Clinical Excellence Coaching

SHARED GOVERNANCE RESOURCE PACKAGE

SHARED GOVERNANCE · TRAINING GUIDE

Building a Unit Practice Council

A complete, field-tested handbook for starting and sustaining shared governance at the point of care.

INSIDE THIS HANDBOOK

01 What Is Shared Governance?

02 Building the Structure

03 You Are the Chair — Now What?

04 Running an Effective Meeting

05 Reading Quality Reports

06 Using Best Practice to Improve Quality

A SELF-PACED COMPANION

TO THE SHARED GOVERNANCE RESOURCE PACKAGE

HANDBOOK · FIRST EDITION

ABOUT THIS HANDBOOK

Clinical Excellence Coaching

Clinical Excellence Coaching helps nursing teams build cultures of clinical excellence — partnering with frontline staff, chairs, and leaders to put shared decision-making to work at the point of care.

This handbook is the teaching companion to the *Shared Governance Resource Package*. It distills a full-day, instructor-led workshop into a self-paced reference you can read end to end, teach from, or pull apart chapter by chapter. Every chapter pairs with a ready-to-use document in the companion Resource Templates folder, so the teaching and the tools go hand in hand.

A note on adapting this material. This package describes a complete, proven shared governance model. It is intentionally generic so any hospital, health system, clinic, or care setting can adopt it as-is or tailor the council names, titles, and tools to fit local structure. Wherever you see a placeholder such as *your organization*, *your meeting platform*, or *[insert your council email]*, substitute your own.

Building a Unit Practice Council — A Shared Governance Handbook. First edition. Published by Clinical Excellence Coaching as part of the Shared Governance Resource Package.

Provided for educational use. The structure, council names, and tools are generic and may be adapted to any care setting. © Clinical Excellence Coaching. All rights reserved. Helping nursing teams build cultures of clinical excellence.

BEFORE YOU BEGIN

How to Use This Guide

This guide is built for one practical purpose: to help a nursing team start and sustain a unit practice council, and connect that council to a healthy, organization-wide shared governance structure. It follows the same sequence as the live workshop, in six chapters.

Who this is for

- New and prospective unit practice council chairs and co-chairs — whether you are starting a council from scratch or stepping into an existing one.
- Council members and secretaries who want to understand their role and contribute well.
- Nurse managers, assistant managers, and nurse leaders who sponsor, resource, and protect the work.
- Anyone curious about how shared decision-making actually works at the point of care.

How it is organized

CHAPTER	WHAT IT COVERS
One	**What Is Shared Governance?** — the model, its principles, and why it works.
Two	**Building the Structure** — the councils, the roles, and how a practice change flows from an idea to organization-wide adoption.
Three	**You Are the Chair — Now What?** — a literal, step-by-step path to standing up a unit practice council.
Four	**Running an Effective Meeting** — parliamentary procedure (Robert's Rules) made simple, with a full meeting walk-through.
Five	**Reading Quality Reports** — how to interpret the data that will be put in front of you.
Six	**Using Best Practice to Improve Quality** — turning data into a project, and a project into shared practice.

Teaching and tools, together. Each chapter points to the matching template in the companion Resource Templates folder — the bylaws, the practice-change SOP, the chair to-do list, the meeting script, and the agenda and minutes templates — so you can move straight from reading to doing.

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CHAPTER ONE

1

What Is Shared Governance?

The model, its four principles, and why putting decisions at the point of care works.

IN THIS CHAPTER

- Describe shared governance and its main components.
- Identify the barriers to implementing it successfully.
- List ways to incorporate it into organizational and unit activities.

Shared governance is an organizational model that creates shared decision-making among professionals. When it is implemented well, it has been shown to improve patient care and produce strong outcomes — because it lets decisions be made at the point of care, by the people doing the work.

Most well-functioning organizations bring the voice of the people doing a job to the table when decisions about that job are made, rather than mandating change from the top down. Think about it from a leader's chair: healthcare changes quickly, and someone who has stepped away from the bedside has limited visibility into the daily experience of frontline staff. If a decision is going to affect the work they do, why would you not include them? Shared governance is the vehicle that brings leaders, frontline staff, and everyone in between to the same table.

FOUNDATIONS

The Four Key Principles

Four principles hold the whole model together. They are worth memorizing.

Partnership

The foundation for building relationships. It involves nurses at *all* levels in the decision-making process — not just leadership, and not just the bedside.

Equity

Equity keeps the focus on services, patients, and staff; it is the measure of value. It does not mean equality of scope or practice — a frontline nurse and a chief nurse do not have the same authority, and that is appropriate. What equity *does* mean is that every role is essential and everyone has a voice. No single role is more important than another.

Accountability

What makes decision-making real. When people take accountability for their actions, they are far more likely to follow through — and follow-through leads to ownership.

Ownership

The end game of any well-functioning structure: the recognition and acceptance of the value of the profession's work. The goal is to get people to own the work that they do.

KEY INSIGHT · WHY OWNERSHIP MATTERS

If you are told what to do, you will do it. But if you were asked to help *create* the solution — here is the issue, design a fix and run it — you have a stake in whether it succeeds, because it is yours. The only way to get there is through equity and accountability: people have to be at the table when decisions are made, so there is a vested interest by everyone involved.

THE HONEST OBJECTIONS

The Concerns You Will Hear

Shared governance is not always an easy sell, especially to frontline staff and managers who are stretched thin. These concerns are common, and they are not unreasonable:

- *"I'm too busy for one more meeting."*
- *"It takes too much time away from patient care."*
- *"I can't see how this is going to help me become a better nurse."*
- *"It doesn't get me more money or better benefits, so why bother?"*
- *"I don't have enough staff to let them keep going off to meetings."*

Most of these opinions form in environments where people are used to being told what to do. Human nature focuses on the short term: get through the shift, keep the lights on, take care of the patients, go home. The long-term rewards of shared decision-making are hard to picture until you have seen them work. A decentralized structure changes those attitudes — partnership, equity, accountability, and ownership happen at the point of service, and that is where the decisions should be made.

WHO OWNS THE DECISION

The 90 / 10 Rule

At least 90% of the decisions that affect frontline work should be made and owned by frontline staff. So what is the other 10%? Those are the things that are genuinely mandated — a regulatory requirement, a crisis response, an executive or system directive based on information the unit may not have. You cannot vote those away, and being realistic about what is and is not within your control is part of the discipline.

