

N O T E S

Questions related to membership are slightly different from the PC framework for membership. Some questions include:

What interest do you have in the quality assurance council?

What do you know about quality assurance?

Are you able to take risks in your relationship with your peers?

Can you be firm when standards are at issue?

What does "corrective action" mean to you?

Do you understand that you will be involved in peer-based disciplinary processes?

Have you been personally involved in quality assurance activities?

What makes you want to serve on this council?

Are you willing to give this work a 2-year commitment, if necessary?

Initially the council will focus on its own understanding of the shared governance process and the role quality assurance plays in governance activity. Regarding quality assurance, the following activities will form the core of its initial work:

- Understanding current processes associated with shared governance
- Reviewing the quality assurance plan
- Delineating quality assurance accountabilities and priorities
- Establishing the unit-based guidelines and parameters for quality assurance activities
- Defining the relationship of career advancement and the evaluation of candidates for advancement
- Translating the performance expectations or standards into criteria for performance evaluation
- Outlining the elements and processes associated with the credential and privilege process

The quality assurance process often will be the most difficult to undertake in the shared governance approach. It is the governance activity that is most changed and requires the greatest adaptation. From the traditional dislike and mistrust of quality assurance to the dependence on quality assurance as a fundamental part of the operation of the nursing professional activities is a fairly strong leap from historical activity. Most nurses have looked on quality assurance as a necessary evil. In shared governance it becomes a mainstay of professional accountability for which every nurse will have some accountability.

Beside defining the professional basis for relationship and practice, the QAC is the one group that will most often have to connect to other quality assurance activities within the health care setting. All departments and disciplines are required to give evidence of some level of quality assurance activity. In addition, the quality assurance function in each of the services must somehow intersect with others to create an integrative approach to ensure the quality of care. Therefore the QAC must be involved in the following activities:

- Agency or institutional quality assurance activities
- Interdisciplinary activities that integrate quality assurance activities
- Regulatory processes that define the processes the QAC will assess for quality assurance
- Defining and exercising activities related to the institution's quality assurance plan
- Unit-based quality assurance activities to ensure they are appropriate and consistent with the quality assurance priorities of the organization
- Necessary report preparation of its quality assurance activities and its consolidation of those activities with the organization's priorities for quality assurance

Important in the initial work of quality assurance is the definition of the priorities for quality assurance. The clinical units need to have a clear idea of the kind of activities they will be involved in that relate to the priorities for quality assurance for the council. Here the council must give the units some direction with regard to their plan of activities by doing the following:

- Defining the framework for quality assurance and outlining quality assurance plan
- Establishing the priorities for quality assurance from which the units can develop their plan of QA activities
- Delineating the roles in quality assurance that members of the staff must undertake to fulfill their staff requirement for either seeking privileges for practice or applying for employment.
- Ensuring the existence of a framework for corrective action that has an impact on every unit's level quality assurance function to ensure compliance with defined expectations

In keeping with the move in health care toward total quality improvement processes, the QAC must be committed to processes that provide for higher levels of

N O T E S

function and improvement in the clinical activities of the practitioners. In the past, quality assurance was a process that focused on the quality process as a series of events, which once addressed, were left alone. In shared governance and the continuous quality improvement effort, all quality is an unceasing process that moves along a continuum that in good measure raises the standard and challenges the provider to impart higher levels of practice and care. In this way, quality is a seamless process that does not have a definitive point of achievement; rather, it exemplifies an ongoing series of activities that are continuously altered to reflect higher levels of expectation and performance.

Although implementing the QAC plan is vital to the operation of the clinical organization, it is only one half of the processes associated with the efforts for quality assurance. As indicated earlier, the quality of the care giver is as important as the quality of the care he or she renders. This, too, is a vital part of the quality assurance process.

The board of trustees of the health facility expects that the facility will have on its staff acceptable performers who can fulfill the expectations of their roles. Indeed, it entrusts to the professions the obligation for ensuring that competent staff are available and working in the best interests of the organization and of those it serves. Because the board often cannot judge whether a particular candidate is appropriate for a specific role, it expects that the worker's peers and managers will be able to do that in its best interests and in their own. It is assumed that the profession would not want on staff anyone who would compromise the standards of care that exemplified the values of the profession. While this does not prove true 100% of the time, it is generally accepted that a colleague would not want a worker who is unable to fulfill the expectations of the role or who would violate the standards of the profession.

