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Shared Governance among Nurses: A Descriptive Study from Jordan

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ABSTRACT

Background: Shared governance of employees is crucial in building trust within healthcare organizations. Control over practice, ownership of actions, feeling of independence and involvement in work decisions significantly increase employees' intent to stay, whereas exclusion from the decision-making process leads to a higher rate of turnover. Improving decision-making and enhancing collaboration among nursing staff and nurse leaders pave the way for greater autonomy and management of healthcare delivery. ***Purpose***: The study aims to examine shared governance perceptions among Jordanian registered nurses in different clinical areas. ***Methods***: A descriptive, cross-sectional design was used using the RN-focused index of professional nursing governance survey. A convenient sample consisting of 261 nurses was recruited from three hospitals in Jordan between 2017 and 2018. ***Results***: The total shared governance score ranged between 86 and 344 with a mean of 175.6. There were slight differences in the total shared governance scores among the hospitals under study. However, when the sub-scales were compared across the three hospitals, some differences emerged, specifically in nurses' total perceived personnel and total perceived goal and conflict. The median age of the sample members was 28 years and about a half of them (54%) were males. ***Conclusion***: Our results demonstrated that there is a room to increase the level of nurses' control and influence in decision-making, particularly in those departments that scored lower on the index of professional nursing governance. ***Implications for Nursing***: The study results have implications in nursing administration, policy development and decision-making when choosing/adopting a model of organizational SG to cultivate excellence in the workplace.

Keywords: Shared governance, Registered nurses, Work environment.

What does this paper add?

1. Shared governance plays an important role in improving nurses' attitudes and relationships that can have a profound effect on patient care.
2. Administrations that encourage worker engagement beat their competitors in terms of performance, profitability and job satisfaction.

1. Introduction

The concept of shared governance (SG) in healthcare, particularly in nursing, was introduced during the 1970s and 1980s through the utilization of social and behavioral management theories (O'May & Buchan, 1999; Porter-O'Grady, 1992; Swihart & Porter-O'Grady, 2006). Shared governance plays an important role in direct patient care and employee engagement in healthcare. In the literature, several terms are interchangeably used to describe SG, such as shared leadership, shared decision-making and collaborative models (Hess, 2005). In nursing, according to Tim Porter-O'Grady who is famous for his broad research and initial groundwork on SG models, SG is "a structural model through which nurses can express and manage their practice with a higher level of professional autonomy" (Porter-O'Grady, 2003; O'Grady & Clavelle, 2021).

Healthcare providers, including nurses, can be empowered to make decisions that improve their working relationships with one another, their ability to provide patient-centered care and their own job satisfaction by implementing a system of SG.

To give their staff, including nurses, a chance to participate in shared decision-making and feel in control of their practice, many healthcare organizations are still working to implement a system of SG (Fray, 2011).

2. Background

Despite the spread of SG in the late 19th century, as well as the current resurgence, there is limited literature addressing SG. A creative management approach called "shared governance" bases decision-making on partnership, equity, accountability and ownership philosophies, with employees and healthcare managers implicitly sharing decision-making (Anderson, 2011). The work environment becomes more professional if these principles are used collectively within team skills and behaviors (Batson, 2004; Swihart, 2006). These guidelines play a significant role in staff morale, retention rates and indirect effects on care quality and patient safety (Bogue et al., 2009; McKnight & Moore, 2021).

Although the governance structure is necessary to ensure that the shared decision-making principles are upheld, structure by itself is insufficient (Anderson, 2011, O'Grady & Clavelle, 2021). According to Anderson, "the concept is more than a structure; the philosophy of professional accountability must be implemented" (Anderson, 2011). Research shows that the full implementation of SG as philosophy and approach may take three to five years (O'Grady & Clavelle, 2021).Due to this high level of conceptualization and implementation, measuring the impact of SG is seen to be a challenge.

The challenge of assessing SG results is linked to determining whether SG is actually implemented within an organization. In fact, the assessment of the level of SG implementation and the impact of the governance structure on outcomes should be included in the evaluation of SG (Anderson, 2011).