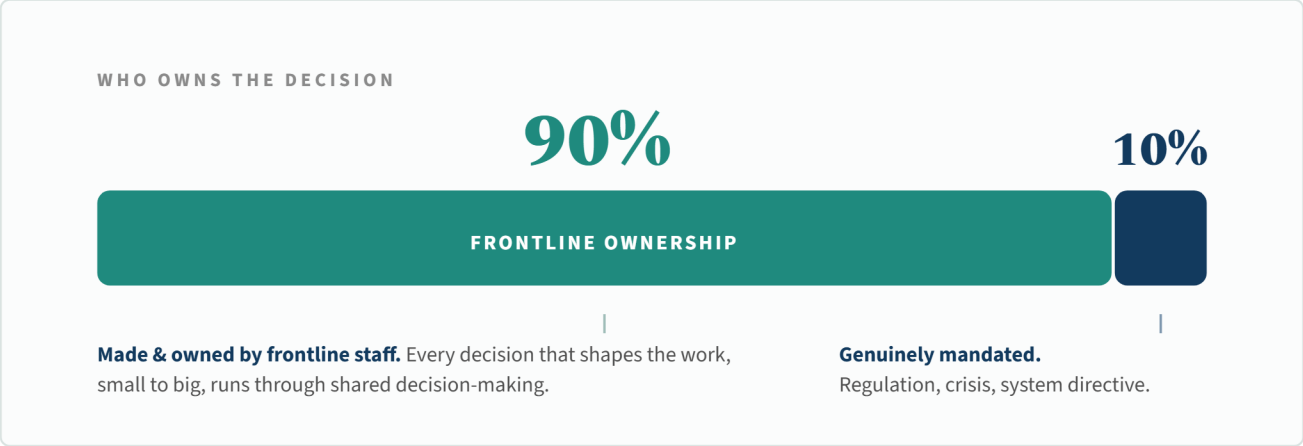


Figure 1. The 90 / 10 ownership split. The discipline is to fight for the 90% while being honest about the 10% you cannot vote away.

> *"When your thoughts and opinions are genuinely valued, you feel like part of something greater than yourself. That is the culture this builds."*

The evidence is strong and consistent

When shared governance is well established, organizations see:

- **Greater longevity of employment** — staff stay, because they feel valued.
- **Higher employee satisfaction** — people who feel heard work harder and want to show up.
- **Improved patient safety and quality of care.**
- **Enhanced patient satisfaction and shorter lengths of stay.**

Shared decision-making is not unique to nursing. It is heavily used in academia among faculty, in private institutions, and the entire premise of democratic government is built on it. Many of the structures in this guide borrow directly from that tradition.

HOW IT FAILS

Pitfalls to Avoid

Knowing the common ways shared governance fails will help you avoid them. Watch for these:

- Establishing it in only *some* parts of the organization — pockets where staff feel devalued keep the whole from reaching its potential.
- Fostering competition instead of collaboration. This is not nurses versus physicians or one unit against the world; it is collaboration, discipline to discipline.
- Tolerating leadership that fails to support or participate.
- Not providing enough resources — time, a real meeting space, a computer or microphone. Nurses should not run councils from the corner of a nursing station.
- Not inviting interprofessional partners — including, where appropriate, patients.
- Not addressing disengaged or toxic employees, and not benchmarking or measuring progress.

THE MANAGER'S ROLE

Working With Nurses, Not Around Them

Managers disengage in recognizable ways: not allowing staff time to attend; taking over the meeting and turning it into a staff meeting; or refusing to let staff participate at all. Effective managers instead work *with* nurses through shared leadership — holding a strong, constructive standard while respecting that strong partnerships require each side to understand and respect the others' roles.

> **KEY INSIGHT · YOUR COUNCIL IS NOT YOUR STAFF MEETING**
>
> There is wide flexibility in how a council runs — right after the staff meeting, before it, or at huddle. But a council meeting, however short or informal, should be run by the council chair. Keep the two distinct.

What your council needs to identify

As you think about your own council, you will need to settle a few things up front (the rest of this guide walks you through each):

- Membership and the roles of members — who should be on the council, and why.
- The roles of nurses, the nurse manager, unlicensed assistive personnel, and interprofessional partners.
- A chair to coordinate activities, work with the manager and direct-care nurses, decide what to bring forward, and communicate back to staff on all shifts.

Pairs with: the **Shared Governance Bylaws (Template)** — the governing rules of your whole structure.

CHAPTER TWO

2

Building the Structure

The councils, the roles people play, and how a practice change travels from an idea to organization-wide adoption.

IN THIS CHAPTER

- Map the councils and how they relate to one another.
- Understand the roles, terms, and protected time that sustain the work.
- Follow a proposal through the three-lens approval path.

Chapter 1 covered the big picture. This chapter describes exactly how a shared governance structure is built — the councils, how they relate to one another, the roles people play, and how a proposed change travels from an idea to organization-wide practice.

A FRAME TO BUILD INSIDE

Vision & the Four-Domain Framework

A useful way to anchor the model is with a shared vision statement — one that bakes in words like *partner*, *accountability*, *expectations*, and *stakeholders*. Those are the same ideas from Chapter 1, made concrete.

Many organizations frame their model inside a recognized professional-practice framework. A widely used one organizes nursing excellence into four domains — **Transformational Leadership**, **Structural Empowerment**, **Exemplary Professional Practice**, and **New Knowledge, Innovation & Improvements**. Shared governance lives squarely inside *structural empowerment*: it is one of the structures that supports the professional nurse. Use whatever framework your organization has adopted; the council model below fits inside any of them.

THE ANATOMY

The Councils

A mature structure typically includes a foundation of unit practice councils, a set of organizational councils that each look at practice through a different lens, and an executive council at the top.

Unit Practice Council (UPC) — the foundation

Gives a unit, clinic, or work setting a shared voice over its practice, work environment, professional growth, and patient-care outcomes. In a perfect world, every unit has one. Without UPCs, whole groups of staff are disconnected from the organization's decisions — exactly what shared governance exists to prevent.

Clinical Practice Council (CPC) — the most important council

The face of the structure, because it represents the largest body of workers. Anyone who wants to propose something that affects nursing practice goes through the CPC. Its members are the unit chairs from the UPCs — so when those chairs show up, they collectively represent the entire organization.

Nursing Operations Council (NOC)

Reviews administrative practices and human and fiscal resources — equipment procurement, educational activities, and the clinical practices that support frontline staff. In the practice-change flow, the managers here determine a proposal's scope and whether it is feasible with the resources in place.

Nurse Executive Council (NEC) — the final approving body

The last stop for practice change, and the final approving board for all new or revised nursing practices. Its power is its membership: senior nurse executives and the chairs of every organizational council. An educator, a frontline staff nurse (the CPC chair), an advanced practice nurse, an informatics nurse, and a manager all sit at the highest table — and the frontline nurse's vote carries the same weight as the chief nurse's.

