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Existence of Professional Nursing Governance and Leadership Competency

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Abstract: **Achieving optimal flow of information, decision making and decision support, improve plans and actions, innovative problem solving which all lead to enormous health outcomes requires a decentralization of nursing management rather than traditional nursing management in which staff nurses' participations is either minimal or not exist.**

Aim: This research aimed to measure the level of professional shared nursing governance in one of the most high caliber and high performance hospital which work on a partnership with a developed country.

Method: A descriptive study design was used to examine the existence of professional shared nursing governance and level of leadership competency by using two reliable scales of data collection, each scale applied to one group of staff nurses working in different nursing units.

Sample: A total of 70 participants' constituted a homogenous sample were divided into two equal groups.

Results: Existence of shared nursing governance was evident by the first group, in addition to excellent level of leadership competency of head nurses were perceived by the staff nurses in the second group.

Conclusion: Shared nursing governance was existed (total score=244/430, cutoff point of shared ≥173) which indicate to presence of primarily nursing management/administration with some staff nurse input combined with excellence level of leadership competency of head nurses (total score=245/260) that was perceived by staff nurses at the selected study setting.

Keywords: **Professional nursing governance, shared governance, Leadership competency.**

I. INTRODUCTION

In a developing country, nursing service still crawls on a sole decision making from nursing directors and medical administrators despite the presence of high degree of nursing staff who possesses expertise and similar qualifications as such bachelors, masters and doctorates. Challenges in health services in today's global health are having promising solutions generated by developing countries **(Shamsuzzoha et al., 2012).** Benefits of developed countries are highly significant to developing country especially in nursing profession, where more autonomy and control are given to nurses. So, merging lessons from developed and developing countries can create new ideas on how to solve challenges of health filed such as nursing **(Crisp, 2010).**

The Index of Professional Nursing Governance (IPNG) and the Index of Professional Governance in healthcare have become the standard tools for measuring shared governance **(Joseph & Bogue, 2016).** Empowered work environments typically have the structure of shared governance enable nursing and leadership collaboration along with a decentralized organization structure and participative management style. In additionally to providing nurses with a sensibility of empowerment, shared governance also provides nurses with a deeper conception of hospital policies, which increase organization involvement **(Twigg & McCullough, 2014).**

Shared governance is described as a structure that centralizes staff on the decision-making process and notice the facilitative leadership role of managers. Moreover, shared governance enables healthcare leaders to 'talent manages' frontline staff to prepare them for future leadership positions. This is a major benefit as many senior nurse managers are

approaching retirement age **(Haines, 2013).** Shared governance has a positive correlation with the nursing practice environment, as increases in perceptions of shared governance are linked to a better nursing work environment **(Clavelle, Porter-O'Grady & Drenkard, 2013).**

Healthcare executives realize that quality care is best delivered by staffs that are committed to the organization and empowered to practice their profession with no restraints and full autonomy. Successful leaders have been able to achieve these outcomes through the implementation of shared governance **(Michelle, 2013).** Shared governance increases nurses' participation in the operations of professional practice and engages them in decision making. This engagement gives nurses the authority, confidence, and assertiveness to make a difference and change nursing practice **(Bretschneider, Echardt, Glen-West, Green-Smolenski & Richardson, 2010).**

The nurse manager plays a vital role in healthcare services, since professional is responsible for the management of nursing services and for taking measures that include the administrative care and teaching research areas with a view to deliver quality care. The requirements concerning the work of nurse managers include, in addition to the management of nursing, knowledge and interaction with the entire organizational environment in order to contribute to the success of the institution **(Patrcia de Oliveira Furukawa & Isabel Cristina KowalOlm Cunha, 2011)**.

The literature review disclosed that head nurses should plan strategy and set goals associated with persons, supplies, and quality services in order to achieve these goals. Head nurses must be concerned with human rights as well as advocate for the patient, solve problems, and apply nursing management based on ethics and law **(Thailand Nursing and Midwifery Council, 2011).** But unfortunately, most head nurses were thus not prepared for their positions **(Thailand Nursing and Midwifery Council, 2013).** Therefore, developing leadership skills is mandated for all nursing staff.

