



The Impact of Shared Governance Intervention program on Nurse Leaders' Shared Leadership Style

Ola Youssef Hassan ⁽¹⁾ Magda Atiya Gaber ⁽²⁾ Aisha El-Sayed El-Araby ⁽³⁾

¹ M.Sc. Nursing Science, Faculty of Nursing, Faculty of Nursing, Zagazig University

² Professor, Department of nursing administration, Faculty of Nursing, Zagazig University

³ Assistant professor, Department of nursing administration, Faculty of Nursing, Zagazig University

Corresponding Author: Ola Youssef Hassan, ola.ali21@nursing.zu.edu.eg

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Abstract

Background: Shared governance is a professional practice model that decentralizes decision-making authority and promotes collaborative participation of nurses in organizational governance. It is defined as a structural and relational framework through which nurses at all levels engage in decisions affecting clinical practice, work environment, and organizational policies. **The aim** of the present study was to assess the effect of a shared governance intervention program on nurse leaders' shared leadership style. **Design:** A quasi-experimental design was used to conduct the present study. **Setting:** the study was conducted at all Hospitals affiliated with the Directorate of Health Affairs in Sharkia Governorate - Egypt. **Subject:** The samples included 230 nurse leaders. **Tools:** Three tools were used for data collection Index of Shared Professional Nursing Governance, Shared Governance skills, and Shared Leadership survey. **Results** Nurse Leaders' perception of Shared Professional Nursing Governance significantly increased in a study group, reaching 48% immediately post-program and 76% at three months follow-up. Additionally, 44.4% Shared Governance Skills, while 30.4% and 73% exhibited high level of shared leadership immediately and three months after the program, respectively. **Conclusion:** The shared governance intervention program led to statistically significant improvements in nurse leaders' Shared Professional Nursing Governance, Shared Governance skills, Shared Leadership. These improvements were sustained three months after program implementation. **Recommendation:** Provide organizational support for shared governance, including adequate time, resources, leadership support, and clear roles and responsibilities for participation in shared governance activities. Provide continuous training and professional development for nurse leaders focusing on shared leadership, participatory decision-making, communication, collaboration, delegation, conflict management, and accountability.

Keywords: Shared Governance, Shared Leadership, Nurse Leaders.

Introduction

Shared governance offers an organized method to facilitate this transition by engaging nurses in decision-making across various organizational tiers and by distributing accountability and impact for professional practice. Recent findings depict shared governance as an organizational approach that enhances nurses' involvement in decision-making, professional independence, empowerment, responsibility, communication, and teamwork. A randomized controlled trial in 2024 revealed that adopting a shared governance model enhanced nurses' participation in decision-making and reinforced their views on professional governance (Hamdan & Jaafar, 2024).

Shifting to shared governance also changes what's expected of nurse leaders. Instead of depending mainly on top-down authority, leaders now need to foster participation, open up channels for nurses to shape decisions, support ongoing professional growth, and build systems that encourage nurses to take ownership of their practice. Recent studies highlight that nurse leaders have a key responsibility to deliberately create the structures and habits that sustain professional governance and active nurse engagement (Clavelle & Tarasenko, 2024).

Shared governance and shared leadership are closely linked, yet they refer to distinct concepts. Shared governance offers the organizational structure and processes that allow nurses to take part in decision-making, while shared leadership refers to how leadership influence and responsibility are distributed among team members. As a result, shared governance can foster a setting in which shared leadership grows, by giving nurses formal chances to participate, practice professional autonomy, and shape decisions. Recent evidence points to leadership, empowerment, accountability, communication, and collaboration as connected elements of effective shared governance (Adkins, 2023).



Hamdan & Jaafar (2024) underline that recent evidence indicates that putting shared governance structures in place can greatly boost nurses' involvement in decision-making, while current professional-governance research highlights the value of leadership, empowerment, accountability, and staff voice.

Skills in shared governance are vital for nursing organizations to implement and sustain shared governance successfully. Competencies including communication, collaboration, decision-making, conflict management, negotiation, leadership, accountability, empowerment, critical thinking, change management, and evidence-based practice allow nurse leaders and staff nurses to engage effectively in organizational decision-making and problem-solving. These competencies promote meaningful staff involvement, reinforce professional accountability, and help translate nurses' knowledge and expertise effectively into practice (**Porter-O'Grady, 2021**).