The quality of the care giver, therefore, is the obligation of the clinical staff. In shared governance this falls within the staff's accountability and authority. Because it is a quality function and builds on the performance standards identified by the Practice Council, the accountability for the mechanism for credentialing and privileging falls to the QAC. Issues that relate to this function follow:

- clear definition of the expectations for clinical roles
- a mechanism for structuring review of qualifications for clinical positions
- a definitive enumeration of the criteria for evaluating credentials
- full definition of the accountability of the QAC for evaluation of candidates
- an ongoing structure and process for performance evaluation owned by the clinical staff
- a context for disciplinary action that is consistent with the privileging process

This mechanism is fundamentally different from any approach to dealing with the staff, especially in relation to competence and shared roles. In shared governance, the peer process takes on important value and the role of the staff is enhanced in the process. The problem is that peer processes have been disparaged in the past. Some of the reasons for this:

- No clear criteria that have the confidence of the staff in their fair application of judgment they may make about their peers

- A lack of confidence and trust between staff with regard to each other and the ability to objectively relate to the evaluative process

- An effective structure for the peer process that uses clear criteria that the individual can control and can be equitably applied to an individual's role

- A prevailing belief that evaluation is essentially a punitive or controlling process

The expectation that performance and hiring or firing are specifically management roles for which the staff has only a passive relationship

N O T E S

Clearly, for this process to become an acceptable part of the operation of the professional organization, attitudes and understanding regarding the meaning of the process and its application have to change. The QAC will have to explore all the issues and be fully cognizant of the questions that they will have to face in confronting formation of a peer-based privileging process:

Are the quality assurance criteria specific enough and measurable?

How are the position description elements translated into performance criteria?

How does the peer-based performance evaluation system fit with the career advancement program (career ladder)?

Who is involved in the peer part of the staff evaluation process?

What is the role of the manager in the staff evaluation?

How do performance evaluation criteria fit with the care evaluation process?

What is the mechanism(s) that the QAC will put in place for ongoing performance appraisal?

Is there a critical path for performance evaluation from application for privileges to renewal of privileges in the organization?

N O T E S

How does the QAC assure the board of trustees and administration that the profession's evaluation process is objective and adequate?

This is relatively new territory for nurses and other nonmedical model disciplines. The goal in this process is to access accountability for colleague relationships and provide appropriate competence standards for the profession and the organization within which practice unfolds. Good models for employee-based professional operating systems are just emerging. Therefore much of the work to build good credentialing and peer-based evaluation systems is currently being created. Most organizations will be writing the script as they go.

Some principles will be helpful for the planner in initiating the development of professional credentialing and privileging processes:

1. Consistency in establishing the credential framework for the various services or functions is critical to its being applied equitably to all candidates for positions.
2. Definitive standards for acceptable certifications must be developed. As much as possible, national or discipline defined standards or certification requirements should always take precedence.
3. Generic credentialing standards should always be developed first and used as the basis for service and institution-specific credentials requirements in order to establish a premise for consistency.
4. The QAC should have a mechanism that establishes the role of each group or individual in the credentialing process that can operate without the direct intervention of the QAC in the ongoing program.
5. Most of the credentialing and privileging process should occur at the unit level. Peer relations and accountability should provide the foundation for the program, this always occurring at the practice level.
6. Credentialing for management and practice candidates should be a separate process with activities designed in each for the role of the other in the credentialing process.
7. The credentialing and privileging process for staff should be staff driven with the final approval of candidates for practice privileges resting with the QAC.
8. The right to credential and privilege is a Board of Trustee prerogative delegated to the profession acting on behalf of the board. Board approval and acceptance of the credentialing and privileging process *must* occur at some time in the implementation process before it can be an official or acceptable operating process.
9. Managers *always* play a role in credentialing and privileging because of their resource accountability. That role is most often included in the unit process.
10. The bylaws must spell out the credentialing and privileging process of the professional service in understandable and applicable terms. This ensures that a consistent and replicable process is in place and can be applied in any setting.

Needless to say, credentialing processes are not the first agenda item for the QAC. There is much preparatory work before this process is in place. It depends on several organizational factors operating in the clinical system:

- A conceptual model has been selected.
- Clinical standards of practice are present.

Performance standards have been developed and form a basis for evaluation processes.

A staff-based performance evaluation system is operating.

The quality assurance program is running effectively.

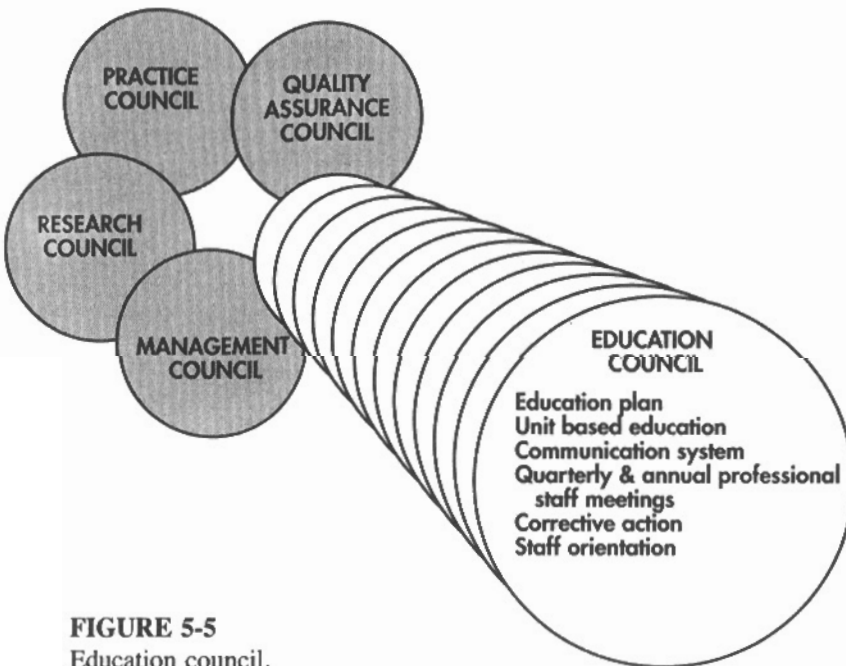
Goals and objectives and council priorities have been constructed and are in place.

