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The Effect of Shared Governance Educational Program for Head Nurses on Nurses' Organizational Commitment

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Abstract

Background: Shared governance is a collaborative leadership system implemented on the principles of partnership, justice, responsibility, and, ownership. This actually accomplishes many benefits to the organization and improves nurses' organizational commitment level. **Aim:** assess the effect of shared governance educational program for head nurses on nurses' organizational commitment. **Research design:** A quasi-experimental design was applied in this study**. Setting:** This study was conducted at Kafer El Sheikh General Hospital. **Subjects:** Include all head nurses (60) & a simple random sample of (184) nurses, working at the previous setting. **Tools:** There were three tools; (I) Shared Governance Knowledge Questionnaire, (II) Professional Shared Governance Questionnaire, and (III) Organizational Commitment Questionnaire. **Results:** The majority (88.3% and 76.6%) of head nurses had good knowledge level at the post and follow-up program phases, respectively, the majority (93.3% and 85.0%) of head nurses had high shared governance level at post and follow up program phases, respectively. The most (89.7% and 66.8%) of studied nurses had high organizational commitment level at post and follow up program phases, respectively. **Conclusion:** The educational program was effective and resulted in improvement in head nurses' shared governance knowledge & level at post and follow up program phases. Moreover, a highly statistical significant positive correlation between head nurses' total shared governance knowledge and level and total nurses' organizational commitment level at post program was found. **Recommendations:** Integrating the perspectives of shared governance into the norms and strategy of the organization through establishing guidelines which associated with the objectives and techniques of its implementation. Maintaining a supportive work environment to promote nurses' organizational commitment.

Key words: Commitment, Educational program, Head nurses, Nurses, Shared governance.

1. Introduction

Shared governance is a participative management system and a wide change in the work environment that offers nurses a voice in decision making process through managerial construction which allow staff members for constructing clinical decisions. It is the main empowerment mechanism in nursing organization nowadays [1]. Using a decentralized decision-making system, staff members interact under the shared governance model to decide decisions regarding clinical practices, professional advancement, patients' experience, quality improvement, and research. Shared governance improves nurses commitment, job satisfaction, nurse retention, and patient satisfaction [2].

The implementation of shared governance dimensions and sharing of power at all levels has significant implications because it aims to increase staff empowerment to take part in decision-making, improve their professional control, official authority, abilities for conflict resolution, great access to crucial information, have organizational influences, and be accountable for their actions and decisions for improving clinical practices[3].

Partnership, justice, responsibility and ownership are the principles of nursing shared governance that act as the basis and the cornerstones of successful shared governance and in turn generate a positive work environment, facilitate open communication, and collaboration [4]. Partnership, includes all staff in decisions and processes. Justice means that no role is more significant than another. While, responsibility means taking ownership of decision-making process and results. Ownership, greeting that the organization is only as strong as it's individual staff ability [5].

Professional shared governance implies retraining managers, engaging staff, reallocating liability, and constructing an appropriately staff-focused model of decision and act [6]. All of these result in a variety of advantages such as improvement in team integration, communication, and decision making, increase nurses perceived organizational commitment, competence, job satisfaction and peer support that result in career motivation and giving a high quality of care in addition to, decrease turnover among nurses and managers**,** as it perceived as the most important innovation and evidence-based way to promote career motivation [7].

Organizational commitment is described as a force that directs an individual's actions toward one or more goals according to the relative strength of the individual [8&9]. These behaviors demonstrate nurses adherence to the organization and represent the next phase in which nurses show support for their organization, achievement, and personal

growth. Strong willingness to stay as a group member, willingness to work hard as the organizational aspiration, and a certain willingness to accept the values and goals of the organization are also behaviors that reflect staff loyalty to the organization.. So, organizational commitment improves relationships in work and increased outcome [10&11].

Shared leadership decisions are excellent indicators of how are committed nurses will be within their organization. Responsible leaders can cultivate and build a climate where the interests of staff are considered and their well-being and contributions are cared about [12], higher levels of involvement and engagement in an organization are correlated with a feeling of belonging and being seen as insiders [13]. Organizational commitment is a relative strength for nurses' involvement and attachment in their workplace, it's a crucial component of nurses' attitudes because it promotes altruistic and pro-social behaviors which enhance performance through their affective, continuous, and normative commitment [14].

Nurses who are committed to their organization are better able to go above and beyond what is required of them, define their work more broadly, and engage in actions that are good for the environment within their organization [15]. When nurses are more committed to their organization, they work harder to meet both their organization and their own personal goals. As a result, they are more likely to put further greater effort to perform acts that support their organization [9].

Significance of the study

Shared governance model offers guidance for achieving the objectives of nurses commitment, engagement, and satisfaction, which improve quality, safety of patients [16]. Shared governance varies in councils framework, decision-making competences, and diversity from including nurses to encompassing an interdisciplinary model to achieve quality and excellence in patient care, helps to improve nurses' working condition, commitment, and support to healthcare organization for delivering the best healthcare available, thus benefiting the nurses, investors, and patients in addition to the healthcare sector [17]. From the investigators' clinical observation, it was noted that there was poor implementation of shared governance in which nurses didn't have the opportunity to participate in the process of decision making that affect their organizational loyalty. So, this study will be conducted to assess the effect of shared governance educational program for head nurses on nurses' organizational commitment. It is hoped that this program will increase the level of shared governance among head nurses.

