



PERCEIVED SHARED GOVERNANCE AMONG NURSE LEADERS IN LEVEL II HOSPITALS IN LUCENA CITY: BASIS FOR A SHARED GOVERNANCE FRAMEWORK

Hannah Paula Jacobo, RN, MSN¹, Vivian L. Dedace, RN, MAN, EdD, FANSAP, FPCHA, FPSQUA²

¹Sacred Heart College, Lucena City, Philippines

²Sacred Heart College, Lucena City, Philippines

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ABSTRACT

Shared governance is a professional practice model that promotes collaboration, empowerment, and shared decision-making among nurses and nurse leaders. This study determined the perceived shared governance among nurse leaders in Level II hospitals in Lucena City and examined differences in perceptions when grouped according to demographic profile. A quantitative descriptive design utilizing descriptive-survey, descriptive-evaluative, and descriptive-comparative approaches was employed. A total of 114 nurse leaders participated through purposive sampling. Data were collected from July to September 2024 using the Index of Professional Nursing Governance-Short Form (IPNG-S), which measures six governance dimensions: control over personnel, access to information, influence over resources supporting practice, participation in organizational decisions, control over practice, and ability to set goals. Descriptive statistics and non-parametric inferential tests were used for data analysis. Results showed an overall IPNG-S mean score of 118.18, interpreted as primarily management with some staff input. Influence over resources supporting practice was perceived as equally shared, while access to information, participation in organizational decisions, and control over practice were perceived as management-controlled. No significant differences were found when grouped according to age, sex, and educational attainment. However, significant differences were noted by length of service for control over personnel and access to information. The findings served as the basis for developing a shared governance framework aimed at strengthening nurse leader participation in governance processes within Level II hospitals.

KEYWORDS: Shared Governance, Nurse Leaders, IPNG-S, Nursing Administration, Level II Hospitals

INTRODUCTION

Healthcare organizations increasingly rely on nurse leaders to balance administrative responsibilities with clinical excellence. Shared governance has emerged as a professional practice model that allows nurses and nurse leaders to participate in decisions affecting patient care, professional practice, and organizational outcomes. By promoting shared accountability and collaboration between management and staff, shared governance supports empowerment, autonomy, and professional growth within nursing practice.

Despite its recognized benefits, shared governance remains inconsistently implemented across healthcare settings. Many institutions continue to operate under hierarchical leadership structures where decision-making authority is centralized, limiting nurse participation in governance processes. Studies have shown that restricted access to information and limited involvement in organizational decision-making can negatively affect nurse satisfaction, engagement, and retention.

In the Philippine context, nurse leaders play a critical role in hospital operations; however, empirical evidence on shared

governance practices, particularly in Level II hospitals, remains limited. Understanding nurse leaders' perceptions of shared governance is essential in identifying gaps and developing governance frameworks tailored to local organizational contexts. This study therefore examined perceived shared governance among nurse leaders in Level II hospitals in Lucena City as a basis for developing a shared governance framework.

METHODS

Research Design

A quantitative descriptive research design was employed, integrating descriptive-survey, descriptive-evaluative, and descriptive-comparative approaches.

Participants and Setting

The study involved nurse leaders from Level II hospitals in Lucena City, Quezon Province, Philippines. Participants included chief nurses, nurse supervisors, unit managers, head nurses, and charge nurses. Using purposive sampling, 114 nurse leaders were recruited.

**Instrument**

Data were collected using the Index of Professional Nursing Governance–Short Form (IPNG-S). The instrument consists of 50 items rated on a 5-point Likert scale and measures six governance domains: control over personnel, access to information, influence over resources supporting practice, participation in organizational decisions, control over practice, and ability to set goals.

Data Collection

Data collection was conducted from July to September 2024 through online and paper-based survey administration. Participation was voluntary, and informed consent was obtained from all respondents.

Data Analysis

Descriptive statistics summarized demographic characteristics and governance perceptions. Normality and homogeneity tests guided the use of non-parametric tests. Kruskal–Wallis H test was used for multiple-group comparisons, while Mann–Whitney U test was applied for two-group comparisons. Dunn–Bonferroni post hoc tests were conducted for significant results.

Ethical Considerations

Confidentiality and anonymity were ensured. Participation was voluntary, and respondents were informed of their right to withdraw at any time.