The QAC, along with its work, is not initially one of the easiest groups with which to interest the staff. In addition to appearing hard to understand, a great deal of work seems attached to the quality improvement process. While this insight is true, the council also has the most profound impact on the staff and influences who can be a member of the staff and what staff do in their professional roles in the organization. In time, it is one of the more sought after groups in the shared governance process.

**IMPLEMENTING THE EDUCATION COUNCIL**

The Education Council (EC) is primarily responsible for issues related to professional competence (see Figure 5-5). Factors associated with maintaining ongoing competence and continuing education are also the main focus of this group. The change in the organization recognizes that the staff has a strong obligation for the continuing and ongoing competence of its members. That obligation is a collateral accountability in that each member of the staff has the obligation to be competent in his or her practice and ensure that all others are as competent. The issue in a professional framework is that those who do the work of the profession must be mutually able to do it and maintain the requisites during the extent of their tenure.

Again, this council is a clinical council and has the same membership characteristics as the Practice Council. Because of the unit-based focus of a great deal of shared governance education processes, there are often more members from the staff on this council than on the other clinical councils because each unit is represented. There is no structural reason why this must be so; however, specific settings have program structures that call for unit representation. As can be assumed, if implementation were taking place in a large organization, it could create a great



**FIGURE 5-5**  
Education council.

N O T E S

deal of difficulty in both organization and cost to have such a large council. Here again the tension is between effectiveness and size as it is with all the councils. Because of the wide diversity of functions the tendency for all the councils is to enlarge rather than keep the groups to a manageable size; however, a membership of 7 to 10 is best.

Historically, it has been considered the obligation of the institution to ensure that its *employee* is competent. There has been no belief that the professional worker brings that obligation with him or her and that activities related to ensuring competence remain within the context of that individual's responsibility. The employee relationship changed the locus of control for this issue and illegitimately placed it into the institutional hands. Since that process is in place, all regulators and accreditors now expect the institution to manage staff education.

Clearly the introduction of accountability-based approaches challenges some of the prevailing operational beliefs. The following questions help to focus the issue more clearly:

Where is the nursing education located on the organizational chart?

What does the nursing education department (or hospital education department) do regarding professional education?

What is the role of the individual professional in managing his or her own education program?

Do staff teach each other in the formal education program as a primary professional obligation?

Is education unit or department based rather than centralized?

Is all professional education patient focused, and, at times, does it include the patient?

Who keeps the staff member's education record, the staff member or the institution?

Does the staff member use the education record as a performance validation tool in his or her performance evaluation?

The obligation of the staff member for his or her own education has been an expectation of the profession but not structured into the organizational system where nurses practice. In shared governance, the whole process of competence delineation moves to the accountability of the staff. Structures are provided that ensure that education- and competence-based activities are incorporated into the obligations of each staff member.

Included in the consideration of the EC's work is the development of both standards and processes for the transition of this process from the organization to the EC. It is not the obligation of the EC in shared governance to do all the activities now associated with the education department. The accountability, however, does transfer to the EC. In effect, the education service or department is accountable to the professional body for its activity. In this professional model, the EC defines the expectation, roles, and services provided it by the education service. Of course, in most organizations with shared governance, the education department leadership has representation on the EC. Here again, the staff election and representation process models what has occurred in the other clinical councils. The development of operating rules and regulations and the issues of service and tenure parallel what has happened in the other councils. Since this is a staff council, it is assumed, as with the other clinical councils, that the majority of members are from among the practicing staff.

### **Communication**

While the traditional issues that affect staff competence are certainly a part of the role of the EC, the whole arena of effective communication in the shared governance system is also a major consideration for the EC. Since education is primarily a process of communication, the connection of the communication system with the EC is both logical and appropriate. In most shared governance models the EC is generally responsible for constructing and managing the professional communication model. Some of the elements addressed in developing this accountability are identified below:

- Generating information among the councils for their connectedness and effective problem solving
- Producing data related to shared governance activities for the organization's leadership or for specified purposes
- Informing the staff regarding the activities of the leadership and the activities of shared governance
- Communicating between the councils and the staff as a whole at a regular interval for staff feedback and input on the activities of the councils
- Creating an annual process that reviews the goals and objectives of the organization, selects the staff leadership, reports on council outcomes, and celebrates the staff accomplishments
- Generating a staff newsletter or other communication device where the staff can communicate their own impressions, issues, professional values, research, and other matters of concern to the staff and the councils

There is often much discussion about the development of peer relations in the professions. The format for peer processes is often not present in the organization,



N O T E S

making it difficult for the staff to really identify what kinds of relationships they want and how to develop them. The staff always note that there is little enough time to devote to establishing ways of communicating and relating to each other in a more formalized way. At the same time, they admit that such relationships are essential to good working relationships. The EC makes such issues its concern, and the possible mechanisms for peer interaction and process are explored with the outcome, an organized way of accomplishing these relationships. Such processes as those that follow are often considered.