The concept of leadership as described by **Peter N. (2013)** is the "process whereby an individual influences a group of individuals to achieve a common goal" this concept interpret that organizational successes, healthy workplace, staff satisfaction, the influence of environment in the provision of standard care, and the quality of healthcare are all elements depend on the leadership competencies of head nurses **(Germain et al., 2010; Aiken et al., 2011).**

Leadership styles are varied such as directing, coaching, facilitating and delegating autocratic, democratic, laissez-faire. Directing leader provide detailed instructions and set specific goals and objectives. Coaching leader, represent management position in a convincing manner, sell staff within their own ability to do the job. Facilitating leader, make staff feel free to ask questions and discuss important concerns and hold team and delegating leader, expecting staff to find and correct their own errors and delegate broad responsibilities and expect them to handle details **(Warren, 2014).** A good leader uses all different styles, based on situation, follower and leader relationship **(Mehmet et al., 2012).**

II. BODY OF ARTICLE

Subjects and Methods:

The purpose of this paper is to measure the level of professional shared nursing governance and leadership competency of head nurses in the most caliber, high technology and most profound hospital in Egypt.

Research Hypothesis:

$\mathbf{H_0}$ there is no existence of professional shared nursing governance

$\mathbf{H_1}$ there is an existence of professional shared nursing governance in high technology hospital.

$\mathbf{H_2}$ an excellent level of leadership competency will be combined with the existence of professional shared nursing governance**.**

Study Design:

A prospective descriptive study design was used to evaluate the existence of shared governance in a high technology hospital combined with excellent level of leadership competency for head nurses.

Setting:

The study implemented at Magdy Yacob Heart Foundation, which located at Aswan governate (https://myf-egypt.org/; http://aswanheartcentre.com/).

Sample:

A total sample of (70) nurses working in different nursing units were approached to participate in the study, the nursing supervisor facilitated and provided the time to collect the data through structured interview with some participants working full time and at least has completed 6 months at work. The sample was divided into two equal groups each composed of 35 nurses.

Data Collection Tool:

Two scales of data collection were used; the first scale was the Index of Professional Nursing Governance (IPNG) which aimed to measure the existence of shared governance in a high technology hospital. The IPNG is multidimensional tool designed by **Hess R. (1094),** it contains two main parts; the first part concerned with the demographic data of the study sample as, age, sex, educational preparation, employment status, number of years as a practicing nurse, type of nursing unit working on, number of years worked in this hospital. The second part composed of 86 statements divided over six subscales:

{CONTROL = 13 items *(Q1- Q 13)*, INFLUENCE = 14 items *(Q 14 - Q 27)*, PARTICIPATION = 10 items *(Q 28 - Q 37)*, AUTHORITY = 22 items *(Q 38 - Q 59)*, INFORMATION = 15 items *(Q 60 - Q 74)*, and ABILITY = 12 items *(Q 75 - Q 86)*}, this part measures the professional governance on a continuum concept ranging from traditional to shared to self-governance.

Scoring System:

To obtain the score of the scale, the nurses were asked to circle on the group of 5-points Likert scale: "1 = Nursing management/administration only", "2 = Primarily nursing management/administration with some staff nurse input", "3 = Equally shared by staff nurses and nursing management", "4 = Primarily staff nurses with some nursing management/administration input", and "5 = Staff nurses only". The scores for the full scale and subscales are computed by summing the responses of each nurse across all 86 items (total score = 430) and items composing each subscale respectively.

The scores of shared governance index were measured according to this weight: nursing management/administration only (1 = 86–172), primarily nursing management/administration with some staff nurse input (2 = 173–258), equally shared by staff nurses and nursing management (3 = 259–344), primarily staff nurses with some nursing management/administration input (4 = 345 – 430), or Staff nurses only (5 = 430).

The Second Tool was the leadership competency **scale** of head nurses which created by **Tongmuangtunyatep and colleagues, (2015).** It is a valid and reliable scale composed of 5 main factors with 52 statements. The 5 factors titled; (1) leadership = 15 items, (2) healthcare environment management = 7 items, (3) policy implementation and communication = 13 items, (4) management = 8 items, and (5) professional ethics = 9 items. The scale aimed to measure head nurses' leadership competency as perceived by the study sample.

Scoring System:

The perception of the nurses to their head nurses leadership competency is evaluated by using a 5-point Likert scale, the sample responses of the second group of nurses was interpreted as: "1 =strongly disagree", "2 =disagree", "3 =neutral", "4 =agree", and "5 =strongly agree".

The scores of the head nurses leadership competency were perceived as poor competence (1= 52–104), moderate competence (2= 105 – 156), good competence (3= 157 – 208) or excellent competence (4= 209 – 260).

