Nurses' Perception toward Shared Governance in Clinical Practice at General Hospitals in Jeddah City

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ABSTRACT

***Context*:** Shared governance is an evidence-based approach. The characteristics of the work environment of shared governance are autonomous and empowering, where nurses providing direct care have a voice in influencing areas that have been controlled previously by the managers. Shared governance structure aims to improve communication, increases personal growth and nurse satisfaction, and improves patient outcomes.

Aim: To assess nurses' perception toward shared governance at general hospitals in Jeddah city.

Methods: A quantitative descriptive cross-sectional study design was conducted. The study was carried out at three general ministry of health hospitals in Jeddah city. The study sample involved 321 registered nurses using stratified random sampling. The data were collected by using one tool. The index of the Professional Nursing Governance (IPNG) tool was used to measure the nurses' perceptions of governance.

Results: The overall mean score of nurses' perceptions toward shared governance was 118.70±40.85, which scored within the shared governance range. The highest mean score was Resources subscale with 24.74±7.75, while the Goals subscale had the lowest mean score (12.54±5.12). Statically significant differences were found in nurses' perceptions toward shared governance according to their educational degree, current position title, and the working unit at p-value ≤ 0.05.

Conclusion: This study has shown that nurses perceived the governance in the first level of shared governance, which indicates that the decision is made primarily by management with some staff input. Therefore, continuous education and training are needed for nurses to increase their knowledge about shared governance, conflict management, and decision-making skills.

Keywords: Shared governance, nurses' perception, clinical practice.

1. Introduction

As the largest healthcare professionals, nurses play a crucial role in today's healthcare system for improving patient outcomes, handling culture change, and transparency *(Gerard et al., 2016).* Developing and sustaining high-quality systems in today's complex healthcare environment presents tremendous challenges for accountable nurse leaders *(Dearmon et al., 2015).* In response, nurse leaders understand the significance of implementing and encouraging the frontline nurses to participate in shared decision-making and empower the bedside nurses to practice their profession with no restraints and full autonomy *(Cohen, 2015).*

The American Nursing Credentialing Center (ANCC) awards the Magnet designation to hospitals that demonstrate exemplary nursing practice and foster an environment that inspires nursing autonomy and control over nursing practice *(Abou Hashish & Fargally, 2018).* Shared governance is a vital element of the American Nurses Credentialing Center (ANCC) Magnet Recognition Program, which falls under the structural empowerment component *(ANCC, 2008).*

Generally, governance in healthcare organizations varies between traditional, shared, and self-governance. In traditional governance, the administration is the dominant group that makes the decisions, while in shared governance, the decision making is shared with the nurses. Lastly, the decision making in self-governance is made by only the staff nurses in the organization *(Lamoureux et al., 2014).*

The introduction of shared governance was first established in the late 1970s based on social and behavioral management theories, yet this concept started to emerge in the nursing arena in the 1980s by shared governance pioneer Tim Porter-O'Grady *(Wilson, 2013). Porter-O'Grady & Finnegan (1984)* proposed a flat nursing structure where the frontline nurses take place in leadership positions on hospital committees.

Tim Porter-O'Grady defines shared governance as "a structural model through which nurses can express and manage their practice with a higher level of professional autonomy" *(Porter-O'Grady, 2003).* Another definition of shared governance by *Swihart (2006)* was "a management structure for shared decision making based on the principles of partnership, equity, accountability, and ownership."

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Furthermore, *Hess (2017)* defines shared governance as "a nursing management innovation that legitimizes nurse decision-making control over their professional practice while extending their influence on administrative areas previously controlled by management." Also, many terms have been used to describe shared governance, such as "collaborative governance," " shared decision-making," "shared leadership," and "clinical governance" *(Jordan, 2019).*

Shared governance is an evidence-based approach that empowers nursing staff closest to the bedside within an organization to claim ownership of their nursing care practice. In other words, the shared governance structure is a decentralized and collaborative structure characterized by balancing the power between nursing administration and direct care nurses on issues related to their professional practices *(Vigodsky, 2018).* Many organizations attempt to measure and evaluate their shared governance's implementation process by using the most reliable and valid tool among nurses, which is the Index of Professional Nursing Governance (IPNG) *(Keane, 2017).*