Aim

Assess the effect of shared governance educational program for head nurses on nurses' organizational commitment**.**

1- Assessing head nurses' knowledge related to shared governance through the phases of the program.
2- Assessing head nurses shared governance' level through the phases of the program.
3- Assessing the level of nurses' organizational commitment through the phases of the program.
4- Designing & implementing the educational shared governance program to head nurses.
5- Assessing the educational shared governance program' effect to head nurses on nurses' organizational commitment.

Hypothesis

A significant increase in the knowledge and level of shared governance among head nurses after application of the prepared program will achieved. A positive effect from the educational program about shared governance to head nurses on the level of nurses' organizational commitment will reached.

2.Subjects & Method

I- Technical design:

Design: using a pretest based quasi-experimental study approach, posttest and follow up assessments after three months post program implementation.

Setting: The research was performed at Kafer El Sheikh General Hospital, the hospital bed capacity was 420 bed, the studied departments were Medical, Surgical, and Critical departments and the total number of the studied units were 26 units.

Research Subjects: Include all head nurses (60), and (184) of nurses who were working at previous setting..

Tools of Data Collection:

The data collected using the following tools: **Tool (I):Shared Governance Knowledge Questionnaire.** It consists of: **Part I**; personal characteristics regarding head nurses e.g. age, gender, marital status, qualifications, department, years of experience, & attending past educational programs on shared governance. **Part II;** developed by the investigator based on the literature review of shared governance [7,18&19], It consisted of 37 questions, 17 of them were true or false questions and 20 multiple choice questions.

Scoring system: Answers for each item, scores were allocated as: true answer (1), false answer (0). The respondent who had higher than 75% indicates good level of knowledge, if the score is from 60-75% indicates average level of knowledge & if lower than 60% indicates poor level of knowledge.

Tool (II): Professional Shared Governance Questionnaire: constructed by the investigator following analyzing the relevant literatures [7, 19, 20&21]. It was utilized to evaluate the shared governance level among head nurses. Includes 7

categories as follow; Participation (6 items), Organizational influences (11 items), Professional controls (11 items), Official authority (5 items), Ability (7 items), Access to information (8 items), and Accountability (12 items).

Scoring system: for answering each question, scores were assigned as follow: Disagree (1), uncertain (2), & agree (3). The respondent who gain a percent higher than 75% indicates a high level, score from 60-75% indicates moderate level & lower than 60% indicates lower shared governance level.

Tool III: Organizational Commitment Questionnaire. It consists of: **Part I:** included the nurses personal characteristics e.g. age, gender, marital status, qualifications, department, and years of experience**. Part II:** Adopted from [22] to evaluate the nurses' organizational commitment level. Consists of 18 items grouped into main three subscales namely: Affective commitment (6 items), Continuance commitment (6 items), & Normative commitment (6 items).

Scoring system: For answering each item, scores were assigned as follow: Disagree (1), uncertain (2), and agree (3). The respondent who gained a percent higher than 75% indicates high organizational commitment level, scores from 60-75% indicates moderate organizational commitment level & lower than 60% indicates low organizational commitment level.

II- Administrative design:

Approval: A letter was obtained from the Dean of Faculty of Nursing, Benha University to gain permission for collecting the data from the Kafer El Sheikh General Hospital director.

Ethical Consideration: Prior to starting the study, participants received guarantees about the privacy and anonymity of the data they provided. They were made aware of their right to decline research participation and their freedom to leave the study at any time.

III- Operational design:

A-Preparatory Phase:-

To create the study instruments for data collection, the investigator looked at the current and historical literatures, both national and worldwide, as well as texts, articles, journals, and theses related to the study's topic. The study supervisors accepted the instruments and the educational program after they had been revised and modified it.

Content Validity:

A panel of five experts, including two nursing administration professors from Tanta University, two assistant professors of nursing administration from Tanta University, and one assistant professor of nursing administration from Benha University, evaluated the validity of the instruments. Finally, adjustments were made in response to their feedback, including (modify some words to give the right meaning for the phrase which were not clear).

Reliability:

The reliability of the study tools was evaluated using Cronbach's Alpha test. Strong reliability was confirmed for the tools.

B- Pilot Study:-

The tools of data collection were tested among ten percent of the participants of the study, (6) head nurses. The knowledge questionnaire was provided, and the time required to respond to the questions was between 20 and 25 minutes.. After that, a professional shared governance questionnaire was presented, and it took between 30 and 35 minutes to complete. Also, nurses' organizational commitment questionnaire was used on 18 nurses representing ten percent of total studied nurses and the times consumed was 5-10 minutes, No adjustments were made after the pilot study analysis; the final form was constructed, and the participants were enrolled to the sample for the study.

