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Relationship between Organizational Silence and Organizational Learning among Staff Nurses

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Abstract: Background: Organizational silence obstructs the effective organizational learning, as this constitutes a barrier to organizational change and development. **Purpose**: To determine the relationship between organizational silence and organizational learning. **Design**: A descriptive correlational design was conducted. **Sampling**: A convenient sample of 300 staff nurses was included in Menoufia University Hospital. Instruments: Two instruments were used which are organizational silence questionnaire and organizational learning questionnaire. **Results**: The current study shows that more than two thirds of studied nurses (69.4%) had a high level of organizational silence and more than half of studied nurses (53.3%) had a low level of organizational learning. **Conclusion**: There was a negative correlation between organizational silence and organizational learning. **Recommendation**: Nurses should have periodic meetings to encourage them to talk and express their opinions, provide all needed learning experiences and provide courses to improve their knowledge.

Keywords*: Organizational learning, organizational silence, nurses.*

Introduction

The subject of organizational silence in healthcare organizations has recently begun to receive attention. As is known, when the healthcare staff in an organization do not express themselves well and information transfers and communication are ineffective, it negatively affects the motivation and job satisfaction of healthcare professionals (Çaylak and Altuntaş, 2020). Organizational silence behaviors among nurses are the most important and significant barriers that influence organizational effectiveness and efficiencies. The propensity of nurses to maintain silent would be affecting the provision of safe care and quality of patient care versus their willingness to speak up about patient adverse events and medical errors. Thus, nurse managers must consider the effect of workplace silence behavior on nurses, patient and organization outcomes in health care settings (Bordbar et al., 2021).

Organizational silence that occurs due to intra-organizational dynamics of health services, which are based on teamwork, may result in cases, which include irrecoverable moral and conscientious responsibility. When organizational silence occurs amongst

nurses, it is stated that nurses are afraid of making their voices heard and of coming together since many managements in health care organizations
react adversely to the nurses who make their voice sound more, and criticize specific issues (Yalçın and Baykal, 2019).

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react adversely to the nurses who make their voice sound more, and criticize specific issues (Yalçın and Baykal, 2019).

There are several implications of organizational silence, as silence is of a significant impact on individuals and the organization. Organizational silence correlates negatively with three dimensions of organizational trust (trust in the organization, trust in leadership, and trust in the supervisor). This means that the more silence means less trust (Bogosian, 2021). The three types of individuals‟ or groups‟ response to organizational silence are the affective, cognitive and instrumental. Affective response refers to the feeling of being linked to satisfaction or anxious about change. Cognitive responses are opinions relating to usefulness and necessity and about knowledge required to handle change. Instrumental responses refer to actions already taken or which will be taken to handle the change (Gambarotto et al., 2020).

Weber (2020), notes that organizational silence is a negative phenomenon due to the reluctance of workers to express their opinions and ideas on labor issues, both technical and organizational opinions, which negatively affects the processes of improvement and organizational development and organizational ability for learning.

Organizational learning is a process or capacity within organization which enables it to acquire, access and revise organizational memory thus providing

directions for organizational. One of the strategic values of an organization lies in becoming an "organizational learning". These organizations have an enterprise architecture that converts the firm into a place of learning, so the organization can make appropriate approaches to changing environment (Ramírez et al., 2020).

In the opinion of Mayo (2019), organizational learning consists of all the methods, mechanics and processes, which are used, in the organization in order to achieve learning. Learning is about taking action. It is about using the information that we gather to create knowledge management systems and statistical databases and then using that knowledge to improve the organization. Absence of organizational silence and presence of learning capabilities of an organization have essential role in generation of innovation. However, innovation itself implies generation, acceptance and implementation of new ideas, processes, products and services. (Weerawardena, 2020).

Organizational learning is described in several ways. It is said to be the cumulative product of the learning of small groups or teams and the collective learning that occurs in an organization that has the capacity to impact an organization's performance .It is also described as a process of increasing organizational effectiveness and efficiency through shared knowledge and understanding which is a system- level phenomenon that stays in the organization regardless of the changes in health care teams or team members (Peirce, 2021).

Regulated health professional are expected to engage in continuing education to maintain and update knowledge and skills to provide safe patient healthcare as continuing education of health care professionals has shown to be related to improved patient outcomes .Learning means action and action means change. That means that the learning organization should have the capacity not only of increasing its level of knowledge, but also of improving its economic performance through change. Also, such a learning organization would be able to adapt to a turbulent environment more quickly than its competitors could, and to achieve a world-class performance (Stewart, 2020).

Organizational learning involves five stages; from the process of knowledge acquisition to knowledge sharing to knowledge interpretation to knowledge maintenance and finally to knowledge utilization. Organizational effectiveness must be experienced before one can claim that organizational learning has taken place. (Peirce, 2021).