Healthcare organizations are progressively acknowledging the necessity for leadership strategies that extend beyond solely hierarchical, top-down decision-making, allowing for more involvement of frontline nurses in decisions that impact professional practice and the work setting. Conventional hierarchical frameworks focus authority in official management roles, while modern nursing leadership increasingly prioritizes teamwork, professional independence, empowerment, and nurses' participation in organizational decisions. This change is especially significant in intricate healthcare settings, where frontline nurses have considerable clinical expertise and experience that can influence decisions related to patient care, quality enhancement, policies, and professional practices (**Maged et al., 2021**).

Coordination of nursing services, staff support, quality and patient safety promotion, resource management, and organizational change facilitation are all critical functions of nursing leaders. Leadership, communication, decision-making, interpersonal, and managerial skills are all necessary for their employment. According to recent research, successful nurse leaders must also possess vision, knowledge, support, excellent communication skills, and the ability to spearhead change. These skills give nursing leaders the ability to develop teamwork, foster supportive work cultures, and increase the efficacy of nursing care (**Perez-Gonzalez et al., 2024**).

A collaborative leadership method known as "shared leadership" divides leadership power, accountability, and decision-making among team members rather than concentrating them all in a formal leader. It encourages delegation, teamwork, accountability, and group problem-solving while allowing nurses to contribute their knowledge and experience to clinical and organizational choices. Shared leadership is relevant to modern nursing teams because recent nursing research has shown that it is linked to crucial elements of nursing practice, such as delegation and collaboration (**Atalla et al., 2023**).

Nurse leaders play a key role in turning shared governance principles into everyday nursing practice. They encourage staff involvement by giving nurses chances to voice their opinions, take part in councils and committees, and help shape policy and practice decisions, and share accountability for results. Effective nurse leaders also supply resources, education, communication channels, and supportive settings that allow staff to engage meaningfully, rather than simply being consulted (**Mohammad et al., 2023**).

Aim of the study

The study aimed to assess the effect of a shared governance intervention on nurse leaders' shared leadership style.

This aim will be achieved through the fulfillment of the following research objectives:

- Assess nurse leaders' perceptions of shared nursing governance pre-and post-program implementation.
- Assess nurse leaders' skills regarding shared nursing governance pre-and post-program implementation.
- Determine level of nurses' perception towards shared leadership style pre-and post-program implementation.

Research hypothesis

- Nurse leaders' perception of shared professional nursing governance will be significantly improved after the implementation of the nursing governance training program.
- Nurse leaders' of shared governance skills will be significantly improved after the implementation of the nursing governance training program.
- Nurse leaders' of shared leadership will be significantly improved after the implementation of the nursing governance training program.

1. Methods

1.1. Research Design

A quasi-experimental design was used to achieve the aim of the current study.

1.2. Study Setting

The study was conducted in all hospitals (twenty five hospitals) affiliated to nineteen centers and cities affiliated with the Directorate of Health Affairs in Sharkia Governorate - Egypt, which served as the study's site. The hospitals' combined bed capacity is roughly 2640 beds.

1.3. Sample

The study involved two different samples: nurse leaders and nurses, the study sample was calculated by K. Thompson Equation. The sample size of nurse leaders was (230): (all nurse manager (50) and (180) head nurses of various department from a total population of (277)).



Inclusion criteria: Nurse Leaders of both genders, had been in their current job for at least one year.

Exclusion criteria: Participants had been on long - term leave, and anyone who has received training on participatory governance.

1.4. Tools of data collection: Three tools were used to collect the necessary data.

Tool (I): Index of Shared Professional Nursing Governance (IPNG) it consists of two parts: **Part I:** personal and professional characteristics of the nurse leaders (nurse managers and head nurses) such as age, marital status, nursing qualification, residence, work department, experience years, previous attendance of training programs on shared leadership or nursing governance.

Part II : It was developed by **Hess (2010)** to assess the 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 six subscales.

Scoring system: The response to each item was on a five-point Likert scale, Scores from 5 to 1 were assigned: higher scores indicated greater nurse self-governance, while lower scores reflected traditional management governance. The total score ranges from 50 to 250: 50 to 149 reflecting a traditional management decision-making environment, 150 to 199 reflecting an environment utilizing professional nursing shared governance decision-making between nurses and management, and 200 to 250 reflecting self-governance where nurses are the decision makers.

Tool (II): Shared Governance skills tool It was developed by the researcher guided by the Index of Professional Nursing Governance (**Hess, 2010**) and related literature (**Saxena, et al. 2022, Bayat, et al. 2022**) to assess nurse leaders and head nurses' practice of shared governance. It consists of 37 items under five dimensions.

