Perception of Shared Governance among Registered Nurses in a Jordanian University Hospital

Ibrahim G. Al-Faouri, R.N., Ph.D.
Assistant Professor
School of Nursing
Jordan University of Science and Technology (JUST)
P.O. Box (3030)
Irbid 22110, Jordan.

Nahla Al Ali, PhD, RN
Assistant Professor
School of Nursing
Jordan University of Science and Technology (JUST)
P.O. Box (3030)
Irbid 22110, Jordan.

Mohamed Bany Essa Ms, RN
Quality Department
King Abdullah University Hospital
P.O. Box: 630001
Irbid 22110, Jordan.

Abstract

Introduction: *Shared governance considered a framework for developing independent decision making in professional nursing practice, standards, policies, and procedures. It's evident that shared governance enhances professional nursing practice, communication, professional collaboration, a positive work environment, quality decision making, and patient care outcomes.*

Purposes: *the purposes of this study were to examine how registered nurses in a Jordanian University hospital perceive shared governance; to examine the difference between nurse mangers and staff nurses regarding perception of shared governance; to examine the difference of nurses perception of shared governance according to working areas and to examine if there was relationship between perception of shared governance and nurses demographic characteristics.*

Methods*: A descriptive survey design used. Hess Index of Professional Nursing Governance 1998 was utilized to study the nurses' perceptions of shared governance in a Jordanian University hospital. Sample consisted of all registered nurses working at one of two Jordanian University Hospitals, the response rate was 72% (n=282). Descriptive statistics, analysis of variance ANOVA, post hoc test analysis and Pearson correlation were used in the current study.*

Results: *Findings showed that the Jordanian University hospital nurses' perceived that decisions equally shared by staff nurses and nursing managers in all IPNG subscale (Nursing Personnel, Information, Goals, Resources, Participation, and Practice), in addition there was no difference between staff nurse and nurse manger in regarding perception of shared governance. The results also showed that nurses working at operation room and critical care unit have perceived more shared governance than medical ward. Significant relationship was found between experience and nurse's perception of shared governance.*

Conclusion: *result of study would be the input for stakeholder and nursing leaders in hospitals to enhance nurse's perception of shared governance by developing or adopting shared governance model, which in turn could enhance retention of nurses and improve quality of nursing care.*

Keywords: Shared governance; Nurse; University hospital; Jordan

1. Introduction

Creating a shared governance culture in hospitals allow nurses to be actively involved with administration in decision influencing practice; and enhance decentralization which will lead to make organizational structure and professional practice more complimentary (Hess 2004, Fallis & Altimier 2006) and will ensure that bed side nurses are involved in decisions regarding their practice (Doherty & Hope 2000) . Omay and Buchan (1999) defined shared governance as " a decentralized approach which gives nurses a greater authority and control over their practice and work environment ; engenders a sense of responsibility and accountability; and allow active participation in the decision-making process, particularly in administrative area from which they were excluded previously " (Omay & Buchan 1999 P2).

Applying shared governance framework claimed to improve delivery of quality of care (Mcdonagh *et al.* 1989, Kovner *et al* 1993, Scott & Caress 2005, Agnes *et al.* 2011), develop collaborative relations between health care professionals, improve their quality of care and over all clinical effectiveness; increase staff confidence; assist them to develop personal and professional skills; increase their professional profile; which lead in improving their communication; facilitate development of new knowledge and skills ; increase professionalism and accountability; increase direction and focus and reduce duplication of effort (Broughton, 2003, Kramer & Schmalenberg, 2003, Aroskar *et al.* 2004, Agnes *et al.* 2011).

