Novelty Journals

ISSN 2394-7330

International Journal of Novel Research in Healthcare and Nursing
Vol. 8, Issue 2, pp: (34-49), Month: May - August 2021, Available at: www.noveltyjournals.com

Relationship between Nursing Governance and Shared Leadership Style as Perceived by Nurses

Yara Hesham Ali Fouad Abd El Gwad Maged[1], Nora Ahmed Bassiouni[2], Amal Diab Ghanem Atalla[3]

[1](Demonstrator of Nursing Administration, Faculty of Nursing, Alexandria University, Egypt)

[2](Professor of Nursing Administration, Faculty of Nursing, Alexandria University, Egypt)

[3](Lecturer of Nursing Administration, Faculty of Nursing, Alexandria University, Egypt)

Abstract: **Today's complex healthcare organizations are facing many challenges. These challenges affect nurses' responsibilities and accountabilities without adding power or authority. Healthcare managers and leaders recognize that quality care is best delivered by creating an attractive work environment, implementing nursing governance and shared leadership. Aim: To investigate relationship between nursing governance and shared leadership style as perceived by nurses. Study design: A descriptive correlational research design was used to conduct this study. Setting: The study was conducted at Alexandria Main University Hospital. Subjects: All nurses who were available at Alexandria Main University Hospital (N = 724) were included in the study and classified as follows: from medical care units (n = 221), from surgical care units (n = 307) and from intensive care units (n= 196). Tools: Two tools were used in this study. Tool I was Index of Professional Nursing Governance (IPNG) survey and tool II was Shared Leadership survey. Method: Self- administered questionnaires were utilized by the researcher to collect the required data. Results: The vast majority of nursing profession related decisions was taken primarily by nursing management and leaders without or only little input from nurses. The highest mean percentage score of the studied nurses' governance was related to ability to set goals and conflict resolution. On the other hand, the highest mean percentage score of the studied nurses' shared leadership style was related to culture. Conclusion: There was a statistically significant difference with positive low correlation between overall nursing governance and overall shared leadership style. Recommendations: Implement strategies that promote nursing governance through providing nurses with equal opportunities for education and training on nursing governance practices. Also, enhance skills of first line nurse managers and nurses such as communication, goal setting, teamwork, resolution of conflict and decision making processes.**

Keywords: **Relationship, Nursing Governance, Shared Leadership Style, Nurses.**

1. INTRODUCTION

Nowadays, healthcare delivery systems are confronting great evolution and rapidly growth of new innovations, information technology and new communication systems. This evolution resulted in more rapid and dramatic changes in healthcare organizational structure and the way it operates (Nasr, El-sayed and Ibrahim, 2018). Many work redesign efforts have been refocused to overcome this evolution by enhancing quality of care and increasing productivity (Farghaly and Nabil, 2019). For this purpose, great attention has been directed toward nurses who are the key frontline elements in serving patients to ensure providing high quality of care and improve outcomes. Healthcare managers and leaders recognize that high quality care is perfectly delivered by nurses who are being more motivated in their work environment. Also, by those nurses who are committed to healthcare organization and empowered to carry out their professional

practice. This only can be done through generally creating an attractive satisfying organizational environment and specifically enhancing participation in decision making; implementing nursing governance (Wilson, 2013; Cohen, 2015; Farghaly & Nabil, 2019).

Nursing Governance was defined by Hess (2011) as a multidimensional concept that involves the structure and process through which professional nurses direct, control, regulate goal-oriented efforts of their practice and influence the organizational context in which it occurs through organizational recognition, facilitating structures, the liaison of information and the alignment of goals". Among nursing governance models is shared governance that is defined as the extension of power, control, and authority to frontline staff nurses over their clinical practice (Hess, 2011). Applying nursing governance in healthcare has a great impact on nurses' empowerment, autonomy, quality of their decision, job satisfaction and their intention to stay at their work (Abo Hashish, 2017).

Porter-O'Grady (2019) reported that there are three fundamental principles validate the presence of effective and sustainable nursing governance structures and practices as follows: firstly, professional governance is grounded on promoting nurses' accountability; secondly, structures are built around professional accountability and clinical decision-making; and finally, professional governance structures reflect distributive decision-making. These principles are shared in organizations to clarify the key elements of nursing governance and the characteristics essential to its effectiveness and sustainability. Also, Hess (2011) classified nursing governance by using Index of professional Nursing Governance survey into six dimensions namely: control over practice, influence over resources, control over personnel, participation in committee structures, and access to information, in addition to the ability to set goals and negotiate the resolution of conflict at different organizational levels. In Egypt, Abo Hashish (2017) reported that there is a positive weak relationship between professional nursing governance and nurses' knowledge, innovations, and improvement. Also, she supported the assertion that nurse leaders are integral in enhancing professional practice environments. Moreover, Ahmed (2012) found a positive correlation between shared governance and nurses work satisfaction.

To support implementation of nursing governance, development of leadership activities is required. Where the leader's role in influencing the organizational behavior is vital, challenges that are encountered in the professional life have caused an increase of questions regarding integrating leadership roles and its impact on nurses, organizational performance and outcomes. Recently, advanced leadership styles were introduced in healthcare practice to promote delivery of high quality care among these leadership styles is shared leadership (Scott and Caress, 2005). Shared leadership is one of nursing management models that supports nurses and invites them to participate in decision making process that affects their practice, environment, development and self-fulfillment (Rosengen and Bondas, 2010). It plays an important role in sharing responsibilities and tasks, improving nurses' performance and work standards, increasing job satisfaction and commitment to organization. Moreover, shared leadership model balances the burden of day-to-day management (Rosengen and Bondas, 2010).

According to Ropo and Eriksson (2001) shared leadership means respect for others' capacities including listening, encouraging, sharing knowledge, information and engaging in decision making. Bergman, Rentsch, Small, Davenport and Bergman (2012) indicated that shared leadership occurs when every member engage in leadership of the team in an effort to influence and direct fellow members to maximize team effectiveness. Shared leadership is classified according to Brussow (2013) into four domains: Collaboration, Vision, Delegation, and Culture. *Collaboration* means the degree in which two or more people work together towards shared goals. *Vision* refers to the ultimate goal of what team member like to accomplish guiding its internal decision making. *Delegation* refers to the degree of assigning any authority to another person to carry out specific activities. It is one of the core concepts of management leadership. *Culture* means the set of shared attitudes, values, goals and practices that characterizes an organization.

