Shared Governance as A Pathway to Organizational Excellence: A Suggested Strategy for Selected University Hospital

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Abstract

Background- Applying a shared governance strategy could develop collaboration between health care personnel, increase their confidence; develop their personal and professional skills; and increase their professional profile and accountability. **Purpose–** developing a suggested shared governance strategy for Suez Canal University hospital, Egypt: through, measuring shared governance among health care personnel at the hospital, analyzing the shared governance, and developing and validating a shared governance strategy. **Design/methodology/approach–** a methodological design was utilized to conduct the study. the study sample was composed of 825 health care personnel with different categories (Physicians, Accountants, Nurses, Pharmacists, Dieticians, and Social workers). Index of Professional Governance was used and a suggested shared governance strategy was developed and validated. The fieldwork lasted from April to October 2019. **Findings–** The study revealed that health care personnel' ages ranged between 30 and 40 years, median 35.0, Their median years of total and hospital experience were 11.0 years. 71.5% of them reported that hospital governance has done primarily by hospital management with some staff input. As well, the highest percentages of them reported the same results regarding all shared governance dimensions. The shared governance among health care personnel at Suez Canal University hospitals was generally low, the hospital had the dominant in total scores of governance 96.6% and all shared governance dimensions. **Originality/value–** Despite the vast number of published researches that dealt with Shared governance as a decentralized approach that gives nurses greater authority and control over their practice, there is a limited focus in studying shared governance among healthcare personnel as a whole, especially the university hospitals, which represent scientific models in providing ideal care. **Recommendations**, it is a priority for university hospitals to enhance the application of the suggested shared governance strategy or a suitable governance model that focuses on strong leadership and a sound shared governance infrastructure; for allowing a professional practice environment.

Keywords: shared governance, health care personnel, strategy development, pathway, Organizational excellence, university hospitals.

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Introduction

The concept of governance originated from the Latin gubernare, which means to govern, direct, or guide. In the health care setting, the term governance has been developed and pointed to management practices that could be adopted to improve care delivery

for individuals and populations(Santos et al., 2014). For the past 40 years, the idea of shared governance has existed, and it involves characteristics such as accountability, professional commitment, collateral relationships, and decision-making **skills (Kon, 2016; Siller et al., 2016).** Shared Governance, according to **Stifter (2017),** is an organizational practice that encourages professional autonomy and cooperation. It helps health-care professionals and leaders to cooperate in making clinical practice, guidelines, and procedures decisions.

Control over staff, access to information, influence over resources, involvement in the committee structure, control over professional practice, and goal setting & conflict resolution are the six dimensions of shared governance defined by **Hess (2010).** Leadership support, position delineation, clear vision, communication plans, education, managerial support, career ladders, and skilled researchers are all included in the effective implementation of shared governance, according to **Glasscock, (2012); Torres et al., (2015).** Shared governance also necessitates staff engagement, involvement, transparency, decision-making authority, fairness, collaboration, and non-competitive, interdisciplinary partnerships that concentrate on the task.

Significance of the study

Shared governance has become an obligation within healthcare settings, particularly within organizations plans for high reliability in the delivery of high-quality patient care and/or interested in meeting health care standards, or jumping on the pathway to excellence**(Olender et al., 2020).** Shared governance is an organizational innovation, which gives legitimacy to healthcare personnel to make decisions in their practices while extending their influence into administrative areas. It is also, characterized by reciprocity, collegiality, cooperation, transparency, and open communication, timely exchange of information, representation, participation, and use of the democratic process, mutual accountability, and clarity of rules.

Despite the large number of published studies defining shared governance as a decentralized approach that gives nurses more power and influence over their practice and working environment, instills a sense of obligation and transparency, and enables active involvement in decision-making, it remains a controversial subject. There is a limited or almost non-existent focus in studying shared governance among healthcare personnel as a whole with their different job categories in the hospital, especially the university ones, which represent scientific models in providing ideal care.

