Relationship between Staff Nurses' Perception of Professional Shared Governance and their Job Satisfaction

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Abstract: Background: Work environments that focus on a decentralized organizational structure facilitate control over nursing practice. Shared governance is an environment where professional nurses have the legitimate authority to make decisions about practice and the accountability for the outcomes of these decisions. This is fundamental to job satisfaction, recruitment and retention, and subsequent quality of care and patient safety. **Aim:** The present study aimed to examine the relationship between staff nurses' perception of professional shared governance and their job satisfaction. Design: a descriptive correlational design was used. **Methods:** The study was conducted in four different work places at El Manial University Hospital. A purposive sample of (90) staff nurses were constitute the study sample. Nurse managers and those in senior nursing administration were excluded from the sample .Data were collected through utilizing two tools, the first consists of two parts, the first part was intended to collect individual characteristics of the study sample, the second part was the Index of Professional Nursing Governance . The second tool was Work Quality Index (WQI) used to measure the job satisfaction of nurses. **Results:** results revealed that ,nurses had lowest mean scores regarding their perception of shared governance which indicates that overall they did not have professional control over their work environment as their work environment are controlled by nursing administrator only or primarily by nurse administrator with some staff input. A highly significant difference between the professional shared governance dimensions total mean scores as well as nurses job satisfaction according to different work places. There was a significant positive correlation between nurses' perception of shared governance and their overall job satisfaction. **Recommendations**: Top manager should play an important role to support the presence of staff nurses at all levels of decision making and measuring patient, nurse, and systems outcomes. Providing the staff nurses formal authority to control practice and have influence in decision making that positively affects their professional respect, job satisfaction, and organizational commitment.

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1. Introduction

Organizational restructuring and reform in the health care system has impacted the ability of staff nurses to participate in and influence decision making that affects the delivery of patient care (**Alvarado et al, 2000; Kennerly, 2000 , McGirr& Bakker, 2000,; Nevidjon & Ives-Erickson, 2001** and **Green & Jordan, 2004).**. Staff nurses maintain and advocate a professional responsibility to practice according to specific standards, policies and procedures, and to meet the needs of the patient and family members. Clinical nurses participation in decision making at the patient, unit and administrative levels recognizes their abilities and skills as professionals; however, nurses continue to experience a limited role in the decision making and control over nursing practice at all of these levels(**Spence et al , 2000 , Broughton, 2001; Ma et al, 2003; Sengin, 2003; McNeese-Smith & Crook, 2003; Brooks, 2004; and Greco et al, 2006;,**

The literature review examines professional shared governance including control over nursing practice and how this complex concept is difficult to define and undervalued within the staff nurses' professional practice environment. Shared governance, which gives staff nurses control over their professional practice, is an essential element of a professional practice nursing model, providing structure and context for health care delivery. The nursing shortage has revitalized the need for shared governance in nursing (**Hess, 2004**) During the 1980s, when shared governance was first introduced, participatory management in which staff nurses were involved in decision making processes led to increased job satisfaction and improved patient outcomes (Mangold, et al, 2006) .

Shared governance provides an opportunity for nurses to exercise control over their practice .Nurses need to be empowered to make decisions about their practice. Decision making that is staff driven is a strong indicator of excellence. Excellence in nursing practice can only be achieved and sustained if nurses have influence that leads to satisfaction and excellence. Shared governance provides a vital communication and decision-making infrastructure that is an essential

element for a professional practice environment. As health care systems embark on systems of shared governance, it is important to evaluate their effectiveness and their impact on satisfaction for the hospital-based nurse(**Hess, 2004**)

The concept of shared governance came into nursing practice in the 1980s through the work of Porter-O'Grady. It was seen as a strategy to enable nurses to exercise control over decisions that affected their practice. Porter- O'Grady emphasized that shared governance is a professional practice model based clearly in the principles of partnership, equity, accountability, and ownership at the unit level where the point of service occurs. Shared governance is a form of participative management that provides nurses with a voice in decision making. In the 1980s, shared governance in nursing began to grow as a result of nurses' dissatisfaction within their respective hospitals(**Barden et al ,2011**)

It is evident in the literature that control over nursing practice is important to the nurses' professional practice environment ultimately affecting job satisfaction, recruitment/retention, and patient outcomes (**Tourangeau *et al.*,2005 and Nedd, 2006;**).Control over nursing practice is explored in relation to internal and external factors that affect the professionalism of the nursing staff. Internal factors are those that are more closely related to the nurse's scope of practice and include professionalism, satisfaction, safe quality patient care, empowerment, and autonomy. The external factors are outside the immediate scope of the nurses yet directly and indirectly affect control over nursing practice including health care restructuring, organizational influence, and nursing leadership.