In the same line Carson (2007) identified that shared leadership focuses on sharing tasks through an overall team environment which is divided into three main cornerstones mainly: Shared purpose, Social support, and Voice. *Shared purpose* understands and appreciates main collective goals. *Social support* provides emotional support to each other. *Voice* appreciates each team member's contribution. Also Wang, Waldman and Zhen (2014) confirmed that the influence of shared leadership is much stronger when the work of team members is more complex". Wang, Waldman and Zhen (2014) proposed that there are three different types of shared leadership namely: Shared traditional leadership, Shared new-genre leadership, and Cumulative, overall leadership. Firstly, *shared traditional leadership* refers to a task-oriented,

transactional form of leadership. Secondly, *shared new-genre leadership* grounded on transformational leadership; more visionary, growth, inspirational and change-oriented form of leadership. Finally, *cumulative, overall leadership* is based on member's ratings of leadership influence for each of his peers. These studies confirmed that both shared new-genre and cumulative, overall leaderships have positive strong relationship with team effectiveness than shared traditional leadership.

During the last years, several studies have been published focusing on assessing nurses' perception of shared leadership. Pearce et al. (2004), Mehra et al. (2006) and Carson et al. (2007) proofed that there is a positive influence of shared leadership on team effectiveness. It was found that teams often work better when leadership is shared. Sims (2015) claimed that shared leadership is perhaps the most important factor in creating team atmosphere in the organization and loyalty of staff of all levels. Forsyth and Mason (2017) revealed that Shared Leadership is closely linked to the stronger professional and institutional identity of healthcare professionals.

SIGNIFICANCE OF THE STUDY

Today's complex organizations of healthcare settings are facing many challenges as nursing shortage, work overload, decreased workforce, increased patient acuities, increased roles and regulations. These challenges affect nurses' responsibilities and accountabilities without adding power or authority to address changes need improvement in nursing practice. Healthcare managers and leaders recognize that quality care is best delivered by those who are committed to organization and empowered to practice their profession through creating an attractive work environment and implementing nursing governance (Abo Hashish and Fargally, 2017)**.** Although, increasing attention has been given to management functions in healthcare organizations, less attention has been given to integration of nursing governance and leadership roles. Therefore, baseline assessment of the degree of nursing governance and shared leadership can help in improving the quality of nursing care, achieving excellence in nursing profession, raising the community confidence in nursing graduates' performance, improve marketing and reputation of hospitals and nursing image both nationally and internationally.

AIM OF THE STUDY

The study aims to: Investigate relationship between nursing governance and shared leadership style as perceived by nurses.

Research Question: What is the type of relationship between nursing governance and shared leadership style as perceived by nurses?

2. MATERIALS AND METHOD

Design: A descriptive correlational research design was used to conduct this study.

Setting: The study was conducted at a governmental hospital at Alexandria governorate namely, Alexandria Main University Hospital. It is the largest governmental hospital in Alexandria. This hospital was selected because it has the largest number of bed capacity about 1633 beds. It has the greatest number of healthcare providers. It has different categories and qualifications of nurses such as professional, technical and diploma nurses. It receives patients from all governorates in Egypt. It provides wide range of healthcare services such as inpatient, outpatient, intensive and critical care, radiological, laboratory and physiotherapy services.

Subjects: All nurses who were available at the previously mentioned setting, Alexandria Main University Hospital (n = 724). They were classified as follows: from medical care units (n = 221 nurses), from surgical care units (n = 307 nurses) and from intensive care units (n= 196 nurses). Nurses included in the study subjects were selected based on the following criteria: working in previously selected settings, have experience at least one year and provide direct patient care.

Tools: Two tools were used in order to conduct this study as follows:

Tool (1): Index of Professional Nursing Governance (IPNG):

This survey tool was firstly developed by Hess (1994) then updated several times by him in (1998), (2011) and (2017) to assess level of professional nursing governance environment on a continuum ranging from traditional to shared

governance to self-governance depending on the respondents answers. It consists of 50 items divided into the following six dimensions titled; control over professional practice (8 items), influence over resources (8 items), official authority or control over personnel (12 items), participation in committee structure (8 items), access to information (9 items), and ability to set goals and conflict resolution (5 items).

Participants responded to items on a 5-point likert scale that was ranging from 1 to 5 as follows: 1 = nursing administration only, 2 = primarily nursing administration with some nurses input, 3 = equally shared by nurses and nursing administration, 4 = primarily nurses with some nursing administration and 5 = nurses only. Scoring for the total scale and subscale was ranged from 50-250 of total scores reflecting nursing governance environment according to the following levels: 50 to 149 reflecting traditional management decision making environment, 150 to199 reflecting an environment which utilizes professional nursing shared governance decision making between nurses and management and 200 to 250 reflecting nurses are the decision makers group, self-governance.

Tool (2): Shared Leadership survey:

This survey was developed by Brussow (2013) to assess level of nurses' perception towards shared leadership. It consists of 20 items divided into four main domains of shared leadership namely: collaboration (5 items), vision (4 items), delegation (6 items), and culture (5 items). Participants will respond on a 5-point likert scale that is ranging from 1= strongly disagree to 5= strongly agree. The scoring of shared leadership survey ranged from 20 to 100 of total scores reflecting shared leadership environment. The scoring of shared leadership depended on its dimensions as follows: Good > 75%, fair 50-75% and poor < 50%. In addition, part of socio-demographic data was developed by the researcher includes: age, gender, type of current working units, educational qualifications, years of experience since graduation, years of experience in current working units, working hours (per week), previous attendance of training programs on shared leadership and nursing governance and need to attend training programs on shared leadership and nursing governance.

Method:

- Official permission was obtained from Ethical Research Committee, the Dean of Faculty of Nursing, Alexandria University to conduct the study.

- Official permission was obtained from the managers of the selected hospitals, the nursing director and the first line nurse manager in each unit to collect the necessary data.

- Tool I (Index of Professional Nursing Governance (IPNG) survey) and tool II (Shared Leadership survey) were translated and back translated into Arabic, and tested for its face validity by five experts in the field of the study. They were two professors and three lectures from nursing administration department, Faculty of Nursing, Alexandria University. Necessary modifications were done based on their opinions.

- **Reliability analysis:** internal consistency of the study tools was assessed using cronbach's alpha coefficient test. The results of the two tools revealed that they were highly reliable as follows: Tool I (Index of Professional Nursing Governance (IPNG) survey) with α value 0.914 and Tool II (shared leadership survey) with α value 0.844.

- **Ethical considerations:**

- A written informed consent from the study subjects was obtained after explaining the aim of the study.
- Subjects participated in the study on voluntary base, and their right to withdraw from the study at any time was assured.
- Confidentiality of subject's data and privacy of the study subjects were maintained during data collection.