Aim of the study

This study aimed to:

Develop a shared governance strategy for Suez Canal University hospital.

Objectives:

- Measure shared governance among health care personnel at Suez Canal University hospital.

- Analyze the shared governance among health care personnel at Suez Canal University hospital.

- Develop and validate a suggested shared governance strategy for health care personnel at Suez Canal University hospitals.

Research question:

- Is Suez Canal canal university hospital apply shared governance as a management strategy?

Operational definitions:

1. **Shared governance** is an innovative management strategy; the structure for the strategy is shared control over personnel, shared goal setting, shared influence on resources and outcomes, shared access to information, shared participation in the committees' structure, and shared control over the professional practice, and the strategy' outcome is the organizational excellence.

2. **Organizational excellence** is the adoption of an effective management model or strategy to keep the working staff stays away from all that is typical and routine in the performance and behaviors, which reflect Excellence in leadership, Excellence in service delivery, and Excellence in Operations Management.

3. **Strategy development** is a scientific designated framework that suggests the direction and scope of an organization over the long-term period to have significant potential improvements in the organization's outcome.

Subjects and methods

Study design

A methodological design was used in conducting this study.

Study Setting

The study was carried out at Suez Canal University hospital, located in Ismailia governorate, Egypt. It was established in 1974. The hospital was selected as it one of the major and accredited Egyptian' universities hospitals that provide all the types of health care services for the Suez Canal region. Besides, Suez Canal University Hospitals provide evidence-based health care services that utilize top-notch technologies to serve the Egyptian community. The hospitals consist of six buildings that contain different medical departments and various health services as inpatient departments for different specialties (323 beds), Outpatients' clinics (20 clinics in different specialties), emergency department, diagnostic departments (laboratories, Radio diagnostic, MRI, and endoscopes department), blood bank, in addition to educational parts. There are also private paid rooms and specific surgeries' buildings, an oncology building (64) beds, and one building for emergency cases.

Study subject

The study sample included 825 health care personnel with different categories (Physicians, Accountants, Nurses, Pharmacists, Dieticians, and Social workers) working in Suez Canal University hospitals during the time of the study. We utilized a stratified sampling technique to cover the required number by dividing members of the population into homogeneous subgroups before sampling. Then a simple random sampling had applied within each stratum as follows: (Physicians 104, Accountants 86, Nurses 438, Pharmacists 58, Dieticians 123, and Social workers 16).

Sampling design

The sample size was determined using openepi. Com **(Dean, Sullivan & Soe, 2013).** Through the following equation:

$$n = [DEFF*Np\ (1-p)] / [(d^2/Z^2_{1-\alpha/2}*(N-1) + p*(1-p)]$$

Where

(N)= 1811

(p) = 50%+/-5

(d) = 5%

(DEFF) = 1

The final sample size is **825** health care personnel at a confidence level of 99.99 %.

Tools of data collection

To achieve the aim of the study a self-administered questionnaire sheet was utilized by the researchers, this tool composed of two parts as follows:

Part I: This part consists of 11 items that include personal and job data, including sex, age, educational preparation, highest educational degree, job title, number of years worked in this hospital, number of years worked in this current job, in addition to one-item question rate the health care personnel' overall satisfaction with their professional practice within the hospital.

Part II: Index of Professional Governance (IPG).

The IPG measures professional governance dimensions on a continuum ranging from traditional to shared to self-governance, It was developed by Hess (1998), and it was updated and adopted from Hess (2010). It consists of 86 items divided into six subscales, as following:

Control over Personnel is the first subscale, and it includes 22 elements on who controls personnel and related structures. The second subscale, Access to Information, has 15 elements that deal with who has access to information that is important to governance activities. Subscale 3: Influence over Resources has 13 elements that deal with who affect resources that help clinical practice. Subscale 4: Committee Structure Membership includes 12 elements on who participates in processes relevant to governance activities at various organizational levels and committees. control over Professional Practice is the fifth subscale, and it includes 16 elements on who has control over professional practice. Goal Setting & Conflict Resolution is a subscale 6, that includes eight elements on who sets goals and negotiates conflict resolution at various organizational levels.

