

Evaluating a Shared Governance Intervention Program for Nurse Leaders and its Effects on nurses' Structural Empowerment, and Work Engagement

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ABSTRACT

Background: Shared governance is a nursing management model that encourages nurse participation in decision-making and fosters professional autonomy and accountability. It enhances structural empowerment by providing better access to information and resources, resulting in increased work engagement. Adopting this model is a strategic way to enhance nurse empowerment and engagement in their roles. **The aim** of the present study was to assess the effect of a shared governance intervention program for nurse leaders on nurses' structural empowerment and work engagement. **Design:** A quasi-experimental design was used to conduct the present study. **Setting:** the study was conducted at all Hospitals affiliated with the Directorate of Health Affairs in Sharkia Governorate - Egypt. **Subject:** The samples included 230 nurse leaders and 450 nurses. **Tools:** Three tools were used for data collection Shared Professional Nursing Governance, collection Conditions of Work Effectiveness Questionnaire (CWEQ), Utrecht Work Engagement Scale. **Results** Nurse Leaders' perception of Shared Professional Nursing Governance significantly increased, reaching 48% post-program and 76% at three months follow-up. Nurses' perception of Structure Empowerment significantly increased, reaching 58.4% post-program and 87.6% at three months follow-up. Additionally, 77.3% post-program and 87.8% at three months follow-up work engagement. **Conclusion:** The shared governance intervention program resulted in significant enhancements in nurses' Structural Empowerment and Work Engagement, with these improvements maintained three months post-implementation. **Recommendation:** Nurse Leaders should consistently apply shared governance principles and strengthen nurses' structural empowerment by providing access to information, resources, support, delegation, accountability and professional development. They should encourage nurses' participation in decision-making, problem-solving, and supportive relationships to enhance nurses' work engagement.

Keywords: Shared Governance, Structure Empowerment, Work Engagement, Nurse Leaders, Nurses.

Introduction

to workplace conditions that empower them, and empowerment may in turn foster greater work engagement. Through shared governance, nurses gain chances to shape decisions and practice professional autonomy, whereas structural empowerment supplies the resources, information, support, and opportunities needed to turn that participation into effective professional practice. These conditions, in turn, may deepen nurses' involvement, dedication, and connection to their work. Recent accounts of shared governance efforts have recorded gains in nurse engagement, empowerment, autonomy, and participation in organizational change and quality-improvement activities (Sanchez et al., 2024).

Aim of the study

The study aimed to effect of a shared governance intervention program for nurse leaders on nurses' structural empowerment and work engagement.

This aim will be achieved through the fulfillment of the following research objectives:

- Assess nurse leaders' perceptions of shared nursing governance pre-and post-program implementation.
- Identify the level of structural empowerment of nurses' pre-and post-program implementation.
- Assess level of work engagement of nurses' pre-and post-program implementation.

Research hypothesis

- Nurse leaders' perception of shared professional nursing governance will be significantly improved after the implementation of the nursing governance training program.
- The structural empowerment of nurses will be significantly improved after the implementation of the nursing governance training program.
- The work engagement of nurses will be significantly improved after the implementation of the nursing governance training program.

1. Methods

1.1. Research Design

A quasi-experimental design was used to achieve the aim of the current study.

1.2. Study Setting

The study was conducted in in all hospitals (twenty five hospitals) affiliated to nineteen centers and cities affiliated with the Directorate of Health Affairs in Sharkia Governorate - Egypt, which served as the study's site. The hospitals' combined bed capacity is roughly 2640 beds.

1.3. Sample

The study involved two different samples: nurse leaders and nurses, the study sample was calculated by K. Thompson Equation. The sample size of nurse leaders was (230): (all nurse manager (50) and (180) head nurses of various department from a total population of (277)), while nurses sample size was (450) from a total population (4162). The calculated sample size was 390 nurses. However, the final sample size was increased

to 450 nurses following the voluntary willingness of additional eligible nurses to participate in the study.

Inclusion criteria: Nurse Leaders and Nurses of both genders, had been in their current job for at least one year, and agree to participate in the study, also nurses included who is provide direct patient care.

Exclusion criteria: Participants had been on long - term leave, and anyone who has received training on participatory governance.