RESULTS AND DISCUSSION**Demographic Characteristics**

Among the 114 respondents, the majority were aged 31–40 years (53%), female (63%), with 6–10 years of service (36%), and held a baccalaureate degree in nursing (79%). This profile reflects an early- to mid-career nurse leadership population.

Perceived Shared Governance

The overall IPNG-S mean score of 118.18 indicated primarily management with some staff input, suggesting that shared governance is partially implemented. Influence over resources supporting practice was perceived as equally shared, reflecting some collaborative decision-making. However, access to information, participation in organizational decisions, and control over practice were perceived as management-only, indicating limited nurse leader involvement in key governance areas.

Differences by Demographic Variables

No significant differences in shared governance perceptions were found when respondents were grouped according to age, sex, and

educational attainment ($p > 0.05$). This suggests that governance perceptions are influenced more by organizational structures than by demographic characteristics.

Significant differences were identified when grouped according to length of service, particularly for control over personnel ($p = 0.04$) and access to information ($p = 0.01$). Post hoc analysis revealed that nurse leaders with 16–20 years of service reported lower perceptions in these domains compared with early- and late-career counterparts. This finding indicates that mid-career nurse leaders may experience increased responsibility without proportional authority or access to governance-related information.

These results highlight the need for leadership development strategies and governance reforms that support nurse leaders across all career stages, particularly those in transitional mid-career roles.

CONCLUSION

Nurse leaders in Level II hospitals in Lucena City perceive shared governance as predominantly management-driven, with limited staff participation in several governance domains. While collaboration exists in resource-related decisions, restricted access to information and limited involvement in organizational and practice-related decisions hinder full shared governance implementation. Length of service significantly influences governance perceptions, underscoring the need for targeted leadership support and inclusive governance structures. The findings provide a foundation for developing a shared governance framework to enhance nurse leader engagement and organizational effectiveness.

Recommendations

Hospital administrators are encouraged to strengthen shared governance by expanding nurse leaders' access to information, increasing participation in organizational decision-making, and supporting mid-career nurse leaders through leadership development initiatives. Adoption and evaluation of the proposed shared governance framework may enhance collaborative leadership and improve nursing practice environments. Future studies may examine long-term outcomes of shared governance implementation using mixed-method or longitudinal designs.

Table A. Age Distribution

| Age Group | Frequency | Percent |
|-----------|-----------|---------|
| 21–30 | 42 | 37% |
| 31–40 | 60 | 53% |
| 41–50 | 11 | 9% |
| 51–60 | 1 | 1% |

**Table B. Sex Distribution**

| Sex | Frequency | Percent |
|--------|-----------|---------|
| Female | 72 | 63% |
| Male | 42 | 37% |

Table C. Length of Service

| Years | Frequency | Percent |
|-------|-----------|---------|
| 1–5 | 40 | 35% |
| 6–10 | 41 | 36% |
| 11–15 | 21 | 18% |
| 16–20 | 8 | 7% |
| 21–30 | 3 | 3% |
| 31+ | 1 | 1% |

Table D. Educational Attainment

| Degree | Frequency | Percent |
|-----------|-----------|---------|
| BSN | 90 | 79% |
| MSN | 21 | 18% |
| Doctorate | 3 | 3% |

Table 1. IPNG Subscale Means and Interpretation

| Factor Subscale | Shared Governance Range | Current Study Mean Total IPNG | Verbal Interpretation |
|-----------------------------------------------------------|-------------------------|-------------------------------|--------------------------------------------|
| Total IPNG Score | 101–200 | 118.18 | Primarily management with some staff input |
| 1. Control Over Personnel (12 items) | 25–48 | 29.74 | Primarily management with some staff input |
| 2. Access to Information (9 items) | 19–36 | 16.23 | Management only |
| 3. Influence Over Resources Supporting Practice (9 items) | 19–36 | 27.96 | Equally shared by staff and management |
| 4. Participate in Organizational Decision (8 items) | 17–32 | 16.70 | Management only |
| 5. Control Over Practice (7 items) | 15–28 | 14.85 | Management only |
| 6. Ability to Set Goals (5 items) | 10–20 | 12.70 | Primarily management with some staff input |

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