Nursing administrators play an essential role in facilitating the development, implementation, and sustainability of shared governance structures in their organizations by giving authority to nursing staff to make decisions and require staff to accept responsibility and accountability for outcomes. The development of empowerment is the key element to begin and maintain the process of shared governance. The process begins with administrators making most of the decisions while they keep mentoring staff nurses. By the time, nurses gain confidence and competence, and the administrators make less of the staff nurse appropriate decisions. In the end, the staff nurses become self-directed and have authority to make decisions that are specific to the various nursing councils, as nurses become empowered, the shared governance process continues *(Meyers & Costanzo, 2015).*

2. Significance of The Study

Lack of knowledge and awareness of shared governance in direct care staff nurses in the ministry of general health hospitals provide the need to assess nursing perception regarding shared governance. Also, limited studies were conducted in Saudi Arabia to measure the nurses' perception of shared governance. Thus, this study will provide the baseline data to assist the nursing leaders to enhance the degree of nursing professional shared governance in the future. Furthermore, this study will provide the nursing leaders with the opportunity to understand the current situation of the governance in the ministry of health hospitals to promote the nursing practice toward nursing excellence.

3. Aim of The Study

To assess nurses' perception toward shared governance at general hospitals in Jeddah city.

3.1. Research question

- What is the nurses' perception of shared governance in general hospitals in Jeddah?

4. Subjects and Methods

4.1. Research design

Research design is defined as "the plan for answering the research question, including strategies for maintaining the study's integrity" *(Polit & Beck, 2017).* A quantitative descriptive cross-sectional research design was conducted. Cross-sectional designs are used by empirical researchers at one point in time to describe a population of interest. In cross-sectional designs, researchers record information but do not manipulate variables *(Allen, 2017).* The researcher selected this design following the study aim, which was to assess the nurses' perception toward shared governance in general hospitals in Jeddah.

4.2. Research setting

The researcher selected three general ministry of health hospitals in Jeddah city to conduct the study because these hospitals include many nurses. Hence, they could represent all the nurses working in the general ministry of health hospitals in Jeddah city. All three settings included most of the medical specialties and were accredited by the Saudi Central Board for Accreditation of Healthcare Institutions.

4.3. Subjects

The study sample involved registered nurses working at the setting mentioned above, according to the following criteria. The inclusion criteria included all nurses with at least one year of experience working in general wards, critical care wards, and nursing administration, including nursing quality, and nursing education departments. Additionally, all nursing managerial levels were included. The exclusion criteria of the sample include nurses working in ambulatory settings and nursing aids.

The researcher used stratified random sampling to enhance the representativeness of the sample. The sample was divided into three homogenous strata in each hospital based on the working area. These strata include registered nurses working in nursing administration departments, nurses working in general departments, and nurses working in critical care departments.

The total number of nurses in the targeted hospitals was 1915. The Raosoft program at confidence level (95%) was used with a margin of error (5%), the presentative sample size was 321 nurses. The sample size for each hospital and the stratum within each hospital was calculated based on the following equation:

Sample size per stratum = (sample size/population size) x stratum size.

4.4. Tools of data collection

Data collected using one questionnaire.

4.4.1. Index of Professional Nursing Governance (IPNG)

It was developed by *Dr. Robert Hess in (1994)* to measure the nurses' perceptions of governance. The researcher utilized the shorter IPNG version 3.0, which was available in June 2017. The Arabic version of the tool was adopted by *Abou Hashish & Fargally (2018)*, with Cronbach's alpha α = 0.970. For the current study instrument, Cronbach's alpha was 0.96, which indicates the tool's high reliability. The study questionnaire was divided into two sections Section A and Section B, which explained below.

4.4.1.1. Section A (demographic data)

This section was developed by the researcher to reflect the study population. This section consists of the participants' demographic data and clinical experience, including gender, nationality, age, educational degree, years of experience in nursing, current position title, working unit, and the number of years worked in this organization.

4.4.1.2. Section B (IPNG)

Section B, the (IPNG) 3.0 questionnaire consists of 50 items (table 1), including six subscales representing the dimensions of professional governance. The subscales are *Control Over Personnel*, which refer to who controls personnel and related structures—for instance, they conduct disciplinary action of nursing personnel and procedures for hiring and transferring nursing personnel. The second subscale is *Access to Information*, which refers to who has access to information relevant to governance activities, including who has access to the unit and nursing departmental goals and objectives, organization's strategic plans, and the results of patient satisfaction surveys.

