https://menj.journals.ekb.eg
Print ISSN: 2735-3974
Online ISSN: 2735-3982
DOI: ----------

MNJ
Menoufia Nursing Journal
Faculty of Nursing
Menoufia University

The Relation Between Organizational Silence and Organizational Learning among Nurses

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Abstract: Background: Organizational silence leads to dissonance and this in turn results in low motivation, satisfaction, and commitment from staff nurses. Learning is a critical variable in the organization's ability to deal with the ever-changing environment successfully and is vital to decision-making for achieving the desired organizational outcomes. **Purpose:** To identify the relation between organizational silence and organizational learning among nurses at Quesna Central Hospital. **Design:** A descriptive correlational research design was used. Setting: This study was conducted at Quesna Central Hospital in selected units (inpatient, outpatient, and critical care units). **Sampling:** A convenience sampling technique of 200 staff nurses were recruited. **Instruments:** Two instruments were utilized to collect data for the current study, including the organizational silence scale and organizational learning scale. **Results:** As reported by nurses, levels of organizational silence and organizational learning were moderate. The highest mean among the organizational silence dimension was in subordinates' fear of negative reactions, Vs the lowest mean was in support of supervisors for silence. Regarding organizational learning sub dimensions, the highest mean was in the dynamics of learning while the lowest mean was in the application of technology. **Conclusion:** There was a highly statistically significant negative correlation between total organizational silence and total organizational learning among nurses. **Recommendation:** Hospital and nursing administrators should maintain a good practice environment for nurses that welcomes suggestions and opinions and supports learning throughout the organization.

Keywords: *Nurses, Organizational learning, Organizational silence.*

Introduction

The ability to address changes in a complex medical environment represents a constant challenge for organizations devoted to meeting the growing demand for healthcare services. Nurses on the front line frequently are in a better position than their leaders to identify appropriate

responses when problems exist or arise in the facilities where they work (Yang et al., 2022).

Staff nurses are an important asset of an organization, as they often have ideas, information, and opinions for constructive ways to improve work and promote organizational success. Staff nurses express their emotions, experiences, thoughts, perceptions, and attitudes about the work and organization through communicating using multimedia. At the same time, nurses in an organization, due to its management policies or other reasons, may be incapable of expressing their feelings or emotions in any manner. They withdraw themselves from commenting about the function or drawbacks of the organization in which they are working (John & Manikandan, 2019).

Organizational silence is a group of little responses to significant problems that an organization faces. Organizational silence is a behavior that can increase or decrease organizational performance. Although organizational silence is a difficult style of expression, it is an effective method of pointing out pleasing or displeasing situations in the organization (Takhsha et al., 2020).

Organizational silence can be triggered by factors such as competitors in the workplace, technological advancements, organizational dynamics, managerial procedures, personality, self-esteem, locus of control, sense of responsibility, and individual workplace experiences (Aydin & Agun, 2021).

Organizational learning provides new insights in helping to restructure the problems of the organization by affirming the individual learning in the structure and getting consequences for the organization as a whole. Organizational learning is a process that improves actions with new or developed knowledge and understanding. Organizational learning is a process that allows an organization to develop, acquire, and transform new knowledge that stimulates innovation (Verma et al., 2022).

Organizational learning has become a necessity for healthcare organizations to use it to increase their resources and skills and achieve sustainability in competitive advantage (Tu & Wu, 2021). Organizational learning is "the process through which organizations change or modify their mental models, rules, processes or knowledge, maintaining or improving their performance". Organizational learning is crucial for organizations operating in unpredictable environments to respond to unforeseen circumstances more quickly than their competitors, Organizational learning enables organizations to transform individual knowledge into organizational knowledge (Evenseth et al., 2022).

The competition among organizations, environmental conditions, and technological developments causes the notions of organizational silence and organizational learning to become of more importance day by day. Even if the nurses who show silence in organizations work in learning organizations, in order for the organization to reach a better situation,

their knowledge, ideas, and suggestions intentionally hidden should be expressed and provided for solving the problems and finding solutions for the sake of organizations. Hence, organizational learning brings a myriad of benefits to the organization by diminishing the silence in the organization along with its future negative effects and consequences on the organization (Oduyoye, 2020).

