Relation between Shared Governance and Organizational Commitment among Nursing Managers in Port-Said Hospitals

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ABSTRACT

Background: The concept of shared governance added into nursing in the 1980s as a professional practice model in which both nursing staff and nursing management are involved in decision-making. Successful implementation of shared governance leads to a greater commitment to the organization. ***Aim:*** the current study aimed to determine the relation between shared governance, and organizational commitment among nursing managers in Port-Said hospitals. ***Subjects and Methods:*** A descriptive correlation design was applied in this study. The study was conducted in eight hospitals affiliated to the Ministry of Health in Port-Said Governorate. Study sample was 118 nursing managers. Two tools were used for data collection; Index of Professional Nursing Governance Questionnaire and Organizational Commitment Scale. ***Results:*** The results of the present study showed the majority of nursing managers (94.9%) had shared governance and more than two-thirds of them (72.9%) were committed to their organizations. ***Conclusion:*** Based on the results of the present study, it can be concluded that, there was no statistically significance relation between shared governance and organizational commitment among nursing managers in Port-Said hospitals. It was recommended that hospitals' organizational structure officially redesigned and develop or adopt shared governance model.

Keywords: shared governance, organizational commitment, nursing managers.

INTRODUCTION

In today's work environment, nurses expect a motivating, satisfying work environment that includes support for decision-making. Many nurses today are unwilling to remain outside the decision-making loop. Work redesign efforts to increase productivity and lower costs have contributed to increased tension regarding the role of nursing and nurses in decision-making **(Yoder-Wise, 2015)**. Moreover, information technology and new communication systems have resulted in many changes in hospital structure and the manner in which organizations operate. One of the significant changes has been the advent of shared governance **(Ellis & Hartley, 2012)**.

Huber (2014) pointed out that shared governance has become common terminology in health care; it was defined as a model of organizational decision-making premised on a decentralized organizational structure in which staff nurses are empowered through autonomy and accountability. In addition, shared governance was defined as a professional practice model in which both the nursing staff and the nursing management are involved in decision-making. Staff nurses at every level within the organization should govern their practice and be involved in decisions that affect their practice; it enables staff nurses to assume greater levels of autonomy and control over practice **(Ellis & Hartley, 2012)**.

Shared governance was divided into six dimensions: control over personnel, access to information, influence over resources, participation in committee structure, control over professional practice, and goal setting & conflict resolution **(Hess, 2010)**. According to **Wilson, Speroni, Jones, and Daniel (2014)** there are three core principles associated with shared governance; these are responsibilities for nursing care delivery must reside with clinical staff, authority for nurses to act must be recognized by the organization, and accountability for quality patient care and professionalism must be accepted by the clinical staff.

According to **Wilson (2013)**, there are several benefits of implementing shared governance models within an organization; improved the quality of care, increased the satisfaction of nurses and physicians, and the decrease in turnover. **Cherry and Jacob (2013)** mentioned the importance of shared governance as a model that provides an

organizational framework for nurses to become committed to nursing practice within their organizations. Additionally, shared governance leads to increased staff autonomy, enhanced perceptions of control over practice, and improved staff retention **(Hoying & Allen, 2011)**. Moreover, organizational benefits of shared governance include increased accountability of the nurse, and commitment of staff to the organization **(Huber, 2014)**.

Organizational commitment is an important concept that is particularly relevant to nurses **(Carver & Candela, 2008)**. According to **Armstrong (2012)** commitment represents the strength of an individual's identification with, and involvement in, a particular organization. Also, commitment refers to the attachment and loyalty; it is associated with the feelings of individuals about their organization. Furthermore, **Williams (2014)** defined organizational commitment as the degree to which a nurse emotionally and psychologically identifies with the philosophy, mission, and values of his or her organization and thereby extends the effort to help achieve strategic initiatives.

Organizational commitment has a strong positive relation to employee's performance and productivity **(Jones, 2014)**. Employees with high levels of organizational commitment are more work-oriented than other employees. They get more satisfaction from work and view their jobs as fulfilling more of their personal needs. As a result, they are willing to exert a considerable effort on behalf of the organization **(Kaplan, Ogut, Kaplan and Aksay, 2012)**.

