Assessment Of Clinical Governance Climate and Its Relationship With Job Empowerment Among Healthcare Providers

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Abstract

Background: *Clinical governance has evolved to improve healthcare delivery and ensure high standards of care. A positive clinical governance climate leads to improved job empowerment and performance of health care providers.* ***Aim:*** *This study aims to assess the clinical governance climate and its relationship with job empowerment among healthcare providers.* ***Research Question:*** *What is the relationship between clinical governance climate and job empowerment among healthcare providers?* ***Research design:*** *a descriptive correlational research design was used to carry out this study.* ***Setting:*** *This study was conducted at all inpatient units of Matrouh General Hospital, Matrouh governorate which is affiliated to the Ministry of Health and Population (MOHP).* ***Subjects:*** *A non-probability quota sampling technique was used to recruit the study participants (n = 301) who participated in the study at the time of data collection.* ***Tools:*** *Two tools are used to collect the necessary data The "Clinical Governance Climate Questionnaire" (CGCQ) and the Condition for Work Effectiveness Questionnaire (CWEQ-I).* ***Results:*** *The majority (94.68%) of healthcare providers had a moderate perceived level of clinical governance climate levels. More than three quarters (76.74%) of them also had a moderate perceived level of job empowerment.* ***Conclusion:*** *There was a statistically significant positive correlation between clinical governance climate and job empowerment among healthcare providers (r= 0.150, p= 0.009).* ***Recommendations:*** *Develop training programs for healthcare providers of clinical governance climate and job empowerment in the healthcare organization by Promoting teamwork and encouraging open and transparent communication that reflects the quality of patient care.*

Introduction

The recent era has witnessed many challenges such as the increased demand for quality, the limited funds to improve the quality of healthcare services delivered to patients, the rising costs of health services, the economic strain across the world, and the high prevalence of chronic and infectious diseases that require long-term care (Antony, et al., 2019). Healthcare institutions strive to find a methodology to overcome these challenges. Clinical governance (CG) is the most prominent methodology applied in the contemporary healthcare context to overcome the challenges of healthcare services (Ochang, et al., 2022).

Clinical governance is a critical pillar that is emphasized in hospital standards developed by the Egyptian General Authority for Health Accreditation and Regulation (GAHAR). Meanwhile, the General Authority for Health Accreditation and Regulation in its foundational level of accreditation standards made it mandatory for each health facility to apply the

principles of CG to be eligible for the new universal health insurance schemes (General Authority for Health Accreditation and Regulation, 2021).

The Department of Health, National Health Service (NHS, 2022) defined clinical governance as the system through which organizations are

accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish. This definition is intended to embody three key attributes of clinical governance: recognizable high standards of care, transparent responsibility and accountability for those standards, and a constant dynamic of improvement (NHS Department of Health, 2022).

Clinical governance provides a unique and comprehensive strategy for bringing all local activities into a single coherent program for continuous quality improvement as a systematic model. It encourages everyone in the organization to work to improve the quality and safety of patient care (Abd El Fatah, et al., 2019). Moreover, CG gives an opportunity to understand as well as learn how to build the essential elements required to support the creation of a high-quality care culture that values questioning, learning, and no blame. It also fosters strong leadership and an environment where staff members are respected and encouraged to build patient partnerships (Fardazar, et al., 2015).

It's essential to remember that CG is based on seven critical pillars: clinical audit, risk management, education, training, and ongoing professional development; patient and public involvement; information management; staff management; and evidence-based care and effectiveness. The framework for implementing clinical governance in any facility is made up of these pillars. The monitoring and controlling process is guided by the implementation techniques and indicators specific to each of these pillars. (Patel & Jenkyn, 2021).

Healthcare organizations could cultivate an environment that supports CG by embracing six essential principles. These principles include creating a culture in which service improvement is the responsibility of all customers through building an integrated and planned quality improvement program, using a proactive approach to assess and eliminate actual and potential risks, absence of unjust blame and punishment, encouraging inter-professional collaboration with relevant recognition of staff contributions, opening channels for continuous training and development for staff, and building a learning environment where staff and organization can use lessons learned from the past experiences to strengthen the present and promoting the future (Alrige, et al., 2022).

Recent research concludes that the principles of creating a CG climate in any healthcare organization may present opportunities for healthcare providers to become more empowered (Schiavone, et al., 2022). In the context of CG , empowering healthcare providers refers to an organization's capacity to successfully mobilize and inspire its workforce to achieve favorable results in the workplace (Kulari, et al., 2022). Giving healthcare providers the ability to make decisions, giving them the authority to take decisions, and/or providing opportunities for them to influence decisions are all ways to empower patients (Ageiz, et al., 2022).

Laschinger, (2013) described the leaders' empowering behaviors that significantly influence health care providores perceptions of formal and informal power, and access to empowerment structures (information, support, resources, and opportunity). Formal power refers to the amount of flexibility and rewards for innovation on the job; informal power is concerned with collaboration between physicians, peers, and managers; access to the information concerned with knowledge about work goals, plans, decisions, and environment relationships in the organization(Saleh, et al., 2022). Access to support is positive feedback, acknowledgment of achievements, and support of the work environment. The success of empowerment is further linked to access to resources which include funds, space, materials, and time to obtain needed resources. Access to opportunity refers to the chance to increase; competencies, recognition, rewards, and possibilities of advancement (Ajanaku, et al., 2022).

