

Enablers and barriers of implementing shared governance in nursing departments: a case study from the United Arab Emirates



Original article

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Received: 12 January 2024; Accepted: 25 March 2024; Published: 20 December 2024

Abstract: Objective: The literature provides evidence about the positive impact of shared governance implementation in nursing departments and units, as well as on several aspects of nursing practice, including nurse empowerment, engagement, well-being, job satisfaction, retention, and positive outcomes in direct patient care. Accordingly, many nursing departments of United Arab Emirates (UAE) hospitals have implemented shared governance in their units. However, the success of implementation varies among these hospitals. Therefore, the study aimed to explore the progress of shared governance implementation in hospitals, identify the enablers and inhibitors of implementing the model, and produce a recommendation to help the nursing departments of hospitals to overcome challenges and accelerate the implementation process.

Methods: The study used an inductive, qualitative case-study research method and semi-structured in-depth interviews with a purposive sample of 15 nurses working in various units in a tertiary hospital in UAE. The authors used a thematic data analysis approach to find the results.

Results: The results identified immediate manager understanding and support as a significant enabler and lack of senior management support, nurses' attitudes and behaviors, and time as the main barriers. The study highlights that nurses are positive and enthusiastic about improving the current situation of shared governance by providing several suggestions and strategies.

Conclusions: The study highlights that senior nursing managers should re-evaluate shared governance implementation and modify the strategies accordingly.

Keywords: nursing • nurses • participatory • leadership • shared governance • UAE

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1. Introduction

1.1. Shared governance

The nursing literature provides several definitions for shared governance, for example, the Clinical

Knowledge Network (CKN) defines shared governance as a professional practice model that promotes nursing empowerment and makes a shared decision

How to cite this article: Kurup S, Manalastas AP, Ciruelas J. Enablers and barriers of implementing shared governance in nursing departments: a case study from the United Arab Emirates. *Front Nurs.* 2024;4:415–426.

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by staff nurses that impacts policies, procedures, and processes at the point of care.¹ Accordingly, the shared governance model allows nurses to participate in decision-making about many aspects of their practice, for example, decisions regarding best practices about patient care, education and development, engagement and well-being, policies and procedures, and others. The literature also provides evidence for the impact of shared governance on nurses' empowerment, engagement, satisfaction, and retention, which improve hospital performance, for example, customer satisfaction and nurse productivity.

Anthony² has claimed that building a proper structure of shared governance and the related processes is a challenge for the nursing department in any hospital. For example, nursing departments should spend adequate time on self-assessment, planning, implementation, and evaluation of the outcome of the new program. However, the success of implementing shared governance in these hospitals varied according to several variables, such as leadership and other resources. For instance, some scholars did not believe that a shared governance model, a Western-derived concept, could be implemented in the Middle East hierarchy-driven environment culture such as in Saudi Arabia and other countries.³

O'May and Buchan⁴ have stated that shared governance is a distributed approach that gives nurses authority and allows control over their working environment and practice. According to Hess⁵, shared governance is an organizational innovation that legitimizes healthcare professionals to control decisions over their practices while extending their influence to previously managed administrative areas. Furthermore, Hess^{5,6} has stated that nurse managers invented shared governance, the middle part of the continuum between traditional and self-governance shared governance. Swihart and Hess⁷ define shared governance operationally as a management process model with a structure, process, and outcome that ensures collaborative decision-making at points of service and care.

O'May and Buchan⁴ have claimed that shared governance allows active participation in making decisions to give a sense of responsibility and accountability, specifically related to administrative aspects. However, Olson⁸ has pointed out that shared governance is complex as it requires a delicate balance between staff participation in planning and decision-making processes and administrative accountability.

On the other hand, Kutney-Lee et al.⁹ have claimed that a formal structure and process that allows organizational decision-making is needed to promote shared governance. Porter-O'Grady¹⁰ state that shared governance focuses on building a structural framework for nursing practice, consistent with the frameworks

that govern other leading professions. They also mark three fundamental principles that affirm and validate the presence of an effective and sustainable structure, including nurses' accountability practice, built around professional accountability, making a clinical decision, and reflecting distributive decision-making. Therefore, Swihart and Hess⁷ argue that shared governance structures, accompanied by their intrinsic complexities, responsibilities, and accountabilities, must be carefully designed, implemented, and measured to be sustained.