- **A pilot study** was carried out on a number equal to 10% of nurses (n= 72) from El Moasat Hospital, they were not part of the study subjects. The pilot study was carried out in order to check and ensure the clarity, applicability, and feasibility of the study tools and identify obstacles and problems that might be encountered during data collection and necessary modifications were done.

- Data collection: data was conducted by the researcher through self-administered questionnaires. The study tools were hand delivered and distributed on the study subjects after explaining the purpose of the study, they were asked to return it back to the researcher. The study tools were completed in the presence of the researcher to ensure the following: Objectivity of the respondents' responses, non-contamination of their opinions and that all items were answered. Data collection lasted for a period of 2 months started from 15\9\2020 to 15\11\2020.

- Statistical analysis: After completion of data collection,

- Appropriate statistical analysis tests were used to determine the relations and answer research question.
- After collecting data, they were coded, transferred and entered into special designed formats to be suitable for computer feeding.
- Data collection was fed to computer SPSS using Statistical Package for Social Science program for statistical analysis version 20.
- Data were entered as numerical or categorical, as appropriate.
- Following data entry, checking and verification process were carried out in order to avoid any errors.
- The following statistical analysis test was utilized:

A. Descriptive analysis:

- Data were described using numbers, average (minimum) maximum, arithmetic mean ($\overline{X}$), standard deviation (SD) such as: age, years of experience since graduation, years of experience in working units and working hours (per week).
- Categorical variables were described using frequency and percentage of total such as: distribution of levels of nursing governance and shared leadership among nurses at the study hospital. Also, the relationship between the studied nurses' governance levels and their shared leadership levels as perceived by nurses.

B. Analytical analysis:

The following statistical analysis measures were used:

- Pearson's correlation (p) was done to measure the degree of association between two normally distributed quantitative variables. The size of correlation coefficient was assessed.
- Chi-square test (X^2) was used for categorical variables, to compare between different group variables.
- Student T- test and paired T-test were employed to compare the difference between two means and to judge whether an observed difference is significance.
- An Alpha level is set to 5% with a significance level of 95% and α value ≤ 0.05.

3. RESULTS

Table (1) shows that slightly less than one half of the studied nurses (47.1%) were in the age group ranged from 20 years to less than 30 years with mean age 34.15 ± 8.390, while 8.7% of them had more than 50 years. Regarding the gender of the studied nurses, this table reveals that the majority of them (82.5%) were female. Related to current working units, 42.4% of the studied nurses worked in surgical units. According to educational qualifications, more than one third of the studied nurses (37.8%) held Diploma of Secondary Technical Nursing School. As evident in this table, 43.8% of the studied nurses had less than 5 years of experience with mean 10.47 ± 7.942. In relation to years of experience in current working units, this table illustrates that slightly less than one third of studied nurses (30.5%) had more than 20 years of experience in the current working units with mean 9.710 ± 7.5116. Concerning the working hours (per week), more than one half of studied nurses (55.7%) working from 36 to less than 40 working hours per week with mean 39.19 ± 4.059.

Regarding the studied nurses' previous attendance of training program on shared leadership style, this table shows that, 61.5% didn't attend such a program, while slightly around two thirds of them (65.5%) needed to attend such a program. Concerning their previous attendance of training program on nursing governance, two thirds of the studied nurses (66.7%) didn't attend such a program, while more than two thirds of than (67.8%) needed to attend such a program.

Novelty Journals

ISSN 2394-7330

International Journal of Novel Research in Healthcare and Nursing
Vol. 8, Issue 2, pp: (34-49), Month: May - August 2021, Available at: www.noveltyjournals.com

Table (1): Distribution of the Studied Nurses According to their Demographic Characteristics:

Nurses' characteristics	Total N=724	
	No.	%
Age (years)		
▪ 20-	341	47.1
▪ 30-	188	23.2
▪ 40-	152	21.0
▪ ≥50	63	8.7
Min-Max	25-55	
Mean ± SD	34.15 ± 8.390	
Sex		
▪ Male	127	17.5
▪ Female	597	82.5
Current working units		
▪ Medical units	221	30.5
▪ Surgical units	307	42.4
▪ Critical care units	196	27.1
Educational qualifications		
▪ Technical Nursing Secondary School Diploma	274	37.8
▪ Technical Nursing Institute Diploma	190	26.2
▪ Bachelor of Nursing	260	35.9
Years of experience since graduation		
▪ < 5	317	43.8
▪ 5-	92	12.7
▪ 10-	70	9.7
▪ 15-	90	12.4
▪ ≥20	155	21.4
Min-Max	3-22.5	
Mean ± SD	10.47 ± 7.942	
Years of experience in the current working units		
▪ < 5	219	30.2
▪ 5-	113	15.6
▪ 10-	68	9.4
▪ 15-	103	14.2
▪ ≥20	221	30.5
Min-Max	3-22	
Mean ± SD	9.710 ± 7.5116	
Working hours (per week)		
▪ < 36	115	15.9
▪ 36-	403	55.7
▪ ≥ 40	206	28.5
Min-Max	33-45	
Mean ± SD	39.19 ± 4.059	
Previous attendance of training program on shared leadership		
▪ Yes	279	38.5
▪ No	445	61.5
Need to attend training program on shared leadership		
▪ Yes	474	65.5
▪ No	250	34.5
Previous attendance of training program on nursing governance		
▪ Yes	241	33.3
▪ No	483	66.7
Need to attend training program on nursing governance		
▪ Yes	491	67.8
▪ No	233	32.2

Novelty Journals

ISSN 2394-7330

International Journal of Novel Research in Healthcare and Nursing
Vol. 8, Issue 2, pp: (34-49), Month: May - August 2021, Available at: www.noveltyjournals.com

Table (2) reveals that the vast majority of the studied nurses (94.2%) had traditional levels of nursing governance. On other hand, only 0.3% of them had self-governance levels of nursing governance.