As skilled professionals, nurses should be recognized for having control over nursing practice by participating in decision making at all levels including critical decision making at the bedside. However, relevant researches (**Aiken *et al.,* 2001; Havens &Vasey, 2005; Tourangeau *et al.,* 2005** and **Nedd, 2006**) illustrates that nurses experience a limited role in the decision making and control over nursing practice at the unit, management, and administration levels. As described by many researchers,**(Broughton, 2001; Kramer&Schmalenburg, 2003** and **Aroskar et al, 2004;** nurses believe control over nursing practice is a fundamental responsibility of professional nursing. Since the perception of one's ability to function independently as a professional is an important aspect of autonomy, it is important to understand nurse's perceptions of their own control over nursing practice.

Spence et al, (2003) agree that a practice environment that provides staff nurses with opportunity to make decisions also promotes their autonomy and control over nursing practice. Contrary to this, centralized authoritarian decision making has a negative and direct impact on the nurses' perception of their control over nursing practice and their ability to provide patient care (**Alvarado *et al.,* 2000; Bakker, 2000; Baumann *et al.,* 2001; Kuokkanen &Katajisto, 2003; Larrabee *et al.,* 2003; McGirr & Porter-O. Grady, 2003; Sengin, 2003**)and **Green & Jordan, 2004;**). As well, an organizational environment that places limits on nurses' control over nursing practice creates challenges in the recruitment and retention of nursing staff and thus affecting their job satisfaction. Moreover, lack of control over nursing practice have been resulted in nurse's frustration, absenteeism, decreased productivity, overall poor morale, job dissatisfaction and subsequently compromising patient care (; **Alvarado *et al.,* 2000; McGirr& Bakker, 2000; Nevidjon & Ives-Erickson, 2001** and **McGillis Hall, 2003)**

Job satisfaction describes how individuals feel about their work. McGillis Hall (2003) presents information on nurses' job satisfaction that can be studied through nursing behaviors such as intent to leave, job stress, organizational commitment, burnout, and turnover. She also identifies different factors that affect job satisfaction such as salary, communication, participation, control over nursing practice, autonomy, organizational commitment, support from management, and educational opportunities. Other factors affecting nurses' job satisfaction include a supportive organizational culture and practice environment, availability and access to resources, adequate staffing to meet patient acuity and demands, and accountability and authority in decision making. (**Aiken *et al.,* 2001a, Havens &Vasey, 2005; Tourangeau *et al.,* 2005** and **Nedd, 2006).**

Significance of the Study:

Nursing Administrators, educators, nurses, and other stakeholders from all sections of the health care system recognize the current trends and future predictions of the nursing shortage. Most of these stakeholders are determined that quality patient care in a quality work environment be developed and maintained (**McGirr & Bakker, 2000; Broughton, 2001; Leatt, 2001, Nevidjon & Ives-Erickson, 2001, Canadian Nurses Association, 2002; and McIntyre & McDonald, 2003).** This study provides nurses an opportunity to share their perceptions of professional governance including control over nursing practice within the organization. Awareness of these perceptions can lead to strategies that address valuing and strengthening nursing staff control over nursing practice at all levels, which will support their retention/recruitment and job satisfaction.

Aim of the study:

The present study aimed to examine the relationship between staff nurses' perception of professional shared governance and their job satisfaction

2. Methodology:

Study Methods

Design:

Descriptive correlational design was utilized in this study

Study setting:

Study was conducted in four different work places at El Manial University Hospital. The specialties of these work place environments were as the following; Surgical Departments, Medical Departments, critical care units and other specialties (Obstetric, Orthopedic).

Sample:

A purposive sample of 90 staff nurses working in the previous mentioned clinical setting and who were willing to be participated in the study constituted the study sample. The criteria for inclusion in the sample included being a staff nurse practicing clinical nursing .Nurse managers and those in senior nursing administration were excluded from the sample as they are responsible for a different aspect of nursing services.

Tools:

Data for the present study was collected through utilizing the following tools:

1- Index of Professional Nursing Governance [IPNG]:

In this study a description of staff nurses perceptions regarding the professional practice environment including control over nursing practice was created by using (IPNG) questionnaire. The questionnaire was developed by (**Hess, 1998**) contained two sections, The first section collected demographic information, including age, sex, educational preparation, employment status, number of years as a practicing nurse, type of nursing unit working on, number of years worked in this hospital .The second section includes 64 items that measures nurse's perceptions about who governs the professional environment, including control over practice. It divided into the following five subscales:

- *Professional control*: (i.e. who has control over professional work in a formal organization; it includes (13 items)
- *Organizational influence*, (i.e. who has influence over information and resources that support professional work, (14 items),
- *Facilitating structures*, (i.e. who determines and participate in a structure that provide a vehicle for making governance decisions in organization, (10 items),
- *Liaison (i.e.* who has access to information necessary to control practice and influence allocation of organizational resources, (15 items)
- *Alignment (i.e.* opportunity to negotiate and manage conflict within organization (12 items).