Scoring system

Shared governance: The items were on a Likert-type 5-response scale: “hospital management only”, “primarily management/administration with some staff input”, “equally shared by staff and management/administration”, “primarily staff with some management/administration input”, and “staff only”; these respectively scored from one to five. The scores of each domain and the total scale were summed-up so that a higher score indicates more staff governance while lower scores indicate more traditional or administration governance. The results were also, represented according to the five categories of the scale.

Operational design

Preparatory phase: During this phase, the researchers reviewed the literature related to the study subject using paper and electronic sources both locally and internationally. This helped in the selection and preparation of the data collection tools.

The research tool was translated into the Arabic language; to match the Egyptian culture, and retranslated into

English by the researchers and a language expert, and tested for its validity and reliability.

Tool validity: Upon preparation of the preliminary form of the tool, it was presented to a panel of seven experts for validation. Following their opinions, minor modifications were applied. The tool was then modified according to their recommendations and suggestions.

Testing reliability: Cronbach's alpha coefficient was calculated to assess the reliability of the tool through its internal consistency. Reliability of the whole Shared governance scale = (0.97). Reliability of the subscales as the following, Access to information =0.93, Control over personnel 0.94, Goal setting = 0.84, Influence on resources = 0.92, Participation in committees = 0.78, and Professional practice = 0.93.

A Pilot Study: 10% of the target population was included in the pilot study with a total number of 83 healthcare personnel divided into (10 Physicians, 9 Accountants, 44 Nurses, 6 Pharmacists, 12 Dieticians, and 2 Social workers); they had selected from the health care personnel outside the study sample. The purposes of the pilot study were to ascertain the clarity and feasibility of the tool and to detect any possible problems concerning the data collection tool that might face the researchers and interfere with data collection. It also helped to identify the suitable time and place for data collection and to estimate the exact time needed for data collection.

The fieldwork

Phase I After obtaining an official agreement from the hospital directors, the researchers met with the staff, explained to them the aim and process of the study, confirming confidentiality of their data and ensuring that all data will remain confidential and be anonymous through using a series of research codes that are only known by the researchers.

The self-administered questionnaire had distributed to those who gave their consent to participate. Each staff took a time duration of about 25-30 minutes to fill in the form. The data collected from staff for four months from April 1 to October 1. The setting was visited two days per week (Monday, and Wednesday) as it not the hot days of the hospital and for four hours each time from 10 AM to 2 PM).

Phase II after completion of the data collection stage, Analysis of the shared governance dimensions among health care personnel at Suez Canal University hospitals was done to determine the category of shared governance, assessing and prioritizing the weak points according to the analyzed data and results,

Phase III based upon, Development of a suggested shared governance strategy had done. The developed strategy was validated by a panel of experts composed of seven medical and nursing professors from the Suez Canal and Port Said Universities. Accordingly, the required modifications had done. Then the researchers met with hospital administrators to discuss the feasibility and applicability of the developed shared governance strategy in the hospital.

Statistical analysis

SPSS 20.0 statistical software package was used. For qualitative variables, descriptive statistics such as frequencies and percentages are used, while for quantitative variables, means, standard deviations, and medians are used.

Cronbach's alpha coefficient was used to determine the governance scale's internal accuracy, which was used to determine its reliability. The Mann-Whitney and Kruskal-Wallis tests were used to compare quantitative continuous results. The inter-relationships between quantitative and rated variables were evaluated using Spearman rank correlation. Multiple linear regression analysis and analysis of variance were used to classify the independent predictors of governance. Statistical significance was considered at a p-value <0.05.

Results

The study involved 825 health care personnel. 41% of them their age ranged from 30 to less than 40 years, with a median of 35.0. As illustrated in **Table 1**, 69.1% of health care personnel were female, nearly; half of the study sample had a bachelor's degree (49.6%). Their median years of total and hospital experiences were 11.0 years respectively and 7.0 years of experience in their current job.