Table (2): Distribution of Levels of Nursing Governance among the Studied Nurses at the Study Hospital

Dimensions	Levels of nursing governance (N= 724)					
	Traditional governance		Shared governance		Self-governance	
	No.	%	No.	%	No.	%
▪ Control over prof. practice	650	89.8	61	8.4	13	1.8
▪ Influence over resources	647	89.4	68	9.4	9	1.2
▪ Official authority (Control over personnel)	650	89.8	63	8.7	11	1.5
▪ Participation in committee structure	640	88.4	76	10.5	8	1.1
▪ Access to information	639	88.3	76	10.5	9	1.2
▪ Ability to set goals and conflict resolution	564	77.9	123	17.0	37	6.1
▪ **Total nursing governance levels**	682	94.2	40	5.5	2	0.3

Table (3) clarifies that the overall nursing governance mean percentage scores was 39.05% with mean 97.70 ± 29.963. The highest mean percentage score of the studied nurses' governance was related to ability to set goals and conflict resolution (42.06%) with mean10.51 ± 4.715.

Table (3): Ranking of the Studied Nurses According to their Nursing Governance Mean Percentage Scores at the Study Hospital

Dimensions	Mean Scores		Mean Percentage Score
	Min- Max	Mean ± SD	
▪ Control over prof. practice	8-37	15.66 ± 5.769	39.64%
▪ Influence over resources	8-40	16.45 ± 5.552	41.14%
▪ Official authority (Control over personnel)	12-59	22.83 ± 8.910	38.05%
▪ Participation in committee structure	8-38	14.46 ± 6.216	36.15%
▪ Access to information	9-45	17.59 ± 6.692	39.09%
▪ Ability to set goals and conflict resolution	5-25	10.51 ± 4.715	42.06%
▪ **Total nursing governance mean percentage score**	50-207	97.70 ± 29.963	39.05%

Table (4) illustrates that slightly more than one half of the studied nurses had fair levels of shared leadership (53.0%). On other hand, 21.0% of them had poor levels of shared leadership.

Table (4): Distribution of Levels of Shared Leadership among the Studied Nurses at the Study Hospital:

Dimensions	Levels of shared leadership (N=724)					
	Poor		Fair		Good	
	No.	%	No.	%	No.	%
▪ Collaborative	130	18.0	338	46.7	256	35.4
▪ Vision	143	19.8	270	37.3	311	43.0
▪ Delegation	162	22.4	353	48.8	209	28.9
▪ Culture	126	17.4	289	39.9	309	42.7
▪ **Total shared leadership levels**	152	21.0	384	53.0	188	26.0

Novelty Journals

ISSN 2394-7330

International Journal of Novel Research in Healthcare and Nursing
Vol. 8, Issue 2, pp: (34-49), Month: May - August 2021, Available at: www.noveltyjournals.com

Table (5) shows that overall mean percentage scores of the studied nurses' shared leadership style was 69.88% with mean 69.88 ± 14.479. Moreover, the highest mean percentage score of the studied nurses' shared leadership style was related to culture (71.31%) with mean 17.83 ± 4.229.

Table (5): Ranking of the Studied Nurses According to their Shared leadership Style Mean Percentage Scores at the Study Hospital

Dimensions	Mean Scores		Mean Percentage Score
	Min- Max	Mean ± SD	
▪ Collaborative	5-25	17.60 ± 4.057	70.39%
▪ Vision	4-20	13.99 ± 3.596	69.97%
▪ Delegation	6-30	20.47 ± 4.894	68.22%
▪ Culture	5-25	17.83 ± 4.229	71.31%
▪ **Total shared leadership style mean percentage score**	20-100	69.88 ± 14.479	69.88%

Table (6) illustrates that there was a statistically significant difference with positive low correlation between overall nursing governance and overall shared leadership style (P= 0.054 r= 0.172). As specified in this table, there was a highly statistically significant positive low correlation in participation in committee structure with overall shared leadership, collaborative, delegation and culture of shared leadership (P= 0.004 r= 0.106, P= 0.001 r= 0.123, P= 0.008 r= 0.099, P=0.007 r= 0.101 respectively). Moreover, both control over professional practice and access to information had no significant difference with all dimensions of shared leadership.

Table (6): Correlation Matrix between the Dimensions of Nursing Governance and Shared Leadership Style as Perceived by Studied Nurses:

Dimensions			Dimensions of shared leadership Style				
			Collaborative	Vision	Delegation	Culture	Total shared leadership
Dimensions of Governance	Control over prof. practice	r	0.003	0.021	0.015	0.036	0.010
		P	0.942	0.569	0.682	0.336	0.797
	Influence over resources	r	0.070	0.042	0.093	0.197	0.190
		P	0.061	0.259	0.012*	0.009**	0.015*
	Official authority (Control over personnel)	r	0.120	0.047	0.090	0.115	0.109
		P	0.001**	0.207	0.016*	0.002**	0.003**
	Participation in committee structure	r	0.123	0.033	0.099	0.101	0.106
		P	0.001**	0.373	0.008**	0.007**	0.004**
	Access to information	r	0.020	0.036	0.043	0.033	0021
		P	0.585	0.328	0.247	0.382	0.578
	Ability to set goals and conflict resolution	r	0.010	0.073	0.036	0.016	0.038
		P	0.786	0.049*	0.339	0.661	0.310
	Total nursing governance	r	0.077	0.005	0.071	0.185	0.172
		P	0.039*	0.895	0.055*	0.022*	0.054*

r = Pearson correlation * Significant p at ≤0.05 ** high significant p at ≤0.001

r ≥0.9 very high correlation r 0.7-<0.9 high correlation r 0.5-<0.7 moderate correlation r < 0.5 low correlation

International Journal of Novel Research in Healthcare and Nursing
Vol. 8, Issue 2, pp: (34-49), Month: May - August 2021, Available at: www.noveltyjournals.com

4. DISCUSSION

Nursing governance has been deeply incorporated in nursing profession as a management model essential for providing a structural framework within the healthcare organizations. This framework helps to direct care provided by nurses and improve the overall organizational practice. Nursing governance activities provide nurses with many opportunities in association with nursing management. Also, nursing governance provides the healthcare organization with framework for a collaborative environment of nursing leaders and nurses **(**Frith & Montgomery, 2006 and Mahmoud, 2016**).** This collaborative environment is achieved through decentralization and sharing of leadership activities within healthcare organizations. Shared leadership is necessary to be engaged with nursing governance structures in order to have a powerful collaborative work environment within healthcare organizations (Konu & Viitanen, 2008).

Regarding levels of nursing governance, the findings of this study revealed that the vast majority of the studied nurses practiced the first level of nursing governance; traditional governance level. On the other hand, the least of them had self-governance levels. It reflected that the nursing profession related decisions were taken primarily by nurse managers and leaders without or only little input from nurses. This could be attributed to many factors such as lack of nurses' autonomy and accountability in clinical practice. They might have resistance to change, poor educational qualifications of nurses as most of them were diploma nurses, lack of experience in the current working units, lack of training on nursing governance and increase nurses' workload without being noticed or rewarded. Also, duty rota and nursing shortage can affect nurses' participation in decision making. Moreover, it can be due to the top-down nature of mandated changes and organizational hierarchy within the study hospital, as well, the ineffective use of organizational resources and the miss-use of the process of sharing opinions in decisions.