Organizational silence leads to poor organizational learning to some extent arguing that nurses failed to talk with their superiors about the problems of work. Silence obstructs effective organizational learning. This constitutes a barrier to organizational change and development and suppresses pluralism, hence innovation and creativity (Alqarni, 2020).

Significance of the study

Organizations need employees who are responsive to the challenges of their environment, are not afraid to express ideas about organizational problems and challenges, and share information and knowledge to survive and stay competitive (Faulks et al., 2021). However, today, experts in management and organization prescribe organizational learning as medicine to all organizational problems (Alerasoul et al., 2022).

Through the investigator's observation in the clinical settings, it was found that organizational silence results from the nurses' lack of awareness and their lack of sufficient knowledge to make decisions and act independently in practical situations related to patient care, and they are unable to take initiatives that help them to improve health care. Accordingly, the organizational learning provided by healthcare institutions must take place by providing a safe environment for this learning to occur among healthcare personnel, which helps to build knowledge resources that enable them to communicate and the ability to express their opinions. So, the purpose of the current study is to explore the relation between organizational silence and organizational learning among nurses.

Purpose of the study

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Research questions

- What is the level of organizational silence among staff nurses at Quesna Central Hospital?
- What is the level of organizational learning among staff nurses at Quesna Central Hospital?
- What is the relation between organizational silence and organizational learning among nurses?

Methods

Research Design:

A descriptive correlational research design was used to investigate the relation between organizational silence and organizational learning among nurses at Quesna Central Hospital.

Setting:

This study was conducted in selected units (inpatient, outpatient, and critical care units) including: -Inpatient units (pediatric ward, medical department, surgical department) -Outpatient units (outpatient departments)-Critical care units (neonate intensive care unit, pediatric intensive care unit, intermediate intensive care unit, adult intensive care unit, emergency department, emergency operation room, and kidney dialysis unit).

Sample:

The sample of this study included a convenience sampling technique of 200 out of 386 staff nurses recruited from Quesna Central Hospital in Quesna who were accepted to participate in the study. The sample of this research is calculated by using the Taro Yamane formula to determine the number of staff nurses who participated in the research study (Yamane, 1967).

n = N / (1+Ne^2)

N→ total no. of staff nurses is (386) nurses

n → sample size

e→ error tolerance (0.05)

1→aconstant value

Sample size of staff nurse ═ 386 / 1 + (386*0.05^2) ═ 196 staff nurses

The sample increased to 200 to compensate for the attrition rate.

Data Collection Instruments

Two instruments were utilized by the investigator to collect data for the current study.

<u>Instrument one:</u> Organizational silence scale.

It was developed based on Schechtman, (2008) and Brinsfield, (2009) studies to assess the level of organizational silence among nurses. The instrument contained 27 items. It is divided into five subscales: Support of the top management for silence (five items), lack of communication opportunities (six items), Support of supervisor for silence (five items), Official authority (five items), and Subordinate's fear of negative reactions (six items).

Scoring system:

The items were rated on a 3-point Likert scale (1- disagree, 2- neutral, and 3- agree). The overall score ranges from 27 to 81. The low level of organizational silence ranges from 27 to 45 which represents < 55%, the moderate level ranges from 46 to 63 which represents 55%-77% and the high-level ranges from 64 to 81 which represents>77%. These scores are based on Dyne et al., (2003).

<u>Instrument two:</u> Organizational learning scale.

It was developed by Nafei (2016b), to assess the level of organizational learning among nurses. This scale is a 25-item composed of five main subscales: Dynamics of learning (five items), Conversion of the organization (five items), nurses' empowerment (five items), Knowledge management (six items), and the application of technology (four items).

Scoring system:

The items were rated on a 3-point Likert scale with (1- rarely, 2- sometimes, and 3- always). The overall score ranges from 25 to 75. The low level of organizational learning ranges from 25 to 41 which represents < 55%, the moderate level ranges from 42 to 58 which represents 55%-77%, and the high-level ranges from 59 to 75 which represents>77%. These scores are based on Dyne et al., (2003). These scores are based on Miri et al., (2019).

Validity of instruments:

To measure the face and content validity of the data collection instruments; a panel of academic experts (four experts from Menofia University and one expert from Benha University) were asked to carry out a jury of the proposed questionnaire. Based on the jury results, some modifications and additional arrangements of items were made. The instruments were back-translated as follows: First, the items were translated from English into Arabic by research experts (university lecturers), and by language experts. Second, a focus group was held to discuss the translated items (equivalence of meaning). Third, the language experts back-translated the items into English. Fourth and lastly, the equivalence of meaning of the original and adapted versions was checked.