Allen and Meyer (1990) developed a model of organizational commitment which consisted of three components: the affective component which refers to an employee's emotional attachment to, identification with, and involvement in, an organization, the continuance component which refers to the commitment level based on the costs that an employee associates with leaving an organization, and the normative component which refers to an employee's feelings of obligation to remain with an organization. This model delineates whether an employee wants to, needs to or should remain in an organization.

Significance of the study:

Today's healthcare environment is challenging for nurses as there is a significant shortage of staff to meet the comprehensive needs of patients **(Ahmed & Safadi, 2013)**. Organizations that apply shared governance provide many of the opportunities for involvement, commitment, and transparency within the organization. Employees are more likely to have increased feelings of respect for and trust in management and organizational justice, which relates to one's commitment to an organization, which may impact retention **(Moore & Hutchison, 2007)**. The implementation of shared governance leads to a greater commitment to the organization among nurses. Furthermore, it's evident that shared governance enhances professional nursing practice, communication, professional collaboration, a positive work environment, quality decision making, and patient care outcomes **(Al-Faouri, Al Ali & Essa, 2014)**. So, this study aims to determine the relation between shared governance, and organizational commitment among nursing managers in Port-Said hospitals.

AIM OF THE STUDY:

The aim of the current study is to determine the relation between shared governance, and organizational commitment among nursing managers in Port-Said hospitals.

The research questions:

1- What is the status of shared governance of nursing managers?

2- What is the level of organizational commitment of nursing managers?

3- Is there a relation between shared governance and organizational commitment of nursing managers?

SUBJECTS AND METHODS:

A descriptive correlational research design was used for the current study.

Settings:

This study was carried out at eight hospitals affiliated to the Ministry of Health in Port-Said Governorate, namely: Port-Said General Hospital, Port-Fouad General Hospital, El-Zhour General Hospital, El-Nasr General Hospital, Ophthalmology Hospital, Tropical Disease Hospital, Chest Disease Hospital, and Mental Health Hospital.

Subjects:

The subjects included all nursing managers: nurse executives, vice nurse executives, nurse supervisors, head nurses, and chief nurses in the following hospital committees: infection control, quality assurance, training, and patient safety; who were working in the study setting during the time of data collection with a total number of **(118)** nursing managers.

Tools for data collection:

Two tools were used to collect data for this study.

Tool (I): Index of Professional Nursing Governance (IPNG).

This tool used to assess nursing shared governance. It was developed by Hess (1998); updated and adopted from **Hess (2010)** after obtaining his acceptance, and modified. It consists of two parts:

Part (I): This part includes personal and job characteristics, including: hospital, sex, age, educational preparation, highest educational degree, job title, etc.

Part (II): This part measure shared governance; it consists of 79 items which divided into seven subscales, as following:

- **Setting goal**: consisted of three items.
- **Control over practice:** consisted of 17 items.
- **Influence over resources:** consisted of 11 items.
- **Control over personnel:** consisted of 16 items.
- **Participation in committee structures:** consisted of 12 items.
- **Access to information:** consisted of 14 items.
- **Ability to conflict resolution:** consisted of six items.

The tool was translated into Arabic and retranslated into English by the researcher and a language expert, and tested for its validity and reliability. A self-instruction questionnaire was utilized for data collection.

Tool (II): Organizational Commitment Scale.

This tool was developed by Mayer and Allen's (1991) to measure nurses' organizational commitment and adopted from **Elsherbiny (2013)**. It consists of 26 items which divided into the following three dimensions:

- **Affective commitment:** consisted of nine items.
- **Normative commitment:** consisted of nine items.
- **Continuance commitment:** consisted of eight items.