The third subscale *is Influence Over Resources*, which measures who influences resources that support professional practice, such as who make daily patient care assignments for nursing personnel and regulate the flow of patient admissions, transfers, and discharges. The fourth subscale is *Participation in Committee Structures*, which measures nurses' engagement in and creating committee structures related to governance activities such as participation in unit committees for administrative matters and participation in hospital administration committees for employee benefits.

The fifth subscale is *Control Over Practice*, which refers to nurses' control over their professional practice, including determining what nurses can do at the bedside and determining nursing care delivery models. The last subscale is *Goal Setting and Conflict Resolution* subscale, which includes who sets goals and negotiating conflict among professional nurses and other healthcare services at various organizational levels.

Scoring system

Participants respond to indicate which group controls or influence over each item using a 5-point Likert scale, which ranged from 1 to 5, where 1= "nursing management/ administration only", 2 = "primarily nursing management/administration with some staff nurse input", 3= "equally shared by staff nurses and nursing management/ administration," 4 = "primarily staff nurses with some nursing management/administration input", and 5 = "staff nurses only". Then, the subtotal and total scores were calculated to determine how the participants perceived the organization's governance.

The lowest score of IPNG 3.0 is 50, and the highest score is 250. According to *Hess (2017),* the IPNG scoring guideline and benchmark (Table 2): Total scores of 50 to 100 represent traditional governance, where the decision is made by management/administration input only. Scores between 101 and 200 represent shared governance (a score of 101 to 149 indicates that the decision is made primarily by management/administration with some staff input, a score of 150 indicates that the decision is equally shared by staff and management/administration, and a score of 151 to 200 indicates that the decision is made primarily by staff with some management/administration input). The total score of 201 to 250 represents self-governance, where the decision is made by staff input only.

Table (1): (IPNG 3.0) Subscales and Items related to each Subscale.

Subscales	Number of Items	Question Numbers
Control Over Personnel	12	5, 11, 12, 15, 16, 17, 18, 19, 20, 21, 25, 26
Access to Information	9	37, 38, 39, 40, 41, 42, 43, 44, 45
Influence Over Resources	9	9, 10, 13, 14, 22, 23, 24, 27, 28
Participation in Committee Structures	8	29, 30, 31, 32, 33, 34, 35, 36
Control Over Practice	7	1, 2, 3, 4, 6, 7, 8
Goal Setting & Conflict Resolution	5	46, 47, 48, 49, 50
Total	**50**	**50**

Table (2): IPNG 3.0 Scoring Guideline.

Classification	Overall IPNG score
Traditional Governance	**50-100**
Shared Governance	**101-200**
Self-Governance	**201-250**

4.5. Procedures

Data collection took about six weeks from July to August 2019 for all the three hospitals with two weeks assigned for each hospital. Questionnaires were distributed to the selected nurses within the morning shift, and the remaining nurses within the afternoon and night shift. The questionnaire was submitted to the head nurses of each department. The average number of seven questionnaires was completed daily by the nurses. Each questionnaire required 25-30 minutes to be answered, so the researcher distributed the questionnaires for all the departments in the morning and received it back by the lunch break time while

some busy departments such as critical care departments completed for the next week.

Ethical approval was obtained from the Ethical Committee of Nursing College within King Abdulaziz University (KAU). Also, official approval from the general directorate of health affairs-Jeddah to implement the study within three general ministry of health hospitals at Jeddah city. Finally, the permission letter was received from Dr. Robert Hess to use the (IPNG) Questionnaire.

Voluntary participation was maintained by explaining to the participant the right to enroll and withdraw from the study. The human right to anonymity and confidentiality were protected as the nurses were not required to reveal their names. The researcher declared to the participant that there is no benefits nor risk from participation to the study. The privacy of the data collected was granted.

4.*6. Data analysis*

Data was entered into the computer and coded using Statistical Package for Social Sciences (SPSS) program version 22. The statistical analysis of the study's data follows the guidelines provided by Dr. Hess: The Measurement of Professional Governance Scoring Guidelines and Benchmarks.

Descriptive statistics were used to describe and represent the demographic data in frequencies and percentages. Descriptive statistics (means and standard deviations) were calculated for the overall IPNG and each subscale.

The inferential statistic was used to assess the significant differences between the means of governance scores according to their educational degree, current position title, and working unit. The non-parametric Kruskal-Wallis test was used to test whether there is a significant difference between means of governance scores of more than two independent samples that do not follow a normal distribution. The significance level was set at p-≤0.05.

