

8 *Structure, Accreditation, and Bylaws: Creating a Framework for Governance*

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MOVING FROM MANAGEMENT TO GOVERNANCE

Decentralizing structures and systems and developing high-performing work groups is the cornerstone to successful implementation of a shared governance model. Transition from hierarchical centralized structures reduces the layers within the organization to successfully move decision making to the point of service. In the transition from management to governance, managers share power in a highly developed partnership based on defined accountability with the nursing staff. This selective vertical and horizontal decentralization disperses power within the organization to managers and staff who work on teams within the redesigned organization. Inherent in this new structure is the potential for fragmentation and the need for coordination through centralization of defined functions to ensure desired outcome attainment for the entire system.

For the system to be successful, coordination must be individualized by function and clinical issues and be assigned to the appropriate level of expertise within the nursing organization. Managers in this new governance structure "manage" by coordinating, integrating, and facilitating within the context of a peer liaison–consultative role. Power within this structure rests wherever the relative expertise lies and is not vested in one person or group. Operating "ad hoceracies" develop the ability to solve problems directly on behalf of their constituencies. Within these models specialized skills of operating and administrative work are blended so that it is often difficult to distinguish planning and design from implementation (Mintzberg, 1989). In these new structures there is equity among group members. Managers derive their influence from their expertise and interpersonal relationships rather than their position. Organizations will no longer have two-tiered management and staff systems. These hierarchical systems will be abandoned and new structures and systems related to coordination will emerge.

Nursing Practice Accountability

A challenge for these systems that place authority and accountability with groups of practicing staff nurses is to ensure achievement of true behavioral accountability for clinical practice, and quality outcomes. A traditional and bureaucratic viewpoint that "no one ever holds groups accountable for their work" (Jaques, 1990, p. 128) must be considered as shared governance is implemented. Belief in this assumption focuses on the concept that group authority without accountability is dysfunctional and that accountability cannot rest with groups. Nursing has begun to challenge these assumptions by shattering the traditional structures, permitting staff to take risks, and placing accountability for both the process and outcomes of nursing practice with the collective group of practicing clinical nurses. Accountability will become increasingly important as consumer expectations increase for patient-centered services that result in predetermined quality outcomes at a predetermined cost. In the governance systems of the future, only those who are responsible for providing nursing practice will have the authority and accountability to manage it.

High-Performing Work Groups

Development of high-performing work groups provides some insights into the transition from traditional management structures to shared governance systems. The origin of high-performing work groups is derived from a group of individuals who initially have individual goals and are beginning the process of identifying their purpose, responsibilities, and norms for group behaviors. The group expects the leader to provide direction and assume accountability and authority for group functions. These groups frequently expect the manager to assume this leadership role, a behavior counterproductive to the successful transition to governance. Often this period can be "stormy" as functions are realigned with clinical nursing staff and the manager's role undergoes marked redefinition and clarification. The final stage of this process is development of a group that is able to focus energy, respond quickly, and assume behaviorally based accountability. Internalization of group purpose by individuals and the collective group is critical to success. Rewards are shared by the group and are often intangibles such as group decisions that have been effectively implemented to improve nursing practice. Group growth does not proceed in a straight line and can be impacted by changes in membership, group leadership, and new challenges and opportunities.

Characteristics of these high-performing work groups (Bukholtz and Roth, 1986) include:

1. A defined common purpose
2. Sharing responsibility among all members
3. Open, trusting communication and relationships
4. Challenges seen as growth opportunities
5. Individual and group empowerment
6. An outcome focus
7. Synergy through use of strengths
8. Ability to make expeditious decisions

Managers' and staff growth must be parallel for success of shared governance structures. A primary focus of management is to provide opportunities for employee growth as they relinquish legitimate power and authority to clinical nurses. Stages of growth can be compared to biologic growth and development, with the nursing staff moving from dependence to interdependence and managers from controlling to influencing to ultimately a true partnership relationship.