Reliability of instruments:

These instruments were tested for reliability to estimate the consistency of measurements performed using the Alfa Coefficient test (Cronbach alpha). Both instruments were proved to be reliable where $\alpha = .92$ for the organizational silence scale and 0.90 for the organizational learning scale at a statistical significance level of $p \leq .05$.

Ethical considerations:

The study was conducted with careful attention to the ethical standards of research and the rights of the participants. Written approval was obtained before conducting the study from the ethical and research committee of the Faculty of Nursing Menoufia University (number 910).
The respondent's rights are protected by ensuring voluntary participation so that written informed consent was obtained after explaining the purpose, nature, time of conducting the study, potential benefits of the study, and how data will be collected. The respondents assured that the data will be treated as strictly confidential. Furthermore, the respondents' anonymity was maintained as they were not be required to mention their names.

Pilot study:

After reviewing the instrument, the experts, and the investigator conducted the pilot study before administrating the final questionnaire. The purpose of the pilot study was to ascertain the clarity, relevance, and applicability of the study instruments and to determine obstacles that may be encountered during data collection. It also helped to estimate the time needed to fill out the questionnaire tools. The study was conducted on 10% of the study sample (20 staff nurses). Staff nurses involved

in the pilot study were included in the study because there was no modification to the instruments of data collection.

Procedure:

An official letter was submitted from the Dean of the Faculty of Nursing, Menoufia University to the directors of Quesna Central Hospital containing the purpose of the study and methods of data collection. The investigator represented herself to the study sample and explained the purpose of the study to them. The two instruments were translated into Arabic. Data collection instruments were distributed between staff nurses in the previously mentioned study setting. Data was collected in three shifts (morning, afternoon, and evening) using a self-administered questionnaire. Every staff nurse took about 15 minutes to fill out the questionnaires. Data collection took about 6-8weeks.

Statistical analysis:

Data was coded for entry and analysis using the SPSS statistical software version 22 package. Descriptive statistics were presented in the form of frequencies and percentages. Correlation between variables was evaluated using Pearson and Spearman's correlation coefficient (r). A significance was adopted at P<0.05 for the interpretation of the results of tests of significance (*). Also, a high significance was adopted at P<0. 01 for the interpretation of the results of tests of significance (**) A very highly statistical difference was considered if P0.001. Student t test: a test of significance was used for comparison between two groups having quantitative variables. ANOVA(f) test: a test of significance used for comparison between three or more groups having quantitative variables.

Results

Table (1): As evident from this table, the highest percent of staff nurses (93.5%) were females, married (86%), and between the ages of 25 to less than 35 years old. Nearly one-third of them (38.5%) had a bachelor's degree in nursing and 38.5% had less than 5 years' experience. Also, the highest percentage of staff nurses (16%) were working at a neonate intensive care unit.

Figure (1): As shown from that figure, most of the staff nurses (60%) had a moderate level of organizational silence followed by a low level of organizational silence (26%) and a high level of organizational silence (14%).

Figure (2): As shown from that figure, nearly two-thirds of staff nurses (68%) reported that organizational learning was at a moderate level followed by a low level of organizational learning (20%) and a high level of organizational learning (12%).

Table (2): As evident from this table, there was a highly statistically significant negative correlation between total organizational silence and total organizational learning among nurses (P= .003).

Table (3): As evident from this table, there was a highly statistically significant relation between total organizational silence among nurses

and the age of studied participants, with the highest mean scores of silence for nurses at the age of 35- <45. (p=0.004). However, there was no statistically significant relation between total organizational silence among nurses and marital status, gender, nursing educational levels, years of experience, and working unit (p=0.914,0.125,0.310,0.130and 0.099respectively).

Table (4): As evident from this table, there was a highly statistically significant relation between total organizational learning among nurses and their educational levels, their gender, and working unit. However, there was no statistically significant relation between total organizational learning among nurses and age, marital status, and years of experience (p=0.210, 0.417and 0.443respectively).

Table (1): Percentage Distribution of Personal Characteristics of Studied Staff Nurses (n = 200).