C- Work field includes:-

Program assessment: Initiated from the beginning to the end of November 2021. The study's purpose was defined by the investigator before distributing the study questionnaires sheets, components of tools were explained to the participants. The knowledge questionnaire sheet was given to the head nurses, and the necessary instructions were verbally given to ensure understanding and then it was collected from them, then the professional shared governance questionnaire sheet was given to head nurses, and then it was collected from them. In addition, organizational commitment questionnaire was distributed to nurses. The participants completed the questionnaire and gave it back to the investigator to check its completeness.

Planning phase: Began at the beginning to the end of December 2021. In accordance with their departments, the researcher grouped the head nurses into four groups: two groups consisted of 10 and the other two groups had 20 head nurses. The program took about six days, the researcher gave them ideas during the meetings and the participants were informed of the study. After reviewing appropriate literature and organizing the educational program based on the analysis of the data from the assessment phase, the researcher developed the handouts for the shared governance educational program. Following discussions with the nursing director and collaboration with the leader of the committee of training and development, the schedule was decided upon and the place for the educational program was reserved. According to records, the audiovisual equipment was also reserved.

Program implementation: Started in the beginning and ended in January. 2022. The session took two hours per day. The educational program

was conducted in the training hall at Kafr El Sheikh General Hospital. The researcher provided an overview of the educational program's goals, plan, material summaries, and evaluation procedures during the first session. Daily feedback was applied at the end of each session the researcher give to the participants concise and summarization regarding the content of the session.

The investigator went to the study site stated earlier six days a week from 10 AM to 12 PM. The researcher presented herself to the head nurses, explained the goal of the study, and obtained their oral consent to participate in the study. The educational program was implemented and took about six days for each group, the total educational programs' time was four weeks, two hours per day.

Teaching methods used during the implementation of the educational program were lecture, group discussion, brain storming, and practice session such as setting objectives individually and problem solving using real clinical problems. Teaching aids were used such as data show (ppt.) and hand outs were distributed as appropriate to head nurses.

Evaluation phase: Initiated from the beginning to the end of May (2022). Following program execution, a follow-up evaluation of head nurses' knowledge was conducted and their shared governance level by using the same tools immediately after the implementation and after three months post program. In addition, Through the use of the organizational commitment questionnaire, information was gathered from nurses to evaluate their level of commitment throughout program phases.

IV-Statistical Design:

Data were acquired, confirmed, coded, tabulated, and made available to the Statistical Package for Social Sciences (SPSS version 22.0). To handle data and display graphics, Microsoft Office Excel was also used. For quantitative data, descriptive statistics were utilized in the form of mean and standard deviation, while frequency and percentages were used for qualitative variables.. Between-variables person correlation coefficient was assessed. At $P \leq 0.05$, it was statistically significant, and at $P \leq 0.001$, it was highly statistically significant. In order to compare mean scores, parametrical tests (such the independent (t) test and the paired (t) test) were applied.

3. Results

Table (1): This shows that more than half (55.5%) of head nurses are between the ages of 30 and 35. at mean score 34.10±2.86, and all of them (100%) were females. In addition, the most (96.7%) of head nurses were married, and more than two thirds (68.3%) of them held a nursing bachelor's degree.. More than two fifth (41.7 %) of head nurses were working at surgical departments. Fewer than two thirds (65.0%) of head nurses had between 10 and less than 15 years of experience with mean scores 12.20±2.56. Moreover, the most (96.7%) of head nurses didn't attend any previous educational courses about shared governance.

Table (2): Indicates, more than half (53.3%) of the nurses who participated in the study were under 30 years old. with mean score 27.77+3.82, the majority (88.6% & 86.4%) of them were females and married, respectively, and more than one third (38.0 %) of studied nurses were working at surgical departments. More than half (56.0%) of them held a nursing bachelor's degree. Additionally, more than half (51.1%) of the nurses who participated in the study had experience of 3 to 5 years, with mean score 5.12+3.65.

Figure (1): Highlights that, the majority (80.0%) of head nurses had poor shared governance knowledge at preprogram phase, but it enhanced to 88.3% & 76.6% good knowledge at post & follow up phases (after three months), respectively.

Table (3): Summarizes, a highly statistically significant difference was present between mean scores of total knowledge among head nurses regarding shared governance through the program phases at $P \leq 0.001$. The highest mean percent (91.0 and 86.2 %) with mean score and standard deviation 4.55±0.64 and 4.31±0.77 was related to knowledge about advantages and disadvantages of shared governance at post and follow-up phases of the program, respectively. While the least mean percent (78.8 and 74.5 %) with mean score and standard deviation 3.15±0.73 and 2.98±0.79 was related to concept of shared governance at immediate post and follow-up phases of the program, respectively.

Figure (2): Highlights, more over two fifth (46.7%) of head nurses had low level of shared governance at preprogram phase, while the majority (93.3% and 85.0%) of them had high shared governance level at immediate post and follow up phases, respectively.