The scoring system was 5 point Likert scale regarding how the staff nurses perceive control over nursing practice. The Likert scale contains the following response possibilities: 5 = staff nurses only; 4 = primarily staff nurses with some nursing management input; 3 = equally shared by staff nurses and nursing management, 2 = primarily nursing management/ with some staff nurse input; 1 = nursing management only. Reliability of the tool was done by using Cronbach's alpha which considers the most commonly used test of internal consistency of tools having likert scale format. Cronbach,s alpha of the professional shared governance instrument was as 0.95

2-The Work Quality Index (WQI). It was developed by Whitley and Putzier (1994) to measure the job satisfaction of nurses. The WQI is a 29 items, divided into 6 subscales: (a) Professional work environment (7 items), (b) autonomy of practice (3 items) (c) work worth to self and others(5 items), (d) professional relationships(3items) , (e)professional role enactment(3 items), and (f) benefits(8 items). The internal reliability of the scale was established with a Cronbach's alpha of .94 for the entire WQI. The scoring system was 5 point Likert scale as followed: 5 (strongly agree),4 (agree),3(neutral), 2 (disagree) and 1(strongly disagree)

Tools validity:

The two tools contents were developed and tested for its content validity through five expertise from nursing administration department in two different universities. Based on their recommendations the necessary modifications were made. Double translation English-Arabic-English was done to ensure validity of translation.

The Pilot Study:

A pilot study was conducted in 10 % of study sample in order to test the clarity and validity of the study tools contents, add or omit questions and assess time needed to respond to each questionnaire.

Administrative and ethical consideration:

An official permission was obtained from hospital's medical director as well as nursing director to conduct the study at the selected units. They were reassured that the collected information was being treated confidentiality.

Procedure:

Once permission was granted, the purpose of the study was explained to staff nurses who accept to participate in the study. An explanation of each instrument was done before it handed to the studied sample on their work places .Sheets was filled out at range of 30 minutes. Data collection was done at morning and afternoon shifts and it consumed two months.

Statistical analysis:

The collected data were organized, tabulated and statistically analyzed using SPSS software statistical computer package version 15. mean and standard

deviation were calculated. For comparison between more than two means, the F value of analysis of variance (ANOVA) was calculated, where LSD (least significant differences) test was performed to compare between each two means if F value was significant. Correlation between variables was evaluated using Pearson's correlation coefficient. Significance was adopted at $p<0.05$ for interpretation of results of tests of significance. (**Dawson &Trappy (2001)**.

3. Results:

Demographic characteristics show that the study sample consisted of 90 nurses.34% their age was between 20-25 years old, while 11.1% were between 26-31 years old. The highest percentage (98.8%) was female. In relation to level of education , study results clarifies that , 98% representing the majority had diploma of nursing school ,while only 2% had baccalaureate nursing degree. As well as the majority of study sample (93.3%) working full time. According to the places which they work in,40.%were working in intensive care units, 22.2% were working in medical departments, while only 14.4 % were working in the in other departments. As regard years of experiences, result of the present study shows that 50% had less than 5 years of experience, while 23.3 % had years of experiences ranged between 11-16 years. In relation to the length of stay at work, 61.1% stayed from 1-5 years, and 17.7 % stayed less than one year.

When comparing between the demographic variables of nurses in relation to their perception of professional shared governance and job satisfaction. Table (1) revealed that there was a significant difference between the age of the participants and their perception of the shared governance (F-ratio =47.624, *P*=0.000) and their job satisfaction (F-ratio =725.78, *P* =0.000).As well as there were highly significant differences between nurses perception of shared governance and their job satisfaction in relation to employment status (F-ratio =8.252, *P* =.005,F-ratio =7.247, *P* =008,) years of experiences (F-ratio =153.141 *P* =0.000, F-ratio =131.668, *P* =0.00) nursing units (F-ratio =22.184, *P* =0.000, F-ratio =20.706, *P* =.000.) and numbers of years in the present hospital ((F-ratio =34.758 *P* =.000, F-ratio =29,522, *P* =.000) . While data in the same table shows that there were no statistically significant differences between both sex and educational preparation and the study variables.

Regarding to mean scores of nurses perception of shared governance ,data in table (2) clarifies that nurses had lowest mean scores in all subscales which is reflected in total mean scores respectively(1.816±.443), indicating that staff nurses dose not perceive that they have professional control over their work environment as their work environment are controlled by nursing administrator only or primarily by nurse administrator with some staff input. This results can be explained more in figures from (1-5) that illustrates the frequencies of nurses responses regarding who has influence in decision making and control over nursing practice. Regarding to professional control subscale, it is clear from table (2) that nurses had lowest mean scores (2.237±.756), and figure (1) also clarifies that nurses perceive that greater participation lies with primarily nursing management with some staff nurses input and moving to equally shared by both with limited input of staff nurses to control their professional work .