Scoring system: Nurse leaders' responses were measured on a Three-point Likert scale ranging from "Done" "Partly done" and "Not done" The total score ranges from 0 to 2, with a higher score reflecting a more shared leadership environment. These scores were converted into percent score. Study subjects had low nurse leaders' skills if the total score was less than 50%. While it was considered moderate level if the score was from 50% to 75%, and it was considered high level if the total score was more than 75%, internal consistency was measured by Cronbach's alpha.

Tool (III): Shared Leadership survey it was developed by **Brussow (2013)** to assess the level of nurses' perception towards shared leadership. It consists of 20 items divided into four main domains of shared leadership.

The scoring system: Participants were respond on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." The total score ranges from 20 to 100, with a higher score reflecting a more shared leadership environment. These scores were converted into percent score. These scores were converted into percent score. Study subjects had low nurse leaders' shared leadership if the total score was less than 50%. While it was considered moderate level if the score was from 50% to 75%, and it was considered high level if the total score was more than 75%, internal consistency was measured by Cronbach's alpha.

Validity of the tools:

The tools was three in present study, it was assessed by a panel of five experts (two professors and three assistants' professor) from the faculty of Nursing-Zagazig University in administrative department.

Tool I and tool III was developed by Hess (2010), and Brussow (2013). Experts were reviewed the tools for face and content validation through examining their applicability, clarity, relevance, comprehensiveness, understanding and ease of implementation of the items. While tool II was developed by researcher. The experts revised the tools for face and content validation through examining their applicability, clarity, relevance, comprehensiveness, understanding and ease of implementation of the items in relation to the study objectives. The experts reviewed all tools and confirmed their content validity. No modifications or recommendations were suggested by the expert.

Pilot study: A pilot study was conducted after tools validation and before the commencement of actual data collection to assess clarity, feasibility, and applicability of the study tools and to detect any possible obstacles that might face the researcher and interfere with data collection based on the result of the pilot study. Since no changes were needed in the data collection tool, the pilot sample was included in main study sample. The pilot sample included 23 nurse leaders (10% of the study sample) selected from the study setting. Each participant received a copy of the study tools along with a brief explanation of the study purpose. The average time required to complete the tools ranged from 30 to 45 minutes. Nurse leaders included in the pilot study were included in the main study sample.

Shared Governance intervention program (Field work):

Fieldwork was conducted over three months from the first of July to the end of September 2025. The researcher divided the governorate into four regions due to the long distance between cities (central, middle, northern, and southern), each group consisting of 58 nurse leaders. The intervention program was implemented for the study group through 20 sessions totalling 51 hours (30 hours theoretical and 21 hours practical).

The program consisted of two parts. The theoretical component covered key concepts of definition, principles, models of Shared Governance, Shared governance skills definition, characteristics of nursing shared leadership, impact of Shared Governance, Role of Nurse Leaders in Shared Governance



The second part is practical in the form of giving activities and exercises for nurse leaders. Nurse leaders divided into small groups to achieve the activity. The researcher read instructions to them, and then nurse leaders played their roles according to the situation; nurse leaders played roles by rotation to learn how to act according to the assigned role.

At the end of each session, the researcher evaluated the accomplishment of the shared governance exercise through direct observation of performance, Evaluate each nurse-leader group based on the shared governance skills. The researcher used various teaching methods to attract nurses' attention and motivate them to participate, such as lectures, group discussion, brainstorming, role-play, and situations. The teaching media included PowerPoint, a whiteboard, and a copy of the program and brochure, which covered theoretical and practical information about shared governance.

Ethical Considerations:

The study was approved by the Ethics Research Committee at the Faculty of Nursing, Zagazig University. The verbal explanation of the nature, purpose, and benefits of the study was performed by the researcher to nurses included in the study sample. In addition, oral and written consent was obtained from each participant prior to inclusion in the study. Confidentiality of the subjects was also assured through coding of all data. The researcher assured participants that the participation is absolutely voluntary, and they can withdraw at any stage of the research without giving any reason. The collected data and information was confidential and was used only for the purpose of the study.