Unit-based staff meetings that include staff roles in reporting, problem solving, and even socializing

Informal and social opportunities for staff to get together to meet, discuss issues of common concern, or simply to build community

Continued education offerings created by the staff for themselves and/or connecting to other professionals in the community or outside of their own service frame of reference

Informal or formal meetings with other disciplines for dialogue and problem solving and, as appropriate, socialization

Clearly the work of the EC is important to the milieu of the professional organization. It can often set the framework for shared governance growth and development. A focus on the context and the behaviors associated with professional activity helps maintain the structure or context of shared governance and provides a vehicle for educating the staff and keeping them invested from within the organizational system.

Important, too, are the orientation processes associated with shared governance. The entire orientation program falls within the auspices of the EC. Here again, it is important that the context for shared governance be communicated to the future member of the staff as soon as possible. A new professional is orienting not only to the work but also to the relations that make up the work place. The EC has a major responsibility to see to it that the candidate has the opportunity, the tools, and the expectation to both perform and behave in a way that empowers, enables, and interacts well with peers and their governance processes. Therefore the orientation process should contain at least the following elements as it relates to shared governance:

The structure of the shared governance format

The role of the staff in a shared governance structure

The obligations of staff members for practice, quality, and competence in shared governance processes

The election or selection processes associated with representation on the governance bodies

The role of the staff on career advancement (ladder) programs and the governance-related activity for advancement

A basic review and beginning understanding of the rules, regulations, and bylaws that govern the activities of the professional staff and the individual's role in governance.

The Education Council sets the context for shared governance in its strong focus on the professional issues that directly affect what the staff do, essentially, for themselves. Some have said that the EC focuses on the person of the nurse rather than the process of nursing (or any practice). This council personalizes the activities of shared governance and often serves to make them real for the individual. It puts a human face to shared governance because it works to connect staff to each other in both formal and informal ways. Through its strong role in communication and managing the communication system, the EC maintains the close connection

to and between the staff. Since it is communication based, it serves to maintain the focus of that role as an ongoing part of its activities.

### **Relationship to other councils**

The EC is most dependent on and directly related to the other clinical councils. Often education work of the EC reflects what has been done by the other councils. To the extent the other councils generate new standards, practices, or processes associated with changing practice or staff behavior, the practice council becomes important to the educational and developmental needs of the staff. The other clinical councils become dependent on the organizational-educational role of the EC for the implementation of education related to major change.

Here again, a level of tension exists between the legitimate educational work of the EC and that of the other councils. The EC is not to become simply a vehicle for the other councils to do their work with the staff. As with all change, there is an educational role related to the activities of each council. It should not be anticipated that the other councils conceive and then direct the education council to develop the staff to do as the other councils direct. There is an equity of accountability between the councils, and the EC has defined roles and functions as identified above, just as the other councils do.

Each council must take on that component of program development or change that addresses its own concerns. When that requires an education component, they may look to the EC for assistance in planning and structuring but the work of processing education associated with the undertaking belongs to the originating council. Education will always be part of the work of the councils. In this case, education falls within the context of the work of the program or the initiative of the generating council.

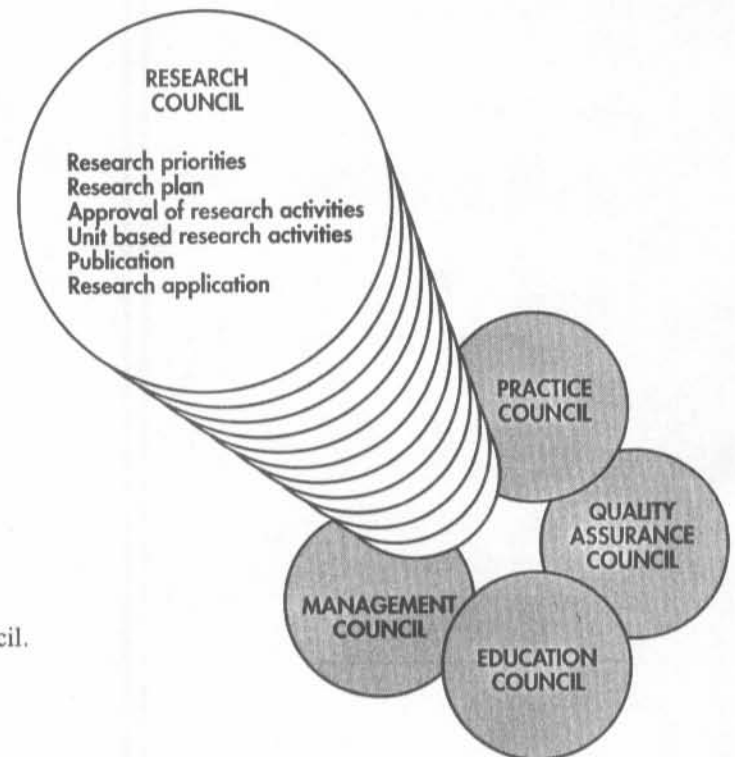
Still, the EC will depend a great deal on the work of the other councils, especially the practice and the quality assurance councils, since much of the formative and structural work will be done by them. From those practice- and quality-based structures much of the education process will take form and will be the basis of some of the work of the EC.