As regard to organizational influence subscale, table (2) indicates lowest mean scores (2.228±.892) as well as figure (2) shows that, nurses perceive many areas that are closer to being equally shared with their administrators, while it is clear also from the same figure that many activities relating to this subscale are being done only with administrator with limited staff input. Data in table (2) and figure(3) which is relating to facilitating structure subscale , indicates that nurses perceive limited opportunity to share and almost all activities pertaining to this subscale are being done by nursing administrator only and by nursing administrator with some staff input , with mean scores of (1.185±.0846).

As regard to liaison subscale which is concerned with who has access to information necessary to control practice and influence allocation of organizational resources, it is clear from table (2) and figure (4) that staff nurses perceive limited opportunity to have access to information and almost all activities pertaining to this subscale are being done by nursing administrator only and by nursing administrator with some staff input, with mean scores of (1.924±.067) It is clear from table (2) and figure (5) which clarifies frequency of nurses' responses regarding alignment subscale, that nurses perceived limited opportunity to negotiate and manage conflict within organization and almost all activities done by nursing administrator only or primarily nursing administrator with some staff input with mean score of (1.368±.210).

It is apparent from table (3) that, there was a highly significant differences between the professional shared governance dimensions total mean scores according to different work place (F =-22.184, *P* = 0.000). As there were a highly significant differences between professional control, organizational influence, facilitating structure, liaison,and alignment mean scores according to different work place (F =-22.043, *P* = 0.000), (F =-24.599, *P* = 0.000), (F=-5.491, *P* = 0.002) , (F =-19.283, *P* = 0.000),(F=13.186, *P* = .0000) respectively. As it is clear that nurses working in ICU have highest mean scores of shared governance compared to nurses working in medical, surgical and other specialties. Multiple comparisons were done by using (LSD) to compare between each work place in relation to nurses perception of shared governance.

Data in table (4) show statistically significant differences between each work place in all subscales of shared governance which is reflected in total mean scores respectively (Medical vs. ICU -33.99*), (Surgical vs. ICU -30.08*), (surgical vs. others specialties 19.01*) and (ICU vs. others specialties 49. 09*).

It is apparent from table (5) that, there was a highly significant difference between job satisfaction dimensions total mean scores according to different work place (F=20.70, P=0.01*). As there were a highly significant differences between professional work environment , autonomy of practice , work worth to self and others, professional relationships, professional role enactment, and benefits mean scores according to different work place (F=21.36, *P*=0.01), (F=15.077, *P* =0.01), (F=21.81, *P*=0.01), (F=21.05, *P*=0.000), (F=14.64, *P*=0.01), (F=18.22, *P*=0.01) respectively**.** As it is clear from the same table that nurses working in ICU have highest mean scores of job satisfaction compared to nurses working in medical, surgical and other specialties. Multiple comparisons were done by using (LSD) to compare between each work place in relation to nurses perception of job satisfaction. Data in table (6) show statistically significant differences between each work place in all subscales of job satisfaction which is reflected in total mean scores respectively (Medical vs. ICU -29.07*), (Surgical vs. ICU -28.91*), (surgical vs. others specialties 14.27*) and between (ICU vs. others specialties 43.18*).

Data in table (7) clarifies that there was a significant positive correlations between nurses perception of shared governance and their overall job satisfaction (r=0.984, *P*=0.01*) as it is a positive correlation between all subscales of shared governance and nurses job satisfaction while there is only a negative correlation between alignment subscale and job satisfaction (r=-652, *P*=0.01*).

Table (1): Comparison between Staff Nurse's Demographic Characteristics and their Perception of Shared Governance and Job Satisfaction

Demographic Data	Shared governance		Job satisfaction	
	F	*P*	F	*P*
1-Age	470.62	0.01*	725.78	0.01*
2- Sex	3.536	.063	3.069	.083
3- Educational level	.171	.680	.354	.553
4- Employment status	8.252	.005*	7.247	.008
5-Years of experiences	153.14	0.01*	131.66	0.01*
6- Nursing units	22.18	0.01*	20.70	0.01*
7- Number of years in present hospital	34.75	0.01*	29.52	0.01*

Table (2): Mean Scores of Nurses' perception Regarding Professional Shared Governance Subscales (Total No 90)

Subscales	Minimum	Maximum	Mean	±SD	Variance
Professional control	1.00	3.23	2.237	.756	.572
Organizational influence	1.08	3.38	2.228	.892	.796
Facilitating structure	.77	1.54	1.185	.0846	.007
Liaison	1.15	2.85	1.924	.670	.450
Alignment	.92	1.85	1.368	.210	.044
Total	1	2.39	1.816	.443	.196