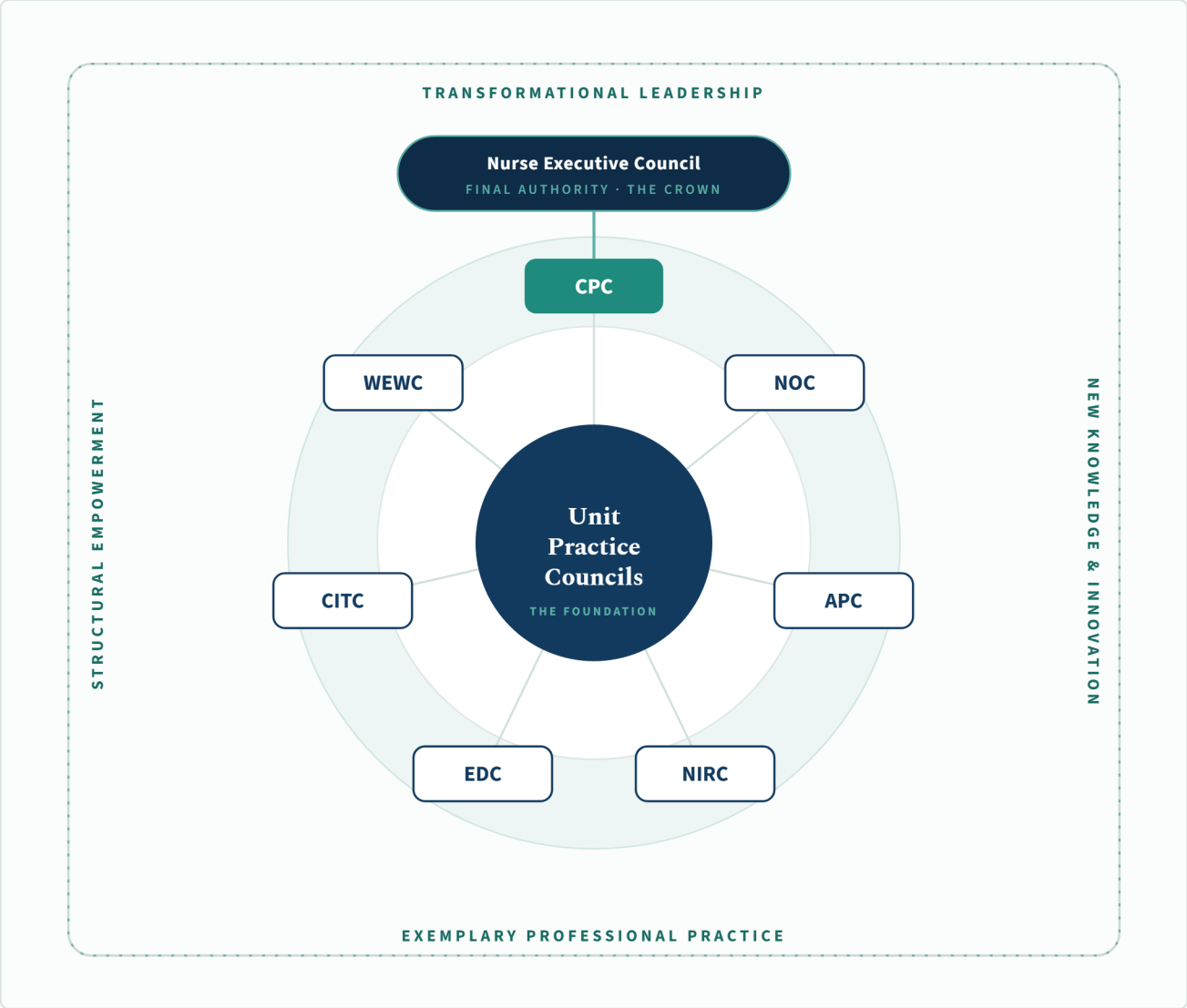


Figure 2. The shared governance structure. Unit Practice Councils form the foundation; seven organizational councils — **CPC** (Clinical Practice), **NOC** (Nursing Operations), **APC** (Advanced Practice), **NIRC** (Nursing Inquiry & Research), **EDC** (Education & Development), **CITC** (Clinical Informatics & Technology), and **WEWC** (Workforce Engagement & Wellbeing) — surround them, with the Nurse Executive Council crowning the model. The whole sits inside the four-domain framework.

The specialty organizational councils

Advanced Practice Council (APC) facilitates communication between leadership, staff, and APRNs, and addresses scope of practice, credentialing, and APRN-led evidence-based practice. **Nursing Inquiry & Research Council (NIRC)** builds the scientific foundation for evidence-based practice and helps staff generate new nursing knowledge. **Education & Development Council (EDC)** owns competence and education at every level and plans the rollouts that change how the organization practices. **Clinical Informatics & Technology Council (CITC)** determines technology and clinical-application solutions and makes documentation templates and system changes happen. **Workforce Engagement & Wellbeing Council (WEWC)** recruits and retains a qualified workforce and — increasingly — owns employee wellness and resilience.

> **KEY INSIGHT · THINK OF IT LIKE A PUZZLE**
>
> Each council does one part of the picture, and they all communicate. A proposal that starts as a clinical idea may need the CITC to build a documentation template, the EDC to plan the training, and the NOC to confirm resources — before the executive council ever approves it.

A CONGRESS OF NURSES

The Representative Model

The structure is, in effect, a congressional model. Each unit elects a chair; the chairs collectively form the Clinical Practice Council; the CPC's elected chair sits on the Executive Council and speaks for the entire clinical staff. At every level, someone is representing their constituents.



Figure 3. The representative "congressional" model. A concern raised at the bedside is carried upward by elected representatives until it reaches the highest decision-making table — where the frontline voice has equal weight.

KEY INSIGHT · WHY ATTENDANCE IS NOT OPTIONAL

When you skip a council meeting, you are not just absent — you are excluding everyone you represent from a decision that may change their daily work. If the council votes to change how vital signs are taken and your area has a method the new approach breaks, your team finds out *after* the fact, with no chance to weigh in.

WHO DOES WHAT

Roles & Responsibilities

Unit Practice Council Chair

Leads and represents the unit; presides at meetings; holds a standing meeting with the nurse manager at least monthly; ensures minutes and reports are submitted on time; and prepares the co-chair to take over when the term ends.

Organizational Council Chair

All of the above at the council level, plus an annual strategic plan with at least one signature goal — "leave your mark before you step out of the seat." Serves on the executive council and may recommend removal of members with more than two unexcused absences in a year.

Co-Chair / Chair-Elect

Learns the role under the chair, stands in during absences, and succeeds to chair after the first year.

Member

Attends regularly and represents constituents — voting the views of the unit, which sometimes means "I need to take this back to my unit first." Communicates activities back to the area, assigns a proxy when absent, and submits agenda items at least seven days ahead.

Nurse Manager / Administrative Liaison

Provides administrative support and is the guardrail for the council's ambitions. Communicates honestly about what is feasible — "even a 'no' with an explanation is better than nothing" — and ensures staff have protected time to participate.

Secretary / Recorder

Serves as timekeeper, oversees attendance, records minutes, submits them on time, and tracks recommendations for follow-up.

THE RULES OF THE ROAD

Attendance, Meetings & Terms

- **Meeting frequency.** Councils meet at least quarterly. The exceptions are the councils practice change flows through — CPC, NOC, and NEC — which meet monthly so proposals do not pile up.
- **Quorum.** A minimum of 51% of voting members present is required to vote (Chapter 4 covers this in detail).
- **Excused absences.** Members are expected at every meeting unless on approved leave or excused in advance with a real reason. "I didn't feel like coming" is not a reason.
- **Terms of office.** The chair and chair-elect each serve a one-year elected term, and the chair-elect automatically becomes chair the following year.
- **Member terms.** Members typically serve two years; councils whose membership is defined by title or position are exempt.

← KEY INSIGHT · THE TWO-YEAR CYCLE

Starting from scratch, your first year you may be largely on your own — that is your first term. In year two you should have a co-chair formally elected to succeed you. From then on there is always a co-chair: each chair spends their second year handing over the reins while the incoming chair learns the role. The cycle simply repeats.

MAKE THE TIME REAL

Compensation & Protected Time

Shared governance only works if the time to do it is real and protected. If a meeting occurs during normal duty hours, members are excused from their work area for the meeting and for assigned activities. If a member is asked to participate while off duty, they must get prior approval to be compensated — it cannot be arranged after the fact. Council members should also be allotted dedicated hours each month to attend, plus time for professional-development activities.