Usually the EC begins somewhat after the time that management, practice, and quality assurance activities get generated in the organization. Because it depends on some of the practice and clinical processes being clearly structured and articulated, the EC will usually be initiated about 6 months to 1 year after the other two councils are formed. This gives them time to do their initial work and to provide a framework with which the EC will build its activities.

Although beginning the EC later than the Practice and Quality Assurance councils is the general approach to implementation, it is not essential. There are many organizations whose sophistication of activities is such that the essential undertaking of the practice and quality assurance processes is sufficient to get the EC going and have it pursue some of its own developmental work. It must be remembered by the implementors that the "self-work" of each council is such that it takes *about 3 to 4 months to get the operating mechanics worked out so that it can effectively begin its work with all the functional capabilities of a governance group.*

### **IMPLEMENTING THE RESEARCH COUNCIL**

In keeping with the five delineators of a professional group (practice, quality, competence, research, management), it is important that research be incorporated into the implementation discussion (see Figure 5-6). It is clear that not all service settings will be adequately prepared to discuss the development of the research governance component and may therefore select to leave this process until much later in the developmental process. Indeed, many shared governance organiza-

N O T E S

**FIGURE 5-6**  
Research council.

tions, otherwise operating very effectively, have not addressed the professional accountability related to the research process.

Several issues affect consideration of the implementation of the research accountability within the shared governance format:

There is an organized research activity within the organization.

A research office (planned?) coordinates the discipline's research activity.

Sufficient resources are committed to the research activity to support research projects.

Staff are involved in and value research activities.

Research activities result in some practice impact in the organization through an organized system of implementation.

Most nursing and other professional organizations do not have a formalized or highly developed research function. Therefore there is usually much preliminary work to do to formally express the professional accountability for research. Planning activities related to setting up the Research Council (RC) could be some of the first activity of the council group if there is sufficient evidence of organizational support for the clinical research process. Because of the newness of the research approach in most clinical departments, the activities of research and preparation for them usually must begin in a very early planning format. Questions related to the possibilities of a governance structure for research might be these:

Is there sufficient evidence of support for research by the clinical staff?

Identify three reasons why it appears that research activities can begin:

1.

2.

3.

Where is the leadership for this activity coming from—management or staff?

Are staff-driven practice, quality, and competence structures (practice, quality assurance, and education) progressing well at the unit level?

Does nursing (or clinical service) have a relationship or membership on the Institutional Review Committee?

Are there clearly identified leadership persons willing to facilitate the development of the research function through all the phases of implementation?

Because organized research activities are rarely found in most service settings in the United States, it will be difficult to move the process along without some challenge. Aside from the organizational challenges, most practitioners will have some difficulty “buying into” the process of research. Many will see it as an additional activity; others will remember that it was a difficult process to comprehend in their academic experience and will be reticent to consider research a part of their professional role. Implementors will have to anticipate these realities as they plan for this governance function.

The initial interest and developmental activities will have to answer the following questions:

## N O T E S

N O T E S

## Chapter 5

What is the level of staff understanding about the research process?

What information is available to facilitate an understanding of research in the staff?

What is the value of clinical research in the organization?

What research is currently done in the organization? Who is permitted to do it?

What material and other informational resources are available to expand staff understanding of the research process?

### **Developmental activities for the research council**

The process of moving to a governance structure for the research function will take a considerable period of time. The following steps and processes will have to be included in any effort to implement the RC:

Format the RC as a beginning group designated to do some of the formative work in preparation for the council format.

Outline the council's philosophy, purpose, and implementation objectives.

As with the other councils, format the operating rules and regulations within which the council will operate.

Develop a basic research activities plan that focuses on the research elements and processes of the council.

Accelerate the developmental level and understanding of the council members regarding the research process.

Develop the research application and approval process.

Establish the criteria for external participation in research activities.

Establish the research priorities for the clinical service.

Define the unit-based connection to the research process and the RC.

Define the authority relationship between the RC and the Institutional Review Committee.

Define the university and/or academic relationship (if any) established within the auspices and control of the RC.

Identify the resource-related processes of funding, paying for, and supporting research activities.

Disseminate research findings to staff and other leadership in the organization.

Establish the nursing role and participation in the institutional product evaluation process.

Undertake evaluation studies of operational and structural processes affecting the appropriate delivery of nursing services.

Obtain the literature and funding source information as a part of the effort to make the research process self-supporting.

