DECISIONAL INVOLVEMENT OF REGISTERED NURSES IN A TERTIARY HOSPITAL IN SAUDI ARABIA

by

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Thesis presented in fulfilment of the requirements for the degree of Master in Nursing in the Faculty of Health Sciences at Stellenbosch University

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DECLARATION

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ABSTRACT

Literature suggests that job satisfaction and retention of nurses can be improved by empowering nurses in decision making (Mark, Lindley & Jones, 2009:120; Mangold, Pearson, Schmitz, Scherb, Specht & Loes, 2006:266; Manojlovich, 2007; and Scherb, Specht, Loes & Reed, 2010:2). Positive work environments such as those found in Magnet® accredited hospitals and those where management models have flat hierarchical structures, support the decisional involvement of registered nurses. Decisional involvement is described as "the pattern of distribution of authority for decisions and activities that govern nursing practice policy and the practice environment" (Havens & Vasey, 2005:377).

The purpose of this study was to explore the decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia. It is hypothesized that an empowering shared governance structure will result in a high level of decisional involvement of registered nurses who provide direct patient care.

A quantitative study with a descriptive exploratory design was chosen to answer the research objectives. Through simple random sampling, n=140 registered nurses who provide direct patient care (target population N=672) and through non-probability purposive sampling n=18 nurse managers (target population N=21), participated in the study. A self-administered questionnaire was designed which included a validated tool, namely the Decisional Involvement Scale (Havens & Vasey, 2003:333). A pilot study was completed to test the validity of the self-designed sections of the questionnaire. Numerical data was analysed using STATISTICA v. 11.5 while the open-ended questions were analysed and placed into themes.

It was found that registered nurses who provide direct patient care have low levels of actual and preferred decisional involvement, implying that the authority for decisional involvement lies with managers. The hypothesis that empowering shared governance structures will result in a high level of decisional involvement is not supported. There was no statistical difference identified between bedside Registered Nurses (bedside RNs) and nurse managers in the overall perception of decisional involvement. Factors that were identified to impact on decisional involvement included educational level, experience, leadership styles, the work environment and a culture of shared decision making.

It is recommended that the focus to improve the decisional involvement of registered nurses who provide direct patient care should be on addressing those activities where more decisional involvement is preferred, while concurrently addressing those factors that were identified which would impact on the decisional involvement of all registered nurses.

OPSOMMING

Literatuurstudies dui aan dat bemagtiging van verpleegkundiges in die proses van besluitneming tot meer werksbevrediging en retensie sal lei. Positiewe werksomgewings soos die by Magnet geakkrediteerde hospitale en die met plat hiërargiese bestuursmodelle dra by tot betrokkenheid van geregistreerde verpleegkundiges in besluitneming. Betrokkenheid by besluitneming word beskryf as 'die wyse waarop outoriteit versprei is sodat besluite en akwiteite wat verpleegpraktykbeleid en die praktykomgewing bepaal, uitgevoer kan word' (Havens & Vasey, 2005:377).

Die doel van die studie was om die betrokkenheid te bepaal van geregistreerde verpleegkundiges by besluitneming in 'n tersiêre hospitaal in Saoedi-Arabië. Die hipotese is dat 'n bemagtigende, gedeelde bestuurstruktuur sal lei tot 'n hoë vlak van deelnemende besluitneming by geregistreerde verpleegkundiges verantwoordelik vir direkte verpleegsorg.

Die navorsingsdoelwitte is beantwoord deur middel van 'n kwantitatiewe studie met 'n beskrywende, ondersoekende ontwerp. Geregistreerde verpleegkundiges (n=140) wat direkte verpleegsorg lewer (teikengroeppopulasie N=672) is gebruik as deelnemers in die studie. Verpleegdiensbestuurders (n=18) is ook gebruik as deelnemers en gekies deur nie-waarskynlike, doelbewuste steekproefneming (teikenpopulasie N=21). 'n Self-toegepasde vraelys is ontwerp, met insluiting van 'n geldig verklaarde Besluitnemende Betrokkenheidskaal (Havens & Vasey, 2003:333). 'n Loodsstudie om die geldigheid van die selfontwerpte deel te bepaal, is voltooi Numeriese data is ontleed deur middel van STATISTICA v. 11.5. Oop-einde vrae is ontleed en in kategorieë georganiseer.

Daar is gevind dat geregistreerde verpleegkundiges wat direkte pasiëntsorg lewer, laer vlakke van werklike en verkose betrokkenheid het in besluitneming, wat aandui dat die outoriteit vir besluitnemende betrokkenheid by bestuurders lê. Die hipotese dat bemagtigende gedeelde bestuurstrukture tot 'n hoë vlak van deelneming in besluitneming sal lei, word nie ondersteun nie. Daar was nie 'n beduidende statistiese verskil tussen geregistreerde verpleegkundiges wat by die bed betrokke is en verpleegdiensbestuurders met algehele waarnemingsbetrokkenheid by besluitneming nie. Geïdentifiseerde faktore wat 'n rol speel by betrokkenheid by besluitneming behels opvoedkundige vlak, ondervinding, leierskapstyle, die werkomgewing en 'n kultuur van gedeelde besluitneming.

Daar word aanbeveel dat aktiwiteite waarby geregistreerde verpleegkundiges wat direkte pasiëntsorg lewer, verkies om meer betrokke by te wees tydens besluitneming, aangespreek word. Terselfdertyd moet geïdentifiseerde faktore wat 'n rol speel in die betrokkenheid van besluitneming van alle geregistreerde verpleegkundiges ook aangeroer word.

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It always seems impossible until it is done
Nelson Mandela

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviations and acronyms that are mentioned in this thesis and that are not commonly known to the average reader are hereby explained:

AHN:	Assistant Head Nurse
ANA:	American Nurses Association
ANCC:	American Nurses Credentialing Center
ANOVA:	*Analysis of Variance*
BSN:	Bachelor of Science in Nursing
CNC:	Clinical Nurse Coordinator
DI:	Decisional Involvement
DIS:	Decisional Involvement Scale
DPC:	Divisional Practice Council
HN:	Head Nurse
HREC:	Human Research Ethical Committee
IOM:	Institute of Medicine
IPNG:	Index of Professional Nursing Governance
ICN:	International Council of Nurses
IRB:	Institutional Review Board
KFSHRC-J.:	King Faisal Specialist Hospital and Research Center-Jeddah branch
MSR:	Manpower Status Report
NDNQI:	National Data of Nursing Quality Indicators
NEC:	Nurse Executive Council
NPQC:	Nursing Practice and Quality Committee
PPM:	Professional Practice Model
RN:	Registered Nurse
SN:	Staff Nurse
UC:	Unit Council

CHAPTER 1: SCIENTIFIC FOUNDATIONS OF THE STUDY

1.1 INTRODUCTION

Nursing is a dynamic profession that is confronted with a global shortage of nurses and an increase in job dissatisfaction. Positive work environments are essential to address these issues if the nursing profession is to continue to develop from strength to strength. One strategy to improve the work environment is the enhancement of the decisional involvement of registered nurses (Havens & Vasey, 2005:376). Involvement in the process of and having the authority to be involved in decision making is known as decisional involvement. Environments in which nurses are empowered to have decisional involvement have also been shown to impact positively on recruitment and retention of nurses as well as on job satisfaction (Mark, et al., 2009:120; Mangold, Pearson, Schmitz, Scherb, Specht & Loes, 2006:266; Manojlovich 2007; and Scherb, Specht, Loes & Reed, 2010:2) and positive patient outcomes, reduced absenteeism and decreased staff turnover (Kowalik & Yoder, 2010:263). Work environments that provide nurses decision making opportunities based on their knowledge, experience and professional judgement, and allow for involvement in decisions regarding the working conditions are highly valued by the nurse (Laschinger, Almost & Tuer-Hodes, 2003:411).

Literature has identified various reasons for the lack of participation in decision making by nurses. Laschinger (2008:323) states that leadership has a direct impact on decisional involvement of registered nurses but does not elaborate what type of impact occurs. Kowalik and Yoder (2010:262) identify possible reasons that include the limited impact of a decision taken on the nurse personally, lack of opportunity to attend decision making meetings and knowledge deficit regarding the issues on which decisions are being made. Liu (2008:293) associates the level of participation in decision making to the attitude and desire for decisional involvement by employees and managers, the relationship and trust levels between managers and employees, the educational level, demographic differences, personality differences and gender differences where female managers are thought to be more receptive to shared decision making with their employees.

1.2 RATIONALE

The setting for the study is at King Faisal Specialist Hospital and Research Center (Gen. Org.) – Jeddah Branch (KFSHRC-J), Saudi Arabia. KFSHRC-J is a tertiary hospital that has an organizational and medical management style based on the American system. The hospital employs predominantly expatriate nurses from Australasia, Europe, the Far East, the

Middle East, North America and South Africa who have a minimum post graduate experience of two years in nursing. Nurses from Saudi Arabia are hired as new graduates directly after completion of their nursing degree. This hospital is on the journey to attain Magnet accreditation from the American Nurses Credentialing Association (ANCC).

The ANCC Magnet Recognition Program® is an "international organizational credential that recognizes nursing excellence in healthcare organizations" (American Nurses Credentialing Center, 2012). The Magnet Model comprises of five components, namely *transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation and improvements; and empirical outcomes*. The ANCC Magnet Recognition Program® advocates the use of a flat hierarchical structure and a management model which allows nurses to participate in decision making regarding issues that affect them. Kramer, Schmalenberg and Maguire (2010:10) describe the nine (9) essentials of a Magnet work environment and one of these essentials is that a visible structure that allows for participation in decision making is implemented in the work environment. Mark, Lindley and Jones (2009:120) also acknowledge that to build and maintain a positive environment requires commitment by both management and staff, and by the development of a structure to support professional nursing practice. It must be conceded, however, that a structure alone does not necessarily bring about desired changes as identified by Kramer, Schmalenberg, Maguire, Brewer, Burke, Chmielewski, Cox, Kishner, Krugman, Meeks-Sjostrom and Waldo (2008:540-541) in their study of control over nursing practice. Other factors as identified in **paragraph 1.1** may also influence the decisional involvement of nurses, regardless of the presence of a structure within the work environment.

Professional practice models (PPMs) provide the structure that organizes nursing care delivery. The ANCC (2009:65) describes a PPM as a schematic depiction of the structure of how bedside RNs practice, communicate, collaborate and develop professionally within the organization. Shared governance is the foundation of many nursing PPMs. Porter-O'Grady (2003:251) defines shared governance as "a structural model through which nurses can express and manage their practice with a higher level of professional autonomy". The process of shared decision making is enabled through these shared governance structures. Thus, the presence of shared governance structures authorizes and empowers the decisional involvement and should impact on the level of decisional involvement of the bedside RN. Havens and Vasey (2005:376) also assert that the quality of the work environment as well as nurse, patient and organizational outcomes are impacted by the manner in which nurses are organized.

The Nursing Affairs Department in the study hospital has adopted a professional practice model (**figure 1.1**) that supports decision making through a defined shared governance structure. This shared governance structure consists of four interrelated council groups i.e. Unit Councils, Divisional Practice Councils, Central Councils and the Nurse Executive Council (NEC). Through this structure, all nurses are given full authority to address issues and make decisions regarding practice, quality, education, research/evidence based research and operational issues that impact on their delivery of patient care through the various councils at the unit level, at the departmental level and at the nurse executive level. Membership is voluntary and this obligates the nurse to choose to participate in decision making and to accept the accountability for their contribution in the decision making process.

However, the introduction of this shared governance structure has resulted in a paradigm shift in the roles and accountabilities for both the nurse manager and the registered nurse (RN) who provides direct patient care (bedside RN). The previous hierarchical management style in the Nursing Affairs Department has progressed from managers having almost exclusive control over the decisions made to managers and bedside RNs now sharing in the decision making processes regarding those issues that impact on the bedside RN.

At the centre and base of the study hospital's PPM (**figure 1.1**) the four groupings of councils are seen. The white outer ring and middle dark blue ring describe the structures and processes that support RNs' control over the delivery of nursing care and the environment in which nursing care is delivered.

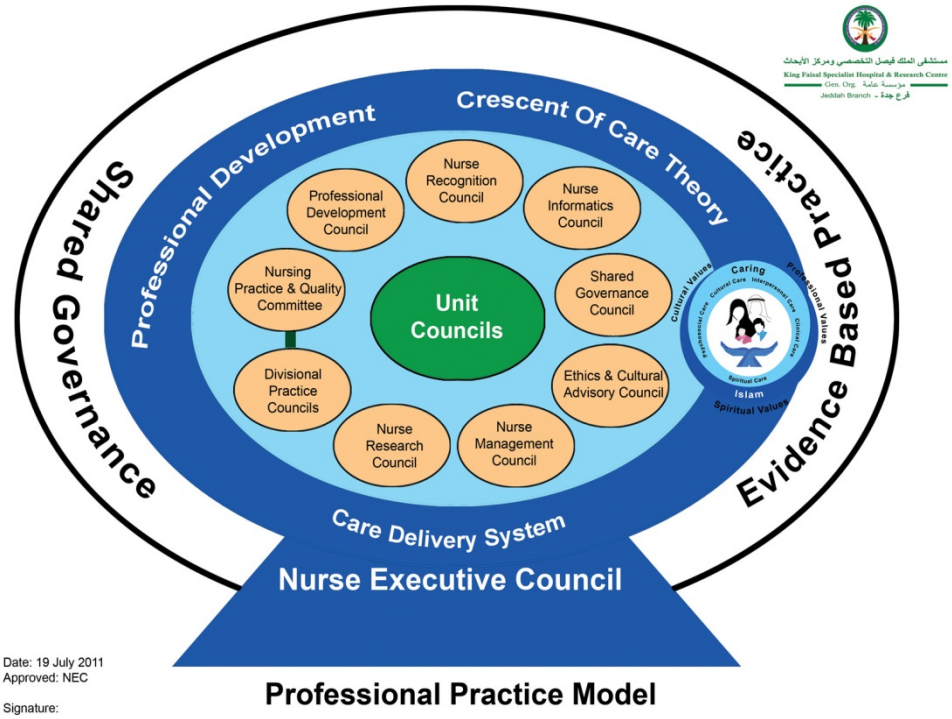

Figure 1.1: Professional Practice Model, KFSHRC - Jeddah

Decisional involvement for nurses is ensured by the authority given through the establishment of the various councils. Empowerment to be involved in the decision making processes is achieved through the open membership on the councils for all nurses. The various councils are described below:

The purpose of the *Unit Council* is to give the bedside nurse at the point of care the authority to participate in decision making regarding issues of nursing practice, quality, education and operational issues that impact at the unit level. Decisions can be taken if the impact is localized to that specific unit. If the impact of a decision is broader which could involve multiple units or the Nursing Affairs Department as a whole, the issue is referred to the relevant Divisional Practice Council or Central Council as appropriate. Membership consists of direct care nurses with the nurse manager (Head Nurse/Assistant Head Nurse) functioning in the capacity of facilitator.

Divisional Practice Councils represent each operational division within the Nursing Affairs Department. The divisional councils have nursing representation from each unit within that specific operational division (**table 4.3**). The purpose of the divisional councils is to make decisions and recommendations regarding issues of practice and quality that impact across a specific division. Decisions that impact across the Nursing Affairs Department as a whole are referred to the Nurse Practice and Quality Committee. Membership consists of bedside nurses, managers and educators from all the units within the specific division.

The purpose of the *Central Councils* is to make decisions and recommendations regarding each council's specific charges including practice, quality, nurse recognition, informatics, professional development, research, management, shared governance, and ethical and cultural issues. Membership consists of bedside nurses, management, administrators and educators across the Nursing Affairs Department.

The *NEC*'s purpose is to coordinate the work of the central councils and make strategic decisions for Nursing Affairs. Membership consists of chairpersons from the Central Councils, bedside RN representatives and senior management.

In April 2010 a nurse satisfaction survey was conducted of RNs who provide direct patient care through the National Database of Nursing Indicators (NDNQI). The NDNQI is a repository for nursing sensitive indicators at the unit level and is governed by the American Nurses Association (ANA, 2012). The survey tool was divided into various divisions and the section titled 'decision making' included questions asking whether the opportunity is given for

participation in decision making, as well as the satisfaction experienced with the level of participation in decision making in the unit. The hospital's overall result for decision making was below the mean in comparison to other Magnet accredited hospitals participating in the survey.

There is minimal information known regarding the extent to which bedside RNs currently have decisional involvement within the hospital. This limited information, however, is based only on one sub-section question in a survey regarding overall job satisfaction. No information is available regarding the desired level of decisional involvement of the bedside RN or of the level that the nurse manager perceives the bedside RN has. The factors that impact on the decisional involvement of RNs in general, i.e. bedside RNs and nurse managers, are also not known.

The researcher was tasked with introducing the concept of shared governance to the nursing staff and to implement Unit Councils into every nursing unit in the hospital giving her insight into the barriers and successes of introducing a decentralized decision making structure. Thus, the researcher has an interest in promoting the decisional involvement of nurses. Gaining information regarding the perception of actual and preferred levels of decisional involvement and of the impacting factors will assist in identifying areas where a change of focus is required to support the enculturation of shared governance and shared decision making.

1.3 PROBLEM STATEMENT

Historically the authority for decision making in the organization was held by the nurse managers while the bedside RN had minimal input into decisions that impacted their delivery of care and the environment in which this care was delivered. The introduction of shared governance and its empowering structures in the study hospital has given the bedside RNs the authority to be involved in decision making and the decision making process. However, subsequent to the introduction of shared governance, the level of decisional involvement the bedside RNs currently hold is not known nor has the level of their preferred involvement been identified. In addition, the perception of the nurse managers regarding the levels of involvement that bedside RNs currently hold and should have has not been ascertained. The factors that may impact on decisional involvement being effectively operationalized in the organization have not been identified.

1.4 RESEARCH QUESTION AND HYPOTHESIS

The research question “What is the decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia?” guided the study.

The researcher hypothesized that the implementation of the empowering shared governance councils should result in the bedside RNs having a high level of decisional involvement.

1.5 AIM OF RESEARCH

The aim of the study was to explore decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia.

1.6 OBJECTIVES

The objectives of this study were to

- determine staff nurses’ (bedside RNs’) actual and preferred level of decisional involvement
- compare whether there are statistical differences between staff nurses’ (bedside RNs’) level of decisional involvement and nurse managers’ perceptions of the staff nurses’ (bedside RNs’) level of decisional involvement.
- identify the factors that impact on the decisional involvement of registered nurses.

1.7 RESEARCH METHODOLOGY

1.7.1 Research approach and design

A quantitative approach with a descriptive exploratory design was used in this study to explore the decisional involvement of RNs and the factors that impact on decisional involvement of RNs in a tertiary hospital in Saudi Arabia.

1.7.2 Population and sampling

Simple random sampling was used to obtain a sample size of 25% (n=168) from the available population of N=672 of RNs who provide direct patient care. A non-probability purposive sampling method was used to obtain a sample of n=21 from the available population of N=23 direct line nurse managers. This method was chosen because of the small sample target population of direct line nurse managers. The Decisional Involvement Scale (DIS) (Havens & Vasey, 2003:333), chosen for this study, allows for the comparison of the perception of the bedside RN to those of the nurse manager resulting in the two target populations being identified.

1.7.3 Inclusion and exclusion criteria

The inclusion criterion required for the target population of a RN was that he/she must provide direct patient care and for a nurse manager was that he/she must be a direct line nurse manager of a RN who provides direct patient care. There were no exclusion criteria. The two groups were mutually exclusive and neither could belong to both groups.

1.7.4 Data collection instrumentation

The self-administered questionnaire was divided into four (4) sections. The first section consisted of a biographical data form, the second section consisted of closed-ended questions and questions using a Likert Scale set to elaborate the objectives of the study, the third section consisted of the Decisional Involvement Scale (Havens & Vasey, 2003:333) and the fourth consisted of two open-ended questions. The self-developed sections, i.e. sections 1, 2 and 4 were based on the literature and the researcher's personal experience in the implementation and on-going support of a shared governance culture.

1.7.5 Pilot study

A pilot study was "...conducted to develop and refine the steps of the methodology" (Burns & Grove, 2007:38) and test the feasibility of the study. The questionnaire was given to n=16 RNs and n=2 nurse managers to assess the validity and reliability of the instrument. The instrument was found to be accurate and without ambiguity. Based on feedback received, the questionnaire was adjusted accordingly. The responses obtained in the pilot study were not used in the main study and the respondents who participated were excluded from the main study.

1.7.6 Reliability and validity

Reliability was ensured by the distribution and collection of the questionnaires by the researcher, by all the participants receiving the same questionnaire and by the researcher being the only contact person for guidance and answering of questions.

The DIS has been measured for *content validity, construct validity and reliability*. A high c*ontent validity* index of 1.0 of was obtained with the independent assessment by three specialist nurses in the field of decisional involvement. *Construct validity* was measured by the level of decisional involvement of the RN. Two independent samples of RNs (n=849 and n=650) were used to evaluate a confirmatory factor analysis of the instrument. *Reliability* of the DIS was measured using Cronbach's Alpha coefficient and a score of 0.91 - 0.95 was obtained.

1.7.7 Data collection

The questionnaire was distributed personally by the researcher. The completed questionnaires were placed in self-sealing, self-addressed envelopes and were returned using the hospital's internal mail system or delivered to the researcher's office by the respondents.

1.7.8 Data analysis and interpretation

"Data analysis is conducted to reduce, organize, and give meaning to the data" (Burns & Grove, 2007:41). The interpreted results were presented in a narrative form with the use of graphs and tables to signify the relationships between the variables. Descriptive statistical analysis and associations between various variables were completed using the Mann-Whitney U test, the Pearson Chi-square test and analysis of variance (ANOVA).

1.7.9 Ethical considerations

The research proposal was approved by the Ethical Committee for Human Science Research of the Faculty of Health Sciences, Stellenbosch University with an extension given for an additional year (addendum A and B), the Chief of Nursing Affairs who granted permission for the study to be completed within the Nursing Affairs Department (addendum C), and the Institutional Review Board (IRB) of KFSHRC-J (addendum D).

This study was conducted according to the ethical guidelines and principles of the Declaration of Helsinki, the South African Guidelines for Good Clinical Practice and the Medical Research Council's Ethical Guidelines for Research. The information leaflet (addendum E) attached to the questionnaire (addendum F) advised the participants that informed consent was assumed by the return of a completed questionnaire. The principles of anonymity and confidentiality were maintained by the researcher. No identifying information was required on the questionnaire. Only the researcher has access to the raw data. The completed questionnaires are stored in a locked cupboard in a secured office of the researcher for a period of five (5) years.

Raw data obtained from the demographic and DIS sections of the questionnaire will be provided to the University of North Carolina to be placed into a data base for use as part of an on-going evaluation of the DIS. Anonymity of the participants is assured by Dr Havens in her acceptance letter for use of the DIS in this study (addendum G). No information for the data base that could be viewed as breaching the participant's anonymity was submitted.

1.8 GUIDING FRAMEWORK

The guiding framework for this study is Kanter's Theory of Structural Empowerment (1977, 1993). Rosabeth Moss Kanter (1993:245) identifies three variables that explain behaviours in the work place, namely the structure of opportunity, the structure of power and the structure of proportions. The main tenet of Kanter's theory is that organizational structure influences the empowerment of individual employees. Kanter believes that these structures impact organizational behaviours more than employees' personality traits do (Finegan & Laschinger, 2001:489).

1.9 DEFINITION OF TERMS

For the purpose of this study the following terms have been defined or described.

360 Degree Feedback Report

Written feedback regarding the performance of a manager that is completed by the manager's immediate work group is known as a 360 degree feedback report. In the study hospital the feedback would be received from the manager's subordinates, peers, supervisor, as well as the medical chairperson of the ward/unit/service. The results of this feedback are included in the performance appraisal of the manager by his/her manager.

360 Degree Interview

A 360 degree interview is the process of interview used for employment for management or administrative positions in the study hospital and includes having the candidate's potential supervisor, colleague and sub-ordinate(s) present at the interview resulting in a comprehensive assessment of the candidate from different perspectives.

Assistant Head Nurse

An Assistant Head Nurse (AHN) is a RN who is responsible for assisting in the management of an assigned unit -and reports to the Head Nurse of the relevant unit. An AHN must have a minimum of four (4) years of acute hospital nursing experience with one (1) year leadership experience.

Associate Degree

An associate degree in nursing focuses on the technical aspects of nursing, in comparison to the theoretical and academic aspects of nursing usually included in a Bachelor of Science in Nursing (BSN) programme. The degree is completed in a two (2) year period where after the nurse can write the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and become licenced to practise as a RN.

Bedside RN

For the purpose of this study a registered nurse who provides direct patient care will be known as a bedside RN. In the study hospital the bedside RN is referred to as a Staff Nurse 1 or Staff Nurse 2 as further described below.

Concordance

This term is used to describe the agreement in opinions between bedside RNs and nurse managers regarding the actual and preferred level of decisional involvement. Concordance is defined as “the state of being similar” (Oxford Dictionary, 2010:300).

Decisional Involvement

Havens and Vasey (2005:377) define decisional involvement as “the pattern of distribution of authority for decisions and activities that govern nursing practice policy and the practice environment.”