In addition, Hess⁶ has introduced four attributes as characteristics of professional governance, that is, accountability, professional obligation, collateral relationships, and decision-making. Swihart and Hess⁷ conclude that shared governance is the measurable realization of the organizational culture as reflected in its mission, values, and philosophy, and it is grounded in the principles of partnership, equity, accountability, and ownership. McKnight and Moore¹¹ emphasize that shared governance also includes decision-making between direct caregiving nurses and nurse leaders, such as research/evidence-based practice projects, new equipment purchases, and staffing.

1.2. Advantages and disadvantages of implementing shared governance

The literature review revealed numerous advantages of implementing shared governance. For example, Hess¹² has claimed that shared governance implementation in specific hospitals could enhance and support further innovation in organizations where it is adopted. Also, Hess⁵ points out that implementing shared governance could lead to delightful changes in collaboration, staff recruitment, retention, autonomy, shared values, organizational culture, high morale, quality patient outcomes, versatility, competency, collegial communication, productivity, empowerment, and satisfaction.

A study in Jordan by Al Faouri et al.¹³ shows that registered nurses perceived upright control over their professional practice, more shared access to information, and compliance with hospital nursing practice and strategic plans of the facility. Kutney-Lee et al.⁹ claim that implementing shared governance is a transformational leadership strategy in evidence-based organizational level interventions that will positively reflect on patient outcomes. They provide empirical evidence that shared governance improves nurse engagement, which helps in staff retention for health institutions as well as helps in patient and staff outcomes. Furthermore, Kaddourah et al.¹⁴ highlight that participation and influence in shared governance enable constant nursing transformation, advancement, and progress.

Brennan and Wendt¹⁵ revealed in their study, on a suburban hospital with a 200-bed capacity, that documentation of intake output increased many times, patient satisfaction went twofold, the incidence of falls reduced to half, and the management and senior administration support improved staff satisfaction. McKnight and Moore¹¹ have stated that shared governance improves staff and patient satisfaction, which may help an institution find future leaders. More specifically, McKnight and Moore¹¹ point out that shared governance is important because it helps promote evidence-based practices, provides a framework for patient-centered care, improves nurse retention, increases job satisfaction, enhances professional growth, and strengthens intra-professional relations.

On the other hand, the reviewed literature highlights that the positive evidence of implementing shared governance still needs further investigation. Some scholars have emphasized some disadvantages of implementing shared governance. For example, Hess¹² argued that shared governance was an innovation with an unpredictable future. In addition, Gavin et al.¹⁶ claimed that when implementing shared governance, nurses are more focused on resource management rather than authority, and it has no significant positive impact on career development, increasing accountability and autonomy, power sharing, or clinical development and empowerment. Gavin et al.¹⁶ have also argued that shared governance has ambiguity, as some supervisors and middle managers feel threatened by the implementation of shared governance.

Bamford-Wade and Spence¹⁷ have claimed that building relationships for collaboration requires spending time together to develop goals, plan, and make shared decisions. Hess et al.¹⁸ have shown that implicitly shared governance in nursing during the COVID-19 pandemic minimally helped the frontline staff to overcome their stress while attending to emergencies and direct care to COVID-19 patients and kept the employees connected to co-workers and the organization's bigger perspective.

1.3. Enablers and barriers to implementing shared governance

A review of the existing literature revealed numerous enablers and barriers to implementing shared governance. Regarding enablers, Brooks¹⁹ has pointed out that active, abundant communication from and to staff while establishing councils and operating policies is critical to success. Hess²⁰ has pointed out that shared governance is about employees playing an active role in unit operations. Thus, staff nurses should understand that participation in nursing practice decisions is their

right and professional obligation. He recommends supporting staff to develop leadership skills and mentions that structure or committees are vehicles that address issues such as clinical practice, management, quality, education, expertise, knowledge, and commitment to the profession and organization, predicting shared governance success.

Ong et al.²¹ have revealed in a study in the Medical ICU at an academic healthcare center in Southern California that newly implemented shared governance enhanced nurses' engagement, and the success of shared governance depends, as well, on the direct manager's leadership styles. El-Shaer and Ahmed²² have emphasized the role of the manager who shares decisions with subordinates, allowing control over their practices, helping to set clear and realistic goals, and contributing to higher career motivation. Atashzadeh-Shoorideh et al.²³ highlight the role of a manager in the successful implementation of shared governance, stating that higher-level managers of educational institutions can empower themselves and their staff in communication and participation skills, as well as serve as the symbol of a participatory model in the leadership position.

Edwards et al.²⁴ also claim that an annual workshop is beneficial, as evidenced by its outcomes, which include preparing nurses for their roles as council leaders, addressing barriers to the council structure, and developing mission, vision, and philosophy statements. Furthermore, the workshop enabled participation, opportunities to lead, and increased confidence in leadership and communication skills.