The study findings were consistent with Seada and Etway (2012) who revealed that nurses had higher perception of traditional governance levels and lower perception of shared governance and self-governance levels. As well, Tourangeau et al. (2005) reported that nurses perceived that they had little or no input in many areas that directly affect the patient care. Also, Kamel and Mohammed (2015) revealed that the total mean score of nursing governance was indicative of traditional governance. In contrast, Farghaly and Nabil (2019) explained that about one half of nurses perceived that they had traditional levels of nursing governance practice in their hospital. While slightly less than half of them perceived that they had shared governance levels of nursing governance and the least of them perceived self-governance practice in their hospital as the present study findings. Also, the findings contradicted with Afeef et al., (2010) who reported nurses' perceptions of their work environment being more closely related to the shared governance structure. In addition, Al-Faouri et al. (2014) found that decisions were shared between nurses and nursing management as perceived by nurses.

Concerning nursing governance mean percentage scores, the results of this study indicated that more than one third of the studied nurses ranked a high mean percentage score of overall nursing governance. Also, the results of the study clarified that the highest mean percentage score of the studied nurses' nursing governance was related to ability to set goals and conflict resolution. These results could be due to the more involvement of nurses in their current working goals and issues which related mainly to the clinical practice and at the point of care level. They might be involved in setting certain work related mission, philosophy and goals during their shifts in the current working. Most of the conflict issues were being resolved at the unit level with little participation from management. Also, this could be due to increasing strategic responsibilities of managers that hinder them from being available all time. Thus, decentralized conflicts are resolved.

In congruence with the study results, Paul, Cherene, Jo, and Cheyne et al (2012) reported that nurses had a more shared ability to set goals and manage conflict with management. Also, Mahmoud (2016) stated that nurses could participate with nursing management in taking clinical practice decisions; although, nurses had limited ability to participate in committees that relate to strategic planning, multidisciplinary professionalism, and organizational budget. Moreover, he declared that the highest mean percentage score of the studied nurses' nursing governance was related to ability to set goals, then conflict resolution. Additionally, Jacobs (2012) highlighted that the flexibility for nurses to participate in different ways led to increase nurses' participation and strengthened nursing governance structure.

The study results did not agree with Kamel and Mohammed (2015) who revealed that the mean score of setting goals and conflict resolution was the lower score in nursing governance dimensions. They suggested that engaging nurses in decision making, work redesign and conflict resolution enhanced nurse empowerment within the work environment, and that nurses had limited skills in this area. Therefore, nurses needed more knowledge and training regarding conflict

resolution strategies in order to improve their ability to advocate for and provide quality patient care. Also, Al-Faouri Et Al., (2014) and Afeef Et Al., (2010) identified that nurses had highest mean score of nursing governance was for the access to information. In addition, Kieft et al. (2014) confirmed that nurses were not frequently allowed to make their own decisions about nursing issues all the time. Additionally, he reported that the highest mean score of nursing governance was for participation in committee structures as the nurses reported that they were more involved in the process and development of nursing policies. Thus, it would have a great positive influence on direct patient care. Moreover, Seada & Etway (2012) clarified that nurses perceived many fields within healthcare organization to be equally shared with nursing management as access to information.

Shared leadership is considered to be significant because it provide nurses with an interactive process with nurse leaders and managers (Konu & Viitanen, 2008). Also, shared leadership is necessary for respecting nurses' skills, as well as listening, encouragement, the sharing of knowledge, rewards, and influence in decision-making process. Thus, incorporation of nursing governance and sharing of leadership activities help to ensure sustainability of collaborative and empowering environment within healthcare organizations (Konu & Viitanen, 2008). Regarding levels of shared leadership, the findings of this study illustrated that slightly more than one half of the studied nurses practiced fair level of shared leadership. On other hand, the least of them had poor levels of shared leadership. This could be due to the presence of supportive leadership, good communication and interrelationships between nurses and healthcare managers in a respectful manner. It also, could be due to the presence of at least a certain level of democracy within the study hospital, providing nurses with a certain degree of autonomy and accountability for their clinical practice. Moreover, they had a certain degree of participation in setting goals and decision making in their current working units.

Supporting the study findings, Lee et al. (2011) and Sutanto et al. (2011) illustrated that moderate levels of shared leadership were found in the temporary groups which were formed for certain short-term tasks which had. Also, Konu and Viitanen (2008) identified that the response rate of their participants to shared leadership was moderate. In opposite with the findings of this study, Minaee (2014) mentioned that slightly less than one third of his study group had fair levels of shared leadership. In contrast, around a third of the study group had poor levels of shared leadership, those who avoided leadership activities. He also, showed that sharing of the leadership activities did not generally secure group outcomes as much as the sharing of leadership itself. Also, Mihalache et al. (2014) found poor levels of shared leadership in his study group that related mainly to managers of the study group when measured at the group level.

Concerning shared leadership style mean percentage scores, results of this study showed that more than two thirds of the studied nurses ranked a high mean percentage score of overall shared leadership. Moreover, regarding correlation between the dimensions of shared leadership, there was a highly statistically significant positive correlation between overall shared leadership and all dimensions of shared leadership. This could be attributed to a fair and mutual trusting work environment in the study hospital. This also, could be related to the nurses' inner professionalism, collaborative approach, being involved in task completion and share responsibility. They also, had decentralized interaction and supportive leadership. They had open lines of communication and interrelationships that motivate them. Also, they had certain degree of sharing information, concerns, views, experiences and leadership activities with other nurses to improve learning and continuous organizational development. There was a climate of common goals and interest. Moreover, they had a degree of participation in setting goals and influence over resources in their current working units.

The results of this study were supported by the study of Ong, Lim, Tan, Chan, and Lim (2016) who indicated that more than one half of the respondents perceived a high mean score of overall shared leadership. Additionally, Carson, Tesluk & Marrone (2007) reported a high mean score of shared leadership in their study project. The study participants felt more recognized within their team, they were more willing to share responsibility and commit to the team's collective goals. They determined that both shared purpose and voice were found to be highly correlated with shared leadership. They also, identified that when team members feel recognized within their team, they are more willing to share responsibility and commit to the team's collective goals. Conversely, Konu and Viitanen (2008) mentioned that less than one half of the study subjects reported high mean score of shared leadership. They added that shared leadership was more common and limited to the managers of the study setting. Also, Ong, Lim, Tan, Chan and Lim (2016) reported low mean score of shared leadership among his study group. They noted to the necessity of increasing socialization in team processes and culture so the team members would be able to develop deeper bonding and attachment with each other. They would be

able to transcend profession-specific boundaries to norm and perform as a team, thus enhancing the sharing of leadership in the decision-making process.