Organizations should not indiscriminately embrace a centralized structure or reject a decentralized structure of knowledge and learning networks. While centralization may entail efficiency and convenience for information seeking, decentralization may facilitate the distribution of critical information "Organizational learning is as natural as learning in individuals as they attempt to adjust and survive in an uncertain and competitive world (Mayo, 2019). Organizational silence obstructs the effective organizational

learning. This constitutes a barrier to organizational change and development and suppresses pluralism, hence innovation and creativity (Morrison and Milliken, 2021).

On the other hand, perceived organizational support and good and positive communication is related to organizational learning positively; the more nurses perceive support from the organization, the more the organizational learning will be. The reason may be that the nurses' motivation for learning will be higher when they are feeling the organizational support and freedom to express their opinions (Elaine, 2020).

Significance of the study

Nurses have an important role in success in organization. Nurse silence affect organizational atmosphere in occurring of new ideas, exhibition of talents and information share, this means a significant danger for organization .Organizations need nurses who are responsive to the challenges of the environment and who are not afraid to share information and knowledge which lead to continuous organizational learning and use of knowledge to improve innovation which can serve as a critical key for organizational success. The concept of organization silence has been linked to organizational learning and innovation in organizations. (Power and Waddell, 2020).

From the researcher's clinical experience, it is observed that many of nursing supervisors interact negatively with their staff and give them vocal criticism which lead to inability and unwillingness of staff nurses to communicate about certain issues (silence) which will affect nurses ability to learn.

Therefore, the current study was conducted to determine relationship between organizational silence and organizational learning.

Purpose of the Study

To determine relationship between organizational silence and organizational learning among staff nurses at Menoufia University Hospital.

Research Questions

1- What are the levels of organizational silence among staff nurses?
2- What are the levels of organizational learning among staff nurses?
3- Is there a relationship between organizational silence and organizational learning among staff nurses?

Study Design

A descriptive correlational design was conducted.

Study Setting:

The study was conducted at Menoufia University Hospitals at Shebin El-Kom which established in 1993, it is considered one of the largest hospitals in Delta region of Egypt. The bed capacity of this hospital is 1000 beds and the estimated number of the nursing workforce is 1200 which distributed into 800 nurses in critical care units, 400 nurses in general departments. This hospital contains four buildings (Emergency hospital, General hospital, Specialized Hospital

and oncology hospital). All of these buildings provide medical and surgical care to different population with different ages.

Sampling:

The study included 300 staff nurses working at above mentioned setting at Shebin El-Kom University Hospital during the time of study and who accept to participate in this study.

Sampling technique:

Convenient sample technique was used to conduct this study. The sample size was 300 staff nurses according the following equation:

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

n= is the sample size

N= is the total number of staff nurses are (1200) nurse. e= is coefficient factor=0.05

1= is a constant value

Sample size of staff nurse = $1200 /1+ (1200\times (.05)^2 = 300$ staff nurses.

Instruments

Two instruments were used by the researcher.

<u>Instrument one</u>: Organizational silence questionnaire.

It was adopted from Brinsfield (2009), Çakıci (2008), Van Dyne (2003) and Schechtman (2008). It contained three parts:

- **Part1**: characteristics of nurses as: age, gender, marital status, educational level and years of experience.
- **Part 2**: Types of Silence: It contained15 items used to determine organizational silence levels among nurses divided into three dimensions related to types of organizational silence: acquiescent silence (5 items), defensive silence (5 items) and prosocial silence (5 items).

Scoring system:

three - points Likert scale used for each statement as follows disagree (1), neutral
(2) and agree (3).Total score (15-45).The scores of less than (27) was considered a low level of organizational silence, while (27-34) was considered a moderate level of organizational silence, and more than (34) was considered a high level of organizational silence (Diab and Mohamed, 2020).

- **Part**: Causes of Silence: It used to assess the causes of organizational silence and staff nurses level toward organizational silence and included (27) items divided into five dimensions: Support of thetop management of silence (5 items), lack of communication opportunities (6 items), Support of supervisor for silence (5 items), Official authority (5 items) and subordinate's fear of negative reactions (6 items).

Scoring system:

Five - points Likert scale used for each statement as follows: very ineffective (1), ineffective (2), neither effective (3), effective (4) and very effective (5). Total score (27-135).The scores of less than (81) was considered ineffective causing factors of silence, while the scores of (81) and more was considered effective causing factors of silence (Diab and Mohamed, 2020).

The second instrument: Organizational learning questionnaire.

It was adopted by researchers from Chiva and Alegre (2009). It aimed to assess staff nurses level toward organizational learning and included (23) items divided into five dimensions: Managerial commitment and empowerment (6 items), Experimentation (4 items), Risk taking (3 items), Interaction with the external environment, (5 items) and knowledge transfer and integration (5 items).

