

---

# Implementing the Governance Councils

---

# 5

The approach of this workbook is the implementation of shared governance within the entire division (department) rather than within a single unit of service. Also, the councilor model is used as the framework for implementation simply because it is the single most frequently developed model in the United States and there are more data available regarding its implementation. However, the rules and guidelines for implementation are the same for any of the models. The adjustments are more related to focus than to substance. The strategies for implementation included in this section are appropriate for any of the models. The reader need only substitute his/her design for the one identified here.

Figure 5-1 depicts the councilor model.

## DEVELOPMENT OF A PLAN

As with any major change, it is appropriate to develop a strategy for implementation to serve as a map to the implementors and a tool for evaluation. Since what we achieve rarely looks exactly like what we conceive, the planners should expect differences in outcomes from those originally planned. At the outset it is often difficult to see the outcome of one's work with the same clarity of vision one has after having achieved success. The process teaches us much about what we have done that could have been learned only by doing it. This especially holds true in the implementation of shared governance.

This section is meant as a guide only. Not every element that the implementors of shared governance confront can possibly be anticipated. The major components of the process, however, are covered here and will serve as an appropriate backdrop to individual program planning.

The plan really has two parallel implementation patterns: one for the managers and the other for the clinical staff. Since so much adjustment must be undertaken in the role of the manager, it becomes imperative at the outset that the manager be the focus of attention in the planning process as soon as possible. It should be anticipated that the planning time line will be a minimum of 3 years. The organization is undergoing significant organizational change—indeed, transformation—and that cannot be accomplished overnight. The anticipated time for full implementation is from 3 to 5 years. This does not mean that it takes this long to see organizational and behavioral change (this happens soon after the first year), but it does mean that it takes a considerable amount of time for the process to be completed.

## THE ROLE OF MANAGEMENT

The first year for the management team is critical to the success of the process. Most of the initial work with the management is developmental in nature. This

## N O T E S

N O T E S

**FIGURE 5-1**  
Governance councils.

means that understanding, accepting, and leading the process is essential to the success of shared governance. Many of the behaviors that lead to success in shared governance are idealized in the industrial models but rarely actualized. If shared governance is to be successful, these behaviors will have to emerge in the manager's role (see Appendix E).

The shift in accountability for the issues of practice, quality assurance, education, and research toward the staff's role also changes the role and relationship of the manager and calls for some developmental work that will assist the manager in understanding and facilitating her emerging role and the authority of the professional staff.

Issues related to the first year of management development include:

- Introduction to the concept of shared governance
- Management values clarification in shared governance
- Impact of shared governance on accountability
- Changes in authority in shared governance
- Increased role of the staff in shared governance
- Systems model design and impact on the role of the manager

The role of the manager in shared governance becomes a serious area of dialogue. Since the growth of the staff is essential to the successful implementation of shared governance, the manager must be able to move successfully from the role of director to facilitator. She knows that the staff must have a role in decision making consistent with their area of accountability.

The unit manager must be aware of the areas of accountability that are hers and her expected performance within them. The five areas of management accountability that are central to the role of the manager are:

- Human resource provision
- Fiscal resources (dollars and budgets)
- Material resources
- Support activities
- Systems management

The manager must be able to exemplify the skills necessary to effectively perform the role of manager. There is often a great deal of debate about whether the clinical manager is primarily a coordinator of clinical care or a part of the organi-

**TABLE 5-1**  
Differences Between the Management Team and the Management Council

Management Team	Management Council
Usually controlled and run by the clinical or service executive	Made up of all levels of management
Can make recommendations or participate in policy recommendations for approval of the executive	Sets policy and direction within the management accountability. Has a defined obligation to make decisions
Is usually formed for discussion and to make suggestions to the formal manager(s)	Is an accountability-based body with clear authority
Often limited to those at the "top" of the clinical organization	Clinical or service executive is a member with a defined role and single vote in decisions made by the group
Is not invested with formal powers and authority	In many cases in larger organizations is an elected group representing the interests of their management peers

zation and the management team. In shared governance the controversy is resolved. The clinical manager is defined by the manager role, not by staff or clinical delineations. Since role definition, not status or positioning on the hierarchy, is central to effectiveness in shared governance, the manager holds an equitable position with the staff. However, it is described in a different context from the practicing or clinical professional. The role is important, valuable, and necessary to shared governance. Only its characterization and expectations change.

