinal study in two-year intervals, n=469 nurses second round: n=326 third round: n=599	to identify the strengths and weaknesses of the SG model as well as the opportunities it presents and threats it faces, and after the second round, to evaluate the redesigned SG model	surveys using IPNG 2.0 and 3.0, statistical analysis, including descriptive statistics	unit level and organization-wide councils	first and second round evaluations placed the organization in the traditional governance range but after redesigning the model, the organization reached the SG range
Di Fiore et al. 2018 USA	a longitudinal study, n=106 RNs, rr=14 round two: n=197, rr=27%	to examine nurses' perceptions of shared decision-making immediately after implementing SG and 3 years afterwards	a survey using IPNG and statistical analysis, including a multivariable linear regression model	unit level and organization-wide councils as well as a nursing congress (council)	the governance was perceived to be primarily completed by nurse managers and the IPNG score improved only slightly in the second round

*RN = registered nurse, **SG = shared governance, ***IPNG = The Index of Professional Nursing Governance

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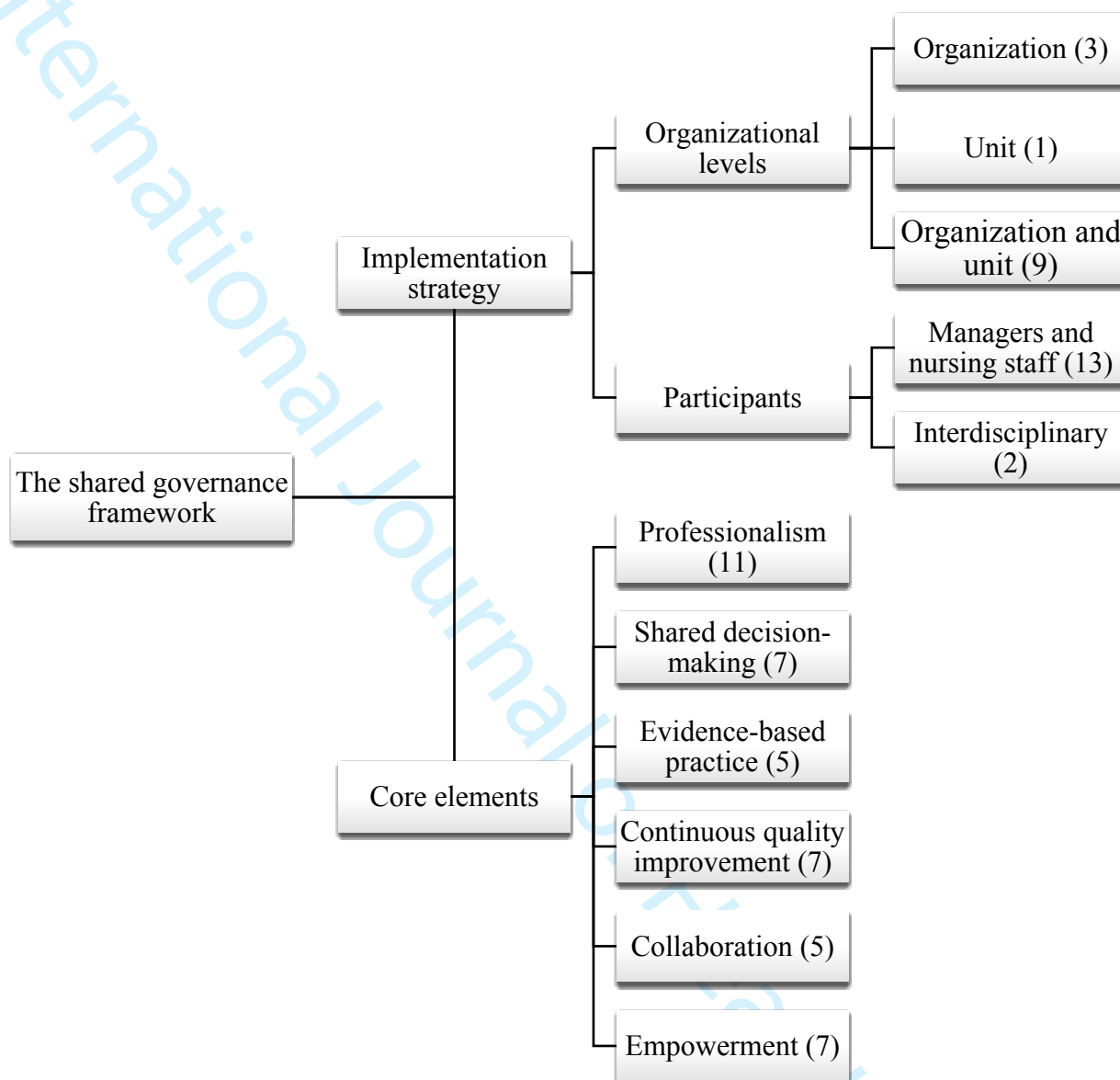46
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Figure 2. The shared governance framework presented as a map of outcomes. Numbers in parentheses indicate the number of articles included in the scoping review that discussed the corresponding elements and types of implementation strategy.