Administrative and Ethical Consideration:

The nurses were recruited by the operating room nursing supervisor who volunteered to participate in the study. She has overseas experience, the questionnaires were explained in details with extended documents explained the concept behind shared governance. Each participant was reassured about the provided information as it will be used for research purpose only.

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The Procedures of Data Collection:

The first group had received the scale of professional nursing governance during March 2018, and then the second group has received the competency scale of head nurses leadership during April 2018.

Statistical analysis:

The obtained data were arranged, tabulated and statistically analyzed using SPSS software statistical package version 20. Calculation of statistical mean and standard deviation, and variance were used as well as chi-square test to determine whether the observed frequencies are significantly different from expected frequencies for the two groups of the sample. Statistical significance will be at $p<0.05$.

III. STATISTICAL RESULTS

TABLE I: Socio-demographic characteristics of the study sample (n=70).

	Governance Group		Competency Group	
Item	**N.**	**%**	**N.**	**%**
Gender:				
Male	21	60.0	18	51.4
Female	14	40.0	17	48.6
Age:				
< 25 years	10	28.6	11	31.4
25 – <30	15	42.8	14	40,0
31 – < 35	5	14.3	6	17.1
36 – < 40	2	5.7	3	8.6
> 40 years	3	8.6	1	2.9
Basic Nursing Educational Preparation				
Diploma nursing degree	10	28.6	17	48.6
Bachelor degree	25	71.4	18	51.4
Highest Educational Degree				
Diploma nursing degree	10	28.6	17	48.6
Bachelor degree	25	71.4	18	51.4
Master	0	0.0	0	0.0
Ph.D.	0	0.0	0	0.0
Employment status				
Full Time	35	100.0	32	91.4
Part Time	0	0.0	3	8.6
Job Position:				
Staff nurse	28	80.0	31	88.5
Charge nurse	4	11.4	3	8.6
Instructor	2	5.7	1	2.9
Infection control nurse	1	2.9	0	0.0
Years of practices:				
<1 year	6	17.2	7	20,0
2 – < 5	10	28.6	11	37.1
5 – < 10	12	34.2	13	31.4
10 - < 15	5	14.3	4	11.5
> 15 years	2	5.7	0	0.0

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Work Place:				
Units	11	31.4	13	37.1
Operating room	2	5.7	5	14.3
Post anesthesia care unit	4	11.4	0	0.0
Intensive care units	18	51.5	17	48.6
Total years of experience worked in the institution				
<1 year	9	25.7	13	37.1
1 – < 3 years	7	20.0	4	11.4
3 – < 5 years	13	37.1	14	40.0
5 – < 7 years	3	8.6	4	11.4
> 7 years	3	8.6	0	0.0
Specialty Certification:				
Yes	29	82.8	31	88.6
No	6	17.2	4	11.4

Table 1: Display the personal data of the two groups of the study sample. The majority were from male nurses, the range of age was from 25 – < 30 years. All nurses were working full time except of minimal percent. The years of experience for the first group ranged from 5 – < 10 years, while the years of experience in institution ranged from 3 – < 5 years for the two groups. Most of nurses in the two groups had positive previous training.

TABLE II: Frequency distribution of dependent variables of professional governance subscales (n=35).

Variables (score of total items = 430	**Administration only (1)**	**Primarily Administration with some staff input (2)**	**Equally Shared (3)**	**Primarily staff nurses with some administration (4)**	**Staff Nurses Only (5)**	**Total**	**X2**	**P**
Controls: Total=*65* *(Q1- Q 13)*	157 (34.7%)	150 (33.1%)	94 (20.8%)	38 (8.4%)	14 (3.1%)	453 (100%)	8.97	0.345
	Mean ± Standard deviation = 27.8 ± 7.9 Variance = 63.1							
Influences Total=*70* *(Q 14 - Q 27)*	172 (35.1%)	143 (29.2%)	83 (16.9%)	67 (13.7%)	25 (5.1%)	490 (100%)	13.08	0.219
	Mean ± Standard deviation = 31.4 ± 10.3 Variance = 106.6							
Participation Total=*50* *(Q 28 - Q 37)*	123 (35.1%)	161 (46.0%)	56 (16.0%)	8 (2.3%)	2 (0.6%)	350 (100%)	24.14	0.004
	Mean ± Standard deviation = 18.7 ± 5.0 Variance = 25.6							
Official Authority Total=*110* *(Q 38 - Q 59)*	341 (30.4%)	488 (43.6%)	187 (16.7%)	91 (8.1%)	13 (1.2%)	1120 (100%)	8.14	0.52
	Mean ± Standard deviation = 47.2 ± 12.4 Variance = 155.3							
Access Information Total=*75* *(Q 60 - Q 74)*	175 (33.5%)	143 (27.3%)	150 (28.7%)	43 (8.2%)	12 (2.3%)	523 (100%)	1.40	1.00
	Mean ± Standard deviation = 33.2 ± 9.8 Variance = 97.5							
Ability Total=*60* *(Q 75 - Q 86)*	134 (31.9%)	142 (33.8%)	107 (25.5%)	33 (7.9%)	4 (1.0%)	420 (100%)	6.17	0.80
	Mean ± Standard deviation = 25.4 ± 9.1 Variance = 83.4							
Total Responses	**979 (32.6%)**	**1066 (35.5%)**	**621 (20.7%)**	**272 (9.0%)**	**68 (2.2%)**	**3006 (100%)**	**20.82**	**0.00**