Personal data	No.	%
Gender		
• Male	13	6.5
• Female	187	93.5
Marital Status		
• Married	172	86.0
• Unmarried	28	14.0
Age		
• < 25	56	28.0
• 25 - < 35	108	54.0
• 35 - < 45	25	12.5
• 45 and more	11	5.5
Nursing Educational levels		
• Diploma of Nursing School	51	25.5
• Associate nursing degree	52	26.0
• Bachelor's degree in nursing	77	38.5
• Postgraduate in nursing	20	10.0
Years of experience		
• < 5 years	77	38.5
• 5 - < 10 years	52	26.0
• 10 - < 15 years	51	25.5
• 15 years and more	20	10.0
Working unit		
• Pediatrics department	17	8.5
• Medical department	14	7.0
• Surgical department	10	5.0
• Outpatient department	6	3.0
• Neonatal intensive care unit	32	16.0
• Pediatric ICU	5	2.5
• Intermediate ICU	20	10.0
• ICU	27	13.5
• Emergency department	19	9.5
• Emergency operation room	19	9.5
• Hemodialysis unit	31	15.5

Figure (1): Distribution of Staff Nurses According to Level of Organizational Silence (n=200)

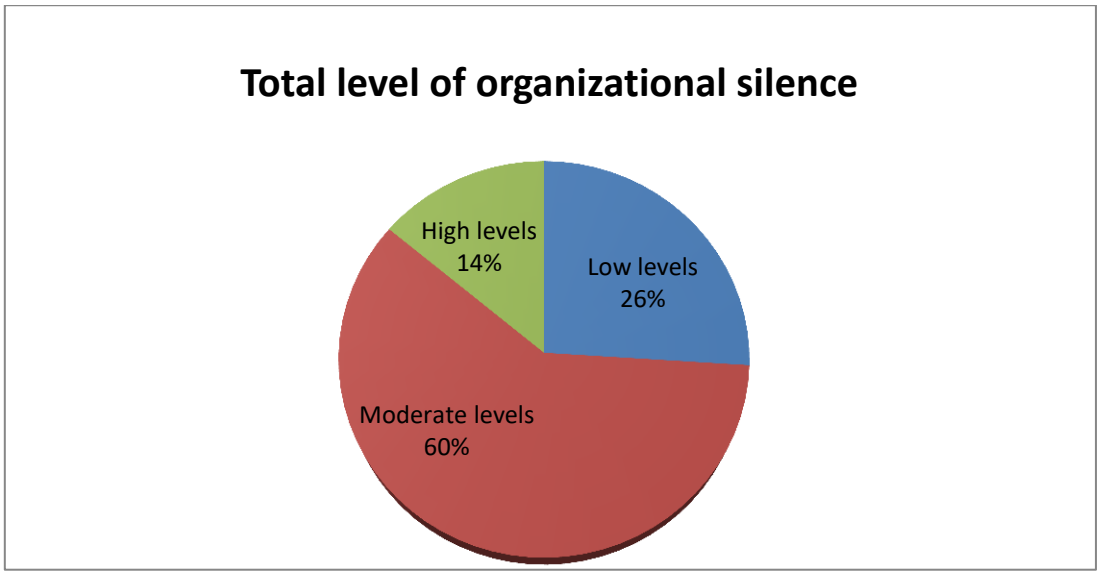

Figure (2): Total Level of Organizational Learning among Nurses (n=200).