In relation to correlation between dimensions of nursing governance and shared leadership, the findings of this study illustrate that there was a statistically significant difference with positive low correlation between overall nursing governance and overall shared leadership style. This could be attributed to the availability of opportunities for growth and development in variety of ways to increase empowerment and sharing of leadership such as providing nurses with information openly and honestly which help them to accomplish their work and increase and supporting development of leadership skills. On the other hand the supportive organizational culture, informal power and developing relationships within the study hospital that influence and facilitate the work. Thus, increase access to these power structures and enhance collaborative the work environment. Also, the certain degree of participatory work environment with healthcare managers allowed to increase nurses' participation in decision making regarding patient care and increased their accountability over their clinical practice.

The findings of this study were supported by the study of Kamel and Mohammed (2015) who revealed a statistical significant positive correlation between nurse's perception of nursing governance and shared leadership through enhancing nurses' empowerment, which was considered to be a key influence for shared leadership in this study. Also, Bogue, Joseph, and Sieloff, (2009) stated that there was a relationship between nursing governance and empowering nurses to share in leadership. They added that staff empowerment was essential for nursing governance as well as shared leadership, including both the state of empowerment itself and the structures that facilitate it. Additionally, the findings showed that there was a highly statistically significant positive low correlation in participation in committee structure with overall shared leadership and each of collaborative, delegation and culture of shared leadership. This could be related to the certain degree of nurses' participation in organizational decisions and formation of certain decisions related to organizational committees with nursing management. Also, the presence of a collaborative work environment, a supportive organizational culture, open lines of communication with mutual trust with delegation of certain management roles to decrease work load and responsibilities of nurse managers and administrator help to increase nurses' participation and have more engagement in nursing governance practices.

Supporting the findings, Al-Faouri et al. (2014) determined a relationship between nursing governance and shared leadership. He also, identified the presence of several factors that were necessary for success and achievement of nursing governance and shared leadership programs as support from managers and leaders, clear role delineation, and support for the time nurses need to participate. Regarding collaboration; a main dimension of shared leadership, Kanste, Halme and Perala (2016) identified that there was a significant relation between nurses' control over work; a main dimension of nursing governance and collaboration. They added that good awareness of services, agreement upon collaboration practices and well-functioning collaboration were associated with staff influence over their own work and social support from managers. Also, Sayed, Ahmed, Bakr, and Sherief (2019) illustrated that there was a significant relationship between nursing governance and collaboration. He reported that nursing managers collaborate with nurses to develop and implement a model of nursing care that supports nurses' professional control over nursing practices. Regarding delegation as a main dimension of shared leadership, Schwarz, Ward, Cornwell and Coccetti (2020) clarified that there was a significant relation between governance and delegation. He clarified that good governance was integral to successful delegation which is a main dimension of shared leadership.

5. CONCLUSION

The findings of the present study concluded that the vast majority of the studied nurses practiced the first level of nursing governance; traditional governance level as the nursing profession related decisions were taken primarily by nursing management and leaders without or only little input from nurses. Additionally, more than one third of the studied nurses ranked a high mean percentage score of overall nursing governance and the highest mean percentage score of the studied nurses' nursing governance was related to ability to set goals and conflict resolution. Moreover, more than one half of the studied nurses practiced fair level of shared leadership. Furthermore, more than two thirds of the studied nurses ranked a high mean percentage score of overall shared leadership. Likewise, there was a statistically significant difference with positive low correlation between overall nursing governance and overall shared leadership style (P= 0.054 r= 0.172).

International Journal of Novel Research in Healthcare and Nursing
Vol. 8, Issue 2, pp: (34-49), Month: May - August 2021, Available at: www.noveltyjournals.com

6. RECOMMENDATIONS

Healthcare administrators should:

1 Provide nurse managers with opportunities to attend educational and training programs, conferences, workshops and online meetings that focus on nursing governance practices, professional and interpersonal leadership skills and capabilities to promote effectiveness and efficiency of organizational performance.

2 Maintain a collaborative, healthy work environment through having open lines of communication by arranging protected times away from times of patient care, and adjusting schedules for staff nurse meetings and training programs with their healthcare managers to improve interdisciplinary relationships between nurses and healthcare managers, also, their participation in decision making.

3 Support nurses' participation in professional work environment, problem-solving, conflict resolution, committees and organizational decision-making as key ingredients for organizational success to foster greater professional nursing engagement.

4 Enhance mutual respect and trust among healthcare managers and nurses by fairly treating them, likewise, equally allocating resources and opportunities such as control over professional practice, accessing of information, as well as opportunities for training programs and professional promotion.

5 Give nurses monthly reports to remind them of the vital issues that could affect their clinical practice as well as quality of patient care. As well, supporting them emotionally and with premiums regarding their efficient work performance to ensure sustainability of organizational success.

6 Review and revise the organizational policies periodically to eliminate policies that specifically reduce nurses' control over their professional practices, allocation of resources and share in decision making. As well, support the organizational policies that enhance open communication, interdisciplinary relationships, nurses' empowerment, delegation and collaborative work environment.

First line nurse managers should:

1. Implement strategies that promote nursing governance through providing nurses with equal opportunities for education and training on nursing governance practices.

2. Give nurses protected times to participate in nursing governance and accomplish their work functions regarding the role in their units.

3. engage nurses' in decision making at their unit level during their work by adjusting schedules for attending staff nurses' meetings and listening to their opinions, ideas, views and concerns in order to foster nurses' autonomy, accountability, empowerment, engagement, ownership, citizenship and sense of responsibility.

4. Enhance skills of first line nurse managers and nurses such as communication, goal setting, teamwork, resolution of conflict and decision making processes.

5. Assist nurses who have a vital role in nurses' work engagement by listening to their concerns and supporting them with solutions and training programs to enhance their awareness, knowledge and performance, likewise, promoting self and career development

6. Establish and implement change management strategies that will secure nurses' work engagement such as maintaining flexible schedules, obvious clear communication and feedback, and treating nurses fairly in the units.

7. Encourage nurses to make the best choices and learn from their mistakes through applying proper counseling and punitive actions to eliminate unwanted behaviors.