Dissonance

Dissonance describes a “gap between the levels of actual and preferred decisional involvement” (Havens & Vasey, 2003:332) and in this study it is utilized to identify the differences of perceptions between the bedside RN and the nurse manager.

Head Nurse

A Head Nurse (HN) is responsible for the 24 hour management of an assigned unit in the study hospital. The HN must have six (6) years hospital experience as a RN and two (2) years leadership experience.

Manpower Status Report (MSR) lines

Manpower Status Report (MSR) lines are a list of all employees, who are employed at KFSHRC-J. Each employee is allocated a specific number. The MSR lines are maintained by the Human Resource Department.

Nurse Manager

A nurse manager is a RN who retains 24 hour responsibility and accountability for the management of a unit. A nurse manager working in KFSHRC-J is referred to as a Head Nurse or an Assistant Head Nurse.

Nursing Affairs

Nursing Affairs is the department that is responsible for the operations of nursing within the hospital.

Nursing Position

The nursing position refers to the various job titles of the RN respondents in this study, i.e. Staff Nurse and Head Nurse/Assistant Head Nurse.

Perceptions

Refers to "an interpretation or impression based on one's understanding of something" (Illustrated Oxford Dictionary, 2003:606). Within the context of this study perceptions refer to the views and opinions of RNs regarding their level of involvement in decision making and those factors that impact on their decisional involvement.

Registered Nurse

A registered nurse (RN) is a nurse who meets the hospital's criteria to practise as an independent nurse based on her/his credentials from her/his home country. RNs must have a minimal current clinical practical experience of two (2) years. Both nurse managers and Staff Nurses are RNs but the term used in the study hospital for the bedside RN is known as the Staff Nurse.

Shared Governance

"Shared governance is an organizational structure that enhances staff-leader partnerships of shared decision making regarding issues that impact on practice, quality, education, research and the work environment. Shared governance entails the principles of nurses' autonomy, accountability and decision making responsibilities relating to the immediate working environment and issues of practice, quality and safety. Shared governance aims at maximizing the clinical (practice) functions of nurses creating a professional work environment that fosters professional development of nurses, facilitates patient-care decision making and creates a shared vision of professional nursing care" (Nursing Practice Plan - Nursing Affairs, Unpublished document, 2011).

Shared Governance Structure

The shared governance structure consists of formal forums where decision making is authorized for specific accountabilities and charges. The chosen model in KFSHRC-J is the councilor model and it consists of the following decision making councils:

- Unit Councils
- Divisional Practice Councils
- Central Councils
- Nurse Executive Council

Staff Nurse 1

In the study hospital a RN who is hired to provide direct patient care is referred to as Staff Nurse 1 (SN1). To practice as a SN1, the nurse must meet three criteria. Firstly, the nurse must be licenced to practise as a RN in their home country, secondly they must be registered with the Saudi Council for Health Specialties as a RN and lastly, they must meet the criteria set by the hospital to work as a RN which include a minimum of two years of acute current practical experience. In addition, the SN1 must meet the educational requirements as set out by the study hospital and these vary according to the country of origin. An example would be that a diploma in nursing is acceptable for a nurse from South Africa but not from certain provinces in India where the nurse must hold a bachelor degree in nursing.

Staff Nurse 2

A Staff Nurse 2 (SN2) is also a RN who is hired to provide direct patient care. The SN2 must also meet all the criteria set for the SN1 but may not necessarily meet the set educational requirements and therefore has limits set on certain privileges such as holding the key for controlled/scheduled drugs.

Staff Nurse 3

A Staff Nurse 3 (SN3) is a nurse that is not licenced to practise as a RN in the study hospital and who provides basic nursing care under the direct supervision of the SN1 or SN2.

1.10 STUDY OUTLAY

The research study will be conducted according to the following plan:

Chapter 1: Scientific foundation for the study

In chapter 1 a general overview of the research is given and the reasons for conducting the research are identified. The researcher's hypothesis is introduced and a description of the problem statement, the aim and the objectives of the study, the research methodology, ethical considerations and the guiding framework is given.

Chapter 2: Literature review

In this chapter the concept of decisional involvement and the factors that impact on the involvement in decision making are described. Relevant research studies are reviewed and discussed.

Chapter 3: Research methodology

Chapter 3 contains the description of the research methodology that is used in the study.

Chapter 4: Data analysis, interpretation and discussion

In chapter 4 the results of the study are analysed, interpreted and discussed.

Chapter 5: Conclusions and recommendations

In chapter 5 the conclusions and recommendations based on scientific evidence obtained in the study are presented.

1.11 CONCLUSION

Literature has identified that decisional involvement of nurses positively impacts on staff satisfaction, nurse recruitment and retention rates. This chapter included a preliminary review of the literature and the rational for conducting the study. The researcher described the hypothesis set for the study, the aim, objectives and the research methodology used to guide the study. A questionnaire was selected as the method for data collection and a brief description of this questionnaire was provided. The guiding framework is presented and briefly discussed. In the next chapter, chapter 2, an in-depth literature review regarding decisional involvement will be presented.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The intention of having a literature review is to contribute towards gaining a better appreciation of the problem that has been identified (De Vos, Strydom, Fouche & Delport, 2005:123) through appraisal of the current theoretical and scientific knowledge available regarding the identified problem (Burns & Grove, 2007:135). This literature review was conducted to explore decisional involvement of RNs, which is the aim of this study, as it has been researched and published.

An electronic search was conducted of the various databases including EBCSO host, Pubmed, Sage, Ovid-Medline and other academic websites. Key words used in the search were ‘nurse’, ‘decision making’, ‘decisional involvement’ and ‘empowerment’. The search was extended to include articles from 1977 to 2012 in order for the researcher to gain a clear understanding of nursing involvement in decision making.

With the significant redesigning of the work environment globally over the years an increasingly higher demand has been placed on the bedside RN whose role has become more complicated with more responsibilities (Mrayyan, 2004:326). These changes brought on by this higher demand are due to advances in technology, financial constraints, changing needs of the population, advances in medicine, the increasing demand for bedside RNs that has exceeded the supply and the aging workforce (Swihart, 2006:5). The effect of these changes and the inherent stressors of taking responsibility for the well-being of patients have contributed to an increase in job dissatisfaction and a decreased level of retention of bedside RNs. One strategy that has been identified to address these issues is to improve the work environment by increasing the involvement that bedside RNs have in decision making in issues that affect them (Havens & Vasey, 2005; Scherb et al., 2010).

Although the main focus of this study is decisional involvement, it is beneficial to firstly place decision making into perspective. The process and interrelated decision making concepts in nursing are discussed below.

2.2 DECISION MAKING IN CONTEXT

Sullivan and Decker (2005:100) describe decision making to be at the very core of nursing. Decision making is illustrated as a complex cognitive task that requires the involvement of critical thinking, memory and evaluation (Oetjen, Oetjen & Rotarius, 2008:4). Decision

making usually occurs unconsciously without any thought being given to the process. There are five phases in the decision-making process as described by Booyens (2005:506):

- *recognizing the problem;*
- *gathering relevant information;*
- *developing and evaluating alternative solutions;*
- *selecting a solution and*
- *post-decision activities which include evaluation.*

A continuum is described by the Oxford Dictionary (2010:316) as a "series of similar items in which each is almost the same as the ones next to it but the last is very different from the first". Thus, on the continuum of decision making the lower level involves minimal or passive involvement while the higher level encompasses autonomous and proactive involvement. The sharing of information and offering of suggestions are considered to be at the lower levels of the decision making continuum while decision making regarding how the work is done, what work is done and how the work is organized are found at the upper levels of the continuum (Weston, 2008:405).

Various concepts related to decision making and that are applicable to the aim of this study of decisional involvement of RNs are discussed below.

- The Illustrated Oxford Dictionary (2003:212) defines *decision* (noun) as "the act or process of deciding; a conclusion or resolution reached after consideration; a formal judgement and a resolution".
- The Oxford Dictionary (2010:378) defines decision making (noun) as the "process of deciding". Decision making can simply be described as the act of deciding.
- *Clinical decision making* specifies decision making linked to the patient and patient care within the clinical setting.
- *Shared decision making* refers to the mutual involvement in decision making by all parties. Shared decision making can be described as sharing in the act of deciding.
- A concept that is not well-known or understood is that of *decisional involvement*. Decisional involvement is not defined in the dictionary. However, the word decisional is the adjective for decision and involvement is defined as "causing participation and making necessary" (Illustrated Oxford Dictionary, 2003:426). By combining the two words using the individual definitions decisional involvement can be described as the authority to participate in a judgement, resolution or decision.
- A common characteristic for both decisional involvement and decision making is *autonomy*. Weston (2009:87) refers to autonomy as the "freedom, power and authority to make decisions related to professional nursing practice". Gagnon,

Bakker, Montgomery and Palkovits (2010:22) concur with this description and further describe autonomy as the "freedom to exercise the scope of practice by making independent and interdependent nursing and patient care decisions".

- *Control over nursing practice* is described by Weston (2008:405) as "decision making related to the work of the unit, department or organizational operations".
- Booyens (2004:133) defines *authority* as "the power given to someone to make decisions and to take actions". Marriner Tomey (2007:114) is in agreement and further explains authority to be legitimate power which is determined by the structure within an organization including rules, roles and elations.
- *Empowerment* is the noun for empower and is defined by the Illustrated Oxford Dictionary (2003:264) as to "authorize, licence, give power to, make able". Empowerment can be explained as the process of attaining control.

In summary, the above explained concepts of clinical decision making, shared decision making, decisional involvement and control over nursing practice are all interrelated concepts that describe how the bedside RN influences decisions and the decision making process in the professional practice environment. Empowerment, authority and autonomy are the essential elements necessary for all of the above mentioned concepts to be successfully actualized.

As identified, there are multiple interrelated concepts associated with decision making. These concepts have been briefly explored but it is important for the aim of this research study to have a clear understanding of and reflect in detail regarding decisional involvement.

2.3 DECISIONAL INVOLVEMENT

To better understand this relatively unknown concept which is the focus of this study, decisional involvement will be defined and discussed; related empirical studies will be reviewed where after decisional involvement will be placed into context within the professional practice environment.

2.3.1 The Concept of Decisional Involvement

In recent years a new concept identified by various researchers within the realms of the bedside RNs' involvement in decision making is that of decisional involvement. It was first described by Laschinger, Sabiston and Kutszcher in 1997 (1997:341) as the "control over the content and context of nursing practice. They define content as the "perceived autonomy or ability to act on one's knowledge and judgment" (Laschinger, Sabiston & Kutszcher, 1997:343), while context is identified as the organizational structure in which bedside RNs

practise. Subsequently, decisional involvement was defined by Havens and Vasey (2005:377) as “the pattern of distribution of authority for decisions and activities that govern nursing practice policy and the practice environment”. Both of these definitions establish that the focus of decisional involvement is the autonomy and authority that is granted to bedside RNs to make decisions that go beyond clinical bedside decision making to include operational and organizational decision making.

For the purpose of this study the definition of decisional involvement developed by Havens and Vasey (2005:377), as noted above will be used. Using this definition as a foundation, the following definitions are used to describe actual and preferred decisional involvement.

- *Actual decisional involvement* is described as the *current* “pattern of distribution of authority for decisions and activities that govern nursing practice and the practice environment” (Havens & Vasey, 2005:377). Actual levels of decisional involvement represent what bedside RNs perceive to be currently occurring in their environment.
- *Preferred decisional involvement* is described as the *favoured* “pattern of distribution of authority for decisions and activities that govern nursing practice and the practice environment” (Havens & Vasey, 2005:377). Preferred levels of decisional involvement are those that represent the desired involvement of bedside RNs in the decision making process in the organization.

Decision making in the practice environment is well discussed and researched but traditionally bedside RNs’ decision making is mostly linked to clinical patient care decisions within the nurses’ scope of practice. Generally, bedside RNs are not involved in the broader operational and organizational decision making processes that ultimately impact on how patient care is delivered and on their practice environment. Authority for this decision making usually rests with managers. This is supported by Fusilero, Lini, Prohaska, Szweda, Carney and Mion (2008:529) who state that nurses believe that administrative decision making occurs at many different levels (from executive managers to nurse managers) that impacts on their day to day work but that they, the nurses, are not involved in these decisions.

What does it mean to have decisional involvement? Decisional involvement takes decision making, i.e. the act of deciding, one step further and includes the bedside RN in the processes of decision making, through the issuance of formal authority, to be involved in decision making regarding issues that affect their practice and the practice environment. Decisional involvement entails all phases of the decision making process as described in **paragraph 2.2**. However, decisional involvement is not possible without staff being empowered with the authority to be involved in decision making and the decision making process. Historically, as discussed above, this authority usually rests with the manager who

by virtue of his/her position has the power for control over decision making and the decision making process, while bedside RNs are in varying degrees excluded from having involvement in decision making. On the decision making continuum as described in **paragraph 2.2** decisional involvement can be placed at the higher level where the bedside RN must be involved in determining *how* the work of a bedside RN is done and organized and *what* work must be done.

Decisional involvement is a complex collaboration between nursing and a hospital's leadership (Kowalik & Yoder, 2010:259). Partnerships where bedside RNs and management meet each other half way are essential for decisional involvement to be successfully actualized. Bedside RNs are required to make the choice to participate in the organizational processes regarding the work environment, working conditions and practice in the health care setting (Kowalik & Yoder, 2010:262). Managers need to create positive work environments and this can be achieved through decentralized organizational structures with few hierarchical layers and management styles that are supportive of the bedside RN having the opportunity to participate in decisional involvement as discussed in **paragraphs 2.6.2 and 2.6.3.**

Only eight (8) papers that explore the elements of decisional involvement were located during the literature search of which only four (4) are published studies. The first study involving decisional involvement is found in the literature in 1997 when Laschinger, Sabiston and Kutszcher (1997:341), using a descriptive correlational design, investigated the patterns of relationships between empowerment and decisional involvement. This study identified that access to work empowerment structures positively affects decisional involvement of nurses. In 2003 Havens and Vasey (2003:332) published their definition of decisional involvement, as defined in **paragraph 2.3.1** and developed a tool, the Decisional Involvement Scale (DIS), to measure the elements of decisional involvement. This tool is discussed in detail in **paragraph 3.5.4.** In 2010 a concept analysis of decisional involvement was completed by Kowalik and Yoder (2010:259) where the defining attributes, antecedent and consequences of this concept are presented.

The review of literature identified only three (3) published studies that measure the levels of RNs' decisional involvement and one (1) study that measures the decisional involvement of senior nurse leaders. Using a convenience sample in their quantitative study, Mangold et al. (2006:271) identified that the RNs perceived that they had low levels of actual decisional involvement and that there was a statistically significant difference between the actual and preferred level of decisional involvement of the RNs. RNs were shown to prefer to have more decisional involvement than they actually had. Another study by Scherb et al. (2010:10),

using a descriptive correlational design, identified that the level of actual decisional involvement for RNs was low and their level of preferred decisional involvement remained low, not reaching the level of the mid-range score of shared decision making. Managers in this study agreed that they preferred not having shared levels of decisional involvement with the bedside RN. The only study regarding decisional involvement that could be found in the literature that was completed in a similar setting was conducted in Iran in 2010. This quantitative descriptive study used a random sample of RNs and identified that the nurses perceived themselves to have only somewhat actual decisional involvement but to have high levels of preferred involvement (Jaafarpour & Khani, 2011:16). The only study identified in the literature search that tests the decisional involvement of leaders was conducted by Wong, Laschinger, Cummings, Vincent and O'Connor (2010:122) amongst senior nurse leaders in Canada. A purposive sampling method was used in this descriptive correlational study that identified that senior nurse leaders are able to influence decisions throughout the organization. In review, the empirical studies indicate that bedside RNs generally perceive that they have low actual decisional involvement and would prefer to have more decisional involvement.

In summary, it has been identified that bedside RNs who are empowered to have the freedom to initiate and participate in the decision making processes, resulting in change which ultimately impacts positively on themselves, their patients and the work environment, are said to have decisional involvement.

2.3.2 Decisional involvement within the professional practice environment

The type of professional practice environment that the bedside RN practises in is a strong determinant of how bedside RNs are supported in decisional involvement.

2.3.2.1 The Professional Practice Environment

The professional practice environment can be described as those characteristics in a work environment that either facilitate or limit professional nursing practice (Lake, 2002:178). The professional practice environment supports nurses to function at the uppermost level of their scope of practice, to be effective within the multidisciplinary team of health care providers and to mobilize resources quickly (Lake, 2007:106). The American Association of Colleges of Nursing (AACN, 2002) acknowledges that the working environment of a nurse is one of the most demanding and in 2002 they released a white paper entitled the "Hallmarks of the Professional Practice Environment" that identifies eight key characteristics. These key characteristics include the creation of collaborative relationships amongst the members of the multidisciplinary health care team, the empowerment of the bedside RN in clinical

decision making and the organization of clinical care systems in a decentralized organizational structure for decision making.

Arford and Zone-Smith (2005:468) suggest that professional practice environment characteristics are generic and can be applied to all work environments, whether they are professional or not. They propose that people will want to work anywhere as long as the environment allows control over practice, fosters respect for all employees, gives positive feedback and allows the feeling of meaningful productivity.

Leadership in nursing is responsible for cultivating a professional practice environment that facilitates bedside RNs' involvement in decision making (Swihart, 2006:48). Leaders need to adapt their styles of management to facilitate decisional involvement and recognize that positive outcomes can be achieved for the patient, bedside RNs and the organization if there is a positive professional practice environment that empowers bedside RNs. One strategy for leaders to communicate their value of a professional practice environment is through the development of a professional practice model.

2.3.2.2 Professional Practice Model

A professional practice model (PPM) sets the tone for the professional practice environment of an organization. This is confirmed by the American Nurses Credentialing Center (ANCC) (2009:64) who describes PPMs as a schematic depiction of the structure of how bedside RNs practise, communicate, collaborate and develop professionally within the organization. The details of the PPM are unique to each organization but it is recommended that models that support autonomy, control over nursing practice and involvement in decisional involvement will have a positive impact on the work environment (Hitchings, Capuano, Bokovoy & Houser, 2010:61). They further state that the only commonality of different organizational PPMs is the principles that represent empowerment that describe the structure for the decision making processes. However, Hitchings et al. (2010:69) caution that a PPM must fit the culture of an organization for it to be successful.

Barden, Quinn, Donahue and Fitzpatrick (2011:212) propose that RNs must be empowered by a PPM that includes shared governance. This is supported by Hitchings et al. (2010:61) who state that shared governance is the foundation of many nursing PPMs and Barden et al. (2011:216) further agree that shared governance is an essential element of PPMs. The research hospital's PPM (**see figure 1.1**) clearly delineates the decision making structure within the Nursing Affairs Department. This structure gives the authority for decisional involvement of all bedside RNs within the Nursing Affairs Department.

Having an organization specific PPM is a core requirement for attaining Magnet accreditation. Magnet accredited hospitals are exemplary professional practice environments that are conducive to positive work practices.

2.3.2.3 The Magnet Recognition Program®

The Magnet Recognition Program® is an accreditation program under the auspices of the American Nurses Credentialing Center (ANCC) that awards international recognition for nursing excellence and reports that better patient and staff outcomes can be attributed to positive professional practice environments for nurses (ANCC:2012). A significant predictor of Magnet strength is the decision making culture within the organization (Rondeau & Wagar, 2006:248). Research has shown that Magnet accredited hospitals are known for excellence in nursing care and for attracting nurses to work in these hospitals (Wilkins & Shields, 2009:225), improved nurse work environments (Erenstein & McCaffrey, 2007:304), empowerment (Armstrong & Laschinger, 2006:124) and greater job satisfaction (Laschinger et al., 2003:410).

The standards for obtaining Magnet accreditation are evidence based and include requirements for *visionary leadership, nursing structure, professional practice, quality improvement, nursing research and outcomes*. Quality and safety standards are included in the requirements. The development of standards can be traced through the history of the Magnet Recognition Program®. In 1983 a study was conducted by the American Academy of Nursing Task Force on Nursing Practice to ascertain what type of work environments were able to attract and retain well-qualified nurses. Of the 163 organizations that were studied forty-one were identified as having the qualities and they were described as “magnet” hospitals to indicate their ability to attract and retain nurses. The characteristics that were identified were labelled as “Forces of Magnetism” and they were used as the measurement standards to obtain Magnet accreditation. In 2008 a new conceptual model that grouped the “Forces of Magnetism” into five components was introduced (ANCC, 2012). The Magnet Model’s five components comprise of *transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation and improvements; and empirical outcomes*. The structural empowerment component promotes decisional involvement and advocates the use of a shared leadership/participative decision making model that organizes bedside RNs to participate in decision making regarding issues and policies that affect their practice and the delivery of patient care. It is the requirements of this component that prompted the researcher to identify and explore the objectives of this study regarding decisional involvement of RNs and the factors that impact on their decisional involvement.

Only 6.83% of registered hospitals in the United States have achieved ANCC Magnet Recognition® status, while internationally there are currently five (5) organizations that have achieved this accreditation (ANCC: 2012). The research hospital is currently on the journey to attain Magnet accreditation. This process to attain accreditation includes the submission of a document that describes and demonstrates, through presentation of empirical outcomes, how the set standards are met. Three independent appraisers review the document and score it applicably. Only organizations that score at the level of excellence will proceed to having a site visit where the appraisers validate and verify the evidence presented in the document. If the evidence is substantiated, Magnet accreditation is awarded for four (4) years where after re-designation must be pursued.

On review, the concept of decisional involvement has been defined and discussed as it has been reviewed in the literature. It has been identified that the manner in which decisional involvement is actualized is dependent on the professional practice environment that will either facilitate or limit the opportunity for bedside RNs to have the authority to participate in decision making. It has also been discussed that professional practice models set the tone for a professional practice environment and provide a formal structure for decisional involvement in an organization. Magnet accredited hospitals have been identified as exemplary professional practice environments that recognize the importance of decisional involvement and recommend the implementation of structures to operationalize decisional involvement of bedside RNs. For a better understanding of the concept of decisional involvement, the defining characteristics of this concept need to be identified and discussed.

2.4 CHARACTERISTICS OF DECISIONAL INVOLVEMENT

A characteristic can be described as the “typical or distinctive” (Illustrated Oxford Dictionary, 2003:142) quality or feature of a concept. Decisional involvement has defining characteristics that help differentiate between making a decision at any specific time and participating in decisional involvement. A concept analysis of decisional involvement by Kowalik and Yoder (2010:260) identifies the following defining characteristics: (a) autonomy; (b) collaboration; (c) distribution of authority; (d) empowerment; (e) responsibility; and (f) accountability. It is of interest to note that these characteristics for decisional involvement are similar to those of job satisfaction as described by Sengin (2003:317-318) which includes autonomy; collaboration; the decentralization of authority for decision making and the control over nurse practice.

a) The first characteristic essential for defining decisional involvement is autonomy. Autonomy is described by Kowalik and Yoder (2010) as being the central theme for decisional involvement. Autonomy in decision making gives nurses the freedom to make choices, act on the choices and then justify the choice. Bedside RNs who

perceive that they have a high level of autonomy also perceive that they have a high level of decisional involvement (Kowalik & Yoder, 2010:261). Autonomy together with control over decision making is vital to staff satisfaction.

b) The second characteristic of decisional involvement is that of collaboration. Collaboration between bedside RNs and managers is essential for decisional involvement to succeed. Positive collaboration between bedside RNs and managers impacts on job satisfaction. In their study of RNs and their work related experiences by Andrews, Burr and Bushy (2011:74), it was identified that RNs perceived that they were excluded by upper level nursing management and hospital administrators from decision making related to patient care and work conditions. These RNs perceived that their input was not desired nor was it valued. This is an example of where the level of decisional involvement is low because of the lack of trust in the bedside RN. For decisional involvement to be effective both parties need to recognize that working in partnership is necessary. Bedside RNs need to actively participate in the decision making process, while managers need to support shared decision making.

c) Authority in decisional involvement is fundamental to successful bedside RNs' participation in the decision making process. A decentralized distribution of authority in an organization that has few hierarchical layers supports decisional involvement and allows bedside RNs to influence decisions while in an organization that has a centralized distribution of authority the managers retain control of decision making as discussed further in **paragraph 2.6.2.**

d) Empowered work environments involve bedside RNs in a decision making process. Bedside RNs who are empowered to be involved in decision making are more likely to feel that they are being trusted to participate and are more willing to contribute to the unit and organizational goals. Empowerment is linked to decisional involvement through the organizational structures of shared governance or participative management which will be discussed in more detail in **paragraph 2.6.2.**

e) Responsibility is defined as an "obligation to complete a task" (Sullivan & Decker, 2005:144). Nurses are responsible to their patients, their colleagues, the organization and themselves to improve nursing care through involvement in decision making (Mangold et al., 2010:261). This responsibility means participating in clinical and organizational work improvement strategies that ultimately will lead to improved patient outcomes.

f) The final characteristic that defines decisional involvement is accountability. Accountability is the readiness to invest in decision making and demonstrate ownership for the decisions taken (Swihart, 2006:3) regardless of the outcome from

> the taken decision. Having to accept accountability for participation in decisional involvement may prevent staff from becoming involved in the process of decision making (Kowalik & Yoder, 2010:262).