2. Literature Review

Governance usually includes structure and process where a group of members direct, control, and regulate the goal oriented efforts of other members in the organization (Hess 1998). Shared governance considered as a way of conceptualizing empowerment and building structures to support it while as a philosophy require acknowledgment and application of its principles (Porter-O'Grady 2001). Shared governance defined as the accountability-based governance system that shares power, control, and decision making with the professional nursing staff within a clinical decision making framework (Prince 1999, Anthony 2004). Shared governance as formal programs should involve professional nurses in governance decisions by having the right to control over their professional practice and extending their authority to such areas as budgeting, scheduling, and evaluating personnel, which were previously controlled exclusively by managers (Hess 2004). Porter-O'Grady (2001) describes four principles of shared governance: partnership, accountability, equity, and ownership.   The establishment of a partnership between the nurses and the health care organization promotes power bases that afford nurses optimal work environments, strengthen their positions at the administrative and organizational levels which enable them to effectively advocate for patient care (Green & Jordan, 2004). In addition to that nurses become more accountable within their professional practice through advocating for quality workplace environments affecting job satisfaction and retention (Green & Jordan, 2004) and have control over their own nursing practice and act autonomously (Anthony 2004).

Shared governance is seen as a strategy to build a partnership, create ownership, and facilitate equity and accountability between the nurses and the work environment. This is fundamental to the nurse's job satisfaction, recruitment and retention, and subsequent quality of care and patient safety (Tourangeau *et al.* 2006, Richard *et al.* 2009). To ensure high quality of care, education and specialization is necessary, however, the importance of expertise is evident in all areas of nursing. Better patient outcomes are also evident in workplace environments that follow a formal staffing plan consisting of nurses that are highly educated, experienced, and supported by the workplace. Quality of care affected positively by professional nursing practice model in the structure provided by shared governance (Anthony 2004). Shared governance is a framework that focuses on strategies that empower nurses (Edmonstone 2008) in an environment that respects and encourages individual professional accountability (Dorthy 2008, Agnes *et al.* 2011). Also shared governance considered as a form of participative management that provides nurses with a voice in decision making (Kramer *et al.* 2008) and managerial structure that enable staff members for making clinical decision and is the key empowerment mechanism in nursing organization today (Dorthy 2008).

Nurses' satisfaction considered as a key outcome of shared governance and has often included as measure in nursing literature also has strong influence on many aspects of nursing. The major component of satisfaction related to shared governance is the degree of participation extended to nursing staff (Omay & Buchan 1999, Anthony 2004).

Moreover include a supportive work environment, access to resources and information, adequate staffing to meet patient needs (Tourangeau *et al.* 2006), and influence in decision making at all levels (Anthony 2004). Lack of control over workload could lead to nurses' absenteeism, frustration, decreased productivity, poor morale, and compromising patient care (Geiger-Brown *et al.* 2004). Nurses who are working on the shared governance unit have higher job satisfaction with the work (Anthony 2004), more positive composite constructive culture, also greater satisfaction in professional status and administration, However traditional unit show higher retention rate than shared unit (Stumpf 2001).

Many research's found that control over nursing practice, empowerment, participation in decision making (Green & Jordan, 2004), and a sense of value by the organization have a direct impact on nurses job satisfaction (Stumpf 2001), team functioning, retention, and commitment (Buckles Prince, 1997, Bell, 2001). The implementation of shared governance leads to positive changes including increased control over nursing practice, decreased turnover and a greater commitment to the organization among nurses (Omay & Buchan 1999). The organizational structure that incorporates shared governance also promotes a professional work environment especially when shared governance utilized as a strategy for professional and organizational improvement. Generally nurses prefer to work in organizations that adopt shared governance model. The nurse managers, nurse specialty groups, and nurse educators had higher governance scores than the general duty nursing staff in literature (Howell *et al.* 2001).

The magnet recognition program by the American Nurses Credentialing Center (ANCC) considered as one of key frameworks for attracting and retaining nurses in the United States. Magnet hospital environments supports professional nursing practice models characterized by a high degree of nurses autonomy, control over nursing practice (Spence Laschinger *et al.* 2003), communication and collaboration, and a strong and visible nursing, shared governance continues to be an important and successful element in the Magnet hospital environment, also magnet environments promote quality work environments for their employees leading to a positive experience for nurses, an increase in recruitment and retention (Bumgarner & Beard, 2003), and better patient outcomes (Kramer *et al.* 2009).