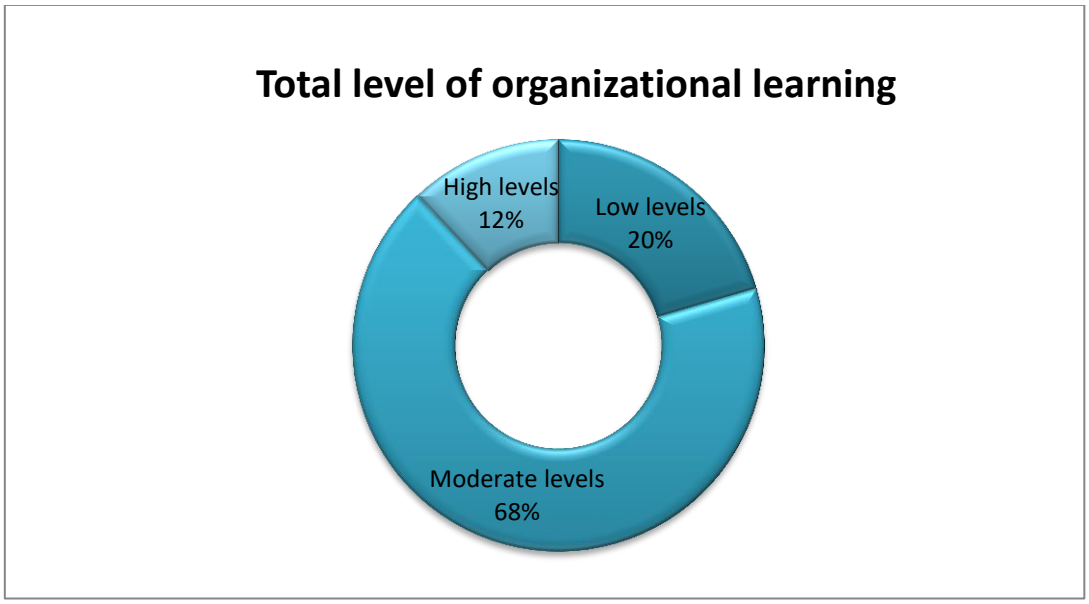

Table (2): Correlation between Total Organizational Learning and Total Organizational Silence among Nurses (n=200).

	Total organizational silence among nurses (N=200)	
	R	P value
Total organizational learning among nurses	-.191	.003**

Table (3): Relation between Personal Characteristics and mean level of Organizational Silence among Nurses (n=200).

variables	mean level of organizational silence among nurses	Test of sig.	P value
	Mean±SD		
Age/years		F	.004*
• < 25	51.4286±8.46352	2.115	
• 25 - < 35	50.9630±10.59971		
• 35 - < 45	59.2400±11.12535		
• 45 and more	50.1818±14.34446		
Marital status		t-test	
• Married	52.0523±10.61680	-0.108	.914
• Unmarried	52.2857±10.87592		
Gender		t-test	
• Male	56.4615±9.93827	1.54	.125
• Female	51.7807±10.63015		
Nursing Educational levels		F	
• Diploma of Nursing School	51.4239±11.63193	1.404	.310
• Associate nursing degree	53.1528±9.08436		
• Bachelor's degree in nursing	50.2759±10.96715		
• Postgraduate in nursing	57.2857±9.34013		
Years of experience		F	
• - < 5 years	53.6364±9.79112	2.803	.130
• 5 < 10 years	51.6154±10.42650		
• 10 < 15 years	49.4314±10.60425		
• 15 years and more	54.1000±13.33732		
Working unit		F	
• Pediatrics department	48.9412±7.93308	1.564	.099
• Medical department	56.1429±10.57470		
• Surgical department	52.2000±7.19259		
• Outpatient department	49.6667±10.15218		
• Neonatal intensive care unit	55.0625±9.62167		
• Pediatric ICU	47.6000±12.19836		
• Intermediate ICU	53.3500±13.08384		
• ICU	48.2963±9.92206		
• Emergency department	53.6316±13.37996		
• Emergency operation room	47.7368±11.60863		
• Hemodialysis unit	54.2581±8.78244		

Table (4): Relation between Personal Characteristics and Mean Level of Organizational Learning among Nurses (n=200).

Variables	Total organizational learning among nurses	Test of sig.	P value
	Mean±SD		
Age/years			
• < 25	50.1071±9.51492	F	
• 25 - < 35	48.2130±8.43784	1.523	.210
• 35 - < 45	47.5200±7.29794		
• 45 and more	44.0909±16.95556		
Marital status			
• Married	48.6453±9.15090	t-test	
• Unmarried	47.1071±10.11907	.813	.417
Gender			
• Male	43.6154±11.12459	t-test	
• Female	48.7647±9.07959	1.948	.050*
Nursing Educational levels			
• Diploma of Nursing School	49.1413±7.21808		
• Associate nursing degree	50.6250±8.94339	F	
• Bachelor's degree in nursing	42.0000±11.48913	7.609	.000**
• Postgraduate in nursing	43.1429±14.35768		
Years of experience			
• < 5 years	48.5325±8.87721	F	
• 5- < 10 years	48.3462±8.17429	1.477	.443
• 10 - < 15 years	49.5098±8.72553		
• 15 years and more	45.5000±13.96424		
Working unit			
• Pediatrics department	45.4706±8.67552		
• Medical department	45.9286±11.08335		
• Surgical department	47.8000±9.00370		
• Outpatient department	45.1667±10.87045		
• Neonatal intensive care unit	45.5000±8.65466		
• Pediatric ICU		F	
• Intermediate ICU	43.4000±5.98331	1.768	.050*
• ICU	49.9500±13.02821		
• Emergency department	51.7037±7.15120		
• Emergency operation room	50.3158±13.27928		
• Hemodialysis unit	52.7368±7.03832		
	48.2258±3.96409		