The defining characteristics that are most frequently associated with decisional involvement have been identified and discussed but for decisional involvement to be actualized there are essential prerequisites that must be in effect.

2.5 DECISIONAL INVOLVEMENT PREREQUISITES

For decisional involvement to be successfully actualized, Kowalik and Yoder (2010:262) suggest that fundamental prerequisites must be in place. These prerequisites are a *shared governance structure or participative management, nurse control over practice and the choice of the staff to be involved in the decision making process,* all of which require further discussion.

2.5.1 Shared Governance Structure or Participative Management

Decisional involvement must have a suitable management structure, such as shared governance or participative management available for it to be effectively implemented. This management structure must empower the bedside RN to participate in the decision making process. Porter-O'Grady (2003:251) defines shared governance as "a structural model through which nurses can express and manage their practice with a higher level of professional autonomy". The second identified management structure of participative management is described as "a process of dynamic interactive decision making and problem solving…" (Muller, 2005:109). Even though both shared governance and participatory management involve bedside RNs in the decision making process, there is one key difference between these two organizational management structures. This difference is that in participatory management the authority and power to make the final decision rests with the manager while in shared governance the authority and power for decision making regarding issues that impact on bedside RNs is shared between the bedside RNs and managers. These management structures are discussed in detail in **paragraph 2.6.3.**

2.5.2 Nurse control over practice

Control over nursing practice is defined by Kramer, Schmalenberg and Maguire (2008:25) as "a participatory process enabled by a visible, organized structure through which nurses have input and engage in decision making about practice policies, as well as, personal issues affecting nurses". Weston (2008:407) elaborates further that control over nursing practice is the "degree to which nurses have opportunities, expectations and authority to make

decisions that affect their practice". Bedside RNs having control over their practice is essential to support and encourage their participation in decisional involvement.

2.5.3 Choice to participate

Even if there is a structure in place and bedside RNs have control over their practice it is ultimately the individual nurse's choice to participate in decisional involvement and to choose to what extent this participation will be. Mangold et al. (2006:270) identified that RNs do not wish to actively be involved in decision making and suggest that RNs felt overwhelmed in their role as a nurse and did not have the inclination to invest time and energy in being involved in decision making. However, Kramer (2008:553) proposes that some nurses enjoy being involved in decision making while others only become involved out of professional obligation but family obligations prevent full involvement in the decision making process.

The preceding prerequisites identify the necessity for a participatory or shared governance management structure to be in place for decisional involvement where bedside RNs are empowered to have control over their practice and where bedside RNs must make a conscious choice to participate in decisional involvement. It is important to look beyond these prerequisites at the multiple factors that impact on decisional involvement of bedside RNs.

2.6 INFLUENCING FACTORS ON DECISIONAL INVOLVEMENT

As already discussed decision making is at the foundation of nursing and occurs subconsciously but multiple and varied factors may impact on how decision making is initiated and concluded and how decisional involvement is actualized.

2.6.1 Organizational Climate and Culture

Both the climate and culture of an organization can be considered as factors that impact on decisional involvement. It is this climate and culture that sets the tone for how decisional involvement of bedside RNs is valued and actualized within the organization.

The organizational climate is described as the perceived characteristics of an organization (Sullivan & Decker, 2005:27). The work climate includes a variety of elements such as "supervisory support, autonomy, job structure, cohesion, interpersonal relationships and managerial relationships" (Gormley, 2011:34). The climate of an organization depicts the practices and procedures within the organization and influences the attitudes and behaviours of the bedside RNs. However, bedsides RNs usually have minimal control over the climate, as it is managers who generally set the climate in which bedside RNs work. This control ultimately impacts on the bedside RN's decisional involvement. Climates where bedside RNs

can derive job satisfaction from participation in decision making are preferred (Swansburg & Swansburg, 2002:307).

Culture signifies the norms and traditions of an organization (Sullivan & Decker, 2005:27). The culture of an organization is comprised of elements that include the formal hierarchical organizational structure, the informal networking and relationship structure and the political structure that indicates the distribution of power (Booyens, 2005:196). An organizational culture may restrict decisional involvement because of the hierarchies, management style and norms within the organization. Weston, Estrada and Carrington (2007:7) propose that to create a culture that captures the wisdom of employees it is necessary to create the commitment of employees through a professional practice environment, have a culture of learning, have sharing of information through social networks and to encourage involvement in decision making.

As discussed, the climate and culture of an organization provide indications to the organizational structure that is implemented. These organizational structures impact largely on the bedside RNs decisional involvement.

2.6.2 Organizational Structure

Another factor considered to have an impact on decisional involvement is the organizational structure within the hospital. An organizational structure describes the pattern of arrangement of the work group (Marriner Tomey, 2007:268) and the manner in which an organization is structured impacts on bedside RNs' involvement in the decision making processes. Structures can be described as *flat* versus *tall* and *decentralized* versus *centralized.*

Flat structures are built along horizontal lines while *tall* structures are built along vertical lines. Marriner Tomey (2007:275) describes flat structures as having a short administrative distance between top and bottom, while conversely tall structures have a long administrative distance between the top and bottom because of the multiple intermediate levels in the hierarchy. *Flat* structures have a democratic management style that encourages decisional involvement and where the moral of staff is high. However, Booyens (2005:212) contends that larger organizations having a flat structure require more coordination; where managers have a larger span of control and where consensus decision making takes longer. *Tall* structures often have an autocratic leadership style where managers have absolute control over the decision making process. Marriner Tomey (2007:276) argues that autocratic styles are necessary in situations that need swift changes and exact coordination through swift

decision making. It is thus expected that flat structures are more conducive to decisional involvement than tall structures.

Decentralization is described by Marriner Tomey (2007:277) as the “degree to which decision making is diffused throughout the organization”. In decentralized organizations the authority for decision making is spread across the organization, while in centralized organizations the decision making authority is controlled by a few individuals who are usually senior managers. Decentralization results in the authority and responsibility being pushed downwards (Booyens, 2005:133) to the front-line staff. Decisions made in decentralized organizations may be more effective because staff who make the decision usually know the situation and will be those who implement the solutions (Marriner Tomey, 2007:277). Staff who feel that they have a voice in decision making are more willing to contribute in achieving the organizational goals. Staff morale is usually high in decentralized organizations because they feel that their voices are heard and that their work is valued. However, decentralized decision making does not mean that the manager has no control but can rather be viewed as an environment that is conducive to allowing nurses to think and act (Ritter-Teitel, 2002:31).

Decisions in *centralized* organizations are made and controlled at the top level by a small number of managers. These managers are responsible for and have authority to make decisions by virtue of their positions in the organization. In centralized organizations the unit nurse manager does not have full authority for decision making which is retained by administrative senior management. Staff members at lower levels in the hierarchy are not involved in decision making. This results in staff becoming passive because they are not challenged to think critically or to problem solve (Booyens, 2005:132).

For decisional involvement to be effective a flat decentralized structure is a necessity. Schroeter (2010:221) supports this and states that organizations that have a flat, flexible and decentralized structure support bedside RNs in taking appropriate actions in the care of their patients and support their decisions and actions.

The organizational structure describes the hierarchy levels that either impede or facilitate decisional involvement but it is ultimately the organizational management styles that give the authority to staff for decisional involvement.

2.6.3 Organizational Management Styles

The style of management that an organization adopts impacts on the decision making culture of the organization and thus can be considered as a factor that impacts on decisional involvement. For the purpose of this study only three decision making management styles

that are relevant to the study are discussed: *bureaucratic, participatory and shared governance.*

2.6.3.1 Bureaucratic

A common healthcare organizational management style is bureaucratic management (Marriner Tomey, 2007:59). It has a tall, centralized decision making structure (Lake & Friese, 2006:2). Bureaucratic management is further described by Marriner Tomey (2007:59) to have its foundations in historical norms and traditional operating procedures of the organization. Booyens (2005:188) describes bureaucracy to be arranged in a hierarchical order where decision making authority is given to senior managers who delegate the authority downwards. This delegation of authority is at the discretion of the manager. Managers within this organizational management style are often considered to be autocratic and bedsides RNs at the point of patient care have limited involvement in the decision making process. The researcher is of the opinion that this management style does not support decisional involvement in any manner.

Participatory management and shared governance are adhocracy organizational models that are “more free form, open, flexible, and fluid than older bureaucratic models” (Marriner Tomey, 2007:287). Behavioural research of job satisfaction has led to the development of these two models.

2.6.3.2 Participatory

Participatory management takes place in flat, decentralized decision making structures. Bedside RNs at the point of care are actively involved in the decision making process and problem solving. The essence of this management style is consultation by the manager with subordinates and the request for suggestions and opinions (Sullivan & Decker, 2005:52). Staff can influence decision making but the final authority lies with the manager. The role of the manager is to facilitate rather than direct subordinates (Booyens, 2005:134). Participatory management is supportive of decisional involvement but it is also limiting because the authority for decision making still rests with the manager.

2.6.3.3 Shared Governance

Shared governance management structures are flat and decentralized. Swansburg and Swansburg (2002:375) described shared governance as “the allocation of control, power, or authority among mutually interested parties”. Shared governance is an accountability based approach where bedside RNs are given authority to participate in decision making regarding issues that impact on them (Anderson, 2011:197). The essence of this management style is the empowerment for shared decision making between bedside RNs at the point of care and

managers. The role of the manager is similar to that of the participative management style but the key difference is that the decision making authority is shared. For this management style to be effective managers must relinquish their autocratic roles in decision making to become coaches, teachers and facilitators of shared decision making (Marriner Tomey, 2007:293). Shared governance as a management style is fully supportive of decisional involvement through empowerment of bedside RNs in sharing in the process of decision making with the managers.

Organizations who adopt a shared governance management style create new organizational structures such as committees or councils which are vehicles for gathering bedside RNs and managers in one forum to make decisions usually addressing practice, quality management and education (Hess, 2004). These committees and councils are viewed as formal power structures for decision making (McDonald, Tullai-McGuinness, Madigan & Shively, 2010:148). Kanter (1993:277) is supportive of the implementation of structures that empower staff to be involved in decision making. However, shared governance promotes shared decision making between all parties who are accountable for a specific process. In summary the process of shared decision making is actualized through the structure of shared governance which is based on the principles of partnership, ownership, equity and accountability (Swihart, 2006:2). Shared governance is only effective if the managers are willing to let go of the control of all authority, if there are known structures in place that are recognized for being effective and if there is widespread participation of all staff.

Shared governance developed in the 1980s as a result of nurse dissatisfaction but this surge dissipated in the 1990s (Barden et al., 2011:214). There has been a recent resurgence in shared governance and it is linked to Magnet accredited hospitals where it is usually the model implemented for shared decision making (Schwartz, Spencer, Wilson & Wood, 2011:741). In their study of healthy work environments in Magnet accredited hospitals Kramer, Maguire and Brewer (2011:15) identified that all 34 hospitals studied had a structure where shared decision making was evident and that 19 of these hospitals had based the decision to participate in the research study only after unit staff councils recommended it to their central research councils. This recognition emphasizes the importance of decisional involvement.

There are varied views regarding shared governance as a management style. Muller (2005:112) describes shared governance as the second element in participative management, while Marriner Tomey (2007:293) states that participatory management is the foundation for shared governance. However, Swansburg and Swansburg (2002:375) disagree and state that shared governance is not a form of participatory management.

Regardless of the link between shared governance and participatory management styles, they share one commonality: both encourage bedside RNs to become involved in the decision making process.

Both participative management and shared governance take place in flat, decentralized organizational structures. These flat, decentralized organizational structures allow for closer association between bedside RNs and managers thus encouraging decisional involvement, while the bureaucratic tall, centralized structures distance themselves from the front line workers resulting in no or limited decisional involvement of bedside RNs.

The organizational management style and the leadership style of a manager are two vital factors that impact on the decisional involvement of bedside RNs. The organizational management style that is chosen for the organization will only be truly effective if the leadership style of the managers within the organization is supportive of the chosen model.

2.6.4 Leadership Styles

Leadership styles are a factor that has a direct impact on decisional involvement of RNs (Laschinger, 2008:323). Personality traits, rigidity in management style and preconceived ideas of a manager are obstacles to problem solving and decision making (Sullivan & Decker, 2005:111). Less effective leadership styles that limit participation in decisional involvement and cause staff dissatisfaction to varying degrees are autocratic, bureaucratic and to some extent laissez-faire styles. In contrast democratic and transformational leaders are seen to positively impact on staff involvement in decision making.

The autocratic leader makes all the decisions without the consultation of the staff. There is little autonomy experienced by the staff and those decisions taken by the leader are usually not in the best interest of the staff (Marriner Tomey, 2007:170). Bureaucratic leaders do not trust themselves or their staff to make decisions and rely on organizational rules and regulations or policies to guide decision making. The laissez–faire leader is non-directive and abdicates decision making to the staff which often results in chaos (Marriner Tomey, 2007:170).

The democratic leader involves staff in problem solving and decision making. A democratic leader will act as a facilitator in the decision making process. Booyens (2005:424) identifies that decision making under “democratic leadership is not as efficient quantitatively as authoritarian leadership”. This inefficiency is as a result of having to involve all the staff in a decision which can be time consuming and delay the decision from being taken. A transformational leader “engages others with a common purpose and meaning to achieve a common goal” (Schwartz et al., 2011:739). A key area related to this type of leadership is the

provision of adequate opportunities for all bedside RNs to be involved in decision making in the organization. These leaders inspire a shared vision with their staff. Transformational leaders are essential for the creation and maintenance of a Magnet environment and the importance of this is evident by the inclusion in the Magnet Model component of Transformational Leadership. In a study conducted in similar settings to the research setting in Saudi Arabia it was concluded that in the multinational organizations that transformational leadership is the predominant style used (Suliman, 2009:307).

In view of the various styles of leadership that have been discussed male and female leaders were found to have different styles of leadership (Marriner Tomey, 2007:196). Men tend to have a more autocratic style, while women have a democratic style that includes sharing power with subordinates through participative management. Men use their power accorded to them through their position and the organization's formal authority structures to influence subordinates to do their work and accomplish the organizational goals. Women, however, acknowledge the importance of collaboration and recognition and use their interpersonal skills and networking skills to influence their workers to achieve the set goals and complete their work (Marriner Tomey, 2007:196). In view of this study this aspect was included in the questionnaire. This is supported by Liu (2008:293) who cites Steers (1977) who suggested that female managers are more willing to ask employees to be involved in decision making in comparison to male managers.

In summary of this section, decisional involvement has been identified to function optimally under a democratic and transformational leader who is willing to share decision making with bedside RNs while autocratic and bureaucratic leadership styles tend to exclude bedside RNs in the decision making processes resulting in a low level of decisional involvement. The laissez-faire leader leaves decision making process up to the bedside RNs without giving direction or support and usually is only effective if the bedside RNs who work under these leaders are well experienced and confident to take ownership of the decision making. As previosly discussed in this section men have been identified to be more autocratic than women who are more democratic, while women find it easier to share decision making with subordinates more than men do. This suggests that decisional involvement is implemented more effectively and more easily under the leadership style of a female leader. The leadership style is one factor that impacts on decisional involvement but it also has a considerable impact on the work environment for nurses.

2.6.5 Work Environment

The work environment describes the place that the nurse works and it is this work environment that affects the performance, productivity and efficiency of the nurse. Havens

and Vasey (2005:376) assert “that the way nurses are organized affects the quality of the working environment and nurse, patient and organizational outcomes”.

Two types of environment have been identified in the literature: positive/healthy (Kramer, Maguire & Brewer 2011:5; Ritter 2011:29; Warshawsky & Havens, 2011:28) and poor/unhealthy work environments (Ritter, 2011:28). A positive or healthy work environment is conducive to decisional involvement (Ritter, 2011:29) while conversely poor/unhealthy environments do not support decisional involvement. A core concept for positive and healthy work environments is identified as bedside RN involvement in decision making. This is supported by Mark et al. (2009:120) who describe a supportive positive practice environment as having multiple defining characteristics that include the involvement of staff in decision making, autonomy and collaboration between all the stakeholders in patient care. A healthy work environment is identified by Ritter (2011:29) as being vital to job satisfaction, best practices and staff retention. Liou and Cheng (2009:219) support this and state that the quality of the nurses practice environment has a direct impact on job satisfaction. Conversely, poor work environments have poor staff satisfaction and difficulties exist in recruiting and retaining qualified staff in these environments (ICN, 2012).

Involvement of bedside RNs in decision making is acknowledged in a number of reports and initiatives as one of the elements necessary to achieve improved working conditions. In 2003 the Institute of Medicine (IOM) published a report discussing the link between practice environments and patient safety. The report highlighted that unsafe work and workplace design contributed to medical errors. As a consequence of this, several recommendations were made to improve the work environment of nurses including the involvement of “direct care nurses in operational decision making and the design of work processes and work flow” (IOM 2003:8) and the employment of management structures and processes that “engage workers in non-hierarchical decision making and in the design of work processes and work flow” (IOM 2003:9). In summary, the IOM (2003) suggests that nurses must be empowered in order to achieve patient safety and quality of care required in the current health environment and this can be achieved through nurse decisional involvement.

Following this landmark report by the IOM in 2004, the American Organization of Nurse Executives (AONE), as a member of the Nursing Organizations Alliance™, commissioned a report to address the need for improved work environments. The Healthful Practice/Work Environments Report contains nine key principles and elements that include a collaborative practice culture, a culture of accountability and shared decision making at all levels. It is also suggested that a structure be in existence for shared decision making at all levels (AONE, 2004).

The Positive Practice Environments Campaign was launched by the International Council of Nurses (ICN) in 2007 in recognition of the importance of and need for positive practice environments. The ICN (2007) defines positive practice environments (PPE) as “cost-effective health care settings that support excellence and decent work, have the power to attract and retain staff and to improve patient satisfaction, safety and outcome”. The checklist developed by the ICN (2007) for Positive Practice Environments recognizes the importance and value of involving staff in decision making and this is addressed through the promotion of professional autonomy and control over practice; through effective management practices that involve employees in planning and decision making affecting their practice, work environment and patient care; through the promotion of transparency in the decision making processes; and through support structures that engage nurses in the assessment and improvement of the work design and work organization. This campaign empowers nurses to take control of their work environment through decisional involvement.

All of these abovementioned reports and initiatives link positive work environments to involvement in decision making within health care organizations. However, the manager also has a vital responsibility in the promotion of these environments. This is supported by Etchegaray, St. John and Thomas (2011:45) who in their review of the literature regarding high-performance work systems in health care settings identify that managements’ role is considered important in establishing positive work environments and in influencing staff involvement in decision making. They suggest that if organizations want to achieve improved reliability, performance and safety then it is essential for managers to engage staff by encouraging them to participate in decision making and allowing staff to be more autonomous in how their work is completed. Managers help define the organizational climate and culture and can contribute in the redesigning of the environment into a positive practice environment that includes decisional involvement as tested in the questionnaire. As already identified, Magnet accredited hospitals have positive professional work environments. In their study testing the revised Essentials of Magnetism Tool (EOMII), Schmalenberg and Kramer (2008:8) established that Magnet accredited hospitals consistently score higher at having excellent work environments in comparison to non-Magnet hospitals.

With the global migration of nurses the work environment is becoming culturally and ethnically diverse. This diversity results in varied values and beliefs within an organization. This is distinctly evident in Saudi Arabia where the workforce predominantly consists of expatriate nurses (Almalki, FitzGerald & Clarke, 2011:305). This conglomeration of nurses from many different countries inevitably means that there are a multitude of cultures within the same professional environment. A notable difference between nurses in Western cultures

and those from the Asian culture is that Westerners have a professional value of involvement in decision making whereas Asians take a more passive role in nursing (Xu, 2006:420).

As discussed it is evident that positive and healthy environments and the professional practice environment will benefit from the bedside RNs' involvement in decision making. Empowerment within a work environment is another factor that impacts on the decisional involvement of staff and this will be further explored below.

2.6.6 Empowerment

A factor that impacts significantly on decisional involvement is the empowerment of staff to participate in decision making. McDonald et al. (2010:149) define empowerment "as employee perceptions of workplace conditions that allows for high levels of formal and informal power, on-going opportunities for development and access to information, support and resources". Empowerment signifies the power to complete work in a meaningful manner (Laschinger, Gilbert, Smith & Leslie, 2010:5). However, if staff are not empowered then it can be assumed that decisional involvement will be at a low level and that staff may potentially have low job satisfaction.

Empowered work environments have decentralized and flat organizational structures that facilitate decisional involvement. Formal empowerment structures enable nurses to participate in decision making regarding the content and context of their practice (McDonald et al., 2010:149). One of the nine (9) essential criteria for Magnet/healthy work environments is for empowered, shared decision making structures for control of the context of decision making (Kramer, Schmalenberg & Maguire, 2010:10). These empowerment structures described by Kramer et al., (2010:12) were identified to be shared leadership, governance councils and forums, and emphasize that the structures must have shared power that permits decision making on significant issues. Kanter's theory of structural empowerment (1977,1993) is supportive of having structures in place to ensure that the authority for decision making is shared to empower bedside RNs to be involved in the decision making process. Bedside RNs who work in organizations that have empowering structures are more likely to be more committed and this in turn has a positive impact for the organization.

Empowerment of staff impacts significantly on a manager's role but does not imply that management roles are no longer required. However, managers can still undermine the empowerment of bedside RNs. Hess (2011:239) states that there is always a difference in perceptions between managers and staff in health care regarding governance where managers always report higher scores of empowerment than nurses. This is tested in the

study questionnaire to answer the objective of whether there is a statistical difference between bedside RNs and managers' perception of decisional involvement.

.As empowered staff learn new professional behaviours and exercise ownership and accountability in decision making managers may feel threatened that they are losing control. The role of a manager evolves to one of servant leadership (Swihart, 2006:45). It is further described by Marriner Tomey (2007:190) that a servant leader is one who prioritizes serving the group, "takes a holistic approach, shares decision making and builds a community". The empowering manager now becomes the coordinator and facilitator for the empowered staff with whom they now share decision making (Swihart, 2006:45).

Empowerment is empirically linked with job satisfaction (Laschinger, Almost & Tuer-Hodes, 2003:410), emotional exhaustion (Laschinger, Wong & Greco 2006:358) and intent to stay (Nedd 2006). McDonald et al. (2010:148) identified that there is a positive relationship between staff perception of empowerment and their involvement in organizational structures.

2.6.7 Other Contributing Factors

Other varied contributing factors that may be attributed to affecting the decisional involvement of staff have been identified in the literature and are discussed in the following paragraphs. Kowalik and Yoder (2010:262) describe possible reasons for the lack of involvement in the decision making process to include the lack of opportunity to attend decision making meetings, inadequate knowledge regarding the issues for which decisions are being made and the limited impact of the decision made on the nurse personally. Liu (2008:293) also suggests that the level of involvement in decision making is impacted by the attitude and desire for involvement in decision making by employees and managers, the relationship and trust levels between managers and employees, the educational level, demographic differences, personality differences and gender differences where female managers are thought to be more receptive to shared decision making with their employees. It was furthermore identified by Mangold et al. (2006:270) in their study of perceptions and characteristics of RN's involvement in decision making that educational level and years of experience did not impact on decisional involvement. This is contradicted by Liu (2008:293) who suggests that educational levels are one of the possible reasons that impact on the level of decisional involvement. Mangold et al. (2006:270) also suggest that RNs may not have the desire to be actively involved in decisions and cite a number of possible reasons for this including feelings of being overwhelmed in the RN role resulting in a lack of time and energy to invest in the decision making process, and that the bedside RNs are satisfied with decisions being made because they feel that they do not need to be involved. Other factors that may contribute to the involvement in decision making are job satisfaction, level of

commitment to the organization and the level of autonomy (Mangold et al., 2006:271) Mangold et al. further suggest that RNs working in smaller organizations with smaller workgroup sizes make it easier to be involved in decision making. Effective nurse-physician collaboration was suggested by Krairiksh and Anthony (2001:16) as a factor that may positively affect nurse's involvement in decision making.

As discussed in **paragraph 2.6.4** gender differences are evident in leadership styles and empowerment of staff in decision making. This is further supported by Liu (2008:293) who cites Denton and Zetinoglo (1993) who identified that women believed themselves to have less involvement in decision making than men do and that minorities perceive themselves to have less participation in decision making.

Various influences that impact decisional involvement have been identified and discussed in detail and these will be tested in the study questionnaire which will answer the objective that explores the factors that impact on decisional involvement of nurses. A common thread through all the organizational factors discussed is that leaders have considerable influence over decisional involvement of bedside RNs through the climate and culture they set, the organizational and management structures they endorse, their leadership styles that set the tone of the work environment and the empowerment of their subordinates. Other factors that do not fall into any of the abovementioned categories that stem from a more personal perspective such as demographic differences, as well as unit level factors, play as an important a role as the larger organizational issues do on the decisional involvement of bedside RNs. All of this being said, it is important that the various factors be addressed using a number of strategies to improve the decisional involvement of nurses.

2.7 STRATEGIES TO PROMOTE DECISIONAL INVOLVEMENT

There are a number of strategies that can be implemented to assist with the operationalization of decisional involvement. Decisional involvement, in principle, is an option for any nursing environment. As discussed in detail in this literature review there are multiple factors that enhance or impede the involvement of bedside RNs in decision making and the environment in which the bedside RN practises. These can be addressed and actions taken to promote decisional involvement in the work environment.