American University of Beirut Medical Center is the only hospital in the Middle East completed the magnet journey and became magnet hospital implementing shared governance program. In Jordan, one study presented at the third Jordanian Nurse Council (JNC) international conference 2010 done at King Hussein cancer center (KHCC) as a part of their magnet journey (Afeef *et al.* 2010). University hospitals considered as a corner stone for the health care system in Jordan' Therefore, the purposes of this study were to examine how registered nurses in a Jordanian University hospital perceive shared governance; to examine the difference between nurse mangers and staff nurses regarding perception of shared governance; to examine the difference of nurses perception of shared governance according to working areas and to examine if there was relationship between perception of shared governance and nurses demographic characteristics.

3.   *Method*

This study used a descriptive survey design to obtain information at the current status of shared governance. The setting of the study was one of two university Jordanian hospitals. This hospital located in the northern part of Jordan and considered as a referral hospital, serving approximately one million inhabitants. The hospital total capacity was 550 beds in different specialties' and facing pressures that include accommodating high patient volumes, high acuity and complex patient needs, and availability of optimal resources to ensure the best patient outcome.

The target population for this study was all registered nurses employed in the study setting. The inclusion criteria are: a) Being a registered nurse practicing clinical nursing; b) Working during data collection period; c) Completed the orientation period (3 month) prior to the start of the study. Licensed practical nurses (LPN) were excluded from the survey as they are responsible for a different aspect of nursing services.

3.1. Sample: The registered nurses who were eligible to participate in the current study and   met inclusion criteria were 390 out of 580 nurses employed in the hospital. Of the 390 questionnaires distributed to eligible nurses in ten nursing unit, 282 completed questionnaires (response rate of approximately 72%). The majority of the sample were from critical care units 28% (n=81). Females were 61% (n=173) of the sample, while the mean age of the participants was 28 years, and 90% of the participants had bachelor degree. The registered nurses composed 89% of the participant, and 49% received special training.

3.2. Ethical considerations: The study does not has any actual or potential threat on the participant however the participant receives a detailed letter that highlight the components of the study and addresses the right of participant such as confidentiality and right to withdraw at any time. Jordan University of science and Technology (JUST) and the hospital approved the study. Also a written approval from the author to use Index of Professional Nursing Governance [IPNG] was obtained

3.3. Measurements/instruments: Index of Professional Nursing Governance [IPNG] which was developed by Hess (1998) was used in the current study. IPNG contains 86 questions measures the perceptions of governance of health care personnel on a continuum from traditional, to shared, and to self governance. The scores are based on a 5-point Likert-like response scale. The scale ranges from 1- 5 including 1 = nursing management/administration only, 2 = primarily nursing management /administration with some staff nurse input, 3 = equally shared by staff nurses and nursing management/ administration, 4 = primarily staff nurses with some nursing management/administration, and 5 = staff nurses only. Likert scores of 1 and 2 indicate decision making dominated by management/administration. Scores higher than 3 indicate more staff nurse participation in decision making. The IPNG range of total scores reflecting traditional (management) decision making environment is from 86 - 172. An environment which utilizes shared decision making between nurses and management would have an IPNG range of 173 - 344. If nurses are the decision making group IPNG range would be from 345- 430. IPNG measures six dimensions of governance including a) Nursing Personnel include twenty-two items measuring who controls nursing personnel and related structures. b) Information includes fifteen items related to who has access to information relevant to governance activities. c) Resources include thirteen items related to who influences practice. d) Participation includes twelve items related to who participates in structures related to governance activities at different organizational levels. e) Practice includes sixteen items measuring who controls professional practice. f) Goals include eight items related to who sets and negotiates the resolution of conflict at different organizational levels. The Cronbach's coefficient alpha for the total IPNG scale in the current was (0.94).