Table (4): Indicates, a highly statistically significant difference was present between mean scores of total head nurses' shared governance level throughout the program phases at $P \leq 0.001$. The greatest mean percent (91.5 & 86.2 %) with mean score & standard deviation 30.20±1.27 and 28.45±2.02 was related to professional controls at immediate post and follow-up phases of the program, respectively. While, the lowest mean percent (78.2 & 76.1 %) with mean score & standard deviation 18.76 ±1.81 and 18.35±1.83 was related to access to information at the program's immediate post and follow-up phases., respectively.

Figure (3): Shows, more than two fifth (42.4%) of studied nurses had high organizational commitment level at preprogram phase, which increased to 89.7% and 66.8% at the program's immediate post and follow-up phases, respectively.

Table (5): Reveals, a highly statistically significant difference was present between mean scores of nurses' total organizational commitment throughout the program phases at P ≤ 0. 001. The highest mean percent (85.1 and 82.5 %) with mean score and standard deviation 15.32±1.60 and 14.85±1.49 was related to nurses' normative commitment at immediate post and follow-up phases (after three months) of the program, respectively. While, the least mean percent (83.1 and 82.2 %) with mean score and standard deviation 14.43±1.54 and 14.85±1.62 was related to nurses continuance commitment at the program's immediate post and follow-up phases, respectively.

Table (6): Presents, a highly statistically significant positive correlation was present between head total nurses' shared governance knowledge, total shared governance level & total nurses' organizational commitment level at the program's immediate post phase. In addition, a highly statistically significant positive correlation was found between total head nurses' shared governance knowledge & total level of shared governance & nurses' total organizational commitment level at follow up phase, while, a significant positive correlation was noted between head total nurses' level of shared governance and total nurses' organizational commitment level at follow up phase.

Table (1) Personal traits of head nurses (n=60)

Personal traits	No.	%
Age		
30 ≥ 35 years	33	55.0
35 ≥ 40 years	24	40.0
40 years and more	3	5.0
Min – Max	**30-40**	
Mean ± SD	**34.10±2.86**	
Gender		
Male	0	0.0
Female	60	100.0
Marital status		
Married	58	96.7
Unmarried	2	3.3
Educational level		
Diploma degree in Nursing	0	0.0
Associate degree in Nursing	0	0.0
Bachelor degree in Nursing	41	68.3
Post-graduation studies in Nursing	19	31.7
Department		
Medical	20	33.3
Surgical	25	41.7
Critical	15	25.0
Experience		
> 10 years	10	16.7
10 ≥ 15 years	39	65.0
15 years and more	11	18.3
Min – Max	**8-18**	
Mean ± SD	**12.20±2.56**	
Attending previous educational courses about shared governance		
Yes	2	3.3
No	58	96.7

Table (2) Personnel traits of nurses (n=184)

Personal traits	No.	%
Age		
20 ≥ 25	31	16.8
25 ≥30	98	53.3
30 ≥ 35	39	21.2
35 - 40	16	8.7
Min – Max	**22-40**	
Mean ± SD	**27.77±3.82**	
Gender		

Personal traits	No.	%
Male	21	11.4
Female	163	88.6
Marital status		
Married	159	86.4
Unmarried	25	13.6
Educational level		
Diploma degree in Nursing	3	1.6
Associate degree in Nursing	75	40.8
Bachelor degree in Nursing	103	56.0
Post-graduation studies in Nursing	3	1.6
Department		
Medical	60	32.6
Surgical	70	38.0
Critical	54	29.3
Experience		
5 years > 3	94	51.1
10 years > 5	75	40.8
15 years > 10	3	1.6
15 - 20 years	12	6.5
Min – Max	**2-20**	
Mean ± SD	**5.12±3.65**	