Significance of the study:

Clinical governance in healthcare organizations becomes a vital necessity to safeguard standards of care and maintain transparency which is required for achieving efficiency. Clinical governance and hospital staff empowerment are positively correlated. Effective governance is advantageous to physicians, nurses, and medical/nursing students, according to Aldossary, (2022). Furthermore, clinical governance promotes an academic environment where medical professionals are motivated to enhance their

decision-making and health outcomes. Consequently, funding CG could contribute to improved hospital employee empowerment and performance.

Aim of the study:

This study aims to assess the clinical governance climate and its relationship with job empowerment among healthcare providers.

Research Question:

What is the relationship between clinical governance climate and job empowerment among health care providers?

Materials and Method

Research design: A descriptive correlational research design was used to carry out this study.

Setting: This study was conducted at the inpatient units of Matrouh General Hospital which is affiliated to the Ministry of Health and Population (MOHP) at Matrouh Governorate, Egypt. It is the largest general tertiary care hospital that admits all types of medical, surgical, and critical care cases. This hospital has a 376-bed capacity with the largest number of healthcare providers and a wide range of healthcare facilities. The total number of inpatient care units that were included in the study was 12 units This hospital was selected. because it is the first hospital in Matrouh Governorate that takes the initial steps to achieve the accreditation requirements developed by GAHAR and aspires to be registered in Universal Health Insurance Systems.

Subjects:

The target population of the present study was all healthcare providers (n = 546) who had been working in the above-mentioned selected setting and they were termed as physicians, nurses, pharmacists, and technicians involved in the patient units. A non-probability quota sampling technique was used to recruit the study participants (n = 301) who were willing to participate in the study at the time of data collection. They were directly or indirectly dealing with patient care and had no administrative activities. In addition, they were work in the selected hospital for at least 6 months to become familiar with the hospital system. The calculation was calculated using the Epi info, as follows:
1. Total population of health care providers = 546
2. Confidence level = 99%
3. Margin of error = 5%

4. Effect size = 0.5
5. Minimum sample size = 301

Tools:
Two tools were used to conduct this study:

Tool (I): Clinical Governance Climate Questionnaire (CGCQ):

The Clinical Governance Climate Questionnaire (CGCQ) was developed by (Freeman, 2003) and revised by (Karassavidou et al., 2011). The questionnaire was adopted by the current researcher and was used to assess the clinical governance climate levels as perceived by healthcare providers. It consists of 60 items grouped under six dimensions as follows: planned and integrated quality improvement program (21 items), proactive risk management (11 items), absence of unjust blame and punishment (9 items), and working with colleagues (n= 6 items), training and development opportunities (8 items), and organizational learning (5 items) .

Responses were measured using a five-point Likert scale ranging from 1=strongly disagree, and 5=strongly agree. Total scores of the clinical governance climate questionnaire range from (60 to 300) as follows: Scores ranging from (220 to 300) are described as a high level of clinical governance, (140 to 219) as a moderate level of clinical governance, and (60 to 139) as low level of clinical governance. The questionnaire had high reliability using Cronbach's Alpha Coefficient α= 0.950 (Karassavidou et al., 2011).

Tool (II): A Condition for Work Effectiveness Questionnaire (CWLQ-II)

Firstly, a Condition for Work Effectiveness Questionnaire (CWEQ-I) was derived from Kanter's (1977) original ethnographic study of work empowerment and modified by Chandler, (1986) for use in research studies. Then a Condition for Work Effectiveness Questionnaire (CWEQ-II) is shorter and targeted for use in a nursing population developed by (Laschinger, et al., 2001) and modified by Laschinger, (2013). That it was adopted by the researcher in the current study. The questionnaire was geared towards measuring healthcare providers' perceptions of job empowerment which contributes to working effectively in their job. It

comprised 21 items that measure six subscales, opportunity (3 items), resources (3 items), information (3 items), support (3 items), formal power (job activity scale) (3 items), informal power (organization relationships scale) (4 items). In addition, global empowerment (2 items) was added to the questionnaire as a validation index.

Responses to subscales were measured on a 5-point scale as follows 1= none, 2= rarely, 3 = once in a while, 4= all the time, 5= a lot. A subscale means the score was obtained by summing and averaging the items. An overall empowerment score can be calculated by summing all six subscales. The total empowerment score range between 6-30. Higher scores represent stronger perceptions of empowerment levels from 23-30. Scores ranging from 14-22 represent moderate perceptions of empowerment levels. Scores ranging from 6-13 represent low perceptions of empowerment levels (Laschinger, 2013).

Method

Approval from the Research Ethics Committee (REC) - Faculty of Nursing and Alexandria University was obtained before conducting the study Permission no.2022-7-46, IRB00013620 (9/19/2025). Allowed permission from the Dean of the Faculty of Nursing, Alexandria University to conduct the collecting data for the current study was obtained. The official letter was directed to Matrouh General Hospital authority to have its agreement to conduct the research after explaining the aim of the study.

English versions of the tools were translated into Arabic, and a back-to-back translation method was used. The study tools were investigated for their face and content validity by a Jury of five experts in the related field of the study. The reliability of the study tools was done to test the internal consistency of the items using Cronbach Alpha for the clinical governance climate questionnaire (α = 0.856) and CWEQ-II (α= 0.97). A pilot study was conducted on (10%) of healthcare providers (n=30). Data collection was completed during five months from 15 February 2023 to 20 June 2023.

Ethical Considerations

Written informed consent from the health care providers was obtained after providing an appropriate explanation about the aim of the study. Confidentiality of data was maintained. The anonymity and privacy of the study subjects were kept. Subjects participated in the study voluntarily and had the right to withdraw at any time from the study.