3.4. Procedure: a pilot study was conducted in three departments in the hospital with fifteen nurses to assess the face validity and the cultural-sensitivity of the questionnaire. Thirty to forty five minutes was the time needed to complete the questionnaire, almost all participants agreed on the cultural sensitivity of the questionnaire. A list of nurses was obtained from the director of nursing, and then the questioner was distributed by hand to the all nursing division according to number of nurses working at that division. The researchers collected the completed questioner after one day by hand from the participants. Data collected within 6 weeks in 2011.

3.5. Data analysis: To meet the study purposes means, standard deviation, ANOVA, Post-Hoc for multiple comparisons between groups and Pearson correlation analysis were used in the current study.

4. Result

The total IPNG score was (193) for the whole sample and that falls within the range of organizations that are shared governed (range173-344). Also all sub-scale scores are consistent with shared governed hospitals, specifically; nurses perceive that decision making is shared between nurses and administration.

In nursing personnel (i.e., who controls nursing personnel) Jordanian registered nurses mean score = 69; which falls within shared governance range (44–88); reflects shifting toward staff nurses in decision making process. For the rest of subscales, Jordanian registered nurses scores reflect scores from organizations with newly implemented shared governance models. Information (i.e., who has access to information relevant to governance activities) Jordanian registered nurses mean score = 33 within shared governance range (31–60), and Goals (i.e., who sets goals and negotiates resolution of conflict at different organizational levels) Jordanian registered nurses mean score = 17; in the border line of shared governance range (17–32). Resources (i.e., who influences the resources that support professional practice) Jordanian registered nurses mean score = 34; within shared governance range (27–52). Participation (i.e., who creates and participates in committee structures related to governance activities) Jordanian registered nurses mean score = 27, in the border line of shared governance range (25–48), and Practice (i.e., who controls professional practice) Jordanian registered nurses mean score = 40; which falls within shared governance range (33–64) (see table 1).

Table 1: The IPNG Sub-Scale, Total Means and Shared Governance Ranges

Factor subscales	Shared Governance Range*	Current Study Mean (SD)
Total IPNG score	173-344	193.17 (53.415)
1. Nursing personnel	44-88	68.49 (15.879)
2. Access to information	31-60	33.36 (11.306)
3. Goals and conflicts	17-32	17.50 (6.365)
4. Resources supporting practice	27-52	34.41 (8.367)
5. Participation	25-48	26.72 (10.181)
6. Control over practice	33-64	39.66 (9.998)

*reference point from instrument (IPNG)

One-Way ANOVA used to examine if there is significant difference between staff nurses and nurse mangers regarding the perception of shared governance. In addition to examine if there is significant differences in perception of shared governance according to the participants demographic characteristics and specialty working area. The result did not show significant statistical difference between staff nurses and nurse mangers regarding the perception of shared governance (F=.991; P=.320). The results did not show significant difference in nurses perception of shared governance according to demographic characteristics (gender, professional specialty training, and nursing education). Also there was significant difference in nurses perception of shared governance (IPNG) total score according to the specialty working areas (i.e., Medical, Operation, Emergency, surgical Care, Recovery Room, Clinic, Critical Care, and "other" (Education, quality, infection) (F=3.784, df = 272, P<0.05). (see table 2)

Table 2: IPNG Total Score by Unit, One-way ANOVA

Gender(N)	Mean IPNG Score (SD)	F	Sig.
Medical (43)	167.53 (46.447)		
Surgical (59)	190.47 (53.717)		
Critical Care (81)	208.37 (54.008)		
Operating Room (15)	238.93 (56.273)		
Recovery Room (5)	180.20 (60.850)	3.784	.000
Emergency Room (13)	175.38 (35.939)		
Clinic (11)	180.09 (18.934)		
Maternity (14)	182.86 (65.964)		
Pediatrics (25)	185.88 (48.863)		
Other (16)	200.00 (44.050)		

For multiple comparisons between units Shefee Post Hoc test done, the result showed that there's a statistically significant difference between critical care unit and medical ward toward critical care unit (P = 0.041), also operating room had significant difference compared to medical unit toward operating room (P = 0.012) (see table 3).