This paper aimed to examine the SG perceptions among Jordanian RNs and to compare the perceptions of SG among nurses in different clinical areas.

There is minimal scientific evidence that SG improves patient outcomes. The broader concept of structural empowerment in nursing, however, has been linked to a number of outcomes, including job satisfaction (McKnight & Moore, 2021; Laschinger wt al., 2004; Manojlovich & Laschinger, 2007), burnout (Cho et al., 2006), intention to leave (Nedd, 2006), nurse-reported patient-safety climate (Armellino et al., 2010; Armstrong & Laschinger, 2006) and level of care (Laschinger, 2008). In one of the few studies that focused on SG, Stumpf (2001) found that SG units had higher nurse-and patient-satisfaction scores than traditionally controlled units after surveying patients and nurses in 16 units across 5 hospitals.

Organizations that value employee engagement outperform their rivals in terms of productivity, profitability and performance (Harter et al., 2002), facing a value-based, competitive marketplace and potential staffing shortages (Health & Services, 2008). Given that nurses make up the majority of hospital staff, hospitals have a strong interest in fostering an engagement culture among this group. One strategy for increasing nurse involvement is SG, which involves empowering front-line caregivers to take an active role in institutional decision-making (Barden et al., 2011; Porter-O'Grady & Finnigan, 1984).

Nearly a half of Jordan's 30,000 registered nurses (RNs), (16,245) are employed, while the remainder are either unemployed or have emigrated. Males make up about a half (51%) of Jordanian nurses (JNC, 2016). Although around 1,500 nurses graduate each year in Jordan (JNC, 2016). there are about 16.6 nurses for

every 10,000 people (MOH, 2016). The nurse-patient ratio varies between general wards and critical-care units in both public and private hospitals. Critical-care units are one-to-one in private hospitals, compared to one-to-two in public ones (JNC, 2016). The nurse-patient ratio in medical-surgical departments varies from one-to-six in private hospitals to one-to-twelve in public hospitals. Depending on the type of hospital and unit a nurse works in, the context of the Jordanian healthcare system may present particular challenges to nurses (MOH, 2016). Despite widespread interest in quantifying professional nursing governance, little research has been published that has clearly examined it. It is presently unknown how far the professional nursing governance baseline evaluation has progressed. In order to inform nurse leaders of concerns and issues with the current hospital and nursing structure and to give them priority-focused areas for improvement in order to achieve nursing excellence, it is essential to assess the current state of professional nursing governance in hospitals.

Using the index of professional nursing governance and the ANCC magnet framework, baseline evaluation of the status of professional nursing governance is a timely research topic that can help in identifying improvement strategies that may improve the quality of nursing care, attain quality in the nursing profession, increase community confidence in nursing graduates' performance and improve marketing and status of hospitals and nursing image.

3. Methodology

3.1 Design and Sampling

This study used a descriptive, cross-sectional design. Three hospitals representing Jordan's private, public and academic sectors were used to gather a convenient sample. Each hospital has a bed capacity of more than 300 and is accredited by the local Health Care Accreditation Council (HCAC) and Joint Commission International (JCI).

3.2 Sample

Based on a statistical power of 0.80, a significance level of 0.05 and a moderate effect size (ES=.25 for the analysis of variance test), a sample size of 261 participants was calculated (Faul et al., 2007). The study sample was composed of 261 nurses from six clinical areas in the selected hospitals.

3.3 Ethical Approval

The ethical approval was acquired from the Institution Review Boards (IRBs) of the university-affiliated and the other targeted hospitals. Each hospital received an invitation letter explaining the purpose and goals of the study. Upon acceptance, the primary investigator met with the hospital administrators to coordinate the recruitment and data-collection process.

Each potential study participant received an envelope with the study questionnaire, an informed consent form and a cover letter outlining the study's objectives. Participants' special identification information was not required and respondents were asked not to mark or write their names on the questionnaire forms in order to maintain privacy and confidentiality. The questionnaire forms were filled out, returned in a secret envelope and given to the researchers.