Design and complete a developmental plan for the RC that would include at least the following:

- Research priorities
- Accountability (autonomy, authority, and control)
- Piloting (if appropriate)
- Administration (or staff functions)
- Essential relationships
- Financing plan
- Reporting-publishing activities

The activities of the RC will necessitate the clinical staff being involved to a greater extent in research activities than has been previously expected in most health care organizations. To do so will require careful consideration and planning. Whatever research activities will be undertaken, they cannot appear to add to the workload of the staff. Whatever is initiated by the RC will have to fit within the existing workload arrangements of the staff and will therefore require the establishment of a close working relationship with the practice, quality assurance, and education councils. Data collection activities, as well as research design processes, will have to be incorporated into both clinical care and documentation processes already in place. Included in the strategy of implementation should be the following elements:

- A method for systematically identifying patient care problems (usually quality assurance)
- A clearly defined research format
- A mechanism for incorporating research designs
- Formats or document design supportive of research
- A mechanism for changing research-generated practice activities
- Organized mechanisms for disseminating research data or outcomes
- A way to manage research-based funds
- An organizational standard or policy requirement for participation in research activities (sometimes included in the career advancement program)

The planning for the formation of the research council should occur in the initial stages of the planning for shared governance. It may not be realistic for the council to take form until the staff is far along in the developmental process. The work of the other councils becomes important, indeed, takes priority because of their foundational work. Often, many of the processes needed by the research council will be developed by one of the other councils. The work of each developed council should assist the efforts of subsequent councils. *There is no need to reinvent the wheel: preparation by one council in relation to structure and organization should be replicated by the subsequent councils in their own development, to the extent applicable.* Because so much of the work of the RC is developmental, it has the potential to benefit most directly from the work already accomplished by the other councils, especially the quality assurance council. Good communication among the councils from the outset is essential to the success of the process.

## **THE ROLE OF THE EXECUTIVE COUNCIL**

As indicated in the previous sentence, communication is essential to the success and facilitation of the implementation of shared governance activities. Initially the Shared Governance Coordinating Council plays that role. It provides the base for development and communication of all the activities in implementing shared governance. It moderates and monitors the implementation activities and deals with

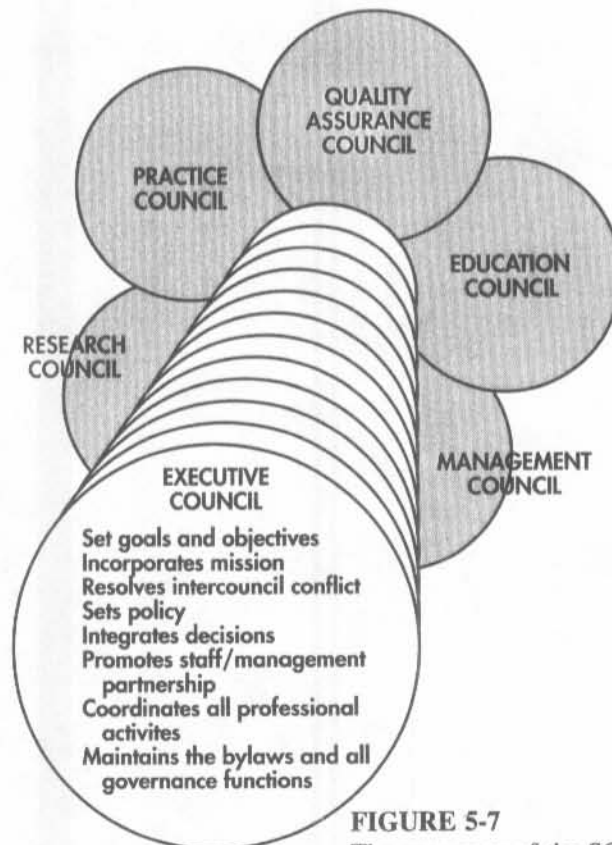
## N O T E S

the problems and issues associated with unfolding the shared governance concepts. Integration of the developmental processes is central to the activities of the coordinating council.

The tenure of the SGCC is directly related to the implementation of the governance councils (practice, quality assurance, education, research, and management). As the councils operate more independently with anticipated outcomes, the value of the SGCC begins to diminish. Since its function is directly related to the implementation process, its value in the governance integration function is relatively minor. However, integration becomes vitally important in the governance activities as the councils produce more outcomes and begin to have an impact on the functional activities of the organization. As this occurs, the SGCC becomes less effective or appropriate and must consider ending its work and making the transition to the development of the Executive Council (see Figure 5-7). This usually begins to become evident after the first year following the full implementation of the practice, quality assurance, education, and management councils. It is not a sudden revelation but a transitional process where the need and effectiveness of the SGCC begin to diminish.

### The transition to the executive council

Originally the SGCC was broadly constructed with a great number of categories of professional representatives. This strong and diverse grouping from the discipline ensured that initial structures and processes associated with shared governance had extensive dialogue and ample support. As the structures take form and the councils do the work for which they were empowered, the design issues take on less significance and integration issues become paramount. Since this issue relates to governance integration, a structural adjustment or shift will be necessary.



**FIGURE 5-7**

The successor of the SGCC: the executive council.

