



College of Management

The Impact of Nursing Shared Governance on the Hospital Performance

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2025

Declaration

I, Khalid Mitairi, hereby declare that this research titled “*The Relationship Between Governance Practices and Hospital Performance Among Registered Nurses at Dr. Sulaiman Al Habib Hospital in Riyadh, Saudi Arabia*” is my original work. It has not been submitted previously, either in whole or in part, to any university or academic institution for any degree or qualification. All sources and references used in the preparation of this work have been appropriately cited and acknowledged.

Dedication

To my cherished family—your constant support, heartfelt encouragement, and endless prayers have been my strength throughout this journey. This work is also devoted to the dedicated healthcare professionals whose daily commitment brings hope, healing, and dignity to countless lives.

Acknowledgment

All praise is due to Allah, whose guidance and grace sustained me throughout the course of this study. I am deeply grateful to my supervisor for their insightful mentorship, constructive feedback, and unwavering support that shaped the direction of this research. My sincere thanks go to the administration and nursing staff at Dr. Sulaiman Al Habib Hospitals for their valuable cooperation and participation. I also wish to express heartfelt appreciation to my family and friends, whose patience, encouragement, and belief in me have been a constant source of motivation.

Table of Contents

Content	Page
Dedication	i
Acknowledgment	ii
Declaration	iii
Abstract	iv
List of Tables	v
List of Figures	vi
Chapter One: Introduction	1
1.1 Introduction	2
1.2 Problem Statement	5
1.3 Justification	7
1.4 Research Objectives	10
1.5 Research Questions	11
1.6 Study hypothesis	12
Chapter Two: Literature Review	13
2.1 Theoretical Framework	13
2.2 Conceptual framework	17
2.3 Review of Related Studies	21
2.4 Critical Analysis and Summary	24
2.5 Literature gap	26
2.6 The contribution of the current study	27
Chapter Three: Methodology	28
3.1 Research Design	28

Content	Page
3.2 Study Setting and Population	28
3.3 Sampling and Sample Size	29
3.4 Data Collection Tool	30
3.5 Data Collection Procedure	32
3.6 Ethical Considerations	32
Chapter Four: Results	34
4.1 Demographic and Professional Characteristics	34
4.2 Shared governance assessment findings	41
4.3 Hospital performance assessment findings	45
4.4 Correlations Between Governance and Performance	49
4.5 Analysis by Demographics	51
Chapter Five: Discussion	53
5.1 Discussion	53
Chapter Six: Conclusion	58
6.1 Conclusion	58
6.2 Recommendations	59
6.3 Study limitations	60
6.3 Study implications	61
References	62
Appendices	65

Abstract

Background: Nursing shared governance has emerged as a strategic framework for promoting decentralized decision-making, enhancing staff autonomy, and improving hospital performance. However, its direct impact on performance outcomes in Saudi healthcare institutions remains underexplored, particularly from the perspective of frontline nursing staff.

Aim: This study aimed to assess the relationship between nursing shared governance and hospital performance as perceived by registered nurses working at Dr. Sulaiman Al Habib Hospital in Riyadh, Saudi Arabia.

Methods: A descriptive correlational design was employed. The study included a convenience sample of 255 registered nurses from diverse clinical and administrative units. Data were collected through a structured questionnaire covering governance dimensions (control, authority, participation, and access to information) and hospital performance indicators (quality, safety, efficiency, and clinical governance). Descriptive statistics, Pearson correlation, and subgroup comparisons were conducted using SPSS.

Results: The findings showed moderate governance engagement (overall mean = 3.00/5) and relatively low hospital performance perceptions (overall mean = 1.52/3). A statistically significant positive correlation was found between shared governance and hospital performance ($r = .479$, $p < .001$). Governance control was strongly associated with general healthcare quality ($r = .267$, $p < .001$) and overall performance ($r = .352$, $p < .001$). Female nurses and those with baccalaureate degrees reported significantly higher governance scores ($p = 0.005$ and $p = 0.025$, respectively). Participants who rated their satisfaction as “5” had the highest governance and performance scores.

Conclusion: Nursing shared governance was positively associated with improved perceptions of hospital performance. However, despite moderate governance structures, performance ratings remained suboptimal. These findings showed the need for reinforcing shared governance frameworks, enhancing nurse participation in decision-making, and aligning governance roles with institutional performance goals.

Keywords: Shared governance, hospital performance, nursing leadership, decision-making, Saudi Arabia, healthcare quality

List of Tables

Table Number	Title
Table (1)	The distribution of the participants according to their gender
Table (2)	The distribution of participants by Basic Nursing Educational Preparation
Table (3)	The distribution of participants by Highest Educational Degree Attained
Table (4)	The distribution of participants by Employment Status
Table (5)	The distribution of participants by Current Position Title
Table (6)	The distribution of participants by Type of Nursing Unit
Table (7)	The distribution of participants by Specialty Certification Status
Table (8)	The distribution of participants by Overall Satisfaction Level
Table (9)	Descriptive Statistics of Selected Continuous Variables
Table (10)	Descriptive Statistics of Governance Dimensions and Items
Table (11)	Descriptive Statistics of Hospital Performance Domains and Items
Table (12)	Correlation Matrix between Governance Variables and Hospital Performance Indicators
Table (13)	The relation between Mean Scores of Governance and Performance by Demographic and Professional Variables

List of Figures

Figure number	Title
Figure (1)	The distribution of the participants according to their gender
Figure (2)	The distribution of participants by Basic Nursing Educational Preparation
Figure (3)	The distribution of participants by Highest Educational Degree Attained
Figure (4)	The distribution of participants by Current Position Title
Figure (5)	The distribution of participants by Specialty Certification Status
Figure (6)	The distribution of participants by Overall Satisfaction Level
Figure (7)	Scatter plot for the correlation between the overall mean scores of the shared governance with the hospital performance

Chapter One: Introduction

1.1 Introduction

Nursing shared governance is a management approach that integrates nurses into decision-making processes, ensuring they actively contribute to shaping hospital policies and improving clinical practices. Unlike traditional hierarchical management models, shared governance promote collaboration between hospital leadership and frontline nursing staff, enhancing professional autonomy, accountability, and collective responsibility. This approach has been widely recognized for its ability to drive improvements in hospital performance by optimizing operational efficiency, enhancing patient outcomes, increasing staff satisfaction, and ensuring financial sustainability. As Phillippe (2019) showed, shared governance strengthens the professional role of nurses, providing them with decision-making authority that directly influences patient care quality and hospital outcomes. Given the complex and rapidly evolving nature of healthcare systems, engaging nurses in governance structures is essential for achieving high-quality care and institutional effectiveness (O'Grady & Clavelle, 2021).

Historically, hospital management structures followed a top-down decision-making approach, where hospital executives and administrators dictated policies with minimal input from nursing staff. This rigid system often resulted in inefficiencies, workforce dissatisfaction, and increased patient safety concerns. Shared governance emerged as a solution to these challenges, offering a decentralized model that distributes authority across different levels of nursing practice. Through structured mechanisms such as nursing councils, unit-based committees, and interdisciplinary decision-making teams, shared governance ensures that those directly involved in patient care contribute to policy development, workflow optimization, and quality improvement initiatives (Owen et al., 2021). Jaber et al. (2022) further showed that engaging nurses in governance structures strengthens hospital administration by reducing hierarchical inefficiencies and promoting participatory leadership.

The impact of shared governance on hospital performance extends beyond workforce engagement. Research has demonstrated that hospitals implementing shared governance models report higher clinical efficiency, reduced medical errors, improved patient safety, and greater

financial sustainability (Kutney-Lee et al., 2020). Additionally, shared governance promote a culture of teamwork, transparency, and leadership development, enabling nurses to take on more active roles in hospital administration and healthcare delivery. As Brennan and Wendt (2021) observed, shared governance contributes to improved interprofessional collaboration and enhances institutional decision-making processes, leading to overall hospital performance improvements.

Hospital performance assessment involves evaluating multiple aspects, including clinical effectiveness, operational efficiency, financial management, and patient-centered care. Shared governance plays a critical role in improving these dimensions by enabling collaborative decision-making, reducing inefficiencies, and strengthening communication across hospital departments. Speroni et al. (2021) found that hospitals with well-integrated governance structures demonstrated superior patient care outcomes, reduced delays in clinical procedures, and enhanced overall service delivery. One of the most significant contributions of shared governance to hospital performance is its impact on clinical outcomes and patient safety. When nurses actively participate in governance structures, they become more engaged in patient-centered care models, leading to fewer medical errors, improved adherence to evidence-based practices, and better infection control measures. Studies indicate that hospitals with well-established shared governance frameworks have witnessed a 10%–20% decrease in hospital-acquired infections (HAIs) and a significant reduction in preventable medical errors (Barasteh et al., 2021). Additionally, higher nurse engagement has been linked to better patient satisfaction scores, as patients receive more attentive and coordinated care. Albargi et al. (2024) showed that when nurses influence policy decisions, hospitals experience improved clinical efficiency, as well as strengthened accountability in patient care.

Beyond clinical improvements, shared governance significantly enhances hospital operational efficiency. Traditional hospital management models often suffer from bureaucratic delays, poor communication, and inefficient resource allocation, which can negatively impact hospital performance. Shared governance addresses these issues by promoting collaboration between nurses, administrators, and other healthcare professionals, leading to more effective decision-making and streamlined workflow processes. Hospitals that adopt shared governance models have reported a 15% increase in overall efficiency, including shorter patient wait times,

reduced length of hospital stays, and faster response times to clinical issues (Nurmeksela et al., 2021). Improved coordination among nursing teams and hospital departments also helps minimize workplace conflicts, creating a harmonious work environment that enhances productivity and service delivery.

Financial sustainability is another key area where shared governance contributes to hospital performance improvement. Many healthcare institutions face financial strain due to high operational costs, workforce turnover, and inefficiencies in hospital management. Shared governance helps mitigate these financial challenges by reducing nurse turnover rates, optimizing resource utilization, and improving budget allocation. Hospitals that successfully implement shared governance models have reported a 20% decrease in turnover rates, leading to significant cost savings on recruitment, onboarding, and training expenses (Adkins, 2023). Additionally, nurses who feel empowered in decision-making are less likely to experience burnout, absenteeism, or job dissatisfaction, reducing the financial burden associated with excessive overtime and staff shortages. Meyer and Allen (1991) showed that when employees feel a strong sense of commitment to their organizations, they are more likely to remain in their positions, reducing overall turnover costs.

Workforce stability and leadership development are also essential components of hospital performance, and shared governance plays a crucial role in these areas. When nurses are given the opportunity to participate in decision-making, they develop stronger leadership skills, a sense of professional accountability, and a commitment to institutional success. Hospitals that invest in shared governance not only benefit from higher levels of nursing engagement but also create a pipeline for future healthcare leaders (Blau, 1964). Encouraging nurses to take on advisory and leadership roles promote continuous learning, professional development, and career satisfaction, contributing to a more resilient and skilled healthcare workforce. Herzberg (1959) showed that employee motivation is driven by factors such as professional growth, recognition, and involvement in decision-making, all of which are enhanced by shared governance models.

In Saudi Arabia, the healthcare sector has undergone significant transformations under Vision 2030, which prioritizes improving healthcare services, strengthening workforce

engagement, and promoting patient-centered care. As part of these reforms, Saudi hospitals have been increasingly adopting shared governance models to enhance hospital performance and workforce satisfaction (World Health Organization, 2020). Hospitals under the Ministry of Health (MOH), King Fahd Medical City, King Saud Medical City, and specialized military hospitals have integrated shared governance principles to strengthen nursing leadership and participation in healthcare decision-making (World Health Organization, 2021).