*****Existence of shared nursing governance.

Final score = 244 *

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Table 2: Revealed the frequency distribution of means and standard deviation in addition to variance of subscales variables of professional governance index as evaluated by the first group of nurses. The highest scores were arranged respectively for official authority (M±SD= 47.2 ± 12.4, variance=155.3), access information (M±SD= 33.2 ± 9.8, variance= 97.5), influences (M±SD= 31.4 ± 10.3, variance= 106.6), control (M±SD= 27.8 ± 7.9, variance= 63.1), ability (M±SD= 25.4 ± 9.1, variance= 83.4), and then participation (M±SD= 18.7 ± 5.0, variance= 25.6).

TABLE III: Frequency distribution of dependent variables of leadership competency subscales (n=35).

Variables (score of total items = 260	**Strongly Disagree (1)**	**Disagree (2)**	**Neutral (3)**	**Agree (4)**	**Strongly Agree (5)**	**Total**	**X2**	**P**
Leadership Total=*75* *(Q1- Q 15)*	0	0	12 (2.3%)	63 (12.0)	450 (85.7)	525 (100%)	14.80	0.001
	Mean ± Standard deviation = 67.6 ± 4.4 Variance = 19.6							
Healthcare Environment Management Total=*35* *(Q 16 - Q 22)*	0	0	4 (1.6)	12 (2.3%)	129 (88.9)	145 (100%)	20.82	0.000
	Mean ± Standard deviation = 34.4 ± 1.6 Variance = 2.6							
Policy implementation &Communication Total=*50* *(Q 23 - Q 65)*	0	0	20 (4.4)	59 (13.0)	376 (82.6)	455 (100%)	14.80	0.001
	Mean ± Standard deviation = 62.1 ± 5.6 Variance = 32.2							
Management Total=*40* *(Q 36 - Q 43)*	0	0	4 (1.6)	29 (10.4)	247 (88.0)	280 (100%)	14.80	0.001
	Mean ± Standard deviation = 38.9 ± 2.2 Variance = 4.8							
Professional Ethics Total=*45* *(Q 44 - Q 52)*	0	0	8 (2.5)	37 (11.7)	270 (85.8)	315 (100%)	14.80	0.001
	Mean ± Standard deviation = 43.4 ± 3.4 Variance = 12.1							
Participants' Responses	**0**	**0**	**48 (2.6%)**	**200 (11.0%)**	**1572 (86.4%)**	**1820 (100%)**		
* High perception of excellent level of leadership competency of head nurses.					**Final score = 245 ***			

Table 3: Exposed the frequency distribution of means and standard deviation in addition to variance of subscales variables of dependent variables of leadership competency as perceived by the second group of nurses. The highest scores were arranged for these factors respectively: leadership (M±SD= 67.6 ± 4.4, variance= 19.6), policy implementation and communication (M±SD= 62.1 ± 5.6, variance= 32.2), professional ethics (M±SD= 43.4 ± 3.4, variance= 12.1), management (M±SD= 38.9 ± 2.2, variance= 4.8), healthcare environment management (M±SD= 34.4 ± 1.6, variance= 2.6).

TABLE IV: Pearson Correlation of dependent variables of professional nursing governance subscales (n=35).

