



RESEARCH ARTICLE

Decisional involvement among Nurses: Governmental versus Private Hospitals

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Abstract

Background: The responsibility for making sound decisions was never more critical. All nurses have responsibilities for planning patient care therefore; nurses must make effective decisions that affect groups of patients and other staff as well as their own actions.

Aim: The current study aimed to identify if there is dissonance between nurses actual and preferred decisional involvement and examine the effect of certain samples' characteristics such as age, gender, educational level and years of experience on actual decisional involvement among nurses in governmental and private hospitals.

Method and material: A non-experimental correlational research design was used. The study was conducted at two different health care sectors: private and governmental sector in Amman, Jordan. A convenience sample of 130 nursing managers and staff nurses completed a demographic form and the Decisional Involvement Scale.

Result: The data revealed that there were no correlation among age, gender, educational level, years of experience and actual decisional involvement among study sample. Nurses in the governmental hospitals had more decisional

involvement than nurses in the private hospitals. Both managerial and non-managerial nurses need more participation in decision making than they already practice.

Conclusion: The study concluded that there was a dissonance in the actual and preferred decisional involvement between managerial and non-managerial nursing personnel. Only type of hospitals (governmental versus private) had relationship to the nurses' involvement in decision making in the study sample

Keywords: Nurses, decisional involvement, shared governance, dissonance in the actual and preferred decisional involvement

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Introduction

In healthcare systems, several aspects, such as clients and financial system, technology, and rules may have an effect on the cost, accessibility and quality of healthcare services.

These aspects may work together and produce more difficult problems and ambiguity in a healthcare system.¹

Today's healthcare environment is challenging for nurses when there is a significant shortage of staff to meet the comprehensive needs of patients. To cope with the realities of today's health care system, nurses must be prepared to be critical thinkers. They must also be ready to welcome change and succeed in rapidly changing environment. The primary request for successful management and leadership are problem solving, critical thinking, and decision making. Much of any manager's time is spent in critical examination of issues, solving problems, and making decisions.²

Decision making is considered one of the most important everyday jobs in management and selecting the type and method of decision making is considered to be one of the most important skills of a manager.³ Additionally, nurse managers and supervisors from various health care organizations make different decisions during the day. Therefore, they (especially novice nurse managers and supervisors) are able to enhance their decision making abilities by matching decision theories to their problems⁴. As a result, the possibility of making effective decisions increases by the coordination between decision making methods of a manager and the conditions of decision making.⁵

Decision-making is a compound movement, mainly when studied in the reality of the clinical setting.⁶ Decision making is a complex, cognitive, process that is defined as choosing a particular course of action. Furthermore, effective decision making is grounded on both personal characteristics and the ability to think critically.

Nurses who consistently make effective decisions develop and maintain a current knowledge base through active participation in continuing education programs, on-going self-study, and thoughtful reflection on clinical experience.⁷

Moreover, clinical decision making is the process nurses use to gather patient information, evaluate the information and make judgments that result in the provision of patient care. This complex cognitive process, essential to nursing practice, involves six various thinking processes: description, selection, representation, inference, synthesis, and verification.^{8,9}

As nurses gain essential knowledge, thinking processes and experience, effective clinical decision-making processes grow eventually.¹⁰

Because of nurses' close relations with clients and their families in all health care settings, nurses assist understand clients' needs and expectations for health care. They are involved in decision-making at clinical practice level as well as in management.¹¹

Ineffective clinical decision making among nurses have different consequences on patients' outcomes especially in critical care units.^{12, 13}

Although a number of research studies have highlighted barriers to nurses' clinical decision making,¹⁴ effective decision making is important for both patients and nurses to improve the quality of patients' care.¹⁵

Participation in decision making originates from the idea of participative management which supports staff to share with the goals and work of the organization, as a consequence create the chance for persons to have a sense of personal achievements.¹⁶

Unfortunately, participation in decision making is often neglected in the nursing profession and is disregarded in the area of health care.¹⁷ As nurses constitute the largest professional group in the health care system and make up about half the total workforce in the health care area¹⁸, the low participation rate of nurses in the higher levels of

the hierarchal system of hospitals has caused the feeling of disability to become widespread in health care organizations.¹⁹

Consequently, those who are less participated in decision making, who have less control over their activities, become inflexible and resistant to change and finally, lose their motivation due to the increased level of anxiety and frustration.²⁰

Additionally, lack of decisional involvement among nurses in clinical setting is a chief cause of nurses' job dissatisfaction.²¹

Furthermore, the value of decisional involvement within the work environment is obvious, but there is little nursing literature evaluates this involvement. The limited research studies on decisional involvement do not compare actual to preferred decisional involvement. Additionally, it has been recognized that similarity between actual and preferred decisional involvement is significantly related to both work satisfaction and organizational commitment.²²⁻²⁴

The purposes of this study were to identify the perceived actual level of nurses decisional involvement, determine the preferred level of decisional involvement, identify decisional dissonance, determining concordance between staff and management perceptions of actual and preferred levels of decisional involvement and examine the influence of demographic characteristics such as age, gender, educational level, and years of experience on the nurses decisional involvement at various positions.