3.4 Instruments

In this study, Robert Hess' (2009) RN-focused Index of Professional Nursing Governance (IPNG) survey tool was used to gauge nurses' perceptions of SG and their predominate control, authority and power (Hess Jr., 2011). The IPNG, which consists of 86 items with a five-point Likert scale, identifies who oversees or has influence over different activities, resources and organizational practices (i.e., management only, shared between nurses and management, nurses only). The sum of the item scores yields an overall score that represents the governance structure. The scores for traditional governance are ranging from 86 to 172, those of shared governance from 173 to 344 and those of self-governance from 345 to 430.

The IPNG includes six sub-scales: 1) Who controls the nursing staff? A 22-item survey of nursing personnel and related structures; 2) Information access (15 items) assessing who has access to governance activities and any pertinent information; 3) Influence over organizational resources, measuring who is influencing organizational practice (13 items); 4) Participation, measuring who is participating in governance activity structures at different organizational levels (12 items); 5) Control over nursing practice, measuring who controls professional practice (16 items); and 6) Control over goals and conflict, measuring the good input of RNs on setting unit goals, as well as a good control on putting solutions for conflict situations at the

institutional level (12 items).

The IPNG was validated in hospitals and its psychometric properties have been tested using 1,162 RNs showing a content validity of 0.95 (Hess Jr., 1995). Furthermore, the construct validity was established by comparing scores between SG and traditionally governed hospitals (Hess Jr., 1995, 1998, 2011). In the current study, the six sub-scales of the IPNG questionnaire had an internal-consistency reliability of 0.87 using Cronbach's alpha.

3.5 Statistical Analysis

IBM SPSS, version 25 was used to analyze the data, which included total score, demographic summaries and descriptive statistics. Descriptive statistics included frequencies, means and standard deviations to describe the sample characteristics. The sum of the individual item scores was used to calculate the overall governance score. The six sub-scales were used as the dependent variables in each MANOVA analysis to investigate variances among significant independent variables (such as campus, unit, age, gender, … etc.). In various one-way analyses of variance (ANOVAs), the full-scale score was the dependent variable.

4. Results

4.1 Participant Characteristics

261 of the 300 questionnaire forms that were distributed were returned, representing 87 percent of the distributed questionnaire forms with almost equal responses across the three hospitals. The participants' mean age was 28 years (SD = 3.7, range = 22-45), with 54% of them being males. The majority of nurses had a bachelor's degree (90.1%) with a work experience that ranged from 1 to 13 years. About two-thirds of the sample members worked in general wards (Table 1).

Table 1. Participants' characteristics (N= 261)

Characteristic	n (%)
Age, years	28 ± 3.7
Gender	
Male	142 (54.4)
Female	119 (45.6)
Education level	
BSN	237 (90.8)
MSN	24 (9.2)
Hospital	
University	83 (31.8)
Public	91 (34.9)
Private	87 (33.3)
Clinical Area	
Medical	70 (26.8)
Surgical	60 (23.0)
ICU	56 (21.5)
OR	20 (7.7)
ER	26 (10.0)
Pediatric	29 (11.1)

Table 2 shows the differences between hospitals in the total SG scores and in the six sub-scales of professional nursing governance. The mean of total SG scores for the whole sample was 175.6, which was just above that of the traditional governance, but at the borderline of the shared governance range (173-344). The differences in the means of the total SG scores among university (182.9), public (173.9) and private (170.4) hospitals were not significant; however, the total SG score in the private hospital falls under that of traditional governance, implying that decision-making was primarily the duty of nurse managers and administrators.

When the sub-scales were compared across the three hospitals, some differences emerged, specifically on the nurses' perceptions of perceived resources' goals and conflicts. Fisher's Least Significant Difference (LSD) *post hoc* comparisons showed that the participants at the university hospital had higher perceived resources than the participants in the public and private hospitals ($F=2.95$, $p\leq0.05$). In addition, the participants at the private hospital had the lowest perceived goals and conflicts in comparison to the participants in the university and public hospitals ($F=10.47$, $p\leq0.01$).