On the other hand, the reviewed literature disclosed several barriers to shared governance implementation. For example, Brooks¹⁹ emphasized that leaders faced challenges when working with colleagues who ignored verbal, written, and electronic communication regarding the implementation of shared governance. Hess²⁰ pointed out that staff nurses are often confused about their power to change in bureaucratic facilities. While, Church et al.²⁵ identified that the barriers to the proper implementation of shared governance include, among others, insufficient managerial support for direct care nurses, poor teamwork among the unit nurses, disruption to patient care due to shared governance participation, inadequate or lack of compensation to direct care nurses for participating in shared governance, and the insufficient time provided to shared governance members to complete their deficient or lack of education regarding their responsibilities.

In one study, Keane²⁶ highlighted the lack of participation in shared governance by registered nurses as a barrier. In addition, Motte²⁷ identified several barriers that prevent nurses from participating in efficient shared

governance unit-based council, including the perception of time constraints or the lack of time, awareness of shared governance purpose, goals, and the existence of committees, do not attend meetings due to distance as they live too far away, and have management issues, for example, the director sits in and speaks out if the discussion is opposing and lacks ultimate authority to implement ideas brought from the shared governance team, and some nurses lack interest.

Maged et al.²⁸ claimed in a cross-sectional study in the Arabic context that the vast majority of nursing profession-related decisions were made primarily by nursing management and leaders with little or no input from nurses. They explained that this could be due to a variety of factors such as lack of autonomy, lack of accountability, nurses resistance to change, poor educational qualifications, lack of experience in working units, lack of training on nursing governance, increased nurses' workload without being noticed or rewarded, nursing shortage, the top-down nature of mandated changes and organizational hierarchy, ineffective use of company resources, and the misuse of the process of sharing opinions in decisions.

1.4. Significance of the study

The study will rebound on the nursing profession and the implementation of shared governance in United Arab Emirates (UAE) hospitals that are trying to overcome barriers and highlight the enablers. It will break the barriers and open an opportunity to improve and maximize the execution of shared governance.

This study is also significant as it is in a Middle Eastern culture with a hierarchical governance system. The study puts forth recommendations that will assist nursing departments in hospitals for overcoming obstacles and accelerating the implementation process.

1.5. Purpose of the study

In the UAE, numerous well-known hospitals have sought to implement shared governance in nursing departments, responding to the Magnet Accreditation. Abu Dhabi Cleveland Clinic was the first and only in the UAE to grant Magnet accreditation in nursing excellence in 2019. On the other hand, several hospitals in the country are still working to meet the criteria, including implementing the shared governance model. Therefore, this study aimed to explore the level of progress in these hospitals, identify the enablers and inhibitors of implementing the model, and provide recommendations for fixing the gaps and for improvement. The following are the objectives of this study:

1. Explore nurses' understanding of the concept of shared governance;
2. Understand the nurse's perception of the benefits of the shared governance model in their units;
3. Explore the extent of the level of progress of UAE hospitals in implementing the shared governance model;
4. Identify the enablers and barriers to implementing a shared governance model in nursing units;
5. Identify the perspectives of UAE hospital nurses on how to enhance the shared governance model.

2. Methods

The shared governance theory provided the theoretical framework. The theoretical framework significantly determined the research aims and objectives and assisted in identifying the survey questions. The framework also guided the data analysis and interpretation phases. Accordingly, the study's theoretical framework was based on the definition and theory of Hess,^{12,20,29} who stated that shared governance is about employees participating in nursing practice decisions; he provided a structure, that is, committees, to address issues such as clinical practice, management, quality, and education.

The study adopted the interpretivism research paradigms to answer the research inquiry. The interpretivism view assumes that realities are multiple, intangible mental constructions, socially and experientially based, local, and specific in nature and rely upon the participant's views of the situation.^{30,31} An inductive, qualitative case study was used as the research method. The qualitative research design is recommended for investigating and comprehending the meaning that individuals or groups are assigned to a social or human situation and inductively growing from specifics to broad themes.³⁰ According to Sekaran and Bougie,³² an inductive research design is where the authors look at particular phenomena and make extensive inferences from them. They also state that a case study is purposeful in gathering information about a specific object, event, or activity, such as a particular unit or organization.³²

The study was conducted between January and March 2023 in the nursing department of Tawam Hospital, a tertiary hospital located in Al Ain City in the UAE, attempting to fully implement a shared governance model to get the maximum possible benefits. The interviews took place in a serene and conducive environment.