5. Results

Table 3 illustrates that 95.3%of the studied subjects were females, and 62% were non-Saudi. Considering the age of nurses, 45.8% of nurses aged less than 30 years old, and 70.7% of nurses had a baccalaureate degree in nursing. For their years of experience in nursing, 41.1% of nurses had 5 to 10 years of experience. Regarding the current position title, 90.7% of the study sample were staff nurses, 47%, and 29.3% of the study sample worked in general inpatient and critical care departments. In terms of the number of years worked in this organization, 48.6% had from 1-<5 years.

Table 4 presents the distribution of mean scores and standard deviations of overall IPNG score and subscales. The results show that the overall mean score of the nurses' perception toward shared governance in all three general hospitals was118.70±40.85, which falls within the shared governance range. Similarly, all IPNG subscales, except (Personnel), were within the shared governance range. The personnel subscale mean score was just below the limit of the shared governance range 24.18±12.41. The highest mean score was influenced over resources subscale with 24.74, while the Goals subscale had the lowest mean score with12.54±5.12.

As shown in Table 5, the nurses' educational degree showed significant differences in perception of shared governance on all subscales and overall governance except for goal setting and conflict resolution subscale. Nurses reported the highest overall mean score with a diploma in nursing, 128.03±41.14, with *p*-value 0.001. Also, they reported the highest mean scores for all subscales. However, the lowest overall mean score and the lowest mean scores in all the subscales were reported by nurses with a postgraduate degree in nursing.

Table 6 presents that nurses' current position title had significant differences in control over personnel, participation in committee structures subscales, and overall governance. Staff nurses reported the highest overall mean score of 120.44 ± 41.09 with *p*-value 038 and all the six subscales.

Table 7 shows that according to the unit where the participant is currently working, there was statistically significantly different in control over personnel, access to information, participation in committee structure subscales and overall perception of shared governance. Besides, nurses working in the emergency unit reported the highest overall mean score of 127.88±39.84 with *p*-value 0.023 and in all subscales except for influence over resources subscale. The resources subscale scored the highest mean score of 25.18 by nurses who are working in critical care departments.

Table (3): Frequency and percentage distribution of the nurses' demographic characteristics among three MOH hospitals at Jeddah city (n=321).

Demographic characteristics	Frequency	%
Gender		
Male	15	4.7
Female	306	95.3
Nationality		
Saudi	122	38.0
Non-Saudi	199	62.0
Age		
<30	147	45.8
30-40	125	38.9
>40	49	15.3
Educational degree		
Nursing Diploma	83	25.9
Baccalaureate Degree in Nursing	227	70.7
Postgraduate Studies in Nursing	11	3.4
Years of experience in nursing		
1-<5	100	31.2
5-10	132	41.1
>10	89	27.7
Current position title		
Staff nurse	291	90.7
Managerial Positions	16	5.0
Others	14	4.4
Working unit		
General inpatient departments	151	47.0
Critical Care departments (ICU- PICU-NICU)	94	29.3
Emergency	50	15.6
Nursing office (Nursing quality, Nursing education, nursing administration)	26	8.1
Number of years working in this organization		
1-<5	156	48.6
5-10	106	33.0
>10	59	18.4

Table (4): Mean and standard deviation of nurses' perceptions toward shared governance (n= 321).

Subscales	Mean±SD	Shared Governance Range
Control over personnel	24.18±12.41	25-48
Access to information	21.51±8.34*	19-36
Influence over resources	24.74±7.57*	19-36
Participation in committee structures	17.02±8.27*	17-32
Control over practice	18.09±5.93*	15-28
Goals setting and conflict resolution	12.54±5.12*	10-20
Overall IPNG score	118.70±40.85*	101-200

**within Shared Governance Range.*

Table (5): Means and Standard deviations of nurses' perception toward shared governance according to their educational degree.

Subscales	Nursing Diploma	Baccalaureate Degree in Nursing	Postgraduate Studies in Nursing	Df=2	
	M±SD	M±SD	M±SD	Chi-Square	*p*-value
Control over personnel	27.39±13.19	24.30±12.10	15.00±5.17	11.275	0.004
Access to information	23.08±8.00	21.23±8.43	15.54±5.76	9.881	0.007
Influence over resources	26.26±7.50	24.46±7.41	19.00±8.44	9.272	0.010
Participation in committee structures	18.66±8.25	16.75±8.28	10.18±2.75	12.119	0.002
Control over practice	19.46±5.69	17.82±5.94	13.18±4.26	13.068	0.001
Goals setting and conflict resolution	13.15±5.08	12.40±5.17	10.90±4.01	2.955	0.228
Overall IPNG Score	128.03±41.14	116.98±40.37	83.81±23.76	13.157	0.001

Table (6): Means and standard deviations of nurses' perception toward shared governance according to their current position title.