Discussion

Organizational silence is a reflection of the forces affecting the relationships between individuals and groups and regulations governing these relationships which prevent staff from talking about the organization's problems (Lehner, 2022). In an organization without feedback mechanisms, mistakes turn into a mechanism for carrying out activities or become more severe (Takhsha et al., 2020). On the other hand, organizational learning encourages a spirit of dialogue that allows people to talk and listen. Through this action, they create a field of alignment and produce tremendous power to invent new realities in conversation and to bring about new realities in action (Hsiao& Wu, 2022). So, the aim of the present study was to investigate the relation between organizational silence and organizational learning among nurses.

Regarding the level of organizational silence among nurses, the findings of

the present study revealed that nearly two-thirds of staff nurses had moderate level of organizational silence. From the investigator's point of view, this result may be due to subordinates being more sensitive to the risks of talking more than the benefits, believing that talking about work problems might deprive them of their jobs or upgrade to higher positions within the organization, avoiding disagreements with others, lack of management support, fear of breaking their relationships with their colleagues, avoiding potential conflict that may escalate and fear of being ignored.

The present findings were in harmony with Abdelaliem & Abou Zeid (2023) who revealed that the overall score of nurses' silence was moderate. Also, Yang et al., (2022) reported that the overall level of organizational silence among nurses was moderate. Additionally, these findings were supported by Aslan (2022) who found that silence at a medium level.

On the opposite line, El Abdou et al., (2023) reported that more than half of staff nurses had a high level of organizational silence. Meanwhile, more than one-quarter of them had a low level of organizational silence. Also, these findings disagreed with Abd El-Fattah et al., (2022) who revealed that the workplace silence behaviors among nurses were high. Moreover, Abd-Erhaman et al., (2022) illustrated that two-thirds and the majority of staff nurses had a low level of organizational silence in the studied setting.

On the other hand, regarding the level of organizational learning among nurses, the findings of the present study revealed that nearly two-thirds of staff nurses reported that organizational learning was at a moderate level. From the investigator's point of view, this may be due to the presence of an educational team that includes clinical instructors were keen to provide nurses with knowledge and improve their job performance, and leaders at the hospital were enthusiastic to guide and train their staff nurses. Additionally, nursing managers were actively supplying their nurses with instructions to ensure that the tasks of nurses were done properly.

The findings of the present study were in the same line with ElSayed & Abdel-Ghani (2020) who indicated that nearly two-thirds of staff nurses reported that the learning organization level was moderate. This finding was also in congruence with Miri et al., (2019) who reported that the scores of learning organization and creativity in public teaching hospitals were moderate.

On the opposite line to the findings of the present study, Nair& Mathew (2023) revealed that participants reported higher levels of organizational learning. Also, Al Nawaiseh et al., (2021) showed that their observations of organizational learning elements were at a high level. Additionally, Goula et al., (2021) clarified that the level of learning organizational culture and capacity in the health units are very low.

According to the correlation between organizational learning and

organizational silence among nurses, the findings of the present study revealed that there was a highly statistically significant negative correlation between total organizational silence and total organizational learning among nurses. From the investigator's point of view, this may be due to silence leading to many negative results that weaken the ability to learn at the level of the organization, which not only affects nurses but also the organizational level because silence diminishes the nurses' readiness to express their concerns, creative ideas, and constructive suggestions which results in a decrease in performance levels due to interruption of communication, knowledge sharing, loss of trust and respect between nurses and managers, and reduced opportunities for growth and development which represent an obstruction to the processes of organizational learning, change, and development.

In the same line, Yeo & Li (2022) reported that organizational silence has a negative impact on the removal of inadequacies and mistakes occurring in organizational activities as well as on the establishment of a healthy feedback mechanism. Organizational silence negatively affects the behavior of individuals working in the organization. These effects are represented in the individual's feeling of being unappreciated, lack of the individual's ability to control, and suffering from cognitive dissonance.