The suggested sample size was anywhere from 5 to 50 participants for qualitative studies in most books, as claimed by Dworki³³; Mason³⁴ also found in a systematic literature review that the presenting sample sizes were multiples of ten. However, Mason³⁴ claimed that authors

often use saturation as a guiding principle during data collection.

Accordingly, the study used semi-structured in-depth interviews with a purposive sampling technique until reaching the saturation point capacity, where the interview sessions do not provide new information to save the author's time and resources. The participants were chosen based on predefined criteria, which included registered nurses with at least 5 years of experience in working at Tawam Hospital.

Six non-leading, open-ended questions based on literature, such as Hess²⁹ and Glasscock³⁵, guided the study interviews. The authors added some questions and prepared several narrower sub-questions that assisted in getting enough information to answer the main study questions. The questionnaire used for the study has two parts: the first part collected demographic data about the participants, such as their age, gender, education, unit, position, and years of experience; the second part included six questions, as follows:

Question 1: Could you please tell me what comes to your mind when you come across the term shared governance?

Question 2: What are, in your opinion, the expected benefits of implementing shared governance in your hospital?

Question 3: How do you perceive the outcome of implementing a shared governance model in your hospital?

Question 4: What are, in your opinion, the barriers to implementing shared governance in your unit/hospital?

Question 5: What are, in your opinion, the enablers of implementing shared governance in your unit/hospital?

Question 6: Could you please share any suggestions or recommendations for improving the current shared governance practices in your unit/department?

Although the authors are senior nurses working in the study tertiary hospital and have experience in implementing shared governance and a role in leading the shared governance councils in their units, they avoided any influence on the participants or toward guiding them to any specific conclusion. They analyzed and reported the data based on the participant's feedback without personal bias and kept their names anonymous to avoid any potential lack of transparency.

3. Results

The data analysis included demographic data analysis and thematic qualitative data analysis. The demographic data analysis disclosed that 15 nurses from various

units were interviewed. Most of the nurses were female, between 31 years old and 45 years old, staff nurses, and holding a bachelor's degree in nursing. The demographic data analysis revealed that the sample met the study inclusion criteria. More specifically, all participants were staff and charge nurses with >5 years in their current position (see Table 1 for details).

The study conducted thematic data analysis to classify the findings. The authors complied with the steps of thematic qualitative data analysis recommended by Caulfield,³⁶ that is, familiarized themselves with the data by reviewing the data several times, highlighting phrases or sentences of the text to come up with short-hand labels or "codes" identifying patterns among them to generate themes, and reviewing and naming those themes (see Table 2 for the results).

The analysis ended with nearly 197 statements after deleting unusable texts. The results ended with six main themes. In Theme 1, participants understand the shared governance; 14 participants out of 15 used 38 right words relevant to shared governance, including authority and empowerment, sharing or involvement in decision making, partnership with the management, teamwork, sharing the rule or activities, participation, accountability, equity, and improving leadership qualities among nurses. In Theme 2, participants understand the benefits of shared governance; 12 participants out of 15 mentioned 20 correct statements related to the benefits the shared governance implementation; 5 stated in 7 sentences that nurses will be able to solve their problems by themselves; 5 mentioned 5 statements that nurses can escalate their concerns; others specified other benefits, including nurses are treated equally, become happy, work as a team, improve the work environment, staff-patient ratio, and patient's care.

The analysis also ended with Theme 3: "Participants demonstrated contradictory views about the outcome of implementing shared governance in their hospital." Nine participants did not perceive any benefits of implementing shared governance; they mentioned 30 comments confirming that they did not see any changes, were not aware of any outcomes, or perceived low results. In all, 7 perceived advantages of implementing shared governance; they mentioned 12 positive comments.

Regarding enablers and barriers, the results revealed Themes 4 and 5. Theme 4, immediate manager understanding and support, was a significant enabler of implementing shared governance, as 11 participants mentioned immediate manager understanding and support in 17 statements. Few participants stated other insignificant enablers; 2 highlighted senior management support; 3 specified nurses' readiness, cooperation, and teamwork; 1 nurse mentioned