Scoring system: Five - points Likert scale used for each statement as follows: Strongly disagree (1), disagree (2), neutral (3), agree (4) and strongly agree (5). Total score (23-115).The scores of less than

(69) was considered a low level of organizational learning, while (69-86) was considered a moderate level of organizational learning and more than (86) was considered a high level of organizational learning.

Validity and Reliability of instruments

Validity of the questionnaires was assessed by using content validity by three experts in the nursing administration department (two professor of nursing administration, faculty of nursing, menoufia university and one professor of nursing administration, faculty of nursing, ain shams university) in order to check relevancy, clarity, fluency and simplicity of each component in the questionnaires. The investigator asked the panel to critique the instrument as a whole, including identifying areas of concern and reviewing the construction, flow and grammar. The panel examined the following criteria: relevant to the purpose of the study, clear and simple wording of research questions, instrument is easy to be understood, comprehensive questions, appropriate length of the instrument and each question, appropriate ordering of questions, unbiased and no redundancy in questions. Necessary modifications were done to reach the final valid version of the instruments which considered valid from the experts' perspective.

Reliability of instruments

These instruments were tested for reliability to estimate the consistency of measurement. Reliability was done using Cronbach's Alpha coefficient test. These instruments were tested for reliability to estimate the consistency of measurement. Reliability performed using Alfa Coefficient test (Cronbach alpha). Internal consistency of the first instrument (Organizational silence questionnaire) with Cronbach alpha is 0.98. Internal consistency of the second instrument (Organizational learning questionnaire) with Cronbach alpha is 0.91.

Pilot study

The pilot study was carried out on (30) nurses representing (10%) of the total nurses from different departments in study setting. The purpose was to determine the applicability of the study, the clarity and feasibility of the study instruments. The participants in the pilot study were included the main

study sample because no modification was done.

Ethical Consideration

The study was conducted with careful attention to ethical standards of research and rights of the participants. The ethical committee at faculty of nursing, menoufia university revised study protocol and accepts the topic as they assured this study didn't violate the rights of the participant.The sample rights were protected by ensuring voluntary participation so that informed consent was obtained by explaining the purpose, nature, time of conducting the study, potential benefits of the study and how data was be collected. The subjects were assured that the data would be treated as strictly confidential; furthermore, the respondents' anonymity was maintained as they weren't required to mention their names.

Data Collection Procedure

Before any attempt to collect data, an official letter was submitted from the dean of the nursing college to collect data from the pre-mentioned study settings, also a written approval letter was submitted to the director of Menoufia university hospital. The letter contained the title, aim of the study and methods of data collection. Data collection procedures, analysis and reporting of findings were undertaken in a manner designed to protect confidentiality of subjects.

Before beginning to collect data from the study subjects the investigator introduced herself to them, explained the aim of the study and informed them that their information was be treated confidentially and will be used only for the purpose of the study; additionally, each participant was notified about the right to accept or refuse to participate in the study. Data was collected in the morning, afternoon and night shifts and the subjects' response to questions was in the presence of the investigator to ascertain that all questions were understood and answered. Data was collected upon five months started from November 2021 to Mars 2022. Questionnaire takes 20 minutes to be filled.

Statistical Analysis:

Data was coded and transformed into specially designed form to be suitable for computer entry process. Data was entered using SPSS (software statistical package for social science) version 22. For quantitative data, descriptive statistics were used and presented by mean and standard deviation. For qualitative data, comparison was done using: Firstly, the chi-square test ($\chi 2$) which is a test used to identify the differences throughout the study phases. Also, correlation between variables was evaluated using Pearson and Spearman's correlation coefficient r. A significance was adopted at $P<0.05$ for interpretation of results of tests of significance (*). Also, a highly significance was adopted at $P<0.01$ for interpretation of results of tests of significance (**).

Results:

Table (1): shows that more than half of nurses (54.6%) had their age between 25-35 years. According to sex, near to two thirds of sample (63%) were females. Regarding to experience about

half of the nurses (52.8%) had (5-10) years of experience. Concerning to educational level, the majority (77.3%) were holding associated degree in nursing. Regarding to marital status, near to half of nurses (46.6%) were married.

Table (2): shows percentage distribution, mean score and ranking of organizational silence causes as reported by studied nurses. It shows that the highest percentage (23%) of organizational silence causes among studied nurses was "Official authority " and in first rank while the lowest percentage (16.5%) of organizational silence causes among studied nurses was "Support of supervisor for silence" and in last rank. Also, there was highly statistical significance between all causes of organizational silence as (p value= 0.000).