THE RULE THAT TRIPS PEOPLE UP

To be protected, you must notify your supervisor *before* the schedule is published. Ask the week of, and staffing gives them every reason to say no. Flag a known need well in advance — "I'll need these hours in May for our project" — and it should be granted. A smart habit: schedule development time on the same day as the monthly council meeting, so the work happens back to back.

THE ENGINE OF THE SYSTEM

How a Practice Change Flows

Here is how an idea becomes practice. The principle that triggers it is simple — **anything that impacts nursing practice must come through shared governance.** It does not matter how big or small, or whether the proposer is a nurse, a physician, or a vendor.

STEP	COUNCIL	THE LENS IT APPLIES
1	**Clinical Practice Council**	Nursing-practice feasibility — the frontline view
2	**Nursing Operations Council**	Scope & resources — where it applies, what it takes
3	**Nurse Executive Council**	Organizational feasibility — final approval

The real work happens on the back end: contact the CPC leadership group, engage the stakeholders their review identifies (informatics for the record, education for competency, quality for policy), and resolve them *before* the first presentation — so what arrives at the CPC is as close to a final product as possible. Then it advances CPC → NOC → NEC, and on final approval you move to implementation.

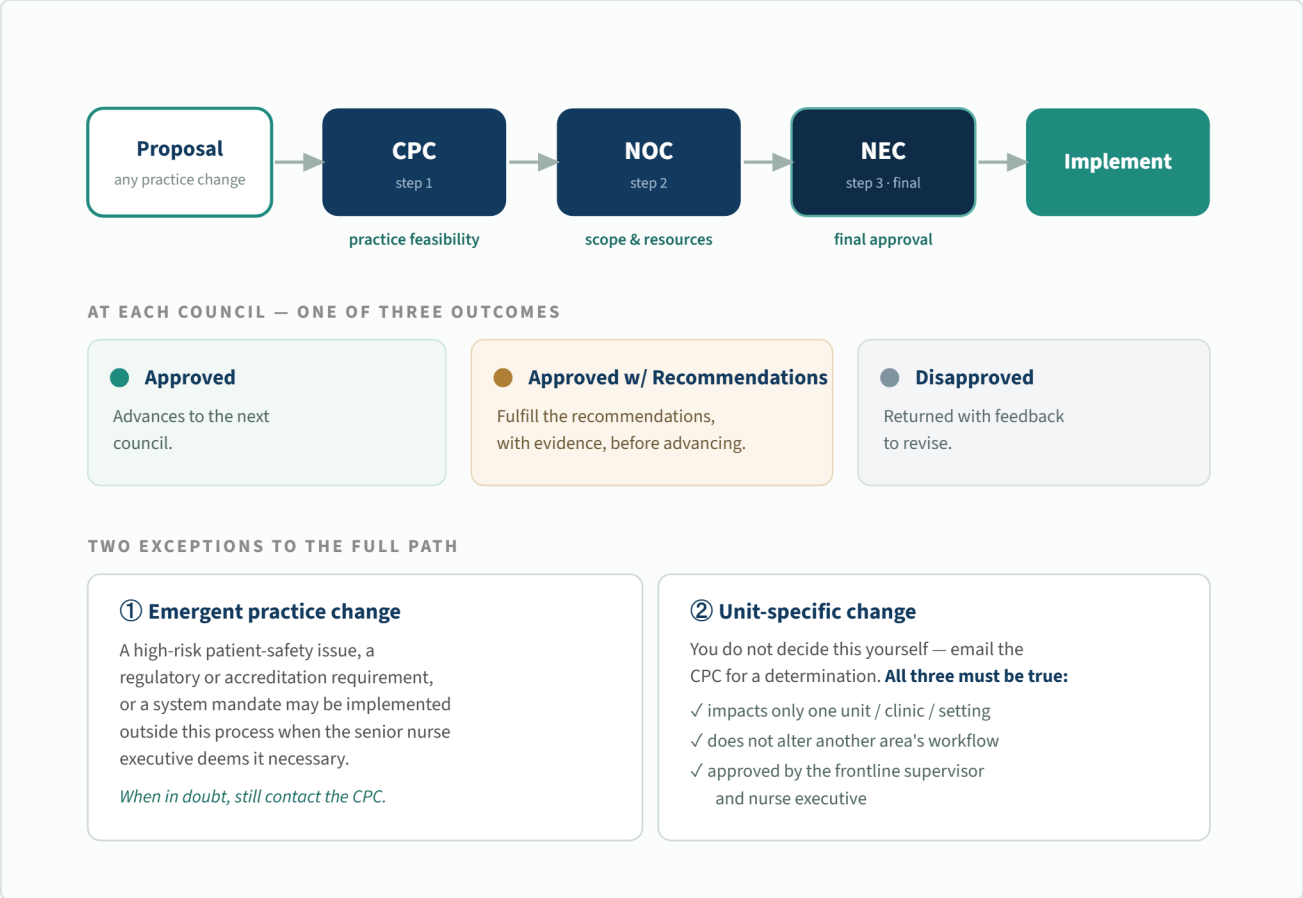


Figure 4. How a practice change flows. A well-prepared proposal can move from agenda to final approval in roughly a month, because the heavy lifting happens before the first presentation. (Referenced again in Chapter 6.)

At each council the vote yields one of three outcomes: **Approved**; **Approved with Recommendations** (fulfill them, with evidence, before advancing); or **Disapproved** (with feedback). Implementation is its own undertaking, and the structure helps: the EDC assists with staff education, the CITC integrates technology or documentation, quality partners finalize any SOP, and the program office helps with dissemination.

Pairs with: the **Nursing Practice Change SOP (Template)** — the step-by-step approval procedure for any practice change.

CHAPTER THREE

3

You Are the Chair — Now What?

A literal, six-step path to standing up a working unit practice council.

IN THIS CHAPTER

- Assemble a council built on quality, not quantity.
- Lock in a date, a mode, and a workable agenda.
- Run the meeting and capture minutes that hold up.

Chapter 2 was the theory. This chapter is the literal, step-by-step path to standing up a unit practice council. Work through these six steps and, by the end, you will have a functioning council. The companion "Unit Council Chair To-Do List" mirrors these steps as a one-page worksheet.

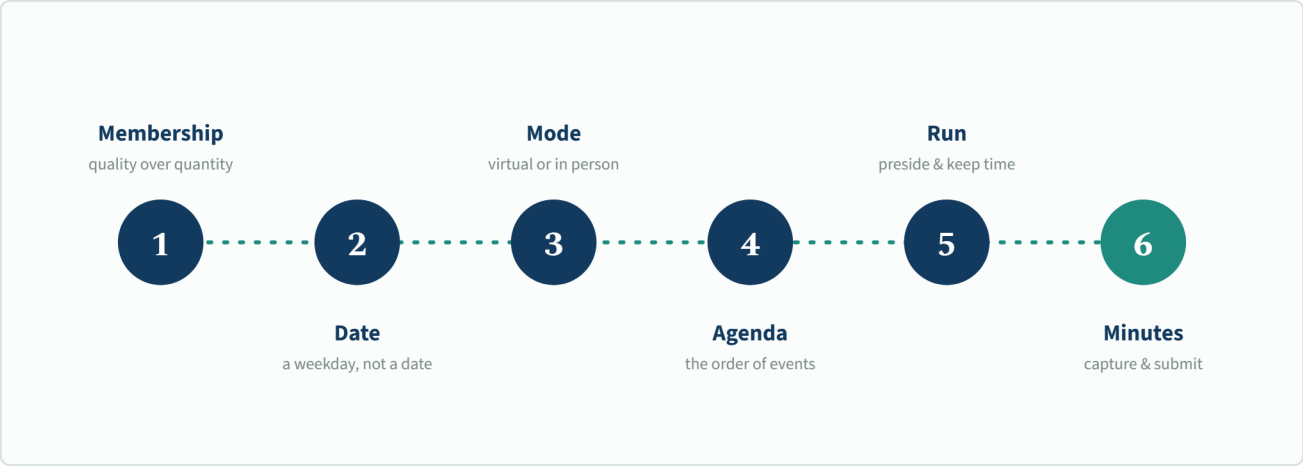


Figure 5. The six-step council startup roadmap. Each step is a decision you settle once, up front — then repeat the rhythm every month.