The role of the manager is defined within the five basic accountabilities of management as identified by Mintzberg (see earlier discussion). These role characteristics can be identified as central to the expectations of the role of manager. Skill becomes critical to the exercise of the manager's role, and a certainty regarding the manager's ability to exercise this skill is vital, especially in a system of shared accountability. Each of the players must be able to play his or her assigned role effectively. All other roles depend on the ability of each player to do his or her part. The essential skills are not often identified, however.

If the manager is to exemplify the essential skills, she must know what they are, to be able to articulate her function within them, and then exercise the skills effectively. Usually that comprises the first steps in the role of the managers in the shared governance council. Indeed, they are usually the first council formed in the implementation process.

### IMPLEMENTING THE MANAGEMENT COUNCIL

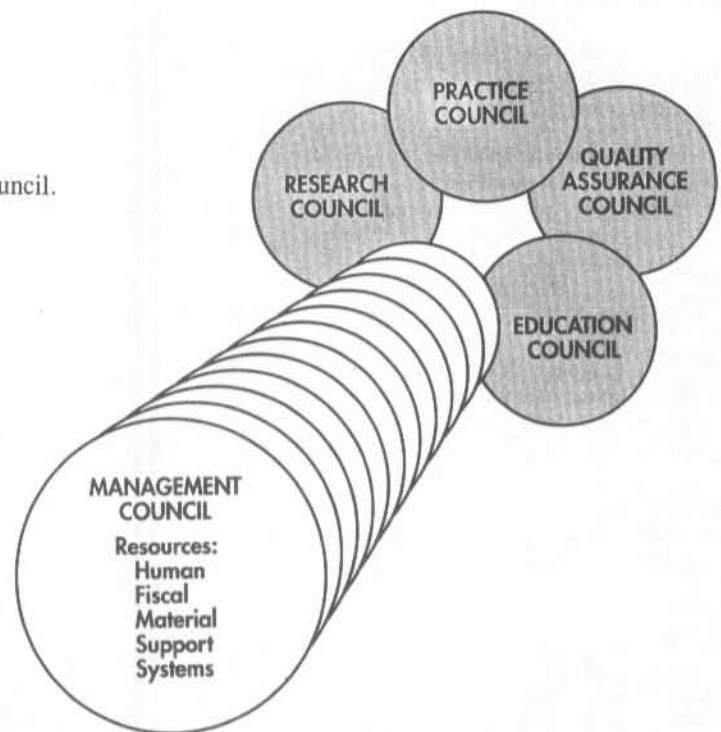
Conceptualizing the management council different from the management committee or team meeting is an important first step. Table 5-1 outlines some of the distinctions of each.

The accountabilities of the management council are directly related to the role of the manager and the power and authority necessary to carry out the defined accountabilities listed above. Accountability determination is therefore one of their first important initial roles. When the SGCC creates and empowers them to begin, the first activity is to delineate as clearly as possible the accountabilities that will initially be necessary for the council to do its work.

When that is done by the management council, the tentative accountabilities are initially approved by the SGCC and can then be implemented by the Management Council (MC). Also, the first chair of the management council is often selected by the SGCC from among its members to ensure consistency between the goals of

N O T E S

**FIGURE 5-2**  
Management council.



shared governance identified by the SGCC and the role and decisions of the MC.

As shown in Figure 5-2, whatever accountabilities are discerned by this council, they should relate to the functional accountabilities associated with the management role:

- Human resources
- Fiscal resources
- Material resources
- Support to staff
- Organizational systems

As pointed out earlier, all accountabilities of management should relate to the above role expectations. *The manager is not accountable for the staff roles that relate to practice, quality assurance, education, and research.* Sorting out these accountabilities early helps the shared governance effort by clarifying general accountabilities first so that confusion about where specific roles or obligations belong does not emerge.