Table 3: Significant Result between Units. Post Hoc test

(I) UNIT	(J) UNIT	Mean Difference (I-J)	Std. Error	Sig.
Medical	Critical Care	-40.84(*)	9.657	.041
	Operating Room	-71.40(*)	15.348	.012
Critical Care	Medical	40.84(*)	9.657	.041
Operating Room	Medical	71.40(*)	15.348	.012

* The mean difference is significant at the .05 level.

Pearson Correlation was used to examine if there is relationship between age, years of experience and score of shared governance, The results showed that age did not have significant correlation with IPNG score (r = -0.044, p = 0.460). On the other hand there is a significant relationship between years of experience and total IPNG Score (r =-0.17, P = 0.004)

5. Discussion

Jordanian registered nurses perceive good control over their professional practice and shared decisional involvement of nurses and management in their work environment.

5.1. Nursing personnel subscale showed that Jordanian registered nurses perceived good control over their professional practice in their formal organization, this subscale had the highest mean score of all the subscales indicating that decisions equally shared by staff nurses and nursing management. Hess (1998) found out only one of 16 hospitals evaluated had Nursing Personnel scores within the shared governance range. George *et al.* (1997) and Howell *et al.* (2001) found that nurses perceptions of their work environment being more closely related to a traditional governance structure. In Jordan result of the current study is congruent with result of study by Afeef *et al.* (2010); the score (mean=40) for this sub scale was few point below shared governance range.

5.2. Access to information Nurses perceived a more shared access to information in areas such as access to resources concerning recent advances in nursing practice, compliance of hospital nursing practice with requirements of surveying agencies and hospital strategic plans for the next few years. This result could be due to the active role of nurses in quality activities at all levels, orientation program for all newly employed nurses, annual training plan for nursing department, and availability of library within hospital. These findings are consistent with the previous study conducted at KHCC (mean = 32) and falls within shared governance ranges (Afeef *et al.* 2010). The current study result is consistence with study findings by Butts *et al.* (2007) the mean for this sub scale around 32 within shared governance range.

5.3. Goals This subscale relate to who sets goals and negotiates the resolution of conflict at different organizational levels. The mean score was 17.5 falls on the lower limit of shared governance range (17-32). This result is consistent with Howell *et al.* (2001) and study by Butts *et al.* (2007) reported that nurses have a more shared ability to set goals and manage conflict with management/administration (Mean=16,Mean= 18 respectively). In Jordan, a study of Afeef *et al.* (2010) have similar result with mean score for this subscale (17) and falls within shared governance range. Green and Jordan (2004) suggest that engaging nurses in decision making, work redesign and conflict resolution enhances nurse empowerment within the work environment, nurses have limited skills in this area. Therefore nurses need more knowledge and training regarding conflict negotiation strategies in order to improve their ability to advocate for and provide quality patient care.

5.4. Resources Subscale The result of current study was within the shared governance range, in comparison with hospitals evaluated by Hess (1998) Jordanian registered nurses score higher than five facilities that Hess previously surveyed and labeled as "shared governance hospitals". Nurses in current study perceived they have influence or formal authority in a variety of procedures including daily patient care assignments, monitoring and obtaining supplies, the flow of admissions and discharges, consulting services both outside of nursing and in the unit, and generating schedules.

This findings of current study are congruent with the literature; Howell *et al.* (2001) mean score was 34.9, and Butts *et al.* (2007) showed that nurses and management equally share decision (mean= 35.6), in Jordan the study by Afeef *et al.* (2010) reported that mean score for this subscale was 32 which also consistence with current study.

5.5. Participation subscale score falls within the shared governance range. The results of current study indicated that nurses perceive to have shared ability with nursing management/administration to participate on most committees particularly related to clinical practices within the unit and nursing department, staff scheduling, and strategic planning. However, nurses perceive they have limited ability to participate in committees that relate to multidisciplinary professionalism, organizational budgets and expenses.