The redesign of the workplace is essential to facilitate decisional involvement for bedside RNs. This redesign can include organizational changes of those factors that have been discussed in **paragraph 2.6,** such as initiating a culture of shared decision making; by the introduction of flat, decentralized organizational structures that have decreased rule bounded hierarchical layers; by having participative or shared governance management styles that

empower bedside RNs; and by changing the leadership styles of managers to more democratic and transformational styles that promote decisional involvement. Including staff in restructuring of the practice environment can lead to positive outcomes (Ritter, 2011:30) Organizations can also improve their working environments by introducing professional practice models specifically designed to fit their organizational culture and that are empowering and supportive of the profession of the bedside RN especially in authorizing decisional involvement of the bedside RN.

A number of other strategies have been proposed in the literature that promotes the bedside RNs' involvement in decision making. Scherb et al. (2010:4) suggest strategies that include having input into resource allocation, promotion of certification, development of skills in conflict resolution, involvement in self-scheduling and participation in review and selection of leaders. Other strategies are the introduction of clinical ladders and peer review, and by promoting good interdisciplinary relations and collaboration with other disciplines (Scherb et al., 2010:14).

Strategies to promote decisional involvement are varied and can be implemented at an organizational level or at a professional practice environment level. The impetus to introduce a strategy or strategies to promote decisional involvement should be the positive outcomes that have been empirically tested because of the decisional involvement nurses have.

2.8 OUTCOMES OF DECISIONAL INVOLVEMENT

Barden et al. (2011:213) recognize that a strong indicator of nursing excellence is staff driven decision making. There are multiple reasons cited in the literature that indicate that decisional involvement has a positive impact on nursing. Involvement in decision making has been positively linked to improved job satisfaction (Andrews, Burr & Bushy, 2011:69; Hoying & Allen, 2011:253; Scherb et al., 2010:14), positive clinical patient outcomes (Kowalik & Yoder, 2010:263; Scherb et al., 2010:3), increased recruitment (Kowalik & Yoder, 2010:263), decreased absenteeism (Kowalik & Yoder, 2010:263), increased retention (Havens, Wood & Leeman, 2006: 463; Hoying & Allen, 2011:253; Scherb et al., 2010:14) and decreased turnover (Kowalik & Yoder, 2010:263). The inability to be involved in decision making and thus make an impact leads to poor job satisfaction and poor self-esteem (Andrews, Burr & Bushy, 2011:74).

Weston, Estrada and Carrington (2007:10) link involvement of staff in decision making with higher financial returns and improved cost savings. In their study regarding nursing working conditions and the impact on unit nursing costs Market et al. (2009:127) suggested that increasing involvement of nurses in decision making would be useful in improving staff

satisfaction and retention which may be an economically viable means in maintaining costs at the unit level.

In summary, the effects of decisional involvement are viewed overall as positive for the patient, bedside RNs and the professional practice and work environments but in light of these outcomes it is important that the tools that are used to measure decisional involvement are evaluated.

2.9 MEASUREMENT TOOLS

Measurement of nurse involvement in decision making is important to assist the profession of nursing in enhancing job satisfaction and staff retention. The research of the literature revealed several tools that measure nurses' involvement in decision making but these were only a smaller element within the larger measurement tool. The main focus was found to be the professional practice environment, job satisfaction, clinical autonomy, control over nursing practice and/or a combination of all these elements. Examples of these tools are Practice Environment Scale (PES), the Nursing Work Index (PES-NWI), Nursing Work Index–revised (NWI-R), and Essentials of Magnetism II (EOM II).

The two tools which were identified that measure the elements of this study are the Index of Professional Nursing Governance (IPNG) and Decisional Involvement Scale (DIS). Both of these tools are able to answer the research question of decisional involvement of RNs. The tools measure similar elements of decision making based on the responsibility and authority to make decisions on practice policies and the practice environment. The IPNG measures involvement in decision making using the variable of governance and explores the levels of actual participation in decision making by nurses. The DIS identifies what type of decisions are made at the unit level, to what extent the bedside RN is involved in these decisions and also allows for a comparison of the bedside RN's actual level of decisional involvement and their desired level of decisional involvement.

To answer the research objectives of this study in which the researcher is interested in exploring, not only the actual levels of involvement in decision making but also the preferred levels of involvement in decision making, the DIS (Havens & Vasey 2003:333) was identified as the most appropriate measurement tool to be used within the context of the study. This choice of instrument is supported by Kowalik and Yoder (2010:264) who acknowledge the DIS as the only instrument available to measure the concept of decisional involvement of bedside RNs.

2.10 KANTER'S THEORY OF STRUCTURAL EMPOWERMENT

In order to gain an understanding of decisional involvement within the context of empowering structures as already identified of shared governance and participative management, the researcher has selected Kanter's Theory of Structural Empowerment (1977, 1993) as the guiding framework to assist in describing the aim of this research study of decisional involvement and in exploring the objectives set to meet this aim.

A framework is described by Burns and Grove (2007:171) as "a brief explanation of a theory or portions of a theory to be tested in a quantitative study". The main tenet of Kanter's Theory of Structural Empowerment is that organizational structure influences the empowerment of individual employees and that the behaviours and attitudes of employees are primarily moulded as a result of a person's position and circumstances within an organization and not to a person's personality traits or socialization experiences. Kanter (1993:277) mentions that by empowering more employees through the allocation of more autonomy, by allowing more involvement in decision making and by sanctioning more access to resources create less domination within the organization.

As already identified, one of the core antecedents of decisional involvement is the necessity of an empowering structure that authorizes the bedside RN to participate in decisional involvement. The main tenet of Kanter's theory suggests that the implementation of empowering management structures, such as shared governance or participative management will impact favourably on promoting decisional involvement because of the power that is afforded to the bedside RN, rather than the bedside RN's personality or social experiences within the nursing environment. The notion that affording bedside RNs more decisional involvement will decrease the domination within an organization can be supported. Having more bedside RNs, who are the majority of the nursing workforce, involved in the decision making processes opens the opportunity for these bedside RNs to collaborate with their managers, who are in a minority within the nursing workforce, thus diminishing the stranglehold of traditional managerial domination.

Kanter's theory was developed following a qualitative study on work environments of American large corporations during the 1960s and 1970s. This theory has subsequently been tested in various studies in nursing (Laschinger & Havens, 1996; Laschinger, Sabiston & Kutszcher, 1997; Nedd, 2006; Matthews, Laschinger & Johnstone, 2006; Armstrong, Laschinger & Wong, 2009; Laschinger, Gilbert, Smith & Leslie, 2010) where relationships have been established between the access to empowerment structures and formal and informal power within the work environment.

As seen **figure 2.1** systemic power factors is divided into two core groups of formal power and informal power. *Formal power*, the focus of this study, is derived from jobs that allow discretion in decision making, recognition and relevance (Kanter 1979:4) while *informal power* results from relationships, networking and association with others within and outside the organization. An example of formal power is seen in the authority that shared governance councils' afford bedside RNs. Collaboration is a key characteristic of decisional involvement that is addressed through informal power. These systemic power factors influences and/or determines the access to job related empowerment structures. Kanter continues (1993:246) and identifies three different empowerment structures in the work place that impact performance and the success of the employee as the structure of opportunity, the structure of power and the structure of proportions.

2.10.1 Structure of opportunity

The structure of opportunity relates to staff expectations and future prospects. Opportunity is associated with job conditions that allow for the possibility to advance within an organization, to develop knowledge and skills and allow for access to rewards and professional development. Staff who have high opportunity jobs are fully engaged and committed to the organization and actively participate in change while those in low opportunity jobs are disengaged, are less committed and are resistant to change. The work structure within nursing is clearly delineated by job descriptions with minimal variations in high and low opportunity jobs for the bedside RN. However, if bedside RNs are given the opportunity to have decisional involvement this may be viewed as a vehicle for advancement within the organization. This structure is not formally addressed within the scope of this research study.

2.10.2 Structure of power

The structure of power is the second of the empowerment structures defined by Kanter (1993:166), as "the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet". It is important to note that power and authority are different concepts but are often confused to mean the same. Power is the ability to influence others while authority is having the permission to direct others. Kanter argues that power is not dominance and influence but rather the ability to mobilize resources for a goal to be achieved.

Employees with a high level of both formal and informal power are highly motivated and able to motivate and empower others by sharing the sources of power (Kanter, 1979:3). However, if staff lack access to resources, information, support and opportunity they are considered powerless and excluded from the organizational decision making process where decisions are made for them without consultation. This usually occurs in bureaucratic multi-layered

structures that have a top-down decision making structure. Powerless staff have little opportunity for growth and mobility within the organization, are disengaged, lack motivation and loyalty to the organization. In a hierarchical organization the higher the bedside RN is in the hierarchy the more power he/she has. Redistribution of power shows confidence of leaders in subordinates. When subordinates secure access to power they increase their autonomy and this results in an increase in their levels of decisional involvement.

Kanter (1979:4) describes three lines of power within the structure of power as the lines of supply, lines of information and lines of support.

- The “lines of supply" indicate the ability to mobilize both human and material resources to achieve organizational goals and to reward which gives support for the work to be completed (Kanter, 1979:4).
- The “lines of information” refer to having knowledge regarding organizational decisions, policies and goals. It also represents the technical knowledge and expertise that is needed to be effective within the organization. Information enhances the ability for staff to make judgements and influence decision making effectively (Kanter, 1979:4).
- The “lines of support” refer to guidance and feedback received from subordinates, peers and supervisors and may include emotional support, advice or assistance. Staff who have access to support are able to make decisions without a complex or multi-layered approval process (Kanter, 1979:4).

2.10.3 Structure of proportions

The third and final structure identified by Kanter is the structure of proportions and it refers to the social composition of the people in the organization. Mangold et al. (2006:267) describe these proportions as the group dynamics that result from numerical distribution of individuals within the organization. This is best demonstrated in the proportion of males to females within the organization but also refers to many factors including ethnic minorities, age groups, religious affiliations and educational levels. The nursing profession is traditionally dominated by the female gender who proportionally outweigh the number of men. Health care institutions in Saudi Arabia are staffed by predominantly with multinational and multicultural staff where the structure of proportions is acutely evident.

Kanter (1993:281) suggests that organizations must create equal opportunities regardless of the distribution of proportions and make use of an employee’s talent within the organization. The implementation of a shared governance or participative management model allows for equal opportunity to all bedside RNs to participate in decisional involvement regardless of which part of the proportion they are within the organization.

In summary, Kanter's Theory of Structural Empowerment focuses on the establishment of empowerment structures to engage employees and suggests that the implementation of decentralized structures decreases the number of hierarchical layers for the authority for decision making (Kanter, 1993:277). She contends that access to empowering structures of opportunity, power and proportions results in highly motivated staff who work more effectively, who perceive that they have more autonomy, are committed to the organization and experience lower burnout levels and have more job satisfaction. Kanter (1979:3) also suggests that the managers' behaviour can be a determining factor of an employee's relationship to their work. As suggested by this theory a prerequisite for decisional involvement to be successfully implemented is for an empowering structure to be in place where staff are accorded with formal power of authority regardless of the group dynamics and numerical distribution of demographic elements.

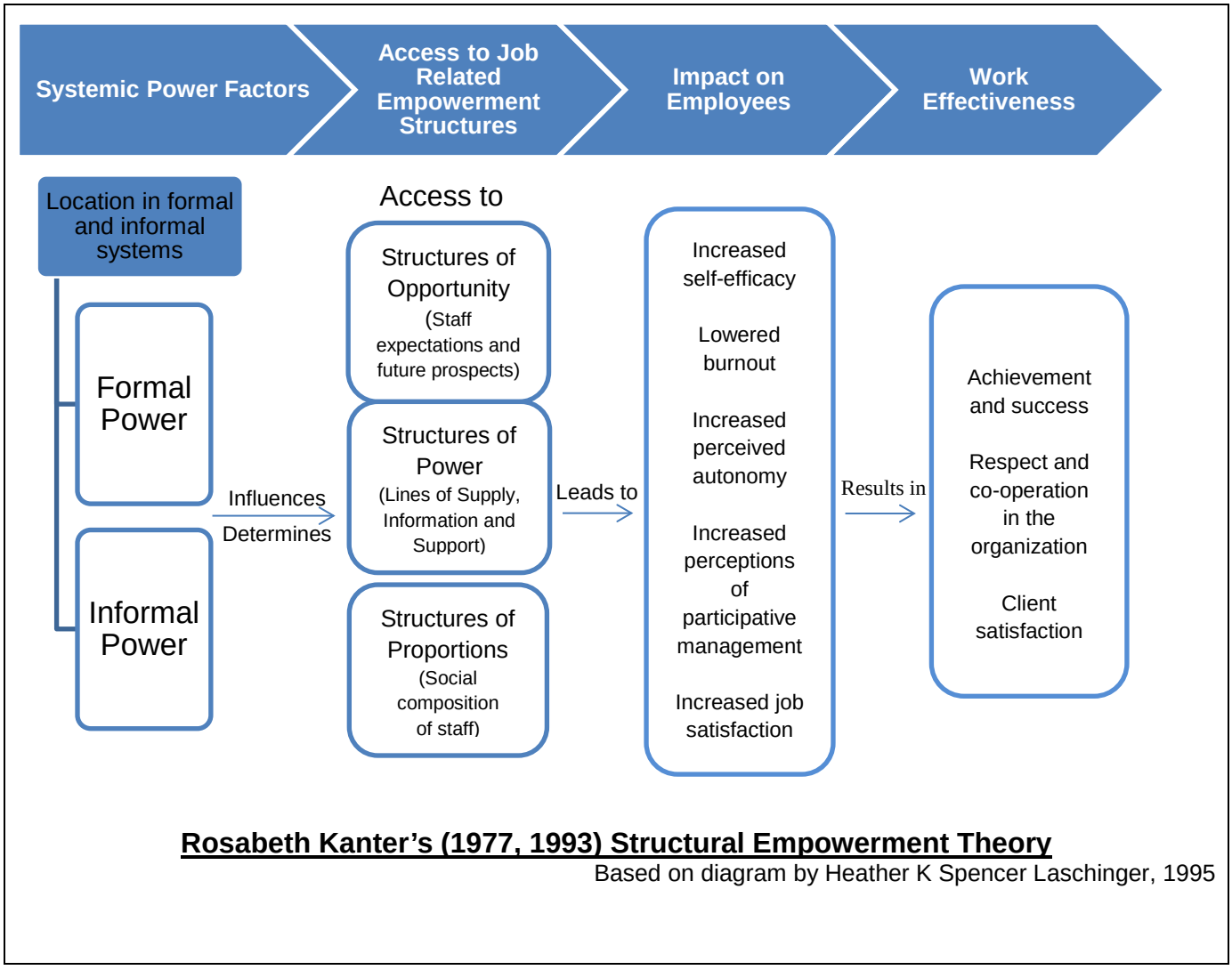

Figure 2.1: Rosabeth Kanter's Theory of Structural Empowerment (Kanter: 1977, 1993)

2.11 CONCLUSION

This chapter commenced with a review of the decision making process and concepts related to decision making. Decisional involvement was then explored and discussed in detail and included the professional practice environment, characteristics, prerequisites, impacting factors, strategies to improve and outcomes of decisional involvement. Various measurement tools were reviewed for applicability to this study and the DIS was identified to be the most appropriate. The theoretical framework that guides this study was introduced.

In summary, minimal empirical research on decisional involvement was identified and only one similar study has been published within the Middle Eastern context. Decisional involvement has been identified to impact on staff satisfaction, recruitment and retention and a positive change in the work and professional environment is necessary for decisional involvement to become effective. These changes can be affected by the introduction of empowering structures that strongly support and accommodate decisional involvement.

In chapter 3 an outline is given of the methodology used to conduct this research in a tertiary care hospital in Saudi Arabia.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The preceding chapters included a description of the background and rationale for the study, as well as a comprehensive literature review regarding decisional involvement. The purpose of this chapter is to describe the research methodology applied to explore the decisional involvement of RNs. The research methodology describes how the study was carried out and what the researcher did to determine the answer to the research questions and objectives (Brink, 2006:191).

3.2 RESEARCH QUESTION AND HYPOTHESIS

Burns and Grove (2007:553) describe a research question as a "concise interrogative statement developed to direct a study". The question that guided this study was "What is the decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia?"

The researcher hypothesized that the implementation of empowering shared governance councils should result in the bedside RNs having a high level of decisional involvement.

3.3 AIM OF RESEARCH

The aim of the study was to explore decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia.

3.4 OBJECTIVES

The objectives of this study were to

- determine staff nurses' (bedside RNs') actual and preferred level of decisional involvement
- compare whether there are statistical differences between staff nurses' (bedside RNs') level of decisional involvement and nurse managers' perceptions of the staff nurses' (bedside RNs') level of decisional involvement.
- identify the factors that impact on the decisional involvement of registered nurses.

3.5 RESEARCH METHODOLOGY

3.5.1 Research approach and design

A quantitative approach with a descriptive exploratory design was used in this study to identify the decisional involvement of RNs in a tertiary hospital in Saudi Arabia. Quantitative research is conducted through a formal and systematic process to generate new information (Burns & Grove, 2007:24). A quantitative approach is applicable to this study because the purpose was to formally obtain objective numerical data to answer the research question of this study. Open-ended questions were included to support the numerical data gained.

A research design is described by Burns and Grove (2007:237) as the blueprint of a study. The design directs the study processes to ensure that there is control over factors that may interfere with the outcome of the study. Burns and Grove (2007:240) describe a descriptive design as “to gain more information about characteristics within a particular field of study”. The purpose of an exploratory design according to De Vos et al. (2005:134) who cite Bless and Higson-Smith (1995) is to gain insight into a phenomena. Thus, a descriptive exploratory design was selected because a descriptive design allowed for the current status of decisional involvement to be described, while an exploratory design allowed for the opportunity to gain insight and understanding of decisional involvement, as well as the factors that impact it.

3.5.2 Population and sampling

Burns and Grove (2007:324) describe a population as all elements that meet the sampling criteria for the study. The study took place at King Faisal Specialist Hospital and Research Center–Jeddah (Gen. Org) in Saudi Arabia. This hospital was chosen because the researcher works at this hospital as a Head Nurse and has easy access to the targeted population. For the purpose of this study the target population were RNs who provided direct patient care (bedside RNs) and RNs who were nurse managers of the bedside RNs. A sample is defined by Burns and Grove (2007:40) as “a subset of the population that is selected for the particular study”. Random sampling allows for the equal opportunity of all elements of the population to be included in a sample for the study. Simple random sampling is achieved by randomly selecting the elements of the population from a sampling frame. Brink (2006:127) further describes simple random sampling as involving a one stage selection process, where each subject has an equal and independent chance of being selected from an accessible population that can be identified and listed.

For this study simple random sampling was used to obtain a sample size of n=168 which was 25% of the available population (N=672) of the eligible RNs (bedside RNs) (see table 3.1). The Manpower Status Report (MSR) line numbers of each of the selected population were

printed, cut up into individual slips of equal sized paper and placed in a container from where they were randomly drawn. After noting the MSR line number, the slip of paper was replaced into the container before the next number was drawn. This was to ensure that all subjects had an equal opportunity to be selected. The MSR line number was used instead of the individuals' names to prevent bias from the researcher who is familiar with many of the staff in the hospital by their name. Burns and Grove (2007:238) define bias as "a slant or deviation from the true or expected". Bias can result in a distortion of the findings. A non-probability purposive sampling method was used to obtain a sample of n=21 from the eligible nurse managers from a population of N=23. This method was chosen because of the small sample target population of nurse managers.

Table 3.1: Population of RNs

Population	Population Size (N)	Sample (n)
RN (bedside RN)	**672**	**168**
Nurse Manager	**23**	**21**

3.5.3 Inclusion and exclusion criteria

Inclusion sampling criteria are those criteria that the subject must have in order to be a part of the target population (Burns & Grove, 2007:325). The inclusion criterion required for the target population of a RN was that he/she must provide direct patient care. The inclusion criterion for a nurse manager was that he/she must be a direct line nurse manager of a RN who provides direct patient care. Exclusion criteria are those characteristics that cause a subject to be excluded from the target population (Burns & Grove, 2007:539). There were no exclusion criteria for this study. The two groups were mutually exclusive and neither could belong to both groups.

3.5.4 Instrumentation

A questionnaire is a printed self-report intended to gather information through written responses of a participant in a study (Burns & Grove, 2007:551). Furthermore, De Vos et al. (2005:166) describe the objective of a questionnaire as being to gather information from people who are informed regarding a specific phenomenon. The questionnaire, to be self-administered, was divided into four (4) sections. Three sections (A, B and D) were self-designed for this study to obtain information to answer the research objectives (as set out in **paragraph 1.6**) regarding decisional involvement and the factors that impact on decisional involvement. Section C consists of the validated Decisional Involvement Scale (DIS) (Havens & Vasey, 2003).

Section A (**questions 1 – 12**) gathered information regarding the respondents biographical data and membership details on shared decision making councils or task forces.

Section B (**questions 13 – 42**) comprised of closed-ended questions, one set of questions using a 4-point Likert Scale and one set of 3-point Likert Scale questions. These questions were designed to explore what factors impact on the decisional involvement of RNs. The questions were developed based on those factors identified during the literature review regarding decisional involvement and on the personal knowledge of the researcher who has an understanding of the concept of decisional involvement due to her responsibility for introducing shared governance into the Nursing Affairs Department. The first set of questions were close-ended questions and required a 'yes' or 'no' answer to set statements. Closed-ended questions limit the answers that a respondent can give to the choices pre-decided by the researcher (Brink, 2006:149). Advantages of closed-ended questions are that the meaning of the questions is better understood, answers are given within the same framework and responses are better compared (De Vos et al., 2005:175). The disadvantages of closed-ended questions are that the answers are limited to options provided by the researcher (Brink, 2006:149). If a question is misinterpreted it may not be noticed and thus give information contrary to what the expected answer was supposed to be. Thus, an open-ended question was formulated to allow respondents to give written comments regarding their perceptions of which factors impact on their decisional involvement.

A Likert Scale measures the opinion, attitude or feeling of a respondent to set declarative statements using a scale ranging from three to seven responses (Burns & Grove, 2007:388). The first set of 4-point Likert questions were set to explore whether the respondent was in agreement or disagreement with a set statement, while the second set of 3-point Likert questions were set to ask how frequently a phenomena occurred.

Section C (**questions 43A&B – 62A&B**) consisted of the Decisional Involvement Scale (DIS) (Havens & Vasey, 2003). Permission to use the DIS was obtained from Dr Donna Havens. This scale consists of two sections of 21 items that measure actual and preferred levels of decisional involvement of RNs. There are six subscales in the DIS: *unit staffing, quality of professional practice, professional recruitment, unit governance and leadership, quality of support staff and collaboration/liaison activities*. The DIS makes use of a 5 point Likert scale that indicates the extent to which the RNs perceive where the authority and responsibility of decision making actually lies and the extent to what is preferred for the primary authority and responsibility of decision making. Response choices are as follows:

1 = administration/management only;

2 = primarily administration/management;

3 = equally shared by administration and staff nurses;
4 = primarily staff nurses with some administration/management input;
5 = staff nurses only.

A higher score is an indication of high bedside RN decisional involvement, mid-range scores are an indication that there is shared decisional involvement between the RNs and management, while lower scores are an indication of low bedside RN decisional involvement (Havens & Vasey, 2003:334). When comparing the decisional involvement from a perspective of bedside RN to that of a nurse manager, there are two major themes described of concordance and dissonance.

Section D (**questions 64 and 65**) were open-ended questions. An open-ended question will allow the "respondent the opportunity of writing any answer in an open space" (De Vos et al., 2005:174). This type of question allows for the respondents to answer in detail and/or to give answers that were not tested in the closed-ended or Likert Scale questions. The open-ended questions were asked only to validate the answers from the closed-ended and Likert type questions.

3.5.5 Pilot study

A pilot study is "...conducted to develop and refine the steps of the methodology" (Burns & Grove, 2007:38). The questionnaire was given to 10% of the targeted population (n=16) bedside RNs and n=2 nurse managers to assess the validity and reliability of the questionnaire. A response rate of 81.3% was obtained from the bedside RNs and a 100% response rate was obtained from the nurse managers. The instrument was found to be accurate and without ambiguity. Minor changes were made to the questionnaire based on the results of the pilot study. The most significant issue identified was that the last page had not been completed by three respondents. This page contained the DIS which has 42 questions. In an attempt to ensure that this error did not occur again the two open-ended questions were removed from Section B and moved to a newly created Section D on the last page. In addition, the font size of the page numbers was increased. Four respondents did not answer questions 10 and 11 regarding participation on councils. This may have been because they were not members of any council thus, an additional choice of "not applicable" was added to both questions. The participants and the responses obtained in the pilot study were excluded from the main study.

3.5.6 Reliability and validity

Before implementation of a study the researcher must ensure that the measurement procedures and instrument for use in the study meet acceptable reliability and validity levels

(De Vos et al., 2005:160). Reliability is described by Burns & Grove (2007:552) as the degree to which an instrument measures a concept consistently. This purports that every time the instrument is used under the same circumstances it should produce identical or almost identical results each time. Validity refers to the "extent to which the instrument accurately reflects the concept being examined" (Burns & Grove, 2007:559). This is supported by De Vos et al. (2007:160) who further explain "that the instrument actually measures the concept in question, and that the concept is measured accurately".