Despite the benefits of shared governance, several challenges persist in implementing this model across Saudi hospitals. The traditional hierarchical hospital structure, combined with cultural resistance to decentralized decision-making, has slowed down the widespread adoption of shared governance (Vroom & Yetton, 1973). Additionally, variations in nurse empowerment levels across different institutions have impacted the effectiveness of governance structures. Addressing these barriers requires strong leadership commitment, structured governance policies, and ongoing training programs to cultivate a collaborative and participatory work culture (Phillippe, 2019).

Nursing shared governance is a transformational model that has demonstrated significant positive effects on hospital performance (O'Grady & Clavelle, 2021). Hospitals that embrace this model report higher patient safety outcomes, improved workflow processes, and increased cost-effectiveness.

In Saudi Arabia, integrating shared governance into hospital management aligns with the country healthcare reforms under Vision 2030, making it an essential strategy for building a high-performing healthcare workforce. As Saudi hospitals continue to expand and develop, shared governance will play a vital role in ensuring better patient care quality, stronger institutional resilience, and long-term workforce engagement (Albargi et al., 2024). Prioritizing this governance model will allow Saudi healthcare institutions to achieve sustainable improvements in service delivery, workforce stability, and overall hospital performance.

1.2 Problem Statement

The efficiency and sustainability of healthcare systems depend mainly on hospital performance, and this performance is affected by governance structures, workforce stability, and operational efficiency. One of the most pressing challenges affecting hospital performance globally is the shortage of nursing professionals, which has reached alarming levels. According to the World Health Organization (WHO), the global nursing shortage affected hospital operations, also increased workloads, stress, and inefficiencies in healthcare delivery (World Health Organization, 2021). Currently, the world has approximately 28 million practicing nurses, yet there remains a deficit of 5.9 million nurses, with projections indicating that this gap will persist, reaching 5.7 million by 2030. The most affected regions include Africa, Southeast Asia, the Middle East, and South America, where hospitals had difficulties maintaining enough staffing levels, resulting in compromised patient care and an increased risk of medical errors (Albargi et al., 2024).

At the regional level, the Eastern Mediterranean region faces a 17% shortage in the nursing workforce, creating severe operational challenges for hospitals and healthcare institutions (Speroni et al., 2021). In Africa, the nurse-to-population ratio stands at 8.7 per 10,000 people, while in Southeast Asia and the Middle East, the ratio is approximately 16 nurses per 10,000 people. This disparity in workforce distribution not only limits access to essential medical services but also overburdens existing hospital staff, leading to increased stress, lower job satisfaction, and declining hospital efficiency (Adkins, 2023). Hospitals in these regions that face chronic nursing shortages experience longer patient wait times, higher rates of preventable complications, and an overall decline in care quality (Jaber et al., 2022).

In Saudi Arabia, nursing shortages present a challenge to hospital quality of care. In 2023, the total number of nurses in the healthcare sector reached 235,461, reflecting a 23% increase since 2020. However, the percentages of Saudi citizens in the nursing workforce remains low at only 37%, showed continued reliance on non Saudi nursing staff (Albargi et al., 2024). The national average for nurses per 1,000 people was reported at 2.2 in 2021, with ambitious targets set to increase this figure to 4.25 per 1,000 people by 2030. Despite these targets, the recruitment and retention of skilled nursing professionals remain challenging due to

global competition for healthcare workers (Brennan & Wendt, 2021). The continued shortage of qualified nurses in Saudi Arabia threatens hospital performance, leading to higher staff turnover, increased medical errors, and reduced patient satisfaction (Speroni et al., 2021).

The consequences of inadequate hospital staffing are extensive, affecting both workforce well-being and patient outcomes. Hospitals with deficient nursing resources reduced patient safety, operational problems, and lower healthcare quality (Kutney-Lee et al., 2020). Nurses working under workloads face higher rates of stress, lower job satisfaction, and a greater rates of leaving the job, further exacerbating workforce shortages (Adkins, 2023). These factors contribute to rising operational costs, declining hospital efficiency, and worsening healthcare outcomes (Jaber et al., 2022). Given Saudi Arabia Vision 2030 healthcare transformation goals, studying workforce problems is essential to improving hospital performance and sustaining healthcare excellence (Albargi et al., 2024).

1.3 Justification

This study will contribute to the theoretical framework of hospital performance and governance models by examining how nursing shared governance will influence the efficiency, quality, and sustainability of hospital operations. Shared governance, as a leadership and management model, will be explored within the context of participatory decision-making, empowerment, and organizational commitment, particularly in the healthcare sector. Through integrating concepts from Health Promotion Theory, Self-Determination Theory, and Organizational Commitment Theory, this research will expand existing literature on how governance structures impact workplace motivation, engagement, and overall hospital efficiency. As Albargi et al. (2024) showed, participatory governance models promote increased engagement and a sense of ownership among healthcare professionals, leading to improved institutional effectiveness.

Theoretical importance

From a theoretical perspective, this study will advance the understanding of how nurse autonomy and involvement in decision-making will contribute to hospital performance. Traditional hospital management structures have placed nurses in subordinate roles, limiting their influence on hospital policies and strategic decisions. This research will challenge hierarchical governance models by providing empirical evidence on how decentralized decision-making frameworks will enhance hospital efficiency, reduce operational inefficiencies, and improve workforce stability. Speroni et al. (2021) showed that governance models that promote nurse participation contribute to improved healthcare delivery and better resource allocation. Furthermore, this study will bridge the gap between leadership theories and hospital performance optimization, offering a foundation for future research on governance frameworks that support hospital sustainability, workforce retention, and patient-centered care.

Additionally, this study will contribute to human resource management theories within the hospital sector by analyzing the relationship between hospital governance, leadership styles, and workforce engagement. As Brennan and Wendt (2021) pointed out, shared governance enhances leadership development among nurses, improving staff engagement and hospital-wide decision-making processes. The study will align with contemporary discussions on healthcare

system resilience and workforce management, reinforcing the importance of collaborative, employee-centered governance models in achieving efficient hospital administration and high-quality patient care.

Practical Importance

The practical significance of this study will lie in its direct application to hospital administration, healthcare leadership, and policy development. Addressing the persistent challenges of hospital inefficiencies, workforce shortages, and operational constraints will become a global priority, and this research will provide evidence-based recommendations for improving hospital performance through shared governance models. As Adkins (2023) observed, shared governance reduces staff turnover and increases retention rates, which significantly improves hospital stability and workforce efficiency.

For hospital administrators and policymakers, this study will show the advantages of nurse-led decision-making structures in creating a more efficient and high-performing hospital environment. When demonstrating how shared governance will enhance hospital workflow, professional accountability, and resource utilization, this study will offer actionable insights for hospitals seeking to improve operational efficiency, optimize workforce retention, and reduce burnout among staff. These findings will be particularly relevant to Saudi Arabia Vision 2030 healthcare strategy, which will prioritize healthcare workforce nationalization, service quality enhancement, and long-term sustainability. Jaber et al. (2022) showed that shared governance improves healthcare outcomes by promoting a collaborative environment where nurses contribute to hospital policies and operational strategies.

For nursing leaders and healthcare practitioners, this study will offer a practical roadmap for implementing shared governance councils, participatory decision-making models, and hospital-wide leadership programs that will empower nurses and enhance institutional efficiency. The study will provide strategic recommendations that can be integrated into hospital operations to strengthen teamwork, improve resource management, and optimize decision-making processes. The research will show how nursing-led governance initiatives will contribute to patient safety, improved care delivery, and enhanced hospital reputation. Speroni

et al. (2021) found that hospitals adopting shared governance models experienced a reduction in patient complications and an increase in healthcare quality metrics.

1.4 Study Objectives

1.4.1 General Objective:

To examine the impact of nursing shared governance on hospital performance in Dr. Sulaiman Al Habib Hospital in Saudi Arabia.

1.4.2 Specific Objectives:

1. To assess the implementation and key characteristics of nursing shared governance in Dr. Sulaiman Al Habib Hospital.
2. To evaluate the hospital performance indicators, including clinical efficiency, patient care quality, and operational effectiveness in Dr. Sulaiman Al Habib Hospital.
3. To analyze the relationship between nursing shared governance and hospital performance, determining how governance structures influence overall institutional effectiveness.

1.5 Study Questions

1.5.1 General Research Question:

What is the impact of nursing shared governance on hospital performance in Dr. Sulaiman Al Habib Hospital in Saudi Arabia?

1.5.2 Specific Research Questions:

1. What are the key characteristics, structure, and implementation strategies of nursing shared governance in Dr. Sulaiman Al Habib Hospital?
2. How does hospital performance, including quality of patient care, clinical efficiency, and operational management, manifest in Dr. Sulaiman Al Habib Hospital?
3. What is the relationship between nursing shared governance and hospital performance, and how do governance practices contribute to improvements in healthcare delivery and institutional efficiency?

1.6 Study Hypothesis

Null Hypothesis (H_0):

There is no significant relationship between nursing shared governance and hospital performance in Dr. Sulaiman Al Habib Hospital in Saudi Arabia.

Alternative Hypothesis (H_1):

There is a significant relationship between nursing shared governance and hospital performance in Dr. Sulaiman Al Habib Hospital in Saudi Arabia.

Chapter Two: Literature review

This study draws upon an integrated theoretical framework comprising four major organizational and behavioral theories that together provide a robust conceptual lens for understanding the impact of nursing shared governance on hospital performance. These theories help elucidate the mechanisms through which participatory leadership, job satisfaction, professional engagement, and institutional trust converge to improve healthcare delivery and operational efficiency within hospital settings.

1. Participatory Decision-Making Theory (Vroom & Yetton, 1973)

At the core of shared governance lies the principle of inclusive decision-making, as articulated in the Participatory Decision-Making Theory proposed by Vroom and Yetton. This theory posits that organizational outcomes improve significantly when employees are actively involved in decisions that affect their roles and responsibilities. In the context of nursing, this implies that engaging nurses in governance structures—such as clinical committees, unit-based councils, or strategic planning forums—enables them to contribute their experiential knowledge to administrative decisions.

Such involvement not only enhances the relevance and feasibility of policy decisions but also increases nurses' ownership of institutional goals. Consequently, hospitals benefit from improved interdisciplinary coordination, reduction in medical errors, and heightened responsiveness to patient needs (Vroom & Yetton, 1973).

2. Herzberg Two-Factor Theory (1959)

Herzberg seminal theory on motivation and job satisfaction distinguishes between hygiene factors (such as salary, work conditions, and job security) and motivators (including achievement, recognition, and growth opportunities). Shared governance aligns strongly with Herzberg framework as it addresses both sets of factors simultaneously.

When providing nurses with a platform to influence clinical and administrative decisions, shared governance enhances their sense of autonomy and professional worth—core motivational drivers. Moreover, this inclusion often coincides with structural improvements

in the work environment, such as transparent leadership, fair workload distribution, and opportunities for continuous professional development. Together, these factors contribute to greater job satisfaction, which in turn supports smoother workflows, reduced turnover, and higher-quality patient care (Herzberg, 1959).

3. Social Exchange Theory (Blau, 1964)

Blau Social Exchange Theory provides a relational foundation for understanding how organizational support mechanisms, such as shared governance, support reciprocal employee behavior. The theory asserts that when employees perceive a high level of investment from the organization—manifested through trust, inclusion, and recognition—they are more likely to reciprocate with loyalty, engagement, and discretionary effort.

Within nursing, shared governance symbolizes a deliberate investment in professional respect and autonomy. As nurses are included in governance processes, they develop a deeper emotional and professional commitment to their institutions. This reciprocal dynamic not only nurtures a culture of trust and collaboration but also contributes to tangible outcomes such as reduced absenteeism, improved retention, and increased operational efficiency (Blau, 1964).