As displayed in **table 2**, 71.5% of health care personnel reported that primarily hospital management did hospital governance with some staff input. As well, the highest percentages of them reported the same results regarding all shared governance dimensions except control over personnel as more than half (55.2%) of them stated that it was done by hospital management only.

Table 3 points to that score of Shared governance among health care personnel was generally low as staff shared governance is 3.4%. Conversely, the hospital had the dominant in total scores of governance 96.6% and all shared governance dimensions.

Table 4 illustrates that there is a statistically significant difference between healthcare personnel' job category and median scores of shared governance among the study sample where Physicians had the highest median scores 218, followed by bachelor nurses 194 and diploma nurses 193. On the other hand, social employees and pharmacists had the lowest median scores 125, and 134 respectively. F= 295.17 and P-value<0.001*.

Table 5 demonstrates a statistically significant positive correlation between all Shared governance dimensions scores. Whereas, the highest correlation of shared governance dimensions was indicated between health care personnel' influence on resources and control over professional practice (r=. 864**).

In a multivariate analysis **table, 6** demonstrated that the scores of qualification, worked years in the current job, job satisfaction and job category are independent statistically significant predictors of health care personnel' shared governance score.

Table 1: Frequency and percentage distribution of demographic characteristics of health care personnel under study (n=825)

Personal and job data	Frequency	Percent
Gender:		
Male	255	30.9
Female	570	69.1
Age:		
<30	229	27.8
30-	339	41.1
40-	223	27.0
50+	34	4.1
Range	21.0-57.0	
Mean±SD	35.7±7.9	
Median	35.0	
Job Category:		
Physicians	104	
pharmacists	58	
Nurses	438	
Dietitian	123	
social worker	16	
Accountants	86	
Qualification:		
Technical diploma	389	47.2
Bachelor	409	49.6
Postgraduate degree	27	3.3
Experience years (total):		
<5	161	19.5
5-	186	22.5
10-	313	37.9
20+	165	20.0
Range	1.0-39.0	
Mean±SD	12.2±7.6	
Median	11.00	
Experience years (hospital):		
<5	178	21.6
5-	180	21.8
10-	317	38.4
20+	150	18.2
Range	1.0-39.0	
Mean±SD	11.8±7.6	
Median	11.00	
Experience years (current job):		
<5	232	28.1
5-	315	38.2
10-	227	27.5
20+	51	6.2
Range	1.0-30.0	
Mean±SD	8.6±5.9	
Median	7.00	

Table 2: Frequency and percentage distribution of Shared governance dimensions with its classification among health care personnel in the selected university hospital (n=825)

Shared governance dimensions	Shared governance classification									
	Traditional governance (hospital management only)		Primarily hospital management with some staff input		Equally shared by staff and hospital management		Primarily staff with some hospital management input		Self-governance (Staff Only)	
	No.	%	No.	%	No.	%	No.	%	No.	%
Access to information	187	22.7	404	49.0	194	23.5	32	3.9	8	1.0
Control over personnel	455	55.2	332	40.2	20	2.4	18	2.2		
Goal setting	96	11.6	398	48.2	197	23.9	78	9.5	56	6.8
Influence on resources	210	25.5	390	47.3	10	1.2	214	25.9	1	0.1
Participation in committee structure	141	17.1	605	73.3	33	4.0	40	4.8	6	0.7
Control over professional practice	221	26.8	386	46.8	16	1.9	197	23.9	5	0.6
Total	189	22.9	590	71.5	18	2.2	28	3.4		

Table 3. Frequency and percentage distribution of shared governance dimensions among health care personnel under study (n=825)

Shared Governance dimensions	Health care personnel		Hospital	
	No.	%	No.	%
Access to information	40	4.8	785	95.2
Control over personnel	18	2.2	807	97.8
Goal setting	134	16.2	691	83.8
Influence on resources	215	26.1	610	73.9
Participation in committees	46	5.6	779	94.4
Professional practice	202	24.5	623	75.5
Total	28	3.4	797	96.6