Subscales	Staff Nurse	Managerial Positions	Others		Df=2	
	M± SD	M± SD	M	SD	Chi-Square	*p*-value
Control over personnel	25.47±12.32	20.93±13.86	14.92±4.93		14.610	0.001
Access to information	21.77±8.43	19.81±8.45	18.07±5.13		3.682	0.159
Influence over resources	24.78±7.46	24.00±8.97	24.78±8.65		.336	0.846
Participation in committee structures	17.50±8.31	13.50±8.14	11.00±2.85		10.258	0.006
Control over practice	18.26±5.96	17.75±5.68	14.85±4.97		4.867	0.088
Goals setting and conflict resolution	12.64±5.12	11.37±5.76	11.85±4.46		1.290	0.525
Overall IPNG Score	120.44±41.09	107.37±43.57	95.50±20.60		6.544	0.038

Table (7): Means and standard deviations of nurses' perception toward shared governance according to their working unit.

Subscales	General inpatient departments	Critical Care departments (ICU-PICU-NICU).	Emergency	Nursing office		Df=3	
	M± SD	M± SD	M± SD	M	SD	Chi-Square	*p*-value
Control over personnel	25.73±13.14	23.95±12.02	27.64±11.69	16.76	6.26	14.509	0.002
Access to information	21.12±9.23	21.92±7.23	24.04±7.51	17.46	6.50	12.191	0.007
Influence over resources	24.61±8.38	25.18±6.56	24.88±6.58	23.65	8.00	.316	0.957
Participation in committee structures	17.54±8.87	16.72±8.03	18.76±7.53	11.73	3.98	12.211	0.007
Control over practice	18.20±6.13	18.08±5.63	19.12±6.10	15.50	4.89	7.292	0.063
Goals setting and conflict resolution	12.43±5.41	12.68±4.98	13.44±4.81	10.96	4.19	4.481	0.214
Overall IPNG Score	119.66±44.83	118.55±36.49	127.88±39.84	96.07	23.12	9.500	0.023

6. Discussion

Shared governance structure enables the frontline nurses to engage in a shared decision-making process *(Moreno et al., 2018).* A professional work environment that adopted shared governance may have a valuable strategy for organizations to boost positive nurse and patient outcomes (*Kutney-Lee et al., 2016).* This quantitative descriptive cross-sectional study aimed to assess nurses' perceptions of shared governance at general hospitals in Jeddah**.**

The result of this research reveals that nurses perceived the first level of shared governance at their organizations. Thus, this would indicate that the decisions are primarily made by management/administration with some staff input. What can be explained from this result is that nurses' involvement and participation in activities, which were similar to shared governance activities. Also, nurses were empowered to make decisions and to have control over their practice. This result was also reported *by Lamoureux et al. (2014); Al-Faouri et al. (2014); Wilson (2014); Vigodsky(2018) ; Abou Hashish and Fargally (2018),* who found that the nurses perceived their organizations as shared governance organizations.

Among the six subscales, the only subscale that was out of shared governance range was the control over personnel subscale, which included items regarding control over annual budget, nursing salaries and benefits, hiring and transferring, promoting, and disciplinary actions for nursing personnel (Appendix IA). Nurses in the study setting approved that they had no control over these areas, which was an expected result because those areas mostly controlled through the Ministry of Civil Service or Self-Operation Program, which had specific regulations for financial benefits and recruitment. This result was consistent to the results of *Mouro et al. (2013); Lamoureux et al. (2014); Dechairo-Marino et al. (2018); Weaver et al. (2018); Jordan, (2019),* who found that personnel subscale had the lowest scoring and failed to reach shared governance score .

Regarding the access to information subscale, nurses in the current study believed that they had access to the information related to governance activity as the nurses scored the highest on the following items: Physician/nurse satisfaction with their collaborative practice, nurses' satisfaction with their general practice and management's opinion of the quality of bedside nursing practice as well as the results of patient satisfaction surveys (Appendix IB). This result might be due to the availability of the information through the official MOH website or hospital monthly online journals. Also, it might be due to the use of the MOH e-mail to facilitate the communication of work-related information and to keep the employee updated with the latest information from the MOH and the other departments in the hospital such as human resources department and patient experience department.