Correlations							
		Controls	**Influences**	**Participates**	**Authority**	**Information**	**Ability**
Controls	*R*						
	p						
Influences	*R*	.753**					
	p	.000					

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Participation	*R*	.226	.025				
	p	.191	.885				
Authority	*R*	.857**	.871**	.135			
	p	.000	.000	.439			
Access Information	*R*	.388*	.637**	.131	.516**		
	p	.021	.000	.453	.002		
Ability	*R*	.716**	.850**	.147	.892**	.598**	
	p	.000	.000	.399	.000	.000	

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 4: Explored Pearson correlation of dependent variables of professional nursing governance subscales, there was obvious positive strong correlations with high statistical significance differences ($p \leq 0.05$) respectively, between authority and ability (r=0.892), authority and influences (r=0.871), authority and control (0.857), then ability and influences (r=0.850). Other correlation noted between control and influences (r=0.753), control and ability (r=0.716). In addition to, other moderates positive correlations between the majorities of the subscales were evident.

TABLE V: Pearson Correlation of leadership competency subscales as perceived by the second group of sample (n=35).

Correlations						
		Factor_1 Leadership	**Factor_2 Healthcare Environment management**	**Factor_3 Policy implementation**	**Factor_4 Management**	**Factor_5 Professional Ethics**
Factor_1 Leadership	*r*					
	p					
Factor_2 Healthcare environment management	*r*	.956**				
	p	.000				
Factor_3 Policy Implementation	*r*	.998**	.973**			
	p	.000	.000			
Factor_4 Management	*r*	.995**	.981**	.999**		
	p	.000	.000	.000		
Factor_5 Professional Ethics	*r*	.985**	.992**	.994**	.997**	
	p	.000	.000	.000	.000	

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 5: Displayed leadership competency subscales, there was very strong positive correlations with high statistical significance differences ($p \leq 0.05$) respectively appeared between management and policy (r=0.999), leadership and policy (r=0.998), management and professional ethics (r=0.997), management and leadership (r=0.995), professional ethics and policy implementation (r=0.994), professional ethics and healthcare environment management (r=0.992).

TABLE VI

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The median of differences between Shared Governance and Leadership Competency equals 0.	Related-Samples Wilcoxon Signed Rank Test	.000	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

Table 6: Revealed P value at 0.00 for Wilcoxon test as statistical significance differences was noted between the professional nursing governance index and the leadership competency, which means the absence of variance between the two groups and indicated to the rejection of the null hypothesis.

IV. DISCUSSION

Shared governance was defined by **Hess (2011)** as an "organizational innovation that legitimizes healthcare professionals' decision-making control over their practice, while extending their influence to administrative areas previously controlled by managers".

The findings of the study disclosed the existence of shared nursing governance in the high technology hospital as the total score of the overall scale was above the cutoff point (173), participant responses (total score=244/430) which indicated to the presence of primarily nursing management/administration with some staff nurse input while the score was also so closed from total shared of mutual management between hospital management and nursing staff inputs.

Regarding the demographic characteristics of the study sample, male to female percent was almost balanced between the two groups of sample. The highest range of age was from 25 to less than 30 years, the highest educational preparation was bachelor degree of nursing. Above 30 % was the previous work experience in nursing from (5 to less than 10 years) and from (3 to less than 5 years) of experience in the same institution for the two groups of nurses. Almost the majority of the sample (> 80%) was receiving continuous training related to clinical work specialty, such as infection control, Basic Life Support (CPR) and first aid. These findings might be reflected from the performance of the high caliber hospitals and the highlight of their role on the development of the nursing staff.

In another descriptive study applied to 24 professionals conducted in 14 hospitals certified by the National Organization of Accreditation and the Joint Commission International in Brazil, the nurse managers' profiles showed that 69.2% came from private colleges, all with more than 10 years' experience since graduation and 92.3% had attended a post-degree program in health management **(Patrcia de Oliveira Furukawa& Isabel Cristina KowalOlm Cunha, 2011).**

As aforementioned the current study finding deduced to the existence of the professional shared governance, this finding compared to other two studies applied in Egypt; the first one was in Cairo El-Manial University Hospital by **Seada and Etway (2012),** their results revealed that nursing work are controlled by nursing administrator only concurrent with multi-factorial reasons influence on nursing such as lack of autonomy of nursing leaders. While the second study was in Alexandria Medical Research Institute by **Abou Hashish, and Fargally (2018),** their study revealed primarily nursing management who take the decision with some staff input with mean score (187.59 ± 63.74).

This difference in the results of the two studies may came due to the sample type wherein the first study sample constituted from staff nurses only while in the second study medical administrators "Physicians" and nursing staff were constituted the whole sample. This difference could explain the variance between the two studies, by another meaning, the input of the medical administrators could affect the results from no shared governance to shared governance.

