

The Participation Of Nurses In Decision Making

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ABSTRACT

Background and Aim: Staff nurse decisional involvement is associated with positive patient outcomes including a higher nurse-perceived quality of patient care, lower patient mortality, fewer complications and lower levels of job strain and burnout. The aim of this study was to investigate the actual and preferred levels of the decisional involvement of nurses in the Iranian state. **Material and Methods:** This was a descriptive study that was performed at the ILAM general hospitals, IR, during the year 2010. The research instrument which was used was the decisional involvement scale (DIS). A sample of 96 registered nurses (RN) were enrolled in the study by using a simple random sampling method. Descriptive and inferential statistical analyses were performed by using the Statistical Package for Social Sciences Program, Version 11.5

(SPSS). **Results:** The nurses reported the actual involvement in their work environment to be only somewhat ($M = 2$, $SD = 0.75$) and also reported high levels of preferred involvement ($M = 3$, $SD = 0.75$). Collaboration/liaison activities were the most actual involvement aspect in the work environments of the nurses ($M = 3.1$, $SD = 0.69$) and unit governance and leadership were the most preferred forms of involvement ($M = 4.2$, $SD = 0.56$). **Discussion and Conclusion:** The results provide support for decisional involvement in the population of Iranian nurses. Therefore, efforts to improve the quality of the nursing work environments into decisional involvement are critically important to sustaining a strong nursing work force in the future. These findings have important implications for nursing leadership.

Key Words: Nurses, Decisional involvement, Decision making

INTRODUCTION

Patient safety is a major concern in today's resource constrained healthcare environments. A recent report by the Institute of Medicine (IOM) identified nursing as essential to patient safety and pointed to the poor management practices and the negative working conditions as major threats to patient safety [1]. Nurses comprise a large proportion of the hospital workforce, and the centrality of nursing in determining the overall quality of patient care is unarguable. Hospitals and their patients depend on nurses around the clock every day [2]. The IOM report noted that the quality of patient care is directly affected by the degree to which the hospital nurses are active and are empowered by the participants in making decisions about their patient's plan of care and by the degree to which they have an active and central role in organizational decision making [1].

Decisional involvement is defined as the pattern of the distribution of authority for the decision and the activities that govern the nursing practice policy and the practice environment [3].

Key organizations and the new legislation are promoting staff nurse involvement in the decision making about the nursing practice and patient care as a long-term strategy to improve the culture of the work environment [4].

A research on Magnet hospitals has shown that hospitals that support unit-based decision making, have a powerful nursing executive and promote professional nursing practice are more likely to provide superior patient care [1]. Changes in patient needs, medical technology and financial resources create uncertainty in healthcare organizations and they require a redesign of their structure and their processes of care. Redesign changes have increased the nurses' responsibilities

in their care for the patients. As a result, nurses require a greater autonomy and participation in decision making. A greater participation in decision making by the nurses results in better outcomes [5].

Research shows that the way in which nurses are organized, affects the quality of the working environment and the nurse, patient, and organizational outcomes, in particular, nurse satisfaction and retention. For instance, organizational attributes that are features of professional nursing practice models such as participative management and decentralized administration, have been associated with greater nurse satisfaction [6],[7].

Work environments which are characterized by these features have also been associated with greater registered nurse (RN) intent to stay [8],[9]. These features have also been associated with lower levels of job strain and burnout [6],[7],[10]. Finally, enhanced decisional involvement is associated with fewer psychosomatic and physical complaints, and documented physical disorders [10],[11].

Staff nurse decisional involvement has also been associated with positive patient outcomes, including a higher nurse-perceived quality of patient care [12],[13], lower patient mortality and fewer complications [14], shorter mean length of stay- less use of ICU [15] and fewer patient and family complaints [16]. Finally, actual decisional involvement at the unit level was significantly and highly correlated with staff RN perceptions of the quality of care which was delivered by a nursing unit [4].

Inviting and hearing the voices of physicians and nurses in governance deliberations and decision making would seem to be intuitively both appropriate and important [17]. Therefore, the aim

of this study was to investigate the actual and preferred levels of decisional involvement by nurses in the Iranian state .