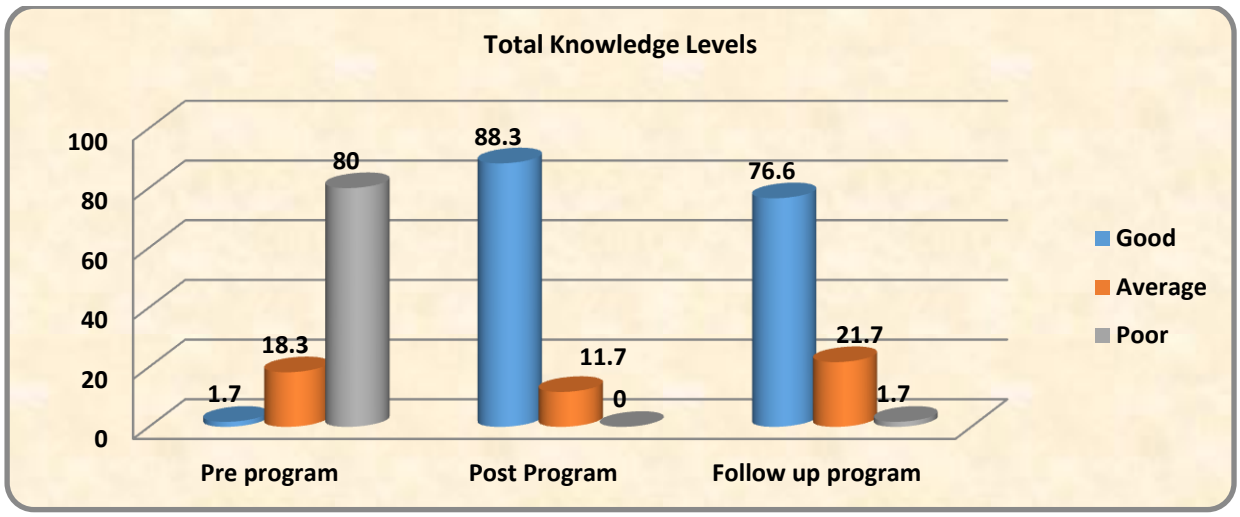

Fig. (1) Head nurses' total knowledge levels concerning shared governance during program stages.

Table (3) Total mean scores & standard deviation of head nurses' knowledge concerning shared governance during program stages (n=60)

Items	Max Score	Pre- Program		Post-Program		Follow-up Program		t_1	P-value	t_2	P-value
		$\overline{XX}$ ±SD	Mean %	$\overline{XX}$ ±SD	Mean %	$\overline{XX}$ ±SD	Mean %				
Concept of shared governance	4	1.81±1.50	45.3	3.15±0.73	78.8	2.98±0.79	74.5	5.79	0.000**	5.25	0.000**
Importance of shared governance	3	1.40±1.23	46.7	2.43±0.72	81.0	2.25±0.75	75.0	5.97	0.000**	4.62	0.000**
Theories of shared governance	5	1.75±0.96	35.0	4.06±0.88	81.2	3.85±0.93	77.0	14.77	0.000**	11.34	0.000**
Advantages and disadvantages of shared governance	5	2.61±2.20	52.2	4.55±0.64	91.0	4.31±0.77	86.2	6.43	0.000**	5.64	0.000**

Items	Max Score	Pre- Program $\overline{XX}$ ±SD	Mean %	Post-Program $\overline{XX}$ ±SD	Mean %	Follow- up Program $\overline{XX}$ ±SD	Mean %	t_1	P-value	t_2	P - value
Principles of shared governance	4	1.53±1.15	38.3	3.45±0.69	86.3	3.26±0.77	81.5	11.04	0.000**	10.02	0.000**
Benefits of shared governance	6	3.31±2.00	55.2	5.11±0.94	85.2	4.68±0.92	78.0	6.18	0.000**	4.94	0.000**
Models of shared governance	5	1.99±1.14	39.8	4.30±0.72	86.0	3.93±0.82	78.6	12.57	0.000**	10.35	0.000**
Challenges of shared governance application	5	1.95±1.15	39.0	4.16±0.86	83.2	3.78±0.95	75.6	11.47	0.000**	9.14	0.000**
Total knowledge	37	16.31±4.90		31.23±2.33		29.06±2.66		20.09	0.000**	16.87	0.000**

** A highly statistical significant difference P ≤ 0. 001 t_1 between pre and post program t_2 between pre and follow up program

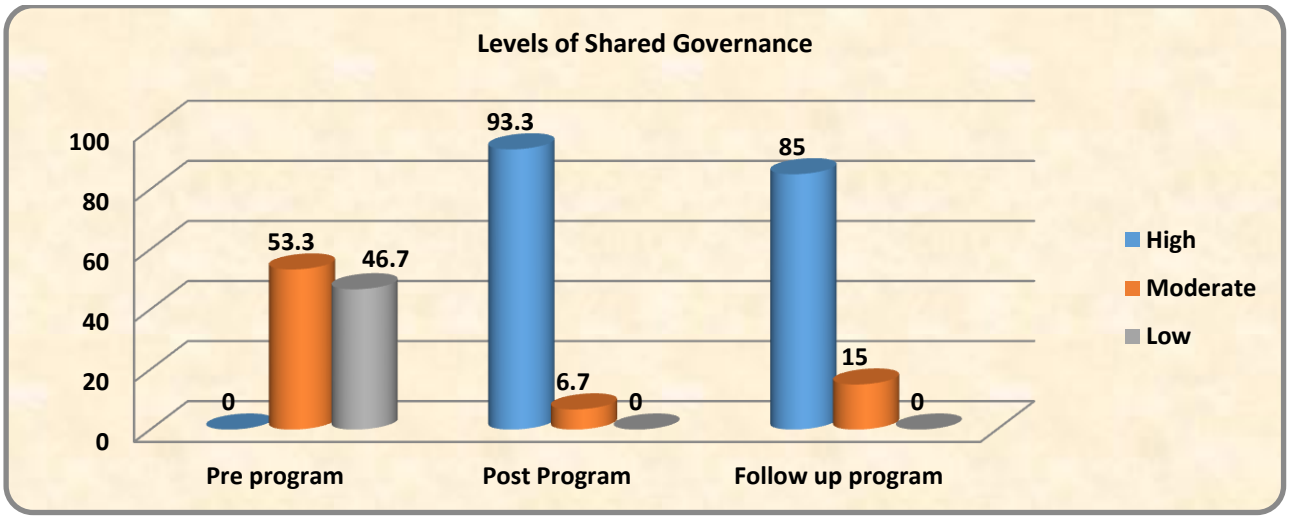

Fig. (2) Total levels of head nurses' shared governance during program stages

Table (4) Total mean scores & standard deviation of shared governance' dimensions among head nurses through program phases (n= 60)