Category	F	%
<i>Gender</i>		
Male	4	26.7
Female	11	73.3
<i>Age (years old)</i>		
24–30	2	13.3
31–45	13	86.7
46–60	0	0
>60	0	0
<i>Experience in the hospital (years)</i>		
1–4	0	0
5–15	11	73.3
15–24	4	26.7
>24	0	0
<i>Position</i>		
Staff nurse	14	
Charge nurse	1	6.7
Nursing manager	0	0
<i>Unit</i>		
Pediatric Intensive Care Unit (PICU)	1	6.7
Emergency Department	1	6.7
Medical ward	1	6.7
Surgical ward	3	20
Intensive care unit	1	6.7
Cardiac care unit	1	6.7
Operation room	3	20
Specialized Medical Unit (SMU)	1	0.067
Outpatient clinics	3	20
<i>Education</i>		
Diploma	0	0
Bachelor	14	93.3
Master	1	6.7
PhD	0	0

Table 1. Demographic data analysis.

work culture; and 1 mentioned multicultural nurses. In Theme 5, “Participants perceived several significant barriers, mainly lack of management support, nurse’s attitudes and behaviors, and time.” A total of 12 participants mentioned 27 statements highlighting the lack of management support as a barrier to implementing shared governance; 7 participants said 8 phrases about negative nurse attitudes and behaviors on implementing shared governance; and 9 participants mentioned 16 statements highlighting time as a barrier to shared governance implementation, for example, inconvenience time for meetings and other activities due to the patient’s continuous need for care and shift duty. See Table 2 for details.

However, the thematic analysis also revealed Theme 6, where participants were positive and enthusiastic about improving the current situation of shared governance, as all of them were positive and suggested at least one or more actions to improve shared governance implementation in their units and hospital; they mentioned 58 statements suggesting 15 strategies improving shared governance implementation. See Table 2 for details and the emergent themes.

4. Discussion

In the UAE, numerous well-known hospitals sought to implement shared governance in nursing departments responding to the Magnet Accreditation. Many hospitals in the country are still working to meet the criteria, including implementing the shared governance model. This study aimed to explore the level of progress in those hospitals, identify the enablers and inhibitors of implementing the model, and produce a recommendation for fixing the gaps and for improvement.

The analysis disclosed six themes, including participants understanding the concept of shared governance, participants understanding the benefits of shared governance, participants demonstrating contradictory views about the outcome of implementing shared governance in their hospital, immediate manager understanding and support could be a significant enabler of implementing shared governance, participants perceived several significant barriers, mainly lack of management support, nurses attitudes and behaviors, and the time, and participants were positive and enthusiastic about improving the current situation of shared governance.

Theme 1 reflected that participants had an adequate understanding of the shared governance concept as authority and empowerment, involvement in decision-making, partnership with the management, and teamwork, which is similar to the work of McKnight and Moore¹¹ and Swihart and Hess.⁷ For example, one participant said that it is a partnership between staff and the higher management for shared decision-making, another described shared governance as the staff and management making decisions together, and a third participant said that the first thing that comes to my mind is nursing empowerment, hearing nurse’s voices, and allow nurses to help managers in leading the unit or any other work.

Theme 2 reflected an understanding of the shared governance benefits, for example, nurses can solve their problems by themselves and escalate their concerns. One participant said that it empowers the staff to take charge of their workspace and solve by themselves, and another said that the nurses ventilate and bring their