Statistical Analysis

After data was collected and coded, they were transferred into a specially designed format for computer entry. Frequency analysis, cross-tabulation, and manual revision were conducted to detect and manage any errors during data entry. The SPSS program with version (25) was used for both data analysis and presentation. Statistical measures included descriptive measures (arithmetic mean, standard deviation, minimum, and maximum), Independent Samples Test, One Way ANOVA, and Pearson correlation coefficient test, for analysis of quantitative variables. The level of significance used was $P \leq 0.05$.

Results

Table (1) shows the socio-demographic characteristics of healthcare providers included in the study. More than half (53.5%) of healthcare providers were aged from 21-30 years. About one-half (47.8 %) of study subjects were working in critical units. Slightly less than two-thirds (62.8 %) of study subjects were females. The majority (82 %) of them had from 1 to 15 years of experience. In addition, 48.8% of them are diploma holders compared to 47.2% who had bachelor's degrees. Finally, the highest percentage (66.1%) of healthcare providers were married.

Figure (1) reveals the total level of clinical governance climate among healthcare providers; the highest percentage (94.68%) of health care providers had a moderate perceived level toward clinical governance climate.

Table (2) shows a descending ranking order of clinical governance climate and its dimension by healthcare providers. This table reveals that there was a statistically significant difference concerning clinical governance climate dimensions as perceived by healthcare providers as follows; proactive risk management, working with colleagues, and organizational learning (F = 4.721, 3.297, and 4.312 p<0.01 respectively). In addition, the highest mean score of clinical governance climate dimensions was " the organizational learning dimension" as the first rank among

physicians, pharmacists, and professional nurses (3.38±0.59, 3.35±0.49 and 3.34±0.59 respectively) as compared to the absence of unjust blame and punishment dimension among technical nurses and laboratory technicians (3.27±0.45 and 3.42±0.48 respectively), as well as proactive risk management among radiology technicians 38±0.55). Meanwhile, the working with colleagues dimension among healthcare providers was ranked as the lowest mean score of clinical governance climate dimensions as follows; Physician 2.99±0.38, pharmacists 2.99±0.33, professional nurses 3.04±0.37, technical nurses 2.88±0.60, radiologist 2.83±0.19and laboratory technician, 3±0.42 respectively.

Figure (2) reveals the total level of job empowerment among healthcare providers; more than three quarters (76.74%) of them had a moderate perceived level of job empowerment.

Table (3) shows a descending ranking order of job empowerment and its dimension by healthcare providers. "The opportunity" dimension was ranked firstly as the highest mean score of job empowerment dimensions used by physicians, professional nurses, technical nurses, and laboratory Specialist (3.4±1.13, 3.34±0.72, 3.51±0.78 and 3.71±0.86 respectively) as compared to "The resources" dimension used by pharmacists and radiologist (3.48±0.78 and 3.47±0.39 respectively). While "the formal power" dimension was ranked as the lowest mean score received for job empowerment dimensions among physicians, professional nurses, technical nurses, radiologists, and laboratory specialists (2.65±0.88, 2.47±0.82, 2.75±0.61,2.03±0.81, and 2.61±0.6 respectively) as compared to "the information" dimension used by Pharmacists 2.37±0.8. Furthermore; there was a statistically significant difference in total job empowerment dimensions and its dimensions as perceived by healthcare providers (F=5.363, 4.086, 4.404, 11.759, 7.313, 2.753, 2.682, and 3.363 p < 0.05 respectively).

Table (4) shows the correlation coefficient of clinical governance climate and job empowerment and its dimensions. There is a statistically significant positive correlation between total job empowerment and total clinical governance climate (r= 0. 150 p= 0.009).

Discussion

Clinical governance in healthcare organizations becomes a vital necessity to safeguard standards of care and maintain transparency which is required toward achieving efficiency. Cultivating a clinical governance climate is one of the recent endeavors that the international society calls for its application on a wide scale in healthcare organizations due to its promising effects in upgrading health services while reducing close calls and errors of healthcare professionals. Meanwhile, fostering a clinical governance atmosphere among empowered healthcare providers was reported in contexts where patients' satisfaction was prominent. This interplay was not tested empirically so, the current study used an interdisciplinary approach to test the correlation between clinical governance climate, job empowerment, and patient satisfaction. This study found clinical governance climate could enhance healthcare providers' job empowerment and exert a great effect on patient satisfaction regarding health care services.

Implementing clinical governance in healthcare settings is a complex issue with many factors that could facilitate or hinder its application. Building a supportive climate for clinical governance in a healthcare setting is a key toward its application and success. Fortunately, the current study revealed a moderate perceived level of clinical governance climate among healthcare providers in the study setting with high scores in the areas of organizational learning and just culture which constitute the critical pillars of clinical governance.

The high level of clinical governance climate in this study is coincident with the direction of the Egyptian state to upgrade the healthcare sector after the inception of universal health insurance. It is important to note that the high perceived level of health care providers in the clinical governance climate could be attributed to the efforts made by GAHAR to raise awareness of the healthcare workforce with patient safety guidelines. Another explanation for this level is the desire of the study setting to be enrolled under the umbrella of universal health insurance makes it dedicate its efforts toward empowering the health work force and cultivate a clinical governance

culture. Moreover, the recent awakening in health sectors worldwide geared toward reducing margins of errors in healthcare makes healthcare organizations adhere to clinical pathways with high considerations to standards of care in a transparent manner. This fuel the clinical governance climate in the study settings where there is a participatory vision from all stakeholders, an appropriate health care work environment characterized by no blame just responses to errors, supportive supervision, and efficient monitoring mechanisms. Healthcare providers perceive these features in an equatorial manner since the current study revealed no significant statistical difference between perceived levels of clinical governance climate among different healthcare providers.