George *et al.* (1997) discovered that nurses from a non-shared governance setting had less participation in decision making than nurses in a shared governance structure. However, Howell *et al.* (2001) have similar result of this study which indicated that nurses have more influence moving towards equally sharing access to information and resources with nursing management/ administration (Mean=27.9). Tourangeau *et al.* (2006) offer similar results to this subscale, as RNs rated the highest aspect of their nursing professional practice environment was related to the increase in participation in hospital affairs. In Jordan Afeef *et al.* (2010) reported mean score of 24 in the border line of shared governance range.

5.6. Control over Practice, Jordanian registered nurses perceived adequate input or control in the following area that directly affect the bedside care of the patient: patient care standards, quality assurance, educational development, products for nursing care, and incorporating research ideas in nursing. However the result showed that nurses have limited control over determining the model of nursing care for their professional work, and staffing levels. These results could be due to accreditation programs at the study setting which gave opportunity to registered nurses to participate in identifying patient care stander needed, and apply quality improvement project and due to implementation of evidence based practice project recently in the hospital. In Jordan the study by Afeef *et al.* (2010) reported results of nurses perceptions of their work environment being more closely related to shared governance structure (Mean=37) (Afeef et al., 2010); similar to result of the current study indicating nurses and administration were involved equally in decisions related to control over professional practice. Howell *et al.* (2001) provided similar results of this subscale indicating equally shared activities between nurses and management (Mean= 33.39). Butts *et al.* (2007) offer similar results to this subscale (Mean= 34) in their study for determining the readiness for shared governance.

Results of the current study; showed that staff nurses and nurse mangers had no significant difference in their perception of shared governance; this mean that management level at the study setting had no effect on perception of shared governance, however both (staff nurses and nurses mangers) perceive that they are working in environment that equally share decisions and control over practice. This result is consistent with previous study measure shared governance within hierarchical structure hospital; the researchers reported that no statistically significant relationship between management level and shared governance (Howell *et al.* 2001).

Results of the current study; showed no significant correlation between Demographic Characteristics (age, gender, management level, education, special training) and shared governance subscale (nursing personnel, information, goals, resources, participation and practice). This result is consistent with previous studies; the researchers reported that no statistically significant relationship between demographic variables and shared governance (George *et al.* 1997, Howell *et al.* 2001, Nancy 2009). In addition, the results show that there is a statistically significant difference between nursing units; critical care unit, medical unit, and operation room at level (P ≤ .05). This means that both critical care and operation room have more shared governance than medical unit.

6. Implications and Recommendations

The study findings can be used to improve nurses work environment and enhance shared governance. These results would be the input for stakeholder and nursing leaders in hospitals to enhance nurses' perception of shared governance by developing or adopting shared governance model. Also future research using focus groups to discuss shared governance in nursing practice in their particular area this would enable identification of challenges that nurses and management face to be acknowledged, and perhaps allow for necessary interventions to follow. Nevertheless, nurses are not fully aware with the concept of shared governance, the role of nursing leadership is crucial and vital to focus and train nurses and nurses mangers more about this concept and involve nurses in decision making.

Future research includes; the use of focus groups to discuss control over nursing practice in their particular area, this would enable identification of challenges that nurses and management face to be acknowledged, addressed and supported in the literature and perhaps allow for necessary interventions to follow. Nursing educators need to focus more on concept of shared governance and decision involvement for nursing students. Training in shared governance skills should be available for all nurses, and especially for the nurse managers. Administrators can use the findings of this study to develop or adopt the suitable model for shared governance, furthermore train nurses and nurse managers about shared governance and decisional involvement behaviors and how they affect job satisfaction of staff nurses; implementing these soft skills by nurse mangers in the hospitals, lead to a new environment of organizational culture that is conductive to creativity conflict management, team work, autonomy, sense of motivation, empowerment.

The sample size is limiting the generalizability of the study findings to all Jordanian hospitals. Also the self-reported questionnaire increased the risk of bias and compromised objectivity of participants' responses.

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