Table 4. The relation between health care personnel' Job category and Total Shared governance dimensions mean scores (n=825)

Job category	Total governance dimensions mean scores	
	Mean±SD	Median
Physicians	217.7±37.1	218.00
Bachelor nurses	224.4±32.1	194.00
Diploma nurses	218.2±30.8	193.00
Pharmacists	134.8±22.4	134.00
Dietitian	177.6±42.3	173.00
Social workers	139.4±58.0	125.00
Accountants	163.8±50.1	157.00
F-test	295.17	
p-value	<0.001*	

(*) Statistically significant at p<0.05

Table 5: Correlation matrix of shared governance dimensions scores

Shared governance dimensions	Spearman's rank correlation coefficient Shared governance dimensions Access to information	Control over personnel	Goal setting	Influence on resources	Participation in committees	Control over Professional practice
1. Access to information						
2. Control over personnel	.709**					
3. Goal setting	.405**	.397**				
4. Influence on resources	.786**	.841**	.335**			
5. Participation in committees	.635**	.573**	.640**	.567**		
6. Control over Professional practice	.740**	.722**	.270**	.864**	.519**	

(*) Statistically significant at p<0.05 (**) statistically significant at p<0.01

Table 6: Best fitting multiple linear regression model for the shared governance score (dependent variable) and (age, Qualification, Experience (hospital), Experience (current), Job Satisfaction, and Job category) as independent variables

	Unstandardized Coefficients		Standardized Coefficients	t-test	p-value	95% Confidence Interval for B	
	B	Std. Error				Lower	Upper
Constant	1.29	0.21		6.09	<0.001	0.87	1.70
Age	0.01	0.01	0.15	2.41	0.017	0.00	0.02
Qualification	-6.38	2.16	-0.09	-2.948	0.003	-10.62	-2.13
Experience (hospital)	1.09	0.31	0.18	3.548	<0.001	0.49	1.70
Experience (current)	-2.32	0.40	-0.29	-5.728	<0.001	-3.11	-1.52
Job satisfaction	9.98	1.43	0.22	6.971	<0.001	7.17	12.79
Job category (reference: physician)	-6.43	0.78	-0.26	-8.199	<0.001	-7.97	-4.89

r-square=0.23 Model ANOVA: F=49.39, p<0.001
Variables entered and excluded: age, total Experience

Discussion

Strong leadership and a sound shared governance infrastructure should be the focus of health care personnel' clinical practice environments **(Allen-Gilliam et al., 2016).** Shared governance is an administrative strategy in which top management and organizational staff cooperate to enhance professional practice **(Meyers & Costanzo, 2015).** The principle of shared governance is that delegated decision-making enables workers to exert autonomy over their

practice, while leaders' functions are to provide support, organize resources, and establish boundaries. Staff and leaders work together to develop action strategies, common governance bylaws, and budgets **(Kanninen et al., 2019).**

The present study aimed at developing a shared governance strategy for Suez Canal University hospital through measuring shared governance among health care personnel, analyzing the shared governance, and developing a suggested shared governance strategy.

Assessment of health care personnel' shared governance gives important insight into how they in individual practice areas understand the role and function of shared governance and how can their organizations best support them, and further empower staff to be more engaged in processes that impact their practices**(Mahoney, 2017).**

The study had carried out on a sample of health care personnel with a wide range of ages, job categories, specialties, and experience. This would represent the whole spectrum of staff working in a similar setting so that the external validity of the study findings would be high and allow generalizations from its findings.

The present study findings evidenced that the highest percent of health care personnel reported that primarily hospital management did the hospital's governance with some staff input. As well, the highest percentages of them reported the same findings regarding all shared governance dimensions (Access to information, Goal settings, Influence on resources, Participation in the committee structure, and Control over a professional practice, which reflects that organization adapts to the first level of shared governance). Except for control over personnel as more than, half of them stated that hospital management, which refers to traditional governance, does it.