It is important to note that the highly supportive climate for clinical governance is the case in the studies of Mosadeghrad, et al., (2017); Vassos, et al., (2019); Veenstra, et al., (2017); Alison, (2019); Gurdogan, & Alpar (2016); Karassavidou, et al (2011); and Kaba, & Öztürk, (2022). These studies found clinical governance climate was positively perceived by healthcare providers where hospitals were ready to implement principles of good governance. In these studies, healthcare providers agreed that their organization collects information on clinical risks to support the claim of proactive risk management which is one of the cores of clinical governance climate.

It is worth noting that perception of clinical governance climate dimensions was different among healthcare providers in the current study. Proactive risk management and clinical audit the most perceived factors of the clinical governance climate among healthcare providers. Inter-professional collaboration and just culture were the second-highest perceived factors in the current study. Similarly, the studies of Thanasas, et al (2023), Wijekoon, & Wickramasinghe, (2023), and Lucas, et al (2022) found positive clinical governance climate indicators of planned and integrated quality improvement, proactive risk management, professional development, teamwork, and organizational learning were present within the work environment of heath teams. Meanwhile, the negative indicator of blame and punishment was not present which is like the current study. In this context, Mosadeghrad, et al., (2017) found clinical audit had the most effect on clinical Governance success. Also, patient involvement, management, and leadership

principles contribute significantly to the success of the clinical governance climate. Furthermore, El-sayed et al (2024) found just culture which is a core element in CG was perceived moderately among study subjects.

On the other hand, Bahrami et al., (2015) detected that their hospitals' climates were not supportive sufficient for CG application. Meanwhile, the analysis of mean scores for the CG climate elements shows that the hospitals under study do not have a favorable situation in these areas. Additionally, Ahmed et al (2023), and Fardazar, et al., (2015) concluded that hospitals' readiness for CG implementation was weak. Moreover, Ghavamabad, et al., (2021) found healthcare providers had poor perception and awareness regarding clinical governance. Preconditions were not conducive to a clinical governance climate where clinical audit, staff empowerment, patient involvement, and just culture recorded weak scores. The discrepancy between these studies and the current study may be due to several contextual factors such as lack of leadership support, unavailability of quality assurance programs in the studied settings, and poor employment conditions among healthcare providers.

There is a consensus among scholars and academicians that the clinical governance climate could flourish if process owners in the health system feel empowerment (Ageiz, et al., 2022). This is the case in the current study where the highest percentage of healthcare providers have moderate perceptions regarding clinical governance climate and at the same time, more than three-quarters of health care providers had moderate perceptions toward job empowerment. This may be due to the direction of health authority to empower the health workforce after the Arab Spring in 2011. This finding is in line with Ta'an, et al., (2022), Connolly, et al. (2018), Kamel, & Mohammed, (2015), Azra, (2018), Dan, et al. (2018), and Aleinein, (2016). These studies found considerable job empowerment among the health workforce. In this respect, Mahfouz, et al., (2019) in their study highlighted that healthcare providers especially nurses who had high levels of job empowerment reported their willingness to improve their organizations using approved care maps and standardizations as

tools that reflect ready situations for applications of clinical governance. On the other hand; the studies of Cloninger, et al. (2023); Şenol Çelik et al. (2023); and Al-Rjoub et al. (2023) found poor levels of empowerment among respondents. This may be attributed to poor organizational factors such as a negative work environment, highly arbitrary measures, and hierarchal stagnated leadership styles. In this essence, the study of Al Mutair et al. (2023) found low empowerment levels among healthcare providers and revealed that a less empowered workforce had a low commitment to organizational goals which is a big hinder to clinical governance climate in any setting.

It is great to find that healthcare providers in the current study reported the availability of different avenues for growth and development which is reflected in the mean scores of dimensions of job empowerment since the highest mean score was recorded in the opportunity dimension. This also could be attributed to radical changes done in healthcare settings after the inception of GAHAR since healthcare organizations become obliged to provide different on-job and off-job training to the workforce as a prerequisite to be enrolled under schemes of universal health insurance. This finding could provide another explanation why health care providers in this study had high perceived levels of clinical governance climate. This result is the same in the study of Alrige et al. (2022). This study reported considerable levels of empowerment among healthcare providers with prominent levels appearing around opportunity.

It is necessary to say that clinical governance and job empowerment among healthcare providers go on the same way since the results of the current study revealed that positive correlation between clinical governance climate and job empowerment among healthcare providers. This means fostering a clinical governance climate could produce a tangible feeling of empowerment among healthcare providers. This relationship is expected since the clinical governance climate clarifies roles, responsibilities, and decision-making processes. When healthcare providers understand their responsibilities, they feel more empowered to make informed decisions.

In addition, clinical governance encourages participation in quality improvement initiatives, policy development, and patient safety efforts. Involving healthcare providers in decision-making fosters a sense of ownership and empowerment.

Moreover, an effective clinical governance climate ensures access to necessary resources, training, and professional development. Empowered healthcare providers have the tools and knowledge needed to excel in their roles.