This shift can be facilitated if planned for at the outset of the formative processes of the SGCC. As indicated at the outset in the discussion of the SGCC's work, one of the main functions of the SGCC is to work itself out of operation as the other governance functions began to accomplish what is expected of them. A transitional time frame can be used as a way of evaluating the appropriate time and mechanism for making the change.

Questions asked to indicate the time for change may include the following:

Are all the anticipated council formats currently implemented?

Are the issues being addressed by the SGCC of a structural or functional nature?

Has it been a year to a year and a half since the SGCC was formed?

Yes (Should be close to closure) No (Problems?)

Work left to be done:

1.

2.

3.

4.

5.

Council chairpersons are in place and operating effectively?



N O T E S

Councils are on course in undertaking their work?

More work is unfolding in the councils rather than the coordinating council?

The answers to these questions should provide the information that will help the SGCC decide its own readiness and timing of change. It should be remembered that the process of bringing closure to the group will be difficult. A group has a life of its own. Relationships are established, bonds are formed, and positive and creative outcomes are achieved. The group becomes an extension of its members. They are reluctant to disband and often can find many reasons to continue.

The expressive power of this group is extensive. When the SGCC brings closure to its work, the impact of the shift of power becomes clear. Here again, it is often difficult to actually give over that power to the emerging leadership. The ownership and investment of the SGCC members are powerful and can really prohibit or slow the transfer of the power. A plan of transition can be very helpful in this regard, giving the transition some parameters. The following can help in the transitional process:

A timetable for transition

An evaluation tool to assess readiness

Completion of predetermined activities

Subsequent activities for group members

A mechanism for personal transitioning

A way of acknowledging accomplishments

A social or symbolic activity of transition

Perhaps the most effective way of facilitating the transition to the executive council is to incorporate the formation of the ExC in the transition of the SGCC. Many facilities have the charter (first) chairpersons of the individual councils selected from the SGCC or, if not, they become members of the SGCC on their initial selection. In this way a tie exists between each of the governance councils and the SGCC at the outset. At a predetermined time members, not council chairpersons, transition off the SGCC and are not replaced. This usually occurs over the first 1 to 2 years of implementation so that at the end of the second year only the council chairpersons remain members of the SGCC and they can then make the transition more easily into the ExC.

The ExC is the integrating group made up of the elected chairpersons of the governance councils and the chief nursing (or service) officer of the department, division, or service. This council focuses entirely on the role of integration. It has no accountability of its own, since only the governance councils can express professional accountability as can the chief nursing (or service) officer. The ExC is delegated responsibility by the councils and the administrative leadership for integrating the activities of governance and the operation of the organization. It is the place in the service where the partnership (remember, shared governance is a partnership between the profession and the organization) gets played out. It is where the profession and the organization come together to fulfill the mandates or requisites of their relationship. The following activities are most noted as the work of this body:

- Problem solve between and among the governance councils.
- Settle disputes between the councils regarding issues of accountability.
- Formulate the goals and objectives of the organization.
- Merge the mission, purposes, and goals of the organization with those of the profession.
- Evaluate the effectiveness of the shared governance structures.
- Approve the budget and other policy or process functions of the service as a whole.
- Remove chairpersons not functioning appropriately for their role or obligation.
- Construct and control the bylaws.
- Report shared governance activities regularly to the staff.
- Represent the profession and organization at formal processes as indicated.

Those who worry that this body may be the implementation of another hierarchical function must remember that its only obligation is to integrate the organization. None of the accountabilities of the councils can be taken on by this group. It cannot assume accountabilities that belong to the councils. Its first obligation is to see that difficulties in function and accountability can be resolved by the appropriate councils. When that is not possible, then it does have the right to resolve the difficulty. First, it assigns resolution to the council it deems to be the appropriate one. If this fails, only then can it actually act to define the solution to the issue.

The ExC acts more as a court of last resort than a source of directing activity in shared governance. The directing function must rest with the governance councils, which are the only legitimate authorities for such activity. The ExC is a trust extended by the staff and the councils to ensure that linkage between the councils, staff, management, and board is in place and that the desired and designed system of shared governance operates as structured. The ExC must ensure that it continues to operate in the best interest of the organization and the profession whose partnership it represents.

The nurse executive (or service executive) is a member of this group and provides the following role and activities within the group:

- Links the ExC with the board and administrative goals, plans, and processes influencing the operation of the service

- Provides information essential to executive decision making and planning and access to other information resources affecting quality decisions

- Serves as a forum for the visions, plans, and notions of the executive regarding the effective functioning of the service and the merging of mission and purposes of the organization with those of the profession or service

- Processes issues of conflict between the organization and the profession directed to solution seeking

- Serves as a safe place for dialogue with regard to the constraints of the organization and the strategic activities to address the challenges of the organization in meeting its service objectives

- Leads the evaluation of the effectiveness of the shared governance system and proposes adjustments and enhancements to more effectively accomplish the work of the profession and the organization.

The issue of the executive's role in a shared governance approach is always in question. It becomes an emotional issue when all the personal and power ramifi-

N O T E S

cations are included in the discussion. The issue of veto is always lingering in the wings on the stage of the discussion regarding the authority of the executive in shared governance.