4. Meyer and Allen Three-Component Model of Organizational Commitment (1991)

This model outlines three dimensions of employee commitment: affective (emotional attachment to the organization), continuance (perceived cost of leaving), and normative (sense of obligation to stay). Shared governance primarily influences affective and normative commitment by promoting a sense of belonging and moral duty among nursing staff. When nurses are actively involved in shaping hospital policy, budgeting, quality initiatives, or patient safety programs, they develop a stronger emotional tie to the institution and a deeper sense of responsibility for its success.

These psychological bonds serve as buffers against burnout and turnover, enhancing staff stability and institutional continuity—both of which are essential to high-performing healthcare systems (Meyer & Allen, 1991).

So, these theoretical models collectively provide a comprehensive understanding of how nursing shared governance can serve as a strategic tool to improve hospital performance. Through participatory decision-making, motivation, reciprocal organizational support, and strengthened employee commitment, shared governance emerges as a multifaceted mechanism for enhancing institutional effectiveness, promoting patient-centered care, and sustaining a stable and satisfied nursing workforce.

2.1.4 Relevance to the Current Study

The theoretical foundations discussed above are directly aligned with the objectives and framework of the current study, which investigates the impact of nursing shared governance on hospital performance at Dr. Sulaiman Al Habib Hospital in Riyadh, Saudi Arabia. Each theory offers critical explanatory power for understanding how shared governance mechanisms contribute to operational excellence, staff engagement, and patient care quality.

Participatory Decision-Making Theory is central to this study as it supports the premise that involving nurses in institutional governance enhances decision-making quality, reduces communication breakdowns, and promote interdisciplinary collaboration. In a complex healthcare environment where frontline knowledge is vital, this theory justifies the inclusion of nurses in organizational structures, thereby reinforcing the study assumption that shared governance positively influences hospital operations.

Herzberg Two-Factor Theory underlines the dual influence of shared governance on both extrinsic and intrinsic aspects of nursing roles. The study hypothesizes that when nurses are empowered through governance roles, they are more satisfied with their jobs, which translates into improved commitment and clinical performance. Herzberg framework therefore validates the study focus on governance not only as an administrative model but also as a motivator for professional growth.

Social Exchange Theory reinforces the conceptual link between shared governance and workforce stability. The study posits that when nurses perceive the organization as supportive and inclusive, they are more likely to respond with loyalty, reduced turnover intention, and higher

productivity. This mutual reinforcement strengthens the proposed relationship between governance and key performance indicators such as efficiency, safety, and collaboration.

Lastly, **Meyer and Allen Organizational Commitment Model** provides a deeper understanding of how shared governance impacts long-term retention and institutional continuity. The current study assesses not just performance outcomes but also workforce behaviors—such as job satisfaction, role commitment, and engagement—all of which are influenced by the emotional and ethical bonds nurses develop through participatory governance structures.

2.2 Conceptual Framework

The conceptual framework guiding this study is informed by participatory leadership theories, organizational behavior models, and empirical literature on healthcare governance. It is constructed to explore the pathways through which nursing shared governance influences hospital performance. The framework showed the role of participatory decision-making, autonomy, and nurse engagement in shaping operational efficiency, clinical outcomes, and organizational effectiveness. Additionally, it recognizes the potential moderating role of demographic and professional characteristics in influencing governance outcomes.

2.2.1 Independent Variable: Nursing Shared Governance

Nursing shared governance is conceptualized as the independent variable. It refers to the decentralized organizational structures that empower nurses to participate in institutional decision-making, policy formulation, and clinical leadership. The construct is operationalized across four key dimensions, derived from literature and governance assessment models:

- **Governance Control:** The extent to which nurses have authority over clinical practices, care models, and administrative processes affecting nursing work.
- **Official Authority Over Governance:** The degree to which formal institutional policies support nurse-led decision-making and structural empowerment.
- **Participation in Governance Committees:** Involvement of nurses in organizational committees, task forces, and strategic planning forums.
- **Access to Information:** Availability and transparency of operational data, clinical guidelines, and performance metrics that allow nurses to make informed decisions.

These dimensions collectively capture the degree of autonomy, collaboration, and leadership exercised by nurses within the governance structure. The theoretical underpinnings are rooted in **Participatory Decision-Making Theory** (Vroom & Yetton, 1973), **Herzberg Two-Factor Theory** (1959), and **Social Exchange Theory** (Blau, 1964), which collectively showed the impact of engagement and empowerment on organizational effectiveness.

2.2.2 Dependent Variable: Hospital Performance

Hospital performance is conceptualized as the **dependent variable**, encompassing the institution ability to deliver safe, efficient, and high-quality care. It is measured through four composite indicators aligned with global healthcare performance frameworks:

- **General Evaluation of Healthcare Quality:** Reflecting compliance with clinical standards and patient care protocols.
- **Compliance with Patient Safety Standards:** Capturing implementation of safety measures, training, and reporting systems.
- **Operational Efficiency and Resource Management:** Assessing use of medical resources, scheduling, and patient throughput.
- **Medical Staff Participation in Clinical Governance:** Reflecting interdisciplinary collaboration, decision-making inclusivity, and professional engagement.

These domains are supported by **hospital quality literature** and measurement tools such as hospital accreditation standards and patient safety indicators. The theoretical foundation for performance outcomes is reinforced by **Meyer and Allen Organizational Commitment Model** (1991), which links staff engagement and loyalty with institutional success.

2.2.3 Other Variables: Demographic and Professional Characteristics

Demographic and professional variables are treated as **moderating variables** in this study. These include gender, age, years of experience, education level, certification status, job title, type of nursing unit, and employment status. These characteristics may influence how nurses perceive their governance roles and how effectively these roles translate into performance outcomes.

For instance:

- **Nurses with longer experience** may value stability and structured governance more than newer staff, who may prioritize autonomy and innovation.

- **Educational background** may shape understanding and engagement with policy and clinical decision-making processes.
- **Job position and department** may moderate the level of access to decision-making platforms or influence in institutional planning.

These moderators help contextualize the effect of shared governance within diverse professional settings, and are theoretically supported by **Social Exchange Theory** and **Organizational Commitment Theory**, both of which show the importance of role clarity, perceived fairness, and individual agency.

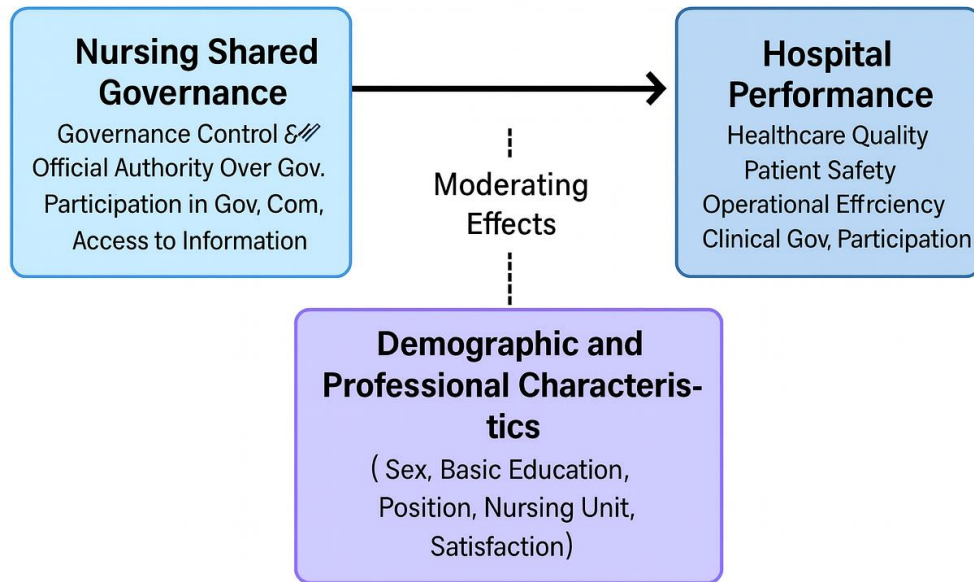
Hypothesized Relationships

Based on the conceptual framework and theoretical foundations, the following relationships are posited:

1. **Nursing shared governance is positively associated with hospital performance** across efficiency, safety, and clinical quality domains.
2. **Different dimensions of shared governance** (e.g., participation in committees, access to information) may vary in their influence on specific performance outcomes.
3. **Demographic and professional variables moderate** the relationship between shared governance and performance, strengthening or weakening the effect depending on background factors.

This conceptual framework integrates theoretical models with empirical evidence to capture the complexity of governance-performance dynamics in healthcare institutions. It offers a structured lens to examine how participatory nursing leadership contributes to systemic efficiency, and how contextual variables shape these interactions. In the setting of Saudi Arabia's private hospital sector, where performance optimization and staff retention are strategic priorities, this model provides practical and scholarly value in guiding both evaluation and reform.

Conceptual Framework



Study framework

2.3 Previous studies

Research on nursing shared governance and hospital performance has gained significant attention due to its role in enhancing healthcare efficiency, patient outcomes, and workforce stability. Numerous studies have explored how shared governance structures contribute to improved decision-making, operational effectiveness, and overall hospital quality. Existing literature suggests that hospitals implementing shared governance models experience better workflow coordination, reduced medical errors, and stronger staff engagement. These studies also showed the impact of shared governance on hospital-wide collaboration, showing its role in promoting a culture of accountability and professional autonomy among nursing staff. The following review presented studies that assessed the relationship between nursing shared governance and hospital performance, providing empirical evidence on its effectiveness in improving healthcare delivery and institutional efficiency.

Albargi et al. (2024) conducted a qualitative study in Saudi Arabia to examine how nursing shared governance influences hospital performance by analyzing nurses' perspectives, experiences, and challenges within governance structures. The study explored factors that either facilitate or hinder the integration of nurses in hospital decision-making processes. Using semi-structured interviews with 13 registered nurses, the study revealed that many nurses had limited understanding of shared governance but acknowledged its potential to enhance hospital efficiency and care quality. The findings indicated that hospitals with structured shared governance models experienced better workflow coordination, improved staff morale, and higher levels of operational efficiency. Nurses involved in governance reported greater trust in hospital leadership, better interdepartmental communication, and more effective resource utilization. The study concluded that nursing shared governance positively influences hospital performance by increasing workforce engagement and optimizing healthcare operations. However, it showed the need for stronger leadership support and structured governance policies to maximize its benefits in Saudi hospitals.

Phillippe et al. (2019) investigated the effect of nursing shared governance on hospital performance in the United States, focusing on how governance models impact hospital efficiency, decision-making processes, and staff collaboration. The study found that shared governance

promote improved hospital performance by promoting interprofessional collaboration and increasing nursing accountability. Hospitals with established shared governance structures reported enhanced decision-making efficiency, fewer medical errors, and improved patient satisfaction scores. The study concluded that integrating nurses into governance strengthens hospital workflow, reduces inefficiencies, and improves financial management by lowering turnover costs and enhancing staff retention. It showed that hospitals adopting shared governance benefit from a more engaged nursing workforce, optimized hospital operations, and improved healthcare delivery.

Owen et al. (2021) conducted a study examining the impact of shared governance on hospital efficiency and institutional effectiveness. Using a quantitative cross-sectional design, the study surveyed 69 full-time faculty and staff members to analyze their perceptions of governance structures. The results indicated that hospitals with participatory governance models demonstrated higher workflow efficiency, improved hospital coordination, and reduced administrative bottlenecks. The study further revealed that nurses in hospitals with strong shared governance frameworks reported higher engagement in decision-making, which contributed to streamlined hospital operations and improved patient care standards. The findings showed that shared governance is a key factor in optimizing hospital performance by enhancing communication, reducing workplace conflicts, and improving hospital resource allocation.

Adkins et al. (2023) examined the role of nursing shared governance in improving hospital efficiency and service quality in acute care settings. The study was prompted by rising nurse attrition rates and hospital performance challenges, showing the need for governance models that support workforce retention and operational efficiency. The study found that hospitals that implemented shared governance experienced a 25% improvement in patient throughput, reduced administrative delays, and increased staff collaboration. Additionally, hospitals with strong shared governance structures reported lower medical error rates, higher patient safety scores, and improved hospital-wide communication. The study concluded that shared governance is a practical, cost-effective approach to strengthening hospital performance by improving efficiency, workforce stability, and patient care delivery.