In other words, a clinical governance climate could lead to empowered healthcare providers in a given context as it emphasizes feedback, performance evaluation, and recognition. When healthcare providers receive constructive feedback and acknowledgment, they feel valued and empowered. Furthermore; aligns individual goals with organizational objectives. When healthcare providers understand how their work contributes to overall quality and safety, they feel motivated and empowered. Finally, the current study proved that clinical governance and job empowerment are intertwined. When healthcare providers are actively engaged in clinical governance processes, they feel empowered to provide high-quality care and contribute positively to their organizations.

The finding of the current study was consistent with Ta'an, et al., (2022); Mahmoud, (2016); Kutney- Lee et al. (2016); Kamel and Mohammed (2015), and Siller et al. (2016) who stated that there was a positive correlation existed between clinical governance and structural empowerment. In this context, the work of Hastings et al. (2014); and Veenstra et al. (2017) clarified that clinical governance activities should start with empowerment of healthcare providers to ensure future success which is the case in the current study. Finally; the work of El-sayed et a., (2023) found job embedded and empowered nurses had low level of missed nursing care which is a common outcome for cultivation of CG climate. Conversely; the studies of Choi & Kim, (2019); and Ott & Ross, (2014) found clinical governance climate is sub-optimal due to extensive feelings of powerlessness among healthcare providers. Investigations of poor empowerment feelings among subjects revealed a lack of just culture with reflection of system failures and errors on the shoulders of process owners only which is against the principles of clinical governance climate.

Conclusion:

The current study concluded that clinical governance climate is moderately perceived among different healthcare providers. This coincides with moderate perceived levels of healthcare providers' job empowerment. There were positive statistically significant differences between clinical governance climate and job empowerment among health care providers.

Recommendation

Based on the findings of the present study, the following recommendations are suggested:

1. Hospital directors and policymakers should provide favorable conditions to cultivate a clinical governance climate as it is a promising strategy toward care efficiency and standardization.

2. Empowerment strategies of the workforce could be used parallel with clinical governance activities while planning a road map for improving the quality of healthcare services in any healthcare setting.

Table (1): Distribution of the health care providers according to their Socio-demographic characteristics

Socio-demographic data	Frequency (N=301)	Percent
Age		
▪ 21-30 years	161	53.5
▪ 31-40 years	90	29.9
▪ 41-50 years	37	12.3
▪ > 50 years	13	4.3
Sex		
▪ Male	112	37.2
▪ Female	189	62.8
Department /Unit you work in (Specialty)		
▪ In-patients' units	81	26.9
▪ Critical units	144	47.8
▪ Health care facilities	76	25.3
Number of years of experience in the hospital		
▪ 1-15 years	247	82.0
▪ 16-30 years	49	16.3
▪ > 30 years	5	1.7
Number of years of experience in the current department		
▪ 1-15 years	282	93.7
▪ 16-30 years	18	6.0
▪ > 30 years	1	0.3
Educational Qualification		
▪ Diploma	147	48.8
▪ Bachelor	142	47.2
▪ Master	12	4.0
Marital status		
▪ Single	90	29.9
▪ Married	199	66.1
▪ Divorce	9	3.0
▪ Widow	3	1.0

Figure (1) : Total healthcare providers clinical governance climate level (n=301)

Moderate, 94.68%
Low, 1.99%
High, 3.32%
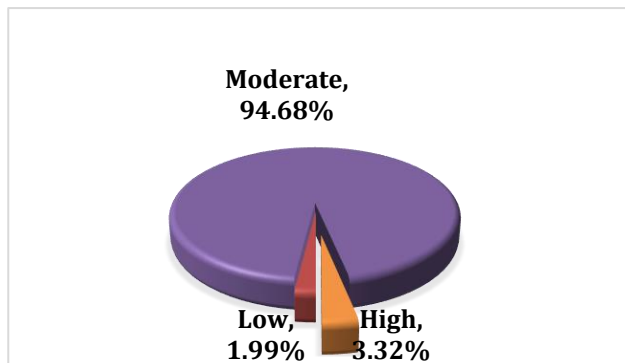
Figure (2): Total healthcare providers job empowerment level (n=301)

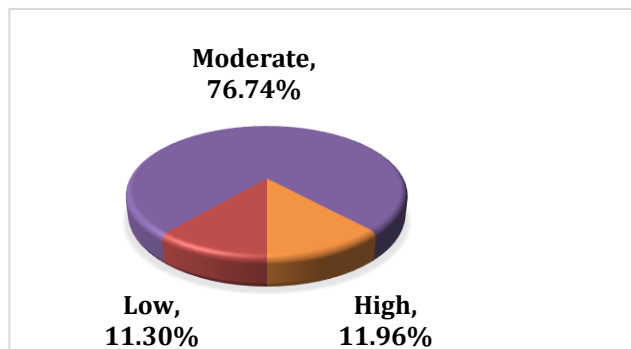Moderate, 76.74%
Low, 11.30%
High, 11.96%

Table (2): A descending ranking order of clinical governance climate and its dimension as perceived by healthcare providers:

Clinical governance climate dimension	Physicians (n = 49)		Pharmacists (n =25)		Nurses Prof. nurses (n =86)		Nurses Tech. nurses (n =109)		Technicians Radiology (n =10)		Technicians Laboratory (n =22)		F-test	P-value
	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank		
Planned and integrated quality improvement program	3.16±0.40	4	3.20±0.30	3	3.21±0.437	4	3.14±0.44	2	3.23±0.20	2	3.29±0.29	3	F=0.419(0.658)	
Proactive risk management	3.25±0.47	3	3.12±0.43	4	3.25±0.52	2	3.00±0.49	5	3.38±0.55	1	3.19±0.51	5	F=4.721(0.010)*	
Absence of unjust blame and punishment	3.28±0.32	2	3.22±0.33	2	3.25±0.42	3	3.27±0.45	1	3.02±0.49	3	3.42±0.48	1	F=0.010(0.990)	
Working with colleagues	2.99±0.38	6	2.99±0.33	6	3.04±0.37	6	2.88±0.60	6	2.83±0.19	6	3±0.42	6	F=3.297(0.038)*	
Training and development opportunities	3.15±0.31	5	3.08±0.29	5	3.18±0.42	5	3.12±0.49	3	2.92±0.18	5	3.24±0.29	4	F=0.656(0.520)	
Organizational learning	3.38±0.59	1	3.35±0.49	1	3.34±0.59	1	3.09±0.46	4	2.92±0.45	4	3.39±0.40	2	F=4.312(0.001)*	
Total clinical governance climate	3.19±0.25		3.16±0.20		3.21±0.32		3.10±0.33		3.12±0.12		3.26±0.25		F=2.015(0.077)	

* p ≤ 0.05 at 5% level denotes a significant difference

Table (3): A descending ranking order of job empowerment and its dimension as perceived by healthcare providers:

Job empowerment dimensions	Physicians (n =49)		Pharmacists (n = 25)		Nurses Professional (n = 86)		Nurses Technical (n = 109)		Technicians Radiology (n = 10)		Technicians Laboratory (n = 22)		F-test	P-value
	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank	X̄±S.D	Rank		
Opportunity	3.4±1.13	1	2.96±0.6	3	3.34±0.72	1	3.51±0.78	1	2.97±0.6	4	3.71±0.86	1	F=4.086(0.001)*	
Information	2.89±0.96	4	2.37±0.8	7	2.8±0.76	6	2.87±0.91	6	2.1±1.21	6	3.39±1.01	5	F=4.404(0.001)*	
Support	2.78±0.93	5	2.83±0.62	5	3.01±0.73	3	3.5±0.65	2	2.97±1.16	3	3.67±0.8	2	F=11.759(0.000)*	
Resources	2.99±1	3	3.48±0.78	1	2.85±0.69	4	2.98±0.61	5	3.47±0.39	1	3.56±0.61	4	F=7.313(0.000)*	
Formal power	2.65±0.88	7	2.69±0.72	6	2.47±0.82	7	2.75±0.61	7	2.03±0.81	7	2.61±0.6	7	F=2.753(0.019)*	
Informal power	3.13±0.78	2	3.03±0.52	2	3.05±0.87	2	3.26±0.74	3	3.08±0.83	2	3.64±0.58	3	F=2.682(0.022)*	
Global empowerment	2.67±1.34	6	2.9±0.77	4	2.8±0.85	5	3.12±0.89	4	2.8±1.11	5	3.32±0.87	6	F=3.363(0.006)*	
Total Job empowerment	2.96±0.53		2.90±0.36		2.9±0.55		3.14±0.51		2.8±0.75		3.42±0.52		F=5.363(0.000)*	

* p ≤ 0.05 at 5% level denotes a significant difference

Table (4): Correlation coefficient of overall clinical governance climate and job empowerment level as perceived by health care providers

Clinical governance climate dimensions		Job empowerment dimensions							
		opportunity	information	support	resources	formal power	informal power	global empowerment	Total job empowerment
Planned and integrated quality improvement program	r	0.195**	0.123*	0.102	0.160**	0.116*	0.154**	0.163**	0.210**
	P	0.001	0.032	0.077	0.005	0.045	0.008	0.005	0.000
Proactive risk management	r	-0.131-*	-0.071	-0.278-**	-0.023	-0.207-**	-0.235-**	-0.189-**	0.214-**
	P	0.023	0.219	0.000	0.688	0.000	0.000	0.001	0.000
Absence of unjust blame and punishment	r	0.376**	0.276**	0.263**	0.146*	0.148*	0.320**	0.215**	0.360**
	P	0.000	0.000	0.000	0.011	0.010	0.000	0.000	0.000
Working with colleagues	r	0.183**	0.185**	-0.002	0.027	0.024	-0.031	0.140*	0.097
	P	0.001	0.001	0.977	0.644	0.676	0.593	0.015	0.092
Training and development opportunities	r	0.198**	0.152**	0.087	0.142*	0.007	0.110	0.143*	0.182**
	P	0.001	0.008	0.131	0.014	0.901	0.056	0.013	0.002
Organizational learning.	r	0.037	-0.028	-0.175-**	0.024	-0.111	-0.040	-0.090	-0.082
	P	0.521	0.633	0.002	0.674	0.054	0.488	0.120	0.154
Total clinical government climate	r	0.193**	0.165**	0.015	0.150**	-0.005	0.077	0.098	0.150**
	P	0.001	0.004	0.797	0.009	0.925	0.185	0.090	0.009

Correlation is significant at the 0.01 level (2-tailed).   ***Spearman correlation test
* Correlation is significant at the 0.05 level (2-tailed).

References:

Abd El Fatah, T. A., Ali, N. A., Elazazy, E. M., Dowidar, N. L., Abd Elgalil, H. M., & Mohamed, S. S. (2019). Assessment of clinical governance in primary health care services: a case study on Dakahlia governorate, Egypt. *The Egyptian journal of hospital medicine*, *76*(1), 3355-3365.