Methodology

Research Questions

- 1) What is the perceived actual level of decisional involvement?
- 2) What is the preferred level of decisional involvement?
- 3) Is there dissonance between staff and management perception of actual and preferred levels of decisional involvement?
- 4) Do demographic characteristics such as age, gender, educational level, and years of

experience influence the nurses' decisional involvement?

Operational definition

Decisional dissonance: the degree of difference between actual and preferred levels of decisional involvement by study sample.

Research Design

The research design is a quantitative non-experimental correlational design. The exact translation of the Latin term *ex post facto* is "from after the fact". This phrase is meant to explain that the research has been conducted after the variations in the independent variable have occurred. The main purpose of *ex post facto* research design is to understand relationships among phenomena as they naturally occur, without any intervention from the researcher.^{25, 26}

Setting

The study conducted in seven hospitals (governmental and private sector) in Amman, Jordan. Governmental hospitals included: Al-Bashier, Al-Sult, Al-Tutangi, and Prince Hamza hospital. While, the private hospitals included: Ibn-Alhytham, Arab Medical Center, and Al-Khaldi hospital.

Sample

Hundred and thirty staff nurses, on charge nurses, first line manager, nursing supervisor, and nursing director; male and female nurses were included in the study. Characteristics of sample involved age, gender, years of experience, educational level, and nurses' position.

Instrument

Decisional involvement is operationalized through the Decisional Involvement Scale (DIS) (Formally the Distribution of Authority Scale) which was developed by Havens and Vasey²⁷. It consists of 21 items, measures actual and/or preferred decisional involvement for staff nurses and managers on a nursing unit. The DIS uses a five likert point scale to indicate the degree to which decisions are the responsibility of staff nurses and administration/management on the nursing unit. A high score suggests a high degree of staff nurses involvement, a low score suggests a low degree of

staff nurses involvement, and a midrange score suggests a state of sharing of decision-making between administration/management and staff nurses. DIS measures nurses involvement in decisions and activities related to six constructs: unit staffing, quality of professional practice, professional recruitment, unit governance and leadership, quality of support staff practice, and collaboration/liaison activities.

Development of the DIS was guided by a theoretical framework that was grounded in the literature on professional nursing practice and the sociology of the professions. DIS content validity is high (1.0). Reliability of the DIS has been assessed through determination of Cronbach's alpha. A total scale alphas ranging from (.91) to (.95), subscale alphas have consistently ranged from .68 (subscale related to collaboration/communication) to .85 (the remaining five subscales).

Procedure

Data were collected after official permission was approved from the selected hospitals. Confidentiality was granted for study participants through anonymity of data collection questionnaires, as well as autonomy for all participants to feel free to participate in the study and withdraw from the sample at any time without any risks for the participant was granted. Informed consent was obtained from each nurse agreed upon participation in the study. Data were collected over a period of six months from January to June 2007. Questionnaire was provided for the participants and the researchers were available for any explanations for the questionnaire. In order to achieve the study objectives the following statistical methods were utilized. Frequencies to describe the study sample, T-test and one way ANOVA test to differentiate between means of ascribed demographic variables.

Limitations of the study

The study implied that there are no correlation among actual decision involvement, age, education and experience; a larger sample size may reveal the correlation among them.

Results

Table 1. Characteristics of study sample (N=130)

Items	No	%
Age		
20-	80	61.5
26-	26	20
31-	11	8.5
>35	13	10
X 26.7± 6.07		
Gender		
Male	61	46.9
Female	69	53.1
Educational Level		
Secondary school	15	11.5
Associate	17	13.1
Bachelor	95	73.1
Master	3	2.3
Years of experience		
< 5	80	61.5
5-	28	21.5
> 10	22	17
X 4.6± 4.7		
Nurses by hospital type		
Governmental	43	33.1
Private	87	66.9
Type of hospitals		
Governmental	4	57.1
Private	3	42.9

Table 1, describes the study sample characteristics; as shown the majority of study sample aged 20-25, and minority of them aged 31-35 with "mean (SD)" age is amounted to 26.7, 6.07. Female nurses were a little bit more than male nurses, with majority of the sample had bachelor degree in nursing while the minority had master degree. Regarding years of experience;

majority of the sample had less than five years of experience, on the other hand, the minority had more than ten years of experience with "mean (SD)" estimated at \bar{X} 4.6, 4.7. In relation to the hospital type; majority of study sample were from private hospitals although governmental were more than private hospitals.