Statistical analysis

Data entry and statistical analysis were performed using the Statistical Package for the Social Sciences (SPSS), version 24.0 for Windows. Reliability analysis was conducted to assess the internal consistency and homogeneity of the study instruments, including the Shared Professional Nursing Governance, Shared Leadership, using Cronbach's alpha coefficient, with a value of ≥ 0.70 considered acceptable. Descriptive statistics were used to summarize the collected data, where qualitative variables such as demographic characteristics were presented as frequencies and percentages, while quantitative variables, including skills, and perception scores, were expressed as mean $\pm$ standard deviation (Mean $\pm$ SD). Inferential statistics included Repeated Measures Analysis of Variance (ANOVA), or paired t-test where applicable, to compare the mean scores across the three phases of the program (pre-intervention, post-intervention, and follow-up). The Chi-square (χ^2) test was used to examine the relationship between participants' personal characteristics and their levels governance perceptions, and leadership skills. Pearson's correlation coefficient (r) was calculated to determine the strength and direction of the linear relationships among the study variables, including nursing governance, shared leadership. For all statistical analyses, the level of significance was set at $p < 0.05$. Results were interpreted as statistically non-significant when $p \geq 0.05$, statistically significant when $p < 0.05$, and highly statistically significant when $p < 0.001$.

Results

Table 1 shows personal data of nurse leaders, it is clear from the table that 62.8% of nurse leaders were aged 30 to less than 40. Nearly all of the sample (98.7%) were females, and all participants (100%) were married. Regarding their department, the highest percentage (23.8%) belonged to the Medical department. Regarding to educational qualification, the vast majority (90.4%) held a Baccalaureate Degree in Nursing. Furthermore, 64.1% of the nurse leaders had 15 to 20 years of experience. Remarkably, none of the studied nurse leaders (100%) had previously attended any training programs regarding leadership or shared governance.

Figure 1 illustrates that more than the half of nurse leaders had a low perception of shared professional nursing governance before the program implementation (57.4%), after the program implementation 48.0% of nurse leaders had high perception of shared nursing, three months after the program implementation, 76.0% of nurse leaders had a high level of Professional nursing governance. This suggests that the program was effective in improving the nurse leaders' Professional nursing governance. These findings suggest that the program was effective in enhancing nurse leaders' perceptions of shared professional nursing governance providing strong support for the study first hypothesis. Consequently, Hypothesis I was supported.

Figure 2 illustrates that the half of nurse leaders had a low level of Shared Governance Skills before the program implementation (50.5%). After the program implementation, (40.0%) of nurse leaders had moderate levels of Shared Governance Skills, three months after the program implementation, 44.4% of nurse leaders had a high level of Shared Governance Skills. This suggests that the program was effective in improving the nurse leaders' Shared Governance Skills. These findings suggest that the program was effective in enhancing nurse leaders' shared governance skills providing strong support for the study first hypothesis. Consequently, Hypothesis II was supported.

Figure 3 shows that the highest percentage of nurse leaders had a moderate level of Shared Leadership before the program implementation (62.6%). After the program implementation, 30.4% of nurse leaders had high levels of Shared Leadership, three months after the program implementation, 73% of nurse leaders had a high level of Shared Leadership. This suggests that the program was effective in improving the nurse leaders' Shared Leadership. These findings suggest that the program was effective in enhancing nurse leaders' perceptions of shared professional nursing governance providing strong support for the study first hypothesis. Consequently, Hypothesis III was supported.



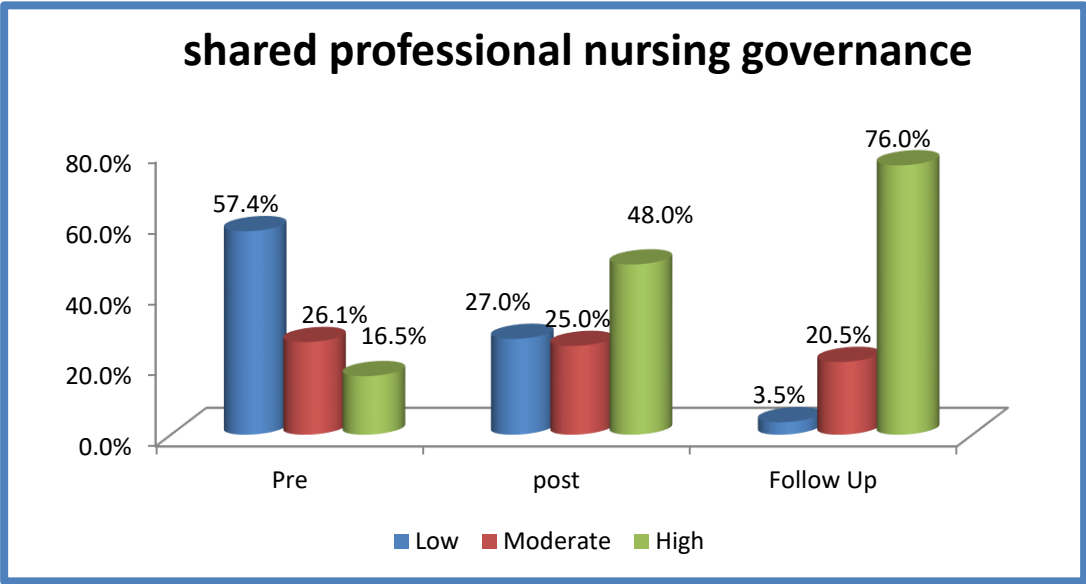
Table 2 concludes that the perception dimensions related to shared professional nursing governance significantly increased among nurse leaders throughout the different phases of the program. A highly statistically significant improvement was observed between the pre, post intervention phases, as well as between the pre intervention and follow-up phases at P-value = (0.000). These results provide significant support for the first hypothesis of the study.