Scoring system of tools:

(A) Scoring system of Index of Professional Nursing Governance (IPNG):

Index of Professional Nursing Governance (IPNG) items were scored 5, 4, 3, 2, and 1, for the responses "nursing management only", "Primarily nursing management with some hospital management input", "Equally shared by nursing management and hospital management", "primarily hospital management with some nursing management input", and "hospital management only", respectively. Hospital management means medical director, administrative and financial director and units' medical managers; while nursing management means all nursing personnel in managerial positions as mentioned previously in subjects. Classification of Index of professional Nursing Governance ranges as in table (1).

Table (1): The Index of professional Nursing Governance ranges.

Classification	Range	Dominant Group
Traditional Governance	79 – 158	Hospital management only
Shared Governance	159- 316	
Below average	159 – 236	Primarily hospital management with some nursing management input
Average	237	Equally shared by nursing management and hospital management
Above average	238 – 316	Primarily nursing management with some hospital management input
Self-Governance	317 – 395	Nursing management only

(B) Scoring system of Organizational Commitment Scale:

Organizational commitment items were scored 5, 4, 3, 2, and 1, for the responses "strongly agree", "agree", "sometimes", "disagree", and "strongly disagree", respectively. For each area, the scoring was reversed in (Normative commitment) item no: 19, 20, 21, and 26. A score of 60% or more was considered committed, while a score less than 60% was considered not committed **(Elsherbiny, 2013)**.

Content validity of the tools:

Revision of tools was ascertained by panel of eleven nursing and medical experts to ensure content validity.

Reliability

Cronbach's alpha coefficient was calculated to assess the reliability of the developed tools through their internal consistency. The reliability of index of professional nursing governance was 0.88. The reliability of organizational commitment scale was 0.91.

Pilot study:

A Pilot study was carried out on 14 nursing managers who represent 10 % of the total sample from the studied hospitals of research work to assure the stability of the answers. The pilot study was conducted for two weeks, 20 - 30 minutes was the time needed to complete the questionnaires by nursing managers for each tool.

Field work:

The data were collected from nursing managers by the researcher and a team composed of ten nurses that were trained by the researcher after obtaining an official agreement from the medical and nursing directors of the studied hospitals. Meeting with the directors of nursing service was conducted by the researcher on an individual basis to explain the objectives of the study and to gain their cooperation. The questionnaire sheet was filled in by the nursing managers while they were on duty only in the morning shift, and after the purpose of the study was explained. Data were collected by the researcher and the team at five days per week in the morning shift from 9 AM. to 1 PM , data were collected from all eight hospitals in parallel. A self-instruction questionnaire was utilized to collect the data related to shared governance using "Index of Nursing Professional Governance" and organizational commitment using "Organizational Commitment Scale" . Data were collected from 23 January to 14 April 2016.

Ethical considerations:

Acceptance to use the tool of Index of Professional Nursing Governance (IPNG) was taken from the author. Official permissions through formal agreement were taken from both medical and nursing directors of the study setting to carry out the study. An informed consent was obtained from nursing managers to participate in the study after explaining the purpose and the nature of the study; they were informed that their participation is voluntary and they have the right to withdraw from the study at any time. Also, they were ensured about the confidentiality of the information collected and it was used only for the purpose of the study, and the anonymity is guaranteed.

Statistical Design:

Data entry and statistical analysis were done using SPSS 20.0 statistical software package. Data were presented using descriptive statistics in the form of frequency, percentages for qualitative data; means and standard deviations for quantitative data. Categorical variables were compared using Chi-square test; Fisher's Exact, and Monte Carlo correction for chi-square when more than 20% of the cells have expected count less than 5. In addition, Spearman coefficient test was used to correlate between shared governance and organizational commitment of nurse managers at Port Said hospitals. The statistical significance was considered at P-value ≤ 0.05 and highly significance at P ≤ 0.001.

RESULTS:

Study results reveal that the majority of nursing managers were females; less than half of them aged over 40 years old, more than two-thirds of them have a nursing diploma as their basic nursing education. Moreover, half of nursing managers were head nurses, more than half of them have more than 15 years of experience as a nurse and more than one-third of them spend between 5 to 10 years in their present position. Furthermore, most of the nursing managers didn't have professional preparations of quality, infection control, and hospital management.