Table 2. Comparison of hospitals' sector on SG sub-scales and the total scale (N=261)

Clinical area	Perceived personnel	Control over practice	Perceived resources	Perceived participation	Access to information	Perceived goals and conflicts	IPNG total
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
1. University	26.2 (9.9)	28.7 (10.2)	48.3 (16.6)	20.0 (8.4)	32.2 (11.5)	27.5 (10.6)	182.9 (60.2)
2. Public	24.6 (6.9)	28.2 (8.5)	44.1 (12.6)	19.1 (6.0)	32.7 (10.6)	25.2 (8.7)	173.9 (43.1)
3. Private	26.9 (7.6)	28.4 (7.9)	43.7 (11.1)	20.1 (7.2)	30.0 (9.5)	21.4 (6.4)	170.4 (36.3)
F-statistics	1.80	0.08	2.95*	0.48	1.57	10.47**	1.57
			1>2&3*			2 & 3** 2 > 3**	

* $p \leq 0.05$; ** $p \leq 0.01$.

Table 3 presents the differences among nurses on SG scales based on working area. Nurses who work in ER and OR have higher levels of SG than nurses who work in medical, surgical and ICU areas. Access to information is the only sub-scale that did not show significant differences among nurses across different working areas in the study. The variables of gender, education level and hospital type also did not show significant differences on SG sub-scales. The only exception was that nurses in the private hospital scored lower than nurses at the university and public hospitals on the perceived goals and conflicts ($F = 10.5$, $p \leq 0.001$).

Table 3. Comparison of participants' characteristics on SG sub-scales and the total scale (N=261)

Clinical area	Perceived personnel	Control over practice	Perceived resources	Perceived participation	Access to information	Perceived goals and conflicts	IPNG total
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
1. Medical (n=70)	24.6 (7.7)	27.9 (8.2)	42.3 (11.9)	18.8 (5.5)	30.9 (10.8)	23.3 (7.6)	167.9 (41.2)
2. Surgical (n=60)	25.8 (7.1)	27.7 (9.0)	42.9 (12.2)	18.9 (7.1)	31.1 (9.9)	23.5 (7.7)	169.7 (42.3)
3. ICU (n=56)	23.8 (7.5)	26.8 (7.8)	43.9 (10.9)	18.8 (7.9)	30.9 (9.9)	23.6 (8.9)	167.9 (39.6)
4. OR (n=20)	29.7 (7.7)	30.7 (7.3)	51.6 (14.4)	20.9 (6.6)	32.1 (10.4)	28.5 (10.2)	193.5 (43.5)
5. ER (n=26)	31.6 (9.8)	32.7 (11.6)	52.2 (16.9)	22.3 (8.0)	34.7 (12.2)	28.2 (11.1)	201.6 (63.6)
6. Pediatric (n=29)	25.6 (9.4)	29.0 (9.6)	49.5 (17.7)	19.7 (8.4)	32.9 (11.4)	26.6 (10.5)	185.9 (60.1)
F-statistics	4.8***	2.0	4.1***	2.2	0.7	2.5*	3.4**
	4>1* 4>3** 5>1*** 5>2** 5>3*** 5>6**	5>1* 5>2* 5>3*	4>1** 4>2** 4>3** 5>1*** 5>2** 5>3** 6>1* 6>2*	5>1* 5>2* 5>3* 6>1* 6>2* 6>3*		4>1* 4>2* 4>3* 5>1* 5>2* 5>3*	4>1* 4>2* 4>3* 5>1** 5>2** 5>3**

* $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$.

5. Discussion

The findings of this study showed that the sample's overall IPNG mean score was (175.6), which is just above that of the traditional governance, but within the range of shared governance. This indicates that the Jordanian RNs have begun to experience a transition towards SG environment in which they participate in the decision-making process with their managers. This result is congruent with other studies (Afeef, 2010; Al-Faouri et al., Essa, 2014; Kanninen et al., 2021; Mouro et al., 2013).