8. Provide nurses with constructive rewards and recognition for their work performance either by verbal encouragement or professional promotion recommendations.

9. Develop trust, inspire power and pride in nurses through leaving beyond their interests, focusing on the interests of the group and the organization as a whole, and being role models for their nursing staff.

10. Inspire nurses in their work environment by having shared goals and mutual understanding of what is mostly important and right. Support them with ideas regarding what is possible, how to fulfill them and improve their meaning, also, enhance their positive expectations about is necessary to be done.

11. Coach and mentor nurses, understand, consider and share others' views, opinions and developmental needs. As well, deal with each nurse uniquely.

12. Measure nurse leaders' performances with obvious, clear goals and measurable objectives, and performance of nurses in shared leadership as well either by client ratings, team member reports, or a previously agreed scale to rate how a task was completed.

13. Spend time for discussing how nurses will be able to make consensus upon to choose best decisions that they will have to make. This can be done by considering team attitudes, priorities and different approaches.

REFERENCES

[1] Abou Hashish, E., & Fargally, S. (2017). Assessment of Professional Nursing Governance and Hospital Magnet Components at Alexandria Medical Research Institute, Egypt. Journal of Nursing Education and Practice, 8 (3), 37:47.

[2] Afeef M, Fayumi W, Qudimat M. (2010). Nurses Perception of Shared Governance: Proceeding of the Third JNC International Nursing Conference, April 27th -28th. Jordan, Amman, Jordanian Nursing Council.

[3] Ahmed, H. (2012). Shared Governance and its Effect on Nurses' Work Satisfaction at Assiut University Hospital. Unpublished Master Thesis. Faculty of Nursing, Assiut University.

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

[5] Al-Sawai, A. (2013). Leadership of Healthcare Professionals: Where Do We Stand?. Oman Medical Journal, 28(4), 285-287.

[6] Andreas, E., & Lindstrom, S. (2008). Shared Leadership as a Future Leadership Style. 30. http://citeseerx. ist.psu.edu/viewdoc/download?doi=10.1.1.519.4395&rep=rep1&type=pdf.

[7] Bergman, J. Z., Rentsch, J. R., Small, E. E., Davenport, S. W., & Bergman, S. M. (2012). The Shared Leadership Process in Decision-Making Teams. The Journal of Social Psychology, *152*, 17:42. http://dx.doi.org/10.1080/ 00224545.2010.538763

[8] Bogue, R. J., Joseph, M. L., &Sieloff, C. L. (2009).Shared Governance as Vertical Alignment of Nursing Group Power and Nurse Practice Council Effectiveness. Journal of Nursing Management, 17(1), 4-14.

[9] Bretschneider, J., Glenn-West, R., & Green-Smolenski, J. (2010). Strengthening the Voice of the Clinical Nurse: The Design and Implementation of a Shared Governance Model. Nursing Administration Quarterly, 34(1), 41:48. https://doi.org/10.1097/NAQ.0b013e3181c95f5e

[10] Brussow, J.A. (2013). Shared Leadership Measure. Lawrence, KS: Center for Research on Learning, University of Kansas.

[11] Carson, J. B., Tesluk, P. E., & Marrone, J. A. (2007). Shared Leadership in Teams: An Investigation of Antecedent Conditions and Performance. Academy of Management Journal, *50*(5), 1217:1234.

[12] Cohen, C. (2015). Leveraging the Power of Shared Governance. Published Doctorate Dissertation. College of Health Sciences, Walden University.

[13] D'Innocenzo, L., Mathieu, J. E., & Kukenberger, M. R. (2016). A Meta-analysis of Different Forms of Shared Leadership-team Performance Relations. Journal of Management, 42(7), 1964:1991.

[14] Farghaly, S., Nabil, L, (2019). Conference Papers. Developing a Strategy for Improvement of Professional Nursing Governance.

[15] Fraith K, Montgomery M. (2006).Perceptions, Knowledge, and Commitment of Clinical Staff to SharedGovernance. Nursing Administration Quarterly, 30(3), 273-284.PMID: 16878013.

[16] Hess, R. (1994). Shared Governance. Innovation or Imitation? Nursing Economics, 12(1), 28:34.

[17] Hess, R. (1998). Measuring Nursing Governance. Nursing Research, 47(1), 35:42. https://doi:htt10.1097/00006199-199801000-00007

[18] Hess, R. (2011). Slicing and Dicing Shared Governance in and around the Numbers. Nursing Administration Quarterly, 25(3), 235:241.

[19] Hess, R., Desroches, C., Donelan, K. et al. (2011). Perception of Nurses in Magnet Hospitals, Non-magnet Hospitals, and Hospitals Pursuing Magnet Status. Journal of Nursing Administration, 41(7/8): 315-323. https://doi.org/10.1097/NNA.0b013e31822509e2

[20] Jacobs, C., Ward C. (2012). Empowering Frontline Nurses to Transform Shared Governance. Nursing, 42(7), 18:20.https://doi.org/10.1097/01.NURSE.0000415321.70217.0d

[21] Kamel , F. , Mohammed, S. (2015). Perception of Shared Governance and its Relation to Nurses Empowerment in Benha and Menoufia University Hospitals. Journal of Nursing Science. Published on http://www.aascit.org/ journal/jns ISSN: 2381-1056; ISSN: 2381-1064.

[22] Kanste, O., Halme, N.&Perala, ML. (2016). Collaboration Management and Employee Views of work and Skills in Services for Children and Families in Finnish Municipalities: The Collaboration Management and Employee Views of Work and Skills. Nordic Journal of Working Life Studies, 6 (1), 61-81.

[23] Kieft R, Brouwer B, Francke A, &Delnoij D. (2014). How Nurses and their Work Environment Affect Patient Experiences of the Quality of Care: a Qualitative Study. BMC Health Services Research, 14(1), 249.http://dx. doi.org/ 10.1186/1472-6963-14-249.

[24] Kocolowski, M. (2010). Shared Leadership: Is it Time for a Change. Emerging Leadership Journeys, 3(1), 22:24.

[25] Konu, A., Viitanen, E. (2008). Shared Leadership in Finnish Social and Health care: Leadership in Health Services, 21 (1), 28-40. DOI 10.1108/17511870810845888.

[26] Lee, K. C., Lee, D. S., &Seo, Y. W. (2011).Effects of Shared Leadership on Team Creativity through Knowledge-Sharing in an E-learning Environment. Paper presented at the 5th International Conference on Ubiquitous Information Management and Communication, Seoul, Republic of Korea.