To achieve content validity of the self-compiled section of the open-ended and Likert Scale questions, the questions were reviewed with the research supervisor and were sent to two experts in the field of nursing, Dr Victoria George and Dr Gladys Mouro, for their review. Dr Victoria George RN, PhD, FAAN is considered an expert in professional practice environments and shared governance implementation. Dr Gladys Mouro PhD(H), MSN, RN was the Chief Nurse Executive for the American University of Beirut Medical Center which under her visionary leadership was the first hospital to introduce a shared governance structure in Lebanon and the first hospital in the Middle East to achieve Magnet accreditation. Being Lebanese, Dr Mouro has an understanding of the study from a Middle Eastern context. A statistician was consulted who reviewed the questionnaire and gave an expert opinion regarding suggested changes.

The DIS has been measured for content validity, *construct validity and reliability*. *Content validity* was obtained with the independent assessment by three specialist nurses in the field of decisional involvement. These specialists completed a review of the items and the instrument and all scored a high content validity index of 1.0. Content validity refers to "how well the instrument represents all the components of the variable to be measured" (Brink, 2006:160) thus, the instrument is said to have a high probability of measuring decisional involvement. *Construct validity* was measured by the level of decisional involvement of the RN. Two independent samples of RNs (n=849 and n=650) were used to evaluate a confirmatory factor analysis of the instrument. Burns and Grove (2007:535) describe construct validity as the determination of whether the instrument measures the theoretical construct that it claims to do. *Reliability* of the DIS was measured using Cronbach's Alpha coefficient for which the results from the two independent samples indicated an overall score of 0.91 - 0.95. This demonstrates that the instrument has a low degree for "random error in the measurement technique" (Burns & Grove, 2007:365).

3.5.7 Data collection

"Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of the study" (Burns & Grove,

2007:41). Data collection commenced on 8 August 2011. The closing date for submissions was extended beyond the planned one month collection period to 14 September 2011 because of a seven (7) day religious holiday that occurred during this period. The questionnaires were distributed in person by the researcher. This method was chosen after identifying that personal contact with the selected participants in the pilot study achieved a high response rate. The individual packages consisted of an information letter, the questionnaire and an addressed self-sealing envelope. The questionnaires were returned either by the hospital's internal mail system or by hand from the participants. Of the N=168 questionnaires that were issued to bedside RNs n=140 (83.3%) were returned and of the N=21 questionnaires issued to nurse managers n=18 (85.7%) were returned (table 3.2).

Table 3.2: Summary of questionnaires distributed and returned

Population	Questionnaires Distributed	Questionnaires Returned	Response Rate (%)
Registered Nurse (bedside RN)	**168**	**140**	**83.3**
Nurse Manager	**21**	**18**	**85.7**

3.5.8 Data analysis

Data analysis reduces, organizes and gives meaning to the data (Burns & Grove, 2007:41). In quantitative studies data analysis does not necessarily provide answers for the research question. To arrive at answers the researcher must interpret the data and results (De Vos et al., 2007:218). Statistics is the most powerful tool available when quantitative data is analysed (Brink, 2006:172).

The data collected from the questionnaires was analysed and interpreted by the researcher with assistance of a statistician and the computer program STATISTICA v.11.5. The interpreted results were presented in a narrative form with the use of histograms and tables that signify the relationships between the variables that assisted the researcher to draw conclusions. Descriptive statistics of frequencies and percentages and the percentages in the text were rounded to the closest integer to simplify the discussion. Descriptive analysis using the mean and standard deviations (SD) was conducted. Mean is defined as "the value obtained by summing all the scores and dividing the total by the number of scores being summed" (Burns & Grove, 2007:545). De Vos et al. (2006:234) state that the mean is the most accurate measure of central tendency. SD is described as the variance of values around the mean of the distribution and is defined as "the square root of the variances" (Brink, 2006:178).

Descriptive statistical analysis and the measurement of relationships between variables were completed using non-parametric and parametric inferential statistics. The non-parametric tests used in this study are Pearson Chi-square test and Mann-Whitney U test. The Chi-square test for independence analyses nominal data to determine whether there is a significant variance between two observed frequencies (Burns & Grove, 2007:532), while the Mann-Whitney U Test analyses ordinal data with a 95% of the power of the *t*-test to identify differences between groups of normally distributed populations (Burns & Grove, 2007:545). The level of statistical significance was set at <0.05% meaning that the confidence level is 95%. These non-parametric inferential statistics are utilized when there is no assumption made regarding the normal distribution of the population and the variables are either nominal or ordinal data (Brink, 2006:183). The parametric test of analysis of variance (ANOVA) is used to test if there are any differences between means (Burns & Grove, 2007:430) and was used to compare the means of the actual and preferred levels of each group in the DIS within each group, i.e. RN to RN and manager to manager. The probability theory is used to explain the extent of a relationship and the probability of it re-occurring or the probability that a situation can be predicted accurately (Burns & Grove, 2007:406).

The open-ended questions (**questions 64 and 65**) were asked to provide supporting information for the quantitative data regarding decisional involvement and the impacting factors. The responses were classified into themes and the frequencies were documented. The identified core themes are discussed in more detail in chapter 4, **paragraph 4.6**.

3.5.9 Ethical considerations

The researcher obtained consent from the Ethical Committee for Human Science Research of the Faculty of Health Sciences, Stellenbosch University and the Institutional Review Board of KFSHRC-J. This study was conducted according to the ethical guidelines and principles of the Declaration of Helsinki, the South African Guidelines for Good Clinical Practice and the Medical Research Council's Ethical Guidelines for Research. The guiding ethical principles were the right to self-determination, the right to autonomy, privacy and confidentiality, the right to fair treatment and the right to protection from discomfort and harm.

The right to self-determination is described by Burns and Grove (2007:204) as based on the ethical principle of respect for a person that allows for the individual to determine their own destiny. In this study the respondents were viewed as autonomous agents, who were informed of the study through the information leaflet accompanying the questionnaire and who were advised that participation in the study was voluntary. The information leaflet also

explained that the return of a completed questionnaire would be interpreted as the participant giving their informed consent to participate in the study.

Anonymity, privacy and confidentiality of all received information were ensured. The anonymity of the participant was maintained by not requiring for the name of the participant to be written on the questionnaire or on the supplied envelope. The questionnaire was returned in a sealed, self-addressed envelope to the researcher either by hand or by the internal mail system used in the hospital. Information that is given anonymously ensures that the participants privacy is protected (De Vos et al., 2008:61). The researcher's management of the private information shared by the participant is referred to as confidentiality (Burns & Grove 2007:212). Confidentiality of participants will be maintained by the storage of the questionnaires in a sealed box in a locked cupboard in the primary investigator's office thus making it inaccessible to unauthorized persons and kept for a period of five (5) years where after they will be disposed of by the use of a shredding machine located in the abovementioned office.

The right to fair treatment is based on the ethical principle of justice. Burns and Grove (2007:213) identify that individuals must be treated fairly and be given what they are due or owed. The information pamphlet explained that there would be no financial benefits if the subject chose to participate in the study. Simple random sampling of the bedside RN group assisted in eliminating some of the researcher's bias as discussed in paragraph 3.5.2. As discussed in **chapter 2 paragraph 2.6.4** the leadership style of a manager directly impacts on the decisional involvement of the bedside RN. As the researcher is a head nurse in the study hospital the potential for impartial judgement throughout the research process of this study may be considered to be high. Bias in the type and phrasing of the questions asked in the questionnaire was limited by the review of the questionnaire by two experts in the field of nursing who have experience in shared governance and by the research supervisor thus ensuring the reliability of the questions asked. "Objectivity and restraint in making value judgements" are tools of a competent researcher (De Vos et al., 2008:63) and thus the researcher consciously strove to maintain a neutral stance and open mind during the analysis of the data in an attempt to limit the bias in favour of one group over the other.

The right to protection from discomfort and harm is based on the principle of beneficence which states that one should do good and but especially do no harm (Burns & Grove, 2007:214). There were no anticipated risks expected in this study that could cause harm to the participants.

Raw data obtained from the demographic and DIS sections of the questionnaire will be provided to the University of North Carolina where it will be placed in a data base to be used as part of an on-going evaluation of the DIS. Anonymity of the participants was assured by Dr Havens in her acceptance letter for use of the DIS in this study. The researcher submitted no information for the data base that could be viewed as breaching the participant's anonymity.

3.6 CONCLUSION

In this chapter the researcher described the goals and objectives of the study. A detailed description of the research methodology was given. In chapter 4 an in-depth description of the data analysis and interpretation will be presented.

CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The purpose of data analysis according to Brink (2007:41) is to “reduce, organize, and give meaning to the data”. To answer the research question that asks “What is the decisional involvement of Registered Nurses in a tertiary hospital in Saudi Arabia?” the findings of the research study will be presented and interpreted in this chapter. As already identified the RN in the study hospital is referred to as a Staff Nurse and this is not to be confused with the similar terminology for the Enrolled Nurse in South Africa. To prevent confusion for the reader the Staff Nurse will be referred to as SN (bedside RN) when analyzing and interpreting the data of this study.

4.2 METHOD OF DATA ANALYSIS

The data that will be presented is quantitative in nature. As discussed in **paragraph 3.5.4** of chapter 3, a questionnaire was used to obtain insight into decisional involvement of SNs (bedside RNs). The analysis of the quantitative data was discussed in detail in **paragraph 3.5.8** of chapter 3.

4.3 SECTION A: DEMOGRAPHIC DATA

This section was asked to gain information regarding the demographic information of the respondent. Permission to use the DIS included the requirement for the collection of certain demographic information for submission to the authors on completion of the study and included: gender; highest educational level; primary assignment of area of work; years of working as a RN; years working as a RN in the hospital and years working as a RN on the current unit. The researcher included the following questions as identified in the literature and those identified to add value to the study which includes information regarding nationality; language; current position; primary work area according to Divisional Council structure; membership on the various shared governance councils and membership on committees and/or task forces within the organization.

4.3.1 Question 1: Age

As indicated in figure 4.1 the highest percentage of respondents 39.9% (n=63) in this study were aged between 36 - 45 years. The second highest percentage age group 33.6% (n=53) were aged between 25 – 35 years, followed by the 46 – 55 year age group 19.6% (n=31). The smallest percentages in age groups were the 55-65 years 4.4% (n=7) and the <25 years

n=4 (2.5%). There were no workers 0% (n=0) aged older than 65 years old. The small percentage for the age group of <25 years is appropriate within this hospital setting which requires that RNs have a minimum of two years of experience after completion of their qualification before being eligible for hire, except for Saudi nurses who are hired as new graduates on completion of their Bachelors of Science in Nursing degree. The hospital does not employ RNs after the age of 60, except in exceptional circumstances, and this is representative of the low percentage of the 55 - 65 years age group in the survey.

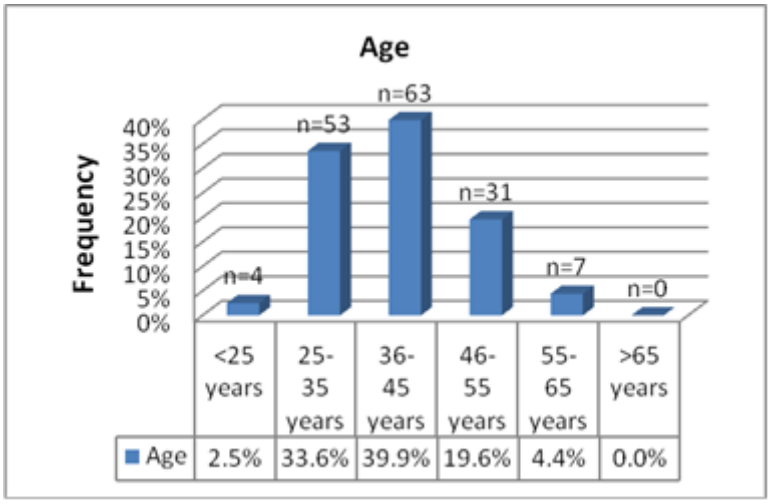

Figure 4.1: Age (n=158)

4.3.2 Question 2: Gender

Three respondents did not answer this question. The majority (more than half) of the respondents 91% (n=141) were female (figure 4.2). Only 9% (n=14) of respondents were male. This result is indicative of the female dominance of the nursing profession (Dyck, Oliffe, Phinney & Garrett, 2009:649; Tracey & Nicholl, 2007:680). On secondary analysis, as seen in figure 4.3, it is interesting to note that male SNs (bedside RNs) comprise of only 6.6% (n=9) respondents but comprise of 27.8% (n=5) from the manager respondents. Males are considered to be more autocratic in their management styles and not willing to share decision making with subordinates (Marriner Tomey, 2007:196). Having more than a quarter of the managers as potentially autocratic leaders, may have a significant impact on the decisional involvement of the bedside RNs.

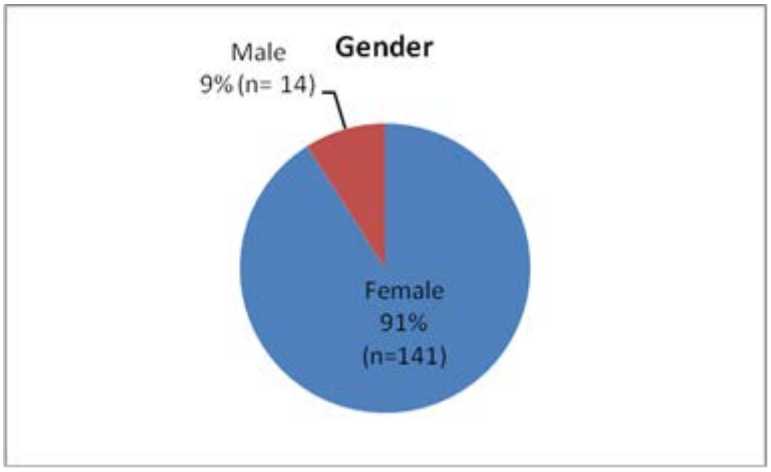

Figure 4.2: Gender (n=155)

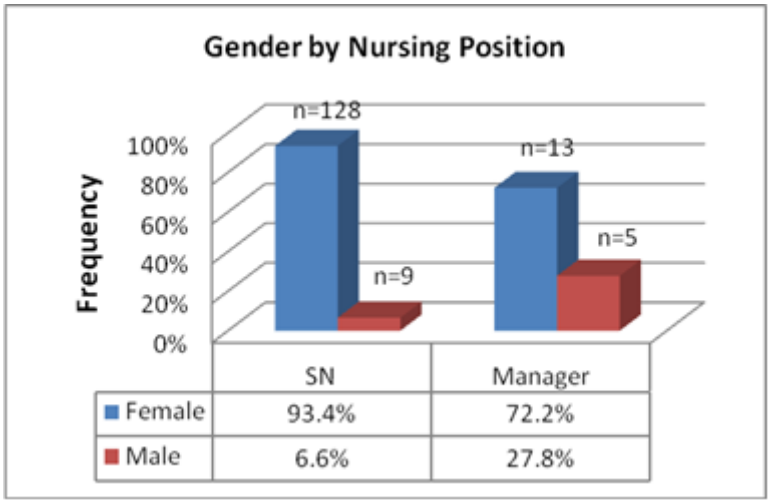

Figure 4.3: Gender by nursing position (n=155)

4.3.3 Question 3: Nationality

As indicated in figure 4.4 the highest percentage of respondents 50.0% (n=79) representing the nationality mix were the Filipinos. South African respondents compromise the second highest percentage 15.8% (n=25), followed by Westerner respondents 8.9% (n=14). The Western nationality comprises of RNs from Australia, Europe, New Zealand and North America. RNs from India 8.2% (n=13), Middle East 7.6% (n=12) and Saudi Arabia 5.1% (n=8) in total comprise of only 20% of the total respondents in this study. The smallest nationality respondent representation was from Malaysia 4.4% (n=7). There were no respondents 0% (n=0) from Singapore and other countries not mentioned by name in the survey question.

Overall, the respondent nationality mix for this study is similar to that of the nationality mix for the study hospital. This is supported by the Nursing Affairs Jeddah Recruitment Report 2011 where Filipinos accounted for 44% of the total nationality mix for the period of 2011

(Unpublished Report: KFSHRC-Jeddah Nursing Affairs, 2012). The occurrence of the wide variety of nationalities in the research hospital is considered normal in this setting as is supported by Almalki, FitzGerald and Clark (2011:305) who highlight that the majority of nurses working in Saudi Arabia are expatriates.

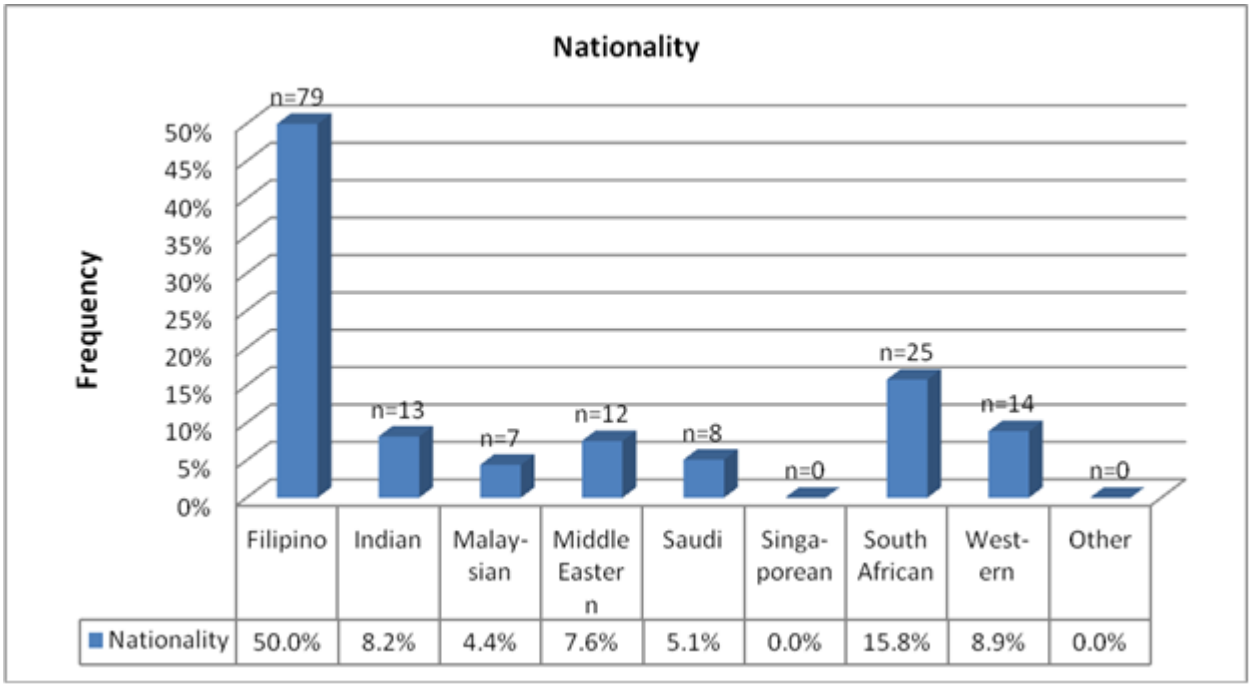

Figure 4.4: Nationality (n=158)

4.3.4 Question 4: Please indicate which your first language is

English is the official communication language of the hospital but only 31% (n=49) respondents speak English as their first language (figure 4.5). The majority of respondents 56% (n=89) in this study do not speak English or Arabic as their first language. Arabic speaking as a first language comprises of 13% (n=20) of the total respondents. As identified, English is the official language of the hospital but it is important to note that those nurses who speak English as their first language do not necessary speak or understand English in the same manner as was identified in a study by Van Rooyen, Telford-Smith and Strümpher (2010:6) that was conducted in a similar setting to the study hospital.

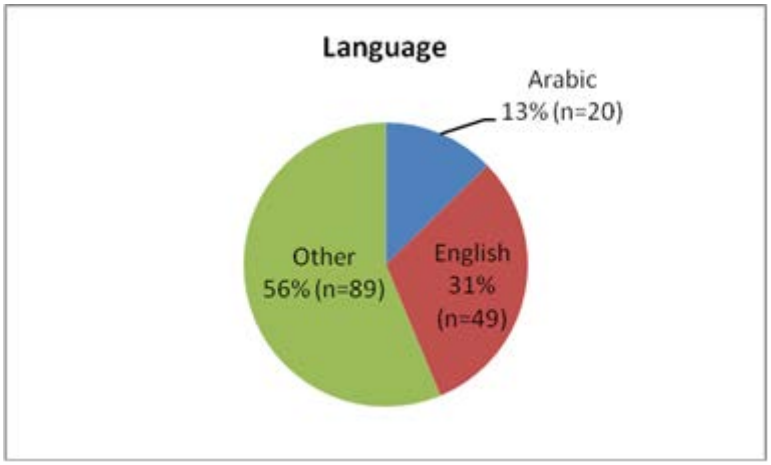

Figure 4.5: Language (n=158)

4.3.5 Question 4: Highest educational level: (Fill in one)

As indicated in table 4.1 the majority of respondents 73.4% (n=116) have a Bachelor's Degree in Nursing. Respondents who hold a diploma have the second highest response rate of 22.2% (n=35). Only 0.6% (n=1) of respondents have an associate degree. The minimal educational requirement to be employed as a RN at the study hospital is a Bachelor's Degree, except for RNs who hold nursing licensure from North America, European Countries, South Africa and certain provinces in India who are required to hold a diploma in nursing or an associate degree in nursing. Nurses from Lebanon are hired if they hold a Bachelor's Degree or a Technical Degree in Nursing (similar to the associate degree) and this is represented by the 2.5% (n=4) respondents who selected Bachelor's Degree in another field. These results are supported by the results of the nationality mix, as seen in **figure 4.4**. On secondary analysis of the category of Master's Degree in Nursing 1.3% (n=2) it was identified that only SNs (bedside RNs) hold this degree.

Table 4.1: Educational level (n=158)

Category	Frequency (*f*)	Percentage (%)
Associate Degree	1	0.6
Bachelor's Degree in Nursing	116	73.4
Bachelor's Degree in another Field	4	2.5
Diploma	35	22.2
Doctorate	0	0.0
Master's Degree in Nursing	2	1.3
Master's in another field	0	0.0
TOTAL:	**n=158**	**100.0**

4.3.6 Question 6: Please select the work unit to which you are primarily assigned to work on a permanent basis

One respondent did not answer this question. The highest response rate of 24.8% (n=39) as seen in table 4.2 was received from the intensive care units (ICUs). The second highest response rate 13.4% (n=21) is shared between the ambulatory care areas and the medical/surgical wards. A response rate of 10.2% (n=16) was received from the paediatric wards of which there are three different units within the hospital. The adult medical ward response rate 8.9% (n=14) followed closely by the emergency department 8.3% (n=13) and the obstetric units 7.0% (n=11). The smallest response rates were received from the special procedures units 5.0% (n=8), the surgical unit 4.5% (n=7) and the operating room/recovery room (OR/RR) 4.5% (n=7). Table 4.3 gives a description of the various wards/units for each of the work areas described above.

Table 4.2: Work area (n=157)

Category	Frequency (*f*)	Percentage (%)
Ambulatory Care	21	13.4
Medical	14	8.9
Paediatrics	16	10.2
Emergency Department	13	8.3
Med/Surg	21	13.4
Intensive Care	39	24.8
Obstetrics	11	7.0
Surgical	7	4.5
OR/Recovery Room	7	4.5
Special Procedures/Cath lab	8	5.0
TOTAL:	**n=157**	**100.0**

Table 4.3: Description of study hospital's nursing wards/units

Area	Units	Divisional Practice Council
Ambulatory care	Day Procedure Unit Endoscopy Unit Family Medicine Unit Home Health Care Outpatient Department	Procedure Procedure Ambulatory Ambulatory Ambulatory
Medical	Adult Medical Ward	Adult
Paediatrics	General Paediatric Ward Paediatric Oncology Ward Paediatric Cardiovascular Ward	Paediatric
Emergency Department	Department of Emergency Medicine	Critical care
Med/Surg	Cardiovascular Ward Oncology Ward Neurosciences Ward VIP Ward	Adult
Intensive Care	Medical Surgical ICU Cardiac Surgery ICU	Critical Care Critical Care

	Paediatric ICU Neonatal ICU Surgical ICU	Critical Care and Paediatric Critical Care and Mat/Child Critical Care
Obstetrics	Labour and Delivery Ward Obstetrics and Gynaecology Ward Normal Newborn Nursery	Mat/Child
Surgical	Adult Surgical Ward	Adult
OR/Recovery Room	Operating Room Recovery Room	Procedure
Special Procedures/Cath Lab	Renal Dialysis Unit Artificial Reproductive Unit	Procedure Procedure and Ambulatory

4.3.7 Question 7: Please indicate your primary work area according to Divisional Council Structure

Two respondents did not answer this question. The six (6) Divisional Practice Councils are representative of the divisions according to the patient population served (**see table 4.3**) and are sanctioned with decision making regarding nursing practice and quality issues. Some work areas may be representative on more than one DPC, for example nurses working in the Neonatal ICU are represented on the Maternal/Child (Mat/Child) DPC and are an ad-hoc member on the Critical Care DPC, while the Emergency Department, an Outpatient Department is represented on the Critical Care DPC and not the Ambulatory Care DPC. As illustrated by table 4.4 the majority of respondents 29.5% (n=46) work in the Critical Care Division and this is supported by the results from **question 6 (table 4.2).** The Adult DPC has the second largest percentage of respondents 25.6% (n=40). Three Divisional Councils within the shared governance structure have equal respondents: Ambulatory Care DPC 11.5% (n=18), the Mat/Child DPC 11.5% (n=18) and the Paediatric DPC 11.5% (n=18). The Procedure DPC has the smallest respondents of 9.6% (n=15). One respondent 0.6% (n=1) could not identify the primary work according to DPC.

