Conceptualizing Nurse Professional Governance to Enhance Performance, Quality and Safety of Health Services

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Abstract

The need of nurses’ engagement in the governance of healthcare systems and organizations has been highlighted in order to improve patients’ experience, work environment, financial performance, as well as increase the quality and safety of health services. There is a need to develop information to explore the current spectrum of nurses’ professional governance, especially at the organizational level. This review aims to explore this concept, as well as survey how nurses’ professional governance has been used to overcome health worker issues in previous studies. Data source of this study included Web of Science, Google Scholars, and Wiley online Library (40 articles). Four distinct themes of nurses’ professional governance strategies were identified from the selected articles, namely: shared governance, professional development, performance management, and clinical governance. A conceptual framework on the dynamic of nurses’ professional governance was proposed to conclude the review. This will help streamline the evaluation and investigation on the consequences and impact of these strategies towards delivery services and patient outcomes.

Keywords: Concept analysis, nurse professional governance, shared governance, professional development, performance management, Clinical governance.

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1.0 INTRODUCTION

The International Council of Nurses (ICN) outlined the strategic direction towards nurses’ involvement in the healthcare system governance via investment in the nursing workforce and engagement of nurses in governance and the policy making process (Stewart, Burton, & White, 2018). ICN emphasized that the engagement of nurses in governance will improve patients’ experience, work environment, financial performance, as well as increase the quality and safety of the health services.

Governance in the health system is a broad concept, and is little studied, especially in the context of the nursing profession. Researchers agreed on the prevalence of a significant gap in knowledge on governance tools/mechanisms, the context of governance, and its consequences (Brinkerhoff & Bossert, 2013; Dieleman & Hilhorst, 2011; Dieleman, Shaw, & Zwanikken, 2011; Siddiqi et al., 2009; Staniland, 2007). Brennan et al. (2013) pointed out that confusion about the term/concept, in particular between governance, clinical governance, shared governance, empowerment, and the different terminologies being used in management and clinical activities(Brennan, Niamh M.; Flynn, 2013). Fragmentation and the lack of coordination between planning, management, and policies in order to improve the efficiency of health systems further confound the concept of
governance (Adams, 2011; Avril, Sarah, John, & Quain, 2013; M. Kim, Song, & Triche, 2015). Governance has been defined in many studies (Table 1).

### Table 1: Definitions of governance in prior studies

<table>
<thead>
<tr>
<th>Sources</th>
<th>Definitions of governance</th>
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<tr>
<td>Brinkerhoff &amp; Bossert (2008)</td>
<td>“Governance is about the rules that distribute roles and responsibilities among government, providers and beneficiaries and that shape the interactions among them. Governance encompasses authority, power, and decision making in the institutional arenas of civil society, politics, policy, and public administration” (Brinkerhoff &amp; Bossert, 2013)</td>
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<td>Hastings et al (2014)</td>
<td>Governance encompasses a whole range of structures and processes through which policies (formal and informal) are enacted to achieve goals, including legislation, regulation and oversight, accountability structures, incentives, and policies to set and maintain strategic direction” (Hastings, Armitage, Mallinson, Jackson, &amp; Suter, 2014).</td>
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<tr>
<td>Siddiqi et al (2009)</td>
<td>Governance comprises the complex mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations (Siddiqi et al., 2009)</td>
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Various theories have been utilized to link governance and the outcome of health workers. Institutionalist perspective view governance in its broadest sense via the Institutionalism Theory, explaining it as “to how institutions, although created in different ways, end up having similar structures and how these institutions might shape the behaviour of the individuals within them” (Staniland, 2007). Several organizational theories also been used to elaborate upon this. A previous study adapted the Work Performance Theory by Blumberg and Pringles (1982) to elaborate upon two main components that play important roles on maximizing the health worker outcome, namely individual and situational factors (including governance, organizational climate, work environment, ruler, and procedure) (Blumberg & Pringle, 1982). Stewardship Theory (Van Puyvelde, Caers, Du Bois, & Jegers, 2012), Kanter’s Theory (Ahmad & Oranye, 2010; Barden, Griffin, Donahue, & Fitzpatrick, 2011), and Principle Agent Theory (Brinkerhoff & Bossert, 2013; Van Puyvelde et al., 2012), all of which have been used to explain the relationship between shared governance and workers’ performance.