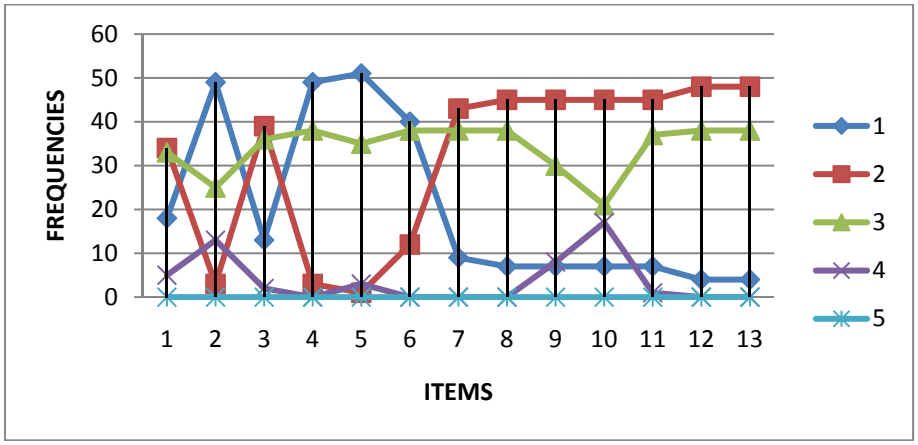

Figure (1): Frequency of nurses' responses regarding to professional control subscale

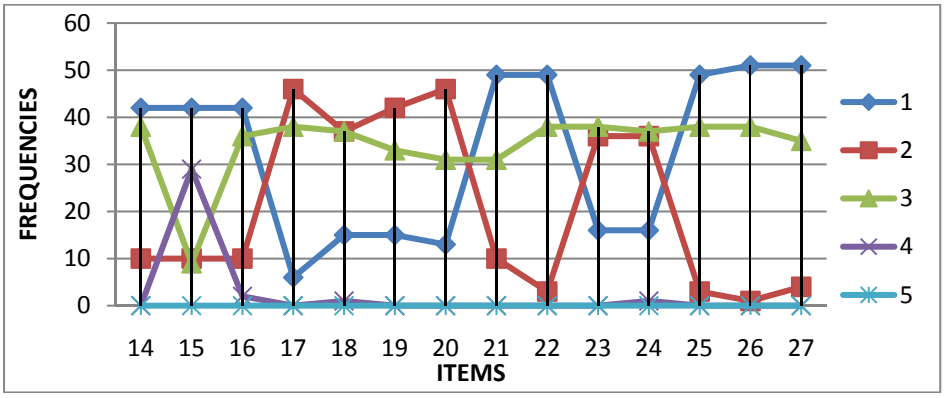

Figure (2): Frequency of nurses' responses regarding to organizational influence subscale

(1) Nursing administrator only
(2) Primarily nursing administrator with some staff nurse
(3) Equally shared (administrator with staff)
(4) Primarily staff nurse with nursing administrator
(5) Staff nurse only

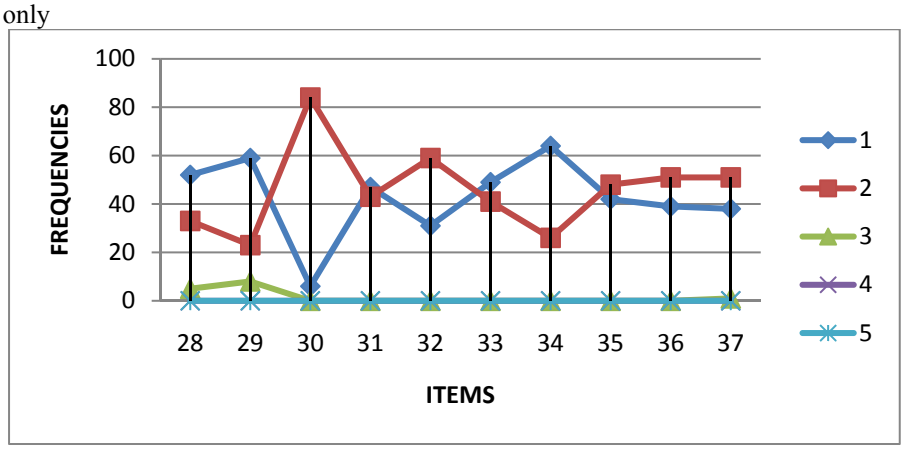

Figure (3): Frequency of nurses' responses regarding to facilitating structure subscale