1.4. Tools of data collection: Three tools were used to collect the necessary data.

Tool (I): Index of Shared Professional Nursing Governance (IPNG) it consists of two parts: **Part I:** personal and professional characteristics of the nurse leaders (nurse managers and head nurses) such as age, marital status, nursing qualification, residence, work department, experience years, previous attendance of training programs on shared leadership or nursing governance.

Part II: It was developed by **Hess (2010)** to assess the level of professional nursing governance environment on a continuum ranging from traditional to shared governance to self-governance depending on the respondents' answers, It consists of 50 items divided into six subscales.

Scoring system: The response to each item was on a five-point Likert scale, Scores from 5 to 1 were assigned: higher scores indicated greater nurse self-governance, while lower scores reflected traditional management governance. The total score ranges from 50 to 250: 50 to 149 reflecting a traditional management decision-making environment, 150 to 199 reflecting an environment utilizing professional nursing shared governance decision-making between nurses and management, and 200 to 250 reflecting self-governance where nurses are the decision makers.

Tool (II): Conditions of Work Effectiveness Questionnaire (CWEQ) it consists of two parts: **Part I:** personal and professional characteristics of the nurse leaders (nurse managers and head nurses) such as age, marital status, nursing qualification, residence, work department, experience years.

Part II: It was developed by Conditions of Work Effectiveness Questionnaire (CWEQ) was developed by **Laschinger et al. (2004)** to measure the level of structural empowerment among nurses. It consists of 19 items covering 6 dimensions. The response to each item is on a five-point Likert scale from “None” to “A lot.”

Scoring system: Nurses response were measured on a Three-point Likert scale ranging from “None” “Sometimes” and “Alot” The total score ranges from 1 to 3, with a higher score reflecting a more structure empowerment. These scores were converted into percent score. Study subjects had low nurses’ structure empowerment if the total score was less than 50%. While it was considered moderate level if the score was from 50% to 75%, and it was considered high level if the total score was more than 75%, internal consistency was measured by Cronbach's alpha.

Tool (III): Utrecht Work Engagement Scale (UWES) tool It was developed by **Bakker et al. (2006)** to measure the levels of nurses’ engagement in their work. It consists of 17 items clustered into three subscales corresponding to the conceptual components of work engagement.

Scoring system: The responses were on a seven-point Likert scale ranging from “0 never” to “6 always” The scores of each dimension were summed up with higher scores reflecting more engagement. These scores were converted into percent score. Study subjects had low work engagement if the total score was less than 50%. While it was considered moderate level if the score was from 50% to 75%, and it was considered high level if the total score was more than 75%, internal consistency was measured by Cronbach's alpha.

Validity of the tools:

The tools were three in present study, it was assessed by a panel of five experts (two professors and three assistants' professor) from the faculty of Nursing-Zagazig University in administrative department.

Tool I was developed by Hess (2010), Tool II was developed by Laschinger et al. (2004), and Tool III developed by Bakker et al. (2006). An experts were reviewed the tools for face and content validation through examining their applicability, clarity, relevance, comprehensiveness, understanding and ease of implementation of the items. No modifications or recommendations were suggested by the experts.

The developed tools was assessed by a panel of five experts (2 professors and 3 assistants' professor) from the faculty of Nursing-Zagazig University in administrative department. They revised the tools for face and content validation through examining their applicability, clarity, relevance, comprehensiveness, understanding and ease of implementation of the items in relation to the study objectives. The experts reviewed all tools and confirmed their content validity. No modifications or recommendations were suggested by the experts; therefore, the tools were retained in their original form and were considered valid and appropriate for use in the present study.

Pilot study: A pilot study was conducted after tools validation and before the commencement of actual data collection to assess clarity, feasibility, and applicability of the study tools and to detect any possible obstacles that might face the researcher and interfere with data collection based on the result of the pilot study. Since no changes were needed in the data collection tool, the pilot sample was included in main study sample. The pilot sample included 23 nurse leaders and 45 of nurses (10% of the study sample) selected from the study setting. Each participant received a copy of the study tools along with a brief explanation of the study purpose. The average time required to complete the tools ranged from 30 to 45 minutes. Nurse leaders and Nurses included in the pilot study were included in the main study sample.