Table (2) shows that the total mean of nursing shared governance score for all nursing managers was (223.24 ± 36.09). Moreover, the highest mean score was for control over practice followed by setting goals (58.72 ± 11.48, 9.42 ± 2.92 respectively). While influence over resources had the lowest mean score (24.54 ± 5.72).

Table (3) describes that the majority of nursing managers (94.9%) had shared governance. Moreover, 4.2% of nursing managers had traditional governance, while only 0.9% of nursing managers had self-governance.

Table (4) indicates that more than two-thirds of nursing managers (72.9%) were committed to the organization. Furthermore, more than half of nursing managers (60.2%) had an affective commitment to the organization, while nearly half of nursing managers (56.8%) didn't have a normative commitment to the organization. Whereas, more than half of nursing managers (62.7%) didn't have continuance commitment.

Table (5) represents that there was a statistically significant negative correlation between setting goals and affective commitment and continuance commitment of nursing managers. As well, participation in committee structures was negatively correlated with continuance commitment of nursing managers. Also, there was a statistically significant negative correlation between access to information and affective commitment and continuance commitment of nursing managers.

Table (6) proves that there was no statistically significant relation between nursing managers' total shared governance and their total organization commitment.

Table (2): Shared governance among nursing managers (N=118).

Nursing Shared Governance	**Mean ± SD**	**Shared Governance range**
Setting goal	9.42 ± 2.92	7 – 12
Control over practice	58.72 ± 11.48	35 – 68
Influence over resources	24.54 ± 5.72	23 – 44
Control over personnel	42.42 ± 10.13	33 – 64
Participation in committee structures	30.85 ± 6.16	25 – 48
Access to information	39.98 ± 7.43	29 – 56
Ability to conflict resolution	17.31 ± 4.26	13 – 24
Overall	**223.24 ± 36.09**	**159 - 316**

Table (3): Shared governance classification among nursing managers (N=118).

Nursing Shared Governance	No.	%
Traditional Governance	5	4.2%
Shared Governance	112	94.9%
Primarily hospital management with some nursing management input	72	61%
Equally shared by nursing management& hospital management	2	1.7%
Primarily nursing management with some hospital management input	38	32.3%
Self-Governance	1	0.9%

Table (4): Organizational commitment level among nursing managers (N=118).

Organizational Commitment Scale	Not committed <60%		Committed ≥60	
	No.	%	No.	%
Affective commitment	47	39.8	71	60.2
Normative commitment	67	56.8	51	43.2
Continuance commitment	74	62.7	44	37.3
Overall	**32**	**27.1**	**86**	**72.9**

Table (5): Relation between nursing managers' shared governance domains and their organizational commitment domains (N=118).

Nursing Shared Governance	Organizational Commitment					
	Affective		Normative		Continuance	
	r_s	p	r_s	p	r_s	p
Setting goal	-0.303*	0.001*	-0.161	0.081	-0.355*	<0.001*
Control over practice	-0.087	0.347	-0.006	0.953	-0.170	0.066
Influence over resources	0.027	0.775	0.186	0.044	-0.130	0.160

Control over personnel	-0.159	0.085	0.084	0.363	-0.100	0.280
Participation in committee structures	-0.099	0.287	0.002	0.985	-0.202*	0.029*
Access to information	-0.223*	0.015*	-0.089	0.337	-0.259*	0.005*
Ability to conflict resolution	-0.031	0.735	0.043	0.640	-0.012	0.900

rs: Spearman coefficient

*: Statistically significant at $p \leq 0.05$

Table (6): Correlation between nursing managers' total shared governance and their total organization commitment (N=118).