The following are some of the initial activities of the management council during its formative period:

- Define its reason for being
- Outline its purpose and objectives
- Select a chairperson
- Outline an implementation schedule
- Define member tenure, role, expectations, meeting time, and responsibilities
- Isolate its accountabilities
- Sort out and define the various roles of the managers
- Determine the council's level of understanding related to the concept of shared governance and its application to management
- Establish the powers of the chair
- Set the priorities for the year
- Construct a manager development plan

**TABLE 5-2**  
**Industrial Management Behaviors vs. Shared Governance Management Behaviors**

Industrial Behaviors	Shared Governance Behaviors
Directing the staff in their work	Supporting staff in identifying their goals
Approving their ideas or work	Raising questions important to the staff's work
Seeing to it that the work gets done	Advising staff with regard to resource implications related to staff decisions
Granting permission to do things	Challenging the staff to seek their own solutions
Asking staff for input, then deciding on their behalf	Supporting staff in critical decisions and after failure
Making clinical decisions	Sharing alternative options in staff planning
Rewarding the staff for being "good" (that really means doing what you thought they should do)	Assisting in staff problem solving
	Holding staff accountable for their work
	Creating an open environment where it is safe for the staff to take a risk and change

The last item on the MC list is a key part of assuring the success of shared governance. In many settings, the failure of shared governance to become what it should relates directly to the inability of the management team to be able to incorporate the essential behaviors into the role of manager. Most of these behaviors relate to the failure to be able to move from the central role of planning, organizing, leading, and controlling for the service she leads to that which facilitates, integrates, and coordinates the staff in doing much of what was once considered part of the manager's role. *Shared governance does not or cannot do away with the role of the manager.* The role, however, has to change dramatically if it is to be effective.

Table 5-2 compares manager behaviors of shared governance and industrial management.

The management council will have to address the behavioral issues outlined in the table in the initial process of implementation. The ability to make these changes will be essential to the successful role of the nurse manager in shared governance. The developmental activities of the MC will therefore have to reflect these changes and represent these developmental issues.

Some suggested topics in the management development process include:

- Facilitation vs. direction
- Collaborative problem solving
- Investing the staff
- Group decision making
- Equity-based management*
- Partnering relationships
- Coaching skills
- Entrepreneurialism and/or intrapreneurialism
- Consensus seeking
- Meeting management

This list is not exhaustive. The nurse manager will want to add her own items of learning to support her adjustment into a different frame of reference for decision making. Even the openness necessary to make the change results in some positive experiences in the growth of both the manager and the staff.

N O T E S

Management development is so critical that any means necessary to assure it takes place should be sought out. Members of the MC will have their own developmental needs that should be addressed. Indeed, some mechanism should be devised to allow the individual manager to outline her own developmental plan and require her to make progress against some reasonably clear objectives for management effectiveness and behavioral change.

The manager will be the one most responsible for the creation of a safe milieu wherein the staff will begin to take on the issues of their own accountability. Since skills of leadership will be developing in this process, the manager may have to assume the role of model and mentor, as well as stimulator, for the emergence of those behaviors that will strengthen the development of the staff. Since many of these behaviors will be those the manager once was expected to exhibit, the shift will be both a personal journey for the manager and a growth experience for the staff. Clearly some of these efforts will require insight and maturity on the part of the manager.

Some of the behavior adjustments necessary in the role of the manager are as follows:

1. Moving from director to facilitator
2. Altering control to coordination
3. Shifting from managing to integrating
4. Changing focus from unit to system
5. Viewing staff as peers, not subordinates
6. Moving from "Mama" to colleague
7. Teaching problem solving, not problem finding
8. Moving to coaching roles from directing behaviors

The MC must always keep its focus on the resource-related issues that are appropriate to managers. Because of the location and mobility of the manager, she is best able to identify system problems and problems associated with shared governance before staff does (because of their relatively fixed location). In this way the manager can act as problem finder and alert the appropriate leadership individual or forum for appropriate problem solving or solution seeking.

Membership on the management council will vary depending on the shared governance approach and the size of the institution. While most models have all the management team as members of the MC, others, claiming size reduces effectiveness, state that it should be representative just as the clinical councils are. Either approach can succeed. However, the value of full membership in assuring the issues are clear to all sometimes appears to be the system of choice. The need of the organization to have full participation and the ability to deliver a consistent message may have greater weight than the need for a smaller more effective work group. Each setting will have to make those trade-offs based on its own needs and its own culture.

Staff representation is usually an issue of concern also. It is important in shared governance to be able to deliver an appropriate and consistent message. There will be management representation on the staff councils, as we shall soon see. Therefore it is acceptable that there be staff representation on the MC. How much representation depends on the size of the organization and the relationship between the staff councils and the MC. Usually this membership is provided by a staff member who is involved in some leadership role in the shared governance process, either the practice council chairperson or an equivalent. Staff governance leadership is selected because it is believed that there is better connection between the MC and the other governance components and the staff person's credibility on the MC is extended because of the staff member's "official" role in the governance process. The tendency to discount the staff member's role is less of a temptation when he or she has some power to implement change in the organization.