The ideal role for the manager in this partnership relationship is one of consultation, integration, and coordination. Upward and lateral communication are the norms in this interdependent relationship. Transactions are based on personal power and the manager's knowledge, rather than on legitimate power based on the manager's role. Performance results are stimulated by the interdependence and commitment to communication and high-level involvement by all participants. Critical to success of this transition for the manager is not only to "talk the talk" but also to "walk the walk." Successful managers focus on empowering, serving the nursing staff as internal customers, and contributing to individual and group growth. The true mark of success is that staff members will surpass the leader if development has truly been successful.

Environments must be created in which teams of nursing staff collaborate with the manager to manage the unit. All members of the group develop a sense of responsibility, become committed to identifying and solving problems that impact their practice and patient outcomes, and feel responsible for coordination. Strengths are complemented, weaknesses minimized, and all are empowered to translate intention into reality within the new structure. One of the hallmarks of success in this transition is that the work group functions equally well with or without the manager. All must feel ownership, accountability, and autonomy for the outcomes, both individually and collectively.

The manager facilitates shared responsibilities; thus the nursing staff members help each other grow as much as the manager does. Shared responsibility can be nurtured by communication—horizontally between the nursing staff, and vertically between the staff and manager and manager and staff. Information sharing and the effective use of information by the team in problem solving are dependent on the team's stage of development. For example, in our setting the nurse executive shared fiscal data, productivity, and skill mix data with the Council on Clinical Practice during our first year of shared governance as the budgetary process was in progress. Staff was somewhat overwhelmed by the data, even after explanation and interpretation of it. Two years later the nursing staff has identified roles and redefined the nursing care delivery system, making recommendations to managers and the nurse executive within the boundaries of available human and fiscal resources.

Regardless of the stage of group development, staff nurses often know more than the manager about the patient and how to best provide care and ensure quality, cost-efficient outcomes. Staff must be empowered to solve problems interdependently.

A clearly defined purpose and vision guide the direction of the work group. Miller's (1984) strategic culture-building model, which addresses the current and future external environments, current and future organizational culture, and cur-

rent and future definitions of who we are and how we are organized, can provide a model for defining the purpose. These issues must be addressed by all within the system before the formalized governance structure bylaws can be developed. This purpose will eventually provide a context for decision making, and a standard for evaluation and a focus for shared responsibility.

The McKinsey 7-S framework reminds managers that the seemingly irrational, intuitive aspects of the organization are actually important to the health and success of the organization. This framework (Peters and Waterman, 1982) examines shared values, structure, strategy, systems, style, staff, and skills. Centering around shared values forces executives and managers to focus on concepts related to the organization and staff that must be realigned in the transition from management to governance.

Health care managers of the 1990s should focus on this framework from the perspective of developing the staff by providing education about the skills necessary to successfully participate in a professional governance structure. Managerial skills and styles must also be redefined to facilitate this process. Shared values about people and the roles they play in the success of the organization will be equally important. Effective change that results in implementing organizational strategies for market-driven quality care and services will be supported by decentralized structures that use individual values to support individual, group, and organizational growth. Human technology changes are vital for health care organizations to obtain strategic advantage in the marketplace. These changes need the ongoing support of systems that provide sophisticated information to enhance data management and facilitate group problem solving.

A successful human culture in which employees love their work can be facilitated by the transformation from management to governance. As the system moves toward a governance model in which the role of the manager is that of consultant, a series of processes is vital to the success of developing a professional leadership model. These include:

1. Planned change focusing on agreement of a shared vision or purpose by key stakeholders
2. Education and skills development for all involved in the systems change
3. Coaching through team meetings and problem-solving sessions
4. Reinforcement of new behaviors

Another transition from management to governance is a concept called *team learning*, defined by Senge (1990) as the process of developing the team so that the shared vision is implemented by building on the ability of the team to attain the vision. Because most decisions in today's health care organizations are translated into actions by teams, one of the tasks for successful transition from management to governance will be the development of team learning, which will markedly impact organizational outcomes. Team learning and interaction allow better solutions to complex issues because of collective creativity and provide for coordinated activity that synergistically capitalizes on individual strengths. This process involves trust, team communication with a focus on active listening, and discussion focusing on divergent and complex points of view.