Items	Organizational Commitment	
	r_s	p
Nursing Shared Governance	-0.124	0.179

rs: Spearman coefficient

*: Statistically significant at $p \leq 0.05$

DISCUSSION:

Regarding shared governance of nursing managers, the findings of the present study revealed that the majority of nursing managers had shared governance; with a total mean score that falls below the average of shared governance. This finding probably due to the marked role of nursing managers in the committees of quality assurance and infection control; this finding was in accordance with **Lamoureux, Judkins-Cohn, Butao, McCue, and Garcia (2014)** who found that the mean total IPNG score was within the range of shared governance.

Concerning nursing managers' sharing in setting goals, the present study findings showed that more than half of nursing managers shared in setting goals, with a mean score fall within shared governance range. Similar findings were reported by **Mahmoud (2016)** who stated that the mean score of sharing in setting goals and conflict resolution fall within shared governance range.

In relation to nursing managers' sharing in control over practice, the present study findings showed that more than two-thirds of nursing managers shared in control over their practice, with the highest mean score that falls above average of shared governance range. This was in disagreement with **Cohen (2015)** who reported that the mean score of control over practice fall below the shared governance range.

Regarding nursing managers' sharing in influence over resources, the present study findings revealed that more than half of nursing managers shared in influence over resources, with the least mean score that falls below the average of shared governance range. This finding was supported by **Meyers and Costanzo (2015)** who mentioned that the mean score of influence over resources falls within shared governance range.

As regarding to nursing managers' sharing in control over personnel, findings of the present study showed that, most of the nursing managers shared in control over personnel, with a mean score fall below the average of shared governance range. In contrasted with the previous finding, **Bennett, Ockerby, Begbie, Chalmers, Hess, and O'connell (2012)** who found that the mean score of control over personnel falls below the range of shared governance.

Concerning nursing managers' sharing in participation in committee structures, the present study findings indicated that most of the nursing managers shared in participation in committee structures, with a mean score fall below the average of shared governance range. This finding was consistent with **Mouro, Tashjian, Bachir, Al-Ruzzeih and Hess (2013)** who indicated that the mean score of participation in committee structures falls below the average of shared governance range.

Regarding nursing managers' sharing in access to information, as revealed by the findings of the current study, the majority of nursing managers shared in access to information, with a mean score fall below the average of shared governance range. On the contrary, in a study by **Meyers and Costanzo (2015)** highlighted that the mean score of access to information fall below shared governance range which indicated that nurses had limited opportunity to have access to information.

As regarding to nursing managers' sharing in the ability to conflict resolution, the present study findings found that most of nursing managers shared the ability to conflict resolution, with a mean score fall below the average of shared governance range. On the same line, as mentioned previously **Wilson (2014)** reported that the mean of setting goals and conflict resolution fall within shared governance range.

Another main objective of the present study was to measure the level of organizational commitment of nursing managers. As revealed by the findings of the current study, approximately more than two-thirds of nursing managers were committed to their organizations; this means that their degree of loyalty to their hospitals is quite strong, this could be explained as more than half of nursing managers spend more than 15 years in their current hospital as they occupied higher positions with more responsibility which in turn make them more integrated into their workplace and create sense of achievement among them.

In relation to affective commitment, the present study findings revealed that more than half of nursing managers have an affective commitment to their hospitals. This is the same view of **Graf and Zimmermann (2015)** reclaimed that almost half of the studied subjects had a high level of affective commitment. **Concerning continuance commitment**, the finding of the present study revealed that more than half of nursing managers didn't have continuance commitment to their hospitals. These findings disagreed with **Motazedi, Hassankhani & Ebrahimi (2012)** who proved that the studied nurses had continuance commitment. **Regarding normative commitment**, the present study findings assumed that nearly half of nursing managers haven't a normative commitment to their hospitals. The findings of the present study is contradicted with **Bahrami, Barati, Ghoroghchian, Montazer-alfaraj, & Ezzatabadi (2015)** who highlighted that the studied nurses had normative commitment.

Concerning the relation between nursing managers' shared governance and their organization commitment, the findings of the present study clarified that there was a statistically significant negative correlation between setting goals & access to information of nursing managers and their affective and continuance commitment.