The SG sub-scale scores indicated a lack of nursing control over personnel, which is related to the structures in their organizations. All organization scores were below the range of SG across the university, public and private hospitals. These findings indicate that nursing managers in these hospitals are making decisions for personnel and human resources with minimal input or control from nurses. This might be related to the hospital policies and regulations as well as managers' reluctance to share young nurses with less work experience in the unit's decisions. Multiple health institutions that used the IPNG found that the lowest scoring sub-scale was control over personnel (Anderson, 2011; Bennett et al., 2012; Clavelle et al., 2013; Hess Jr., 2011, McKnight & Moore, 2021). Furthermore, nurses who participated in this study had a limited control over the professional practice, which is similar to findings of previous studies (Afeef, 2010; Al-Faouri et al., 2014). The absence of formal structures and processes for SG in those hospitals might contribute to this finding.

The nurses' control over resources was within the SG score. The results for this sub-scale were 46.8 for the university hospital, 44 for the public hospital and 43.1 for the private hospital, all of which are considered relatively high when compared with the SG IPNG score (27-52). This finding reflects that Jordanian RNs shared in decision-making according to the availability of resources. This outcome might be attributable to management support, which provides resources to improve quality and safety, in addition to adhering to accreditation standards attained in the participating hospitals. Furthermore, the RNs are involved to a great extent in evaluating and controlling the quality of medical devices and consumables for patient care.

The scores for the subscale of control over goals and conflicts for the three participating hospitals were within the range of SG for hospitals (17-32), which reflects the good input of RNs on setting unit goals, as well as sharing decisions with their management in conflict management. This may be related to the hospital regulations which necessitate nursing managers setting the unit goals with their staff, because they are more familiar with the needs of the department. Nurses shared responsibility to solve the unit problems and conflicts in their units with managers' support, in particular during the absence of their managers and as a part of senior nurses' roles.

The sub-scale of access to information results indicated that both university and public hospitals have higher scores (mean = 31.3 and 32.9, respectively) than the minimal score of SG range. The RNs in these types of hospitals have a good access to information sources within their hospitals either by availability of a scientific library, a scientific internal information system for all staff on the portal site of the hospital or an internal electronic mail address for updating practice issues. This demonstrates hospitals' dedication to fostering a setting that is favorable to learning and career development. The current study indicates that nurses who work in an ER department or in an OR department have higher means of *IPNG*, which contradicts with a study by Overcash (2012) who found that nurses who are employed in the inpatient setting and have a role in SG had a higher mean IPNG score (200.59) than those working in the ambulatory setting (IPNG score = 193.0), while Bennett et al. (2012) in their study in Australia found no differences between the departments in the overall IPNG, but found differences in the sub-scales.

6. Implications and Recommendations

The results of this study could help administrators in assessing hospitals' SG level for developing an action plan and strengthening governance and shared responsibilities in nursing. These results would be important for nursing administrative personnel, policy makers and decision makers to incorporate an excellent working environment through adopting one or more of SG models. Nurses' managers should pay attention for training nurses in order to be involved in decision-making processes and steering the institution to excellence with full empowerment and authority. The study results can be used to develop the nurses' work environment and improve the nursing profession by expanding the nurses' knowledge and their perceptions toward SG, as the nurses are in direct contact with the

patient. It is recommended to investigate the perceptions of RNs in other sectors and other wards of healthcare. Different methods could be used to identify the challenges and barriers that RNs encounter and the strategies to overcome those challenges and barriers.

7. Conclusion

Shared governance is one of the nursing-practice models, being considered as a strength point for the nursing profession, since SG plays an important role in improving nurse attitudes and relationships that can have a profound effect on patient care. Nursing educational level, work experience as a staff nurse, gender, setting (inpatient/outpatient), age and participation in SG activities are not related to the overall IPNG score. Nurses who have a role in SG and work in ER or OR departments have higher scores than those who work in inpatient departments, but with slight differences according to the demographic variables. The study results demonstrated that there is a room to increase the level of nurses' control and influence in decision-making, particularly in departments that scored lower on the IPNG.

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Conflict of Interest

No conflict of interest is to be declared by the authors.

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