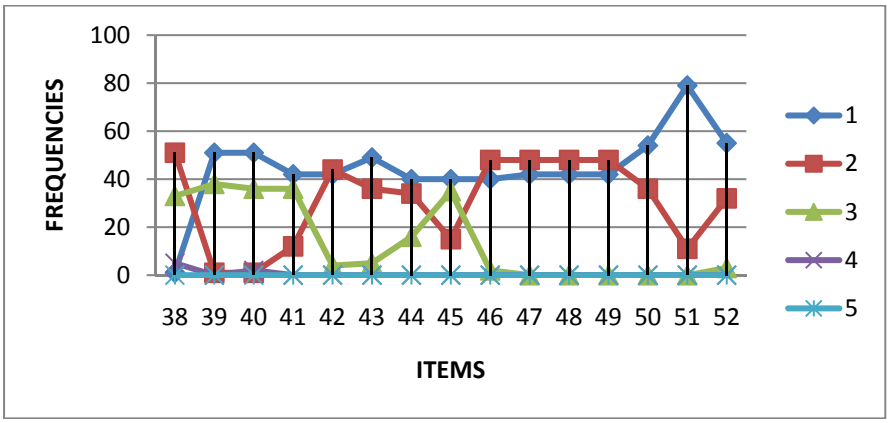

Figure (4): Frequency of nurses' responses regarding to liaison subscale

(1) Nursing administrator only
(2) Primarily nursing administrator with some staff nurse
(3) Equally shared (administrator with staff)
(4) Primarily staff nurse with nursing administrator
(5) Staff nurse only

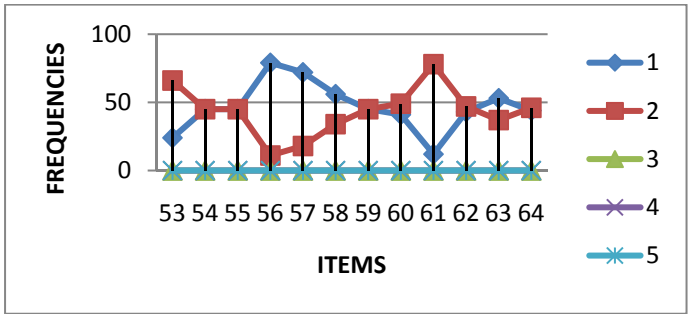

Figure (5): Frequency of nurses' responses regarding to alignment subscale

(1) Nursing administrator only
(2) Primarily nursing administrator with some staff nurse
(3) Equally shared (administrator with staff)
(4) Primarily staff nurse with nursing administrator
(5) Staff nurse only

Table (3): Comparison between Professional Shared Governance Means Scores as Perceived by Nurses according to their Work Place (No: 90)

Shared governance subscales	Medical (n=20)	Surgical (n=21)	ICU (n=36)	Other specialties (n=13)	F-test *P*
	Mean±SD	Mean±SD	Mean±SD	Mean±SD	
Professional control	24.10±6.43	26.19±9.75	36.694±7.66	20.38±3.15	22.043 0.01*
Organizational influence	21.95±7.40	26.38±11.02	38.11±9.07	18.61±2.63	24.599 0.01*
Facilitating structure	15.00±.000	15.14±1.62	15.94±1.04	15.00±.000	5.491 .002*
Liaison	23.20±6.63	21.76±8.49	31.19±7.098	16.000±.000	19.283 0.01*
Alignment	19.70±2.07	18.38±2.95	16.000±2.012	18.84±2.19	13.186 0.01*
Total shared governance	103.95±16.82	107.85±28.09	137.94±22.93	88.84±7.92	22.184 0.01*

*Significant (P<0.05)

Table (4): Multiple Comparisons between each Work place in Relation to Nurses Perception of Shared Governance Using LSD

Shared Governance Subscale		Medical	Surgical	ICU	Other Specialties
Professional control	Medical	-			
	Surgical	-2.09	-		
	ICU	-12.59*	-10.5*	-	
	Other Specialties	3.71	5.8*	16.3*	-
Organizational influence	Medical	-			
	Surgical	-4.43	-		
	ICU	-16.16*	-11.73*	-	
	Other Specialties	3.33	7.76	19.49*	-
Facilitating structure	Medical	-			
	Surgical	-0.14	-		
	ICU	-0.94*	-0.80*	-	
	Other Specialties	0.00	0.14	0.94*	-
Liaison	Medical	-			
	Surgical	1.43	-		
	ICU	-7.99*	-9.43*	-	
	Other Specialties	7.20*	5.76*	15.19*	-
Alignment	Medical	-			
	Surgical	1.31	-		
	ICU	3.70*	2.38*	-	
	Other Specialties	0.85	-0.46	-2.84*	-
Total shared governance	Medical	-			
	Surgical	-3.90	-		
	ICU	-33.99*	-30.08*	-	
	Other Specialties	15.10	19.01*	49.09*	-

