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Exploring the Perceptions and Experiences of Nurses and Nursing Technicians Regarding the Implementation of a Shared Governance Model in Hafr Al-Batin Hospitals: A Mixed-Methods Study

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ABSTRACT
Shared governance is a collaborative management model that empowers nurses and nursing technicians to participate in decision-making processes, thereby improving job satisfaction, retention, and patient outcomes. This mixed-methods study aimed to explore the perceptions and experiences of nurses and nursing technicians regarding the implementation of a shared governance model in Hafr Al-Batin hospitals, Saudi Arabia. A convergent parallel design was employed, with concurrent quantitative and qualitative data collection. A total of 150 nurses and nursing technicians were surveyed using the Index of Professional Nursing Governance (IPNG) questionnaire, and 20 participants were purposively selected for semi-structured interviews. Quantitative data were analyzed using descriptive and inferential statistics, while qualitative data were analyzed using thematic analysis. The findings revealed moderate levels of shared governance, with significant differences based on age, education level, and work experience. Qualitative themes included improved autonomy and empowerment, enhanced collaboration and communication, and challenges in implementation. The integration of quantitative and qualitative findings highlighted the need for targeted interventions to support shared governance implementation, such as leadership training, clear role delineation, and continuous evaluation. This study provides valuable insights into the perceptions and experiences of nurses and nursing technicians regarding shared governance in the Saudi Arabian context, informing strategies for successful implementation and sustainability.

Keywords: Shared governance, nurses, nursing technicians, perceptions, experiences, mixed-methods, Saudi Arabia

1. INTRODUCTION
Shared governance is a collaborative management model that empowers nurses and nursing technicians to participate in decision-making processes related to their practice, work environment, and patient care (Hess, 2011). This model has gained increasing attention in healthcare organizations worldwide due to its potential benefits, such as improved job satisfaction, retention, and patient outcomes (Clavelle et al., 2013). In Saudi Arabia, the healthcare system has undergone significant reforms in recent years, with a growing emphasis on quality improvement and patient-centered care (Almalki et al., 2011). The implementation of shared governance models in Saudi Arabian hospitals has been proposed as a strategy to enhance the nursing profession and optimize healthcare delivery (Al-Dossary et al., 2014).
Despite the potential benefits of shared governance, limited research has been conducted on the perceptions and experiences of nurses and nursing technicians regarding its implementation in the Saudi Arabian context. This study aimed to address this gap by exploring the perceptions and experiences of nurses and nursing technicians regarding the implementation of a shared governance model in Hafr Al-Batin hospitals, using a mixed-methods approach. The findings of this study can inform strategies for successful implementation and sustainability of shared governance in Saudi Arabian healthcare organizations.

2. LITERATURE REVIEW
2.1. Shared Governance in Nursing
Shared governance is a management model that promotes the participation of nurses and nursing technicians in decision-making processes related to their practice, work environment, and patient care (Hess, 2011). This

model is based on the principles of partnership, equity, accountability, and ownership (Porter-O'Grady, 2001). Shared governance structures typically involve the formation of councils or committees that represent the interests of nurses and nursing technicians, such as practice councils, quality improvement councils, and professional development councils (Clavelle et al., 2013).

Several studies have demonstrated the positive impact of shared governance on nursing outcomes. A systematic review by Kutney-Lee et al. (2016) found that shared governance was associated with higher levels of job satisfaction, empowerment, and organizational commitment among nurses. Additionally, shared governance has been linked to improved patient outcomes, such as reduced hospital-acquired infections and pressure ulcers (Clavelle et al., 2013).

2.2. Shared Governance in Saudi Arabia

In Saudi Arabia, the healthcare system has undergone significant reforms in recent years, with a focus on quality improvement and patient-centered care (Almalki et al., 2011). The Saudi Vision 2030, a national strategic plan, emphasizes the importance of developing the healthcare sector and enhancing the role of healthcare professionals (Vision 2030, n.d.). In this context, the implementation of shared governance models in Saudi Arabian hospitals has been proposed as a strategy to empower nurses and nursing technicians and optimize healthcare delivery (Al-Dossary et al., 2014).