Aleinein, A. A. (2016). The impact of job involvement on job performance at UNRWA Gaza field office. *The Islamic University–Gaza Research*.

Ageiz, M. H., Elshrief, H. A., & Rashad, R. M. (2022). Success factors key for lean management practice and clinical governance climate implementation as perceived by nurse managers: A Comparative Study. *Assiut Scientific Nursing Journal*, 10(28.), 25-40.

Ahmed, S. M. I., Awad, N. H. A., & Sayed, N. M. E. The Relationship between Clinical Governance and Organizational Culture at Kafr El Dawar Central Hospital.

Ajanaku, O. J., Lubbe, W., Adufe, I., & Chukwuere, P. C. (2022). The relationship between structural empowerment and organizational commitment among nurses: A structured literature review. *Gender and Behaviour*, *20*(1), 19213-19239.

Al Mutair, A., Alghadheeb, F., Aldukhi, Z., Alarab, G., & Ahmad, G. Y. (2023). Workplace empowerment and organizational commitment: a correlational study in a Saudi Arabian hospital. *British Journal of Healthcare Management*, *29*(2), 1-10.

Aldossary, M. S. (2022). Dental Governance and the Saudi Vision 2030: A Narrative Review. *Saudi Journal of Health Systems Research, 2*(3), 136-142.

Alrige, M., Alshahrani, F., Alharbi, A., Aljuhani, N., & Aldini, N. (2022): The effects of empowerment on health care worker performance during the COVID-19 pandemic in Saudi Arabia. *Quality Management in Healthcare*, 31(3):143-148.

Al-Rjoub, S. R., Aldiabat, B. F., & Yassine, F. L. Y. A. (2023). The impact of employee empowerment on continuous improvement of health care: an empirical and comparative study between hospitals. *Business: Theory and Practice*, 24(1), 13-23.

Antony, J., Lizarelli, F. L., Fernandes, M. M., Dempsey, M., Brennan, A., & McFarlane, J. (2019). A study into the reasons for process improvement project failures: results from a pilot survey. *International Journal of Quality & Reliability Management, 36*(10), 1699-1720.

Azra, S. (2018). Impact of education on women's empowerment: Mediational role of income and self-esteem. *Journal of Research and Reflections in Education, 12*(1), 11-24.

Bahrami, M. A., Sabahi, A. A., Montazeralfaraj, R., Shamsi, F., & Ardekani, S. E. (2015). Hospitals' readiness for clinical governance implementation in educational hospitals of Yazd, Iran. *Electronic Physician*, 6(2), 794.

Chandler, G. (1986). The relationship of nursing work environments to empowerment and powerlessness. Unpublished doctoral dissertation, College of Nursing. University of Utah.

Choi, S., & Kim, M. (2019). Effects of structural empowerment and professional governance on autonomy and job satisfaction of the Korean nurses. *Journal of nursing management*, 27(8), 1664-1672.

Cloninger, C. R., Stoyanov, D., Stoyanova, K. K., & Stutzman, K. K. (2023). Empowerment of health professionals: Promoting well-being and overcoming burn-out. In *Person Centered Medicine* (pp. 703-723). Cham: Springer International Publishing.

Connolly, M., Jacobs, S., & Scott, K. (2018). Clinical leadership, structural empowerment and psychological empowerment of registered nurses working in an emergency department. *Journal of Nursing Management, 26*(7), 881–887. https://doi.org/10.1111/jonm.12619

Dan, X., Xu, S., Liu, J., Hou, R., Liu, Y., & Ma, H. (2018). Relationships among structural empowerment, innovative behaviour, self-efficacy, and career success in nursing field in mainland China. *International Journal of Nursing Practice, 24*(5), e12674. https://doi.org/10.1111/ ijn.12674.

El-Sayed, A. A. I., Asal, M. G. R., Abdelaliem, S. M. F., Alsenany, S. A., & Elsayed, B. K. (2024). The moderating role of just culture between nursing practice environment and oncology nurses' silent behaviors toward patient safety: A multicentered study. *European Journal of Oncology Nursing, 69*,102516. DOI: https://doi.org/10.1016/j.ejon.2024.102516

El-Sayed, A. A. I., Asal, M. G. R., Shaheen, R. S., & Abdelaliem, S. M. F. (2023). Job embeddedness and missed nursing care at the operating theatres: the mediating role of polychronicity. *BMC nursing*, 22(1), 458. https://doi.org/10.1186/s12912-023-01628-8

Fardazar, F. Safari, H. Habibi, F. & Haghighi, F. (2015): Hospitals' readiness to implement clinical governance. *Int J Health Policy Manag*,4(2):69–74. DOI:10.15171/ijhpm.2014.111.

Freeman, T. (2003): Measuring progress in clinical governance: assessing the reliability and validity of the Clinical Governance Climate Questionnaire (CGCQ). *Health Services Management Research*, 16(4), 234-250.

General Authority for Healthcare Accreditation and Regulation (GAHAR), (2021): GAHAR Handbook for hospital Standards. Edition 2021.

Ghavamabad, L. H., Vosoogh-Moghaddam, A., Zaboli, R., & Aarabi, M. (2021): Establishing clinical governance model in primary health care: A systematic review. *Journal of education and health promotion*, 10.

Gurdogan, E. P., & Alpar, S. E. (2016): The Relationship between Nurses' Perceptions of the Clinical Governance Climate and their Job Satisfaction Levels. *International Journal of Caring Sciences*, 9(2).