Items	Max Score	Pre- Program $\overline{XX}$ ±SD	Mean%	Post-Program $\overline{XX}$ ±SD	Mean%	Follow- up Program $\overline{XX}$ ±SD	Mean%	t_1	P-value	t_2	P - value
Participation	18	10.43±2.35	57.9	16.01±1.57	88.9	15.43±1.49	85.7	16.19	0.000**	14.15	0.000**
Organizational influences	33	19.21±2.21	40.0	28.71±2.19	87.0	27.88±2.05	84.5	24.21	0.000**	23.03	0.000**
Professional controls	33	18.18±2.60	55.1	30.20±1.27	91.5	28.45±2.02	86.2	31.62	0.000**	23.96	0.000**
Official authority	15	7.53±1.11	50.2	12.00±2.11	80.0	11.45±1.38	76.3	16.45	0.000**	14.72	0.000**

Ability	21	10.56±2.37	50.3	18.81±1.73	86.6	18.00±1.67	85.7	22.28	0.000**	21.56	0.000**
Access to information	24	13.31±2.01	55.5	18.76±1.81	78.2	18.35±1.83	76.1	16.19	0.000**	15.65	0.000**
Accountability	36	24.30±2.92	67.5	31.95±2.18	88.8	30.08±2.14	83.6	15.70	0.000**	14.11	0.000**
Total practice	180	103.55±7.87		156.46±5.92		149±6.19		42.20	0.000**	39.69	0.000**

** A highly statistical significant difference P ≤ 0. 001 t_1 between pre and post program t_2 between pre and follow up program

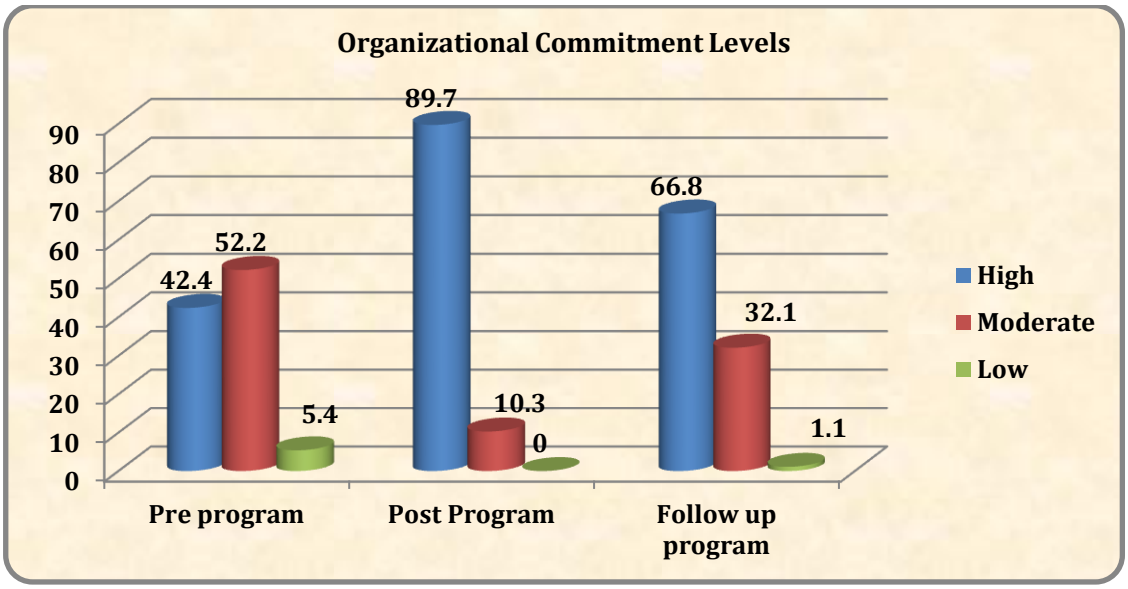

Fig. (3) Total organizational commitment levels of nurses' during program stages

Table (5) Total mean scores & standard deviation of nurses' organizational commitment through program stages (n=184)

Items	Max Score	Pre- Program		Post-Program		Follow- up Program		t_1	P-value	t_2	P - value
		$\overline{XX}$ ±SD	Mean%	$\overline{XX}$ ±SD	Mean%	$\overline{XX}$ ±SD	Mean%				
Affective commitment	18	13.07±2.24	72.6	15.18±1.70	84.3	14.79±1.56	82.4	10.790	0.000**	9.184	0.000**
Normative commitment	18	13.44±1.61	74.7	15.32±1.60	85.1	14.85±1.49	82.5	12.562	0.000**	8.392	0.000**
Continuance commitment	18	12.11±2.24	67.3	14.95±1.54	83.1	14.85±1.62	82.2	14.079	0.000**	12.810	0.000**
Total commitment	54	38.63±4.54		45.46±3.50		44.51±3.22		17.102	0.000**	13.969	0.000**

** A highly statistical significant difference P ≤ 0. 001 t_1 between pre and post program t_2 between pre and follow up program

Table (6) Correlation between head nurses' total shared governance knowledge, total shared governance level, total nurses' organizational commitment through program phases.