YOUR ONE-STOP RESOURCE SITE

Most organizations keep a shared governance resource site — your intranet, a team site, or a shared drive — as the one-stop shop for templates, the proposal/intake channel, the minutes form, and reference materials. If your organization does not have one yet, the companion Resource Templates folder gives you everything you need to create it.

STEP 1

Council Membership: Quality Over Quantity

Work with your manager to assemble a roster that mixes the matrices and shifts on your unit. When you run a project you want someone on each shift who can speak to it — if your whole council is on days, a day-shift project can quietly stall on nights.

KEY INSIGHT · THREE GOOD MEMBERS BEAT THIRTY RELUCTANT ONES

It is not mandatory for everyone on the unit to be a member. A council of three on a unit of thirty is perfectly fine — shared decision-making is about the quality of the members, not the quantity. Your council becomes the coordinating core: even with three members you can run an initiative that touches everyone, and you can assign tasks to non-members — "you're our champion on nights for this audit." Recruit staff genuinely willing to commit; done well, the council feeds directly into clinical-ladder advancement.

STEP 2

Set a Meeting Date

Work with your manager to find a date and time, and lock it in at the council's formation. Scheduling and protected time are managerial decisions, so settle them early rather than improvising later. How often you meet is up to you and your manager, with a minimum of quarterly.

PICK A WEEKDAY AND A WEEK, NOT A DATE

Use "the first Tuesday" or "the third Wednesday" rather than "the 15th." A fixed calendar date lands on a different weekday every month and becomes impossible to staff predictably. A fixed weekday-of-the-month is set in stone — no one is ever surprised by it.

STEP 3

Choose Your Meeting Mode

Virtual or in person is your council's call. If you meet virtually, create a recurring calendar invite and a meeting link, and add every member and expected guest:

1. Create a new meeting in your calendar/meeting platform; a join link is generated automatically.
2. Name it clearly (for example, "Unit Council — Monthly") and add all members and guests.
3. Choose the start time, then set it to recur — monthly (or your cadence), using the day-of-week option ("the first Monday of every month"), not a fixed calendar date.
4. Set an end range (e.g., one year) and save. The series now lives on everyone's calendar.

STEP 4

Set the Agenda

The agenda is simply the order of events for the meeting. Provide it to members and the manager beforehand. If someone wants to be on the agenda, they must submit the item at least seven days in advance, because building a good agenda takes planning. Use the Meeting Agenda Template, and the Sample to see one filled in. (Chapter 4 explains every section.)

STEP 5

Run the Meeting

Your job as chair is to be the presiding officer — to keep the agenda flowing, prevent chaos in discussion, and hold speakers to their time. Time discipline is a courtesy, not rudeness: if you give a presenter five minutes and let them run to fifteen, every presenter after them gets rushed and your members start watching the clock. Chapter 4 and the Council Meeting Script walk through exactly how.

STEP 6

Capture & Submit the Minutes

Make sure someone is documenting the meeting using the Meeting Minutes Template. Minutes are not daunting — they are simply a summary of what happened: who was present, what was announced, what was reported, and what was decided. A few one-line entries per section is plenty. Submit them through your organization's intake — typically a simple form or a designated folder — ideally within seven days. As chair, timely submission is your responsibility.

> **KEY INSIGHT · WHY MINUTES MATTER**
>
> Minutes are quality control. Members review them to confirm that what was discussed and decided is recorded accurately. Distributing the previous meeting's minutes ahead of time lets members catch anything that was changed — which is exactly why the next meeting opens with a vote to approve them.

Pairs with: the **Unit Council Chair To-Do List** — a one-page worksheet that mirrors these six steps.

CHAPTER FOUR

4

Running an Effective Meeting

Parliamentary procedure — Robert's Rules — made simple, from gavel to adjournment.

IN THIS CHAPTER

- Run an orderly meeting using a fixed order of business.
- Establish quorum and approve minutes correctly.
- Make, second, debate, and vote a motion.

> *"Before you are a leader, success is all about growing yourself. When you become a leader, success is all about growing others."*
>
> — JACK WELCH

This chapter covers parliamentary procedure made simple, and walks through a complete meeting. The companion Council Meeting Script is a word-for-word role-play you can use to practice with your team.

THE WHY

What Parliamentary Procedure Is

Parliamentary procedure is a set of rules for conducting meetings that lets everyone be heard and lets a group make decisions without confusion. Robert's Rules of Order, Newly Revised is the basic handbook used by most clubs, organizations, and councils. Its purpose is organization in discussion: many proposals are high-stakes and draw genuine disagreement, and by following a few simple steps a council can surface every view, reach a consensus through a fair vote, and move on — with everyone clear on what was decided.

THE BACKBONE

The Order of a Meeting

Every agenda and set of minutes follows the same backbone:

1. **Call to order**
   the chair starts the meeting; the secretary notes the time
2. **Attendance — establish a quorum**
   more than half of voting members present
3. **Approval of minutes**
   from the last meeting — before any other action
4. **Announcements**
   updates, events, recognition
5. **Committee & standing reports**
   special officers, committees, invited guests
6. **Old business**
   items carried over from a previous meeting
7. **New business — motions & voting**
   where most of the real work happens
8. **Open forum**
   candid check-in; suggest items for next time
9. **Adjournment**
   a motion to adjourn, a second, and the meeting closes

SECTION BY SECTION

Walking Through the Meeting

Call to order & quorum. The chair officially starts the meeting and the secretary verifies that more than half of the voting members are present — a *quorum*. Without a quorum, you cannot vote. The secretary simply tells the chair, “Chair, we have a quorum,” or “we do not.”

NO QUORUM? YOU CAN STILL MEET

If you do not have a quorum, you cannot hold votes — but you can still gather to discuss, share resources, and move voting items to a later meeting. Many chairs simply reschedule. What you cannot do is vote.

KEY INSIGHT · QUORUM IS PROPORTION, NOT HEADCOUNT

A few examples: 5 members, 2 present = 40% — not a quorum, reschedule. 5 members, 3 present = 60% — you may vote. 6 members, 3 present = exactly 50%, which is *not* more than half, so not a quorum. 100 members, 51 present — quorum.

Approval of minutes. Distribute the previous meeting's minutes ahead of time (more efficient) or review them in the meeting. Minutes must be approved before any other action: the chair asks for corrections, then a member moves to approve, another seconds, and the minutes are approved.

Announcements & reports. Announcements are a good moment to share updates from other councils and recognition — a unit six months without a pressure injury, a certification earned. Reports come from special officers (a member tracking the unit's quality indicators) or committees working a defined project; as chair you can invite anyone to report — pharmacy, quality, an educator.