Jaber et al. (2022) explored the effects of nursing shared governance on hospital performance in Jordan, focusing on governance structures in clinical settings. The study, which surveyed 111 nurses, found that shared governance positively influenced hospital operations by improving clinical decision-making processes and strengthening hospital management efficiency.

The study showed that hospitals with participatory governance models reported better coordination between nursing and administrative teams, improved patient flow management, and more effective resource allocation. However, it also showed challenges related to limited nurse involvement in strategic decision-making, suggesting that further efforts are needed to reinforce shared governance as a driver of hospital performance improvement.

Kutney-Lee et al. (2020) conducted a study examining the relationship between nursing shared governance and hospital-wide performance indicators. The study analyzed secondary data from multiple hospitals and found that higher levels of nurse participation in governance correlated with improved hospital efficiency, lower patient complication rates, and increased operational stability. Hospitals with strong governance frameworks demonstrated a 15% reduction in patient readmission rates, a 20% increase in patient safety scores, and overall higher efficiency in hospital administration. The study concluded that shared governance serves as a valuable hospital management strategy, improving workflow processes and reducing inefficiencies in hospital settings.

Brennan and Wendt (2021) investigated how nursing shared governance enhances hospital performance by improving quality control and patient outcomes. The study focused on hospitals implementing structured governance models to optimize workflow processes and enhance service delivery. Findings indicated that hospitals utilizing shared governance frameworks reported a 30% improvement in overall hospital efficiency, a 20% increase in staff engagement, and a 10% reduction in patient wait times. The study concluded that nursing shared governance leads to significant performance gains by promoting transparency, optimizing resource allocation, and reducing inefficiencies in hospital management.

Speroni et al. (2021) conducted an international comparative study to assess how nursing shared governance affects hospital performance across multiple countries. Analyzing data from 2,170 nurses across 205 hospital units, the study found that hospitals with well-established shared

governance models consistently outperformed traditional governance structures in efficiency, safety, and patient satisfaction. The findings demonstrated that hospitals with high levels of nurse engagement in governance achieved a 25% improvement in hospital-wide efficiency metrics, a 30% reduction in adverse patient events, and stronger staff collaboration. The study concluded that shared governance is a critical strategy for optimizing hospital performance, regardless of geographical and institutional differences.

2.4 Critical analysis

Research on nursing shared governance has consistently showed its significance in improving hospital performance across diverse settings. Collectively, the studies reviewed demonstrate strong empirical support for the positive impact of shared governance on workflow coordination, patient safety, staff engagement, and hospital-wide efficiency. However, a critical reading reveals notable differences in the scope, methodologies, and contextual challenges that shape the application and outcomes of shared governance models.

Albargi et al. (2024) provided valuable insights into the Saudi healthcare context through a qualitative exploration of nurses' perceptions and experiences. The study revealed that despite the limited awareness among participants, shared governance was perceived as a potential driver of hospital efficiency and interdepartmental trust. The strength of this study lies in its contextual specificity and its focus on frontline nurses' voices. However, the small sample size (13 participants) and reliance on subjective accounts limit its generalizability. This contrasts with Phillippe et al. (2019), who used a broader institutional lens in the U.S. and found more robust associations between shared governance and hospital outcomes such as reduced errors and enhanced collaboration. Their findings showed cost savings and staff retention, which were less prominent in Albargi et al.'s narrative.

Similarly, Owen et al. (2021) used a quantitative cross-sectional approach and validated the operational benefits of participatory governance, including reduced administrative inefficiencies and stronger coordination. Their use of staff surveys enhanced the objectivity of findings, but the limited sample (69 participants) and single-method design may have constrained deeper analysis of causal relationships. In contrast, Adkins et al. (2023) showed tangible institutional gains such as a 25% increase in patient throughput and improved safety metrics in acute care settings. Their

study strengthened the economic argument for shared governance but lacked longitudinal data to confirm the sustainability of these improvements over time.

Regional variations were also evident. Jaber et al. (2022), in their Jordanian study, echoed many of the benefits reported in previous literature, such as improved resource allocation and team coordination. Nonetheless, they identified persistent challenges in involving nurses in strategic planning, a theme less showed in Western studies. This suggests cultural or structural barriers in some healthcare systems that may hinder the full realization of shared governance's potential. Likewise, Kutney-Lee et al. (2020) utilized secondary data analysis across U.S. hospitals and showed quantitative improvements in clinical outcomes, such as reductions in readmissions and complications. Their findings were robust due to the breadth of hospital-level indicators analyzed, but the study design limited the understanding of how governance practices were operationalized on the ground.

Brennan and Wendt (2021) further showed performance gains including enhanced staff engagement and decreased patient wait times, reinforcing the efficiency narrative surrounding shared governance. Their data suggested that structured governance contributes to transparency and quality control. However, the study lacked details on contextual variables such as hospital size or specialty, which could influence implementation. Finally, Speroni et al. (2021) offered a global perspective with a large multinational sample of over 2,000 nurses, revealing consistent performance improvements across hospital systems that adopted shared governance. The cross-country comparison added weight to the universality of shared governance benefits, though the study faced challenges in controlling for institutional and cultural variations across sites.

In sum, while the reviewed studies provide compelling evidence that shared governance enhances hospital performance, critical analysis reveals variability in measurement approaches, depth of implementation, and contextual barriers. Studies conducted in high-income countries tend to report stronger integration of governance frameworks, clearer performance metrics, and more stable institutional support. In contrast, studies from the Middle East showed structural limitations and a need for leadership buy-in and cultural change. The effectiveness of shared governance, therefore, appears contingent not only on the presence of governance structures but also on how these are supported, understood, and operationalized within specific healthcare environments.

2.5 Literature Gap

Despite the growing body of research on nursing shared governance and hospital performance, significant gaps remain in both global and regional contexts. Globally, existing studies have primarily focused on the impact of shared governance on nursing engagement, job satisfaction, and workforce retention, with limited dependence on how shared governance influences broader hospital performance metrics, such as patient care quality, resource utilization, and operational efficiency. While research from countries like the United States and the United Kingdom has demonstrated the positive effects of shared governance on staff collaboration and institutional effectiveness, fewer studies have provided comprehensive quantitative assessments of its direct impact on hospital-wide performance indicators, including financial sustainability and patient safety outcomes. Additionally, most studies have been conducted in Western healthcare settings, with limited investigation into how shared governance models operate in non-Western healthcare systems where cultural and organizational factors may present unique challenges.

In Saudi Arabia, research on nursing shared governance within hospital performance frameworks remains limited. Existing studies have largely explored nurse participation in decision-making and leadership development, but few have examined the direct correlation between shared governance and hospital efficiency, patient outcomes, and institutional effectiveness. The Saudi healthcare system is undergoing rapid transformation under Vision 2030, with increasing dependence on improving governance structures, enhancing workforce engagement, and optimizing hospital operations. However, the extent to which nursing shared governance has been successfully implemented and its measurable impact on hospital performance in Saudi hospitals remains underexplored. Additionally, there is a lack of region-specific empirical evidence on how shared governance can address challenges related to workforce retention, hospital workflow optimization, and patient safety improvements in the Saudi healthcare context.

2.6 The contribution of the current study

This study aims to bridge these gaps by providing a comprehensive examination of the impact of nursing shared governance on hospital performance in Saudi Arabia. Unlike previous studies that have focused solely on workforce engagement and leadership participation, this research will assess both qualitative and quantitative performance indicators, including hospital efficiency,

operational workflows, patient care outcomes, and institutional sustainability. The findings of this research will contribute to policy development, hospital management strategies, and the advancement of participatory governance models in the region, ultimately supporting the long-term sustainability of the Saudi healthcare sector.

Chapter three: Methods

3.1 Study Design

This study used a quantitative, observational, cross-sectional hospital based research design

3.2 Study Setting

The study was conducted at Dr. Sulaiman Al Habib Hospital in Riyadh, a leading private healthcare institution in Saudi Arabia known for its advanced medical services and large nursing workforce. Dr. Sulaiman Al Habib Hospital in Riyadh is part of the Dr. Sulaiman Al Habib Medical Group, one of the leading healthcare providers in the Middle East. Established in 1995, the group has expanded to include multiple hospitals and medical centers across Saudi Arabia, the UAE, and Bahrain. The hospital in Riyadh is known for its state-of-the-art medical facilities, advanced technology, and highly skilled healthcare professionals.

3.3 Study Duration

The study was conducted over a period of six months, including survey development, data collection, analysis, and reporting.

3.4 Study Population

The target population consists of registered nurses employed at Dr. Sulaiman Al Habib Hospital.

3.4.1 Inclusion Criteria

- Registered nurses employed at Dr. Sulaiman Al Habib Hospital.
- Nurses with at least six months of work experience in the hospital.
- Nurses willing to participate in the study and provide informed consent.

3.4.2 Exclusion Criteria

- Nurses with less than six months of employment at the hospital.
- Administrative staff or healthcare professionals other than nurses.
- Nurses on extended leave (e.g., maternity leave, medical leave) during the study period.
- Nurses unwilling to participate or fail to provide informed consent.

3.5 Sampling

3.5.1 Sample size

Since this was a cross-sectional study, with known number of population (number of participants in the study area and duration who fulfilled the study criteria), the size of the study can be determined through the following formula:

$$n = N / (1 + N (e)^2)$$

Where n is the sample size and N is the population size (number of nurses who fulfilled with the study criteria).

Estimated population size = 699 participants

So, the sample size (n) = $699 / (1 + 699 \times (0.05 \times 0.05)^2) = 255$ participants

3.5.2 Sampling Technique

To ensure a representative sample, the nursing workforce was stratified based on hospital departments, including Intensive Care Unit (ICU), Emergency Department, Surgery, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Outpatient Services. The proportion of nurses selected from each department was aligned with their actual distribution within the hospital, ensuring that the sample accurately reflects the diverse roles and responsibilities within the nursing staff.

3.6 Data Collection Tools

This study utilized a structured self-administered questionnaire composed of three main parts to collect data on participants' demographic and professional characteristics, perceptions of nursing shared governance, and evaluation of hospital performance. Each tool was selected based on its relevance to the research variables and its prior validation in healthcare research contexts.

1. **Part One:** Demographic and Professional Characteristics (13 Items) This section gathered essential demographic and occupational data from the participants. It included 13 items covering sex, age, basic nursing educational preparation, highest academic degree, employment status, total years in nursing practice, current position title, type of nursing unit, number of years in the current institution, number of years in the current position, specialty certification, and a self-rating of professional satisfaction.

These variables were essential in describing the sample profile and served as potential covariates in analyzing the relationship between governance and performance. All items in this section were adapted from the Index of Professional Nursing Governance (IPNG) 3.0 developed by Hess (2017).

2. **Part Two:** Index of Professional Nursing Governance (36 Items, 5 Dimensions) The second section assessed the extent of nurses' involvement in governance processes within their institutions. It was based on the IPNG 3.0, a validated instrument originally developed by Hess (1998) and revised in 2013 and 2017. The tool comprised 36 items categorized into five core dimensions:
 - Governance Control (8 items): Measured the level of authority nurses exercised over clinical practice standards and workplace policies.
 - Influence on Decision-Making (8 items): Assessed the extent to which nurses influenced key operational decisions, such as budgeting, staffing, and interdisciplinary consultation.
 - Official Authority Over Governance (7 items): Captured the formal governance roles assigned to nurses, particularly in setting hiring standards, salary structures, and disciplinary policies.