This result was also reported by *Mouro et al. (2013),* who found that the information subscale was within the shared governance range for hospitals, which were in the journey to excellence, while *Siller et al. (2016)* reported that emergency nurses perceived that nursing administration was the only group who had access to the information related governance activities. Another contrary result was reported by *Meyers (2015),* who found that

nurses in the ambulatory setting perceived the information subscale as traditional governance, indicating nurses had no control and access to the governance information.

Furthermore, nurses also believed that they had shared the ability to influence resources that support their professional practice. This finding was evident because nurses could make daily patient care assignments and regulate the flow of patient admissions, transfers, and discharges (appendix IC). The possible explanation of this result is that nurses were trained since the orientation period to gain the required skills for managing their unit's workflow. Also, nurses can practice the role of the charge nurse in the morning, evening, and night shifts. This finding enhances their skills to deal with everyday tasks and assignments. Moreover, nurses also perceive that they have authority over the monitoring and obtaining supplies for nursing care; this can be explained by the informal and formal communication between nurses and the nursing administration. This result was in agreement with *Seada and Etway (2012); Al-Faouri et al. (2014); Mahmoud, (2016),* who found that the mean score of the resources subscale was within the shared governance range reflecting nurses' perceptions of influencing resources that support their professional practice.

Participation in committee structures is the fourth governance subscale, which determined who created and participated in committee structures related to governance activities. Nurses perceived their participation and involvement as they score high in items related to participation in interprofessional committees and nursing departmental committees for administrative matters (appendix ID). What could explain this is because nurses have membership in the committees for improvement of performance related to patient care with physicians, pharmacists, lab technicians, and other health care professionals. Also, nurses are involved in the quality improvement committee, and patient safety committee in their units as nurses play different roles as data collectors for some key performance indicators or patient safety officers—also, the involvement of nurses in preparations for hospital accreditation.

This result was consistent with *Keane (2017),* who found that nurses could participate in committee structure as the participation subscale mean score was in shared governance range. However, *Cohen (2015)* revealed that nurses reported a low mean score in this subscale, which indicated they could not participate in organizational decisions through engagement in the committee structure.

Likewise, nurses in this study perceived themselves to have control over their professional practice. More specifically, nurses reported high mean scores in items related to determining what nurses can do at the bedside, models of nursing care delivery, and selecting products used in nursing care (appendix IE). This finding might be due to a continuous nursing education program, in-service education. These strong continuous education programs provided by nursing education departments, empower nurses to have more authority over their practice.

In the same line, *Weaver et al. (2018)* reported that after implementing the new shared governance structure in 2017, nurses perceived that they have control and authority over their practice as well as *Abou Hashish and Fargally (2018),* who found that staff nurses had control over their professional practice as the practice subscale had the highest mean score. In contrast to this result, *Seada and Etway (2012)* revealed that staff nurses did not have professional control over their work environment.

Lastly, for goals setting and conflict resolution subscale, nurses believed to share some responsibility for resolutions the conflicts among professional nurses, also between professional nurses and other healthcare services providers, as well as the nursing management. This result probably due to the nurses' attendance to the orientation program and the education programs, which include conflict management strategies. Education allows nurses to handle and manage the conflict effectively. However, nurses score lower in items related to negotiating solutions to conflicts with physicians and the organization's administration (appendix IF). This result could be due to the feeling that nurses do not have control over physicians and the hospital's administration.

The same result was reported by *Keane (2017); Jordan (2019),* who both found that nurses could set goals and negotiate the conflict resolution at various organizational levels, while *Glasscock, (2012)* reported that nurses perceived the goal subscale as traditional which indicate that only nursing administration who had the ability in goal setting and conflict resolution.