As with all the councils, it is wise to select the chairperson of the MC a year in advance of service and have the person serve as a chair-elect. In this way, the incoming chairperson has a year of council service and the benefit of leadership orientation before filling the role of chairperson. The same skills development and role expectations as identified in the role of the chair of the SGCC apply to the chair of the management council.

In the work of the management council the orientation should always be related to problem solving and outcome achievement. The organization will continue to look to the manager and the management team to exemplify the behaviors and supports that indicate that the movement to shared governance is okay and worth achieving. The role and behavioral changes the manager exhibits reinforce those same expectations of the staff. The staff will be testing, looking, pressing, and questioning the manager's support of this shift in structure and decision making. This council provides the initial impetus for the movement toward shared governance and will become the moderator of the process and its operation. It is a uniquely positioned group to influence and measure the success of the process.

Formation of the council early in the process is a vital step in assuring that the developmental process is not jeopardized. Getting the managers on board early and developing their understanding of the concepts and skills necessary to successful shared governance is a critical element in successful implementation.

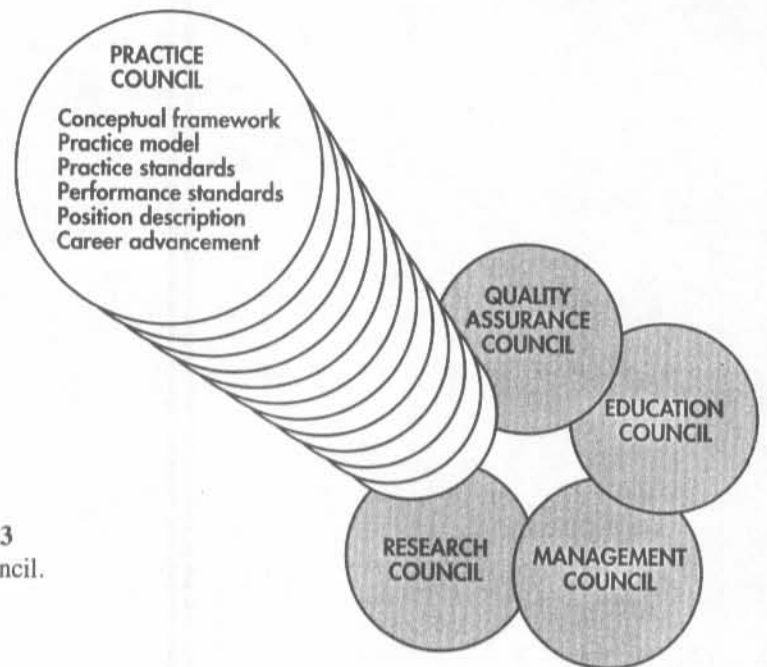
The MC must also develop a strong basis for support of the manager, creating a safe place to look for support, identification, problem solving, and emotional support during some of the more challenging change moments. The MC serves as a place for exploring responses to specific problems related to implementation and the need of the manager to know and understand what is happening in the process of implementation. This group serves as a source of clarification and validation in the tentative processes related to implementing the unit-based strategies. Unfolding this is often like writing a script never before devised and living the script as it is written. Needless to say, there will be some rough spots and some places in the developmental process that will be revisited several times. Flexibility and perseverance will be required.

## **IMPLEMENTING THE PRACTICE COUNCIL**

Along with the management council, the practice council is generally a foundation group essential to all shared governance models (see Figure 5-3). It is the primary clinical decision-making group on which all the other groups come to depend. They need the practice council (PC) because of its role in defining the parameters of practice on which the work of the profession builds. Both the work and the leadership of this council are critical to the success of any shared governance model. While it is identified by different names, in a variety of models, its function is always the same: to define and control issues related to clinical practice.

Invested in this council are the powers necessary to make key decisions about clinical practice and the issues that affect it. Often, it is the way the profession defines itself and its boundaries and provides a control mechanism to make sure that ownership gets played out in the organization. As with all other elements of shared governance, decisions made in this group are final and have the power and weight of the profession to support decisions and activities. To use popular euphemisms, it is here where the "rubber hits the road" or the "pedal hits the metal."