This finding could be interpreted as the hospital has the dominant decision-making, controls personnel, and related structures as hiring, promoting, and formulating unit budgets. While allowing the health care personnel access to some information and influencing the resources supporting their professional practice, limited participation in structures related to governance activities, committees that address Policies and procedures for clinical practice, Staffing/scheduling; goals, and objectives on the unit level. Similar concerns regarding the consequences of shared governance were reported by nurses in a study carried out in Benha and Menoufia University Hospitals, Egypt**(Kamel & Mohammed, 2015)**

Moreover, the findings of the present study indicate that the shared governance among health care personnel at Suez Canal University hospitals was generally low and that the hospital had the dominant governance. In this respect **Stifter, (2017); Wilson & Galuska, (2020)** emphasized that shared governance requires; a culture modification based on retraining managers, engaging staff, reallocating accountability, and building a participative model of decision making. Moreover, establishing a system for professional staff communication and collaboration, a method to let the staff voices, to improve patient care in all areas of the organization. In agreement with this, **Abood & Thabet, (2018)** in their study assessed nurses managers' perception regarding shared governance at Minia University hospitals and ministry of health hospitals and stated that the nurses' managers had low shared

governance and the total scores of shared governance indicated the using of traditional governance in the study setting.

According to statistical study findings, there is a statistically significant relationship between job category and median score of shared governance among the study sample where Physicians had the highest median scores, followed by bachelor nurses. On the other hand, social employees and pharmacists had the lowest median scores. These findings might reflect the involvement of nursing staff, and physicians in determining the unit budget and expenses, the departmental goals and objectives; and hospital's financial status, compliance, and strategic plans and also, monitoring and securing supplies, determining daily assignments, regulating admissions, transfers, referrals, placements, and discharges.

On the other hand, the previous finding ensuring the dramatic neglect of other healthcare personnel in shared governance despite their main and important role in health care organizations. Following this finding **Lawless et al. (2014)** described the global importance of collaborative practice, the shared importance of collaborative practice that is required, and the systematization of collaborative practice. What is the location of Collaborative practice necessitates a strong political framework that promotes interprofessional education, collaboration, shared governance models, and enabling legislation. In line with the findings of the study, **Perlo et al., (2017)** published a framework for Improving Workplace Joy, which stated that, with increasing demands on time, resources, and energy. In addition to inefficient traditional work systems, health-care workers are experiencing burnout and higher rates of turnover, which not only affects the quality of care but also the cost of care. Therefore, all health care personnel needed to be engaged in a participative process where leaders asked colleagues at all levels of the organization, enabling them to better understand the barriers to joy in work, and co-create meaningful and high-leverage strategies.

Establishing the process of shared governance requires effective leadership, implementation of a suitable framework, multidisciplinary working, and examination of the organization's structure and culture**(Scott & Caress, 2005; Hess et al., 2020)**. In multivariate analysis demonstrated that the scores of qualification, worked years in the current job, job satisfaction and job category are independent statistically significant predictors of health care personnel' shared governance score, and account of their variance. In congruence with this, the Results of **(Sarasija & Sciences, 2017)** revealed a significant positive relationship between participation in shared governance and working staff engagement, years of experience, and professional certification. In the same line **(Alrwaihi et al., 2017)**, reported that the interdisciplinary team members share governance and ideas, it is necessary that team members are receptive and can work with individuals having different personalities and perspectives. The education levels of interdisciplinary members affect their abilities to collaborate effectively through communication. In disagreement with this, a study in a Jordanian University hospital revealed no significant correlation between demographic characteristics (management level, education, special training) and shared governance**(Al-faouri & Ali, 2014).**

Shared governance strategy

For professional shared governance and practices, a significant retooling of leadership capacity and skill is required to successfully implement shared governance and sustain it as a way of life in the professional organization**(Swihart & Hess, 2014).** A study by **(Atashzadeh-Shoorideh, et al., 2019)** concluded that managers represent a vital role in the successful implementation of shared governance in the appropriate context of the organization. Hence, the appointments of managers who have managerial participation skills and who can empower themselves and their staff by allowing work resources can a shared governance work context.