Table 2, shows the actual decisional involvement of study sample in governmental and private hospitals. The table indicated that nurses have a midrange score that suggests a state of sharing of decision-making between administration/management of staff nurses in the governmental hospitals, while, nurses have low degree of staff nurses involvement in decision making in the private hospitals. There were also highly significant relationships among all aspects of decisional involvement between nurses in the governmental and private hospital except the collaboration aspect. The table implies that nurses in the governmental hospitals have more decisional involvement than nurses in the private hospitals.

Table 3 (see Annex), reflects the preferred decisional involvement among study sample in both governmental and private hospitals. The table concluded that there were highly significant differences in the preferred decision making among study sample in both sectors in all items only unit staffing that has significant difference and only collaboration activities has no difference in the two sectors.

Table 4 (see Annex), describes the dissonance of actual decisional involvement among managerial and non-managerial nurses in the selected hospitals. This table revealed that there were a decisional dissonance in the actual decisional involvement between managerial and non managerial nursing personnel only in unit governance and leadership and quality of support staff practice.

Table 5 (see Annex), reflects the dissonance of preferred decisional involvement among managerial and non-managerial nurses in the selected hospitals. The table implied that there

was a decisional dissonance in the preferred decisional involvement between managerial and non managerial nursing personnel in the unit governance and leadership item only.

Table 6. The relationship between age, educational level, years of experience and actual decision making among study sample (N=130)

Items	f	P
Age	.725	.539
Educational level	1.551	.205
Years of experience	.362	.781

Table 7. The relationship between gender and actual decision making among study sample

Items	X	SD	t	df	P
Gender					
Male	2.6810	.7433			
Female	2.6204	.7601	.456	127	.649

Table 6, shows the relationship among age, educational level, experience, and actual decision making among study sample. The table implies that none of the variable has a relationship to the decision making among study sample.

The relationship between age, educational level, years of experience and actual decision making among study sample were investigated in this table. The table indicates that there were neither a relationship between actual decision making nor age, educational level, and years of experience among study sample in governmental and private hospital.

Table 7, describes the relationship between gender and actual decision making among study sample. The table indicated that gender has no



relationship to the actual decision making among study sample.

Discussion

The present study revealed that majority of study sample were female working in private hospitals had an age between 20-25 years old, with a bachelor degree in nursing and have less than five years of experience. The study also indicated that there were no relationships among age, gender, educational level, years of experience and actual decisional involvement among study sample. Only type of hospital has a highly significant relationship to decision involvement i.e. nurses working in governmental hospitals have more involvement in decision making than nurses in private hospitals. Perhaps, this could be because private hospital are more concerned with patients as they pay for the health services they rendered, therefore hospital management does not share nurses in their decisions. Furthermore, there was dissonance between actual and preferred decisional involvement among managerial and non-managerial nursing personnel with more preference of nurses to be involved in decision making than they already practice.

These results were congruent with the study conducted by Mangold et al.,²⁸ which was conducted to determine the level of actual and preferred decisional involvement and ascertain whether there was a decisional dissonance among registered nurses (RNs). In addition, the impact of level of education, years of experience, hours worked per pay period, and working setting of actual and preferred decisional involvement were measured. The study concluded that a statistically significant difference was found between RNs actual and preferred decisional involvement, with RNs preferring more decisional involvement than they actually experienced. Work setting was the only variable to which a difference could be attributed.

Furthermore, barriers to clinical decision-making in nurses in Australia were examined by Hoffman et al.²⁹ The aim of this study was to examine whether nurses in Australia participated in clinical decision making to the extent they desired. Some factors that could be inhibiting or promoting participation in clinical decision making, namely educational level, occupational orientation (role values), level of appointment and area of practice (medical/surgical) were also examined. A quantitative, correlational study was utilized. The study showed that nurses holding a professional role value participated more in clinical decision making than those with a paramedical role value. Nurses participating in surgical areas participated less in decision-making than those in medical areas. While a higher educational level was not associated with greater participation in clinical decision-making, it was linked to wanting more participation in this process.

Additionally, Scherbet al.,³⁰ conducted a descriptive study exploring staff nurse and nurse manager ratings of actual and preferred decisional involvement and differences between staff nurses and nurse managers. A sample of 320 RNs from a Midwestern health care network was surveyed using the Decisional Involvement Scale. Nurse managers and staff nurses had statistically significant differences in their perceptions of who was involved in actual decision making in the areas of unit governance and leadership and collaboration or liaison activities. There were statistically significant differences in preferred decisional involvement between staff nurses and nurse managers in the overall DIS scale and the subscales of unit governance and leadership and quality of support staff practice.