The statement of final accountability has historically been okay when applied to the management group; power was always invested in them. It is much more challenging to say that power also rests with others in the organization and then set about certifying that belief by constructing a structure that gives that belief form and direction. This is what the practice council does. It makes the organizational statement that the practicing professional has both the right and a forum for deci-

N O T E S

**FIGURE 5-3**  
Practice council.

sion making that affects the work that she does and that authority is equal to the authority that exists in any other place in the organization. Clearly, this is a risky assertion and a major departure from the traditional bureaucratic structuring of authority.

Here the support of the administration is vital to the success of the shared governance model. The reader can see that if that support is missing, the underpinnings of shared governance cannot take hold and the process cannot unfold on firm ground, so to speak. The opportunity to retreat from previous commitments is too easy and sometimes tempting to the administrator, who begins to see the staff actually taking leadership and moving ahead with the process of making meaningful decisions that affect the work they do. The administrative leader is again reminded of these questions:

Do I believe in staff empowerment?

Am I committed to the staff making decisions that affect their work?

Do I trust an organized body of the staff to make good decisions in the best interest of the profession and the workplace?



Will I maintain my support even during trying times?

N O T E S

Do I understand what I am doing?

At the outset, the Shared Governance Coordinating Council usually plays a major role in the selection of the leadership of the PC. The SGCC will want to assure the integrity of the practice council and assure that it fits within the plan for structuring shared governance entrusted to them by the staff. Usually the first chair of this council is selected from the SGCC and plays a major role in the selection of the members of the PC which will be selected from among the staff. Careful consideration of the leadership for this council should be undertaken by the SGCC because of the needs associated with implementing this major decision-making group:

What are the group leadership skills necessary for the chair role?

Can the candidate undertake the group process activities necessary to facilitate discussion?

Does the candidate have a full understanding of the shared governance concept and have the ability to apply it?

Is the candidate a team player?

Are the objectives of implementation of the practice council clear to the candidate?

Does the candidate have the full support of the SGCC?

N O T E S

When the council chair has been selected, membership on the council has to be identified. In the beginning of the shared governance implementation, the method of selection appears to be less important than the kind of person who serves on the council. It appears much more important to have involved and committed individuals involved in the initial stages than it is to see that the staff is broadly represented. This means that, initially, capable people should be identified for membership regardless of where they may come from in the organization.

Although selecting the best staff members may be more important to the implementation process, some organizations have a problem ignoring or depreciating the representational character of membership on the PC. Since that value is fundamental to shared governance, it needs due consideration in planning the first membership. If the SGCC feels that it can obtain the quality of membership and remain appropriately representational, it should do that. The bottom line is this: the best membership that can be obtained at the outset, should be. Remember that representational considerations are fundamental to the developmental process in implementing shared governance. Thus representation issues will emerge early in the process and structures will be devised to assure them. Whether they begin at the point of generating the first clinical council appears not to be as important to the process as having capable and willing members to initiate implementation of the PC.

**Membership considerations**

Membership on the PC is a more complex consideration than is membership on the management council. Where management council membership is determined by role, membership on the practice council is determined by representation.

Issues related to representation can range from how many members the council should have to where the members should come from. Each institution will have to deal with these issues in a way that reflects its own culture and values. There are some principles that would be helpful to them in making choices. The implementors can check off their own representation process against the following principles:

1. The practice council is a decision-making group. Members should therefore be kept to the lowest possible number. At any rate, the council should have no more than 10 to 14 members. Any size larger than this makes decision making a very difficult process.
2. Staff should always comprise the clear majority of the membership on this council. At least 70% of the members of this group should be selected from among the staff. Other voting members usually include one first line manager, one clinical specialist, and other specialists as defined by the PC.
3. The chair must always be selected from among the staff members. Appointing a manager chair makes the same statement as was always made regarding trust and mistrust in the organization. Staff leadership must be looked at as a viable process and permitted to emerge in legitimate roles. The chair of the practice council is just such a role.
4. Tenure must be established for all members including the chair. Groups with unlimited tenure and the ability to renew membership as an unlimited opportunity creates an elitism that does not encourage staff empowerment or even creativity.
5. A schedule of meetings and meeting times should be published in advance with expectations for attendance. This advance notice should assist in planning for staffing and replacement of members and assure proper attendance at council sessions.
6. Governance sessions are usually considered a part of work-based professional obligations and are therefore paid time. Such meetings are generally scheduled to occur at times when the staff is normally present in the work environment.

The exception will always be the off-shift members who come in at times not considered their scheduled time. These members, too, are paid appropriately for this time.