Table 4.4: Work area according to Divisional Council (n=156)

Category	Frequency (*f*)	Percentage (%)
Adult Division	40	25.6
Ambulatory Care Division	18	11.5
Critical Care Division	46	29.5
Mat/Child Division	18	11.5
Paediatric Division	18	11.5
Procedure Division	15	9.6
Unknown	1	0.6
TOTAL:	**n=156**	**100.0**

4.3.8 Question 8: What nursing position do you currently hold?

As indicated in table 4.5 the majority of the respondents 88.6% (n=140) are Staff Nurse (SN) 1's. There were no SN2 respondents and this is probably due to the limited number of positions being available within the organization. The hospital utilizes the American system and the terminology recognized for the bedside RN is that of the Staff Nurse. The Head Nurses/Assistant Head Nurses had 11.4% (n=18) respondents. All units in the hospital are managed by a Head Nurse (HN) and some of the larger units or specialized units have Assistant Head Nurses (AHN) who provide administrative and/or clinical support to the Head Nurse.

Table 4.5: Nursing position (n=158)

Category	Frequency (*f*)	Percentage (%)
Staff Nurse 1	140	88.6
Staff Nurse 2	0	0.0
Head Nurse/Assistant Head Nurse	18	11.4
TOTAL:	**n=158**	**100.0%**

Simple random sampling was utilized for the population of Staff Nurses and the overall response rate for the SN1 and SN2 group for the study was 83.3% (table 4.6). A purposive sampling method was utilized for the Head Nurse/Assistant Head Nurse and a response rate of 85.7% was received (table 4.6).

Table 4.6: Nursing position from population sampling

Category	Frequency (*f*)	Percentage (%)
Staff Nurse	n=140	83.3
Head Nurse/Assistant Head Nurse	n=18	85.7

4.3.9 Question 9A: How many years have you worked as an RN? (Including those years in the roles of CNC/HN/AHN, if applicable)

Seven respondents did not answer this question. The mean overall years worked as a RN is 13.3 years (SD=8.68). On secondary analysis, as seen in table 4.7, the mean years worked as a RN by the SNs (bedside RN) group is 12.5 years (SD=8.29) and manager group where the mean number of years worked as a RN is 18.9 years (SD=9.65). A comparison between the two groups using the Mann-Whitney *U* test indicates that there is a statistical significant variance (p=0.007) in the number of years worked as a RN by the Staff Nurse (bedside RN) and the manager. This variance is to be expected within the nursing profession where promotion to a management role only occurs after experience is gained as a bedside RN. In

the study hospital a HN and AHN must have a minimum of six (6) and four (4) years of experience respectively and two (2) and one (1) year(s) leadership experience respectively before promotion will be considered. From the results of their study Mangold et al. (2006:270) suggest that years of experience was not a factor that impacted on the decisional involvement of nurses.

Table 4.7: Years worked as an RN (n=151)

Category	Mean	SD
Staff Nurse 1	12.5	8.29
Staff Nurse 2	0	0.0
Head Nurse/Assistant Head Nurse	18.9	9.65

4.3.10 Question 9B: How many years have you worked as an RN at this hospital? (including those years in the roles of CNC/HN/AHN, if applicable)

Three respondents did not answer this question. The mean overall years worked as a RN in the hospital where the study was undertaken is 5.2 years (SD=3.62). On secondary analysis (table 4.8) the mean years worked by the SN (bedside RN) group is 5.1 years (SD=3.31). This is compared with manager group where the mean years worked as a RN at this hospital is 6.2 years (SD=5.47) There is no significant variance between the two groups in the number of years that they have worked as a RN in this hospital (Mann-Whitney *U* test p=0.691).

Table 4.8: Years worked as an RN at this hospital (n=155)

Category	Mean	SD
Staff Nurse 1	5.1	3.31
Staff Nurse 2	0.0	0.0
Head Nurse/Assistant Head Nurse	6.2	5.47

4.3.11 Question 9C: How many years have you worked as an RN on your current unit? (including those years in the roles of CNC/HN/AHN, if applicable)

The mean overall years worked as a RN in the current unit is 4.6 years (SD=3.41). On secondary analysis, as illustrated in table 4.9, the mean years worked by the SN (bedside RN) group is 4.7 years (SD=3.06) compared with manager group where the mean years worked on the same unit is 4.6 years (SD =5.71). A comparison between the two groups

using the Mann-Whitney *U* test (p=0.214) indicates that there is no statistical variance between the two group in the number of years that they have worked on their current unit.

Table 4.9: Years worked as an RN on current unit (n=150)

Category	Mean	SD
Staff Nurse 1	4.7	3.06
Staff Nurse 2	0	0.0
Head Nurse/Assistant Head Nurse	4.6	5.71

For **4.3.12 and 4.3.13** (**questions 10 and 11)** below the various shared governance councils established in Nursing Affairs were named individually and an alternate option of 'none' was given to assist the respondents in answering the question. If any one of the named councils were selected it was considered as a 'yes' and if the option of none was selected it was considered as a 'no'. The shared governance councils are those formal structures that give the authority to involvement in decision making for the bedside SNs (bedside RNs) which is considered to be an essential element for decisional involvement to be actualized.

4.3.12 Question 10: Please indicate if you were previously a member of any of the following Shared Governance Councils

Three respondents did not answer this question. The majority of the respondents 58.1% (n=90) were previously members of a shared governance council as indicated in figure 4.6. On secondary analysis as illustrated by figure 4.7 it was identified that only 55.1% (n=76) of SNs (bedside RNs) while 82.4% (n=14) managers were previously members on a council. Similar results are expected when shared governance is in its initial stages of implementation into an organization that previously had a centralized organizational structure where authority for decision making belonged to the managers. This question was asked to identify whether there had been an increase in membership of both groups since the shared governance structure was newly implemented.

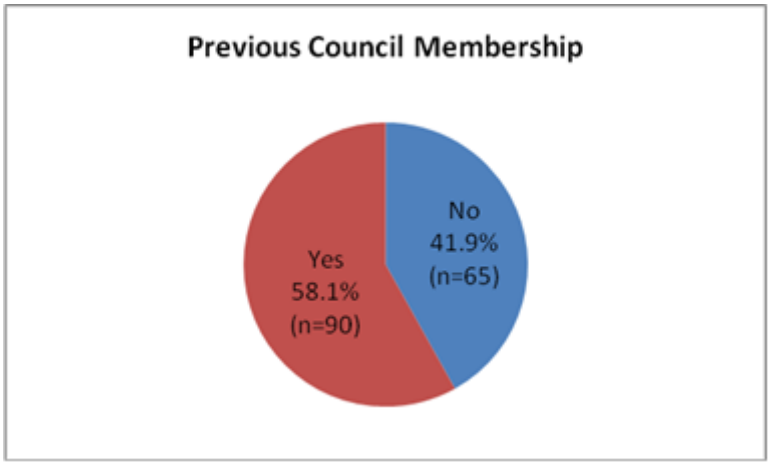

Figure 4.6: Previous council membership (n=155)

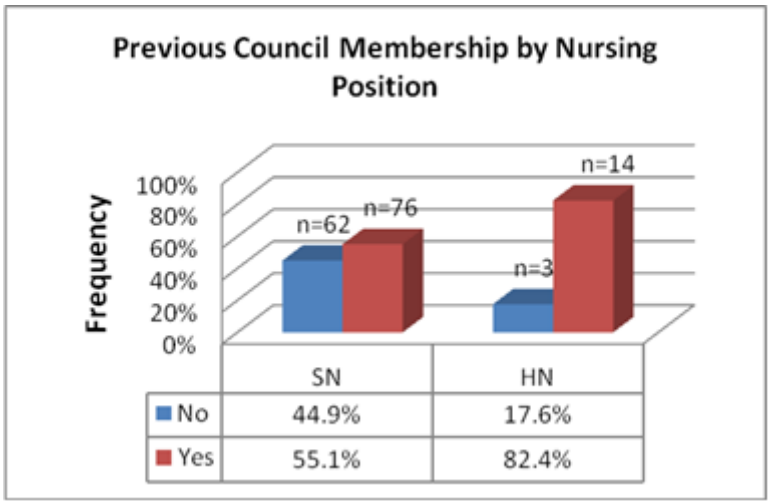

Figure 4.7: Previous council membership by nursing position (n=155)

4.3.13 Question 11: Please indicate if you are currently a member of any of the following Shared Governance Councils

Two respondents did not answer this question. As shown in figure 4.8 the majority of the respondents 65.4% (n=102) are currently members on a shared governance council. This is an increase by 7.3% in comparison to **question 10 (figure 4.6).** A secondary analysis (figure 4.9) indicates that 62.3% (n=86) of SNs (bedside RNs) and 89.0% (n=16) of managers are currently members on a council. With the implementation of a shared governance structure and the enculturation of shared governance through the process of shared decision making it is expected that more SNs (bedside RNs) will become members on councils as they take advantage of the authority that has been given to them. This is illustrated by the increase in results from **question 10 (figure 4.7)** by 7.2%. Of interest is the increase in managers' membership numbers by 6.6% which can be attributed to the expectation set by the executive nursing management that all managers must facilitate their specific unit council and be a member on any one central council. Hess (2011:239) reports that staff who are

involved in shared governance councils report higher scores of governance and thus higher levels of shared decision making.

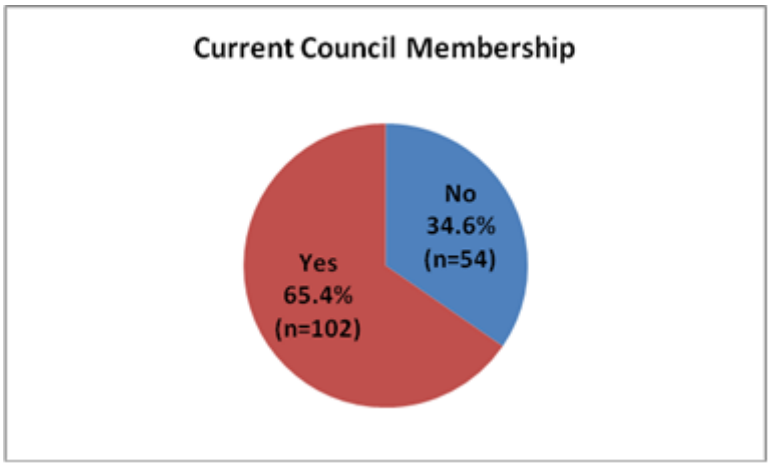

Figure 4.8: Current council membership (n=156)

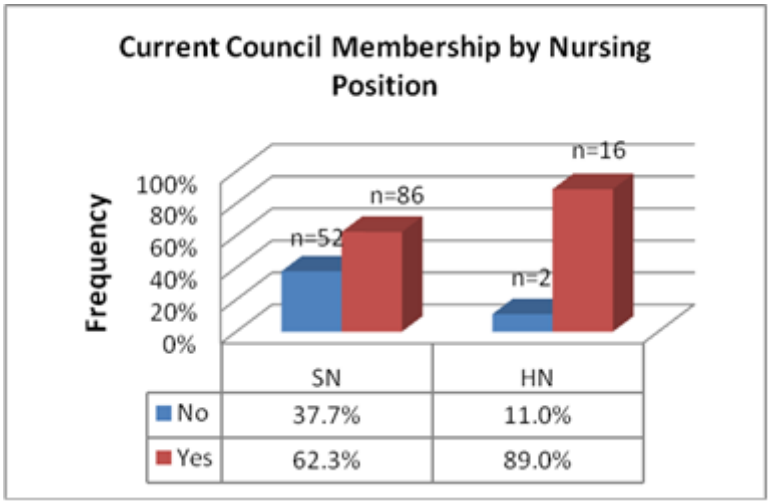

Figure 4.9: Current council membership by nursing position (n=156)

4.3.14 Question 12: Please indicate if you are currently and/or were previously a member of any other committee(s) and/or task force(s) within this organization

Five respondents did not answer this question. Figure 4.10 illustrates that 37.9% (n=58) of respondents are currently, or were previously, a member on a committee/task force while the majority of respondents 62.1% (n=95) have never been a member of a committee or task force. On secondary analysis (figure 4.11) 31.9% (n=43) of SNs (bedside RNs) and 83.3% (n=15) managers are neither currently or were previously members on committees/task forces. Committees and task forces are not a formal element of the shared governance structure, but are still considered to be one forum where decision making occurs. The high membership of managers in comparison to the bedside RNs is indicative of the residual

traditional centralized structures where bedside RNs were seldom asked to become a member but the results indicate that there is a small representation which is considered as a positive in a young shared governance climate.

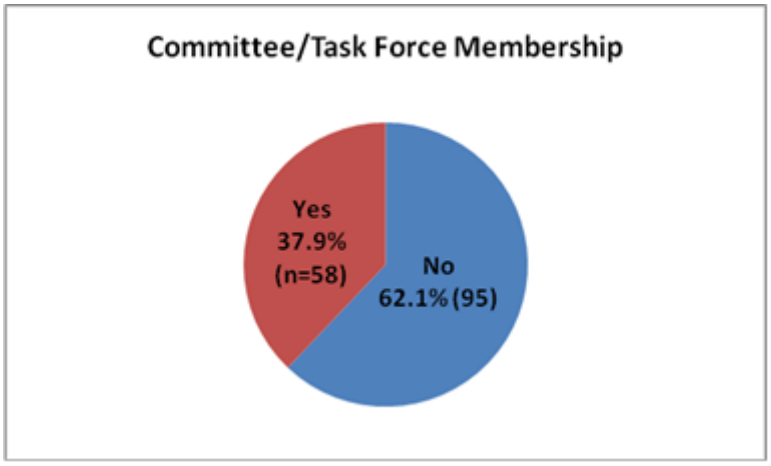

Figure 4.10: Committee/task force membership (n=153)

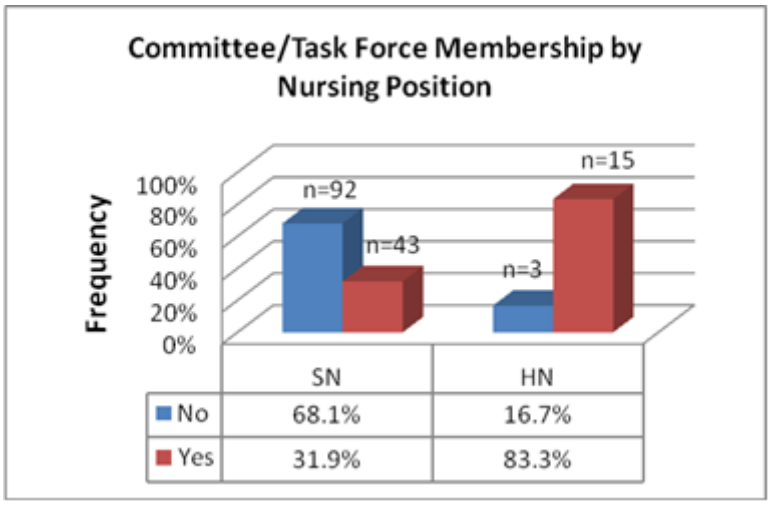

Figure 4.11: Committee/task force membership by nursing position (n=153)

4.4 SECTION B: FACTORS IMPACTING ON INVOLVEMENT IN DECISION MAKING

The data findings presented in this section will provide information regarding those factors which impact, as has been identified in the literature review in chapter 2, on the decisional involvement of nurses, and will answer one of the objectives of this study. This section did not separate the respondents into the groups of bedside RN and nurse managers. The reason for this is because the factors that impact on decisional involvement can be considered to be generic, regardless of the position that a nurse holds.

In questions 13 to 23 the respondents were asked to select either 'yes' or 'no' in answer to the following question *"Do you believe that the following impacts positively on your involvement in decision making?"* by placing a cross (**x**) in the corresponding box.

4.4.1 Question 13: Your gender

As indicated in table 4.10 the majority 53.8% (n=85) of respondents selected 'no' to the question asking if gender impacts positively on involvement in decision making. Liu (2008:293) suggests that one of the possible factors that impact on involvement in decision making is gender but the results of this study challenges Liu's statement. On analysis no statistical significant difference, using Pearson Chi-square test, could be identified when a comparison was made of the results from **question 2** (**figure 4.2**) regarding the demographic distribution of gender to the results of this question, thus countering Liu's proposal that gender impacts on involvement in decision making. Interestingly, the gap between the results of the respondents who selected 'yes' to those who selected 'no' is fairly narrow. A significant number of respondents 46.2% (n=73) suggest that they perceive their gender to impact on their involvement in decision making.

Table 4.10: Gender (n=158)

Category	Frequency (f)	Percentage (%)
No	85	53.8
Yes	73	46.2
TOTAL	**n=158**	**100.0**

4.4.2 Question 14: Your opinion regarding the decision being made

The majority of the respondents 75.3% (n=119) (table 4.11) selected yes and thus agree that their involvement in a decision being made is dependent on their opinion of the decision being taken. This suggests that nurses are more willing to participate in decision making if they have a vested interest in the outcome of the decision.

Table 4.11: Opinion regarding decision being made (n=158)

Category	Frequency (f)	Percentage (%)
No	39	24.7
Yes	119	75.3
TOTAL	**n=158**	**100.0**

4.4.3 Question 15: Your education level

Table 4.12 indicates that the majority of the respondents 77.2% (n=122) selected 'yes' and thus agree that their education level impacts positively on their involvement in decision making. This result is supported by Liu (2008:293) who suggests that education has an impact on the level of involvement in decision making but contradicts Mangold et al. (2006:270) who identified from their study that the educational level was not a factor found to impact on RNs involvement in decision making. It is of interest to note that the respondents from the study of Mangold et al. consisted of only 31.1% of RNs with a Bachelor of Science in Nursing (BSN) or higher, while the results of this study indicate that the majority of respondents 73.4% (n=116) hold a Bachelor Degree in Nursing (**see table 4.1**).

Table 4.12: Educational level (n=158)

Category	Frequency (f)	Percentage (%)
No	36	22.8
Yes	122	77.2
TOTAL	**n=158**	**100.0**

4.4.4 Question 16: Having a personal interest in the decision being made

The majority of respondents 68.4% (n=108) selected 'yes' and thus agree that having a personal interest in the decision being made impacts positively on their involvement in decision making (table 4.13). The literature review identified, (Kowalik & Yoder, 2010:262) that this may be a factor that impacts on the involvement of decision making and it was thus included in the questionnaire to be tested.

Table 4.13: Personal interest in decision (n=158)

Category	Frequency (f)	Percentage (%)
No	50	31.6
Yes	108	68.4
TOTAL	**n=158**	**100.0**

4.4.5 Question 17: Your seniority in your work area

The majority of respondents 72.2% (n=114) as seen in table 4.14 selected 'no' and thus perceive that seniority does not impact on their involvement in decision making. This suggests that the nurses, regardless of their position within the nursing hierarchy, are comfortable to participate in decision making.

Table 4.14: Seniority (n=158)

Category	Frequency (f)	Percentage (%)
No	114	72.2
Ye	44	27.8
TOTAL	**n=158**	**100.0**

4.4.6 Question 18: Your level of experience

As indicated in table 4.15 the majority of respondents 88.0% (n=139) selected 'yes' and thus agree that their level of experience impacts positively on their involvement in decision making. This positive response suggests that experience gives a nurse more confidence to voice their opinion and thus they are more willing to be involved in decision making. No statistical differences were identified when the responses of this question were compared to the years of experience in **question 9a, 9b and 9c**.

Table 4.15: Level of experience (n=158)

Category	Frequency (f)	Percentage (%)
No	19	12.0
Yes	139	88.0
TOTAL	**n=158**	**100.0**

4.4.7 Question 19: An environment that encourages decision making

One respondent did not answer this question. The majority of respondents 81.5% (n=128) selected 'yes' and thus agree that an environment that encourages decision making impacts positively on their involvement of decision making (table 4.16). In the literature review (**see paragraph 2.6.5**) it has been identified that the work environment is a major factor that impacts on the nurses' involvement in decision making. These results support the importance of having a healthy and positive work environment which encourages nurses to be involved in decision making.

Table 4.16: Encouraging environment (n=157)

Category	Frequency (f)	Percentage (%)
No	29	18.5
Ye	128	81.5
TOTAL	**n=157**	**100.0**

4.4.8 Question 20: A positive relationship with your colleagues

Table 4.17 indicates that the majority of respondents 88.6% (n=140) selected 'yes' and thus agree that having a positive relationship with their colleagues impacts positively on their involvement in decision making.

Table 4.17: Positive relationships with colleagues (n=158)

Category	Frequency (f)	Percentage (%)
No	18	11.4
Yes	140	88.6
TOTAL	**n=158**	**100.0**

4.4.9 Question 21: Your nationality

One respondent did not answer this question. The majority of respondents 56.7% (n=89), as illustrated in table 4.18, selected 'no' to the question asking whether nationality impacts positively on their involvement in decision making. The response to this question indicates that nationality is not a factor that impacts on involvement in decision making. Liu (2008:293) suggests that demographic differences are one factor that impacts on decisional involvement but no statistical significant difference (Pearson Chi-square test p=0.258) could be identified in the comparison to the demographic data obtained from **question 3** (**figure 4.4**) regarding the nationality of the respondents to this question. Even though the majority of respondents disagree, it was identified in the open-ended questions (**tables 4.64 and 4.65**) under the theme of RN demographic that nationality impacts negatively on the decisional involvement of the bedside RNs. It is important to note that nurses from different nationalities and cultures have different approaches to nursing care and different attitudes to their colleagues as suggested by Van Rooyen, Telford-Smith and Strümpher (2010:6).

Table 4.18: Nationality (n=157)

Category	Frequency (f)	Percentage (%)
No	89	56.7
Yes	68	43.3
TOTAL	**n=157**	**100.0**

4.4.10 Question 22: Having limited knowledge regarding the decision that is to be made

Two respondents did not answer this question. As seen in table 4.19 the majority of respondents 54.5% (n=85) selected 'yes' and thus agree that having limited knowledge regarding the decision being made impacts on their involvement in decision making. These findings support Kowalik and Yoder's (2010:262) suggestion that this is a factor impacting on decisional involvement.

Table 4.19: Limited knowledge regarding decision (n=156)

Category	Frequency (f)	Percentage (%)
No	71	45.5
Yes	85	54.5
TOTAL	**n=156**	**100.0**

4.4.11 Question 23: Your role in the organization

One respondent did not answer this question. The majority of respondents 82.2% (n=129) selected 'yes' thus indicating that they agree that their role in the organization impacts positively on their involvement in decision making (table 4.20). Kanter's Theory of Structural Empowerment (1977, 1993) suggests that the empowerment of an employee is shaped by a person's position in an organization and the results obtained suggest that respondents believe that the nurses' role in the study hospital is respected and recognized for the contribution to the mission, vision and values of the hospital and thus encourages the nurses to participate in organizational wide decision making.

Table 4.20: Role in organization (n=157)

Category	Frequency (f)	Percentage (%)
No	28	17.8
Yes	129	82.2
TOTAL	**n=157**	**100.0**

In summary of questions 13 to 23 the nurses identified that gender; seniority and nationality do not have an impact on their involvement in decision making. Those factors which do have a positive impact on the nurses' involvement in decision making were identified to be the nurses' opinion regarding the decision being made, the educational level, the nurse having a personal interest in the decision being made, the level of experience, an encouraging environment, positive relationships with colleagues, limited knowledge regarding the decision being made and the role of the nurse in the organization.

In **questions 24 to 31** the respondents were asked to indicate their agreement or disagreement with the set statements by placing a cross (**x**) next to their choice of answer. A four-point Likert scale was used, where 1=strongly disagree, being the most negative, 2=disagree, 3=agree and 4=strongly agree, being the most positive.

4.4.12 Question 24: There is a culture of shared decision making in my unit

One respondent did not answer this question. As indicated in table 4.21 by selecting agree 63.1% (n=99) and strongly agree 14.0% (n=22) the majority of the respondents concur that

there is a culture of shared decision making in their unit. Descriptive statistical analysis of the data indicates the mean=2.82 for a culture of shared decision making (SD=0.77). On secondary analysis using the Mann-Whitney *U* test it was identified that there is a statistical significant difference (p=0.003) between the SNs (bedside RNs) and managers' responses. Figure 4.12 illustrates that a significant number of SNs (bedside RNs) selected strongly disagree 9.3% (n=13) and disagree 16.6% (n=23) while no managers selected either of these two options. This significant number of SNs (bedside RNs) who disagree that there is a shared decision making culture in their unit can be considered as acceptable within an organization that has a young shared governance structure. It is suggested in literature that male managers are more autocratic than female managers. As indicated in **question 2, figure 4.3**, there were 27.8% (n=5) male manager respondents which may also explain the negative responses received from the SN (bedside RN) group who perceive that there is not a shared decision making culture in their unit.