Table (3): shows percentage distribution, mean score and ranking of organizational learning dimensions as reported by studied nurses. It illustrates that the highest percentage (26%) of organizational learning dimensions among studied nurses was for "Experimentation " while the lowest percentage (9%) of organizational learning dimensions among studied nurses was for "Managerial commitment and empowerment". Also, there were a highly statistical significance among organizational learning dimensions as p value = 0.000

Table (4): shows that there was a negative significant correlation between organizational silence and organizational learning among studied nurses as p value <.001 and r -.2

Table (5): shows that there was highly statistical significant relationship between organizational silence and personal characteristics (age, marital status, sex and experience) as p value <0.01 and there was no significant relationship between organizational silence and educational qualifications as p value >0.05. Table (6): shows that there was highly statistical significant relationship between organizational learning and personal characteristics (age, marital status, sex and experience) as p value = 0.001 and there was no significant relationship between organizational learning and educational qualifications as p value >0.05.

Figure(1): represents that more than two thirds of studied nurses (69.4%) had a high level of organizational silence, more than one quarter (28.3%) of nurses had a moderate level of organizational silence while the minority (2.3%) had a low level of organizational silence.

Figure (2): exhibits ranking of organizational silence types as perceived by the nurses. It shows that the highest type that face nurses was prosocial silence (45.5%) while the lowest type was defensive silence (20.5%).

Figure (3): shows total level of organizational learning among studied nurses. It illustrates that more than half of studied nurses (53.3%) had a low level of organizational learning and less than half of studied nurses (45%) had a moderate level of organizational learning, the minority of studied nurses (1.7%) had a high level of organizational learning.

Table (1): distribution of studied nurses according to their personal characteristics. (N=300)

Variable	No	%
Age (years)		
< 25 years	104	34.8
25-35 years	164	54.6
>35 years	32	10.6
Sex		
Male	111	37
Female	189	63
Experience		
<5 years	107	35.6
5-10 years	158	52.8
>10 years	35	11.6
Qualifications		
Nursing diploma	21	4.1
Associated degree in nursing	225	77.3
Bachelor degree in nursing	54	18.6
Marital status		
Married	140	46.6
Unmarried	160	53.4

Figure (1): Total level of organizational silence among studied nurses (N=300)

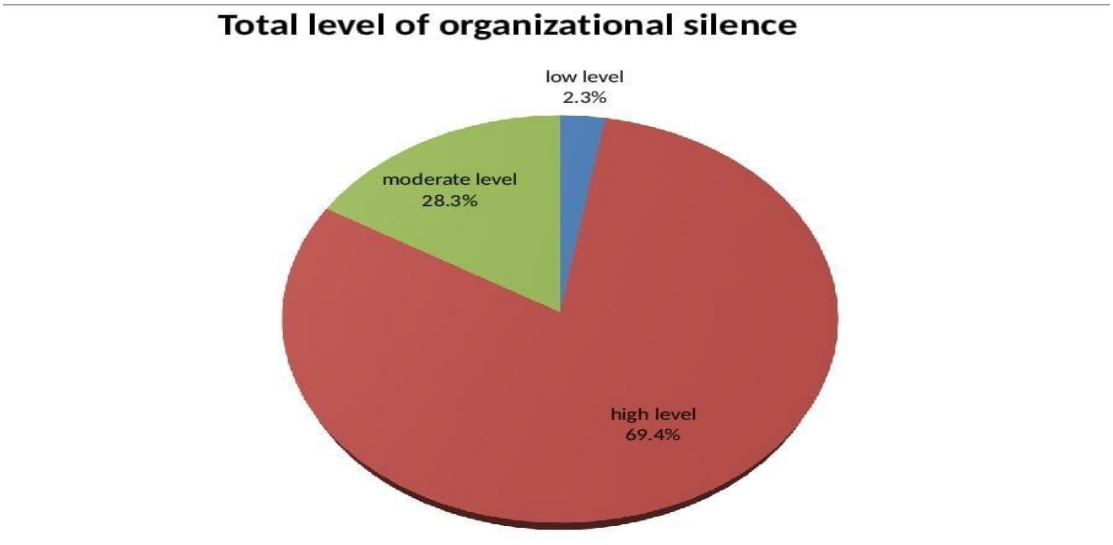

Figure (2): Ranking of organizational silence types among studied nurses (N=300)