Table 3 displays that nurse leaders Shared Governance Skills increased throughout program phases (1.7491 ± 0.104 , 2.903 ± 0.145 , and 2.292 ± 0.138), with a highly statistically significant difference in their Shared Governance Skills in both pre-post and pre-follow-up phases of the program with P-value = (0.000). These results provide significant support for the second hypothesis of the study.

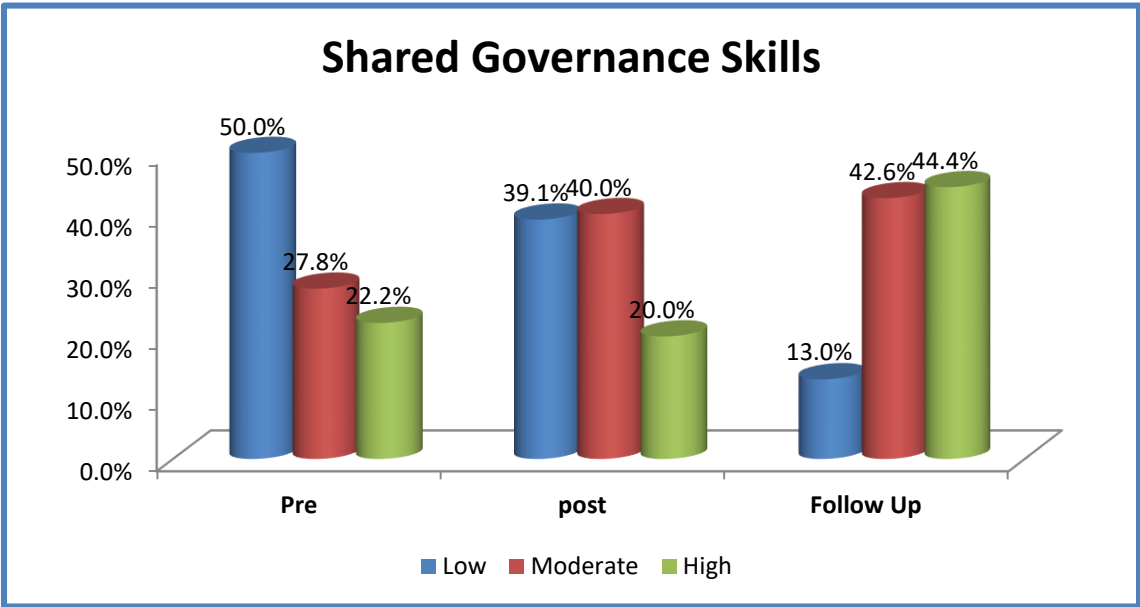
Table (4) demonstrates that the perception dimensions related to nursing Shared Leadership Survey dimension significantly increased among nurse leaders throughout the different phases of the program. A highly statistically significant improvement was observed between the pre, post intervention phases, as well as between the pre intervention and follow-up phases at P-value = (0.000) for all dimensions. These results provide significant support for the third hypothesis of the study.