Nurse Leaders' Shared Governance intervention program (Field work):

Fieldwork was conducted over three months from the first of July to the end of September 2025. The researcher divided the governorate into four regions due to the long distance between cities (central, middle, northern, and southern), each group consisting of 58 nurse leaders. The intervention program was implemented for the study group through 20 sessions totalling 51 hours (30 hours theoretical and 21 hours practical).

The program consisted of two parts. The theoretical component covered key concepts of definition, principles, models of Shared Governance, Shared governance skills definition, characteristics of nursing shared leadership, impact of Shared Governance, Role of Nurse Leaders in Shared Governance

The second part is practical in the form of giving activities and exercises for nurse leaders. Nurse leaders divided into small groups to achieve the activity. The researcher read instructions to them, and then nurse leaders played their roles according to the situation; nurse leaders played roles by rotation to learn how to act according to the assigned role.

At the end of the program, the researcher evaluated the nurse structure empowerment, and work engagement.

Ethical Considerations:

The study was approved by the Ethics Research Committee at the Faculty of Nursing, Zagazig University. The verbal explanation of the nature, purpose, and benefits of the study was performed by the researcher to nurses

included in the study sample. In addition, oral and written consent was obtained from each participant prior to inclusion in the study. Confidentiality of the subjects was also assured through coding of all data. The researcher assured participants that the participation is absolutely voluntary, and they can withdraw at any stage of the research without giving any reason. The collected data and information was confidential and was used only for the purpose of the study.

Statistical analysis

Data entry and statistical analysis were performed using the Statistical Package for the Social Sciences (SPSS), version 24.0 for Windows. Reliability analysis was conducted to assess the internal consistency and homogeneity of the study instruments, including the Shared Professional Nursing Governance, using Cronbach's alpha coefficient, with a value of ≥ 0.70 considered acceptable. Inferential statistics included Repeated Measures Analysis of Variance (ANOVA), or paired t-test where applicable, to compare the mean scores across the three phases of the program (pre-intervention, post-intervention, and follow-up). The Chi-square (χ^2) test was used to examine the relationship between participants' personal characteristics and their levels governance perceptions. Pearson's correlation coefficient (r) was calculated to determine the strength and direction of the linear relationships among the study variables, including nursing governance. For all statistical analyses, the level of significance was set at $p < 0.05$. Results were interpreted as statistically non-significant when $p \geq 0.05$, statistically significant when $p < 0.05$, and highly statistically significant when $p < 0.001$.

Results

Table 1 shows personal data of nurse leaders, it is clear from the table that 62.8% of nurse leaders were aged 30 to less than 40. Nearly all of the sample (98.7%) were females, and all participants (100%) were married. Regarding their department, the highest percentage (23.8%) belonged to the Medical department. Regarding to educational qualification, the vast majority (90.4%) held a Baccalaureate Degree in Nursing. Furthermore, 64.1% of the nurse leaders had 15 to 20 years of experience. Remarkably, none of the studied nurse leaders (100%) had previously attended any training programs regarding leadership or shared governance.

Table 2 shows that the majority of the study sample consisted of female nurses, nearly 89% of the total sample. More than half of them 56% were between 20 and 30 years, and the majority 94.4% were married. Regarding their department of work, the percentages were fairly similar across departments, with the highest percentage working in the medical department 18.7% and the lowest in the Emergency and NICU department 15.3%. About 71.6% of the study sample held a diploma in nursing, followed by those with a bachelor's degree. Regarding years of experience, nearly half of the sample 50.4% had 10-15 years of experience.

Figure 1 illustrates that the highest percentage of nurses had a low level of structure empowerment before the program implementation (35.6%), three months after the program implementation, 87.6% of nurses had a high Perception level of structure empowerment. This suggests that the program was effective in improving the nurses' structure empowerment. These findings suggest that the program was effective in enhancing structure empowerment providing strong support for the study second hypothesis. Consequently, Hypothesis II was supported.

Figure 2 shows that the pre-program, most nurses (71.6%) had a moderate level of work engagement. Immediate post- program was implemented 77.3% of nurses demonstrated a high level of work engagement, and three months later that proportion rose to 87.8%. These results indicate the program effectively increased nurses' work engagement. These results provide significant support for the third hypothesis of the study by indicating that the training was successful in improving the work engagement on nurses. Thus, Hypothesis III was validated.