7. Attendance at governance council sessions generally is considered a commitment. Representatives are usually elected by peers for their roles and represent them in decisions that affect their professional lives and work. They have a right to expect that their representatives are meeting their obligation. The PC should set the required meeting attendance for members and define the consequences of nonattendance up front so that all members are aware of the significance of meeting attendance.
8. The practice council is an authority body that has a defined power to undertake action for which it is accountable. It is not advisory and does not refer its decisions for approval by some other body or person. It is a council precisely because it has authority for its work. Once its accountability has been defined and agreed on, it is free to exercise the authority associated with its accountability. This is what distinguishes shared governance from participatory management systems.

The practice council is uniquely clinical in both design and focus. Here the transformation of the organization is most strongly indicated, and an accountability emerges that exists in no other place in the organization. The staff membership of this council evidences the sharing of power and decision making in ways not expressed in organizations before. It represents the valuation of the profession and the professional and creates the partnership between the professional and the organization. This process exclusively reserves the right of the staff to control their practice and to make decisions that influence both their own practice and the organization.

The practice council cannot know or do its work until the accountability of the council has been clarified and well defined. Dialogue regarding the kind and extent of powers that accrue to the council once its accountabilities are clear becomes important in the effort to certify its role. When those powers are defined, they must clearly reflect the role of the practice council and become inherent in the PC's expression of its role and function in the organization. Here again, it must be emphasized that when accountability has been defined and clarified for this council, it holds those rights and obligations exclusively and must be free to make decisions and to move on them free of constraints not arising from the context of their own deliberations.

The domain of decision making that usually accrues to the practice council includes:

1. The right to define professional practice, including but not limited to the following:
  - Conceptual framework
  - Philosophy of the profession
  - Purposes of the clinical staff
  - Critical objectives of the clinical staff
  - Relationship of the specific service to other disciplines
2. The obligation to define the role and function of the professional within the context of position descriptions reflecting both the values and conceptual framework of the professional staff.
3. Defining the standards of practice for the profession within the context of the organizational role and culture in providing clinical services. Care standards should also reflect level of accountability and elements of the conceptual framework that describe the profession's value system in the practice setting.
4. Any advancement program that has in part criteria for individual performance that will be measured and thus reflected in the role of the professional.

N O T E S

5. The resolution of interdisciplinary problems that directly relate to clinical practice affecting what workers do or how they do it. Practice-based issues are always the concern and consideration of this council.

**Membership selection**

As indicated previously, selecting members is a subjective process adaptable to individual settings. The character of the staff mix, service mix, institution size, clinical configuration, medical staff, and so on all serve to influence size and kind of representation on the practice council. Clearly, every member of the staff cannot be a member of the PC. While it is an important group with significant implication for the clinical staff, it must be maintained as a viable decision-making group. This cannot occur if size becomes a constraining issue.

In most settings, selection of members is generally a regional issue. A certain collective of like services join together to select and send the member to make a contribution to the practice council. Usually the member represents the clinical service from which he or she is selected and acts in that role. It is clear that he or she can never adequately represent a service perspective from those units that may be a part of the collective or "cluster," but it must be remembered that when the person is selected, he or she no longer represents any sectional view or issue. The member now becomes accountable for decisions that affect the profession in the institution as a whole and is dealing with all issues from that perspective. That will certainly make the role more challenging with the staff from the areas he or she has been sent; however, the prevailing obligation of the council member is to make decisions in the best interest of the whole rather than the parts at the expense of the whole.

It is important to distinguish between accountabilities that emerge at the unit level and those that fall within the purview of the PC. Most of the issues that will emerge and are of concern to the staff will arise and be resolved at the unit level of the organization. The only concerns that will be addressed by the PC will be issues that affect the profession as a body, result from conflict regarding an issue between two councils, and are related to the profession's goals and objectives as they affect professional practice.

The staff should be aware of the implications of the role and work of the PC. This awareness need not be detailed or even fully understood at the outset. Understanding is a relative condition and often depends on the readiness to hear and the impact of the message on the receiver. Connecting the role of the PC to some value (the work, how the work is done, how much work is done, who does the work, and so on) helps create a reality orientation regarding what is happening in the workplace that is different and how what is happening applies to the individual.