This might be because, although the nursing managers' marked efforts in the hospital committees "e.g. quality management committee" in determining the vision, mission, goals and objectives of the nursing departments and hospital, it wasn't officially represented in the hospitals' organizational structure.

This finding was supported by **Frith and Montgomery (2006)** who indicated that perception and knowledge of shared governance decreased over the study period while commitment increased.

Furthermore, the findings of the present study indicated that there was no statistically significant correlation between nursing managers' shared governance and their organization commitment. This finding disagreed with **Moore & Wells (2010)** who clarified that there was a significant relation between shared governance and organizational commitment.

CONCLUSION:

Based on the findings of the present study, it was concluded that that the majority of nursing managers had shared governance. Meanwhile, approximately more than two-thirds of nursing managers were committed to their organizations. Whereas, there was no statistically significant correlation between shared governance and organizational commitment among nursing managers in Port-Said hospitals.

RECOMMENDATIONS:

Based on the findings of this study, **the following recommendations can be suggested:** for hospital administration they should: redesign hospital organizational structure and officially develop or adopt shared governance model; support the presence of nursing personnel at all levels of decision-making; facilitate accessibility of information about financial status, budget, strategic plan, and access to supporting resources available for all nursing personnel especially nursing managers. In relation to nursing managers should: attend training program, conferences, seminars, and workshops about shared governance and skills in communication, collaboration, conflict management, and teamwork, as important for participation in governance; advocate for their rights to participate in the decision-making of hospital matters in general and specifically in nursing affairs as well and never abandon this

responsibility; accept their responsibilities in influencing over financial and human resources in the hospitals. Regarding nursing faculties they should: integrate shared governance concept into undergraduate and postgraduate nursing curricula; continuing education in form of conferences, seminars, and workshops in shared governance for academic nursing staff, and hospital and nursing managers as well. For further studies: further research is necessary to pre and post-implementation of shared governance model and evaluates its effectiveness on patient, staff, and organizations outcome; and investigates the barriers to shared governance application in health care organizations in Port-Said.

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العلاقة بين المشاركة فى الحوكمة والإلتزام المؤسسى لدى مدراء التمريض فى مستشفيات بورسعيد

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معيده كلية التمريض جامعة بورسعيد، مدرس ادارة التمريض كلية التمريض جامعة بورسعيد، استاذ ادارة التمريض جامعة بورسعيد

الخلاصة

أضيف مفهوم المشاركة فى الحوكمة إلى مهنة التمريض فى عام 1980 كنموذج للممارسة المهنية والذى يتم من خلاله مشاركة كلا من أفراد هيئة التمريض و إدارة التمريض فى صنع القرار، والتطبيق الناجح لهذا المفهوم يؤدى إلى زيادة فى الإلتزام المؤسسى لدى الأفراد. صممت هذه الدراسة الوصفية الإرتباطية لمعرفة العلاقة بين المشاركة فى الحوكمة والإلتزام المؤسسى لدى مدراء التمريض فى مستشفيات بورسعيد. وقد أجريت هذة الدراسة على 118 مدير تمريض بثمانى مستشفيات تابعة لوزارة الصحة ببورسعيد. تم استخدام أداتين لجمع البيانات وهم: مؤشر حوكمة مهنة التمريض و مقياس الإلتزام المؤسسى. وأظهرت نتائج الدراسة أن غالبية مدراء التمريض (94.9%) يمارسون المشاركة فى الحوكمة و أكثر من ثلثيهم (72.9%) لديهم إلتزام تجاه المؤسسة التى يعملون بها، كما أنه لا توجد علاقة ذات دلالة إحصائية بين المشاركة فى الحوكمة والإلتزام المؤسسى لدى مدراء التمريض فى مستشفيات بورسعيد. وأوصت نتائج الدراسة الحالية بإعادة تصميم للهيكل التنظيمى للمستشفيات بشكل رسمى وتصميم أو تبنى نموذج للمشاركة فى الحوكمة.

الكلمات المرشدة: المشاركة فى الحوكمة، الإلتزام المؤسسى، مدراء التمريض.