Table 3 shows demonstrates that Initial Status Pre the program, the mean score for perception shared professional nursing governance was relatively low at (2.198 ± 0.175) . There was a substantial increase in the mean score immediately following the program, reaching (2.238 ± 0.178) . In Follow-up the scores remained high during the follow-up phase (2.268 ± 0.252) , showing only a negligible decline from the post-test results, which reveals that the intervention had an improving. These findings suggest that the program was effective in enhancing nurse leaders' perceptions of shared professional nursing governance providing strong support for the study first hypothesis. Consequently, Hypothesis I was supported.

Table 4 demonstrates that Initial Status Pre the program, the mean score for structure empowerment was relatively low at $(1.5373 \pm$

0.112). There was a substantial increase in the mean score immediately following the program, reaching (2.6912 ± 0.046). In Follow-up the scores remained high during the follow-up phase (2.6101 ± 0.062), showing only a negligible decline from the post-test results, which suggests the intervention had a lasting effect. These findings suggest that the program was effective in enhancing structure empowerment providing strong support for the study second hypothesis.

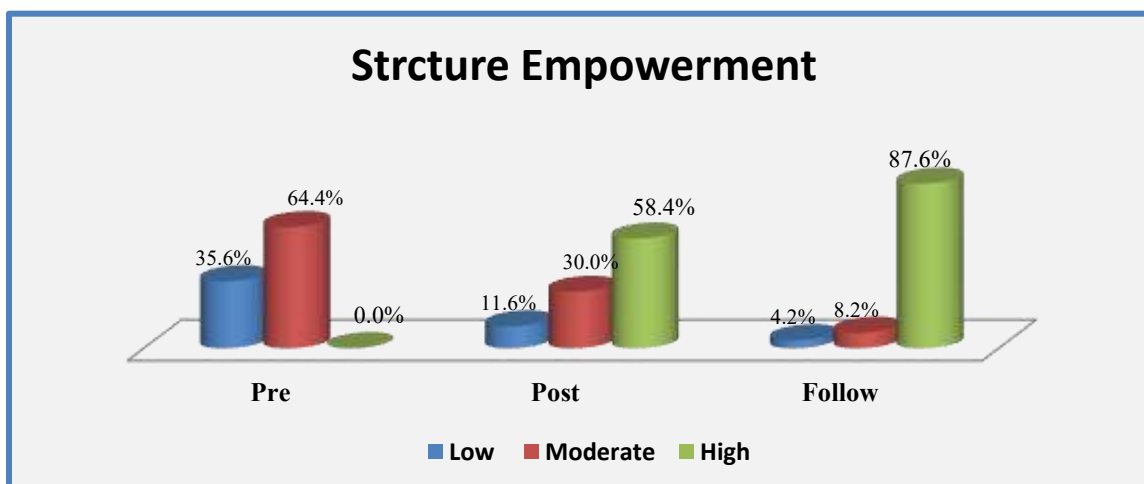
Table 5 displays that Work Engagement increased throughout program phases (3.6611 ± 0.134 , 6.2400 ± 0.311 , and 6.3002 ± 0.043), with a highly statistically significant difference in their Work Engagement in both pre-post and pre-follow-up phases of the program with the study group at P-value = (0.000). These results provide significant support for the third hypothesis of the study by indicating that the training was successful in improving the work engagement on nurses.

Table (1): Frequency distribution of nurse leaders' personal data (n=230)

Personal data	Nurse Leaders	
	No	%
Age		
< 30 – 40	145	62.8
< 40 – 50	72	31.2
<50	13	5.6
Mean ± SD	1.426 ± 0.599	
Gender		
Male	2	.9
Female	228	98.7
Marital Status		
Marriage	230	100.0
Single	0	0.0
Mean ± SD	1.000 ± 0.000	
Department		
NICU	21	9.1
Kidney Dialysis	23	10.0
Assistant Director	25	10.8
Operating Room	22	9.5
Emergency	26	11.3
ICU	25	10.8
Director of Nursing	25	10.8
Medical	55	23.8
Out Clinic	8	3.5
Mean ± SD	5.204 ± 2.46	
Educational qualification		
Baccalaureate Degree in Nursing	208	90.4
Nursing Diploma	22	9.5
Mean ± SD	1.096 ± 0.295	
Years of experience		
< 15 years - 20 years	148	64.1
< 20 years	79	34.2
< 10 years - 15 years	3	1.3
Mean ± SD	1.370 ± 0.510	
Attend training program about leadership		
Yes	0	0.0
No	230	100.0
Mean ± SD	2.000 ± 0.000	
Attend training program about shared governance		
Yes	0	0.0
No	230	100.0
Mean ± SD	1.000 ± 0.000	