*The mean difference is Significant at 0.05 level

Table (5): Comparison between Job Satisfaction Means Scores as perceived by Nurses according to their Work Place (Total No: 90)

Job satisfaction subscales	Medical (n=20)	Surgical (n=21)	ICU (n=36)	Other specialties (n=13)	F-test *P*
	Mean±SD	Mean±SD	Mean±SD	Mean±SD	
Professional work environment	12.35±4.61	15.09±6.88	21.69±5.45	10.76±.438	21.36 0.01*
Autonomy of practice	6.35±2.059	6.52±2.638	9.30±2.63	5.000±.000	15.077 0.01*
Work worth to self and others	10.100±2.712	10.23±3.85	15.66±4.31	8.000±.000	21.81 0.01*
Professional relationship	6.80±2.04	6.38±2.39	10.08±2.85	5.000±.000	21.05 0.000*
Professional role enactment	8.35±2.059	7.76±2.27	10.222±1.79	6.76±.438	14.64 0.01*
Benefits	19.70±5.20	17.80±6.74	25.75±5.95	14.000±.000	18.22 0.01*
Total	63.65±17.63	63.80±24.61	92.72±21.46	49.53±.877	20.70 0.01*

***Significant (*P*<0.05)**

Table (6): Multiple Comparisons between each Work Place in Relation to Nurses Perception of Job Satisfaction Using LSD

Job satisfaction subscale		Medical	Surgical	ICU	Other Specialties
Professional work environment	Medical	-			
	Surgical	-2.74	-		
	ICU	-9.34*	-6.59*	-	
	Other Specialties	1.58	4.32*	10.92*	-
Autonomy of practice	Medical	-			
	Surgical	-0.17	-		
	ICU	-2.95*	-2.78*	-	
	Other Specialties	1.35	1.52	4.30*	-
Work worth to self and others	Medical	-			
	Surgical	-0.13	-		
	ICU	-5.56*	-5.42*	-	
	Other Specialties	2.100	2.23	7.66*	-
Professional relationship	Medical	-			
	Surgical	0.41	-		
	ICU	-3.28*	-3.70*	-	
	Other Specialties	1.80*	1.38	5.08*	-
Professional role enactment	Medical	-			
	Surgical	0.58	-		
	ICU	-1.87*	-2.46*	-	
	Other Specialties	1.58*	0.99	3.45*	-
Benefits	Medical	-			
	Surgical	1.89	-		
	ICU	-6.05*	-7.94*	-	
	Other Specialties	5.70*	3.80	11.75*	-
Total job satisfaction	Medical	-			
	Surgical	-0.15	-		
	ICU	-29.07*	-28.91*	-	
	Other Specialties	14.11	14.27*	43.18*	-

*The mean difference is significant at 0.05 level

Table (7): Correlation between Nurses Perception of Shared Governance and their Job Satisfaction

Shared governance subscales	Job satisfaction	
	R	*P* value
Professional control	.974	0.01*
Organizational influence	.973	.000*
Facilitating structure	.356	0.01*
Liaison	.968	.002*
Alignment	-.652	.000*
Total	.984	0.01*

4. Discussion;

Shared governance is promoted as a management innovation designed to improve outcomes of quality patient care, nurse job satisfaction, productivity, and nurse retention. Nursing shared governance practices and organizational structures have long been promoted as an effective strategy for improving work environment by providing nurses a mechanism to assume responsibility for the definition, regulation of nursing practice and gives them control over their practice that can extend their influence into administrative areas previously controlled only by mangers. (**Robert &Hess 2004 and Nedd, 2006**). When comparing between nurses demographic data and study variables , results of the present study revealed a significant difference between the age of the participants and their perception of the shared governance and their job satisfaction .As well as there were a highly significant differences between nurses perception of shared governance and their job satisfaction in relation to, years of experiences and numbers of years in the present hospital .While no significant differences were found in relation to sex , educational level and employment status. In this respect, **Larrabee *et al.* (2003)** stated that younger nurses and those with fewer years of experiences were more likely to be dissatisfied with their work with limited ability to autonomous decision making than older nurses. In the same issue, **Baggot, *et al.* (2005)** reported that female nurses were more likely to be dissatisfied as well as have the intent to leave their profession and part time nurses had limited opportunity to influence in decision making and control over nursing practice. As for educational preparation, **Larrabee *et al.* (2003)** indicated that technical degree nurses reported an intent to leave the hospital as they were dissatisfied with their work environment.