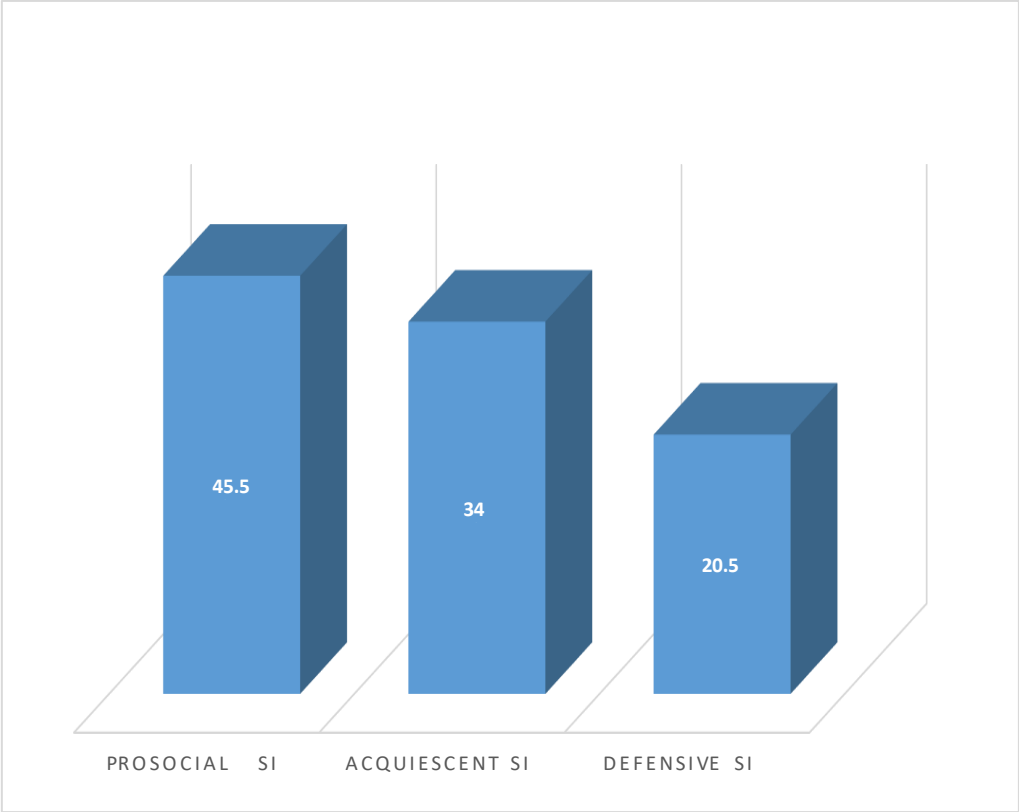

Table (2): Percentage distribution, mean score and ranking of organizational silence causes as reported by studied nurses. (N=300)

Organizational silence Causes	Mean ± SD	Mean Percentage	Minimum	Maximum	Ranking	P Value
▪ Official authority	**17.412 ±4.568**	23%	9	30	1	0.000**
▪ Support of the top management to silence	**16.869± 4.003**	21.3%	5	20	2	0.000**
▪ Subordinate's fear of negative reactions	**15.629 ±4.103**	20%	9	30	3	0.000**
▪ Lack of communication opportunities	**14.450 ±3.140**	19.2%	6	22	4	0.000**
▪ Support of supervisor for Silence	**13.835 ±3.937**	**16.5%**	**8**	**24**	**5**	**0.000****

Figure (3): Total level of organizational learning among studied nurses (N=300)