Table (1): Frequency distribution of nurse leaders' personal data (n=230)

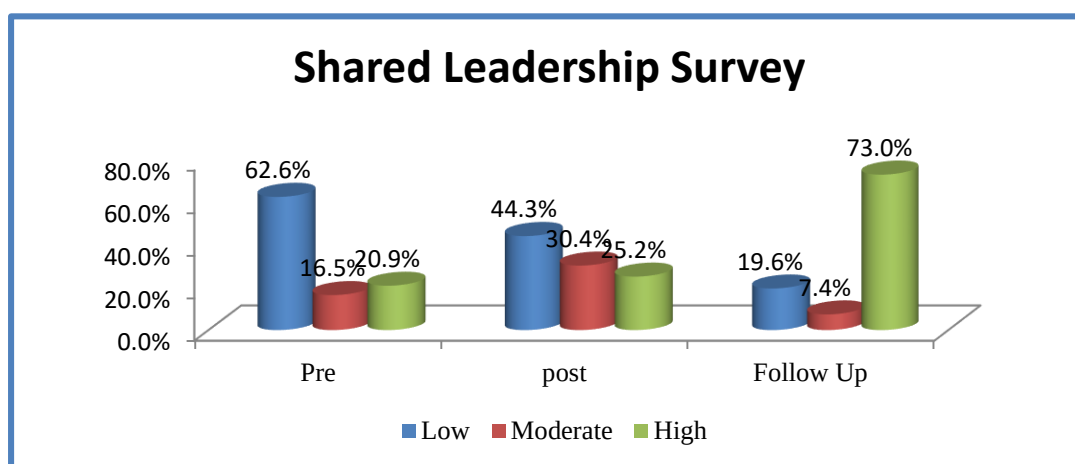
Personal data	Nurse Leaders	
	No	%
Age		
< 30 – 40	145	62.8
< 40 – 50	72	31.2
<50	13	5.6
Mean ± SD	1.426 ± 0.599	
Gender		
Male	2	.9
Female	228	98.7
Marital Status		
Marriage	230	100.0
Single	0	0.0
Mean ± SD	1.000 ± 0.000	
Department		
NICU	21	9.1
Kidney Dialysis	23	10.0
Assistant Director	25	10.8
Operating Room	22	9.5
Emergency	26	11.3
ICU	25	10.8
Director of Nursing	25	10.8
Medical	55	23.8
Out Clinic	8	3.5
Mean ± SD	5.204 ± 2.46	
Educational qualification		
Baccalaureate Degree in Nursing	208	90.4
Nursing Diploma	22	9.5
Mean ± SD	1.096 ± 0.295	
Years of experience		
< 15 years - 20 years	148	64.1
< 20 years	79	34.2
< 10 years - 15 years	3	1.3
Mean ± SD	1.370 ± 0.510	
Attend training program about leadership		
Yes	0	0.0
No	230	100.0
Mean ± SD	2.000 ± 0.000	
Attend training program about shared governance		
Yes	0	0.0
No	230	100.0
Mean ± SD	1.000 ± 0.000	



Low < 50%, Moderate 50% to< 75%, High >75%.
Figure (1): Perception level of shared professional nursing governance throughout the program phases among nurse leaders (n= 230)



Low < 50%, Moderate 50% to < 75%, High >75%.
Figure (2): Level of Shared Governance Skills among nurse leaders throughout the program phases (n= 230)



Low < 50%, Moderate 50% to < 75%, High >75%.

Figure (3): level of Shared Leadership Survey among nurse leaders throughout the program phases (n=230)

Table (2): Comparison of shared Professional nursing governance dimensions among nurse leaders at Pre-, Post-, and Follow-up Tests throughout the Program Phases (n=230)

Professional nursing governance		Mean ± (SD)	T-test
PART 1 (Professional control measuring control over professional practice in the organization)	Pre	2.236±0.138	
	Post	2.427±0.227	
	Follow	4.345±0.709	
P-value	Pre – Post	0.000**	-9.548
	Pre – Follow	0.000**	-44.311
PART 2 (Organizational influence measuring participation in governance activities within the organization)	Pre	2.033±0.160	
	Post	2.312±0.366	
	Follow	2.380±0.314	
P-value	Pre – Post	0.000**	-10.717
	Pre – Follow	0.026**	-15.766
PART 3 (Official authority)	Pre	1.776±0.077	
	Post	1.919±0.347	
	Follow	1.870±0.416	
P-value	Pre – Post	0.000**	-6.065
	Pre – Follow	0.027**	-3.528
PART4 (Participation in committee structure)	Pre	1.566±0.333	
	Post	1.703±0.255	
	Follow	1.824±0.553	
P-value	Pre – Post	0.000**	-5.090
	Pre – Follow	0.001**	-6.053
PART 5 (Information)	Pre	1.694±0.062	
	Post	2.847±0.451	
	Follow	2.921±0.434	
P-value	Pre – Post	0.001**	-38.178
	Pre – Follow	0.000**	-45.319
PART 6 (Ability of conflict resolution)	Pre	2.007±0.538	
	Post	2.171±0.539	
	Follow	2.192±0.511	
P-value	Pre – Post	0.625	-3.319
	Pre – Follow	0.000**	-3.560