The frequency distribution of the professional governance index revealed that the highest mean was for the official authority (M=47.2%), which reflect to the amount of authority awarded to the nurses in writing policy and procedures, standards of patient care and quality assurance improvement programs, in addition to, many other nursing activities controlling patients and nursing care activities.

Similarly, **Mahmoud (2016)** asserted that despite the participation of nurses with nursing management/administration in decisions related clinical practice, but they have limited participation in committees such as strategic planning, multidisciplinary team, and budget. In this context, **Ward (2012)** assured that the accessibly of nurses to participate in certain matters seems to increase their participation and strengthen the structure of shared governance.

Conversely the lowest mean was for the participation (M=18.7). Participation of nurses in inter and intra-departmental committees such as unit committees for clinical practices and hospital administration committees. This finding indicates

that nurses are involved in management committees but still not yet fully engaged in different hospital committees and not fully participating in the process of decision making.

In similar study conducted by **Al-Faouri et al., (2014)** reported that control over professional practice was perceived by nurses as the highest subscale of shared governance index by which contrasting the current research finding. Also, **Picker Institute (2012),** conducted a National Health and Safety (NHS) staff survey, identified that only 29% of staff are involved in important decisions by their senior managers, and only 27% reported that senior managers acted on feedback from staff.

Nurses are not frequently in charge and cannot every time make their own decisions about nursing matters. Likewise, if nurses are more engaged in the development and formulation of nursing policies, it would impact positively on patient care. This was declared by **Kieft et al., (2014)** in a qualitative study of shared governance. Also, **Wilson (2014)** added that shared governance fit a structure for a collaborative work for both nursing managers and nurses.

The results of the scale of leadership competency of the head nurses emphasized on five main factors recognized with high positive perception from the staff nurses with strong positive correlations among all the factors. This promising leadership competency helps in the success of the establishment of shared governance programs and models in the current studying setting. In this context, **(Patrcia de Oliveira Furukawa & Isabel Cristina Kowal Olm Cunha, 2011)** reported that the most constant competencies for nurse managers' are leadership; concentrate on patients, and teamwork.

Although the presence of excellent level of leadership competency, the current study findings revealed primarily nursing management/administration with some staff nurse input (2 = 173–258), despite that higher scores of participants' responses above the cutoff point (173) indicate that the nursing staff has a golden life of professionalism, it was expected that the level of professional governance will be promoted to equal shared governance between administrative management and staff management which means that nurses still have to gain greater influence over their professional practice and decisions making participation in organization.

This finding is congruent with **Al-Faouri et al., (2014)** as asserted that one of the factors that are important to the success of a shared governance program is the support of managers and leaders with clear rights given to nurses. In addition, **Hosny (2014),** reported in her study about leadership styles and the locus of control is that the effective leadership indicates to the extent to which a person act on things that believed to influence outcomes. In the same line, **Abou Hashish, and Fargally (2018),** identified that shared governance are supported by the hospital structure and nursing leadership practices. In the same context **(Bleich, 2018)**, reported that professional nurses increasing the opportunities for engagement within organizations of healthcare, which requires immediate needs for responsive leadership and effective system to support the standardization of practice, whether through implementation of best practice, quality improvement, innovations, or professional development.

Shared governance is a vital program to advance nursing, patients, and organizational outcomes that ultimately improve health care within communities. Furthermore, it is the key way to authorize frontline staff nursing to make difference in nursing field **(Siller, 2016).** It is also corresponding with **Abou Hashish & Fargally, (2018)** as stated that "key ingredients to a successful organization" are the hospital administrators' who have important role for providing supportive organizational structures and the practices of nursing leadership that increases the participation of nursing staff in work design, problem-solving, conflict resolution, committees and organizational decision-making, similarly lead to a healthy and magnet-like work environment.

Paralleled to **Porter-O'Grady and Hinshaw (2005),** If shared governance is to allow for cost-effective service delivery and nurse empowerment, decision-making should be shared at point of care, which means that the management structure must be decentralized through, employee partnership, equity, accountability, and ownership must occur at the point of care (e.g., on the patient care units). At least 90% of the decisions need to be made at this point. Indeed, in matters of practice, quality, and competence, the locus of control in the professional practice environment must shift to practitioners. Only 10% of the unit-level decisions should belong to management.

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V. CONCLUSION

The findings of the study induced to the existence of shared governance in the high technology hospital as the score of the overall scale was above the cutoff point (173) of professional governance, this shared governance in nursing indicated to the input level of nursing staff engagement with the hospital administrators in management concurrent with high level of leadership competency of nursing leaders.