MATERIAL AND METHODS

This was a descriptive study that was performed at the ILAM hospitals, IR, during the year 2010. The study was approved by the institutional review board. The research instrument which was used, was the decisional involvement scale (DIS) [4]. The DIS, consisting of 21 items, measures the actual and/or preferred decisional involvement of the staff RNs and managers on a nursing unit. The sample items included determining the unit schedule, selecting unit leadership, and selecting staff for hire. The DIS uses a five point scale to indicate the degree to which decisions are the responsibility of the staff nurses and the administration/ management on the nursing unit. Exploratory and confirmatory factor analyses showed that the DIS measures nurse involvement in decisions and activities which are related to six constructs: unit staffing, the quality of professional practice, professional recruitment, unit governance and leadership, the quality of the support staff practice, and collaboration/liaison activities.

Two forms of the DIS were available. One form assesses the perceived actual levels of decisional involvement, asking the respondents to indicate the group that they perceive, actually has the primary authority for the activity or decision on their nursing unit. This form can be used as a pre-measurement and post-measurement tool while organizational change is implemented. The second form asks the respondents to report the preferred levels of decisional involvement, which is beneficial as an early assessment when a group is developing shared leadership initiatives. For the measurement of preferred decisional involvement, the respondents were asked to indicate the group that they would prefer had the primary responsibility for the activity or decision. The same five response categories are used to assess both the actual and the preferred levels of decisional involvement.

For each of the 21 items, the respondents were asked to indicate which nursing group (staff nurses or administration/management) they perceived, had the primary responsibility for the decision or activity (actual decisional involvement) or that they would prefer, had the responsibility for the decision or activity (preferred decisional involvement) on the unit on which they worked. The response choices were as follows: administration/ management only = 1, primarily administration/ management with some staff nurse input = 2, equally shared by administration/management and staff nurses = 3, primarily staff nurses with some administration/management input = 4, and staff nurses only = 5. The items can be considered individually, by the six subscales, or by the total DIS scale. A high score suggests a high degree of staff RN involvement, a low score suggests a low degree of staff RN involvement, and a midrange score suggests a state of the sharing of decision-making between the administration/management and the staff RNs. Havens and Vasey (2003) reported the acceptable reliability for the scales .91 TO .95. In this study, the alpha reliability coefficients were 0.84 to 0.89.

The target population comprised of all nurses working within 3 general hospitals within ILAM, IR. A simple random sample of 96 registered nurses (RNs) was selected. The research instruments, along with a demographic questionnaire, were distributed to the nurses. Descriptive and inferential statistical analyses were performed by using the Statistical Package for Social Sciences Program, Version 11.5 (SPSS).

RESULTS:

The mean age of those who completed the questionnaires was 32.2 (± 6.3) years and 65(67.7%) were women. The mean work experience of the nurses was 6.2(± 4.6) years and 58(60%) were married. The mean values and the SD for the major study variables are shown in [Table/Fig 1].

The nurses perceived the actual involvement in their work environment to be only somewhat ($M = 2$, $SD = 0.75$).

Collaboration/liaison activities were the most actual involvement aspect in the nurses' work environments ($M = 3.1$, $SD = 0.69$) and access to unit governance and leadership had the least actual involvement ($M = 1.1$, $SD = 0.67$) [Table/Fig 1].

The nurses also reported high levels of preferred involvement ($M = 3.9$, $SD = 0.75$) [Table/Fig 1].

According to the DIS norms, unit governance and leadership were the most preferred forms of involvement ($M = 4.2$, $SD = 0.56$) and professional recruitment was the least preferred involvement ($M = 3.5$, $SD = 0.65$) [Table/Fig 1].

Instrument	n	Mean	SD
Overall involvement (actual levels)	96	2	± 0.75
involvement subscales unit staffing	96	1.9	± 0.66
quality of professional practice	96	1.8	± 0.72
professional recruitment	96	1.4	± 0.58
unit governance and leadership	96	1.1	± 0.67
quality of support staff practice	96	1.5	± 0.82
collaboration/liaison activities	96	3.1	± 0.69
Overall involvement (preferred levels)	96	3.9	± 0.75
involvement subscales unit staffing	96	4	± 0.65
quality of professional practice	96	3.9	± 0.76
professional recruitment	96	3.5	± 0.65
unit governance and leadership	96	4.2	± 0.56
quality of support staff practice	96	3.8	± 0.67
collaboration/liaison activities	96	3.6	± 0.88

[Table/Fig 1]: Mean values and SD for instrument scales and subscales

DISCUSSION AND CONCLUSION

The nurses perceived themselves to be only somewhat actually involved and reported high levels of preferred involvement.