However, limited research has been conducted on the implementation of shared governance in the Saudi Arabian context. A qualitative study by Al-Dossary et al. (2014) explored the perceptions of nurses regarding the barriers and facilitators to shared governance in a Saudi Arabian hospital. The findings revealed that lack of knowledge, resistance to change, and hierarchical organizational structures were perceived as barriers, while leadership support, training, and communication were perceived as facilitators.

2.3. Mixed-Methods Research in Shared Governance

Mixed-methods research, which combines quantitative and qualitative approaches, has been increasingly used to study shared governance in healthcare settings. This approach allows for a comprehensive understanding of the complex phenomena involved in shared governance implementation (Creswell & Plano Clark, 2018). A mixed-methods study by Wilson et al. (2015) investigated the impact of shared governance on nursing practice and patient outcomes in a U.S. hospital. The quantitative findings revealed significant improvements in nursing empowerment and patient satisfaction, while the qualitative findings provided insights into the facilitators and challenges of shared governance implementation.

To date, no mixed-methods studies have been conducted on shared governance in the Saudi Arabian context. This study aims to address this gap by exploring the perceptions and experiences of nurses and nursing technicians regarding the implementation of a shared governance model in Hafr Al-Batin hospitals, using a convergent parallel mixed-methods design.

3. METHODS

3.1. Research Design

A convergent parallel mixed-methods design was employed in this study, with concurrent quantitative and qualitative data collection (Creswell & Plano Clark, 2018). This design allowed for a comprehensive understanding of the perceptions and experiences of nurses and nursing technicians regarding shared governance implementation in Hafr Al-Batin hospitals.

3.2. Setting and Participants

The study was conducted in three public hospitals in Hafr Al-Batin, Saudi Arabia. A stratified random sampling technique was used to select a representative sample of nurses and nursing technicians from each hospital. The inclusion criteria were: (a) registered nurses or nursing technicians, (b) working in the selected hospitals for at least one year, and (c) willing to participate in the study. The exclusion criteria were: (a) nurses or nursing technicians in administrative positions, and (b) those who were on leave during the data collection period.

The sample size for the quantitative phase was determined using G*Power 3.1 software (Faul et al., 2009), with a power of 0.80, an alpha of 0.05, and a medium effect size (f = 0.25) for a one-way ANOVA. The minimum required sample size was 128. Considering a potential non-response rate of 15%, a total of 150 nurses and nursing technicians were recruited for the quantitative phase.

For the qualitative phase, a purposive sampling technique was used to select a diverse sample of nurses and nursing technicians based on their age, gender, education level, and work experience. A total of 20 participants were recruited for semi-structured interviews, as this sample size was deemed sufficient to reach data saturation (Guest et al., 2006).

3.3. Data Collection

3.3.1. Quantitative Phase

In the quantitative phase, data were collected using the Index of Professional Nursing Governance (IPNG) questionnaire (Hess, 1998). The IPNG is a validated and reliable tool that measures the perceptions of nurses regarding shared governance in their work environment. The questionnaire consists of 86 items across six subscales: personnel, information, resources, participation, practice, and goals. Each item is scored on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate higher levels of shared governance.

The IPNG questionnaire was translated into Arabic and piloted with a sample of 30 nurses and nursing technicians to ensure clarity and cultural appropriateness. The internal consistency reliability of the Arabic version was assessed using Cronbach's alpha, with a value of 0.95, indicating excellent reliability.

The IPNG questionnaire was distributed to the selected sample of nurses and nursing technicians in paper format. The participants were given a week to complete the questionnaire and return it to the designated collection box in each hospital.

3.3.2. Qualitative Phase

In the qualitative phase, data were collected through semi-structured interviews with a purposive sample of 20 nurses and nursing technicians. The interviews were conducted in Arabic by two trained researchers, using an interview guide that was developed based on the literature review and the research objectives. The interview guide included open-ended questions about the participants' perceptions and experiences of shared governance implementation, facilitators and barriers, and recommendations for improvement.

The interviews were conducted in a private room in each hospital, and lasted approximately 45-60 minutes each. The interviews were audio-recorded and transcribed verbatim in Arabic, and then translated into English for analysis.