- Participation in Governance Committees (5 items): Evaluated nurses' participation in unit-level, departmental, and organizational committees.
- Access to Information (5 items): Measured how accessible essential institutional information was to nurses, including satisfaction data, turnover rates, and strategic plans.

Each item was rated using a five-point Likert scale ranging from 1 ("Nursing Management Only") to 5 ("Staff Nurses Only"), reflecting the perceived distribution of governance responsibility.

3. **Part Three:** Hospital Performance Assessment Questionnaire (16 Items, 4 Domains)

The third section evaluated hospital performance using a tool adapted from internationally recognized accreditation standards, with particular reference to the Rwandan Hospital Accreditation Standards Performance Assessment Toolkit (3rd Edition, 2022). It consisted of 16 items grouped into four key domains:

- General Evaluation of Healthcare Quality (4 items): Assessed the presence of standardized assessment protocols, documentation quality, and availability of clinical guidelines.
- Compliance with Patient Safety Standards (4 items): Evaluated the hospital implementation of infection control measures, error reporting, staff safety training, and PPE provision.
- Operational Efficiency and Resource Management (4 items): Measured effective use of hospital space, scheduling efficiency, supply chain management, and emergency preparedness.
- Medical Staff Participation in Clinical Governance (4 items): Explored the involvement of physicians and nurses in quality initiatives, decision-making, and governance structures.

Responses were recorded using a four-point ordinal scale: 0 = Not Implemented, 1 = Partially Implemented, 2 = Implemented with Required Improvements, 3 = Fully Implemented.

The data collection tool consisted of 65 items across all sections. The instrument was developed in English and reviewed by field experts to ensure its content validity and relevance to the Saudi healthcare context.

3.7 Data Collection Procedure

- The survey was conducted both electronically (via Google Forms) and through printed copies distributed to eligible nurses at Dr. Sulaiman Al Habib Hospital, Riyadh.
- Inclusion criteria: Participants must have been employed for at least six months in their current role to ensure familiarity with governance structures and hospital performance standards.
- Informed consent was obtained before survey administration, showing voluntary participation and data privacy.
- The data collection process was last four weeks, with periodic reminders sent to maximize response rates.

3.8 Data Analysis:

- Descriptive Statistics – Mean, standard deviation, and frequency distributions for demographic and hospital performance variables.
- Inferential Statistics – Pearson correlation and multiple regression analysis to examine relationships between shared governance and hospital performance indicators.
- Statistical Software: SPSS (Version 28.0) was used for data analysis.

3.9 Ethical Considerations

- Ethical approval was obtained from the hospital's Institutional Review Board (IRB) before data collection.

- Participants received an informed consent form explaining the study purpose, confidentiality, and voluntary participation.
- Data was anonymous and stored securely to protect participant privacy.
- No personal data was collected.
- Participants can withdraw at any stage without consequences.
- Digital data was password-protected, and printed questionnaires were stored in a locked cabinet accessible only to the research team.

3.10 Budget

This study was self-funded by the researcher.

Chapter four: Results

4.1 Demographic Characteristics of the Participants

The gender distribution of the study participants, as shown in Table (1), revealed an almost equal representation of male and female nurses. Out of the 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital in 2025, 128 (50.2%) were female and 127 (49.8%) were male. This near parity indicates a balanced gender composition among the nursing workforce in the institution.

Table (2) presented the distribution based on basic nursing educational preparation. The largest group of participants held an Associate Degree in Nursing ($n = 90$; 35.3%), followed by Nursing Diploma holders ($n = 83$; 32.5%), and those with a Baccalaureate Degree in Nursing ($n = 82$; 32.2%). This indicates a fairly even spread across the three educational categories, reflecting diversity in entry-level nursing qualifications.

In terms of the highest educational degrees attained (Table 3), the participants demonstrated a wide academic range. The most frequently reported degrees were Associate Degree in Nursing (16.5%), Master Degree (non-nursing) at 15.7%, and Baccalaureate Degree in Nursing and Doctorate in Nursing, each at 15.3%. Fewer participants held Nursing Diplomas (12.2%) or Doctorate degrees in non-nursing fields (11.8%). This variety suggests considerable investment in advanced and interdisciplinary education among the nurses.

As shown in Table (4), most of the respondents ($n = 136$; 53.3%) were employed on a full-time basis, while 119 (46.7%) worked part-time. This showed a near-balanced distribution, indicating flexible employment structures at the hospital.

Regarding position titles (Table 5), the participants were fairly equally distributed across four roles. Staff Nurses (24.3%) and Educators (28.2%) formed the largest segments, followed by Head Nurses (23.9%) and Charge Nurses (23.5%). This distribution reflects a workforce engaged across both clinical and educational functions.

Table (6) displayed the distribution by type of nursing unit. The highest proportion of nurses were assigned to psychiatry units (11.0%) and maternity units (10.2%), followed by the operating room

(9.4%) and medical units (9.0%). Other units such as emergency room, recovery room, and pediatrics also had moderate representation, indicating a comprehensive spread across specialized and general care areas.

Regarding specialty certification (Table 7), 46.7% of participants held such certifications, while 53.3% did not. This suggests that slightly over half of the sample had not pursued formal specialty validation, which may have implications for workforce development initiatives.

Participants' overall satisfaction levels were reported in Table (8). The most common rating was "2" (24.3%), followed closely by "3" (21.6%) and "1" (20.8%). Higher ratings of "4" and "5" were reported by 15.7% and 17.6% of participants, respectively. These findings reflect a somewhat polarized satisfaction landscape, with a notable proportion expressing low to moderate contentment.

Table (1): The distribution of the participants according to their gender

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Sex	Frequency	Percent
Female	128	50.2%
Male	127	49.8%
Total	255	100.0%

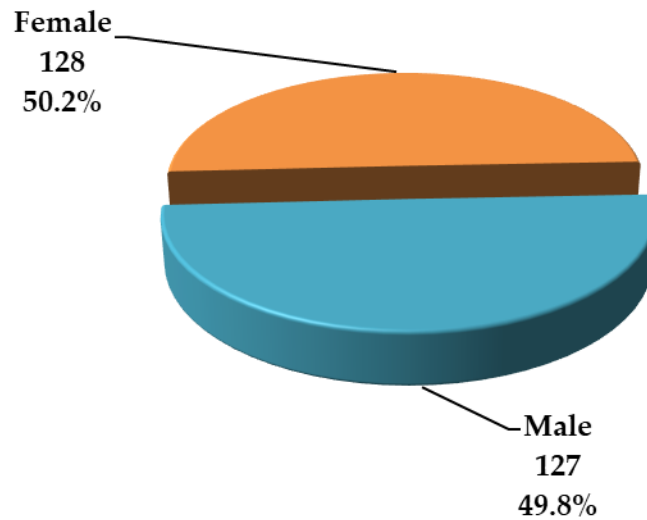


Figure (1): The distribution of the participants according to their gender

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Table (2): The distribution of participants by Basic Nursing Educational Preparation

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Basic Nursing Educational Preparation	Frequency	Percent
Associate Degree in Nursing	90	35.3%
Baccalaureate Degree in Nursing	82	32.2%
Nursing Diploma	83	32.5%
Total	255	100.0%

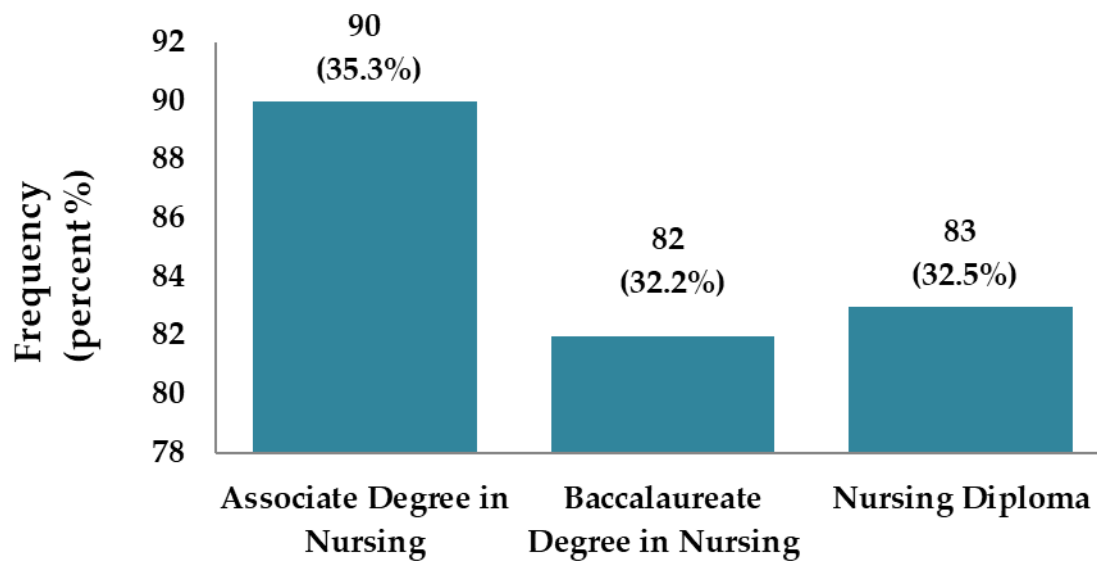


Figure (2): The distribution of participants by Basic Nursing Educational Preparation

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Table (3): The distribution of participants by Highest Educational Degree Attained

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Highest Educational Degree Attained	Frequency	Percent
Associate Degree in Nursing	42	16.5%
Baccalaureate Degree in Nursing	39	15.3%
Doctorate (Non-Nursing)	30	11.8%
Doctorate in Nursing	39	15.3%
Master Degree (Non-Nursing)	40	15.7%
Master Degree in Nursing	34	13.3%
Nursing Diploma	31	12.2%
Total	255	100.0%

Table (4): The distribution of participants by Employment Status

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Employment Status	Frequency	Percent
Full-time	136	53.3%
Part-time	119	46.7%
Total	255	100.0%

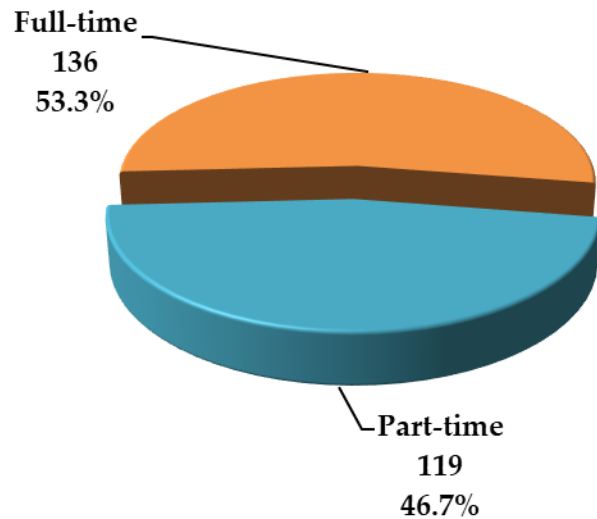


Figure (3): The distribution of participants by Highest Educational Degree Attained

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Table (5): The distribution of participants by Current Position Title

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Current Position Title	Frequency	Percent
Charge Nurse	60	23.5%
Educator	72	28.2%
Head Nurse	61	23.9%
Staff Nurse	62	24.3%
Total	255	100.0%