Hastings, S. E., Armitage, G. D., Mallinson, S., Jackson, K., & Suter, E. (2014). Exploring the relationship between governance mechanisms in healthcare and health workforce outcomes: a systematic review. *BMC health services research*, 14(1), 1-14.

Kaba, N. K., & Öztürk, H. (2022): Nurses' Perceptions of Clinical Governance Climate. *J Educ Res Nurs*, 19(2), 198-207.

Kamel, F., & Mohammed M. (2015). Perception of shared governance and its relation to nurses empowerment in Benha and Menoufia University Hospitals, *Journal of Nursing*

Science, 1-17. Published online MM DD 2015 (http://www.aascit.org/journal/jns). ISSN: 2381-1056 (Print); ISSN: 2381-1064.

Kanter, R. (1977). Men and women of the corporation. Basic Books. Page 189-210.

Karassavidou, E., Glaveli, N., & Zafiropoulos, K. (2011). Assessing hospitals' readiness for clinical governance quality initiatives through organisational climate. *Journal of health Organization and Management. 25*(2):214-40.

Kulari, G., Ribeiro, L., Laneiro, T., Osatuke, K., & Mouta, I. (2022). Studying the relationships between authentic leadership, structural empowerment, and civility in the palliative care sector in Portugal. *Leadership in Health Service,35*(3);355-371.

Laschinger, H. K. S. (2013). Conditions for work effectiveness questionnaire I and II. Western University. Canada. https://www.uwo.ca/fhs/hkl/files/cweq. Docx.

Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: expanding Kanter's model. *The Journal of Nursing Administration (JONA), 31*(5), 260-272.

Lucas, J., Leggat, S. G., & Taylor, N. F. (2022). Association between use of clinical governance systems at the frontline and patient safety: a pre-post study. *International Journal of Health Governance*, *27*(3), 282-295.

Mahfouz, H. H., Ebraheem, S. M., & Mahdy, A. Y. (2019). The Relation among Shared Governance, Empowerment and Job Involvement as Perceived by Medical-Surgical Nursing Staff. *Evidence-Based Nursing Research*, *1*(3), 12-12.

Mahmoud, H. G. (2016). The relationship between nurses' professional shared governance and their work empowerment at Mansoura University and specialized medical hospitals. *Journal of Biology, Agriculture and Healthcare*, *6*(18), 13-21.

Mosadeghrad, A. Arab, M. & Shahidi ,S. (2017): A survey of clinical governance success in Tehran hospitals. *Hakim Health Sys Res. 19* (3):129-140.

National Health Service (NHS, 2022): Governance, patient safety and quality. (Report No, 2-2022. Matron's handbook. Available at: https://www.england.nhs.uk/mat-

transformation/matrons-handbook/governance-patient-safety-and-quality/.

Ott, J., & Ross, C. (2014). The journey toward shared governance: The lived experience of nurse managers and staff nurses. *Journal of Nursing Management,* *22*(6), 761–768. https://doi.org/10.1111/jonm.12032.

Ochang, P., Stahl, B. C., & Eke, D. (2022). The ethical and legal landscape of brain data governance. *Plos one*, *17*(12), e0273473.

Patel, K., & Jenkyn, I. (2021): An introduction to clinical governance in dentistry. *British Dental Journal, 230*(8), 539-543.

Saleh, M. O., Eshah, N. F., & Rayan, A. H. (2022). Empowerment predicting nurses' work motivation and occupational mental health. *SAGE Open Nursing, 8,* 23779608221076811.

Schiavone, F., Pietronudo, M. C., Sabetta, A., & Ferretti, M. (2022): Total quality service in digital era. *The TQM Journal,*9; 1-9.

Şenol Çelik, S., Sariköse, S., & Çelik, Y. (2023). Structural and psychological empowerment and burnout among nurses: A systematic review and meta-analysis. *International Nursing Review*.

Siller, J., Dolansky, M., Clavelle, J., Fitzpatrick, J., Cleveland, O., & Scottsdale, A. (2016). Shared governance and work engagement in emergency nurses. *Journal of Emergency Nurse, 42*(4), 325-330. https://doi.org/10.1016/j.jen.2016.01.002.

Ta'an, W. F., Al-Hammouri, M. M., &Rababah, J. A. (2022). The predicting effects of professional governance and structural empowerment on job satisfaction among Jordanian nurses: A cross-sectional study. *Journal of Nursing Management,* *30*(7), 3013–3021. https://doi.org/10.1111/jonm.13698

Thanasas, G. L., Tatsi, K., Koutoupis, A. G., Davidopoulos, L. G., & Ploumpis, I. C. (2023). Health and Clinical Governance: A Systematic Literature Review. *Review of European Studies*, *15*(4).

Vassos, M. Nankervis, K. & Chan, J. (2019): Clinical Governance Climate within Disability Service Organizations from the Perspective of Allied Health Professionals: Clinical Governance Climate. *Journal of Policy and Practice in Intellectual Disabilities. 16,* 10.1111/jppi.12281.

Veenstra, G. Ahaus, K. Welker, G. Heineman ,E. van der, L. Aan, M. & Muntinghe, F. (2017): Rethinking clinical governance: healthcare

professionals' views: a Delphi study. *BMJ Open.7*(1):12591. doi:10.1136/ bmjopen-012591.

Wijekoon, W. M. C. R., & Wickramasinghe, S. C. (2023). Assessing clinical governance activities in secondary curative health care institutes in the Kandy District, Sri