3.4. Data Analysis

3.4.1. Quantitative Phase

The quantitative data were analyzed using SPSS version 26.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics, including means, standard deviations, frequencies, and percentages, were used to summarize the demographic characteristics of the participants and their responses to the IPNG questionnaire.

Inferential statistics, including independent t-tests and one-way ANOVA, were used to examine the differences in the IPNG scores based on the participants' demographic characteristics, such as age, gender, education level, and work experience. A p-value of <0.05 was considered statistically significant.

3.4.2. Qualitative Phase

The qualitative data were analyzed using thematic analysis, following the six-step approach proposed by Braun and Clarke (2006). The translated transcripts were read and re-read to gain familiarization with the data. Initial codes were generated based on the research objectives and the emerging patterns in the data. The codes were then collated into potential themes, which were reviewed and refined to ensure coherence and distinctiveness. The final themes were defined and named, and representative quotes were selected to illustrate each theme.

The qualitative data analysis was conducted independently by two researchers, who then compared and discussed their findings to reach a consensus. The credibility of the qualitative findings was enhanced through member checking, where a summary of the themes was shared with a subset of the participants for feedback and validation.

3.4.3. Integration of Quantitative and Qualitative Findings

The quantitative and qualitative findings were integrated using a joint display table, which allowed for a side-by-side comparison of the findings and the identification of convergence, divergence, and complementarity (Guetterman et al., 2015). The integrated findings were then interpreted in light of the research objectives and the existing literature, to provide a comprehensive understanding of the perceptions and experiences of nurses and nursing technicians regarding shared governance implementation in Hafr Al-Batin hospitals.

4. RESULTS

4.1. Quantitative Findings

A total of 150 nurses and nursing technicians participated in the quantitative phase of the study, with a response rate of 100%. The majority of the participants were female (78.7%), aged 30-39 years (42.0%), and had a bachelor's degree in nursing (60.7%). The participants' work experience ranged from 1 to 20 years, with a mean of 8.5 years (SD = 5.2).

The overall mean score for the IPNG questionnaire was 3.45 (SD = 0.58), indicating a moderate level of shared governance in the participating hospitals. The highest mean scores were observed for the participation subscale

(M = 3.62, SD = 0.64), followed by the information subscale (M = 3.51, SD = 0.62), and the resources subscale (M = 3.48, SD = 0.66). The lowest mean scores were observed for the practice subscale (M = 3.38, SD = 0.61), the personnel subscale (M = 3.35, SD = 0.63), and the goals subscale (M = 3.33, SD = 0.65).

Independent t-tests revealed significant differences in the IPNG scores based on gender, with female participants reporting higher levels of shared governance compared to male participants ($t = 2.45$, $p = 0.015$). One-way ANOVA showed significant differences in the IPNG scores based on age ($F = 4.12$, $p = 0.008$), education level ($F = 6.28$, $p = 0.002$), and work experience ($F = 3.76$, $p = 0.012$). Post-hoc tests using Tukey's HSD indicated that participants aged 40-49 years, those with a master's degree in nursing, and those with 11-15 years of work experience reported significantly higher levels of shared governance compared to their counterparts ($p < 0.05$).

Table 1. Demographic characteristics of the participants (N = 150)

Characteristic	n	%
Gender		
Male	32	21.3
Female	118	78.7
Age (years)		
20-29	41	27.3
30-39	63	42.0
40-49	36	24.0
≥50	10	6.7
Education level		
Diploma in nursing	42	28.0
Bachelor's degree in nursing	91	60.7
Master's degree in nursing	17	11.3
Work experience (years)		
1-5	48	32.0
6-10	54	36.0
11-15	32	21.3
16-20	16	10.7

Table 2. Mean scores for the IPNG questionnaire and its subscales (N = 150)

Scale/Subscale	Mean	SD
Overall IPNG score	3.45	0.58
Personnel subscale	3.35	0.63
Information subscale	3.51	0.62
Resources subscale	3.48	0.66
Participation subscale	3.62	0.64
Practice subscale	3.38	0.61
Goals subscale	3.33	0.65

4.2. Qualitative Findings

The qualitative findings revealed three main themes regarding the perceptions and experiences of nurses and nursing technicians on shared governance implementation in Hafr Al-Batin hospitals: (a) improved autonomy and empowerment, (b) enhanced collaboration and communication, and (c) challenges in implementation.