VI. RECOMMENDATION

Recommendation of the current study setting is to adopt and implement one of shared governance model to support nursing practice and improve patients' care quality and safety.

Further recommendation for other facilities who may not applying shared governance to strengthen leadership, communication skills and empowering nursing staff for acquiring strong work experience and continuous training, of course with encouraging the acceptance of the medical administrators to the shared role of nursing leaders in management, their values, preferences and decisions related the provision of standard patient care and quality of healthcare. In turn, the challenges that face staff in their daily roles has to be minimized, equity participation, empowerment, collaboration, goal oriented efforts for patients and staff satisfaction are viewed to be the most important issues to be recommended through this study.

Limitations:

The limitations of this study were the length of the scale and the hardness of some items, which obliged the researcher for implementing a structured interview for some participants to accurately response on the scale. Second, the number of the participants was small due to the above mentioned reasons which reflected on lowering response rate. Some shortcomings in the IPNG were also allude by **(Lamoureux, Judkins-Cohn, Buteo, McCue, & Garcia, 2014)** in their survey, that the length of the instrument caused some burden and low response rate.

Implication for practice:

A lot of work for developing new strategies, policies and change in politics are needed and indeed to empower the nursing team and award more rights to nurses to manage their work independently without interferences is required on the hospital level. From other side, on the country level, there should be more agencies to support nursing other than the ministry of health or the Egyptian nursing syndicate such as developing national Egyptian council for nursing, nursing associations in different and various nursing specialties, increasing nursing conferences, seminaries and workshops, upgrading nursing qualifications, increasing the number of bachelor and doctorate in both nursing and academic field. Finally, control and adjust the job description of each level of certified nursing preparation.

REFERENCES

[1] A. Mehmet, K. John, and G. Elif, “The effect of locus of control and culture on leader preference”. International Online Journal of Educational Sciences. (2012):4 (2), 319-324.

[2] Bretschneider, Echardt, Glen-West, Green-Smolenski & Richardson, “Strengthening the voice of the clinical nurse: the design and implementation of a shared governance model”. Nurs Adm Q. (2010) Jan-Mar; 34(1):41-8. doi: 10.1097/NAQ.0b013e3181c95f5e., https://www.ncbi.nlm.nih.gov/pubmed/20023560

[3] Clavelle, Porter-O’Grady & Drenkard, “Structural empowerment and the nursing practice environment in Magnet® organizations”. J Nurs Adm. (2013) Nov; 43(11):566-73. doi: 10.1097/01.NNA.0000434512.81997.3f. https://www.ncbi.nlm.nih.gov/pubmed/24153197

[4] E. Aly Abou Hashish, and S. Mohamed Fargally, “Assessment of professional nursing governance and hospital magnet components at Alexandria Medical Research Institute”, Egypt, Journal of Nursing Education and Practice. (2018).

[5] E. Michelle Wilson, "Evaluating Shared Governance for Nursing Excellence", university Libraries, University of Nevada, (2013). https://digitalscholarship.unlv.edu/.../viewcontent.cgi?

[6] H. Mahmoud, "The relationship between nurses' professional shared governance and their work empowerment at Mansoura University and Specialized Medical Hospitals. Journal of Biology, Agriculture and Healthcare". (2016): 6(18): 13-21.

[7] J. Lamoureux, T. Judkins-Cohn, R. Buteo, V. McCue, & F. Garcia, "Measuring perceptions of shared governance in clinical practice: Psychometric testing of the RN-focused Index of Professional Nursing Governance (IPNG)", Journal of Research in Nursing, (2014): 19,69e87.

[8] J. Siller, M. Dolansky, J. Clavelle, "Shared governance and work engagement in emergency nurses". J EmergNurs. (2016): 42(4):325-330.

[9] J. Wilson, K. Speroni, R. Jones, "Exploring how nurses and managers perceive shared governance nursing". (2014): 44(7): 19-22. https://doi.org/10.1097/01.NURSE.0000450791.18473.52

[10] Jacobs C, Ward C.,"Empowering frontline nurses to transform shared governance. Nursing; (2012):42(7): 18-20. https://doi.org/10 1097/01.NURSE.0000415321.70217.0d

[11] K. Tongmuangtunyatep, W. Kunaviktikul, R. Nantsupawat, T. Akkadechanun, "Development of a Competency Assessment Scale for Head Nurses in Community Hospitals". Pacific Rim Int J Nurs Res (2015): 19(2) 122-134.