Moreover, Hicks et al.,³¹ conducted a pilot study to examine the relationship of education level, years of critical care nursing experience, and critical thinking (CT) ability (skills and dispositions) to consistency in clinical decision making among critical care nurses. The study utilized a non-

experimental and correlational research design. Fifty four critical care nurses from adult critical care units in 3 private teaching hospitals were the sample of this study. The majority of nurses held a BSN or MSN and had an average of 9 years of direct clinical experience in the care of the critically ill. The study implicated that education and experience were not related to CT ability, nor was CT ability related to decision-making consistency.

On the other hand, Nooritajer and Mahfozpour³² evaluated the participation level of head nurses in decision making and its relation to their satisfaction with participative level in the educational hospitals of Iran University of Medical Sciences and Health Services (IUMSHS). A self-reported questionnaire was utilized to conduct this study. 94 head-nurses working in the educational hospitals of IUMSHS, all having employment background of over 6 month in their present word, were investigated and formed the sample study. Data analysis revealed that 40.4% of the head-nurses reported their participation in decision making was moderate and 55.4% of the reported their satisfaction level with participative decision making was also moderate. A relatively strong and statistically significant correlation was observed between participation in decision making and satisfaction with participative decision making ($p=0.001$; $r=0.661$).

Conclusion and Recommendations

The study concluded that there was a dissonance in the actual and preferred decisional involvement between managerial and non-managerial nursing personnel. Nurses in the governmental hospitals had more decisional involvement than nurses in the private hospitals. Both managerial and non-managerial nurses need more participation in decision making than they already practice. Only type of hospitals (governmental versus private) had relationship to the nurses' involvement in decision making in the study sample. Finally, nurses and nurse managers are in need for more

involvement in decision making than they already do.

For further research studies; barriers to nurses involvement in decision making need to be explored. Conduction of other research studies are needed for better identification of factors improves or impedes decisional involvement among nurses.

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ANNEX

Table 2. The actual decisional involvement among study sample in governmental and private hospitals (n=43, 87 respectively)

Items	Govern. Hospitals		Private Hospitals		t-value
	M	SD	M	SD	
Unit staffing	3.1008	.7785	2.4904	.8534	3.947 **
Quality of professional practice	3.0193	.7384	2.4693	.8451	3.635 **
Professional recruitment	3.0310	.9051	2.1571	1.1042	4.495 **
Unit governance and leadership	3.1395	.8023	2.3506	.9010	4.866 **
Quality of support staff practice	3.0775	.7929	2.2490	.9526	4.920 **
Collaboration/liaison activities	3.1163	1.0456	3.2644	1.0671	-.749

* P < .005

Table 3. The preferred decisional involvement among study sample in governmental and private hospitals (n=43, 87 respectively)

Items	Govern. Hospitals		Private Hospitals		t-value
	X	SD	X	SD	
Unit staffing	3.2093	.7275	2.9119	.7427	2.163 *
Quality of professional practice	3.3295	.6026	2.8563	.7072	3.762 **
Professional recruitment	3.2946	1.006	2.7663	.9052	3.023 **
Unit governance and leadership	3.4709	.6619	2.7845	.7492	5.102 **
Quality of support staff practice	3.4496	.6081	2.8467	.8050	4.334 **
Collaboration/liaison activities	3.3488	.9420	3.4195	.9303	-.406

* P < .005

Table 4. The dissonance of actual decisional involvement among managerial and non-managerial nurses in the selected hospitals (N=130)

Items	Managerial nurses		Non-managerial nurses		t-value
	X	SD	X	SD	
Unit staffing	2.7576	1.1165	2.6836	.8583	-.266
Quality of professional practice	2.6061	.9258	2.6455	.8424	.147
Professional recruitment	2.2424	.9671	2.4492	1.1242	.589
Unit governance and leadership	2.2727	.7198	2.6250	.9415	1.207
Quality of support staff practice	2.1818	.8989	2.5395	.9764	1.169
Collaboration/liaison activities	3.1364	1.1851	3.2076	1.0425	.214

* P < .005

Table 5. The dissonance of preferred decisional involvement among managerial and non-managerial nurses in the selected hospitals (N=130)

Items	Managerial nurses		Non-managerial nurses		t
	X	SD	X	SD	
Unit staffing	3.1212	.9342	2.9944	.7331	-.536
Quality of professional practice	3.0909	.9079	3.0000	.6915	-.406
Professional recruitment	2.9091	.9898	2.9294	.9596	.067
Unit governance and leadership	2.7500	.9287	3.0212	.7614	1.109
Quality of support staff practice	3.2424	.9079	3.0113	.7685	-.939
Collaboration/liaison activities	3.5909	.8312	3.3644	.9329	-.776