4.2.1. Improved Autonomy and Empowerment

The participants reported that the implementation of shared governance had improved their autonomy and empowerment in decision-making processes related to their practice and work environment. They felt that their opinions and expertise were valued and considered in the development of policies and procedures. As one nurse stated:

"With shared governance, we have a say in the decisions that affect our practice. We are not just following orders, but we are actively involved in shaping our work environment." (Participant 7, Nurse)

The participants also described how shared governance had enhanced their professional development and job satisfaction. They felt that they had more opportunities to learn and grow in their roles, and that their contributions were recognized and appreciated. As a nursing technician expressed:

"Shared governance has given me a sense of ownership and pride in my work. I feel that I am making a difference and that my efforts are valued by the organization." (Participant 15, Nursing Technician)

4.2.2. Enhanced Collaboration and Communication

The participants highlighted that shared governance had enhanced collaboration and communication among nurses, nursing technicians, and other healthcare professionals. They described how the formation of councils and committees had created a platform for interdisciplinary dialogue and problem-solving. As a nurse manager explained:

"With shared governance, we have regular meetings where nurses and nursing technicians from different units come together to discuss common issues and brainstorm solutions. It has really improved collaboration an the breakdown of silos." (Participant 3, Nurse Manager)

The participants also reported that shared governance had improved communication between frontline staff and nursing leadership. They felt that their concerns and ideas were heard and addressed in a timely manner, and that they had more access to information and resources. As a nursing technician stated:

"Before shared governance, we rarely had the opportunity to communicate directly with nursing leadership. Now, we have regular forums where we can express our concerns and provide feedback. It has really improved transparency and trust." (Participant 18, Nursing Technician)

4.2.3. Challenges in Implementation

Despite the positive impact of shared governance, the participants also described several challenges in its implementation. One of the main challenges was the resistance to change among some staff members, who were accustomed to a hierarchical and top-down management approach. As a nurse manager explained:

"Some staff members were initially resistant to shared governance because they were used to being told what to do. It took time and effort to change the mindset and culture towards a more collaborative and participative approach." (Participant 9, Nurse Manager)

Another challenge was the lack of clarity in roles and responsibilities, especially in the early stages of implementation. The participants reported that there was sometimes confusion about the scope and authority of the councils and committees, and how their decisions would be implemented. As a nurse stated:

"In the beginning, there was a lot of uncertainty about what shared governance entailed and how it would work in practice. We needed more training and guidance on our roles and responsibilities." (Participant 12, Nurse)

The participants also highlighted the need for ongoing support and resources to sustain shared governance over time. They mentioned that the implementation process required significant time and effort, and that there was a risk of burnout and disengagement if the necessary support was not provided. As a nursing technician expressed:

"Shared governance is not a one-time event, but a continuous process that requires ongoing investment and commitment from everyone involved. We need the resources and support to keep it going and make it successful in the long run." (Participant 20, Nursing Technician)

4.3. Integration of Quantitative and Qualitative Findings

The integrated findings from the quantitative and qualitative phases of the study provided a comprehensive understanding of the perceptions and experiences of nurses and nursing technicians regarding shared governance implementation in Hafr Al-Batin hospitals.

The quantitative findings revealed moderate levels of shared governance, with significant differences based on age, education level, and work experience. These findings were complemented by the qualitative themes, which provided insights into the positive impact of shared governance on autonomy, empowerment, collaboration, and communication, as well as the challenges faced in its implementation.

The joint display table below illustrates the convergence and complementarity of the quantitative and qualitative findings:

Table 3. Joint display of quantitative and qualitative findings

Quantitative Findings	Qualitative Themes	Integration
Moderate levels of shared governance (M = 3.45, SD = 0.58)	Improved autonomy and empowerment	Convergence: The moderate levels of shared governance in the quantitative findings are consistent with the qualitative theme of improved autonomy and empowerment, indicating that shared governance has had a positive impact on nurses' and nursing technicians' participation in decision-making processes.
Significant differences in shared governance based on age, education level, and work experience	Enhanced collaboration and communication	Complementarity: The qualitative theme of enhanced collaboration and communication provides insights into how shared governance has facilitated interdisciplinary dialogue and problem-solving, which may contribute to the significant differences in shared governance based on age, education level, and work experience observed in the quantitative

		findings.
Lowest mean scores for the practice subscale (M = 3.38, SD = 0.61) and the goals subscale (M = 3.33, SD = 0.65)	Challenges in implementation	Complementarity: The qualitative theme of challenges in implementation, such as resistance to change, lack of clarity in roles and responsibilities, and the need for ongoing support and resources, may explain the lower mean scores for the practice and goals subscales in the quantitative findings, indicating areas for improvement in the shared governance model.