![Figure 1: Health Governance Framework (Source: Brinkerhoff and Bossert, 2013)](image-url)
Attempts on developing a health governance model can also be found in literature. Brinkerhoff and Bossert (2013) proposed a Health Governance Framework on the basis of three governance actors; (i) Lead agency/politicians and policy makers, (ii) Health service providers in the institutional and organizational level, and (iii) clients/citizens and service users (Brinkerhoff & Bossert, 2013). These actors are simultaneously interconnected in order to enable the operation of health governance (Figure 1).

The concept of multi-level governance in a healthcare system proposed by Kuhlmann & Larsen (2015) suggested that regulatory power of “government” should be distributed to more plural tiers via operational governance on the levels of organizations and across professional groups (Figure 2). They proposed that the complex nature of hierarchical level of health governance and content-related dimensions of governance may block innovation and reduce the efficiency of health workforce management in many ways (Kuhlmann & Larsen, 2015). Kuhlmann & Larsen added that the compartmentalization of these dimension results in ‘unhealthy’ effects ‘piecemeal work’ policy approaches.

The links between governance strategies and performance have been detailed by previous studies. However, research are mostly focused on the impact of governance to organizational performance (Avril et al., 2013; Barbazza, Langins, Kluge, & Tello, 2015; Brinkerhoff & Bossert, 2013; Dieleman et al., 2011; Phillips et al., 2010). Yet, the evidence on the impact of governance mechanisms on individual nurse outcomes is limited (Clark & Beatty, 2016; Staniland, 2007). Previous studies established the need for attention on how governance mechanisms can facilitate change in the nursing workforce. Nurses working in public hospitals expect and value a specific style of governance that proactively respond to their desires and to the best interests of the patients, ensure that evidence drives decisions, and establish a clear agenda for improving services (Clark & Beatty, 2016). Hastings et al. (2014) demonstrated that different approach of government mechanisms have positive impacts on workforce outcomes (e.g. attitude, professional behavior, teamwork) with the presence of clear vision, leaderships, communication, as well as workers’ engagements. Involvement of nurses in the internal governance (practice and policy committee) and the decision making process are highly correlated with job satisfactions, quality of health care, as well as reduced intention to leave (Atefi, Abdullah, & Wong, 2014; C. W. Kim et al., 2013; Van Bogaert, Kowalski, Weeks, Van heusden, & Clarke, 2013). This study intends to explore and synthesize the current state of the concept of professional nurse governance. It also aims to describe how nurse governance have been used to overcome health worker issues in previous studies.

Figure 2: Matrix of multi-level health workforce governance
2.0 DATA SOURCES

This is a descriptive literature review, using published articles to describe/evaluate a governance-related intervention related to nursing professionals. Organizational governance was focused upon instead of international governance. Many common aspects appear among different definitions and frameworks for governance in health; these are often described using a variety of terms. In order to address the term ‘governance’ more systematically and allow for a simple overview, we use the aforementioned governance definition of Kuhlmann & Larsen (2015) as a basis. Using Walker & Avant's (1995) model for concept analysis, this paper clarifies the meaning of professional nurse governance at the organizational level. This article concludes with a discussion of application of the concept to nursing practices.

Multiple databases and search strategies from the Web of Science, Google Scholars, and Wiley online Library were used for literature review. Boolean operators and advanced search tool was employed using combinations of key words such as “health worker governance”, “nurses OR midwives”, “organizational governance” and “shared governance”, between 2012 - 2017. This yielded a total of 2564 publications. The authors applied 2 layers of refinement, which included articles written only in English, and excluded duplicates, non-academic articles, and unavailable articles full text, whittling it down to 168 articles. 40 papers were selected based on the relevancy to the concept for further analysis.

3.0 RESULTS

Five distinct nurse professional governance strategies in the context of organizational level were highlighted in the selected articles: shared governance, structural empowerment, professional development, performance management, and clinical governance. Each strategy assessed in literature had at least some intended effects on nurses’ and patients’ organizational and health services outcomes (Table 2). Most of the studies affirmed the presence of gaps between theories and governance application in practice. Challenges in the implementations of governance processes is identified due to the complex nature and different levels of care between rural and urban areas (Knight, Kenny, & Endacott, 2015). There is also a lack of shared understanding between governance, management practices, and clinical activities, which resulted in confusion when executing related roles and responsibilities that are implicit within the umbrella of these terms (Brennan, Niamh M.; Flynn, 2013). Overall, the evidence is mixed with regards to how well the various governance strategies influence changes in nursing workforce. This necessitates additional research on the effectiveness of each governance strategies.