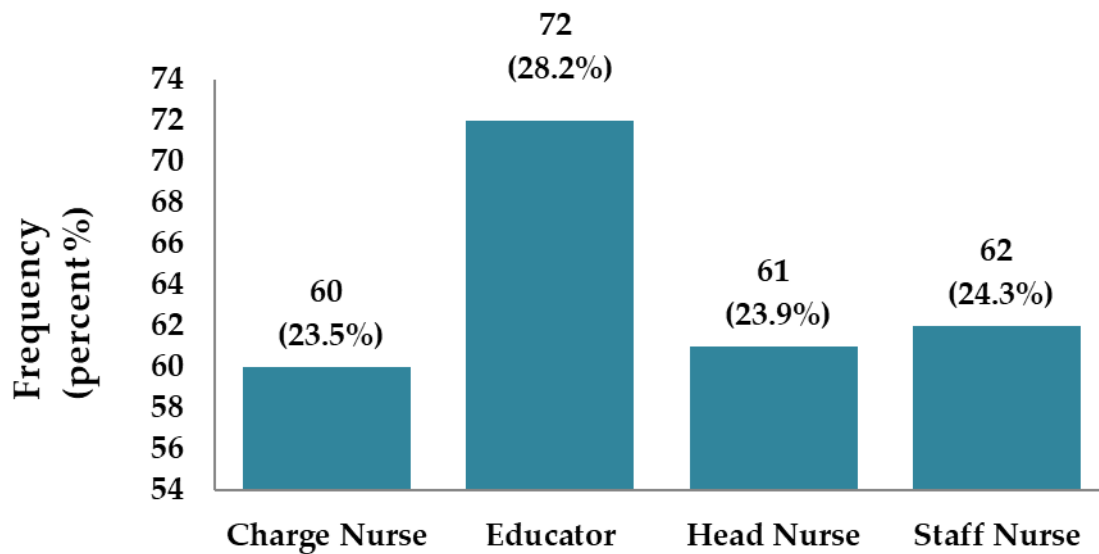


Figure (4): The distribution of participants by Current Position Title

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Table (6): The distribution of participants by Type of Nursing Unit

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Type of Unit	Frequency	Percent
Clinic	18	7.1%
Critical Care	16	6.3%
Education	14	5.5%
Emergency Room	22	8.6%
Maternity	26	10.2%
Medical	23	9.0%
Operating Room	24	9.4%
Other	14	5.5%
Pediatrics	18	7.1%
Psychiatry	28	11.0%
Quality Management	13	5.1%
Recovery Room	23	9.0%
Surgical	16	6.3%
Total	255	100.0%

Table (7): The distribution of participants by Specialty Certification Status

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Specialty Certification	Frequency	Percent
No	136	53.3%
Yes	119	46.7%
Total	255	100.0%

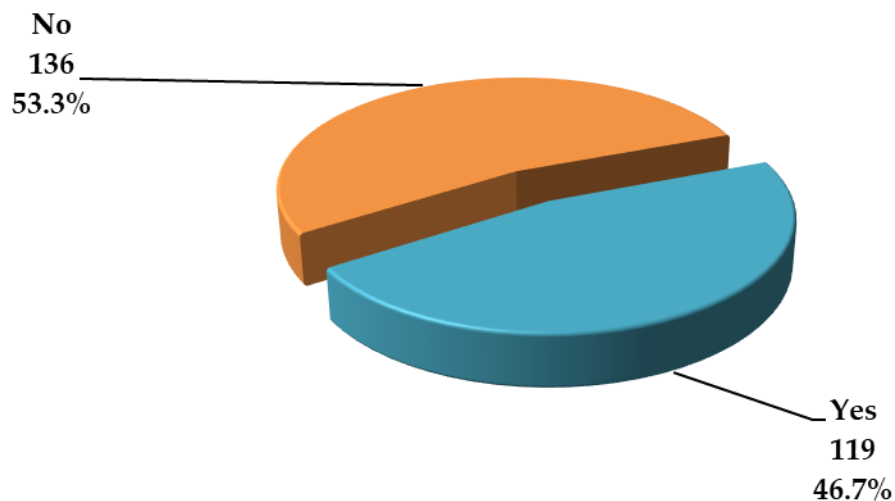


Figure (5): The distribution of participants by Specialty Certification Status

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Table (8): The distribution of participants by Overall Satisfaction Level

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Satisfaction Rating	Frequency	Percent
1 (Lowest)	53	20.8%
2	62	24.3%
3	55	21.6%
4	40	15.7%
5 (Highest)	45	17.6%
Total	255	100.0%

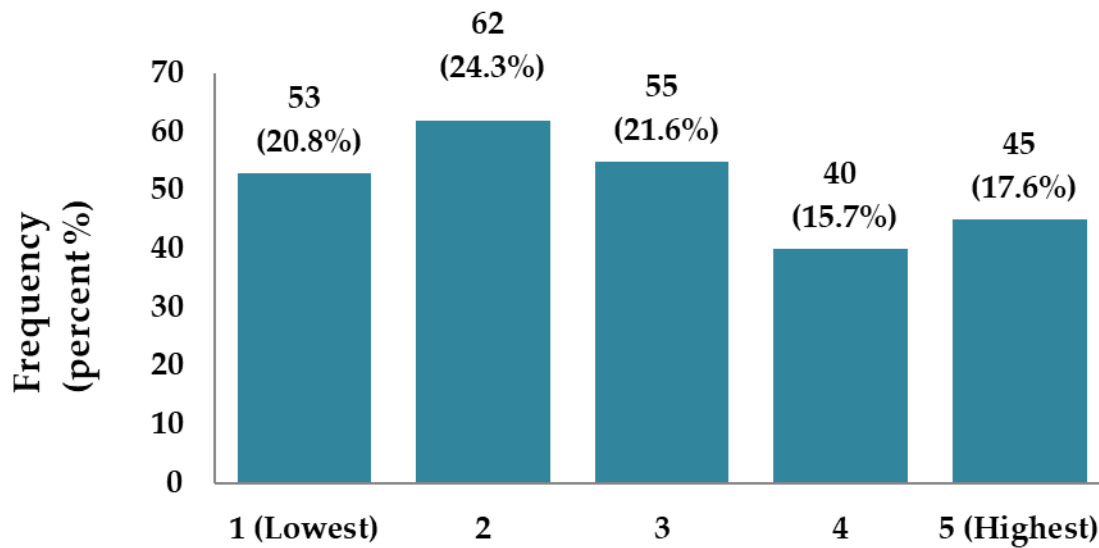


Figure (6): The distribution of participants by Overall Satisfaction Level

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Descriptive Characteristics

Table (9) provided descriptive statistics for continuous variables. The average age of participants was 41.27 years (SD = 11.24), with a range from 22 to 60 years. On average, nurses had 17.13 years of total nursing practice experience, had been at the current institution for 15.04 years, and held their current position for 10.59 years. These values reflect a generally experienced and stable nursing workforce.

Table (9): Descriptive Statistics of Selected Continuous Variables

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Variable	Minimum	Maximum	Mean	Standard Deviation
Age	22	60	41.27	11.239
Total Years in Nursing Practice	1	35	17.13	10.298
Number of Years in This Institution	1	30	15.04	8.669
Number of Years in Current Position	1	20	10.59	6.076

4.2 Governance Dimensions

Table (10) detailed the governance-related dimensions. The overall mean scores for various governance activities ranged around 3.00 on a 5-point scale. The highest individual item scores included conducting disciplinary actions (mean = 3.21), organizational job structure (mean = 3.15), and making daily patient care assignments (mean = 3.10). The composite scores indicated a moderate level of engagement across governance control (3.01), official authority (3.02), participation in governance committees (2.96), access to information (3.01), and an overall governance mean score of 3.00, suggesting a fairly neutral perception of shared governance among participants.

Table (10): Descriptive Statistics of Governance Dimensions and Items

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Variable	Mean $\pm$ SD
Determining bedside nursing practices	3.07 $\pm$ 1.39
Developing and evaluating patient care policies, procedures, and protocols	2.98 $\pm$ 1.41
Establishing qualifications for nursing positions	2.97 $\pm$ 1.43
Determining activities of ancillary nursing personnel	3.05 $\pm$ 1.40
Conducting disciplinary actions for nursing personnel	3.21 $\pm$ 1.39
Assessing and providing for nursing staff development	3.02 $\pm$ 1.36
Selecting products used in nursing care	2.86 $\pm$ 1.41
Determining nursing care delivery models (e.g., primary, team-based)	3.07 $\pm$ 1.43
Governance Control Score	3.01 $\pm$ 0.44
Making daily patient care assignments	3.10 $\pm$ 1.45
Regulating patient admissions, transfers, and discharges	2.98 $\pm$ 1.42
Formulating annual unit budgets	2.92 $\pm$ 1.45
Recommending nursing salaries, raises, and benefits	2.89 $\pm$ 1.40
Consulting with external nursing specialists	2.96 $\pm$ 1.37
Consulting with non-nursing departments	3.05 $\pm$ 1.47

Variable	Mean $\pm$ SD
Creating new clinical positions	2.98 $\pm$ 1.38
Creating new administrative or support positions	3.03 $\pm$ 1.42
Governance Control Score (Alternative)	2.99 $\pm$ 0.48
Credentialing and hiring standards for RNs	2.97 $\pm$ 1.49
Organizational job structure (who reports to whom)	3.15 $\pm$ 1.37
Disciplinary policies for nursing personnel	3.03 $\pm$ 1.36
Hiring and transferring nursing staff	3.13 $\pm$ 1.40
Policies for promoting nurses to leadership roles	2.98 $\pm$ 1.39
Budget recommendations for nursing units	2.85 $\pm$ 1.42
Adjusting nursing salaries and benefits	3.03 $\pm$ 1.41
Official Authority Over Governance Score	3.02 $\pm$ 0.54
Unit-level administrative committees	3.07 $\pm$ 1.33
Nursing department committees for administrative matters	2.90 $\pm$ 1.47
Interprofessional committees for collaborative practice	2.99 $\pm$ 1.41
Hospital administration committees for strategic planning	2.91 $\pm$ 1.42
Forming new nursing departmental committees	2.93 $\pm$ 1.35
Participation in Governance Committees Score	2.96 $\pm$ 0.67
Compliance with regulatory agencies	3.10 $\pm$ 1.39
Unit and departmental goals and objectives	3.07 $\pm$ 1.44
Organizational strategic plans	2.96 $\pm$ 1.43
Results of patient satisfaction surveys	3.02 $\pm$ 1.36
Nurse turnover and vacancies	2.91 $\pm$ 1.44
Access to Information Score	3.01 $\pm$ 0.63
Overall Governance Mean Score	3.00 $\pm$ 0.26

4.3 Hospital Performance Measures

As shown in Table (11), hospital performance indicators received notably lower mean scores. General healthcare quality evaluation had a mean of 1.56, while compliance with patient safety standards and operational efficiency both scored around 1.49–1.55. Medical staff participation in clinical governance received the lowest score (mean = 1.48). The overall hospital performance mean score was 1.52, suggesting that participants perceived performance measures as suboptimal compared to governance perceptions.

Table (11): Descriptive Statistics of Hospital Performance Domains and Items

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Variable	Mean $\pm$ SD
Medical assessments for all admitted patients are conducted according to procedures	1.60 $\pm$ 1.08
Patient conditions are reassessed regularly in accordance with hospital standards	1.55 $\pm$ 1.10
All assessments are documented clearly in medical records	1.54 $\pm$ 1.14
Written guidelines for clinical assessments are available	1.56 $\pm$ 1.11
General Evaluation of Healthcare Quality score	1.56 $\pm$ 0.59
Infection prevention policies are implemented in all departments	1.55 $\pm$ 1.13
All medical errors are recorded and reported	1.48 $\pm$ 1.12
Staff undergoes periodic training on safety protocols	1.56 $\pm$ 1.11
PPE is provided to all staff according to guidelines	1.62 $\pm$ 1.11
Compliance with Patient Safety Standards score	1.55 $\pm$ 0.57
Hospital occupancy is monitored to avoid overcrowding	1.51 $\pm$ 1.10
Surgeries are scheduled efficiently	1.44 $\pm$ 1.11
Medical supplies are efficiently managed	1.51 $\pm$ 1.05
Emergency response plans are in place	1.48 $\pm$ 1.10
Operational Efficiency and Resource Management score	1.49 $\pm$ 0.59
Physicians and nurses participate in quality management meetings	1.51 $\pm$ 1.11

Nurses are involved in decision-making committees	1.39 ± 1.07
Staff feedback is collected and used	1.57 ± 1.13
There is a framework for nursing shared governance	1.46 ± 1.12
Medical Staff Participation in Clinical Governance score	1.48 ± 0.58
Overall hospital performance mean score	1.52 ± 0.37

4.4 Correlations Between Governance and Performance

Table (12) revealed several statistically significant correlations. The overall governance mean score showed a strong positive correlation with overall hospital performance ($r = .479, p < .001$). Governance control was also positively correlated with all performance dimensions, especially with general healthcare quality ($r = .267, p < .001$) and the overall hospital performance mean ($r = .352, p < .001$). Access to information, participation in governance, and official authority also showed statistically significant, though weaker, correlations with various performance indicators. These results showed the influence of effective governance structures on perceived hospital performance.