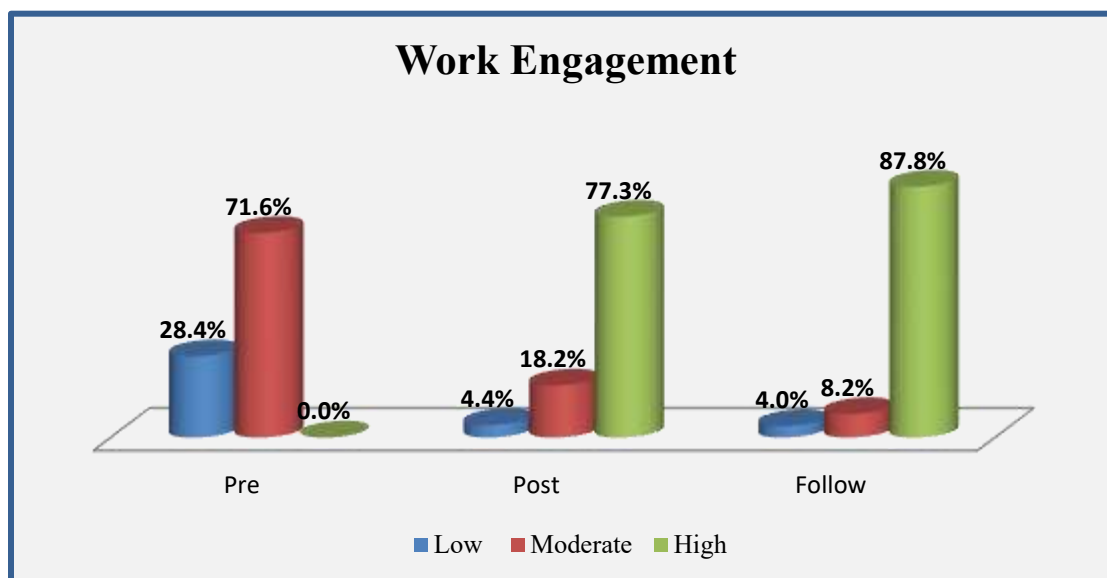
Table (2): Frequency distribution of staff nurses personal data (n=450)

Personal data	Frequency distribution	
	No	%
Age		
20 – 30	252	56.0
< 30 – 40	171	38.0
< 40 – 50	27	6.0
Mean ± SD	1.500 ± 0.609	
Gender		
Male	50	11.1
Female	400	88.9
Marital Status		
Single	25	5.6
Marriage	425	94.4
Mean ± SD	1.944 ± 0.229	
Department		
Medical	84	18.7
Operating Room	81	18.0
Kidney Dialysis	70	15.6
Emergency	69	15.3
ICU	77	17.1
NICU	69	15.3
Mean ± SD	3.402 ± 1.73	
Educational qualification		
Nursing Diploma	322	71.6
Baccalaureate Degree in Nursing	125	27.8
Master's Degree Non – nursing	3	.7
Mean ± SD	1.291 ± 0.469	
Years of experience		
1 year - 5 years	1	.2
< 5 years - 10 years	78	17.3
< 10 years - 15 years	227	50.4
< 15 years - 20 years	102	22.7
< 20 years	42	9.3
Mean ± SD	3.236 ± 0.853	



Low < 50%, Moderate 50% to < 75%, High > 75%.

Figure (1): Perception level about structure empowerment throughout the program phases among nurses (n= 450)



Low < 50%, Moderate 50% > to < 75%, High > 75%.