Questions and sub-category	F	Participants	Main themes and sub-themes
<i>Could you please tell me what comes to mind when you come across the term shared governance?</i>			Participants understand the concept of shared governance.
Authority and empowerment	8	6[P3, P4, P5, P6, P10, P11]	The majority of participants mentioned at least one right phrase or sentence related to the concept of shared governance.
Sharing/involvement in decision making	12	8[P2, P3, P5, P9, P10, P12, P13, P14]	
Partnership with the management	6	4[P1, P9, P10, P11]	
Teamwork	5	4[P5, P8, P12, P13]	
Sharing the rules or activities	2	2[P1, P7]	
Participation	2	2[P12, P14]	
Accountability	1	1[P9]	
Equity	1	1[P9]	
Improving leadership qualities among nurses	1	1[P8]	
<i>In your opinion, what are the expected benefits of implementing shared governance in your hospital?</i>			Participants understand the benefits of shared governance.
Nurses can solve their problems by themselves	7	5[P1, P3, P5, P14, P15]	The majority of participants mentioned at least one benefit of shared governance.
Nurses can escalate their concerns	5	5[P1, P2, P6, P8, P9]	
Nurses will be treated equally	2	2[P3, P11]	
Patients will get a safe and better quality of care.	2	2[P11, P13]	
Nurses become happy.	1	11[P1]	
Improve staff-patient ratio.	1	11[P12]	
The work environment is improved.	1	11[P12]	
Nurses will work as a team.	1	11[P8]	
<i>How do you perceive the outcome of implementing a shared governance model in your hospital?</i>			The participants demonstrated contradictory views about the outcome of implementing shared governance in their hospital.
Nurses who have not seen any changes, are aware of any outcome or perceive low outcome.	26	9[P1, P2, P3, P4, P8, P11, P12, P13, P14]	A greater number of participants did not perceive positive outcomes of implementing shared governance.
Nurses who think that they cannot come up with a solution until it is a multidisciplinary approach.	1	1[P1]	
Nurses who think that the work structure itself has empowered all the nurses whether having a shared governance or not.	1	1[P1]	
There are no minutes of meetings or updates shared with the staff like any questions raised or any problem solved.	1	1[P12]	A smaller number of participants perceived positive outcomes of implementing shared governance.
Not all nurses are raising concerns as they are not asked to do so.	1	1[P13]	
All nurses are under one umbrella.	1	1[P2]	
Nurses are happy as they have a group led by nurses to make the decision.	1	1[P5]	
Staff are not afraid to object and they can say and raise their concerns.	4	4[P6, P7, P9, P10]	
Nurses are advocating for their patients and they are not afraid to escalate things.	2	1[P6]	
We have now more unity.	1	1[P7]	
Nurses can start a new project with the shared governance team.	1	1[P7]	
The shared governance council helped nurses to reduce overtime.	1	1[P14]	
Many have improved their leadership skills since individual responsibilities were given to each staff.	1	1[P2]	Immediate manager understanding and support could be significant enablers of implementing shared governance.
<i>In your opinion, what are the enablers to implementing shared governance in your unit/hospital?</i>			

(Continued)

Table 2. Continued

Questions and sub-category	F	Participants	Main themes and sub-themes
Work culture enhances shared governance activities and participation	1	1[P1]	Participants perceived several enablers of implementing shared governance, that is, the immediate manager understanding and support, senior management support, work culture, nurse cooperation and teamwork, and multicultural nurses.
Immediate manager understanding and support	17	11[P2, P3, P4, P6, P7, P8, P9, P10, P11, P13, P14]	
Senior management support	2	2[P7, P9]	
Multicultural nurses help a lot	1	1[P14]	
Nurses' readiness, cooperation, and teamwork are the enablers.	3	3[P5, P8, P14]	
<i>In your opinion, what are the barriers to implementing shared governance in your unit/hospital?</i>			Participants perceived several significant barriers, mainly nurse's attitudes and behaviors, lack of management support, and time.
Some nurses might feel that maybe our concern is not so important.	1	1[P1]	Nearly half of the participants (50%) perceived nurse's attitudes and behaviors as a barrier.
Nurses will not tell their concerns because they think that they will not be heard or frightened by top management.	3	3[P1, P2, P3]	
Lack of nurse's interest and commitment.	2	2[P4, P7]	
Some nurses are reluctant to follow suggestions from others.	1	1[P5]	
Some issues cannot be sorted out and it is really hard to find a solution.	1	1[P10]	
Lack of open communication between nurses and the management.	1	1[P2]	A greater number of participants (80%) perceived the lack of the senior manager's support as a barrier.
Nurses spend their time and come on their off days.	10	8[P4, P5, P8, P10, P11, P13, P14, P15]	
The immediate manager's authority is limited and not empowered to act or does not act.	2	2[P12, P15]	
The manager does not solve the problem within a given time and they keep promising.	1	1[P14]	
Hierarchy, lack of senior management support, and the management take the final decision.	13	7[P3, P4, P6, P12, P13, P14, P15]	
We don't get feedback about the problem that was raised.	1	1[P14]	A greater number of participants (60%) perceived the time of meetings and other activities as barriers.
Nurses mentioned the time as a constraint for implementing shared governance, including conducting convenience meetings and other activities.	16	9[P6, P7, P8, P9, P10, P11, P13, P14, P15]	
Nurses turnover	4	3[P4, P5, P15]	
The meetings turned to virtual due to the COVID-19 pandemic and after.	1	1[P7]	
<i>Could you please share any suggestions or recommendations for improving the current shared governance practices in your unit/department?</i>			Participants were positive and enthusiastic to improve the current situation of shared governance.
Involve nurses more/more meetings/involve more nurses.	12	8[P2, P3, P4, P7, P8, P12, P13, P15]	A greater number of participants (80%) recommended increasing senior nursing management support.
Management support/empowering nurses/listening to nurse's concerns.	9	7[P3, P4, P8, P12, P13, P14, P15]	
To allocate a certain amount of time suitable for nurses to discuss things and do other activities	10	4[P2, P3, P5, P10]	
Adequate staffing	1	1[P5]	
Motivate nurses.	4	2[P9, P15]	
Share the positive outcomes/success stories of the shared governance with nurses to improve their participation.	8	5[P1, P4, P7, P13, P15]	A small number of participants (33%) suggested sharing positive outcomes with nurses.
The nurses should participate/voice out what they want to say/be more proactive.	3	3[P3, P4, P13]	A small number of participants suggested that nurses should positively contribute.