Shared governance as a concept does not value the notion of veto. If the shared governance structure is formatted appropriately and effectively, the decisions that would historically require a veto are made in a way that a veto process would be a moot consideration. The executive's use of a veto is virtually always a sign that the appropriate decisional processes, so much a part of shared governance, were not appropriately used, were bypassed, or were poorly organized. Use of veto is more a sign of a collapse in the structure of shared governance or of the executive's lowered level of trust in the system's ability to effectively do what it is constructed to do. Either way, its use is indicative of failure in the system, not effectiveness or efficiency, as is often claimed.

The ExC should serve as a forum for those issues that, in other circumstances, would be dealt with only by the upper management leadership in the service. It is important to recognize that confidential and important issues to the service and the discipline can be as effectively discussed and dealt with in the ExC as any decisional group. An old adage is, that given the same information, the same skills, the same opportunity, the same time, people will generally make the same decision. Decision making has less to do with who makes decisions than the resources available to assist persons in making sound decisions. It should be the intent, indeed, the goal of the executive to see that access to whatever the ExC needs to facilitate effectiveness in its work is always available and can be provided to this leadership group in the same way it might be provided to the management team.

The notion of "stakeholding" becomes important in the shared governance concept and the role of the ExC. It is a fundamental belief of the whole approach that all professionals have some ownership over what they do in the context of their discipline. Because of this and because of what they have invested in the organization, and what staff has done to fulfill its goal, a partnership exists between the profession and the organization with both parties to the relationship having a shared outcome resulting from their interaction.

It is this concept of partnering that is most represented by the ExC. The selected leadership and the executive leadership join in this council to deliberate in the best interests of both to best fulfill the mission and purposes of the health care entity including all those issues that might affect the relationship itself. Since all will benefit by the work of this group, it best exemplifies the mutuality expressed in the shared governance structure.

The implementor should not, however, assume that all goes well and that a short cut to heaven has been obtained through the shared governance route. Clearly, in an imperfect world, many issues will demand continued effort. There will never be a time when absolute consensus will be achieved. There will always be those who do not agree that the best possible outcomes have been achieved. There will also be those times when the decision made at one time will have to be later adjusted because the information available is better or leads to different conclusions. These and other variables will always serve to keep the tension of circumstances and issues influencing the process and the outcome. Openness to the process and commitment to the approach of shared governance will be necessary; if present, these will, in the long run, positively support the most appropriate consequence.

In building the long-term effectiveness of the ExC the leadership will be confronted with issues from a number of forums. Some of the issues that emerge along the way are:

The role of the medical staff leadership who seek to have a voice in decisions that affect their practice

The selection of a chairperson or president of the nursing staff. Who should that be? What role will he or she play? What is the relationship to the executive? To the staff? How will the person be selected?

The relationship between the profession within the organization and the professional bodies outside the workplace

Nursing staff leadership emerging in the political or community arenas and the impact on the organizations within which they practice

Critical problem solving between nurses and administrative leadership when the crisis relates to direction, resource allocation, and economic issues

Impact of shared governance as an operating process within the larger workplace arena, especially in changing the characteristics of employment law, labor relations, and the accreditation processes

These and other issues will always confront the leadership as the behaviors supporting professional action begin to take form. As the whole shared governance organization begins to have an impact on the organization beyond the issues of the discipline, the ExC must be willing to integrate those issues and structures into the dialogue and into changing the format of shared governance and the relationship of the discipline with other components of the organization and institution of which nurses and other professionals are a part.

Shared governance as a concept or process is not the property of any one discipline. It is a vehicle for operation and for change. It can work for any and all disciplines. The model used in this workbook is specifically directed to the professional worker and organization and defines structure within that format. It can be modified to almost any work circumstance that involves a preponderance of knowledge workers. It is a less effective model for exclusively vocational or technical workers or those whose learning or work is based essentially in an on-the-job training or learning model.

For those who are interested in incorporating the technical, clerical, or assistive personnel in the decision-making format of shared governance there are a number of options the ExC may use to make that decision.

The nonprofessional groups may select one member for one or the other practice council depending on the focus of their work (e.g., management council for the clerical worker or practice council for the clinical assistants).

Council members may be assigned to any one of the technical, clerical, or assistive personnel committees or work groups and act as their liaison to the governance council(s). Representation would come from a council most aligned with the committee or work group seeking a connection to the council(s).

No connection between the technical, clerical, or assistive workers is made at the divisional council level. Representation is expected at the unit level where these workers are scheduled and where they have their voice.

A body made up of all nonprofessional workers meets with the representative from the ExC and the executive to deliberate issues of concern to them. Their members are selected by their co-workers and have a regular agenda and scheduled function within the organization that connects to the ExC rather than to the governance council(s).

N O T E S

All these issues affecting the professional workplace as a whole that are not a part of the appropriate individual accountability of the governance councils fall within the context of the ExC. The goal of this group is to see that the system functions equitably and effectively and that brokenness anywhere in the process is addressed and the shared governance operation is consistent and contiguous.