The results of the present study came in harmony with Atalla et al., (2022) who showed that the association between the two scales of organizational silence and organizational learning is a weak negative correlation, yet statistically significant. Also, these results were supported by Imran et al., (2022) who reported that employee silence had a negative effect on organizational learning. Furthermore, this finding is consistent with Takhsha et al., (2020) who stated that organizational silence had a negative impact on knowledge-sharing behaviors. On the opposite line to, Areej (2019) demonstrated that there was a direct positive relationship between organizational silence with the quality of working life in the researched organization, which included the promotion of learning in the work environment.

Regarding the relation between organizational silence and personal characteristics of study participants; there was a statistically significant relation between total organizational silence among nurses and the age of studied participants, with the highest mean of silence being for nurses at the age of 35- <45. From the investigator's point of view, nurses and older people are different from young ones as they tend to calm down rather than experience conflicts and differences with others and believe that they have presented their opinions before and nothing has changed.

The present study findings were consistent with Aslan (2022) who revealed that there was no statistically significant difference between gender differences, highlighting that female teachers and male teachers exhibit similar silence behaviors. It was also

noticed that the organizational silence perceptions did not differ according to age differences. On the other hand, Zekeriya (2021) revealed that age may affect the distribution of concepts related to organizational silence.

On the contrary to the present study, Yang et al., (2022) demonstrated that educational status, years of experience, and marital status had significant effects on organizational silence level. Additionally, results of the present study disagreed with Zekeriya (2021) who revealed that gender may affect the distribution of concepts related to organizational silence. Also, De los Santos et al. (2020) showed that years of experience, marital status, highest attained education and position could significantly predict organizational silence but age has no correlation with silence. Moreover, Labrague & De Los Santos (2020) showed that years of experience in the nursing profession affect organizational silence.

Regarding the relation between organizational learning and with personal characteristics of study participants; there was a highly statistically significant relation between total organizational learning among nurses and their educational levels, gender, and working unit. However, there was no statistically significant relation between total organizational learning among nurses and age, marital status, and years of experience. From the investigator's point of view, this may be due to nurses with high levels of education always improve their degree qualifications by pursuing further study. Gender has a role in learning as females are more persistent, committed, and have stronger self-regulation than males (Liu et al., 2021). Additionally, from clinical observation, female nurses were interested in attending workshops and enrolling in postgraduate studies more than males. Working units affect nurses' readiness to learn. For example, intensive care units require highly qualified nurses with continuously updating knowledge and force them to arm themselves with the knowledge and skills required for caring for critical cases.

Along the same line, Goula et al., (2021) showed that professional years of experience had no effect on organizational learning. This result was also supported by Nadhira Putri & Mangundjaya (2020) who revealed that there were significant differences in organizational learning between all levels of education.

Conclusion

In light of the present study results, it could be concluded that organizational silence and organizational learning were at moderate levels as reported by nurses. The highest mean among the organizational silence dimension was in subordinates' fear of negative reactions while the lowest mean was in support of supervisors for silence. Regarding organizational learning sub-dimensions, the highest mean was in the dynamics of learning while the lowest mean was in the application of technology. Additionally, there was a highly statistically significant negative correlation between total organizational silence and total

organizational learning among nurses. Finally, there was a statistically significant relation between total organizational silence and the age of the studied participants. Also, there was a highly statistically significant relation between total organizational learning among nurses and their educational levels, their gender, and working unit.

Recommendations

On the basis of the current study findings, the following recommendations are suggested:

1) At the practical level: Hospitals and nursing administrators should maintain a good practice environment for nurses that welcomes suggestions and opinions and supports learning throughout the organization. Collaborative leadership practices that show a desire to listen to the voice of nurses and ascertain nurses' participation in the decision-making process should be supported. A suitable organizational structure that provides nurses with opportunities for feedback should be supported. A culture that reduces fear to speak about their problems and challenges as well as facilitate learning opportunities should be fostered.

2) At the educational level: Educational workshops are recommended for managers and nurses about the causes and effects of organizational silence. Educational workshops are required for nurse managers about organizational learning and its effect on productivity and quality of care.

3) At research level: the study can be replicated on a larger sample of nurses from different healthcare organizations to ascertain the generalization of the findings. Future research about strategies for minimizing organizational silence and supporting organizational learning are required.

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