[12] LH. Aiken, DM. Sloane, S. Clarke, L. Poghosyan L, Cho E, You L, Finlayson M, Kanai-Pak M, Aungsuroch Y., "Important of work environments on hospital outcomes in nine countries". J Quality in Healthcare. (2011): 23 (4):357–364.

[13] M. L. Joseph & R. J. Bogue, "A theory-based approach to nursing shared governance", Nursing Outlook, (2016): 64, 339e351.

[14] Mohamed Seada and E. Abdelalim Etway, "Relationship between Staff Nurses' Perceptions of Professional Shared Governance and their Job Satisfaction". Journal of American Science; J Am Sci. (2012): 8(5):256-266]. (ISSN: 1545-1003).http://www.americanscience.org

[15] MR. Bleich, Shared Governance-Shared Leadership: Opportunities for Development. J. Contin Educ. Nurs. 2018; 49(9):394-396.

[16] N. Ali Al-Faouri, M. Essa, "Perception of Shared Governance among Registered Nurses in a Jordanian University Hospital" International Journal of Humanities and Social Science. (2014): 46(1): 254-262.

[17] N. Crisp, "Turning the world upside down: the search for global health in the 21st century", Royal Society of Medicine Press, London. (2010).

[18] N. Porter-o'grady and Hinshaw, "The concept behind shared governance, shared governance: a practical approach to reshaping professional nursing practice", (2005): © 2006 hcpro, inc.

[19] N., Peter Guy "Leadership traits; theory and practice", 6th edition, Western Michigan University (2013).

[20] P. Germain, G. Cummings, "The influence of nursing leadership on nurse performance: A systematic literature review". J Nurs Manage. (2010):18: 425-439.

[21] Patrícia de Oliveira Furukawa; Isabel Cristina Kowal Olm Cunha, "Profile and competencies of nurse managers at accredited hospitals", Rev. Latino-Am. Enfermagem vol.19 no.1 Ribeirão Preto Jan./Feb. (2011). http://dx.doi.org/10.1590/S0104-11692011000100015.

[22] Picker Institute, A national NHS staff survey, 2012.

[23] R. Hess G., "The measurement of professional nursing governance", (1994): (January 1, and dissertation available from ProQuest. Paper AA19427505.

[24] R. Hess G., "Slicing and dicing shared governance: In and around the numbers", Nursing Administrative Quarterly, (2011):35(3), 235e241.http://sciedu.ca/journal/index.php/jnep/article/view/12157.Vol 8, No 3.

[25] R. Kieft, B. Brouwer, A. Francke, "How nurses and their work environment affect patient experiences of the quality of care: a qualitative study". BMC Health Services Research. (2014): 14(1): 249. https://doi.org/10.1186/1472-6963-14-249.

[26] S. Haines, "Applying talent management to nursing". Nursing Times; (2013):109: 47, 12-15.

[27] S. Hosny Ahmed, "Head nurses leadership style and their locus of control". International Journal of Current Research, (2014): Issue, Vol. 6, Issue, 12, pp.10605-10614, Available online at http://www.journalcra .com

[28] Shamsuzzoha Syed, V. Dadwal, P. Rutter, J. Storr, D. Joyce Hightower, Rachel Gooden, Jean Carlet, Sepideh Bagheri Nejad, Edward T Kelley, Liam Donaldson, and Didier Pittet, "Developed-developing country partnerships: Benefits to developed countries?". Biomed central, (2012): doi: 10.1186/1744-8603-8-17: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3459713/

[29] Thailand Nursing and Midwifery Council, "Competency of nurse administrators". Thailand Nursing and Midwifery Council: Nonthaburi, (2013): [in Thai].

[30] Thailand Nursing and Midwifery Council, "The Policy and Planning of the Secretariat". Strategic plan for nursing and midwifery council in 2012-2016: Bangkok, (2011): [in Thai].

[31] Twigg & McCullough, "Nurse Retention: a review of strategies to create and enhance positive practice environments in clinical settings", Int J Nurs Stud. (2014): Jan; 51(1):85-92. doi: 10.1016/j.ijnurstu.2013.05.015. E

[32] Warren Chareter, "Traits in Leadership". Mhtml: File. mht. (2014): pp 1-8.

[33] Magdi Yacoub Heart Foundation website; https://myf-egypt.org/

[34] Aswan Heart Center website; http://aswanheartcentre.com