(Continued)

Table 2. Continued

Questions and sub-category	F	Participants	Main themes and sub-themes
Increase nurse's awareness of what is shared governance.	4	3[P5, P13, P15]	A small number of participants (20%) suggested increasing nurse's awareness.
To see some implementation should happen.	1	1[P11]	Other participants suggested various strategies to motivate nurses to participate in implementing shared governance.
Follow-up issues by collecting data, and taking them to the next level are very important.	1	1[P10]	
To set meeting dates as per staff convenience	1	1[P9]	
Assign a special process of writing any issue on a piece of paper and submit it to the shared governance team.	1	1[P1]	
Update nurses by sharing minutes.	1	1[P12]	
Face-to-face meetings are better than virtual meetings.	1	1[P7]	
Involve other allied health professionals.	1	1[P10]	

Table 2. Thematic data analysis.

concerns out without any fear from the top managers. This result matches the earlier findings of Kutney-Lee et al.,⁹ Faouri et al.,¹³ and Hess¹² in terms of controlling their professional practice, autonomy, engagement, and collaboration.

The understanding of the shared governance concept and its benefits by nurses could be due to the efforts spent by the nursing senior managers at the shared governance launching stage, which usually proceeds the Magnet journey. A participant described this stage as there were many reading posters in their unit about shared governance, another participant said that they gave presentations, and another participant expressed that she knew about it only after coming to this hospital. However, the intense effort has slowed down since that time; one participant mentioned that it had started long back, but since the past year, they have not had much shared governance activities in their unit, and another said that most of the nurses have many concerns, not heard since the past year, which is incompatible with the recommendation of Hess³⁷ to move forward and not draw back. A participant said shared governance should be fruitful and beneficial to make nurses happy, and not just for branding.

Theme 3 reflected that participants demonstrated contradictory views about the outcome of implementing shared governance in their hospital. The majority of participants did not perceive positive results of shared governance implementation; a participant said that they had not seen any changes or anything implemented; another said there is a block between the senior management and the nurses and no communication, and a third participant said that the managers take most of

the decisions; they listen to us, but in the end, the manager will be the one who will decide all those things, a fourth participant said that they are trying to implement it, but nothing is happening when it comes to actions and changes, and a fifth participant commented that before we complete a sentence, or raise any issue, we get an answer; at least to listen to our concerns and then give us an answer. On the other hand, a few participants perceived positive outcomes of implementing shared governance; one participant said I believe we are empowered in the hospital; every nurse has a say, and another participant also confirmed that nurses are empowered, and they now think before saying yes and advocate for their patients.

However, this contradiction in the view of the participant reflects a poor outcome, which somehow aligned with the work of Anthony², who claimed that building a proper structure of shared governance is a challenge for the nursing department in any hospital and aligned with the views of some scholars who believed that implementing a shared governance model is difficult in the Middle East hierarchy-driven environment culture.³

Theme 4 reflected that participants perceived immediate manager understanding and support as a primary enabler, as highlighted by most participants. A limited number of participants highlighted other enablers, including senior management support, work culture, nurse cooperation and teamwork, and multicultural nurses. The immediate manager's understanding and support were restricted to meeting specific requests from the nurses, such as change of duty or assignment; one participant said, "My manager is good, supportive,

listens to us, and is approachable”; another participant said, “managers are not fully democratic; they listen to us and readjust.” However, the role of immediate managers is limited in implementing shared governance; one participant said, “Our manager is now 6 months or 7 months in our unit; we did not get any minutes of meetings, and we did not know about any implementation”; another nurse said that sometimes, the managers do not solve the problem within a given time, and they keep saying – okay, we will do it; and a third participant said, “our unit manager recommends staff to be a part of shared governance and sometimes they force nurses to be a part of it.” Some nurses suggested that the immediate manager also needs to be empowered; one participant said that the manager controls every activity in the unit and does things in the way assigned to him; another nurse asked how it would work if the manager cannot act on staff suggestions and does not get the support of higher managers.