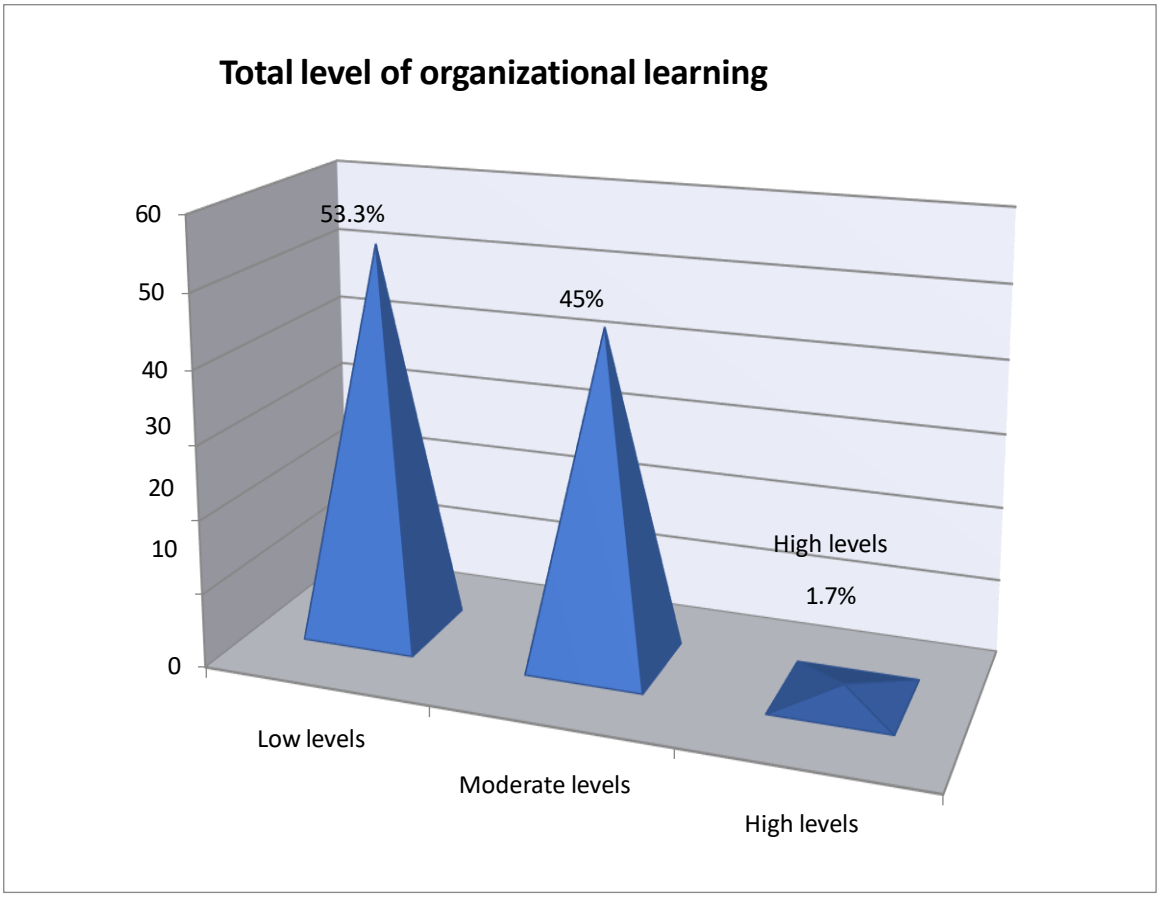

Table (3): Percentage distribution, mean score and ranking of organizational learning dimensions as reported by the studied nurses. (N=300)

Organizational learning dimensions	Mean±SD	Mean percentage	Minimum	Maximum	Ranking	P value
▪ Experimentation	**13.4± 4.9**	**26%**	**4**	**20**	**1**	**0.000****
▪ knowledge transfer and integration	**13.2± 4.2**	**25%**	**5**	**25**	**2**	**0.000****
▪ Risk taking	**12.8±4.9**	**23%**	**3**	**15**	**3**	**0.000****
▪ Interaction with the external environment	**9.7± 3.9**	**17%**	**5**	**24**	**4**	**0.000****
▪ Managerial commitment and empowerment	**7.2 ±3.6**	**9%**	**6**	**26**	**5**	**0.000****

Table (4): Correlation between total organizational silence and total organizational learning among studied nurses (N=300)

	Total organizational silence among nurses (N=300)	
	r	**P value**
Total organizational learning among nurses	-.253**	<.001

Table (5): Relation between personal characteristics and organizational silence among nurses (N=300)

Variables	Total organizational silence among nurses Mean±SD	Test of sig.	P value
Age / years			
▪ <25 years ▪ 25-35 years ▪ >35 years	30.49±5.14 25.76±4.62 26.29±4.30	F 32.580	**.001****
Marital status ▪ Married ▪ Unmarried	25.05±.47 30.65±.60	F 37.275	**.001****
Sex			
▪ Male ▪ Female	31.18±5.30 25.48±4.04	t-test 10.383	**.005****
Educational qualifications ▪ Nursing diploma ▪ Associated degree in nursing ▪ Bachelor degree in nursing	23.91±.28 27.42±5.55 28.38±4.15	F 3.618	**.028**
Years of experience			
▪ <5 years ▪ 5-10 years ▪ >10 years	30.38±5.18 25.72±4.63 26.37±4.12	F 31.608	**.001****

Table (6): Relation between personal characteristics and organizational learning among nurses (N=300).

Variables	Total organizational learning among nurses	Test of sig.	P value
	Mean±SD		
Age / years ▪ <25 years ▪ 25-35 years ▪ >35 years	51.57±21.30 69.54±17.82 46.91±21.99	F 35.044	**.001****
Marital status ▪ Married ▪ Unmarried	60.30±17.64 48.12±20.70	F 59.152	**.001****
Sex ▪ Male ▪ Female	48.80±22.23 68.14±17.91	t-test -8.170	**.001****
Educational qualifications ▪ Nursing diploma ▪ Associated degree in nursing ▪ Bachelor degree in nursing	43.66±1.61 61.75±23.53 64.03±10.29	F 4.606	..011
Years of experience ▪ <5 years ▪ 5-10 years	52.10±21.25 69.29±18.03 50.85±23.68	F 28.882	.001**

DISCUSSION

Organizational silence behaviors among nurses are the most important and significant barriers that influence organizational effectiveness and efficiencies. The propensity of nurses to maintain silent would be affecting the provision of safe care and quality of patient care versus their willingness to speak up about patient adverse events and medical errors. Thus, nurse managers must consider the effect of workplace silence behavior on nurses learning and performance, patient and organization outcomes in health care settings (Bordbar et al., 2021).