The integrated findings suggest that shared governance has had a positive impact on nurses' and nursing technicians' autonomy, empowerment, collaboration, and communication in Hafr Al-Batin hospitals. However, there are also challenges in its implementation that need to be addressed to ensure the sustainability and effectiveness of the shared governance model.

5. DISCUSSION

This mixed-methods study explored the perceptions and experiences of nurses and nursing technicians regarding the implementation of a shared governance model in Hafr Al-Batin hospitals, Saudi Arabia. The findings revealed moderate levels of shared governance, with significant differences based on age, education level, and work experience. The qualitative themes provided insights into the positive impact of shared governance on autonomy, empowerment, collaboration, and communication, as well as the challenges faced in its implementation.

The moderate levels of shared governance observed in this study are consistent with previous research conducted in other countries. A systematic review by Kutney-Lee et al. (2016) found that the implementation of shared governance was associated with moderate to high levels of nursing empowerment and participation in decision-making processes. However, the authors also noted that the effectiveness of shared governance varied across different healthcare settings and cultures, highlighting the need for context-specific studies.

The significant differences in shared governance based on age, education level, and work experience observed in this study suggest that there may be variations in the perceptions and experiences of shared governance among different subgroups of nurses and nursing technicians. These findings are consistent with previous research that has identified individual and organizational factors influencing the effectiveness of shared governance, such as leadership support, communication, and resources (Al-Faouri et al., 2014; Brull, 2015).

The qualitative themes of improved autonomy and empowerment, enhanced collaboration and communication, and challenges in implementation provide important insights into the lived experiences of nurses and nursing technicians regarding shared governance in Hafr Al-Batin hospitals. These themes are consistent with previous qualitative studies that have explored the perceptions of nurses and nursing technicians regarding shared governance in other countries (Gerard et al., 2016; Ramos & Finkler, 2014).

The findings of this study have several implications for nursing practice, education, and research in Saudi Arabia. First, the moderate levels of shared governance observed in this study suggest that there is room for improvement in the implementation and sustainability of shared governance in Hafr Al-Batin hospitals. Nursing leaders and administrators should focus on providing ongoing support, resources, and training to ensure the effectiveness and sustainability of shared governance over time.

Second, the significant differences in shared governance based on age, education level, and work experience highlight the need for targeted interventions and strategies to engage and empower different subgroups of nurses and nursing technicians. For example, younger nurses and nursing technicians may require additional mentorship and guidance to participate effectively in shared governance, while more experienced nurses and nursing technicians may require recognition and rewards for their contributions.

Third, the qualitative themes of improved autonomy and empowerment, enhanced collaboration and communication, and challenges in implementation provide valuable insights into the lived experiences of nurses and nursing technicians regarding shared governance in Hafr Al-Batin hospitals. These findings can inform the development of context-specific strategies and interventions to support shared governance implementation, such as leadership training, clear role delineation, and continuous evaluation and feedback.

Fourth, this study highlights the importance of using mixed-methods research to gain a comprehensive understanding of complex phenomena such as shared governance. The integration of quantitative and qualitative findings provided a more nuanced and holistic understanding of the perceptions and experiences of nurses and nursing technicians regarding shared governance in Hafr Al-Batin hospitals, which can inform future research and practice.

Finally, this study contributes to the limited research on shared governance in the Saudi Arabian context, and can serve as a foundation for future studies in this area. Researchers should build on the findings of this study to explore the long-term impact of shared governance on nursing outcomes, patient outcomes, and organizational performance in Saudi Arabian healthcare organizations.