Table 4.21: Shared decision making culture (n=157)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	13	8.3
2=Disagree	23	14.6
3=Agree	99	63.1
4=Strongly Agree	22	14.0
TOTAL:	**n=157**	**100.0**

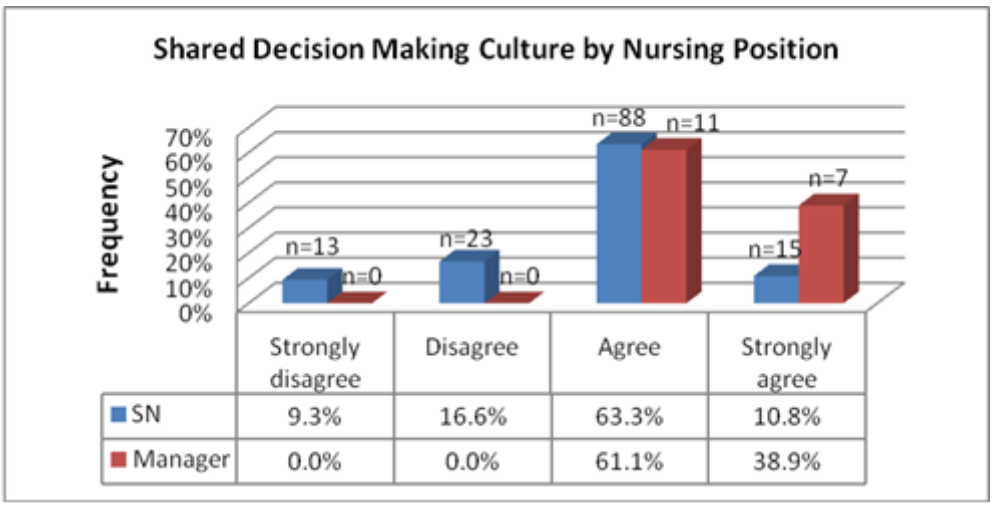

Figure 4.12: Shared decision making culture by nursing position (n=157)

4.4.13 Question 25: I have a manager that encourages my involvement in decision making

One respondent did not answer this question. As illustrated in table 4.22 the selection by the respondents of agree 51.0% (n=80) and strongly agree 31.8% (n=50) indicates that the majority of respondents concur that they have a manager that encourages their involvement in decision making. Descriptive statistical analysis of the data indicates the mean=3.14 for having a manager that encourages the involvement in decision making (SD=0.70). Having an encouraging manager who encourages decision making will assist in the development of high performance environments according to Etchegaray, St John and Thomas (2011:45), where decisional involvement levels will be high. As identified in the literature review (**paragraph 2.6.4**) the management style and the leadership style of managers play a vital role in the implementation of decisional involvement. Democratic and transformational leaders have the qualities that are necessary to promote decisional involvement and this includes the ability to motivate and encourage staff to participate in the decision making process. This result confirms those results for the previous **question 24 (table 4.21)** where the majority of respondents 77.1% (121) are in agreement that there is a culture of shared decision making in their unit. Managers' support of decisional involvement and shared decision making were identified as a theme in the open-ended questions (**tables 4.64 and 4.65**) thus reinforcing that managers play an essential role in actualizing decisional involvement.

Table 4.22: Encouraging manager (n=157)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	1	0.6
2=Disagree	26	16.6
3=Agree	80	51.0
4=Strongly Agree	50	31.8
TOTAL	**n=157**	**100.0**

4.4.14 Question 26: I am autonomous in decision making regarding my practice

Four respondents did not answer this question. The majority of respondents 59.7% (n=92) agree and 16.2% (n=25) strongly agree that they have autonomy in decisions regarding their practice (table 4.23). The mean for this question is 2.88 (SD=0.73). Autonomy, one of the characteristics of decisional involvement as seen in **paragraph 2.4**, is identified in the literature review to be a central theme for decisional involvement and the high combined agree and strongly agree responses of 75.9% (n=117) suggest that in the decisions that the staff are currently taking they have a high level of autonomy and this is conducive to decisional involvement being effectively actualized. This is supported by Kowalik and Yoder

(2010:261) who identify that nurses who perceive that they have a high level of autonomy also perceive that they have a high level of decisional involvement.

Table 4.23: Autonomy in decision making (n=154)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	7	4.6
2=Disagree	30	19.5
3=Agree	92	59.7
4=Strongly Agree	25	16.2
TOTAL	**n=154**	**100.0**

4.4.15 Question 27: I am empowered to make decisions

Three respondents did not answer this question. As illustrated in table 4.24 the majority of the respondents 60.0% (n=93) agree and 13.5% (n=21) strongly agree that they are empowered to make decisions. This result supports the results illustrated in **question 24, table 4.21,** where the majority of respondents agree that they are involved in shared decision making. The mean for this question is 2.82 (SD=0.72). There is a statistical significant difference between the bedside RNs and managers p=0.025 (Mann-Whiney U test). These results are similar to those discussed in **question 24** where a large number of SNs (bedside RNs) indicated that they disagreed that there is a shared decision making culture in their unit. Empowerment is necessary for shared decision making to be effective and Barden et al. (3011:213) suggest that staff driven decision making is a strong indicator of excellence in nursing practice. However, the data (figure 4.13) indicates that more than 25% of the SNs (bedside RNs) perceive that they are not empowered to be involved in decision making. Nurse leaders' empowering behaviours impact greatly on how nurses respond to their environment (Greco, Laschinger & Wong, 2006:41). As identified in the literature review **paragraph 2.6.4** this may be linked to autocratic leadership styles of managers who are not willing to relinquish their control over the authority for decision making. Empowerment was identified as a theme in the open-ended questions (**tables 4.64 and 4.65**) supporting the literature that empowerment is essential for decisional involvement to be actualized.

Table 4.24: Empowered to make a decision (n=155)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	8	5.2
2=Disagree	33	21.3
3=Agree	93	60.0
4=Strongly Agree	21	13.5
TOTAL	**n=155**	**100.0**

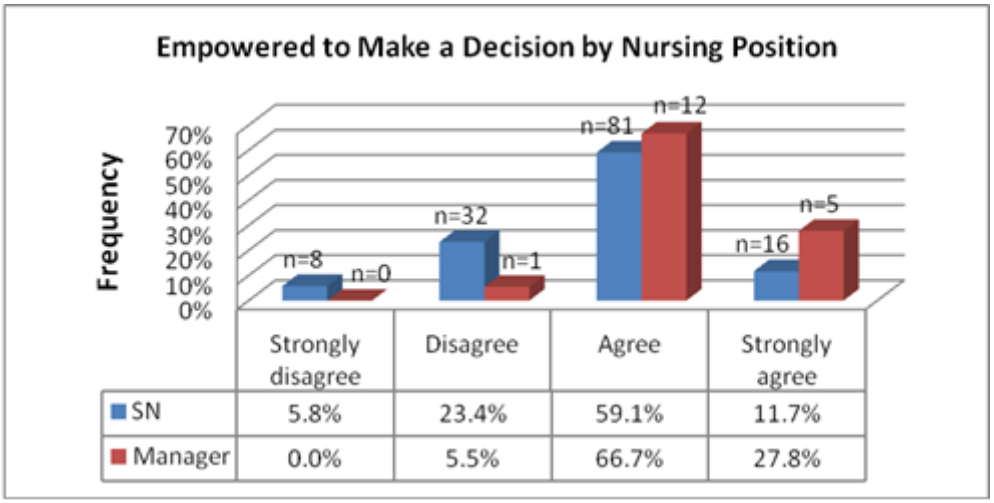

Figure 4.13: Empowered to make a decision by nursing position (n=155)

4.4.16 Question 28: I am held accountable for decisions that I make

One respondent did not answer this question. Table 4.25 indicates that the majority of respondents 54.1% (n=85) agree and 38.9% (n=61) strongly agreed that they are held accountable for their decisions. The mean results for this question is 3.31 (SD=0.58). Accountability is one of the defining attributes for decisional involvement as discussed in **paragraph 2.4**. It is suggested that accountability may be a reason why nurses are not willing to be involved in decision making because they do not want to be held accountable for the decisions taken (Kowalik & Yoder, 2010:262).

Table 4.25: Accountability for decisions (n=157)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	2	1.3
2=Disagree	9	5.7
3=Agree	85	54.1
4=Strongly Agree	61	38.9
TOTAL	**n=157**	**100.0**

4.4.17 Question 29: My experience gives me confidence to participate in decision making

Most of the respondents 48.1% (n=76) strongly agree and 47.5% (n=75) agree that experience gives them confidence to participate in decision making (table 4.26). The mean for this question is M=3.44 (SD=0.58). The results of this question are supported by the results from **question 18** (**table 4.15**) where the majority of nurses identified that their level of experience has a positive impact on their involvement in decision making. This finding is contradictory to Mangold et al. (2006:270) who identified in their study the perceptions and characteristics of RNs' involvement in decision making that years of experience do not impact on decisional involvement of the nurses.

Table 4.26: Experience gives confidence in decision making (n=158)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	0	0.0
2=Disagree	7	4.4
3=Agree	75	47.5
4=Strongly Agree	76	48.1
TOTAL	**n=158**	**100.0**

4.4.18 Question 30: Peer pressure prevents me from making a decision that I believe is the correct decision

Table 4.27 indicates that the majority of respondents 53.2% (n=84) disagree and strongly disagree 15.8% (n=25) that peer pressure is a factor that affects decision making. The mean for this question is 2.18 (SD=072).

Table 4.27: Peer pressure (n=158)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	25	15.8
2=Disagree	84	53.2
3=Agree	45	28.5
4=Strongly Agree	4	2.5
TOTAL	**n=158**	**100.0**

4.4.19 Question 31: I feel that I am reluctant to participate in decision making because of my culture

One respondent did not answer this question. As illustrated in table 4.28 the majority of respondents 51.6% (n=81) disagree and 27.4% (n=43) strongly disagree that their culture affects their participation in decision making. The mean for this question is M=1.96

(SD=0.75). Liu (2008:293) had suggested that demographic differences are a possible factor impacting on decisional involvement, thus this question was asked by the researcher to identify whether the large number of varied cultures within the study hospital, as identified in **question 3** (**figure 4.4**), were a factor. It is important to note that even though the majority of respondents do not perceive that culture impacts has an impact on their involvement in decision making a noteworthy number of respondents 21.0% (n=31) indicated that this is a factor in their involvement in decision making.

Table 4.28: Culture (n=157)

Category	Frequency (f)	Percentage (%)
1=Strongly Disagree	43	27.4
2=Disagree	81	51.6
3=Agree	29	18.5
4=Strongly Agree	4	2.5
TOTAL	**n=157**	**100.0**

In summary to questions 24 to 31 the respondents identified their agreement or disagreement with the factors tested in this section of the questionnaire. The nurses identified that there is a culture of shared decision making in their unit; that managers encourage involvement in decision making; that they are empowered to be involved in decision making; can act autonomously in practice decisions; are held accountable and perceive that their experience gives them confidence to participate in decision making. The nurses also identified that peer pressure does not prevent them from making the correct decision and that culture does not prevent them from participating in decision making.

In **questions 32 to 42** the respondents were asked to indicate their agreement or disagreement with the set statements by placing a cross (**x**) next to their choice of answer. A four-point Likert scale was used, where 1=never, being the most negative, 2=sometimes, 3=always, being the most positive.

PLEASE INDICATE YOUR AGREEMENT OR DISAGREEMENT WITH THE FOLLOWING STATEMENTS:

4.4.20 Question 32: You feel that you must make a decision that you do not agree with

One respondent did not answer this question. As indicated in table 4.29 the majority of respondents 72.6% (n=114) felt that they ‘sometimes’ had to make decisions that they did not always agree with. Reasons for this response may be attributed to peer pressure and

intimidation by senior members of staff. However, the data from **question 30** (**table 4.27**) and **question 35** (**table 4.32**) does not suggest that these are factors that force nurses to make decisions with which they did not necessarily agree. Another possible reason could be attributed to a lack of confidence by the nurse but again this is refuted by the data in **question 33** (**table 4.30**) that indicates that the majority of nurses have confidence when making decisions. One reason not tested by the questionnaire is that a nurse may have to take a decision as a member of a council/task force/committee where the majority have an alternative viewpoint to the nurse resulting in the nurse taking a decision that they do not agree with.

Table 4.29: Making decision not agreed with (n=157)

Category	Frequency (f)	Percentage (%)
Never	37	23.6
Sometimes	114	72.6
Always	6	3.8
TOTAL	**n=157**	**100.0**

4.4.21 Question 33: You feel confident enough to voice your opinion

The majority of respondents 57.6% (n=91), as indicated in table 4.30, suggest that they 'always' felt confident enough to voice their opinion. This response can be linked to **question 15** (**table 4.12**) where nurses perceive that their educational levels, which are predominantly bachelor degrees of nursing, encourage them to be involved in decision making and thus may give them the confidence to voice their opinion.

Table 4.30: Confidence to voice opinion (n=158)

Category	Frequency (f)	Percentage (%)
Never	2	1.3
Sometimes	65	41.1
Always	91	57.6
TOTAL	**n=158**	**100.0**

4.4.22 Question 34: You choose not to participate in the decision making process

The majority of respondents 60.8% (n=96) indicated that they 'sometimes' chose not to participate in the decision making process (table 4.31) while 34.8% (n=55) identified that they 'always' choose to participate and only 4.4% (n=7), all of which were bedside RNs, always choose not to participate in the decision making process. On further analysis 32% (n=45) of the bedside RNs, respondents (figure 4.14) were identified to have selected 'never' in response to this question indicating that almost a third of the bedside RNs always choose to participate in the decision making process. In a study by Mangold et al. (2006:270) the level

of decisional involvement of bedside RNs was low suggesting that RNs did not want to become involved in decision making which was attributed to the feeling of being overwhelmed with work responsibilities, lack of time and energy, and feeling satisfied with the decisions made by others or that nurses may already be satisfied with decisions being taken and therefore do not find it necessary to become involved.

Table 4.31: Choose not to participate (n=158)

Category	Frequency (f)	Percentage (%)
Never	55	34.8
Sometimes	96	60.8
Always	7	4.4
TOTAL	**n=158**	**100.0**

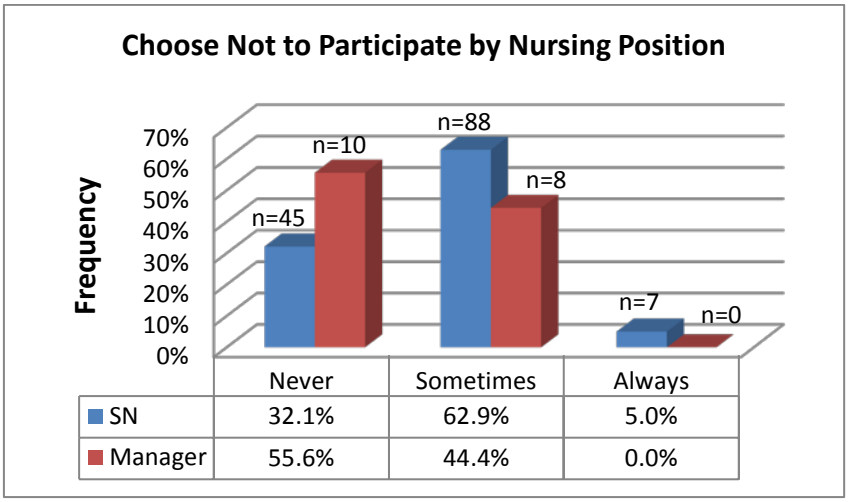

Figure 4.14: Choose not to participate (n=158)

4.4.23 Question 35: You feel intimidated by more senior members of staff

As seen in table 4.32 most of the respondents 50.0% (n=79) felt that they are 'never' intimidated by senior staff, while 44.3% (n=70) selected that they 'sometimes' felt intimidated by more senior staff. A small minority of responses 5.7% (n=9) indicate that they are 'always' intimidated by senior staff. Contrary to these results seniority was identified as a theme in the open-ended questions (**tables 4.64 and 4.65**) suggesting that seniority does impact on the decisional involvement of nurses.

Table 4.32: Intimidated by senior staff (n=156)

Category	Frequency (f)	Percentage (%)
Never	79	50.0
Sometimes	70	44.3
Always	9	5.7
TOTAL	**n=158**	**100.0**

4.4.24 Question 36: You are invited to decision making meetings

As indicated in table 4.33 the majority of the respondents 58.9% (n=93) indicated that they are only 'sometimes' invited to decision making meetings supporting Kowalik and Yoder (2010:262) who identifies that the lack of opportunity to attend decision making meetings is a factor impacting on the decisional involvement of nurses. With the shared governance model that is still young in its implementation this response can be viewed as positive, indicating that nurses are being invited to meetings where decisions are being made as opposed to not being invited at all. The low percentage 15.2% (n=24) may be due to an autocratic leadership style of managers who are not receptive to inviting staff to these meetings that they want to have control over.

Table 4.33: Invited to decision making meetings (n=158)

Category	Frequency (f)	Percentage (%)
Never	24	15.2
Sometimes	93	58.9
Always	41	25.9
TOTAL	**n=158**	**100.0**

4.4.25 Question 37: You are informed when a decision, that will impact you, is being made

As seen in table 4.34 the majority of respondents 58.2% (n=92) indicated that they were only 'sometimes' informed when a decision that would impact them is being made. The shared governance model where nurses are involved in the decision making process has only been implemented in the Nursing Affairs Department while the rest of the organization continues to operate within a bureaucratic model. The respondents could have interpreted this question to include organizational decisions over which the Nursing Affairs Department has minimal influence, such as human resources and financial issues.

Table 4.34: Informed of decision impacting on you (n=158)

Category	Frequency (f)	Percentage (%)
Never	8	5.1
Sometimes	92	58.2
Always	58	36.7
TOTAL	**n=158**	**100.0**

4.4.26 Question 38: There is adequate time to attend decision making meetings

Two respondents did not answer this question. The majority of the respondents n=103 (66.0%) indicates that there is 'sometimes' enough time to attend decision making meetings (table 4.35).

Table 4.35: Adequate time to attend meetings (n=156)

Category	Frequency (f)	Percentage (%)
Never	26	16.7
Sometimes	103	66.0
Always	27	17.3
TOTAL	**n=156**	**100.0**

4.4.27 Question 39: You are able to attend a meeting where a decision is being made

As indicated in table 4.36 the majority of respondents 61.4% (n=97) indicated that they 'sometimes' are able to attend a meeting where a decision is being made. The response to this question and to **question 38** (**table 4.35**) where the majority of the nurses selected 'sometimes' may be attributed to a number of factors that include how busy the ward is, the lack of available staff to cover while attending a meeting, or could be as a result of staff who do not use their initiative to make alternative arrangements in time or at all to attend these meetings. From the SN's (bedside RN's) perspective the care delivery model used throughout the inpatient areas is predominantly the case (total patient care) model where each nurse is responsible for the holistic care of a set of allocated patients. If the nurse leaves the unit then another nurse will have to take responsibility for these patients which may lead to the nurse feeling guilty at overburdening a colleague. Another possible reason for this is that the manager may be autocratic and does not allow the SN (bedside RN) to attend the meetings.

Table 4.36: Able to attend decision making meetings (n=158)

Category	Frequency (f)	Percentage (%)
Never	26	16.5
Sometimes	97	61.4
Always	35	22.1
TOTAL	**n=158**	**100.0**

4.4.28 Question 40: You feel that decisions made by you, or that you participate in, will be valued

One respondent did not answer this question. The majority 66.2% (n=104) of respondents, as indicated in table 4.37 felt that 'sometimes' the decision that they make or participate in making is valued. The findings are contradictory to those Andrews, Burr and Bushy (2011:74) identified in their study. These perceptions may be attributed to the type of decisions that are being made where decisions that have an undesirable impact are viewed negatively by colleagues, or to autocratic leaders who do not value input from bedside RNs, or by colleagues who may have professional jealousy of the control/authority that has been given to, or assumed by, the decision maker.

Table 4.37: Decisions are valued (n=157)

Category	Frequency (f)	Percentage (%)
Never	15	9.6
Sometimes	104	66.2
Always	38	24.2
TOTAL	**n=157**	**100.0**

4.4.29 Question 41: You feel comfortable disagreeing with your manager about a practice decision

One respondent did not answer this question. Table 4.38 indicates that the majority 52.2% (n=82) of respondents 'sometimes' feel comfortable disagreeing with their managers. Shared governance advocates that the nurse accountable for a specific responsibility should have full authority to make decisions about that accountability, in this case a practice decision. The response to this question suggests that nurses do not have the confidence to oppose or confront a manager or have not been given full authority over decision making regarding their practice. New staff to the organization may not be familiar with a structure that authorizes the bedside RN to voice their opinion even if it means disagreeing with their manager and the same principle applies to new managers to the organization who are used to a hierarchical decision making process. As already identified from the literature nurses from Asia are perceived to be less assertive (Xu, 2006:420) and therefore would not easily disagree with a manager.

Table 4.38: Comfortable disagreeing with manager (n=157)

Category	Frequency (f)	Percentage (%)
Never	23	14.7
Sometimes	82	52.2
Always	52	33.1
TOTAL	**n=157**	**100.0**

4.4.30 Question 42: Your unit council has the authority to make decisions

An equal number of respondents selected 'sometimes' n=72 (45.6%) and 'always' n=72 (45.6%) in response to this question (table 4.39). Every unit in the study hospital is mandated to have a Unit Council and this is where most SNs (bedside RNs) have membership within the shared governance structure. The role of the HN/AHN is to be the facilitator of the meetings where they help set the boundaries for decisions taken but do not take part in the decision making. As identified in the literature review a democratic or transformational leader (**paragraph 2.6.4**) can see the value of allowing staff full decision making authority but at the same time giving constructive guidance as to what type of decisions are within the regulations of the hospital. Conversely, autocratic leaders do not like to lose control and will block the authority for decision making in the Unit Council. Based on this discussion these results lean towards the positive even though an equal number of staff selected 'sometimes'. These 'sometimes' results can be attributed to those decisions that are beyond the authority of the Unit Council or may be because of managers still learning the facilitator role and interfering with decisions being made by the bedside RNs. The findings are also supported by the open-ended **question 64** (**table 4.64**) where Unit Councils are identified as an empowering structure where decision making occurs.

Table 4.39: Unit Council has decision making authority (n=158)

Category	Frequency (f)	Percentage (%)
Never	14	8.8
Sometimes	72	45.6
Always	72	45.6
TOTAL	**n=158**	**100.0**

In summary of questions 32 to 42, nurses identified that they 'sometimes' make decisions that they do not agree with, they 'sometimes' choose not to participate in the decision making process, feel that their decisions are only 'sometimes' valued, 'sometimes' feel comfortable disagreeing with a manager about practice decisions and are only 'sometimes' informed when a decision that will impact on them is being made. Invitations to decision making meetings, adequate time to attend meetings and attendance at decision making meetings

were also identified to occur only 'sometimes'. Nurses suggest that they 'always' feel confident to voice their opinions. Empowerment of unit councils with the authority to make decisions was identified as occurring equally between 'sometimes' and 'always'. Intimidation by seniors was identified to 'never' have happened.

4.5 SECTION C: DECISIONAL INVOLVEMENT SCALE (DIS)

The data findings obtained from the Decisional Involvement Scale (Havens & Vasey, 2003:333) will be presented in section C. These findings will be utilized in answering two of the objectives of this study. In this section decisional involvement will be referred to by its abbreviation of DI. The terminology for the bedside RN used in this tool and in the study hospital is referred to as a Staff Nurse. To prevent confusion for the reader the terminology for the purpose of this section when referring to the Staff Nurse in the text will be SN (bedside RN).

For this section the respondents were asked for each question to circle one number in Section A (Actual DI) and one number in Section B (Preferred DI):

5 = Staff nurses only

4 =Primarily staff nurses – some administration/management

3 =Equally shared by administration/management and staff nurses

2 =Primarily administration/management – some staff nurses

1 = Administration/management only

On the scale of 1 to 5 a score of 5 indicates that SNs (bedside RNs) have high decisional involvement while conversely a score of 1 indicates that SNs (bedside RNs) have low decisional involvement. A mid-range score of 3 indicates that there is shared decision making between the SN (bedside RN) and the manager.

4.5.1 Subscale 1: Unit staffing (Questions 43-44)

4.5.1.1 Questions 43A and 43B: Scheduling

Question 43 A - ***Actual DI:***

As illustrated by table 4.40 the results for actual DI in scheduling indicate a mean of 2.19 (SD=1.30) for SNs (bedside RNs) signifying a low level of DI. The mean result for managers is 2.44 (SD=1.42). Both groups have concordance that scheduling is performed primarily by nurse managers with some SN (bedside RN) involvement. Traditionally scheduling is seen as an administrative task that bedside RNs have little or no control over and this is confirmed by the results of this question.