Relinquishment of authority and control to the staff by managers is facilitated during the transition to team learning. Team learning negates systems that control behavior, and focuses on shared visions, understandings, and decentralization as the forum for decision making. During this process managers are researchers and designers (Senge, 1990). Successful managers in the learning organization will understand the organizational system and driving forces that impact change and will create the learning necessary for them to be understood.

Motivation, commitment, and rewards are concepts inherent in the transition to an accountability-based shared governance model. Team energy provides the motivation to continue the development of the governance process. Early in the process small successes emphasize that staff members have assumed accountability for their professional practice, peer relations, and governance. For example, in our setting, staff members had an early success in initiating and implementing a nursing care delivery system change that solidified their role in decision making, and the role of the nursing management in the partnership. Commitment increases as the system matures and more staff members have opportunity to operationalize the bylaws and actively participate in the system. Power increases within the governance system as shared values are operationalized and goals are attained.

Rewards are intangible and are often manifest as staff decisions directly and positively impact patient care. As the governance structure successfully handles complex, difficult issues, individual and group professional growth is noted throughout the organization.

SHARED GOVERNANCE AND JCAHO NURSING STANDARDS

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) agenda for change focuses on quality and clinical and organizational outcome measurement. The philosophic base for the agenda for change is founded on the concepts of continuous quality improvement with the needed transition from the process to outcome. Accountability-based shared governance models are a natural vehicle for compliance with these new standards.

The revised JCAHO nursing standards provide an exciting opportunity for nursing by clearly outlining what patients should receive as a result of nursing care. Although the standards provide a broad framework for nursing practice within a health care setting, they do not dogmatically describe the structure and process of the nursing service but focus more on outcomes of nursing care. Nursing care standards (Joint Commission on Accreditation of Health Care Organizations, 1991) state:

1. Patients receive nursing care based on a documented assessment of their needs. (p. 131)
2. All members of the nursing staff are competent to fulfill their assigned responsibilities. (p. 133)
3. The nurse executive and other appropriate registered nurses develop hospital-wide patient care programs, policies and procedures that describe how the nursing care needs of patient or patient populations are assessed, evaluated and met. (p. 134)

4. The hospital's plan for nursing care is designated to support improvement and innovation in nursing practice and is based on both the needs of patients to be served and the hospital's mission. (p. 136)
5. The nurse executive and other nursing leaders participate with leaders from the governing body, management, medical staff, and clinical areas in the hospital's decision-making structures and processes. (p. 137)
6. As part of the hospital's quality assurance program, the quality and appropriateness of the patient care provided by all members of the nursing staff are monitored and evaluated . . . (p. 138)

The standards incorporate the concepts of professional accountabilities related to practice, quality, competence, resource usage, and research. The parallel accountabilities and authority reflected in nursing staff bylaws complement and mirror the new JCAHO standards.

In our setting, measuring attainment of the standards provided an additional opportunity to strengthen the professional governance model as we prepared for our triennial accreditation survey by developing action plans based on opportunities for improvement identified during self-assessment using the JCAHO standards. Action plans were implemented in collaboration with the nurse executive and nurse managers who ensured resource availability. Nursing management provided coordination, facilitation, and integration during the preparation process.

The decentralized unit-based accreditation visit provided the nursing staff with the opportunity to review their nursing practice, policies, orientation/education/competency documentation and quality assessment, and improvement activities directly with the nurse surveyor. Staff ownership of accountabilities and articulation of practice decisions facilitated positive interactions during the on-site visit. Examples of systems developed as outcomes of shared governance in our setting that incorporated our nursing theoretical model and facilitated compliance with JCAHO standards included:

- Competency-based orientations and skill assessment
- Unit-based education for patients and staff
- Professional review
- Professional practice model
- Outcome-focused care planning/documentation
- Identification of professional references for standards
- Unit-based quality assessment and improvement activities
- Staff-directed selection of nursing staff

In the final analysis, the philosophy and style of nursing management determine how the accreditation standards are put into operation in a health care setting. Sharing power within clearly defined boundaries will be imperative as nursing moves to staff empowerment models and employee involvement systems.