Shared Governance and structural empowerment

Shared governance (SG) refers to “an approach to nursing management which seeks to grant nursing staff control over their professional practice and development and make a genuine contribution to wider corporate agenda”(Gavin, Ash, Wakefield, & Wroe, 1999). Fifteen articles measured the outcomes of shared governance and structural empowerment. Clark and Beatty reported that nurses expected that governance practices reflect the engagement of clinical practices and evidence-based planning, both of which significantly affect nurse’s turnover intentions(Clark & Beatty, 2016). This is mediated by motivation and job satisfaction induced by professional autonomy given to nursing practices (André, Sjovold, Rannestad, & Ringdal, 2014; Atefi, Abdullah, & Wong, 2016; Enns, Currie, & Wang, 2015). Similar results were found in the case of nurses’ productivity (de Almeida Vicente, Shadvar, Lepage, & Rennick, 2016; North & Hughes, 2012). Kutney-Lee (2016) reported that nurses job-outcomes and quality of care are significantly associated with nurse engagement to shared governance in their respective workplaces. Hospitals with lower nurse engagement practices demonstrated the prevalence of low confident patients’ management among and reduced quality in patients’ care (Kutney-Lee et al., 2016).

“Structural empowerment” has been interchangeably used with shared governance in literature (Ahmad & Oranye, 2010; Barden et al., 2011; Bostrom, Rudman, Ehrenberg, Gustavsson, & Wallin, 2013; Choi et al., 2016; Joseph & Bogue, 2016; Van Bogaert et al., 2015). Structural empowerment is defined as formal and informal work characteristics that permit access to information, opportunities to learn, allowing personal development, and support relationships (Laschinger et al., 2014). Organizational practices that grant nurses empowerment via transformational leadership result in nurses establishing a stronger sense of self-determination and competency
Previous studies established that nurses’ empowerment has a significant impact on patient care. Enhanced communication protocols, managerial support, and nurses’ access to ward-based resources will increase the nurses’ coping mechanisms when handling patients with persistent to severe pain (Slatyer et al., 2015). However, structural empowerment suffer from the lack of understanding of its concept amongst nurses (Stewart et al., 2018; Van Bogaert et al., 2016). Staff nurses felt less engaged in broader hospital initiatives, such as the accreditation process compared to the empowerment program, where the latter is directly related to their daily work and patient care. These resulted in increased nurses perceptions on “additional obligation” and demand from the hospital management, which further increased their workload (Van Bogaert et al., 2016).

### i. Professional development

Francke (2004) defined nurses’ professional development as “the process in which individual nurse, based on knowledge and insights that have been develop their own vision of the nature and importance of the nursing profession, as well as of their professional duties and responsibilities”(Brekelmans, Maassen, Poell, Weststrate, & Geurdes, 2016). Eight of the selected articles discussed professional development and education programs. Generally, the training programs for nurses resulted in positive outcomes such as improving the nurses’ knowledge and technical proficiencies (Corner, 2013; Coventry, Maslin-Prothero, & Smith, 2015; Katsikitis et al., 2013).