Old & new business. Old business is items carried over — a shelved vote, or an ongoing effort like event planning. New business is new proposals not previously discussed, and where most of the real work — the motions and voting — happens.

Open forum & adjournment. The open forum is a free-flowing check-in; if you are recording a virtual meeting, stop the recording here so people can speak freely (members still need to be recognized by the chair). Then the chair asks for a motion to adjourn, a member moves, another seconds, and the meeting is closed.

THE MOST IMPORTANT TOOL

Motions

A motion is a formal proposal that the group take a position or action. It is how anything gets decided. The mechanics are simple and always the same:

1. **Obtain the floor.** Wait for the chair to recognize you.
2. **Make the motion.** State it clearly and in the affirmative: "I move that we start rounding every 30 minutes instead of every hour." (Save the argument for discussion.) A presentation by a non-member counts as a motion too.
3. **Get a second.** Another member must second it to be discussed. Seconding does not mean you support it — only that you want it debated. No second, and the motion is lost.
4. **Debate.** Once seconded, the floor opens. The mover speaks first; one person speaks at a time; anyone may move to amend.
5. **Vote.** The chair restates the motion and calls the vote — "those opposed say no… those in favor say yes." Majority rules; the chair announces the result and the action to be taken.

> KEY INSIGHT · INFLUENCE IS NOT A VETO
>
> Here is where councils go wrong: a respected voice says "I don't like that," everyone goes quiet, and the idea dies. That is not how it works. Once a motion is on the floor, it goes to a vote no matter who dislikes it. Your job when you disagree is to *persuade* — like a legislator arguing a bill — not to silence the vote. Everyone gets to vote, and everyone lives with the result.

A note for organizational-level councils

At the larger councils, when a non-member presents a proposal, the discussion and vote happen after the presenter has left the room. Meetings are open to anyone to *attend*, but voting is members-only, so no one's vote is swayed by who is watching. Decisions can also be approved with conditions — "we approve 30-minute rounding *provided* two additional staff are hired" — which is common and appropriate at this level.

PRACTICE IT

The single best way to learn this is to run it. Use the Council Meeting Script to assign roles — chair, secretary, three members, a nurse-manager liaison, an infection-control nurse — and read through a full meeting out loud. After one pass, the flow becomes second nature.

Pairs with: the **Council Meeting Script** and the **Meeting Agenda** & **Minutes** templates (and their samples).

CHAPTER FIVE

5

Reading Quality Reports

How to interpret the data that will be put in front of you — and turn it into a question worth answering.

IN THIS CHAPTER

- Recognize the common types of quality reports.
- Interpret quality data using structure, process, and outcome.
- Tell the difference between an occurrence and a ratio.

BUILDING A UNIT PRACTICE COUNCIL · CLINICAL EXCELLENCE COACHING

As a council member, people will come at you with data — graphs, rates, dashboards, outcome evidence — from many directions: nurses, physicians, pharmacists, researchers, vendors. You have to be able to read it. And when you run your own projects, you will need data to justify and disseminate them. This chapter builds that literacy.

THE BIG PICTURE

Executive Quality Scorecards

Most health systems roll many measures into an aggregate scorecard that benchmarks facilities against one another, often on a 1–5 scale, updated quarterly. Understanding what feeds it explains a lot of the pressure you feel — why a particular audit suddenly matters, why leadership is focused on length of stay. Common domains include:

- **Acute-care mortality** — are patients surviving at or better than the expected rate?
- **Avoidable adverse events** — serious safety events that should not happen.
- **Length of stay** — throughput and how it ties to reimbursement.
- **Patient experience** — how patients perceive their care, teaching, and discharge.
- **Employee satisfaction** — closely tied to performance and retention.
- **Care transitions, access, and capacity** — right care at the right time; bed and resource management.

> **READ THIS AS CONTEXT, NOT PRESSURE**
>
> When you understand what the organization values and measures, the “why” behind day-to-day asks becomes clear. A scorecard is not a bad thing — it is a way to see how you are performing and where to focus.

A FRAMEWORK FOR DATA

Structure, Process & Outcomes

A clean way to think about any measure is the Donabedian model — structure, process, and outcomes. It is widely used to understand change in an organization, and it keeps you from chasing symptoms.

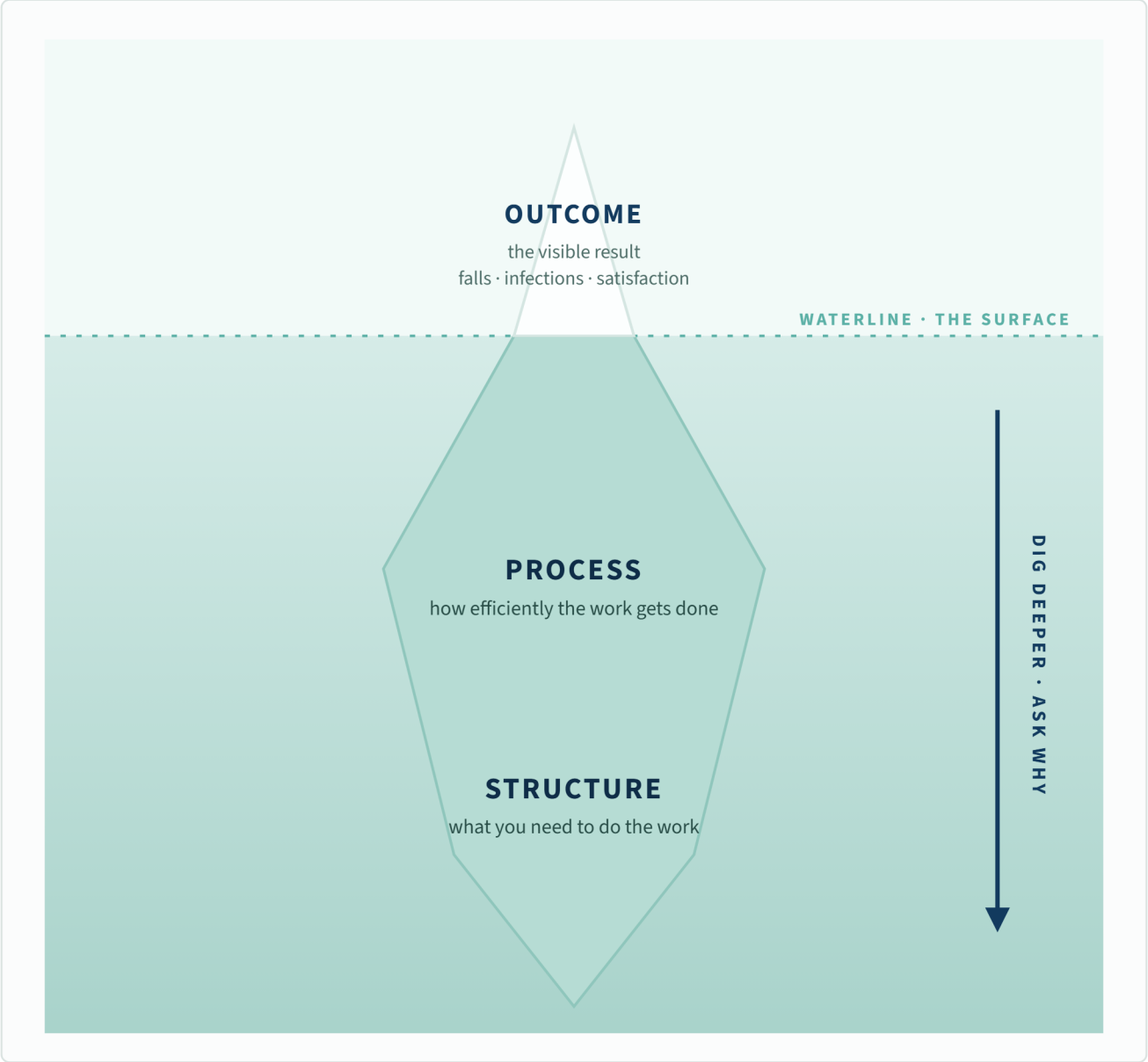


Figure 6. Structure, process, outcome — the iceberg. The outcome is only the tip above the waterline; most of the answer lives in the process and structure beneath it. Don't just react to the falls — ask why patients are falling.