Variables			Total knowledge	Total Shared governance level	Total organizational commitment level
Preprogram phase	Total knowledge	r		0.453	0.718
		p-value		0.024*	0.036*
	Total Shared governance	r	0.453		0.807
		p-value	0.024*		0.009*
	Total organizational commitment	r	0.718	0.807	
		p-value	0.036*	0.009*	
Post program phase	Total knowledge	r		0.660	0.424
		p-value		0.000**	0.000**
	Total Shared governance	r	0.660		0.424
		p-value	0.000**		0.000**
	Total organizational commitment	r	0.424	0.424	
		p-value	0.000**	0.000**	
Follow up program phase	Total knowledge	r		0.818	0.351
		p-value		0.000**	0.006**
	Total Shared governance	r	0.818		0.335
		p-value	0.000**		0.049*
	Total organizational commitment	r	0.351	0.335	
		p-value	0.006**	0.049*	

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

3. Discussion

Implementing of shared governance increases nurses' commitment to their organization, and it is clear that shared governance promotes professional nursing practices, communication, professional teamwork, productive workplace environment, high-quality decision-making, and patient care indicators [23 &24]. The aim of the present study was to assess the impact of shared governance educational program for head nurses on nurses' organizational commitment. Concerning total head nurses' knowledge levels regarding shared governance through program phases, the results of present study showed, the majority of head nurses got a poor knowledge in relation to shared governance at preprogram phase, but it increased at immediate post to good knowledge and slightly decreased at follow up phases. In addition, there was a highly statistical significant differences in head nurses' total knowledge concerning shared governance at pre, immediate post and follow up program phases. These results might be due to that the near all of head nurses not receive any previous learning about shared governance, in addition, the present of Corona virus pandemic which forced head nurses facing time pressure and had no opportunity to attend workshops or to share decision making with their nurses. Implementing the program, and using a variety of instructional techniques, effective booklet, help the head nurses to gain related information about shared governance and become interested with this valuable information, so this program was beneficial for them and led to significant improvements in their knowledge

These results agreed with [25] who reported, between the pre-test and post-test, there was a statistically significant change, which indicated a major advancements in nursing managers' information regarding shared governance. Within that way [26] concluded that, nurses' understanding of and perceptions about shared governance improved to a highly statistically significant degree.

However, this result was incongruent with the outcomes documented by [27] who concluded that there were no statistically significant differences between shared governance participants and non-participants in their opinions on shared governance or structural empowerment..

In relation to mean scores of head nurses' knowledge regarding shared governance, the current study's findings showed that at the immediate post and follow-up phases, the mean scores of all head nurses' knowledge of shared governance improved significantly statistically compared with preprogram phase. The highest mean percent was related to knowledge about advantages and disadvantages of shared governance at immediate post and follow-up phases of the program. The program benefited head nurses from the perspective of researcher to know that shared governance enhance the developmental and career level, help in solving the problems, and allows nurses to take decisions that affect their work.

While, the least mean percent was knowledge about concept of shared governance at immediate post and follow-up program phases. From the

perspective of the researcher, it may have been because the head nurses were unaware of the definitions of various terms, such as decisional involvement, participation, participatory management, shared leadership, and teamwork, which are frequently confused with the concept of shared governance. This may also have been a contributing factor to highlighting the importance of shared governance.

This result was supported by [26] who documented, the overall mean governance knowledge scores in their studies improved at post-application of the structure of governance than pre-application. In addition, [28] indicated that his study's overall mean scores for governance knowledge increased after the introduction of a governance structure compared to before.

Regarding total levels of head nurses' shared governance through program phases, the present study demonstrated that, more than two fifth of head nurses gain the lowest level of shared governance at preprogram phase, while most of them had great shared governance at the post-implementation and follow-up phases. According to the investigator opinion this might related to the program had a greater and successful effect on improving the level of shared governance among head nurses through using effective teaching techniques and real-world scenarios allow the head nurses to acquire specific practices that improve their shared governance level.

These findings were in accordance with [29] who found most of nursing managers had little shared governance.. Also, [30] highlighted that nursing turnover was impacted by the implementation of a multihospital shared governance framework, and the hospital with lower turnover had higher levels of shared governance.