Figure (2): level of Work Engagement among nurses throughout the program phases (n= 450)

Table (3): Comparison of perception shared professional nursing governance among nurse leaders at Pre-, Post-, and Follow-up Tests throughout the Program Phases (n=230)

perception shared professional nursing governance	Time	Nurse Leaders (n=230)	
		Mean ± SD	T-test
	Pre	2.198 ±0.175	
	Post	2.238±0.178	
	Follow up	2.268±0.252	
P-value	Pre - Post	0.020***	-2.340
	Pre – Follow	0.000**	-4.956

Table (4): Comparison of structure empowerment among Nurses at Pre-, Post-, and Follow-up Tests throughout the Program Phases (n=450)

	Time	Nurses (n=450)	
		Mean ± SD	T-test
Conditions for work effectiveness	Pre	1.5373± 0.112	
	Post	2.6912 ± 0.046	
	Follow up	2.6101 ±0.062	
P-value	Pre – Post	0.000**	-111.288
	Pre – Follow	0.000**	-96.870

***p<0.05= significant**

Table (5): Mean score Work Engagement of nurses throughout the program phases (n= 450)

Utrecht Work Engagement (UWES)	Time	Nurses (n=450)	
		Mean $\pm$ SD	T-test
	Pre	3.6611 $\pm$ 0.134	
	Post	6.2400 $\pm$ 0.311	
	Follow up	6.3002 $\pm$ 0.043	
P-value	Pre – Post	0.000	-161.691
	Pre – Follow	0.000	-310.008

*p<0.05= significant

Discussion

Shared governance, nurses' structural empowerment, and work engagement within healthcare organizations, are tightly linked, since shared governance offers the organizational structures and participatory processes that let nurses influence decisions about their practice, gain access to necessary resources and information, receive organizational support, and secure opportunities for professional development. These conditions constitute essential dimensions of structural empowerment and can reinforce nurses' autonomy, accountability, ownership, and professional influence. Greater access to empowering workplace conditions, in turn, may deepen nurses' psychological connection to their work and foster work engagement, which is marked by vigor, dedication, and absorption **Nguyen, L. A. (2023)**.

The findings of the current study demonstrated that the nurse leaders' perception about shared governance in the study increased throughout program phases, with a highly statistically significant difference in both pre-post, and pre-follow up phases. These results are consistent with previous studies, including **Abdel-Latif et al. (2023)**, which reported that statistically significant improvements in head nurses' shared governance perception after the educational program. **Speroni et al. (2022)** reported that nurses and nurse managers working within shared governance environments generally demonstrated favorable perceptions of professional nursing governance. Their study highlighted that stronger governance structures were associated with positive nursing outcomes and greater involvement in decision-making processes.

Current study outcomes diverge from some prior findings, such as those by **Quaid (2023)**, which indicated that educational workshops alone did not lead to significant organization-wide improvements. However, nurses involved in governance councils showed better perceptions of shared decision-making compared to nonparticipants. The suggestion was made that education needs to be supported by organizational commitment, leadership, and active involvement in governance for effectiveness.

The results of this study indicated that nurses' structural empowerment steadily increased across the various stages of the program. In a similar manner, nursing empowerment demonstrated a statistically significant enhancement among nurses throughout the program phases. These results indicate that the intervention effectively increased nurses' access to empowerment resources, such as information, support, tools, and opportunities, which in turn led to enhanced work efficiency.

The noted enhancement in structural empowerment can be understood through Kanter's Structural Empowerment Theory, which argues that employees become more efficient when they have access to organizational resources, support, information, and opportunities for career development. When nurses have increased influence over their work settings and engage more in decision-making, they tend to feel more empowered and able to meet organizational objectives (**Abdelaliem et al., 2021**).

The significant increase in this result which nursing structure empowerment observed throughout the program phases was consistent with previous research demonstrating a positive relationship between structural empowerment and nurses' job performance. **Ta'an et al. (2020)** reported a significant positive correlation between structural empowerment and job performance among hospital nurses, concluding that highly empowered nurses demonstrate higher levels of effectiveness and quality of care. The authors emphasized that empowering work environments enhance nurses' ability to accomplish their professional responsibilities and contribute to organizational success.

In addition, recent research has repeatedly reinforced this association. **Demir et al. (2023)** discovered that structural empowerment was positively linked to favorable outcomes for both nurses and patients, suggesting that empowered nurses are better able to exert control over nursing practice and provide high-quality care. In a similar vein, **Arvidsson et al. (2023)** found that structural empowerment was positively associated with nurses' self-efficacy and work engagement while lowering work-related stress—factors that directly foster greater work effectiveness.