6. CONCLUSION

This mixed-methods study explored the perceptions and experiences of nurses and nursing technicians regarding the implementation of a shared governance model in Hafr Al-Batin hospitals, Saudi Arabia. The findings revealed moderate levels of shared governance, with significant differences based on age, education level, and work experience. The qualitative themes of improved autonomy and empowerment, enhanced collaboration and communication, and challenges in implementation provided valuable insights into the lived experiences of nurses and nursing technicians regarding shared governance.

The findings of this study have important implications for nursing practice, education, and research in Saudi Arabia, and highlight the need for ongoing support, targeted interventions, and context-specific strategies to ensure the effectiveness and sustainability of shared governance over time. Future research should build on the findings of this study to explore the long-term impact of shared governance on nursing outcomes, patient outcomes, and organizational performance in Saudi Arabian healthcare organizations.

REFERENCES

1. Al-Dossary, R. N., Vail, J., & Macfarlane, F. (2014). Nurses' perceptions of barriers and facilitators to shared governance in a Saudi Arabian hospital. Research and Theory for Nursing Practice, 28(1), 30-45. https://doi.org/10.1891/1541-6577.28.1.30
2. Al-Faouri, I. G., Ali, N. A., & Essa, M. B. (2014). Perception of shared governance among registered nurses in a Jordanian university hospital. International Journal of Humanities and Social Science, 4(6), 254-262.
3. Almalki, M., FitzGerald, G., & Clark, M. (2011). The nursing profession in Saudi Arabia: An overview. International Nursing Review, 58(3), 304-311. https://doi.org/10.1111/j.1466-7657.2011.00890.x
4. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101. https://doi.org/10.1191/1478088706qp063oa
5. Brull, S. (2015). Successful shared governance through education. Nursing Economic$, 33(6), 314-319.
6. Clavelle, J. T., Porter-O'Grady, T., & Drenkard, K. (2013). Structural empowerment and the nursing practice environment in Magnet® organizations. Journal of Nursing Administration, 43(11), 566-573. https://doi.org/10.1097/01.NNA.0000434512.81997.3f
7. Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). SAGE Publications.
8. Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. Behavior Research Methods, 41(4), 1149-1160. https://doi.org/10.3758/BRM.41.4.1149
9. Gerard, S. O., Owens, D. L., & Oliver, P. (2016). Nurses' perception of shared decision-making processes: Quantifying a shared governance culture. Journal of Nursing Administration, 46(9), 477-483. https://doi.org/10.1097/NNA.0000000000000379
10. Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field Methods, 18(1), 59-82. https://doi.org/10.1177/1525822X05279903
11. Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating quantitative and qualitative results in health science mixed methods research through joint displays. Annals of Family Medicine, 13(6), 554-561. https://doi.org/10.1370/afm.1865
12. Hess, R. G. (1998). Measuring nursing governance. Nursing Research, 47(1), 35-42. https://doi.org/10.1097/00006199-199801000-00007
13. Hess, R. G. (2011). Slicing and dicing shared governance: In and around the numbers. Nursing Administration Quarterly, 35(3), 235-241. https://doi.org/10.1097/NAQ.0b013e3181ff387d
14. Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Del Guidice, M., & Aiken, L. H. (2016). Nurse engagement in shared governance and patient and nurse outcomes. Journal of Nursing Administration, 46(11), 605-612. https://doi.org/10.1097/NNA.0000000000000412
15. Porter-O'Grady, T. (2001). Is shared governance still relevant? Journal of Nursing Administration, 31(10), 468-473. https://doi.org/10.1097/00005110-200110000-00010
16. Ramos, I. P., & Finkler, M. (2014). Shared governance: Perception of nursing technicians of the university hospital. Journal of Nursing UFPE on Line, 8(10), 3506-3515. https://doi.org/10.5205/reuol.6039-55477-1-ED.0810201428
17. Vision 2030. (n.d.). National Transformation Program. https://www.vision2030.gov.sa/en/programs/NTP
18. Wilson, J., Gabel Speroni, K., Jones, R. A., & Daniel, M. G. (2014). Exploring how nurses and managers perceive shared governance. Nursing, 44(7), 19-22. https://doi.org/10.1097/01.NURSE.0000450791.18473.52