### Table 2: Outcomes of governance strategies examined in this review.

<table>
<thead>
<tr>
<th>Organisational governance strategies</th>
<th>Nurse workforce outcomes</th>
<th>Patients outcomes</th>
<th>Organisational/ health services outcomes</th>
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<tr>
<td>Shared governance</td>
<td>Nurses’ Leadership competencies (Joseph &amp; Bogue, 2016) Turnover intention, loyalty, consistent behaviour, integrity (Clark &amp; Beatty, 2016) Nurses’ empowerment (Barden et al., 2011; Wilson, 2013) Nurses’ job outcomes, dissatisfaction and burnout (Kutney-Lee et al., 2016)</td>
<td>Patient satisfaction, treatment outcomes (Kutney-Lee et al., 2016)</td>
<td>Quality of care, confident in management (Kutney-Lee et al., 2016) Evidence-based decision making, staff engagement (Clark &amp; Beatty, 2016)</td>
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<tr>
<td>Performance management</td>
<td>Reduce absenteeism (García-Prado &amp; Chawla, 2006) Motivation, job performance, productivity (Dieleman et al., 2006; Terzioglu, Temel, &amp; Uslu Sahan, 2016; Top, 2013) Competencies development, retention and attraction (Raven et al., 2015),</td>
<td>Patients’ continuity of care (Raven et al., 2015), Patients’ safety, patient-centred care, satisfaction, increase patient survival, reduced mortality</td>
<td>Transparency in decision, value-driven competition (Melnyk, Bititci, Platts, Tobias, &amp; Andersen, 2014) Financial effectiveness, operational efficiency (Gu &amp; Itoh, 2016)</td>
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<tr>
<td>Organisational commitment and motivation (Weldegebriel et al., 2016)</td>
<td>(Gu &amp; Itoh, 2016)</td>
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<td>Reduce disruptive behaviour (Lux, Hutcheson, &amp; Peden, 2014), reflective practices (Saunila, Tikkanäki, &amp; Ukko, 2015)</td>
<td>Safe medication prescribing (Smith et al., 2014) Accessibility to services (Phillips et al., 2010), patient satisfaction (White &amp; Winstanley, 2010)</td>
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<td>Clinical governance Capability, efficiency and effectiveness (Phillips et al., 2010) Improved clinical supervision, increase support, reduced stress leave, development of skills and knowledge (White &amp; Winstanley, 2010), build trust and knowledge sharing environment (Tuan, 2012)</td>
<td>Healthcare safety and quality (Knight et al., 2015), organisation quality management (Phillips et al., 2010), collaborative approach (Brennan, Niamh M.; Flynn, 2013), quality improvement (Phillips et al., 2010), clinical documentation improvement (Dehghan et al., 2013), improve organisational behaviour (Tuan, 2012)</td>
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Continuous professional development (CPD) and evidence-based practices (EBP) were reported as professional development initiatives at the organizational level. Educational preparation for nurses ensures that the successes of policy implementations are vital in clinical intervention related to patient care. CPD allows personnel development via increased confidence in collaborative practice, and help nurses apply new skills and knowledge sharing in the workplace (Hastings et al., 2014). For example, Smith, Latter, and Blenkinsopp (2014) reported that continuous professional development program facilitates the implementation of non-medical prescribing of nurses via adequate protocol development and support maintaining patients’ safety (Smith et al., 2014). In the same vein, Ing et al. confirmed that the continuous learning process created positive changes and increase nurses’ confident and perceived reduced mortality rate in neonatal and maternal cares (Ing, 2017).

This review showcased various barriers and challenges towards the implementation of professional developments at the organizational level. Coventry et al (2015) emphasized that organizational factors, such as nurses supply, workload, and clinical environment are vital towards determining nurse engagement to professional development initiatives (Coventry et al., 2015). In support of this, Brekelmans et al. (2016) established that professional development activities vary from formal training course to informal activities that are closer to their daily work. Workplace learning is reported to be the most powerful way to learn (Saunila et al., 2015). Learning activities, such as learning by doing task, learning by introducing new intervention to job task, learning by knowledge sharing and reflection, and learning by evidence-based patience experience are acknowledged as part and parcel of workplace learning (Pool, Poell, Berings, & Ten Cate, 2015).

### ii. Performance management

Performance management (PM) is defined as “a continuous process of identifying, measuring, and developing the performance of individuals and teams and aligning that performance with the strategic goals of the organization” (Aguinis, 2009). It has been established that performance management and measurement practices improves individual employee in the context of efficiency and effectiveness, which also results in improvement at the organizational level (Neves, 2012; Saunila et al., 2015). PM enables control and correction based on the level of performance of individual employees relative to the desired level of performance (Melnyk et al., 2014). Evidences on the use (and success) of PM towards facilitating the implementation of policy strategies and visualizing directions to organizational performance become inevitable (Lutwama, 2011; Raven et al., 2015). However, this review confirms that an unclear PM process could well lead to increased burnout rates amongst nurses (Weldegebriel et al., 2016). Lutwama (2011) also discovered that loop holes in PM planning, ambiguity of performance indicator, and the lack of rewards resulted in decreased motivation and job satisfactions.

### iii. Clinical governance and quality initiatives

The concept of Clinical Governance was introduced to promote high quality and ensure good practices in clinical environment in a systematic, integrated, and organized manner (Brennan, Niamh M.; Flynn, 2013).
Clinical Governance is also acknowledged as the “corporate accountability for clinical performance” (Kalsom M. et al., 2010). Clinical governance is based on the philosophy of continuous quality improvement, which integrates all quality initiatives under an umbrella (Staniland, 2007). Clinical governance is defined as “Structures, systems, and standards applying to create a culture, and direct and control clinical activities. Clinical accountability and responsibility, a sub-set of clinical governance, involves the monitoring and oversight of clinical activities, including regulation, audit, assurance and compliance by governors (such as boards of directors), regulators (such as governments and professional bodies), internal auditors and external auditors” (Brennan, Niamh M.; Flynn, 2013).