Concerning personal characteristics of studied nurses, study results found that more than half of nurses had their age between 25-35 years. According to gender study findings revealed that, about two thirds of sample were females. Regarding to nurses' experience study findings revealed that about half of the nurses had 5- 10 years of experience. Concerning to educational level of nurses, the highest percentage were holding technical nursing institute. Regarding to marital status, near than half of nurses were married.

Regarding level of organizational silence, study findings revealed that near to two thirds of studied nurses had a high level of organizational silence,

from the investigators perspectives this is due to nurses tend to remain silent fearing of being fired or not getting promoted, in order not to be seen as a complaining person and so that their social relations are not damaged also unhealthy work environment and lack of communication channels at Menofia University Hospital.

The present study finding at the same line with Badran and Hassan, (2022) who found that more than half of studied staff nurses had high level of organizational silence. Meanwhile, more than one quarter of them had low level of organizational silence. Hence, had moderate level of organizational silence.

In disagreement with present study results Atalla et al., (2022) who revealed that nearly two-thirds of staff nurses had moderate level of organizational silence due to subordinates being more sensitive to the risks of talking more than the benefits, believing that talking about work problems might deprive them of their jobs or upgrade to higher positions within the organization, avoiding disagreements with others, lack of management support, fear of breaking their relationships with their colleagues, avoiding potential conflict that may escalate and fear of being ignored.

Regarding causes of organizational silence, the current study results revealed that the highest percentage of silence causes was for official authority and in first rank while the lowest percentage was for support of supervisor for silence and in last rank. From the investigators perspectives, this result might be due to nurses' fear of official authority and fear from losing their jobs and subordinates believes that the supervisor has the ability to resolve any problem or issue related to work because they finds it useful to talk in the presence of a supervisor who has the powers to solve work problems within the organization

At the same line Erdogdu, (2020) revealed that near to two thirds of studied sample agreed that nurses fear of authority, fear from losing the job, and mostly keep silent for "Administrative and organizational reasons", for this reason, it is important for managers in healthcare organizations to consider these matters in their evaluation of the risks that are caused by organizational silence.

Present study results at in disagreement with Achieng and Owuor, (2020) who reported that the majority of studied sample agreed that factors which causing organizational silence are related to lack of communication opportunities and channels as nurses don't speak up on critical issues in organization because of losing ways of communication.

Regarding to silence types study findings revealed that the highest type of silence that face nurses is prosocial silence and in first rank while the lowest percentage of organizational silence types among studied nurses was defensive silence and in last rank . From investigators perspectives, it is due to nurses withholding work-related ideas, information and opinions with the goal of benefiting other people also nurses who decides to remain silent is not by

themselves but the external factors affect them.

In agreement with current study results Adnan, (2022) revealed that prosocial silence is highest type of organizational silence types and had an impact on continuance commitment. In other words, when nurses' perception of prosocial silence increases, it also causes an increase in continuance commitment behavior.

In contrast with current study results Kose, (2021) found that major of organizational silence behaviors are acquiescent not prosocial silence. Also,Van Dyne, et al., (2019) found that defensive silence is the highest type of organizational silence which as nurses deliberate omission of work related information based on fear of reprisal as they intended to protect the self from external threats.

Regarding level of organizational learning, the study findings revealed that more than half of studied nurses had a low level of organizational learning while the minority of studied nurses had a high level of organizational learning. From the investigators points of view this is due to lack of learning motivation environment at Menoufia University Hospital also lack of presence of an educational team that includes clinical instructors were keen to provide nurses with knowledge and improve their job performance, and

lack of hospital leaders enthusiasm to guide and train their staff nurses. Additionally, nursing managers do not supplying their nurses with instructions to ensure that the tasks of nurses were done properly.

These results agreed with Gulley, (2022) who found that nurses had low level of learning and don't have desire to learn. Moreover Levitt and March, (2022) who revealed that more than half of studied nurses have low level of organizational learning.

These result disagreed with Singh and Paudel, (2020) who expressed that nurses had a high level of organizational learning and are motivated to take responsibility for their own learning. Also, Nair and Mathe, (2023) who revealed that participants reported higher levels of organizational learning.

Regarding to learning dimensions current study results shows that the highest learning dimensions reported by nurses was experimentation while the lowest percentage of organizational learning dimensions among studied nurses was for managerial commitment and empowerment. From the investigator perspective, it is due to nurses who are new in this hospital not encouraged to question the way things are done so they do it by experimentation and there is deficit at management support and empowerment to nurses.