*p<0.05= significant

**p<0.001= highly significant



Table (3): Comparison of Shared Governance Skills among Nurse Leaders at Pre-, Post-, and Follow-up Tests throughout the Program Phases (n=230)

Shared Governance Skills	Time	Nurse Leaders (n=230)	
		Mean $\pm$ SD	T-test
	Pre	1.7491 $\pm$ 0.104	
	Post	2.903 $\pm$ 0.145	
	Follow up	2.929 $\pm$ 0.138	
P-value	Pre - Post	0.000**	-98.547
	Pre – Follow	0.005**	-101.740

***p<0.05= significant**

Table (4): Comparison of Shared Leadership Survey dimension among Nurse Leaders at Pre-, Post-, and Follow-up Tests throughout the Program Phases (n=230)

Shared Leadership Survey		Mean $\pm$ (SD)	T. test
Collaboration	Pre	2.422 $\pm$ 0.607	
	Post	3.893 $\pm$ 1.18	
	Follow	4.595 $\pm$ 0.538	
P-value	Pre - Post	0.000**	-19.118
	Pre - Follow	0.000**	-43.245
Vision	Pre	1.992 $\pm$ 0.619	
	Post	4.070 $\pm$ 1.290	
	Follow	4.529 $\pm$ 0.718	
P-value	Pre - Post	0.000**	-24.082
	Pre - Follow	0.000**	-43.497
Delegation	Pre	1.741 $\pm$ 1.01	
	Post	4.198 $\pm$ 0.802	
	Follow	4.481 $\pm$ 0.590	
P-value	Pre - Post	0.000**	-33.400
	Pre - Follow	0.000**	-38.448
Culture	Pre	2.530 $\pm$ 0.342	
	Post	4.451 $\pm$ 0.788	
	Follow	4.566 $\pm$ 0.666	
P-value	Pre - Post	0.061	-36.134
	Pre - Follow	0.000**	-43.4697

****p<0.001= highly significant**



Discussion

Shared governance is a professional practice model that distributes decision-making power and encourages nurses to take part collaboratively in organizational governance. It is described as a structural and relational framework in which nurses at every level take part in decisions that affect clinical practice, the work environment, and organizational policies (**Choi, 2023**). While **Gooden & Cole, (2023)** stated that allowing every member of the healthcare workforce a voice in decision-making encourages creative feedback that will sustain the organization's operations and the healthcare purpose, this is referred to as shared governance.

The findings of the current study demonstrated that the nurse leaders' perception about shared governance in the study increased throughout program phases, with a highly statistically significant difference in both pre-post, and pre-follow up phases. Moreover the significant improvement in perception among nurse leaders' in the study was likely attributable to the structured implementation of the shared governance program, which incorporated interactive strategies such as simulation, role-playing, group discussions, and multimedia. These methods, supported by the distribution of a comprehensive booklet and brochure, facilitated both immediate learning and sustained retention at three months post-intervention. The findings support contemporary evidence suggesting that educational interventions, when combined with supportive organizational structures, can enhance governance awareness, professional accountability, participative decision-making, and nursing empowerment.

These results are consistent with previous studies, including **Abdel-Latif et al. (2023)**, which reported that statistically significant improvements in head nurses' shared governance perception after the educational program. **Speroni et al. (2022)** reported that nurses and nurse managers working within shared governance environments generally demonstrated favorable perceptions of professional nursing governance. Their study highlighted that stronger governance structures were associated with positive nursing outcomes and greater involvement in decision-making processes. **Atalla et al. (2023)**, founded that nurses who perceived higher levels of professional shared governance reported greater career motivation. The authors emphasized that governance structures foster professional development, autonomy, and participation in organizational affairs, which positively influence nurses' perceptions and attitudes toward their profession.

In contrast, the current study's outcomes diverge from those of However, some studies have reported findings that only partially support the current results. As an instance, **Quaid (2023)** found that educational workshops alone did not produce substantial organization-wide improvements, although nurses actively participating in governance councils demonstrated stronger perceptions of shared decision-making than nonparticipants. The authors suggested that education by itself might be insufficient unless accompanied by organizational support, leadership commitment, and opportunities for active involvement in governance structures.