The impact of Clinical Governance on nursing practices has been acknowledged by (Buetow & Roland, 1999; Danila & Mohamed, n.d.; Farokhzadian, Khajouei, & Ahmadian, 2015; Knight et al., 2015; Phillips et al., 2010). Phillips et al. (2010) established evidence in favor of clinical governance in general practices, such as the quality of prescribing practices among nurses. However, they also emphasized the fact that the clinical governance concept is a poorly understood term and often equated with bureaucratic control. Knight et al. (2015) explored the complexities of rural health and difficulties in implementing clinical governance affecting nurses’ leader capacity to lead quality and safe outcomes in care. Smith, Latter, and Blenkinsopp (2014) added that educational programs play vital roles in ensuring success in the intervention proposed within clinical governance initiatives.

4.0 DISCUSSIONS

The search for this review revealed an abundance of literature related to the context of nurses’ professional governance practices. The concepts of shared governance, professional development, performance management, and clinical governance related to nurse practice has been clarified. The conceptual framework of nurses’ professional governance is illustrated in Figure 3. Organizational-level governance, namely shared governance, structural empowerment, professional development, and performance management, governed by clinical governance, are key components that drives changes in the nursing workforce, nurses performance, organizational behavior, and organizational environment. Nursing practices dictates the nursing professional governance and steered healthcare delivery services. Consequently, this will result in improved patients’ outcomes, organizational performance, and increased quality healthcare and services.

Figure 3: Framework of Nurse Professional Governance in organizational level environment
However, it is predicted that the key challenges to nurses’ professional governance are the strategic planning on the implementations, delegation of accountabilities, and financial and workforce supply of nurses. There is a need to further investigate the consequence of nurse professional governance towards individual, as well as organizational performance.

We recognize several limitations in this review. First is the comprehensiveness of this analysis, especially in the enormous context of the healthcare system. The selected articles are dedicated to certain aspects related to nurses’ professional governance; however, it is not related to the governance of human resource for health as a whole. The massive landscape of governance and HRH policy itself render it impossible to draw conclusions based only on this review. It is reasonable to conclude that there would be a variation in findings for the concept(s) when using alternate methods for analyses.

5.0 CONCLUSIONS

This review described and grouped different aspects of nurses’ professional governance. The framework could help disseminate the broad concept of organizational level-governance and help identify dimensions to be addressed for future research. This review provides initial lessons and interest in investigating multi-level governance strategies, therefore increasing understanding on how different governance dimensions are involved in the development and implementation of policies. The framework developed in this review has several implications for theory development, nursing governance research, as well as nursing practice and working environment. Primarily, it clarifies multiple governance approaches that are used in nursing practice, therefore providing clear focus in articulating roles and accountability in executing these strategies. Secondly, by distinguishing each governance strategy, it helps clarifies confusion among frontline practitioners, especially nurses' workforce.

This review also outlined several theories that were used to explain the basis of nurses’ professional governance, namely Kanter’s Theory, Stewardship Theory, and Principle Agent Theory. Our framework simplified these governance approaches and their respective impacts on specific outcomes of nurses, nursing environment, as well as their effect on patients’ care and healthcare services. This provides a pathway for future theory development and research. A variety of tools were used to measure the level of governance in this review. Some of more common tools used were Practice Environment Scale of Nurse work Index (Nurse Engagement in SG), Hospital governance scale (HGS), Hess's Index of Professional Nursing Governance (IPNG), and Conditions of Work Effectiveness II Questionnaire (CWEQ-II). These tools paved the way for researchers to further develop measurement techniques in the context of nurses’ professional governance. A number of studies also assessed the governance outcomes in nurses’ workforce using the Maslach Burnout Inventory, Intention to stay Scale, Motivation scale, as well as patients’ outcomes using Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHCPs), and Patient’s satisfaction scale. This confirms the gaps pertaining to further assessment, which require us to measure the consequences of nurse professional governance in the context of nurses’ work performance. The challenge that remains is to come up with a comprehensive approach to improving governance, where the key actors in government, civil society, and the health sector need to be committed to in order to positively influence the healthcare system.

REFERENCES


Adams U. Reinterpreting the implementation gap: a case based analysis of District Health System implementation in the Western Cape Province in South Africa. 2011. doi:10.1017/CBO9781107415324.004.


Corner M. Deconstructing reflective practice as a model of professional knowledge in nursing education. 2013.


Ing Y. The effect of continuing professional development from the perspective of nurses and midwives who participated in continuing education programs offered by Global Health Alliance Western Australia: A mixed-method study Master of Philosophy. 2017.