Structure is everything you need in place: the right staff and skill mix, turnover, education and competency, even bed availability. **Process** measures efficiency given that structure — timing, throughput, and how smoothly the work flows. **Outcomes** are the visible result — falls, infections, satisfaction — and the place we tend to fixate.

> **KEY INSIGHT · AN OUTCOME IS A SYMPTOM OF SOMETHING DEEPER**
>
> Train your mind not to react to the outcome alone. If falls are rising, dig: what are our fall processes — and are we actually following them? If yes, look at structure — do we have the staffing, competency, and education to execute? Most of the time the answer lives in process or structure, not in the outcome itself.

MAKE IT CONCRETE

The Dollars: Cost Analysis

Quality events carry real financial cost — and a hospital-acquired event is often not reimbursed, so the organization absorbs it. You do not need official figures: take a credible average cost per event (a quick literature search will do) and multiply by the number of occurrences. A run chart of those costs over time is a powerful way to show the impact of a problem — or the savings from a successful project. The same logic works for staffing: an average hourly rate × 1.5 for overtime × the hours gives a monthly overtime-cost chart. Any event becomes a cost analysis with two ingredients: a dollar amount and a count.

THE DISTINCTION THAT MATTERS MOST

Occurrence vs. Ratio

This is the concept that trips people up most, and getting it right will change how you read every chart. An **occurrence** is simply an event — one fall, one infection. A **ratio** (a rate, percentage, or percentile) puts that event in the context of volume. That little word “per” — per 1,000 patient days, per 1,000 line days — is the giveaway that you are looking at a volume-adjusted ratio.



Figure 7. Occurrence versus ratio. The raw count is identical — "still 2 falls" — but because the clinic handled three times the volume, the rate dropped from 4.0 to about 1.3 per 1,000. That is a real success the occurrence alone would hide.

KEY INSIGHT · WHY THIS MATTERS FOR YOUR PROJECTS

A dashboard can show "10 total falls" next to a rate of "17.57." They are not contradictory: 10 is the count; 17.57 is per 1,000 patient days. The volume changes month to month, which is exactly why the rate moves even when the count does not. When a project's impact depends on a changing volume, lean on ratios.

When your organization has a data dashboard, you can drill into a service line or a single unit and see measures like hourly rounding, call-light response, medication-administration compliance, infection occurrences and rates, fall counts and fall rates, and workforce measures such as call-ins and nursing hours per patient day. Note which columns are occurrences (totals) and which are ratios (rates) — and remember that the underlying volume figure is what generates the rates.

CHAPTER SIX

6

Using Best Practice to Improve Quality

Turning a data signal into an evidence-based project — and a project into shared practice.

IN THIS CHAPTER

- Read a chart and define the real problem.
- Run an evidence-based pilot and read its early results.
- Disseminate a proven change through shared governance.

BUILDING A UNIT PRACTICE COUNCIL · CLINICAL EXCELLENCE COACHING

This final chapter ties everything together: how a council takes a data signal, runs an evidence-based project, and — if it works — shares it across the organization through the practice-change structure from Chapter 2. We will follow one realistic scenario from start to finish.

THE SCENARIO

For the past few months your unit has had a steady increase in central-line–associated bloodstream infections (CLABSIs). Your supervisor hands you a quality report and asks how the council will address it. You are the chair. Here is the path.

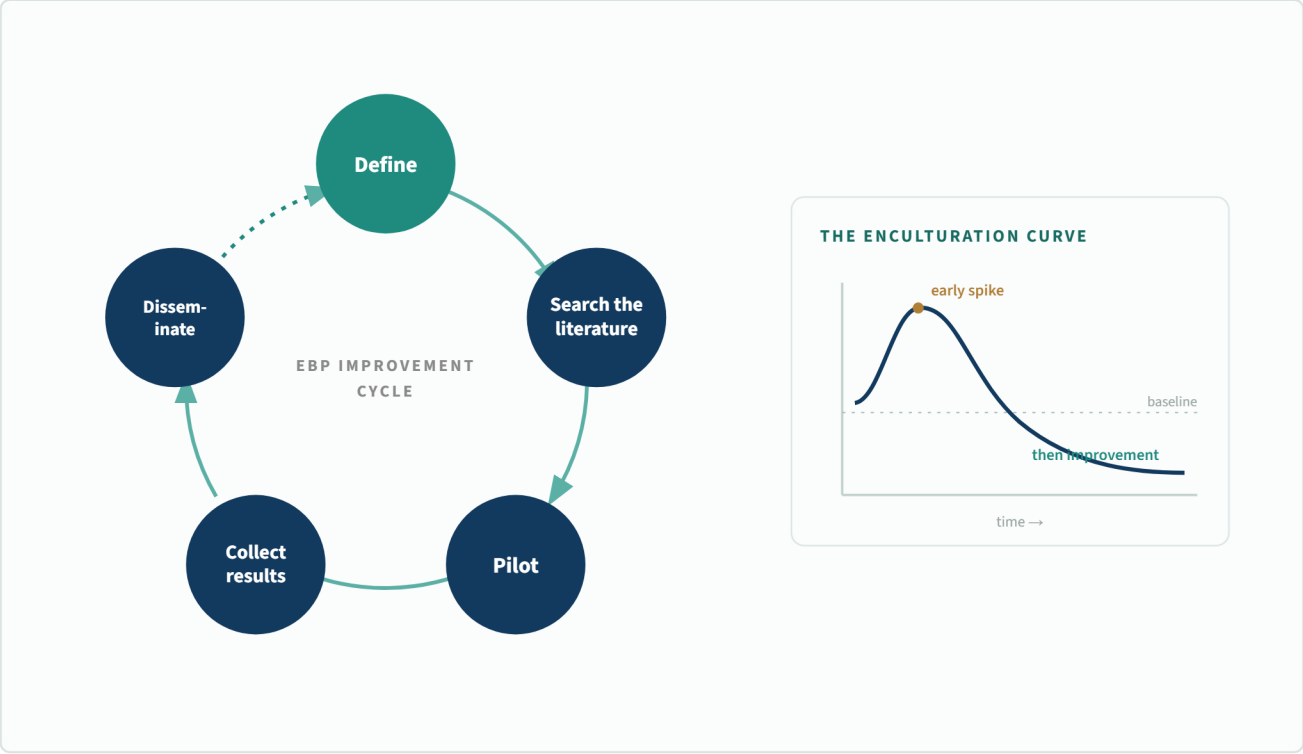


Figure 8. The evidence-based improvement cycle: Define → Search the literature → Pilot → Collect results → Disseminate, which loops back to the next question. The inset shows the enculturation curve — expect an early spike before a new practice settles into the unit's DNA.