Current study findings are in agreement with Weed and Schertzer, (2020) who revealed that organizational learning primarily focuses on the learning process and experimentation to improve the members‟ acquisition of skills, directions, and information, which upgrades the organization and helps its members adapt to new variables, which emerge because of changing environment. In the overall scheme of decisions and plans,

organizational learning plays as an essential component. In adverse with previous results Garvin and David, (2022) who found that experimentation is not important item of learning dimensions, as nurses don't concern with processes such as imitation and trial and error.

Regarding to correlation between organizational silence and organizational learning study findings revealed that there was a statistical negative correlation between organizational silence and organizational learning. From the investigators points of view, this may be due to silence leading to many negative results that weaken the ability to learn at the level of the organization, which not only affects nurses but also the organizational level because silence diminishes the nurses' readiness to express their concerns, creative ideas, and constructive suggestions which results in a decrease in performance levels due to interruption of communication, knowledge sharing, loss of trust and respect between nurses and managers, and reduced opportunities for growth and development which represent an obstruction to the processes of organizational learning.

The current study in the same line with Yeo and Li, (2022) reported that organizational silence has a negative impact on organizational learning as inadequacies and mistakes occurring in organizational learning activities as well as on the establishment of a healthy feedback mechanism.

In contrast with current study findings, Okan and Fidanboy, (2021) found that organizational silence have positive impact on organizational learning with reference to the results gained from the regression. The more the nurses chooses to be silent, the more he/she will learn. Probably this will be because being silent makes a nurse to listen more, to watch more and they all result in the more learning of the nurses.

Regarding to relation between personal characteristics and organizational silence, study findings revealed that there is highly significant relationship between organizational silence and personal characteristics (age, marital status, sex and experience). From the investigators perspectives, this is due to that older nurses are different from young ones, as they tend to calm down rather than experience conflicts and differences with others and believe that they had presented their opinions before and nothing has changed. Also, men behave more comfortably than women when expressing their ideas, as women prefer still silent instead of speaking up their thoughts.

At the same line with current study results Pinder and Harlos, (2019) specify that men prefer expressing their thoughts than women in groups where women and men are together. At the same line Van Dyne, (2019) demonstrated that men behave more comfortably than women when expressing their ideas as women prefer still silent instead of speaking up their thoughts. Adversely Aslan, (2022) revealed that there was no statistically significant difference between gender differences, highlighting that female teachers and male teachers exhibit similar silence behaviors.

Regarding to relation between personal characteristics and organizational learning, study findings revealed that there is highly significant relationship between organizational learning and personal characteristics (age, marital status, sex and experience). From the investigators perspectives, this is due to younger nurses had high desire of education than olders. Sex has a role in learning as females are more persistent, committed, and have stronger self-regulation than males. Additionally, from clinical observation, female nurses were interested in attending workshops and enrolling in postgraduate studies more than males.

In agreement with current study results (Peirce, 2021) who found that, younger nurses have high levels of organizational learning than older nurses. In addition, there is statistically significant relationship between gender and organizational learning as females have high level of organizational learning than males. This result is disagree with Goula et al., (2021) who found that there is no significant relationship between organizational learning and nurses age, marital status and years of experience had no effect on organizational learning.

Conclusion

Regarding to personal characteristics of studied nurses it can be concluded that more than half of studied nurses had their age between 25-35 years, near to two thirds of sample were females, more than half of the nurses had (5-10) years of experience, majority were holding associated degree in nursing and near to half of nurses were married.

Regarding to level of organizational silence study results concluded that two thirds of studied nurses had a high level of organizational silence and the highest organizational silence type that face nurses was prosocial silence while the lowest type was defensive silence. Regarding to organizational silence causes study results concluded that the highest cause was "official authority" while the lowest cause was "support of supervisor for silence".

Regarding to level of organizational learning study results concluded that half of studied nurses had a low level of organizational learning and the highest organizational learning dimensions was "Experimentation " while the lowest dimension was "Managerial commitment and empowerment ". Regarding to correlation between organizational silence and organizational learning study results concluded that there was a highly significant negative correlation between organizational silence and organizational learning.Regarding relation between organizational silence, organizational learning and personal characteristics study results concluded that there was highly statistical significant relationship between organizational silence, organizational learning and personal characteristics (age, marital status, sex and experience).

Recommendations

Make periodic meetings with nurses to encourage them to talk and express their opinions, holding workshops with staff about organizational silence prevention, provide all needed learning

resources to help nurses to accept new knowledge and skills, provide opportunities for nurses to attend national and international nursing conferences and courses to improve their knowledge, provide nurse managers/supervisors with training programs on the art of management, leadership and communication skills to maintain positive communication channels between managers and nurses, further researches is also needed to assess the relationship between organizational silence and organizational learning and replication of the study on large sample size and different settings.

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