With regard to Shared Governance Skills, The study indicated a statistically significant improvement in head nurses' perception scores related to Shared Governance Skills across various phases of the program. This suggests that the program effectively enhanced their understanding of communication, decision-making, leadership, conflict resolution, teamwork, problem solving, negotiation, and accountability. The continuous improvement from pre-program to post-program and follow-up phases highlights that the training intervention not only provided immediate skill enhancement but also supported long-term retention of these competencies.

These findings align with earlier research, such as **Abdelaliem et al. (2021)** which revealed that the shared governance educational program notably enhanced nurse managers' knowledge of governance practices. It improved their leadership behaviors, problem-solving abilities, conflict resolution skills, teamwork, and organizational decision-making competencies. Participants reported greater self-awareness and stronger perceptions of their leadership roles post-intervention, aligning with the improved perceptions of shared governance skills observed in the current study, **El-Shaer & Ahmed's (2019)** study indicated that staff nurses in two hospitals exhibited a high level of control over their professional practice and skills, largely due to their involvement in bedside decisions, educational development, and nursing care models, **Al-**



Faouri et al. (2014) supported these findings, highlighting that staff nurses felt empowered in their professional roles. Similarly **Abou Hashish & Fargally (2018)** noted that nursing staff rated their control over professional practice as a key component of nursing governance, emphasizing their participation in clinical, rather than managerial, decision-making.

Additionally, **Kanninen, Häggman Laitila, Tervo-Heikkinen, and Kvist (2021)** found that head nurses experienced minimal shared governance and exhibited a conventional management style, where top-level managers oversee all shared governance activities. A statistically significant enhancement in head nurses' practices and their nurses' perceptions regarding head nurses' professional shared governance and its aspects was observed after three months of the educational program. This suggested that head nurses were prepared to take accountability for gaining particular skills to implement professional shared governance in their work and promote involving their nurses in the shared governance councils and procedures.

The above findings provide significant support for the second hypothesis of the study by indicating that the intervention program was successful in improving nurse leaders' shared governance skills. Thus, Hypothesis II was validated.

The current study found that head nurses' scores on the Shared Leadership improved significantly across all phases of a shared governance training program. The differences were statistically significant between pre-program and post-program scores, as well as between pre-program and follow-up scores. This indicates that the training effectively enhanced head nurses' perceptions and practices regarding shared leadership, with the competencies being sustained over time.

The findings align with **Elwanis et al. (2023)**, which established a significant positive link between shared leadership and nurses' performance, emphasizing benefits like enhanced staff engagement and development. They advocated for educational initiatives to bolster shared leadership among nursing staff. Similarly, **Hassan et al. (2023)** found that shared governance training enhanced nurse managers' understanding of governance and commitment, promoting collaborative decision-making. Their results reinforce the observation that perceptions of shared leadership improved after training.

Further support comes from recent studies highlight the positive impact of shared leadership in nursing, with **Abd-EL Aliem & Abou Hashish, (2021)**. indicating that the shared leadership predicts organizational well-being and enhances workplace satisfaction, the study emphasized that environments characterized by shared leadership . **Atalla et al. (2021)** confirmed that shared leadership improves nursing outcomes and reduces missed care through effective delegation and collaboration. Additionally, **Kim et al. (2024)** noted that perceptions of shared leadership enhance patient safety and commitment within healthcare settings. The results presented here indicate strong support for the third hypothesis of the study by indicating that the training was successful in improving nurse leaders' perceptions of shared leadership. Thus, Hypothesis III was validated.

Conclusion

Considering the study results, it can be inferred that the program resulted in statistically significant advancements. In the study, nurse leaders exhibited increased levels of perception regarding shared governance right after the program and three months later, compared to their perceptions before the program. Likewise, notable improvements were noted in Nurse leaders' skills concerning shared nursing governance throughout the same time intervals. Moreover, the study revealed that nurse leaders exhibited increased levels of shared leadership. Furthermore, most nurse leaders in the research expressed satisfaction with the shared governance program.

Recommendation: Based on the findings of this study, the nurse's leaders need to:

- Continue developing shared governance and shared leadership competencies through regular training, workshops, and mentoring.
- Encourage staff nurses to participate actively in decision-making, problem-solving, policy development, and quality-improvement activities.
- Delegate appropriate authority and responsibilities to nurses while maintaining accountability for outcomes.
- Promote open communication, active listening, constructive feedback, collaboration, and mutual respect



within nursing teams.

- Act as facilitators and mentors who support nurses in developing leadership skills and confidence in participating in governance activities.
- Monitor the application of shared governance skills in daily practice and identify areas requiring additional support or training.

Conflict of interest

The authors confirmed that there is no any conflict of interest.

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