STEP 1

Define the Problem — Read the Chart

When you read a quality chart, ask three questions in order:

1. **What are the unit's scores?** Identify your own measure. Here the chart is a CLABSI rate (a ratio — note the "per"), and it has been climbing month over month.
2. **Is there a benchmark?** A benchmark is the average of a comparison group. You always want to be on the favorable side — for safety events, below the line; for satisfaction, above it.
3. **What is the trend?** You don't even need a benchmark here — the line is trending up. Rule of thumb: if a measure trends the wrong way for two consecutive periods, act; don't wait for it to get worse.

At the March council meeting you present the chart, the council agrees it must be addressed, and they vote to conduct an evidence-based project.

STEP 2

Search the Literature

The council conducts a literature review of best practices to reduce CLABSIs. At the next meeting a member presents the findings, the council adopts the recommended changes — through the full motion process — and decides to run a pilot study with the supervisor's approval. Members are assigned tasks: some collect data, some educate the rest of the staff. (Even with a small council, you can assign non-members as shift champions to carry the work.)

STEP 3

Collect Results

A few months into the pilot, the supervisor shares the new CLABSI rates. The trend is now heading down.

KEY INSIGHT · EXPECT AN EARLY SPIKE — DON'T PANIC

It is very common to see an initial bump when a project starts. That is the *enculturation phase* — the period before a new practice becomes a habit. You are changing how people work, and that takes time to settle into the DNA of the unit. Give a project at least two to three months before judging the trend. By the end of this pilot, the rate has dropped to zero. The project worked.

STEP 4

Disseminate Through Shared Governance

Now you have something worth sharing house-wide. Because this affects nursing practice, you re-enter the practice-change flow from Chapter 2 (Figure 4) — your project has *become* a proposal. Contact the CPC leadership group with your pre-data, your evidence-based interventions, and your positive post-outcomes; they route any needed consults; then you present to the CPC → NOC → NEC. With approval at each level, your unit project becomes organization-wide practice — and the educators and other councils help you implement it everywhere.

> *"I led an evidence-based project that reduced our CLABSI rate from 3.0 per 1,000 line days to zero — I ran the literature review, collaborated across disciplines, and worked at the organizational level on a practice that reached beyond my own unit."*
>
> WHAT THIS DOES FOR YOU, PROFESSIONALLY

That is concrete evidence for clinical-ladder advancement and professional growth. You are no longer stuck inside your unit — and how active you become is entirely up to you.

THE HARD PART

Bringing Others Along

Most people reading this guide are already engaged. The harder, more important work is reaching the people who are not in the room. If you are a manager: how do you help your staff understand why this matters? If you are a chair: how do you recruit members who see the value, so your council is healthy and durable?

> ☆ **KEY INSIGHT · CELEBRATE EVERY VICTORY, HOWEVER SMALL**
>
> Nursing is relentlessly objective-driven — finish one thing, move to the next fire. How often do we stop and say “good job”? That small recognition can be the battery that keeps someone running another six months. If your falls rate dropped from 5.4 to 4.4, celebrate it. If attendance went up, celebrate it. If a staff member earned a certification, celebrate it. A satisfying environment is what sustains shared governance.

You now have the concepts, the structure, the step-by-step, the meeting skills, the data literacy, and the improvement model. Pair this guide with the companion Resource Templates, start your council, and build a culture where every professional has a voice — and uses it.

REFERENCE MATERIAL

A–C

Appendices

A glossary of key terms, the companion resource templates, and the evidence base behind the model.

BUILDING A UNIT PRACTICE COUNCIL · CLINICAL EXCELLENCE COACHING

APPENDIX A

Glossary of Key Terms

Shared governance

An organizational model that creates shared decision-making among professionals, placing control over practice, quality, and competence at the point of care.

Partnership, Equity, Accountability, Ownership

The four core principles. Equity means every role is essential and every voice is heard — not that all roles are equal in scope.

Unit Practice Council (UPC)

The foundational council for a single unit, clinic, or work setting; led by a chair who represents the area in the broader structure.

Clinical Practice Council (CPC)

The council made up of all unit chairs; the first stop for any proposal affecting nursing practice.

Nursing Operations Council (NOC)

Reviews administrative practice and determines the scope and resourcing of proposals.

Nurse Executive Council (NEC)

The final approving body for new or revised nursing practice.

Quorum

The minimum attendance required to hold a vote — at least 51% of voting members present.

Motion

A formal proposal that the group take an action; requires a second to be discussed and a majority to pass.

Robert's Rules of Order

The standard handbook of parliamentary procedure used to run orderly meetings.

Protected time

Dedicated, approved time for staff to participate in shared governance and professional-development activities.

Practice change

Any change that impacts nursing practice; must travel through the approval path unless designated emergent or unit-specific.

Occurrence vs. ratio

An occurrence is a raw count of an event; a ratio (rate/percentage) adjusts that count for volume — e.g., falls per 1,000 patient days.

Structure, Process, Outcomes (Donabedian model)

A framework for understanding quality: what you need (structure), how efficiently you do it (process), and the result (outcome).

Benchmark

The average performance of a comparison group, used as a reference line for your own scores.

Enculturation phase

The early period of a project before a new practice becomes habit, often marked by a temporary dip in results.

APPENDIX B

The Companion Resource Templates

Each chapter pairs with ready-to-use documents in the Resource Templates folder of this package:

TEMPLATE	USE IT FOR	PAIRS WITH
Shared Governance Bylaws (Template)	The governing rules of your whole structure	Ch. 1–2
Nursing Practice Change SOP (Template)	The step-by-step approval procedure for any practice change	Ch. 2 & 6
Unit Council Chair To-Do List	A one-page worksheet to stand up a UPC	Ch. 3
Council Meeting Script	A word-for-word role-play to practice running a meeting	Ch. 4
Meeting Agenda (Template + Sample)	Building and filling in a meeting agenda	Ch. 3–4
Meeting Minutes (Template + Sample)	Documenting and submitting your minutes	Ch. 3–4

APPENDIX C

Evidence Base

Shared governance is well supported in the professional literature. The following selected references underpin the model described in this guide:

Ballard, N. (2010). Factors Associated with Success and Breakdown of Shared Governance. *Journal of Nursing Administration,* 40, 411–416.

Joseph, M. L., & Bogue, R. J. (2016). A theory-based approach to nursing shared governance. *Nursing Outlook,* 64(4), 339–351.

Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Del Guidice, M., & Aiken, L. H. (2016). Nurse Engagement in Shared Governance and Patient and Nurse Outcomes. *Journal of Nursing Administration,* 46(11), 605–612.

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Porter-O'Grady, T. (1992). *Shared Governance Implementation Manual.* Mosby.

Donabedian, A. (1988). The quality of care: How can it be assessed? *JAMA,* 260(12), 1743–1748.

Robert, H. M., et al. *Robert's Rules of Order, Newly Revised* (current edition).

☑ **Clinical Excellence Coaching** — helping nursing teams build cultures of clinical excellence. End of handbook.