This staff awareness becomes especially important when selection of the representative is occurring. The need to have contributing and thoughtful persons on the PC goes without saying. Finding that person and investing her in the process can at times be challenging. Chances are, however, members on the council will have a variety of backgrounds and abilities to participate fully in deliberations affecting their practice. This reality is not nearly as much of a concern as it may at first appear. Shared governance is a developmental process, and much growth occurs even in the unsuspecting persons. Also, each member brings a set of skills that usually prove to be complementary, and there emerges a broad variety of opportunities to apply them.

Questions are often raised related to educational background needed to undertake a membership role in shared governance, especially on the councils. While it is true the councils, especially the practice council, will be dealing with some complex issues, there is considerable evidence that each level of practitioner has something to contribute to the planning and decision process. The notion that as-

sociate degree or diploma education constrains the development and application of shared governance is essentially untrue. The one problem that arises when appraising the contribution potential of, for example, staff nurses, for any given process or event is that their baseline potential is never established. Therefore it is difficult to realize whether there are certain characteristics of shared governance that cannot be addressed by those only basically educated in their discipline. At this stage it appears that the demands of decision making and operating a shared governance approach do not lie outside the behavior or skill parameters of the nurse prepared at the basic level.

What does appear important to the process of shared governance is the preparation of the participant for the role of membership on a governance council. Staff are not prepared to handle as much authority as the councils generate. Often, they are overwhelmed with the activities necessary to make the kinds of decisions arising in the governance format and are somewhat unprepared to undertake governance activities. An orientation to the role of the council member is often helpful in alleviating the concerns that invariably arise; it even generates some new skills helpful in dealing within a deliberative process. Most organizations with shared governance models have some kind of leadership or membership orientation process that includes:

- shared governance concepts
- problem solving
- communication
- assertiveness
- responsible membership
- accountability
- representation
- council processes and functioning

Armed with these beginning skills, council members have a broader array of skills that can be better applied in the council process and are of benefit in both the practice setting and personal life.

### **The work of the practice council**

The accountabilities of the PC are foundational. Much of the clinical decision making in the service will depend on the outcomes of the PC. The other clinical councils depend on the PC for the foundations on which they will build. The accountability of the PC relates to or builds on the council's work to define and control professional practice. In the shared governance approach, the PC is the place where the exercise of power in relationship to practice emerges and is managed. Because this is true, the delineation of this accountability is essential.

The arena of practice accountability must be clearly articulated by the PC. This serves the purpose of ensuring the work of the PC but also differentiates that work from the work of any other group in the organization (see also Chapter 7 in **Implementing Shared Governance**). If the PC is to be an accountable group, that accountability must not be in evidence in any other part of the institution for those issues over which the PC has designated authority. To do so would negate the effective power of the council to make decisions and to do its work.

The effective powers of the practice council are minimally identified as follows:

- Establish the acceptable conceptual base or framework for professional practice
- Construct an appropriate definition of care for the practice of the profession



N O T E S

Establish and manage all care standards for the profession or approve those either delegated or emerging from the professional staff

Define and control all clinical job descriptions of the profession including the performance factors or expectations the job description should reflect

Define, control, and manage the career advancement program of the staff

Monitor, alter, and redesign the clinical documentation system for effective recording and evaluation of professional services

These accountabilities form the foundation of the role of the PC. They are not all inclusive but provide the basis on which any shared governance approach can build. Clarity with regard to the PC's role related to these accountabilities is important to formalizing the authority base of the practice council.

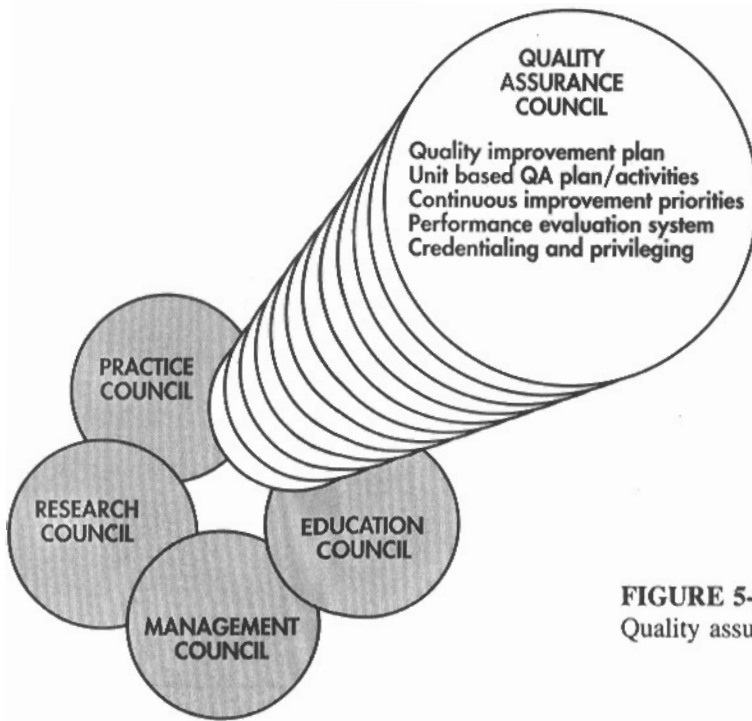
It must be remembered that it is not the role of management to define for this group any rules or administrative mandates that might either jeopardize or compromise the authority and/or work of the council. To prevent co-opting the clinical councils, the management role has been kept to a minimum. It is vital that the message that the clinical authority role is comparable to the management role be legitimate and be expressed. Manager members are kept to a minimum. And it is important that the manager representative have a defined role on the council as the representative from the management council or forum so that there is a logical connection between the management process and the clinical decision making.