The organizational culture within a health care institution and the level of maturity in development of the shared governance model will assist the nurse executive in determining the most appropriate processes to ensure that the responsibility, authority, and accountability for nursing practice reside with the nursing staff. Nursing leadership can most effectively use the professional governance structure

within a consultative model for ongoing interactions with the professional nursing staff. Early in the development of a shared governance model, the nursing executive often provides focused direction for staff but as the staff matures in governance activities, the nurse executive's role moves to one of providing feedback, listening, and asking questions. Staff participation in forums within the health care organization must be facilitated by the nurse executive.

BYLAWS FOR THE NURSING ORGANIZATION

Bylaws define how a professional nursing system operates and also legitimize the nursing structure within the organization. Bylaws are critical to a shared governance model's success. They lend credibility and provide parameters for practice and structural operation just as medical staff bylaws provide a framework for the organization of medical practice within an organization. It is the premise of transitional professional governance models that decisions should be made by those who use the resources, whether they be within the nurse manager–nurse executive relationship, or the nursing staff–nurse manager relationship or the nursing staff–patient relationship. Bylaws, a set of shared values and guidelines about the discipline of nursing that include details about its execution within a setting, can provide a framework in which practice accountability and autonomy at the professional staff nurse level take place.

Bylaws are the rules and regulations adopted by the nursing organization for its governance. They reflect expectations in the interdependent relationship of governance related to performance for professional practice and the manager's role in creating an environment that supports professional practice. Bylaws are a written manifestation of the structure that flows from the organization and replace rigid, administratively generated policies and procedures. Bylaws must clearly describe the structure, functions, and operations of nursing within the health care organization. Provision should be made so that bylaws cannot be amended unilaterally by either the organization or the clinical nursing staff. Refer to Appendix 8-1 for an example of bylaws.

A framework for accountability-based decision making centered on the innate human desire to succeed is created within which the nursing staff can act with a reasonable degree of autonomy for professional obligations to the organization related to patient care. Articles of the bylaws identified by Porter-O'Grady and Finnegan (1984) include the following:

1. Preamble
2. Role
3. Services
4. Membership
5. Governance
6. Discipline and removal
7. Organizational coordination
8. Bylaws revision
9. Rules and regulations
10. Adoption (pp. 168-169)

Bylaw Development

The development of bylaws is based on identification and integration of professional accountabilities related to practice, quality, competence, resource utilization, and research. These accountabilities must be clearly defined with the professional nursing organization as a prerequisite to the process of bylaws development. Issues that serve as a foundation to bylaw development within the context of a professional organization are multifaceted and include:

Practice

- What do nurses do?
- What is nursing practice?
- What are the outcomes of nursing?
- What effect does nursing practice have on clinical and organizational outcomes?

Quality

- How do we define quality?
- What is the quality of service that nurses provide?
- How is the quality of the provider of service ensured?
- How is quality of service measured?
- How are quality assurance and quality improvement ensured within nursing and the health care organization?

Competence

- How is a prior competence assessed?
- What are the organization's standards of competence?
- How do professional nurses within the organization fulfill their obligation to teach each other?
- What are the organization's beliefs about ensuring continuing competence?
- What are nursing's beliefs about lifelong learning for professionals and how are they supported within the organization?

Resource issues

- How will resource accountabilities be integrated with clinical accountabilities for practice, quality, competence, and research?
- What is management's accountability for human, material, fiscal, support, and systems resources?
- How is management accountability related to resources in operation within the organization?

Research

- How does nursing develop new knowledge?
- How does nursing verify existing knowledge?
- What are the role and responsibility of the practicing professional nurse in these processes?
- How do these processes impact nursing practice and clinical outcomes?