It is clear that the momentum for change is building, thus causing the nurses and the hospitals to focus on building nursing practice environments that provide the staff nurses with a strong voice in matters of the nursing practice and patient care. As in the past, there was a shortage of nurses, many are encouraging the implementation of the increased decisional involvement of the nurses into the organization of nursing to enhance the culture of the nursing practice environment, the satisfaction with work, and the quality of patient care, to ameliorate the crisis. Citing nursing's constant surveillance of the patients and the need for efficient operations of the healthcare organizations, for decades nursing and organizational experts have advocated that professional nurses must be more involved in decisions that have an impact on patient care, working conditions, and the organizational policy [3].

Over the past 25 years, physician involvement in hospital governance has become the norm. A national study completed by the Health

Research and Educational Trust in 2005 found that on an average, 20% of the board positions in America's hospitals presently are held by physicians. Comparable information regarding the involvement of nurses on the hospital boards is not readily available. A study in 2005 study on 14 nonprofit general hospitals found that, in total, 52 of the 203 voting board members (26%) were practicing physicians; in contrast, only 4 of the 203 board members (2%) were engaged in the practice of nursing [17].

Thus, it is not surprising that major organizations and legislators are urging the implementation of organizational models that can enhance staff nurse decisional involvement. For instance, the Nurse Reinvestment Act (2002) proposes incentives for hospitals to improve the retention of nurses and to enhance patient care ... by promoting nurse involvement in the organizational and clinical decision making processes of the healthcare facility. The American Nurses Credentialing Center's Magnet Recognition program promotes nursing involvement that makes Magnet Hospital's policy. The implementation of organizational features such as decisional involvement that makes the Magnet hospitals successful, has been encouraged by the American Hospital Association (2002), the American Nurse Association (2002), the American Association of Critical-Care Nurses (2005), and the Joint Commission on the Accreditation of Healthcare Organization (2002). In a recent report by the Institute of Medicine (2003), increased nurse involvement in decision making was identified as a major factor in enhancing patient safety. These calls echo what organizational experts (Begun, 1983; Heydebrand, 1983; Scott, 1982) government officials (Kussero, 1988) and nurse leaders (Aydelotte, 1981: 1983; Maas and Jacox 1977; McClure, Poulin, Sovie and Wandelt, 1983; Prescott and Dennis, 1985) have advocated for decades; the need to organize nursing practice in hospitals to enhance staff nurse influence on the practice and the hospital policy [3].

Increasing the decisional involvement of the nurses also responds to the recommendations made 20 years ago by three "blue ribbon" panels to address the same work environment issues which are confronted by the practicing nurses today. The recommendations from these three classic studies encourage increasing nursing involvement in decision- making to strengthen the patients, the professionals, and the organizational well-being [3],[5].

Similarly, the literature presents compelling evidence that organizing nursing practice to increase staff nurse involvement in decisions about the content and content of practice a mutable feature of the practice environment produces positive outcomes for both patients and the staff [12],[16],[6].

Lake identified 5 aspects of the nurse's work environment, which define the Magnet hospital's nursing settings: nurse participation in hospital affairs; nursing foundations for the quality of care; nurse manager ability, leadership, and support of nurses; staffing and resource adequacy; and collegial nurse-physician relations [18] Laschinger and Leiter [1] found that these characteristics were significantly related to staff nurse burnout and patient safety outcomes. It seems logical to expect that these characteristics would be stronger in empowered work environments.

Brodwin and Bourgeois (1984), in their study on management practices, which was undertaken in 19 organizations, found that collaborative and cultural patterns served to utilize consensus building amongst the hierarchical levels of the organizations. Hewison and Stanton (2002) argued that such a change is taking

place and that the policy emphasis has shifted towards collaborative and co-operative approaches to the provision of health care [19].