[27] Liao, Z., Zhu, J., Yam, K.C. (2019). Shared Leadership: A State-of-the-Art Review and Future Research Agenda. Journal of Organizational Behavior, 39(7), 2:12.https://doi.org/10.1002/job.2296

[28] Luis, J., Lorenzini, A., Regina, S., Lucia, A., Beatriz, S., Lima, A. (2013). Nursing governance: An Integrative Review of Literature. Revista da Escla de Enfermagem da USP, 47(6), 1:12.

[29] Mahmoud, H. G. (2016). The Relationship between Nurses' Professional Shared Governance and Their Work Empowerment at Mansoura University and Specialized Medical Hospitals. Journal of Biology, Agriculture and Healthcare, 6(18), 13–21. https://www.iiste.org/Journals/index.php/JBAH/article/view/33023

[30] Mihalache, O. R., Jansen, J. J., Van den Bosch, F. A., &Volberda, H. W. (2014). Top Management Team Shared Leadership and Organizational Ambidexterity: A Moderated Mediation Framework. Strategic Entrepreneurship Journal, 8(2), 128-148.

[31] Minaee, S.G. (2014). The Effect of Shared leadership on Workgroup Creativity. http://ro.ecu.edu.au/theses/1576/

[32] Nedzinskaite-Maciuniene, R., Merkytė, S. (2019).Shared Leadership of Teachers through their Interpersonal Communication Competence. Vilnius University Press, 42, 85:9. https://doi.org/10.15388/ActPaed.42.6 ISSN 1392-5016 eISSN 1648-665X

[33] Ong, Y. H., Lim, I., Tan, K. T., Chan, M., & Lim, W. S. (2016). Assessing Shared Leadership in Interprofessional Team Meetings: A Validation Study. The Asia Pacific Scholar, 1(1), 9–19. https://doi.org/10.29060/taps.2016-1-1/oa1003

[34] Paul,B., Cherene, O., Jo, B., Cheyne, C., Robert, H. & Bev, O. (2012). Professional Nursing governance in a

[35] Pearce, C., Conger, J. (2003). Shared Leadership: Reframing the Hows and Whys of Leadership. Thousand Oaks, CA: Sage, 1:18.

[36] Porter-O'Grady T. (2001). Is Shared Governance Still Relevant?. Journal of Nursing Administration. 4(10), 468:473. https://doi.org/10.1097/00005110-200110000-00010

[37] Ropo, A., Eriksson, M. (2001). Shared Leadership. A new Challenge for Managing Specialists, in Gronroos, C. and Jarvinen, R. Vantaa: Talentum Media, 108-210.

[38] Rosengen, K., & Bondas, T. (2010). Supporting "Two-Getherness": Assumption for Nurse Managers Working in a Shared Leadership Model. Intensive and Critical Care Nursing, 26(5), 288:295.

[39] Sayed, S., Ahmed, M., Bakr, M., & Sherief, N. (2019). Assessment of Professional Nursing Governance among Egyptian Nurses. Menoufia Nursing Journal, 4(1), 19–24. https://doi.org/10.21608/menj.2019.118479.

[40] Schwarz, M., Ward, E., Cornwell, P. &Coccetti, A. (2020). Delegation Models in Dysphagia Management: Current Policy, Clinical Perceptions and Practice Patterns. International Journal of Speech-Language Pathology, 22(2), 163-173.

[41] Scott, L., Caress, A. (2005). Shared Governance and Shared Leadership: Meeting the Challenges of Implementation. Journal of Nursing Management, 13(1), 4-5.

[42] Seada A, Etway E. (2012). Relationship between Staff Nurses' Perception of Professional Shared Governance and their Job Satisfaction. Journal of American Science, 8(5), 199-208.

[43] Sims, S., Hewitt, G., & Harris, R. (2015). Evidence of a Shared Purpose, Critical Reflection, Innovation and Leadership in Inter-Professional Healthcare Teams: A Realist Synthesis. Journal of Inter-professional Care, 29(3), 209:215.

[44] Skarbaliene, A., Skarbalius,E. (2018).The Aspects of Shared Leadership in Healthcare. Proceedings of The International Scientific Conference: Society, Integration, Education. Vol III, (May 25th-26th), 406-414.

[45] Sutanto, J., Tan, C. H., Battistini, B., &Phang, C. W. (2011). Emergent Leadership in Virtual Collaboration Settings: A Social Network Analysis Approach. Long Range Planning, 44(5), 421-439.

[46] Swihart, D., Porter-O'Grady T. (2006). Shared Governance: A Practical Approach to Reshaping Professional Nursing Practice. Publisher: HCPro Inc. ISBN-10 (1578398568): ISBN-13(978-1578398560).

[47] Tourangeau A, Coghlan A, Shamian J, & Evans S. (2005). Registered Nurse and Registered Practical Nurse Evaluations of their Hospital Practice Environments and their Responses to these Environments. Nursing Leadership, 18(4), 54-65. Published on: http://dx.doi.org/ 10.12927/cjnl.2005.17835

[48] Wang, D. Waldman, D.A. and Zhang, Z. (2014). A Meta-Analysis of Shared Leadership and Team Effectiveness. Journal of Applied Psychology, 99(2), 181:198.

[49] Weaver.S., Hess. R., Williams. B., Guinea. L., Paliwal. M. (2017). Measuring Shared Governance: One Healthcare System's Experience. Evidance-based Nursing Management, 49 (10), 11:14.

[50] Wild, N. (2015). Antecedent Conditions of Shared Leadership: An Examination of Team Personality Composition, Shared leadership and Team effectiveness. The University of Tennessee at Chattanooga, 15(20), 1:50.

[51] Wilson, E.M. (2013). Evaluating Shared Governance for Nursing Excellence. Doctoral Presentation to Doctoral Committee. University of Nevada, Las Vegas, 30:32

[52] Wilson, K. L. (2014). Nurses Perceptions of Shared Governance Two Years Post Implementation of a Councilor Shared Governance Model. 1–74.

[53] Wood, M. S. (2005). Determinants of Shared Leadership in Management Teams. International Journal of Leadership Studies, 1(1), 64:85.

[54] World Health Organization. Egypt Nursing Profile. WHO country office for Egypt. 2012. Available from: http://www.emro.who.int/countries/egy/index.html.

[55] Wu, Q., Cormican, K., Chen, G. (2020). A Meta-Analysis of Shared Leadership: Antecedents, Consequences and Moderators. Journal of Leadership and Organizational Studies, 27(1), 49:64.