A clear organizational commitment to professional governance and the definition of accountabilities are essential steps in the development of formal bylaws.

Although bylaws may be developed before the implementation of a professional governance structure, their development and implementation are often delayed until the model has been implemented to allow ample experience with the governance structure.

Often, in the evolution of professional governance within an institution, both the professional nursing staff and nurse executive have begun to address the political issues of obtaining support and approval for the bylaws. Clearly defined bylaws outline the professional governance activities of nursing and their format needs to be fully integrated with professional nursing responsibilities, authorities, and accountabilities. Administrative support and approval are fostered by ongoing communication with key stakeholders about the development of the professional governance model and their relationship to successful outcome attainment consistent with the mission of the institution.

Bylaws should be as simple as possible. Although each organization's bylaws will be unique, an overview of their generic elements may be useful to those who are beginning the development process. Bylaws must be written and owned by the professional staff. In most settings this is an evolutionary process with growth of the professional organization reflected in bylaws development.

Development of Bylaws Articles

Preamble. The preamble includes information related to the purpose, philosophy, and objectives of the organization. This section provides a clear understanding of the role and function of the organization and what it means to the individual nurse. Issues to be addressed during development of the preamble of the bylaws include:

- Why are bylaws being written?
- What is the purpose of nursing within the institution?
- What is the philosophy of nursing within the organization?
- How is nursing defined within the organization?
- What are the objectives for the organization?
- Are the objectives stated so they reflect the accountabilities of nursing within the hospital?
- What framework best states the nursing organization's objectives from a short- and long-term perspective?

Role. As defined in the nursing organization's bylaws, *role* determines the authority and thereby the accountability for professional nursing. Role functions and activities of the professional nurse are stated as they relate to accomplishing the purpose, critical objectives, and philosophy of the organization. Role identification, expectations, authority, and accountabilities must address:

- What authority and accountability for practice is stated in the nurse practice act?
- What other internal or external standards guide the nurse's authority and accountability for clinical nursing services?
- What are the responsibilities, authorities, and accountabilities of the professional nurse in the organization for clinical nursing services?

- How are nursing services structured to meet individual patient and significant others' needs?
- How are nursing services structured to facilitate the nurses' management of resources to provide quality, cost-efficient, coordinated care and leadership development for the nurse?
- How does the nurse develop interfaces to facilitate patient and organizational outcomes?
- What is the nurse's role related to participation in organizational forums within the health care organization?

Definition of services. Professional nursing services as defined in the bylaws assist those who read them in clarifying the role of nursing within the organization. A synopsis of the nursing organization's scope of care as articulated in the quality assurance plan may be easily translated into this segment of the bylaws. Considerations include:

- What are the primary services provided?
- Who provides them?
- When are they provided?
- Where are they provided?
- What population of patients receives them?
- What is the conceptual framework for nursing practice?
- What is the nursing care delivery system?
- What are the professional nurses' accountabilities for patient care within the scope of nursing services provided?

Membership. Nursing staff membership as a privilege rather than as a condition of employment is a relatively new concept for most nursing organizations. Specifics related to credentials, privileges, tenure, removal, and obligations of accountability will be reviewed later in this chapter. Membership issues include:

- Who will be granted privileges?
- What are the criteria and qualifications for membership?
- What will be the process for granting privileges?
- What will be the duration of privileges?
- What are the conditions for reappointment?
- What are the types of membership to be granted (i.e., provisional, consulting, full)?
- What are the specific role activities, authorities, responsibilities, and accountabilities for each type of membership?
- Who will be responsible for the process of granting membership?
- How does the membership process interface with human resources within the larger organization?