In this research, educational degree, current position title, and the working unit found to have significant differences in nurses' perception of shared governance. Nurses with a postgraduate degree in nursing scored the lowest perception of overall shared governance, including all subscales except for goal subscales. As the nurses have a higher educational degree, they are more aware of the current organizational structure and the implementation of shared governance, which can be a lengthy process. This result might be affecting their perception about who make decisions in the organization and influence nursing practice. However, this result is contrary to the previous studies, which reported that there were no significant differences in nurses' perception to shared governance according to their educational degree *(Wilson,2014; Cohen,2015; Lamoureux et al., 2014; Al-Faouri et al., 2014; Dechairo-Marino et al., 2018).*

According to nurses' position title, it was found that staff nurses reported higher positive perception than those who work as educators, nursing quality coordinators and coordinators in nursing administration for overall shared governance, personnel and participation subscales. A possible explanation for this might be that nurses' participation in different hospital committees has resulted in more power and encouragement, emphasizing their ability to make decisions affecting nursing care. Also, staff nurses rotate in all three shifts, which makes them feel more control and have authority over their practice. This result also accords with previous studies, which found that the

position title resulted in a significant difference in shared governance perception. *Cohen (2015), Kamel, and Mohammed (2015)* found that clinical nurses reported significantly lower perception than nurse manager groups, which contradicts the current study findings.

Lastly, nurses working in emergency departments reported the highest positive perception in overall shared governance and personnel, information, and participation related matters. This result could be explained by the advanced clinical skill and empowerment of the emergency nurses, as most leaders tend to empower and support nurses, specifically those working in the emergency unit. The reason for this, nursing leaders engage emergency nurses in different committees in the hospitals such as quality improvement committees, preparation for the accreditations committee. Additionally, emergency nurses are empowered with information about their practice, goals for the unit, and hospital strategic plans. They also trained and experienced in making a critical decision related to their patients' lives.

This result was consistent with the previous studies, which reported that the difference in nurses' perception, according to the working unit, was statically significant. In the same line, *Kamel and Mohammed (2015)* found that nurses working in critical care units and operating rooms in Menoufia and Benha university hospitals reported a significantly higher perception of shared governance than others. Also, *Al-Faouri et al. (2014)* agreed that the effect of participants' working units has a statistically significant difference in nurses' perception of shared governance, like the nurses who worked in critical care units and operating rooms perceived significantly higher than other groups. Moreover, statistically significant differences were reported by *Lamoureux et al. (2014)*; *Wilson (2013)*, who found that nurses working in intensive and intermediate care units reported higher perception than others. On the other hand, a different result was reported by *Cohen (2015); Wilson (2014)*, who found no significant differences in nurses' perception of their working unit.

7. Conclusion

The study results revealed that nurses perceived the governance as shared at their organizations, which indicates that staff nurses are engaged in decision-making to influence their professional practice. Nurses believed that they have control over all the governance dimensions except for the "control over personnel" dimension, which scored traditional governance. There were significant differences in nurses' perceptions toward shared governance in clinical practice according to their educational degree, current position title, and working unit.

8. Recommendations

Nursing administrators can use the IPNG results of this study to address areas for improvement needed. It will allow nursing administrators to focus their efforts on increasing the scores to reach shared governance in the future.

- Hold shared governance council day and involve all members from the different councils to discuss and share their opinions and participate in decision making related to their practice. Online attendance is one way to ensure maximum participation.
- Eliminate all the obstacles that prevent frontline nurses' engagement to councils and committees' meetings by arranging appropriate scheduling and providing sufficient time to participate in council activities and decision-making.
- Develop an education program and workshops for nurses to increase their knowledge about shared governance, conflict management, and decision-making skills. It can be conducted by a shared governance council team or by the nursing education department.
- Longitudinal research is recommended after proper implementation of shared governance structure in the study settings to remeasure shared governance's perception among nurses.
- Further research is suggested to compare the ministry of general health hospitals and other specialized hospitals in the same region and different regions.
- Conduct future research to explore the association between participation in shared governance processes and positive outcomes.

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Appendix I

Appendix (IA): Mean score of the control over personnel dimension of shared governance.

Control over personnel statements	Mean	Std. Deviation
5. Conducting disciplinary action of nursing personnel.	2.29	1.27
11. Formulating annual unit budgets for personnel, supplies, equipment and education.	2.25	1.29
12. Recommending nursing salaries, raises and benefits.	2.01	1.27
15. Creating new clinical positions.	1.98	1.24
16. Creating new administrative or support positions.	2.00	1.31
17. Mandatory RN credentialing levels (licensure, education, certifications) for hiring, continued employment, promotions and raises.	1.92	1.21
18. Organizational charts that show job titles and who reports to whom.	2.10	1.22
19. Written guidelines for disciplining nursing personnel.	2.07	1.23
20. Procedures for hiring and transferring nursing personnel.	2.02	1.26
21. Policies regulating promotion of nursing personnel to management and leadership positions.	2.04	1.19
25. Process for recommending and formulating annual unit budgets for personnel, supplies, major equipment and education.	2.13	1.26
26. Procedures for adjusting nursing salaries, raises and benefits.	1.97	1.26

Appendix (IB): Mean score of the access to information dimension of shared governance.