This separation of authority is not meant to slight or isolate the role of management. Rather, it ensures that there is no confusion or duplication of accountability between those roles that are appropriate to the staff and those that are a part of the manager's obligation. The manager representation provides a linkage between roles and formalizes the governance relationship within the profession between the two key processes essential to the professional work. This linkage is essential to the effective communication and interaction between staff and management. In most shared governance approaches, there is manager membership on all of the staff councils. This ensures that communication between the staff councils and the management council or body is facilitated and that decisional integration is facilitated.

Staff membership on the management council is generally provided in most shared governance approaches. This is an equity-based principle that delivers the message to the nursing organization that representation is a bilateral obligation and represents the best interests of the profession. Usually the representative is drawn from one of the staff councils to ensure the staff representative has some knowledge of the organization and the governance structure and can apply both insight and authority to a role on the management council. Simply selecting the staff member to the management council from the general staff and holding no membership in a formal position of council or governance authority is usually discouraged. Issues related to credibility, power, being sufficiently informed, and so on are often raised when this staff member is not a member of the formal processes associated with shared governance.

More often than not the practice council will be the first focus of conflict in the shared governance approach. Usually, the organization has some issue of reaction that will involve the management and the PC. A conflict in accountability between the management council and the practice council will arise providing the source of the trouble that will test the application of the system. The commitment to dialogue and resolution will be stretched during this set of circumstances. This testing of the system, however, is a necessary adjustment and a possible affirmation of shared governance, if handled appropriately. In the beginning, the SGCC may be the integrating force in the process that can help create a resolution of the difficulty with a positive outcome. The SGCC and the other councils should be





**FIGURE 5-4**  
Quality assurance council.

ready for this kind of challenge to the system. It validates the process and checks the system's ability to deal with present and appropriate conflict. If handled well, it can be indicative of the effectiveness of council-based problem solving.

### IMPLEMENTING THE QUALITY ASSURANCE COUNCIL

The second major council group addressed by the SGCC is the Quality Assurance Council (QAC; see Figure 5-4). Some organizations may have already made or be in the process of making the transition from traditional quality assurance approaches to quality improvement. In this book we will use the familiar term "quality assurance" to refer to all quality activities. Readers may substitute the term "quality improvement" for quality assurance to reflect their current approach if they so desire. Whether one adopts a QA or QI philosophy, the implementation process is essentially the same.

The timing of the implementation of the quality council is completely up to the time frame of the SGCC. Sometimes it is wise to wait until the PC is up and running, other times it is good to begin the QAC about the same time as the PC. Usually the councils have much developmental work to do to get their internal operations going. This affects timing insofar as the council's relationship to each other. The QAC depends on the standards development of the PC before it is able to undertake any meaningful work. However, the quality assurance plan must also be in place before the QAC can begin any quality-related activity.

All of the council relationships are subjective and depend on what is in place before their specific work can be clarified. The QAC will always have an interdependent role with the PC and therefore will often depend on PC activities in the course of doing its own work.

The formation of the QAC parallels that of the PC. Both councils are clinically driven and have very much the same staff representation. Again, because it is a clinical council, its chair should also be selected from among members of the staff. The rules for empowering the chair and the roles of the members, tenure, and other considerations very much parallel the work of the PC. Time for its self-work is as important as the other councils and must not be short-circuited so that the council is attending to all the realities that affect its work.