The recommendations for creating and sustaining a culture of safety included nonhierarchical communication and decision-making strategies, such as empowering all members of the healthcare team to participate in decisions that affect their work processes as well as empowering them to engage in "constrained improvisation" to immediately address the patient safety issues as they arise.

By ensuring staff nurse access to decisional involvement conditions, nursing leaders will not only increase their organizations' ability to attract and retain nurses but will also create a positive patient safety climate that can support high quality patient care. The results of this exploratory study provide evidence to suggest that nurse leaders have the ability to improve the level of patient safety in their organizations by creating a decisional involvement professional practice environment for the staff nurses.

In conclusion, creating decisional involvement in work environments for the professional nursing practice is an exciting organizational strategy that holds promise for reducing job burnout and job dissatisfaction in healthcare settings. The results of this study highlight the importance of such organizational change efforts.

Limitations of the study: Although the sample size was small, it was acceptable for an exploratory study.

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REFERENCES

- [1] Armstrong kJ, Laschinger H. Structural Empowerment, Magnet Hospital Characteristics, and Patient Safety Culture. *J Nurs Care Qual.* 2006 : 21 (2) ;124-132.
- [2] Prybil L, Nursing Involvement in Hospital Governance. *J Nurs Care Qual.* 2007 : 22(1) ; 1-3.
- [3] Havens DS, Vasey J. The staff nurse decisional involvement scale . *Nursing research.* 2005 : 54 (6); 376- 383.
- [4] Havens DS, Vasey J. Measuring staff nurse decisional involvement, the decisional involvement scale. *JONA.* 2003: 33(6); 331-336.
- [5] Marisa K, Mary A. benefits and outcomes of staff nurses participation in decision making. *J Nurs Adm.* 2001: 31 (1); 16-23.
- [6] Aiken LH, Havens DS, Sloane DM. The magnet nursing services recognition program: a comparison of two groups of magnet hospitals. *Am J Nurs.* 2000;100(3):26-35.
- [7] Laschinger HKS, Shamian J, Thomson D. Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care, and work satisfaction. *Nurs Econ.* 2001;19 (5) : 209-219.
- [8] Davidson H, Folcarelli PH, Crawford S, Duprat LJ, Clifford JC. The effects of health care reforms on job satisfaction and voluntary turnover among hospital-based nurses. *Med Care.* 1997;35(6):634-645.
- [9] Taunton RL, Boyle DK, Woods CQ, Hansen HE, Bott MJ. Manager leadership and retention of hospital staff nurses. *West J Nurs Res.* 1997;19:205-226.
- [10] DeJonge J, Bosma H, Peter R, Siegrist J. Job strain, effort-reward imbalance and employee well-being: a large-scale cross-sectional study. *Soc Sci Med.* 2000;50:1317-1327.
- [11] Elsass PM, Veiga JF. Job control and job strain: a test of three models. *J Occup Health Psychol.* 1997;2:185-211.
- [12] Havens DS. Comparing nursing infrastructure and outcomes: ANCC magnet and nonmagnet CNEs report. *NursEcon.* 2001;19(6):258-266.
- [13] Cassard SD, Weisman CS, Gordon DL, Wong R. The impact of unit-based self-management by nurses on patient outcomes. *Health Serv Res.* 1994;29(4):415-433.
- [14] Baggs J, Schmitt M, Mushlin A, et al. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Crit Care Med.* 1999;27(9):1991- 1998.
- [15] Aiken LH, Sloane DM, Lake ET, Sochalski J, Weber AL. Organization and outcomes of inpatient AIDS care. *Med Care.* 1999;37(8):760-772.

- [16] Havens DS, Aiken LH. Shaping systems to promote desired outcomes: the magnet hospital model. *J Nurs Adm.* 1999;29(2):14-20.
- [17] Prybil LD. Nursing Involvement in Hospital Governance. *J Nurs Care Qual.* 2006 : 22(1); 1-3.
- [18] Lake E. Development of the practice environment scale of the nursing work index. *Res Nurs Health.* 2002;25:176-188.
- [19] Carney M. How commitment and involvement influence the development of strategic consensus in health care organizations: the multidisciplinary approach. *Journal of Nursing Management*, 2007;15: 649-658.

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