Access to information statements	Mean	Std. Deviation
37.Compliance of nursing practice requirements of surveying agencies (The Joint Commission, state and federal government, professional groups).	2.08	1.14
38. Unit and nursing departmental goals and objectives for this year.	2.30	1.14
39. Organization's strategic plans for the next few years.	2.12	1.19
40. Results of patient satisfaction surveys.	2.51	1.21
41. Physician/nurse satisfaction with their collaborative practice.	2.64	1.26
42. Current status of nurse turnover and vacancies in the organization.	2.23	1.29
43. Nurses' satisfaction with their general practice.	2.62	1.34
44. Nurses' satisfaction with their salaries and benefits.	2.41	1.37
45. Management's opinion of the quality of bedside nursing practice.	2.61	1.35

Appendix (IC): Mean score of the influence over resources dimension of shared governance.

Influence over resources statements	Mean	Std. Deviation
9. Making daily patient care assignments for nursing personnel.	3.30	1.33
10. Regulating the flow of patient admissions, transfers, and discharges.	3.04	1.23
13. Consulting and enlisting the support of nursing services outside of the unit (e.g., clinical experts such as psychiatric or wound care specialists, diabetic educators).	2.55	1.22
14. Consulting and enlisting the support of services outside of nursing (e.g., dietary, social service, pharmacy, human resources, finance).	2.56	1.25
22. Procedures for determining daily patient care assignments.	3.02	1.24
23. Daily methods for monitoring and obtaining supplies for nursing care and support functions.	2.88	1.19
24. Procedures for controlling the flow of patient admissions, transfers and discharges.	2.64	1.27
27. Formal mechanisms for consulting and enlisting the support of nursing services outside of the unit (e.g., clinical experts such as psychiatric or wound care specialists, diabetic educators).	2.39	1.29
28. Formal mechanisms for consulting and enlisting the support of services outside of nursing. (e.g., dietary, social service, pharmacy, human resources, finance).	2.37	1.26

Appendix (ID): Mean score of the participation in committee structure dimension of shared governance.

Participation in committee structures statements	Mean	Std. Deviation
29. Participation in unit committees for administrative matters, such as staffing, scheduling, and budgeting.	2.12	1.22
30. Participation in nursing departmental committees for administrative matters such as staffing, scheduling, and budgeting.	2.23	1.25
31. Participation in interprofessional committees (physicians, other healthcare professions and departments) for collaborative practice.	2.25	1.19
32. Participation in hospital administration committees for matters such as employee benefits and strategic planning.	2.09	1.27
33. Forming new unit committees.	2.16	1.23
34. Forming new nursing departmental committees.	2.17	1.25
35. Forming new interprofessional committees.	2.04	1.21
36. Forming new administration committees for the organization.	1.97	1.27

Appendix (IE): Mean score of the control over practice dimension of shared governance.

Control over practice statements	Mean	Std. Deviation
1. Determining what nurses can do at the bed side.	2.98	1.33
2. Developing and evaluating policies, procedures and protocols related to patient care.	2.46	1.15
3. Establishing levels of qualifications for nursing positions.	2.19	1.23
4. Determining activities of ancillary nursing personnel (assistants, technicians, secretaries).	2.43	1.26
6. Assessing and providing for the professional/educational development of the nursing staff.	2.48	1.11
7. Selecting products used in nursing care.	2.77	1.24
8. Determining models of nursing care delivery (e.g. primary, team).	2.78	1.38

Appendix (IF): Mean score of the goal setting and conflict resolution dimension of shared governance.

Goals setting and conflict resolution statements	Mean	Std. Deviation
46. Negotiate solutions to conflicts among professional nurses.	2.64	1.27
47. Negotiate solutions to conflicts between professional nurses and physicians.	2.39	1.17
48. Negotiate solutions to conflicts between professional nurses and other healthcare services (respiratory, dietary, etc.).	2.54	1.15
49. Negotiate solutions to conflicts between professional nurses and nursing management.	2.52	1.24
50. Negotiate solutions to conflicts between professional nurses and the organization's administration.	2.45	1.29