Creating a learning environment that instills competency and confidence enables health care personnel to provide care within their full scope of practice. **(Shepherd et al., 2014; Cometto et al., 2020).** Provided staff with professional development and training opportunities especially for strategic planning, goal setting, and conflict management, to enhance their teamwork, autonomy, sense of motivation, and empowerment **(Kutney-Lee et al., 2016).**

Olender et al., (2020) stated that hospital management should consider shared governance as a way to empower and engage the professional staff. more management support is needed for increasing the participation of working staff in work design, problem- solving, conflict resolution, committees, and organizational decision-making, Engage more staff' participation in committees and councils through reducing the barriers by adjusting schedules to allow time for participation. Also, implement a formal professional advancement structure, such as clinical ladders **(Gilstrap, Flores, Lynch, 2020).**

The Professional Shared Governance Strategy' Pathway For Achievement Of Organizational Excellence.

1. The hospital should allow the health care personnel to share control over personnel through:

1.1. Defining what they are capable of doing in their everyday work life.

1.2.Designing and reviewing patient-care policies, procedures, and protocol

1.3. Setting requirements for roles within their discipline.

1.4. Assessing experts in their respective fields (performance appraisals and peer review).

1.5.Assessing ancillary personnel's tasks (aides, assistants, technicians' secretaries) 1.6. Taking disciplinary action against coworkers in their discipline.

1.7. Assessing and promoting the professional/educational advancement of practitioners in their practice.

1.8. Selecting experts from their specialty as well as support staff to recruit.

1.9. Counseling and supporting coworkers and their support staff.

1.10. Nominating people to positions in management and leadership.

1.11. Selecting supplies and equipment for use in their field.

1.12. Incorporating evidence-based practice into their work.

1.13. Deciding procedures or processes for carrying out their discipline's work.

2. The hospital should permit the health care personnel to share influence over resources through,

2.1. Deciding the number of staff and their level of experience necessary for the routine task.

2.2. Shifting staffing levels in response to changing job demands.

2.3. Assigning work to technical and support workers.

2.4. Keeping track of and receiving materials for clinical practice and support functions.

2.5. Monitoring the movement of services or patients/clients within the hospital.

2.6. Preparing annual unit budgets for their unit or workgroup's staff, materials, facilities, and education.

2.7. Make pay, increases, and benefit recommendations.

2.8. Outside of their team or workgroup advising and enlisting services

2.9. Consultation and enlisting assistance

2.10. Making resource decisions for other departments.

2.11. Deciding cost-effective best practice steps.

2.12. Supporting new services or enterprises.

2.13. Introducing additional health, managerial, or support roles to the hospital.

3. The hospital should share official authority with the health care personnel over the following areas that control practice and influence the resources that support it:

3.1. Written policies and protocols outlining what behaviors professional colleagues should participate in as part of their everyday work.

3.2. Written service standards/protocols and procedures for quality management

3.3. Mandatory professional credentialing standards (licensure, qualifications, and certifications) for recruiting, promotions, and increases.

3.4. A written method for assessing professional workers in their field (performance appraisal, peer review).

3.5. Organizational charts that indicate who reports to whom and what their position titles are.

3.6. Discipline procedures that are written down.

3.7. Annual continuing education and in-service standards

3.8. Recruiting and moving staff in their specialty.

3.9. Policies concerning the promotion of health care personnel to positions of management and leadership.

3.10. Procedures for creating schedules for their discipline's practitioners and support staff.

3.11. Mechanisms for deciding how many personnel and what degree of competence are necessary for their unit's or workgroup's day-to-day operations.

3.12. Methods for assessing staffing levels when job demands are fluctuating.

3.13. Procedures for evaluating work assignments)

3.14. Strategies for tracking and receiving supplies that facilitate their skilled group's practice within the hospital regularly.