Table (12): Correlation Matrix between Governance Variables and Hospital Performance Indicators

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Variables	General Evaluation of Healthcare Quality score	Compliance with Patient Safety Standards score	Operational Efficiency and Resource Management score	Medical Staff Participation in Clinical Governance score	Overall Hospital Performance Mean score
Governance Control score	.267** .000	.195** .002	.211** .001	.214** .001	.352** .000
Governance Control score	.153* .015	.128* .042	.146* .019	.120 .055	.217** .000
Official Authority Over Governance score	.112 .075	.141* .025	.153* .014	.115 .067	.206** .001
Participation in Governance Committees score	.179** .004	.130* .038	.125* .046	.079 .210	.204** .001
Access to Information score	.160* .010	.037 .559	.099 .115	.082 .192	.151* .016
Overall Governor Mean score	.364** .000	.269** .000	.311** .000	.261** .000	.479** .000

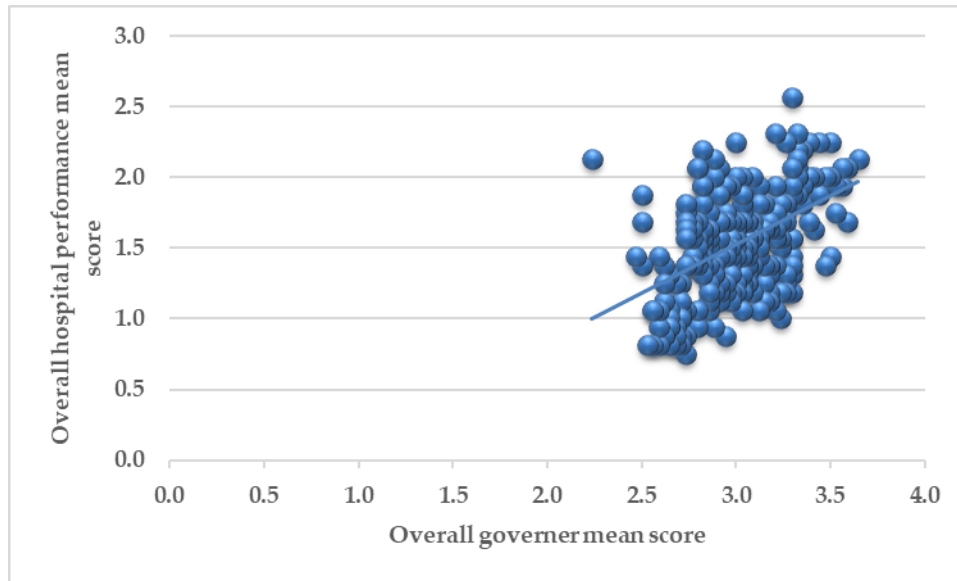


Figure (7): scatter plot for the correlation between the overall mean scores of the shared governors with the hospital performance

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

4.5 Associations by Demographic Variables

Table (13) explored differences in governance and performance scores across various demographic and professional characteristics. Female nurses reported significantly higher governance scores (mean = 3.044) than males (mean = 2.956, $p = 0.005$), although their performance scores were not significantly different. Nurses with Baccalaureate Degrees had the highest governance scores (mean = 3.102, $p = 0.025$), while nurses who rated their professional satisfaction at level “5” had the highest governance (3.137) and performance (1.681) scores, both statistically significant. These findings indicate that personal and professional development, along with satisfaction, are closely tied to perceptions of governance and hospital quality.

Table (13) the relation between Mean Scores of Governance and Performance by Demographic and Professional Variables (n = 255)

(n = 255 registered nurses employed at Dr. Sulaiman Al Habib Hospital, Riyadh, Saudi Arabia in 2025)

Variable	Category	Governance Mean Score	Governance p-value	Performance Mean Score	Performance p-value
Sex	Female	3.044	0.005	1.549	0.207
	Male	2.956		1.491	
Basic Nursing Educational Preparation	Associate Degree	2.996	0.532	1.482	0.262
	Baccalaureate Degree	3.025		1.572	
	Nursing Diploma	2.981		1.511	
Highest Educational Degree Attained	Associate Degree	2.994	0.025	1.521	0.326
	Baccalaureate Degree	3.102		1.614	
	Doctorate (Non-Nursing)	2.933		1.467	
	Doctorate in Nursing	2.935		1.521	
	Master Degree (Non-Nursing)	2.985		1.509	
	Master Degree in Nursing	3.053		1.553	
	Nursing Diploma	2.989		1.431	
	Full-time	2.988	0.408	1.495	0.248

Variable	Category	Governance Mean Score	Governance p-value	Performance Mean Score	Performance p-value
Employment Status	Part-time	3.014		1.549	
Current Position Title	Charge Nurse	2.975	0.743	1.466	0.600
	Educator	3.017		1.524	
	Head Nurse	2.988		1.544	
	Staff Nurse	3.017		1.545	
Type of Nursing Unit	Clinic	2.992	0.533	1.628	0.354
	Critical Care	2.936		1.402	
	Education	3.038		1.518	
	Emergency Room	2.948		1.443	
	Maternity	3.055		1.517	
	Medical	3.013		1.457	
	Operating Room	2.964		1.500	
	Other	3.042		1.612	
	Pediatrics	2.956		1.476	
	Psychiatry	2.997		1.643	
	Quality Management	2.946		1.394	
	Recovery Room	2.981		1.486	
	Surgical	3.149		1.660	
Do You Hold Specialty Certifications?	Yes	2.985	0.392	1.500	0.409
	No	3.013		1.538	
Satisfaction with Professional Practice (1–5)	1	2.948	0.000	1.520	0.013
	2	2.933		1.439	
	3	2.981		1.475	
	4	3.046		1.530	
	5	3.137		1.681	

Chapter Five: Discussion

5.1 Discussion

The present study investigated the impact of nursing shared governance on hospital performance among 255 registered nurses employed in a major Saudi healthcare institution. The findings revealed several key patterns in the participants' demographic and professional profiles, governance perceptions, and the perceived quality of hospital performance. When compared with existing literature, these findings provide both confirmation and context-specific insights that enrich the understanding of shared governance implementation in hospital settings.

To begin with, the demographic profile of the study population reflected a balanced gender distribution and a diverse educational background. This composition is important, as prior studies have shown that heterogeneity in professional backgrounds and gender dynamics may influence perceptions of governance and institutional engagement (Speroni et al., 2021; study conducted across 205 hospital units globally). The diversity observed in educational attainment, including Master and Doctorate degrees, suggested that the nursing workforce in this study was equipped with the academic capacity to participate meaningfully in decision-making processes. In alignment with this, Speroni et al. (2021) found that hospitals with highly educated nursing staff involved in shared governance frameworks achieved significantly better performance indicators, including improved collaboration and a 25% increase in operational efficiency.

However, despite the promising profile of the workforce, the descriptive results from this study painted a more reserved picture regarding actual governance influence. Nurses' perceptions of their participation in governance processes hovered around the midpoint of the 5-point scale, with a mean overall score of 3.00. Specific activities such as disciplinary actions (3.21), job structure design (3.15), and patient care assignments (3.10) recorded slightly higher ratings, indicating modest involvement in decision-making. These results resemble those reported by Jaber et al. (2022) in Jordan, where nurses expressed partial participation in clinical governance but remained largely excluded from strategic decision-making. Jaber et al. showed that while shared governance improved coordination and clinical flow, it was often hindered by organizational hierarchies that limited full nurse engagement.

Notably, the current study found that hospital performance was rated relatively low by participants, with a mean of 1.52 on a 3-point scale. Of particular concern was the medical staff participation in clinical governance (mean = 1.48), and other dimensions such as operational efficiency and compliance with safety standards. These findings echo those of Albargi et al. (2024) in Saudi Arabia, who reported that while shared governance structures have potential, their effectiveness was limited by unclear policies, lack of leadership support, and weak integration between nursing staff and hospital administration. Albargi et al. also found that nurses' unfamiliarity with shared governance concepts impeded their full contribution to performance improvement.

Correlational analysis in the current study provided stronger evidence for the theoretical link between shared governance and hospital performance. The statistically significant positive correlation between the overall governance score and hospital performance ($r = .479, p < .001$) underscored the idea that increasing nurse participation in governance leads to better organizational outcomes. This aligns closely with findings by Phillippe et al. (2019) in the United States, who observed that shared governance significantly enhanced decision-making efficiency, patient satisfaction, and reduced medical errors. The present study confirms these associations in the Saudi context, particularly showing that better governance control correlated positively with general evaluations of healthcare quality ($r = .267, p < .001$).

Additional subgroup analysis in this study revealed that female nurses, those holding baccalaureate degrees, and highly satisfied staff scored significantly higher on both governance and performance measures. Satisfaction level "5" was linked to the highest perceived governance (mean = 3.137) and performance (mean = 1.681), indicating that professional fulfillment is intertwined with empowerment and perceived institutional quality. This insight reinforces the findings of Brennan and Wendt (2021), who reported that governance models which enhance nursing satisfaction resulted in 20% higher engagement and 10% shorter patient wait times. The implication is clear: empowering nurses through structured governance not only improves operational performance but also enhances morale and retention.

In terms of broader implications, the findings of this study showed the crucial role of structured shared governance in improving healthcare delivery. While the current governance

levels were moderate, the positive associations with performance outcomes suggest that with more comprehensive implementation—such as clear role definitions, leadership training, and participatory decision-making forums—hospital performance metrics could improve substantially. This is supported by Adkins et al. (2023), who found that hospitals that implemented shared governance reported a 25% improvement in patient throughput and stronger interdisciplinary collaboration. Similarly, Owen et al. (2021) showed that participatory governance models reduce administrative bottlenecks and enhance staff accountability, which are necessary outcomes for high-performing institutions.

The relatively low score in clinical governance by medical staff may also reflect the need to improve interprofessional collaboration, a challenge well-documented in studies like that of Kutney-Lee et al. (2020), who found that hospitals with strong shared governance frameworks achieved a 15% reduction in patient readmission and better interdisciplinary efficiency. Therefore, promoting joint nurse-physician governance initiatives may bridge this performance gap.

The findings of the present study further resonated with global and regional literature showing the central role of governance and leadership styles in shaping hospital outcomes. For example, Abd El et al. (2021) established a direct association between nursing governance and shared leadership, asserting that inclusive leadership styles enhanced staff engagement and governance effectiveness. In alignment with this, Quek et al. (2021) found that distributed leadership significantly predicted employee engagement and satisfaction in UK nursing contexts. The current study results, especially the positive association between satisfaction and governance perception, reinforced this relationship. Likewise, Alsadaan et al. (2023) showed that leadership behaviors influenced nursing performance outcomes, a finding mirrored in this study, where nurses reporting greater satisfaction levels demonstrated stronger perceptions of both governance and hospital performance. The implication is clear: leadership behavior and governance style are mutually reinforcing and can directly influence organizational culture and operational efficiency.

In addition, several studies have underscored the relevance of autonomy, communication, and generational perspectives in enhancing shared governance outcomes.