Governance. The governance article in the bylaws clearly defines the role, activities, process, responsibilities, and membership of the bodies that comprise the governance structure. If a councilor model of shared governance is selected, councils can be aligned based on accountabilities of the professional nurse. These councils are responsible for the operation and integration of the professional nurs-

ing organization as it organizes, manages, and evaluates delivery of nursing care services within the organization. Basic issues to be addressed are:

- What governance structure best supports the purpose and attainment of the critical objectives of the nursing organization?
- What is the role of each governing group within the governance model?
- What are the authorities and accountabilities of each council or governing group in the governance system?
- How will the business of the governing group be conducted?
- How are members and officers of the governance selected and how long will they serve?
- How is membership rotated so that new members are integrated into the group's work?
- What are the expectations for attendance?
- How are decisions made between scheduled meetings?
- How are task forces and subcommittees appointed and what is their accountability within the governance structure?
- How will the performance of the governing group be measured and what is the relationship of the councils to each other related to integrative and coordinating functions?

Discipline and removal. Discipline and removal from the professional nursing staff are discussed in conjunction with the credentials process. It is imperative that these processes are clearly defined in the bylaws and are implemented within the health care organization's framework, reflect the organization's human resource policies and integrate with them, and meet state and institutional requirements.

Consultation from the hospital's legal counsel and human resource department is imperative in development of this article of the bylaws.

This article of the bylaws has been expanded in some organizations to include information about career advancement and professional review processes. These processes may include advancement from one level of professional nursing practice to another. They may also include information about the professional review process at the time of annual performance evaluation.

Organizational Coordination

This article of the bylaws addresses organizational coordination and governance of the professional nursing organization from the perspective of the role of nursing administration, the coordinating council or body, and the professional nursing staff as a whole. Critical to the development of this section of the bylaws is a clear definition of the role of the nurse executive related to responsibilities and accountabilities to the hospital administrator of the organization for the coordination, integration, and administration of nursing. The nurse executive also has responsibility for ensuring that bylaws are promulgated to staff, and that they are followed according to the existing rules, regulations, policies, and procedures of the particular institution.

The role of the nurse manager on behalf of the nursing staff to coordinate the

nursing service is one that supports the staff's accountability for nursing practice. The primary role of nursing management is to support the work of nursing within the clinical system by integrating, coordinating, and facilitating human, material, fiscal, and systems resources. In this new forum the nurse executive's role in organizational coordination is to provide corporate perspective by clearly expressing visions and supporting staff involvement in forums that facilitate professional governance at all levels of the organization. This ultimately ensures that the corporate or organizational needs for nursing care services are met.

Regardless of the type of governance structure the role, power and authority, membership, and meeting times of the coordinating governing group are clearly delineated in the bylaws. Clear definition of the role of the council chairpersons and the coordinating council for the decision-making process is critical to a governance model's successful function.

The article on organizational coordination also elaborates on the role of the professional nursing staff in decisions affecting it and discusses the purpose, frequency, and procedures for meetings of the professional nursing staff.

Bylaws Revision

Bylaws adoption and subsequent revision or amendment are accomplished by processes that allow for review of the proposed changes by the professional nursing staff and nurse executive before formal approval. Often bylaws in a councilor model of governance state that any member of the professional nursing organization may submit a recommendation to a council chairperson, who will then present the bylaws changes to the coordinating council for review and inclusion on the agenda of a regularly scheduled meeting of the professional nursing staff. Changes are usually approved by a two-thirds majority of staff. In most organizations bylaws are reviewed and revisions or amendments are approved at the annual meeting. Changes often reflect growth within the professional nursing organization or reflect organizational changes impacting the nursing organization.

Rules and Regulations

This section of the bylaws grants permission to the councils or governing groups to develop rules and regulations. Rules and regulations are developed by individual councils or governing groups. These rules and regulations define activities and enable the council or governing group to implement its work consistent with the bylaws. Rules and regulations are often approved by the coordinating council or governance body before implementation and are not attached to the bylaws of the nursing organization.

Adoption

This bylaws section states the process for approval of the bylaws by the professional staff and a section for appropriate signatures, including the president of the nursing staff, and appropriate executive and/or administrative signatures within the institution. Bylaws usually are approved by a two-thirds majority of the nursing staff at the regularly scheduled annual meeting. Ample time for all members to review bylaws before the meeting is imperative to the success of their adoption.