Concerning mean scores and standard deviation of head nurses' shared governance dimensions, The results of the current study demonstrated that there were highly statistically significant increases in the mean scores of all the shared governance aspects among head nurses throughout the program phases. The viewpoint of the researcher, the educational program was effective and increased head nurses' awareness with shared governance dimensions and they began to encourage nurses participation in administrative matters which impact on the clinical practice, encourage nurses to be represented in hospital administration committees, and support nurses in activities which initiated through shared governance and this leads to improvement of total head nurses' shared governance level.

According to the current analysis, the highest mean percent referred to professional control dimension at post and program follow-up. The viewpoint of the researcher, this possibly because the program had greater influence on head nurses for supporting their nurses to take patient' care decisions during nursing care and allowing nurses to participate on developing policies, procedures and protocols related to patient care. This result was congruent with [31] who discovered that nurses' perceptions of control over their professional practices inside their organizations scored the highest subscale, indicating that nursing management and nurses both participate in decision-making. Also, this outcomes were in harmony with [23] who found the highest mean percent was found in the areas of goal planning, conflict management, and professional control for nurses.

In contrast, this result was disagreed with [4] who revealed that the professional control subscale's mean score was the lowest of all the subscales, demonstrating that nursing management and nurses do not participate equally in decision-making.

The current study's findings showed that The lowest mean percentage was matched with access to information dimension at the program's post and follow-up stages. From the viewpoint of the investigator this might due to that nurses not had enough access to the information and communication when needed and departments aren't clearly kept better informed about what's going on in hospital. This outcome was consistent with [23] who reported in his research that the least nurses' shared governance level was access to information item. Also, [32] reported that, access to information dimension had low mean percent.

As opposed to that,, the result disapproved of [31] study in which nurses had high mean percent for the access to information subscale. In addition, [33] reported that access to information subscale had the highest percent. Also, [4] concluded that access to information subscale had the highest percent.

Regarding total nurses' organizational commitment level through program phases, the current research indicated higher than two fifth of nurses who have been investigated had high organizational level of commitment at preprogram phase, which increased at the phase of immediate post and follow-up. This could be because of the educational program about shared governance for head nurses had a greater effect on improving the level of organizational commitment among their studied nurses as head nurses started to support and involve nurses in making decisions process, permit them to decide how to conduct their daily activities, and work professionally.

The findings of the current research were not in agreement with [34] who found that the overall organizational commitment was high. Also, these results were inconsistent with [35] who stated that the research subjects exhibited a high level of organizational commitment.

Concerning mean score of nurses' organizational commitment through program phases, the current research clarified, the nurses organizational commitment' mean scores highly significantly improved in at post & follow up than preprogram. The normative commitment of nurses was associated with the greatest mean percent, the least mean percent was nurses' continuance commitment at immediate post and follow-up stages. According to the investigator, this outcome could be caused by nurses felling that they became a crucial part in their organization and the head nurses gave them the opportunity to participate in decisions which affected their clinical practices.

These findings were congruent with [34] who reported that the normative commitment was found to be the highest dimension, while continuance commitment was the lowest dimension. In addition, [36] who concluded that, the normative commitment domain came first in rank at the highest, while the continuance commitment domain was the lowest mean score.

On the other hand these results were dissimilar to findings reported by [37] who reported that continuance commitment was found to be the highest dimension while affective commitment was the lowest dimension among Saudi nurses.

Regarding correlation between head nurses' total shared governance knowledge, total shared governance level, total nurses' organizational commitment through program phases, the current study results revealed, a highly statistically significant positive connection existed between total head nurses' shared governance knowledge, shared governance total level & total organizational commitment level of nurses at post program immediately.

These results were matched with [38] who found in their study, The organizational commitment and each of the shared governance components showed a strong positive association.

These results were inconsistent with findings reported by [40] who documented that the council of christian colleges and universities enrollment managers, directors report high levels of commitment to their organizations, but this organizational commitment does not seem to be related to the variables used in this study. Organizational commitment was not found to be based upon the level of shared governance they report, nor the size of the institution they work for, it was not found to be contingent upon the demographic variables of age, time on the job, or gender, nor was the organizational commitment level statistically tied to the historic faith based mission of the university.

Conclusion

The educational program was effective and produced notable progress in shared governance knowledge & level among head nurses at post immediately and program follow up stages. At the post immediately and follow-up program, there was a marked improvement in the studied nurses' organizational commitment level. A highly statistically significant positive association existed between total shared governance knowledge among head nurses, total shared governance level and total nurses' organizational commitment level at post immediately the program.

4. Recommendations

- establishing a set of policies relating to the guiding principles and practices of shared governance and incorporating it into the organization's values and mission.
- Providing a practice environment that encourages accountability and allow nurses to make decisions independently.
- Establishing a supportive work environment and encouraging nurses to participate in committees that support their organizational commitment, as the quality, infection control, safety, and training committees.
- Offering nurses with professional growth and training opportunities to enhance, their autonomy, motivation, and commitment.
- preparing newly graduated nurses to take on duties and be willing to engage in decision-making.
- Conducting a study to evaluate the effectiveness of shared governance models on organizational productivity.
- Conducting a research for identifying factors affecting nurses' organizational commitment in their work place.

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