Pursio et al. (2021) identified professional autonomy as a foundational pillar in successful governance structures, which may explain why the current study found higher governance perceptions among nurses with advanced degrees and full-time positions. Similarly, Jankelová and Joniaková (2021) showed the moderating role of communication skills in the relationship between leadership and job satisfaction, reinforcing the importance of interaction quality within shared governance structures. Tan and Chin (2023) provided generational insights, noting that work values and engagement levels varied across age groups, a relevant factor considering the demographic diversity observed in the present study. Moreover, Yelne et al. (2023) called for greater integration of technology and AI to support governance and clinical decision-making, which could be particularly useful in addressing the performance gaps revealed in this study, such as low clinical governance scores.

Moreover, the implications of shared governance for retention, interprofessional collaboration, and diversity cannot be overlooked. Marufu et al. (2021) identified governance quality as a retention factor, which links to the present study finding that satisfied nurses reported higher governance perceptions. Morrison et al. (2021) stressed that diversity and equity frameworks must align with governance strategies to create inclusive, high-performing work environments. This aligns with the balanced gender representation and educational diversity in the current sample, suggesting potential for equity-driven governance advancement. Labrague et al. (2022) provided additional insight into how interprofessional collaboration mediated job satisfaction and patient safety outcomes, which directly supports the call for improved clinical governance and team integration found in this study. Lastly, Faeq (2025) warned against negative leadership patterns, such as narcissistic behaviors, that erode governance efficacy and staff creativity, underlining the necessity of supportive leadership in promoting shared governance success.

The current study contributes valuable local evidence to the global discourse on nursing shared governance and hospital performance. While nurses perceived their governance role as modest and hospital performance as suboptimal, the significant correlations between governance and performance affirm the utility of shared governance as a performance-enhancing strategy. Lessons from comparable studies in Saudi Arabia, the United States, Jordan, and beyond, reveal a consistent pattern: when nurses are empowered through structured governance frameworks,

hospital efficiency, safety, and quality outcomes tend to improve. Future interventions should focus on deepening the governance infrastructure, enhancing leadership commitment, and promoting inclusive participation to fully harness the transformative potential of shared governance in hospital settings.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

This study examined the impact of nursing shared governance on hospital performance among 255 registered nurses in a Saudi hospital setting. The findings revealed that nurses perceived their participation in governance activities to be moderate, with limited but present influence in institutional decision-making processes. Hospital performance, as evaluated by the nurses, was rated relatively low, particularly in areas related to clinical governance and operational efficiency.

However, significant positive correlations between shared governance and hospital performance were identified, indicating that greater nurse involvement in governance was associated with enhanced institutional outcomes. The analysis further showed that nurses with higher educational levels, greater job satisfaction, and full-time employment reported stronger perceptions of governance and performance. These findings confirmed that shared governance contributed to improved hospital performance, although its implementation remained partial and inconsistent.

6.2 Recommendations

- Shared governance policies should be formally integrated into hospital administrative frameworks.
- Regular training workshops on governance structures should be provided to nursing staff.
- Participation of nurses in hospital committees should be actively encouraged and facilitated.
- Leadership support for shared governance initiatives should be strengthened across departments.
- Feedback mechanisms for evaluating governance outcomes should be routinely established.
- Interprofessional collaboration strategies should be enhanced to reinforce clinical governance engagement.

6.3 Limitations of the Study

First, the study was limited by its reliance on self-reported data, which may have introduced response bias.

Second, the findings were restricted to a single healthcare institution in Saudi Arabia, limiting the generalizability of the results to broader healthcare contexts.

6.4 Implications for Practice and Policy

The results of this study underscored the critical role of nursing shared governance in improving hospital performance, showing the need for healthcare administrators to prioritize the institutionalization of governance models that empower nurses.

Policies aimed at promoting nurse participation in decision-making processes may lead to enhanced operational efficiency, increased staff satisfaction, and better patient outcomes. Strengthening shared governance can serve as a cost-effective strategy for workforce retention, quality improvement, and long-term sustainability of healthcare systems.

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Data collection tool

Part 1: Demographic Information

1. **Today's Date:** __ / __ / ____
2. **Sex:** ☐ Male ☐ Female
3. **Age:** _____
4. **Basic Nursing Educational Preparation:**
☐ Nursing Diploma ☐ Associate Degree in Nursing ☐ Baccalaureate Degree in Nursing
5. **Highest Educational Degree Attained:**
☐ Nursing Diploma ☐ Associate Degree in Nursing ☐ Baccalaureate Degree in Nursing
☐ Master Degree in Nursing ☐ Master Degree (Non-Nursing) ☐ Doctorate in Nursing
☐ Doctorate (Non-Nursing)
6. **Employment Status:**
☐ Full-time (36-40 hours per week)
☐ Part-time (Specify number of hours per week: _____)
7. **Total Years in Nursing Practice:** _____
8. **Current Position Title:** _____
9. **Type of Nursing Unit You Work In:**
☐ Medical ☐ Surgical ☐ Critical Care ☐ Emergency Room ☐ Pediatrics
☐ Maternity ☐ Psychiatry ☐ Operating Room ☐ Recovery Room ☐ Education
☐ Quality Management ☐ Clinic ☐ Other (Specify: _____)
10. **Number of Years in This Institution:** _____
11. **Number of Years in Current Position:** _____
12. **Do You Hold Any Specialty Certifications from Professional Organizations?**
☐ Yes ☐ No (If yes, specify type and year received: _____)

13. Rate Your Overall Satisfaction with Your Professional Practice (1 = Lowest, 5 = Highest):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Part 2: Governance assessment

Section 1: Governance Control

Please circle the group that CONTROLS the following areas in your organization:

(1 = Nursing Management/Administration Only, 2 = Primarily Nursing Management with Some Staff Input, 3 = Equally Shared, 4 = Primarily Staff Nurses with Some Management Input, 5 = Staff Nurses Only)

Governance Area	1	2	3	4	5
Determining bedside nursing practices	☐	☐	☐	☐	☐
Developing and evaluating patient care policies, procedures, and protocols	☐	☐	☐	☐	☐
Establishing qualifications for nursing positions	☐	☐	☐	☐	☐
Determining activities of ancillary nursing personnel	☐	☐	☐	☐	☐
Conducting disciplinary actions for nursing personnel	☐	☐	☐	☐	☐
Assessing and providing for nursing staff development	☐	☐	☐	☐	☐
Selecting products used in nursing care	☐	☐	☐	☐	☐
Determining nursing care delivery models (e.g., primary, team-based)	☐	☐	☐	☐	☐

Section 2: Influence on Decision-Making

Please circle the group that INFLUENCES the following activities:

(Same scale as above: 1 = Management, 5 = Staff Nurses Only)

Influence Area	1	2	3	4	5
Making daily patient care assignments	☐	☐	☐	☐	☐
Regulating patient admissions, transfers, and discharges	☐	☐	☐	☐	☐
Formulating annual unit budgets	☐	☐	☐	☐	☐
Recommending nursing salaries, raises, and benefits	☐	☐	☐	☐	☐

Consulting with external nursing specialists (e.g., wound care, psychiatric services)	☐	☐	☐	☐	☐
Consulting with non-nursing departments (e.g., dietary, social services, finance)	☐	☐	☐	☐	☐
Creating new clinical positions	☐	☐	☐	☐	☐
Creating new administrative or support positions	☐	☐	☐	☐	☐

Section 3: Official Authority Over Governance

Please indicate which group has OFFICIAL AUTHORITY over these areas:

(Same scale as above: 1 = Management, 5 = Staff Nurses Only)

Authority Over	1	2	3	4	5
Credentialing and hiring standards for RNs	☐	☐	☐	☐	☐
Organizational job structure (who reports to whom)	☐	☐	☐	☐	☐
Disciplinary policies for nursing personnel	☐	☐	☐	☐	☐
Hiring and transferring nursing staff	☐	☐	☐	☐	☐
Policies for promoting nurses to leadership roles	☐	☐	☐	☐	☐
Budget recommendations for nursing units	☐	☐	☐	☐	☐
Adjusting nursing salaries and benefits	☐	☐	☐	☐	☐

Section 4: Participation in Governance Committees

Please indicate the level of nursing participation in these governance activities:

(Same scale as above: 1 = Management, 5 = Staff Nurses Only)

Participation In	1	2	3	4	5
Unit-level administrative committees (e.g., staffing, budgeting)	☐	☐	☐	☐	☐
Nursing department committees for administrative matters	☐	☐	☐	☐	☐
Interprofessional committees for collaborative practice	☐	☐	☐	☐	☐
Hospital administration committees for strategic planning	☐	☐	☐	☐	☐
Forming new nursing departmental committees	☐	☐	☐	☐	☐

Section 5: Access to Information

Please indicate the level of access nurses have to the following types of information:

(Same scale as above: 1 = Management, 5 = Staff Nurses Only)

Access To	1	2	3	4	5
Compliance with regulatory agencies (e.g., Joint Commission)	☐	☐	☐	☐	☐
Unit and departmental goals and objectives	☐	☐	☐	☐	☐
Organizational strategic plans	☐	☐	☐	☐	☐
Results of patient satisfaction surveys	☐	☐	☐	☐	☐
Nurse turnover and vacancies	☐	☐	☐	☐	☐

Part 3: Hospital Performance Assessment Questionnaire

Instructions:

This questionnaire aims to evaluate hospital performance based on accreditation standards. Each criterion should be rated according to the level of compliance. Please mark (✓) in the appropriate box for each assessment item.

Basic Information

- **Hospital Name:** _____
- **Department:** _____
- **Assessment Date:** __ / __ / ____
- **Assessor's Name:** _____

Section 1: General Evaluation of Healthcare Quality

Criterion	0 - Not Implemented	1 - Partially Implemented	2 - Implemented with Required Improvements	3 - Fully Implemented
Medical assessments for all admitted patients are conducted according to standardized hospital procedures.	☐	☐	☐	☐
Patient conditions are reassessed regularly in accordance with hospital standards.	☐	☐	☐	☐
All assessments are documented clearly and systematically in medical records.	☐	☐	☐	☐
Written guidelines for clinical assessments are available for all medical specialties within the hospital.	☐	☐	☐	☐

Section 2: Compliance with Patient Safety Standards

Criterion	0 - Not Implemented	1 - Partially Implemented	2 - Implemented with Required Improvements	3 - Fully Implemented
Infection prevention policies and procedures are implemented in all medical departments.	☐	☐	☐	☐
All medical errors are recorded and reported for corrective actions.	☐	☐	☐	☐
The medical staff undergoes periodic training on safety protocols.	☐	☐	☐	☐
Personal protective equipment (PPE) is provided to all staff in accordance with health guidelines.	☐	☐	☐	☐

Section 3: Operational Efficiency and Resource Management

Criterion	0 - Not Implemented	1 - Partially Implemented	2 - Implemented with Required Improvements	3 - Fully Implemented
Hospital occupancy rates are monitored and managed effectively to avoid overcrowding.	☐	☐	☐	☐
Surgical procedures are scheduled efficiently to reduce patient waiting times.	☐	☐	☐	☐
Medical supplies are managed efficiently to ensure availability at all times.	☐	☐	☐	☐

Emergency response plans are in place to handle disasters or health crises.	☐	☐	☐	☐
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Section 4: Medical Staff Participation in Clinical Governance

Criterion	0 - Not Implemented	1 - Partially Implemented	2 - Implemented with Required Improvements	3 - Fully Implemented
Physicians and nurses regularly participate in quality management meetings.	☐	☐	☐	☐
The nursing staff is actively involved in hospital decision-making committees.	☐	☐	☐	☐
Staff feedback is collected and used to improve hospital policies.	☐	☐	☐	☐
There is a structured framework for nursing shared governance within the hospital.	☐	☐	☐	☐