3.15. Inside the organization, protocols for managing the distribution of services and patients/clients.

3.16. A mechanism for proposing and establishing annual budgets for their workgroup's staff, materials, facilities, and education.

3.17. Methods for changing the wages, promotions, and benefits of practitioners.

3.18. Formal processes for advising and enlisting the help of other practitioners in their practice who are not part of their workgroup.

3.19. Formal processes for consulting with organizational providers outside of their workgroup and enlisting their support (e.g. dietary, social service, pharmacy, human resources, finance)

3.20. Procedures for reducing or restricting the amount of work they do (closing units, redistributing patient workload)

3.21. Office room, staff lounges, and charting areas: venue, architecture, and access.

3.22. Internet and office devices (such as smartphones, laptops, and copy machines).

4. The hospital should provide health care personnel with opportunities to share in the committee structure through:

4.1. Sitting on unit or work-group committees that deal with clinical practice and logistical problems like personnel, scheduling, and budgeting.

4.2. Membership in departmental committees concerned with clinical practice as well as logistical concerns such as personnel, scheduling, and budgeting.

4.3. Involvement in inter-professional committees for joint practice (physicians, other healthcare professions).

Participation in corporate administrative committees for employee compensation and strategic planning, for example.

4.4. Establishing new committees for departments or workgroups.

4.5. Forming new departmental committees within their area of study.

4.6. Creation of new inter-professional committees

4.7. Creating new corporate administration committees.

5. The hospital should facilitate health care personnel access to information, about the following activities:

5.1. The organization's clinical practice standards.

5.2. Their organization's commitment to surveying agencies' criteria (e.g. The Joint Commission, state and federal government, professional groups).

5.3. Their workgroup has a budget that is both estimated and real.

5.4. The financial state of their organization.

5.5. This year's workgroup and departmental priorities and targets

5.6. The strategic plans for the next few years of their organization.

5.7. Customer satisfaction survey findings.

5.8. The satisfaction of practitioners with their inter-professional partnership.

5.9 Professional turnover and vacancy rates within their specialty in the hospital.

5.10. Colleagues' satisfaction with their general practice, their wages, and benefits (within their discipline).

6. The hospital should appreciate and motivate the health care personnel to share in goals setting and conflict resolution through:

6.1.Resolving disputes among their professional colleagues by negotiation.

6.2. Resolving disputes with their professional peers, other professional associations, executive teams, immediate superiors, and the organization's administration by negotiation.

6.3.Create an official grievance protocol or mechanism for resolving internal conflicts.

6.4. Draw up a list of their immediate workgroup's priorities and objectives.

6.5. Outline their department's philosophy, priorities, and targets.

6.6. Describe the organization's mission, ideology, priorities, and objectives.

6.7. Establish strategies and procedures for their staff.

6.8. Determine departmental policies and procedures.

Conclusions

The findings of the present study concluded that the shared governance among health care personnel at Suez Canal University hospital was generally low. Conversely, the hospital had the dominant total scores of governance and all shared governance dimensions. Based on a suggested shared governance strategy was developed.

Recommendations

The following recommendations are proposed for the university hospital.

- The application of the developed suggested shared governance strategy or a suitable governance model that focuses on strong leadership and a sound shared governance infrastructure, for allowing a professional practice environment.
- Disseminate an organizational culture of shared governance that is based on a commitment to mutual values.
- Adoption of specific policies

regarding authority and standard operating protocol (such as bylaws, corporate handbooks, and policy statements) that codify decision-making authority as well as a detailed, nuanced understanding of board members', organization's, and presidents' respective positions in shared governance, as well as those of their colleagues.

- Even if they do not have a foreman, committees, presidents, and associations hospital should provide daily opportunities to include the voices of health care personnel in the discussion of critical issues and major decisions.

- Future researches

The current study findings suggest the need for future research studies that focus on validating the outcomes of implementing professional shared governance strategies in hospitals.

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