Results of the present study revealed that overall staff nurses had lowest mean scores regarding their perception of shared governance which indicates that they did not have professional control over their work environment as their work environment are controlled by nursing administrator only or primarily by nurse administrator with some staff input . More specific in relation to professional control subscale, results of the present study indicates that nurses perceive that greater participation lies with primarily nursing management with some staff nurses input and moving to equally shared by both with limited input of staff nurses to control their professional work .This results is consistent with **Sullivan et al, (2003)** and **Tourangeau, *et al.* (2005)**, as they reported that staff nurses perceived they have the least amount of control over professional practice as well as they perceived little input or control in many areas that directly affect the bedside care of the patient from bedside nursing, Patient care standards, quality assurance, educational development, and determining the model of nursing care for their professional work.

As regarding to organizational influence subscale, results of the present study revealed that nurses perceive many areas that are closer to being equally shared with their administrators, while other activities relating are being done only with administrator with limited staff inputs. This result is contradicted with **Mangold, *et al.* (2006)** who reported that clinical nurses perceived that they have the most influence and access to information that concerns daily patient assignments, consulting nursing and hospital services, monitoring and regulating staffing levels based on patient census and acuity as well as regulating patient flow.

On the other hand, in relation to the other three subscales of shared governance (facilitating structure, liaison and alignment). Results of the present study revealed that nurses had lowest mean scores than the previous two subscales and they perceived limited opportunity and influence in decision making as almost all activities done only by their administrators or by their administrators with some staff input .In this issue, **Lee *et al.* (2000)** reported that nurses perceive they have limited ability to participate on committees that relate to multidisciplinary professionalism, organizational budgets and expenses, staff scheduling, and strategic planning. Moreover, **Green & Jordan, 2004**; indicates that nursing management has the most access to information and resources in the activities that control and support the professional practice environment.

Results of the present study revealed that there was a highly significant difference between the professional shared governance dimensions total mean scores as well as job satisfaction according to different work place .As it is clear that nurses working in ICU have highest mean scores of shared governance and job satisfaction compared to nurses working in medical, surgical and other specialties. In this respect, **Anthony (2004)** reports that nurses working in ICUs had higher job satisfaction, increased perceptions of giving high quality care, and were more positive about peer support and involvement in decision making than nurses working in general units .From the researcher point of view, the critical care units at Al Manial University

hospital were considered a decentralized units with polices that allow nurses to have the chance to participate in decision making and make control relating nursing practice while other departments at hospital were centralized in which decision are made only by the top manager.

Nurse satisfaction has been considered a key outcome of shared governance and has often been included in the evaluations of the work environment .Results of the present study revealed statistical significant positive correlation between nurse's perception of shared governance and their job satisfaction. In this respect **Anthony (2004)** found that nurses working on units that allow shared ability to participate in decision making had a more positive constructive culture, as well as higher job satisfaction that reflected greater satisfaction with the work, professional status, cohesion, and administration. Moreover Previous researches (**Aiken *et al.*, 2001a; Spence Laschinger *et al.*, 2001; Tourangeau *et al.*, 2005** and **Nedd, 2006**) confirms the lack of ability for nurses to influence and have access to information that concerns resources like adequate staffing to meet patient acuity demands, and decision making at all levels negatively influencing their satisfaction. However, **Faye (2005)** reported a moderate significant relationship between shared governance and job satisfaction.

Conclusions:

Results of the present study revealed the following:

- There were highly significant differences between nurse perception of shared governance, job satisfaction and their demographic data (age, employment status, years of experiences, nursing units and numbers of years in the present hospital)
- Nurses had lowest mean scores regarding their perception of shared governance which indicates that overall they did not have professional control over their work environment as their work environment are controlled by nursing administrator only or primarily by nurse administrator with some staff input
- A highly significant difference between the professional shared governance dimensions total mean scores according to different work places, as nurses working in intensive care units have higher mean scores regarding their perception of shared governance compared to nurses in other specialties.
- A highly significant difference between job satisfactions dimensions total mean scores according to different work places, as nurses working in intensive care units have higher mean scores regarding their job satisfaction compared to nurses in other specialties.
- There was a significant positive correlation between nurses' perception of shared governance and their overall job satisfaction.

Recommendations:

Based on study findings the following were recommended:

- It is important to recognize the efforts that directed at providing the staff nurses formal authority to control practice and have influence in decision making that positively affects their professional respect, job satisfaction, and organizational commitment.
- Top manager should play an important role to support the presence of staff nurses at all levels of decision making and measure both patient and nurse satisfaction as well as systems outcomes.
- Providing resources for staff nurse to research, analyze, develop, and implement a model of nursing care that supports their professional control over nursing practice. This can be done through collaboration between nursing administration, and staff nurses
- Pre and post implementation study of a professional practice model to determine any significant results related to the nursing staff perception of control over nursing practice.
- Replication of this research study and applying it to specific units in other hospitals to provide further information regarding nursing staff perceptions of control over practice

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