Theme 5 reflected that participants perceived several significant barriers. First, a greater number of participants perceived the lack of senior manager’s support as a barrier; one nurse said we rarely see our senior managers; I did not feel that they are supporting us, another participant said, “I think there is a block between the senior management and the nurses; there is no communication”; another nurse said, “staff have concerns about their duty timing, break time or staffing; they will not talk about it because they think that they will not hear.” This barrier explains the poor outcome of the implemented shared governance, which confirms the findings of Maged et al.²⁸ that the majority of nursing professional decisions in the Arabic context were made primarily by nursing management and the need for transformational leadership⁹ and enhancing the role of higher-level managers in empowering their staff.²³

Second, the study identified nurse attitudes and behaviors, similar to Keane,²⁶ as barriers. One participant said, “some of us might feel that their concern is minor”; another said the staff should be brave enough to voice their feelings or what they want rather than talking behind. This barrier is linked to the lack of senior nursing manager support, who should motivate staff, allow them to control their practices, help them to set clear, realistic goals, and empower themselves and their staff in communication and participation skills and serve as the symbol of a participatory model in the leadership position.^{22,23}

Third, the study, similar to Motte,²⁷ identified the time as a barrier in two ways; the nature of the nursing profession and shift duty make it difficult for nurses to meet and discuss issues related to their work and the lack of compensatory time for nurses who come from

their day off or stay after long shifts to attend to those activities. This barrier is also linked to the senior nursing manager’s support.

Theme 6 reflected that participants were positive and enthusiastic about improving the current situation of shared governance; one nurse said that nurses are happy to participate in all the shared governance activities like meeting to bring their problems, and they are always eager to see the result. The participants recommended increasing the senior nursing management support, sharing positive outcomes with nurses, and increasing their awareness. Additionally, they encouraged nurses to contribute positively to shared governance activities.

In the end, the interviews failed to highlight any link between implementing shared governance in the study tertiary hospital and nurse’s innovative behaviors and work innovation; it emphasized that the shared governance model implementation did not reach higher-level outcomes, such as innovation, to improve patient care and organizational performance by generating new ideas.

5. Conclusions

The study highlighted that the outcome of implementing shared governance in a tertiary hospital in the UAE did not achieve its goals. It identified immediate managers’ support as a significant enabler; they were cooperative and supportive. On the other hand, the study identified several barriers, including a lack of senior management support, nurses’ attitudes and behaviors, and time. However, they did not address specific concerns about the structure of shared governance or the local culture of the study context. Furthermore, the study highlighted that nurses are positive and enthusiastic about improving the current situation of shared governance by providing several suggestions and strategies.

The study results are critical to improving the outcome of implementing shared governance. It highlighted the lack of senior management’s support as a significant barrier and identified other barriers, that is, nurse attitudes and behaviors and time, which are also linked to the senior manager’s support. Accordingly, the study spotlighted an opportunity for senior nursing managers to re-evaluate shared governance implementation and modify the strategies accordingly.

The senior managers should believe in shared governance as a strategic approach to improve clinical practice and nurse engagement rather than for branding. They can adopt several strategies, for example, empower their staff in communication and participation skills, support staff and direct managers to develop leadership skills, provide nurses with the

required time, motivate nurses, share the positive outcomes and success stories, and keep nurses aware of what is shared governance. Also, the senior managers should serve as role models for demonstrating participatory leadership, for example, listening, involving, and empowering others.

Recommendations for future research

The enablers and barriers of implementing shared governance are essential topics for nursing authors to understand this phenomenon in various cultures and contexts. We encourage conducting more qualitative research in the context of the Middle East, specifically in the UAE. This study could guide nursing authors in conducting quantitative research to survey a larger sample of nurses in several hospitals.

Limitations

The study was conducted in one hospital in the UAE. It is a qualitative, case study that aimed to find a new theory in the context of the Middle East. Although the study results apply to the study hospital, they cannot be

generalized beyond this particular hospital, for example, to other hospitals functioning in other countries or regions.

Acknowledgment

The authors acknowledge and appreciate Nabeel Al Amiri (a PhD in Business Management – Knowledge Management and Innovation and a Charge Nurse at Tawam Hospital) for extending his generous support and guidance to the research team through all stages.

Ethical approval

This study was approved by the Tawam Hospital Research Ethics Committee (IRB Approval No.: MF2058-2022-881). The authors explained the purposes of the interviews to participants and obtained consent. Moreover, they maintained information confidentiality all the time.

Conflicts of interest

All contributing authors declare no conflicts of interest.

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