These findings also correspond with research centered on educational and organizational development programs. **Sarıköse and Çelik. (2024)** reported that nurses expressing greater satisfaction with orientation and professional development programs also showed significantly higher levels of structural empowerment. Similarly, a recent Egyptian study on a professional shared governance educational program revealed gains in nurses' structural empowerment after the intervention, reinforcing the value of empowerment-focused programs in healthcare settings.

The current findings are consistent with several recent studies. **Kim et al. (2023)** found that shared governance support and workplace resources were significant predictors of nurses' work engagement, emphasizing that supportive organizational environments contribute to higher levels of vigor, dedication, and absorption among nurses. Their findings support the present study's conclusion that interventions aimed at strengthening workplace resources can significantly improve nurses' engagement levels.

In a similar way **Han (2023)** found a robust positive link between work engagement and the well-being of nurses. According to the study, workplace programs that strengthen nurses' autonomy, professional growth, and job resources lead to greater engagement and better occupational outcomes. These findings are consistent with the notable gains in work engagement seen after the current program was put into place.

Additional backing comes from **Iida et al. (2024)**, whose prospective cohort study revealed that team job-crafting interventions were positively linked to nurses' work engagement at both the three-month and six-month follow-ups. The longitudinal design of their results reinforces how the current study's follow-up findings should be interpreted, indicating that interventions fostering collaborative work environments may produce enduring effects on engagement.

Moreover, **Zhou et al. (2023)** discovered that organizational support markedly boosted nurses' work engagement, both directly and indirectly via resilience and innovative behavior. The authors determined that healthcare organizations are able to boost nurses' engagement by offering supportive work environments and fostering professional growth. This result aligns with the current study, in which engagement scores kept improving after the intervention.

Intervention-based research likewise provides support to the current findings. **Nemr et al. (2024)** found that implementing a nursing professional practice model into practice markedly raised nurses' work engagement by promoting a supportive practice environment and reinforcing professional commitment. As in the present study, nurses who received the intervention showed greater engagement following implementation, which affirms that organizational development programs are effective in promoting work engagement.

Furthermore **Mohamed et al. (2023)** found notable positive associations among leadership style, structural empowerment, and nurses' work engagement. According to their results, interventions centered on empowerment strengthen nurses' feelings of ownership, professional worth, and dedication to their work, which could account for the gains seen throughout the phases of the present program.

Recent evidence has also emphasized the contribution of empowerment to improving engagement. **Ibrahim (2023)** showed that structural empowerment has a positive effect on psychological empowerment, which in turn fosters job satisfaction, commitment, and work engagement among nurses. These results back the theoretical assumption that organizational interventions aimed to raising empowerment can eventually improve engagement outcomes.

In a similar manner **Adkins (2023)** found greater work engagement and job satisfaction along with reduced turnover intention. Greater involvement of frontline staff in process improvement projects is likewise an anticipated result, since staff become more engaged. As nurse retention rates rise, the nurse manager can also anticipate reductions in turnover costs.

Conclusion

Based on the key findings of the main study evaluating the Shared Governance Intervention for Nurse Leaders and its effects on nurses' structural empowerment and work engagement, the nurse leaders in the study showed higher levels of shared leadership, nurses' structural empowerment, and nurses' work engagement immediately after the program and three months later, compared with before the program. Moreover, most of the nurse leaders in the study were satisfied with the shared governance program.

Recommendation: Based on the findings of this study, **the nurse's leaders need to:**

- Encourage staff nurses to participate actively in decision-making, problem-solving, policy development, and quality-improvement activities.
- Identify areas requiring additional support or training.
- Continue developing shared governance competencies through regular training, workshops, and mentoring.
- Serve as facilitators who help staff nurse to gain new skills, and monitor the application of skills in daily practice.
- Support every one of the staff to comments about things they should improve.
- Encourage staff nurse by reward them for innovation on their job.

The nurses' need to:

- Participate in quality-improvement initiatives and evaluate the outcomes of implemented changes.
- Participate in identifying and solving clinical problems.

- Share best practices among colleagues
- Work always persevere and proud of their job.
- Ask acquiring help when needed.
- Encourage colleagues to become actively involved in shared governance and promote a culture of collaboration and professional accountability.

Conflict of interest

The authors confirmed that there is no any conflict of interest.

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