Comparison of the results of the two groups using the Mann–Whitney *U* test (*p*=0.490) indicates no significant statistical variance in the distribution in the actual level of DI in scheduling.

Question 43 B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. The results for preferred DI in scheduling, as seen in table 4.40, indicate that the SNs (bedside RNs) mean is 2.88 (SD=1.14) suggesting that they desire more DI and would like to have a more equal share of the authority for this activity with managers. The manager's mean is 2.94 (SD=1.06) indicating concordance with the SNs (bedside RNs) that this activity should be shared equally by both groups. According to the literature (Scherb et al., 2006:5) one strategy to improve the decisional involvement of SNs (bedside RNs) is the introduction of self-scheduling, however it is necessary for commitment between both groups for this activity to be successful.

There is no significant statistical variance *(p* =0.490) between the two groups (Mann–Whitney *U* test).

Table 4.40: Scheduling

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1133.5	0.490				1216.5	0.890
Staff Nurse	140	2.19	1.30			138	2.88	1.14		
Manager	18	2.44	1.42			18	2.94	1.06		

4.5.1.2 Questions 44A and 44B: Unit coverage

Question 44A - **Actual DI:**

Two SN (bedside RN) respondents did not answer this question. SNs (bedside RNs) and managers, as illustrated in table 4.41, have the same mean score of 2.44 for the actual level of DI in unit coverage. The score indicates that SNs (bedside RNs) have a low level of DI for this activity (SD=1.16) and that the authority for unit coverage rests primarily with nurse managers (SD=1.15) with limited SN (bedside RN) involvement. Unit coverage includes ensuring that there is a sufficient number of qualified and appropriately skilled staff to provide safe and quality patient care. This activity is usually executed by managers who are not

always aware of the needs of the SNs (bedside RNs) who are at the point of care while the managers may be somewhat distanced in their administrative role.

No significant statistical difference is indicated by the Mann Whitney *U* test in the actual level of involvement in unit coverage (*p*=0.918).

Question 44B - **Preferred DI:**
One SN (bedside RN) respondent did not answer this question. Table 4.41 indicates that the preferred level of DI for SNs (bedside RNs) is mean=2.86 (SD=0.96) indicating that they would like to have more involvement in, and share the authority with the managers for this task. The managers' mean of 2.83 (SD=1.04) indicate that they are in concordance with the desired level of the SNs (bedside RNs).

A Mann-Whitney *U* test was conducted to evaluate whether SN (bedside RNs) scores differ from manager scores in unit coverage. The results of the Mann-Whitney *U* test (*p*=0.923) indicate that there is no significant difference between the two groups in their preferred level of DI for this activity.

Table 4.41: Unit Coverage

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1223.0	0.918				1233.0	0.923
Staff Nurse	138	2.44	1.16			139	2.86	0.96		
Manager	18	2.44	1.15			18	2.83	1.04		

Review of subscale 1: Unit Staffing (tables 4.40 to 4.41)
The overall review of subscale 1 (table 4.40 and table 4.41) discussing ***unit staffing*** for the actual level of decisional involvement indicates that there is concordance that the decisional involvement of SNs (bedside RNs) is low and the authority for these activities lies primarily with administration/management with some staff nurse (bedside RN) involvement. The preferred level of involvement indicates that a change to more equal sharing in decision making is favoured. There were no statistical differences identified in the perceptions between the SNs (bedside RNs) and managers in this subscale.

4.5.2 Subscale 2: Quality of professional practice (Questions 46-48)

4.5.2.1 Questions 45A and 45B: Development of practice standards

Question 45A - ***Actual DI****:*

Two SN (bedside RN) respondents did not answer this question. The SN (bedside RN) mean score of 2.53 (SD=1.08) indicates that they perceive that their involvement in the development of practice standards is low and lies midway between the full shared decision making authority and managers having most of the authority with only some SN (bedside RN) involvement (table 4.42). This indecision may suggest that the authority for this activity is not clearly defined or that staff from different units may have different levels of actual DI in this activity. This indecisiveness may also be attributed to the membership of SNs (bedside RNs) on a council, where the council charges include the development of practice standards, who may have selected a higher level of actual DI than those who do not belong to any shared governance council. As already identified in **question 10** and **question 11** (**figures 4.6 and 4.8**) the majority of the SNs (bedside RNs) were previously or are currently members on a council but not all councils are charged with developing practice standards which may also explain the indecision in this answer. The managers, however, have a lower mean score of 2.33 (SD=0.97) suggesting that they perceive that the authority for DI lies more with administration/management with only some SNs (bedside RNs) involvement.

There is no significant statistical difference between the two groups in the level of actual DI in the development of standards (Mann-Whitney *U* test p=0.518).

Question 45B - ***Preferred DI:***

Five SN (bedside RN) respondents did not answer this question. Table 4.42 indicates that SNs (bedside RNs) (mean=2.90; SD=0.91) desire to have a slightly higher level of DI in the development of practice standards than what they currently actually have. Managers (mean=3.06; SD=0.54) indicate that they prefer to share the authority for DI for this activity with the SN (bedside RN).

The Mann-Whitney *U* test indicates that there is no statistically significant difference between SNs (bedside RNs) and managers (p=0.481) in the DI for the development of practice standards.

Table 4.42: Development of practice standards

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1125.0	0.518				1090.0	0.481
Staff Nurse	138	2.53	1.08			135	2.90	0.91		
Manager	18	2.33	0.97			18	3.06	0.54		

4.5.2.2 Questions 46A and 46B: Definition of scope of practice

Question 46A - ***Actual DI:***

One SN (bedside RN) respondent did not answer this question. Table 4.43 illustrates that SNs (bedside RNs) have a low level of DI (mean=2.17; SD=1.12). There is concordance between SNs (bedside RNs) and managers (mean=2.17; SD=1.09) that the authority for defining the scope of practice is primarily controlled by administrators/management with only some SN (bedside RN) involvement. It is of interest to note that there is no national scope of practice or career ladder in Saudi Arabia (Zakari, Al Khamis, Hamadi, 2010:302). Each individual hospital develops its own standards and regulations to guide the nursing practice within that specific hospital.

The Mann-Whitney *U* test indicates that there is no significant statistical difference between the SNs (bedside RNs) and managers' actual level of DI (p=0.928).

Questions 46B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. Table 4.43 indicate that managers (mean=2.78; SD=0.55) have a higher preferred level for DI for defining the scope of practice than SNs (bedside RNs) (mean=2.62; SD=1.04). However, the results suggest that SNs (bedside RNs) would prefer to be more involved when defining their scope of practice and share the authority for this activity with managers.

There is no significant statistical difference between the two groups (Mann-Whitney *U* test p=0.557).

Table 4.43: Definition of scope of practice

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	Mean	SD	*U*	*p*	n	Mean	SD	*U*	*p*
				1234.0	0.928				1135.5	0.557
Staff Nurse	139	2.17	1.12			138	2.62	1.04		
Manager	18	2.17	1.09			18	2.78	0.55		

4.5.2.3 Questions 47A and 47B: Monitoring of RN practice standards

Question 47A - ***Actual DI:***

Two SN (bedside RN) respondents did not answer this question. Table 4.44 reveals that SNs (bedside RNs) (mean=2.17; SD=1.13) perceive that they have a low level of DI in the activity of monitoring of RN practice standards indicating that this activity is primarily performed by administration/management with some SNs (bedside RNs) involvement. Managers (mean=2.33; SD=1.03) are in concordance with SNs (bedside RNs).

There is no statistical significance difference between SNs (bedside RNs) and managers in the actual DI regarding the monitoring of RN standards (Mann-Whitney *U* test *p*=0.461)

Question 47B - ***Preferred DI:***

One SN (bedside RN) respondent did not answer this question. Both the SNs (bedside RNs) (mean=2.75; SD=1.07) and the managers (mean=2.89; SD=0.83) have higher preferred levels of DI in comparison to the actual level of DI suggesting that both would prefer the authority for the monitoring of RN standards to be shared between them (table 4.44). Monitoring of RN practice standards would entail peer review using set audit tools that should have been developed with the SN (bedside RN) input. This result suggests that SNs (bedside RNs) desire more involvement in the process but may also suggest that they may prefer to be monitored by a peer rather than a manager.

The Mann-Whitney *U* test indicates that there is no significant statistical difference between the SNs (bedside RNs) and managers actual level of DI (*p*=0.512).

Table 4.44: Monitoring of RN Standards

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1108.5	0.461				1131.5	0.512
Staff Nurse	138	2.17	1.13			139	2.75	1.07		
Manager	18	2.33	1.03			18	2.89	0.83		

4.5.2.4 Questions 48A and 48B: Evaluation of RN practice

Question 48A - ***Actual DI:***

The actual level of DI for the evaluation of the RN practice, as seen in table 4.45, is perceived to be low by the SNs (bedside RNs) (mean=1.98; SD=1.14) and the managers (mean=1.94; SD=0.87) are in concordance with the SNs (bedside RNs). The authority for this activity is perceived to be controlled predominantly by managers with only a limited involvement by the SNs (bedside RNs). Peer review is one method that can be utilized for evaluation of RN practice. There was no formal peer review program in the hospital at the time of the study.

The Mann-Whitney *U* test *p*=0.820 indicates that there is no statistical significant difference in the perceptions between the two groups in the level of actual DI in the evaluation of RN practice standards.

Question 48B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. Table 4.45 indicates that there is concordance between SNs (bedside RNs) (mean=2.61; SD= 1.15) and managers (mean=2.67; SD=0.84) that suggests that both groups prefer more for SN (bedside RN) involvement in the evaluation of the RN practice and that the authority for DI be shared between the two groups. The recognition that the evaluation of RN practice should be shared between both groups suggests that the SN (beside RN), as an expert in a specific skill or specific set of skills, is able to evaluate better if the standards are appropriate and current.

There is no statistical significant difference (Mann-Whitney *U* test *p*=0.777) between the groups.

Table 4.45: Evaluation of RN practice

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1218.0	0.820				1190.5	0.777
Staff Nurse	140	1.98	1.14			138	2.61	1.15		
Manager	18	1.94	0.87			18	2.67	0.84		

Review of subscale 2: Quality of Professional Practice (tables 4.42 to 4.45)

Overall the subscale 2 of ***quality of professional practice*** (tables 4.42 to table 4.45) indicates that the SN's (bedside RN's) actual level of decisional involvement is low. However, the preferred level of decisional involvement suggests that both SNs (bedside RNs) and managers are in favour of more shared decision making in these activities. There are no statistical differences identified in this subscale.

4.5.3 Subscale 3: Recruitment (Questions 49 – 51)

4.5.3.1 Questions 49A and 49B: Recruitment of RNs to practice on the unit

Question 49A - ***Actual DI:***

Table 4.46 shows the actual level of DI in the recruitment of RNs for the SNs (bedside RNs) is low (mean=1.44; SD=0.91) indicating that they perceive that administration/managers have most of the authority for this activity. Managers (mean=2.17; SD=1.29) however believe that SNs (bedside RNs) do have some involvement in recruitment but agree that it is limited.

The Mann-Whitney *U* test indicates that there is a statistical significant difference between the two groups (p=0.020). The recruitment process has traditionally been accepted to be a managerial function but with the introduction of shared governance managers have been encouraged to involve SNs (bedside RNs) which may be indicate the response received from the managers who perceive that they are involving the bedside RN in the recruitment process. SNs (bedside RNs) may not know or understand what is entailed in the recruitment process and may unknowingly be involved by the manager in this activity.

Question 49B - ***Preferred DI:***

SNs (bedside RNs) (mean=1.97; SD=1.14) indicate that they would prefer more involvement in the recruitment of RN's but the results suggest that they would still prefer administration/management to have the primary role with only some SN (bedside RN) involvement (table 4.46). Managers (mean=2.50; SD=1.15) preferred level of DI is also

higher and lies equally between shared decision making and primarily administration/management with some SNs (bedside RNs) involvement. Reasons for this dissonance in perceptions may be due to the recruitment of staff predominantly being viewed as an administrative function of "paperwork" and the low level of preferred DI by SNs (bedside RNs) may be reflective of their unwillingness to be involved in an activity that involves paperwork. One of the prerequisites for DI is that the bedside RN must choose to participate to be involved in decision making. However, in the changing environment where shared governance is being introduced, the managers' higher score reflects their willingness to include SNs (bedside RNs) more in this activity.

The results indicate that there is no statistically significant difference between both groups in the preferred DI in the recruitment of RNs to practice on the unit (Mann-Whitney *U* test p=0.059).

Table 4.46: Recruitment of RNs to practice on the unit

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				836.0	0.020				915.0	0.059
Staff Nurse	140	1.44	0.91			140	1.97	1.14		
Manager	18	2.17	1.29			18	2.50	1.15		

4.5.3.2 Questions 50A and 50B: Interview of RNs for hire on the unit

Question 50A - ***Actual DI:***

SNs (bedside RNs) mean=1.33 (SD=0.76) is low indicating that the interviewing of RN's for hire on the unit is performed by administration/managers (table 4.47). Managers' response however (mean=2.00; SD=1.14) is slightly higher, indicating that interviewing is done primarily by administration/management but that there is some SN (bedside RNs) involvement.

The Mann-Whitney *U* test reveals that there is a statistical significant difference (p=0.011) between SNs (bedside RNs) and managers in the interviewing of RN's for hire on the unit. This result is similar to that of **question 49A** (**table 4.46**) except that in the unique environment of the Middle East many staff are hired without having an interview before approval. Approval takes place based on the Curriculum Vitae (CV) that includes the employment history and a skills checklist of the candidate. Interviewing of staff before hiring

in the study hospital has only recently been made mandatory in specific circumstances. Therefore the bedside RN would have had minimal involvement in this process and those that have been involved in interviewing potential candidates would be representative of the managers' perception that some bedside RNs are involved in the process.

Question 50B - ***Preferred DI:***

One SN (bedside RN) respondent did not answer this question. Table 4.47 reveals that the preferred level for DI for SNs (bedside RNs) is higher than their actual level but still remains low on the scale for DI. SNs (bedside RNs) mean=1.79 (SD=1.07) indicate that the interviewing should be done by managers with only minimal involvement of SNs (bedside RNs). It is apparent that SNs (bedside RNs) have a low desire to be involved in the interview process of new staff. Managers also have a variance in their preferred levels of actual to levels of preferred DI (mean=2.44; SD=0.78) but according to this result are not prepared to commit to full shared decision making with the SNs (bedside RNs).

The dissonance in this result is illustrated by a significant statistical variance between the perceptions of managers and the SNs (bedside RNs) (Mann-Whitney *U* test *p*=0.003). As discussed in **question 49B** (**table 4.46**) the managers can see the value of involving the bedside RN in the recruitment process but the bedside RN may not wish to participate in interviewing RNs candidates. This may be because SNs (bedside RNs) do not have experience or skills in the interviewing process.

Table 4.47: Interview of RNs for hire on the unit

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				794.5	0.011				711.0	0.003
Staff Nurse	140	1.33	0.76			139	1.79	1.07		
Manager	18	2.00	1.14			18	2.44	0.78		

4.5.3.3 Questions 51A and 51B: Selection of RNs for hire on the unit

Question 51 A - ***Actual DI:***

Table 4.48 illustrates that SNs (bedside RNs) have a low level of actual DI (mean= 1.30; SD=0.70) for the selection of RN's to be hired on the unit. There is dissonance between the two groups' results in this activity. The results indicate that SNs (bedside RNs) perceive that administration/managers have almost sole authority in this activity. Managers indicate that

SNs (bedside RNs) DI in the selection of RNs is higher (mean=1.89; SD=1.13) than what the SNs (bedside RNs) themselves perceive.

Using the Mann-Whitney *U* test (*p*=0.028) a significant statistical variance is demonstrated between the two groups in the actual level of DI for the selection of RNs for hire. The reason for this variance may be attributed to the current process whereby candidates are selected after review of the application file as discussed in **question 50**. SNs (bedside RNs) are not given access to the entire file for confidentiality reasons and are asked for input regarding the suitability of candidate based only on the CV and skills check list. This process may even only be a verbal discussion without the SN (bedside RN) having ever viewed the candidates file but the manager perceives that they have included them in assisting in the selection of the RN for hire on the unit.

Question 51 B - ***Preferred DI:***

One SN (bedside RN) respondent did not answer this question. SNs (bedside RNs), as indicated in table 4.48, would prefer more involvement in the selection process in hiring RNs (mean=1.87; SD=1.07) but the score below 2 indicates that they would only prefer minimal involvement in this activity with the majority of the authority for decision making being given to the administrator/managers. Managers' results (mean=2.28; SD=0.83) suggest that they perceive that the SNs (bedside RNs) should have more involvement in the selection process than what the SN (bedside RN) prefer.

There is a statistically significant difference (Mann-Whitney *U* test *p*=0.046) between SNs (bedside RNs) and managers in the activity of selection of RNs for hire to work on the unit. Bedside RNs may not want to be held accountable by their colleagues if the recruited RN does not meet the unit's standard and impacts on the quality of the service provided by the team while managers appear to have some confidence in involving the bedside RN. However, this show of confidence is not particularly high according to the low score which managers have presented.

Table 4.48: Selection of RNs for hire on the unit

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				858.0	0.028				887.5	0.046
Staff Nurse	140	1.30	0.70			139	1.87	1.07		
Manager	18	1.89	1.13			18	2.28	0.83		

Review of subscale 3: Recruitment (tables 4.46 to 4.48)

A review of the third subscale of ***recruitment*** (tables 4.46 to table 4.48) has revealed that the actual level of SN (bedside RN) involvement in recruitment is extremely low. The preferred levels of SN (bedside RN) are marginally higher but remain below a score of 2 indicating that SNs (bedside RNs) prefer to have minimal involvement in the recruitment, interviewing and selection of RNs to work on the unit. Managers indicate that they would prefer higher levels for SN (bedside RN) involvement and this is illustrated in the mean scores between 2.00 and 2.50. There are statistical significant variances between SNs (bedside RNs) and managers in all but one of these questions. It is interesting to note that Scherb et al. (2006:6) identify that nurses feel empowered when they are involved in the interview and hiring process. They describe the creation of a shared governance council that is accountable for interviewing potential SNs (bedside RNs), that has led to an increase in recruitment and retention numbers.

4.5.4 Subscale 4: Unit governance and leadership (Questions 52-57)

4.5.4.1 Questions 52A and 52B: Recommendation of disciplinary action for RNs

Question 52A - ***Actual DI:***

One SN (bedside RN) respondent did not answer this question. Table 4.49 shows that SNs (bedside RNs) (mean=1.48; SD=0.83) and managers (mean=1.50; SD=0.86) are in concordance that the actual involvement of SNs (bedside RNs) in making recommendations regarding disciplinary action is low and is placed midway between some involvement and no involvement in this activity, while managers have almost complete control. This activity is also seen traditionally as a manager's role that is responsible for recommending and taking disciplinary action with almost no SN (bedside RN) involvement.

There is no statistical significance variance in this result between SNs (bedside RNs) and managers. (Mann-Whitney *U* test p=0.888)

Question 52B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. SNs (bedside RNs) mean of 2.03 (SD=0.99) indicates that they would prefer to have some involvement in the recommendation of disciplinary action but that administration/managers should have the primary authority for this activity (table 4.49). The issue of one peer having disciplinary control over another peer is not conducive to a healthy work environment. This is supported by Kanter (1993:248) who suggests that the structure of proportions, such as nationality, and the structure of power impacts on the empowerment of staff. A peer, who may be a member of a controlling "proportion" or who has more informal or formal power can lead to conflict or

intimidation of a colleague. Another possible cause for not desiring high DI in this activity is because of the unwillingness to deal with conflict that may arise because of the recommendation made by the SN (bedside RN). Managers (mean=1.89; SD=1.08) express that they would prefer a lower level of involvement for SNs (bedside RNs) than that preferred by the SN (bedside RN) group. This may be attributed to the managers recognizing the possible conflict that may arise if SNs (bedside RNs) had the authority to recommend disciplinary action.

The Mann-Whitney *U* test (*p*=0.547) indicates that there is no statistical significant variance in this result between SNs (bedside RNs) and managers with reference to the activity of recommending disciplinary action for RNs.

Table 4.49: Recommendation of disciplinary action for RNs

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1225.0	0.888				1133.0	0.547
Staff Nurse	139	1.48	0.83			138	2.02	0.99		
Manager	18	1.50	0.86			18	1.89	1.08		

4.5.4.2 Questions 53A and 53B: Selection of unit leader (e.g. head nurse)

Question 53A - ***Actual DI:***

One SN (bedside RN) respondent did not answer this question. There is concordance, as seen in table 4.50, between SNs (bedside RNs) (mean=1.68; SD=1.04) and managers (mean=1.72; SD=1.02) that the actual DI in the selection of a unit leader is low. Both groups agree that selection is primarily controlled by administration/management with minimal SN (bedside RN) involvement. The level of involvement that SNs (bedside RNs) would have in this activity is at the 360 degree interview process implemented in the study hospital, which all manager candidates must go through before being hired.

There is no statistical significance difference between SNs (bedside RNs) and managers in this result (Mann-Whitney *U* test *p*=0.819).

Question 53B - ***Preferred DI:***

One SN (bedside RN) respondent did not answer this question. Table 4.50 indicates that SNs (bedside RNs) (mean=2.46; SD=1.17) have a higher level of preferred DI indicating that

they would prefer to have more SN (bedside RN) involvement in the activity of selecting a unit leader than they currently have but still allowing the primary authority to lie with administration/managers. The managers (mean=2.24; SD=0.97) have a marginally lower rating than the SNs (bedside RNs) suggesting that they believe that this authority for this activity should primarily remain with administration/management with only some SN (bedside RN) involvement. These results could suggest that managers have little confidence in the SN's (bedside RN's) ability to select a qualified manager and that SNs (bedside RNs) may select a manager whose leadership style may not be appropriate to the setting. The SN (bedside RN), however, identifies that they would like to have some involvement but recognize that management/administration have the skills to select an appropriate manager for the unit. Bedside RNs may not want to participate in the interview process either because of a lack of interviewing skills or the feeling of pressure when participating in an interview that is attended by a senior member of staff.

The results indicate no statistical significant difference between the two groups (Mann-Whitney *U* test *p*=0.550).

Table 4.50: Selection of unit leader

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1209.0	0.819				1076.0	0.550
Staff Nurse	139	1.68	1.04			139	2.46	1.17		
Manager	18	1.72	1.02			17	2.24	0.97		

4.5.4.3 Questions 54A and 54B: Review of unit leader's performance

Question 54A - ***Actual DI:***

SNs (bedside RNs) (mean=2.19; SD=1.23) express that they have some involvement in reviewing of a unit leader's performance but the authority of this activity lies primarily with administrative/management (table 4.51). Managers (mean=2.28; SD=1.18) are in concordance with the SN (bedside RN) results. The level of SN (bedside RN) DI is low. Previously the unit leader's performance was reviewed through completion of a 360 degree feedback report that could voluntarily be completed by SNs (bedside RNs) but this process has been discontinued within the last year which may indicate that some staff perceives that they did have some involvement in this activity.

For this activity there is no statistical significant difference (Mann-Whitney *U* test *p*=0.690).

Question 54B - ***Preferred DI:***

One SN (bedside RN) respondent did not answer this question. As seen in table 4.51 the preferred level for involvement in reviewing a unit leader's performance by SNs (bedside RNs) (mean=2.68; SD=1.14) is marginally higher than that of managers (mean=2.61; SD=1.04). Both groups are in concordance that this activity should be shared more by SNs (bedside RNs) and the administration/managers. The low preferred level of DI by the SN (bedside RN) may be attributed to the fear of conflict arising with the manager if the review is not favourable or they may hold a traditional view that the senior person of the manager should have the responsibility for reviewing their performance.

There is no statistical significant difference between SNs (bedside RNs) and managers in this result (Mann-Whitney *U* test *p*=0.704).

Table 4.51: Review of unit leader's performance

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1186.0	0.690				1181.5	0.704
Staff Nurse	140	2.19	1.23			139	2.68	1.14		
Manager	18	2.28	1.18			18	2.61	1.04		

4.5.4.4 Questions 55A and 55B: Recommendation for promotion of staff RNs

Question 55A - ***Actual DI:***

One SN (bedside RN) respondent did not answer this question. As shown by table 4.52 the actual level of DI for SNs (bedside RNs) (mean=1.72; SD=1.01) in the activity of recommending RNs for promotion is low indicating that the administrators/managers have most of the authority with only some SN (bedside RN) involvement. Managers' (mean=1.83; SD=0.92) results indicate that they are in concordance with SN (bedside RN) results. A strict process that promotes equal opportunity is followed in the research hospital when promotions are considered. This promotion process includes a 360 degree interview where one SN (bedside RN) would be a member of the interview team and this is indicative of the low perception of DI in this question because of the limited number of staff who would have participated in the interviewing process.

The Mann-Whitney *U* test indicates that there is no statistical difference between SNs (bedside RNs) and managers (*p*=0.465).

Question 55B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. SNs (bedside RNs) (mean=2.42: SD=1.07) and managers (mean=2.39; SD=0.78) suggest that they would prefer more SN (bedside RN) involvement in recommending promotion but that the authority for this activity should remain primarily with administrators/managers with some SN (bedside RN) involvement (table 4.52).

For this activity there is no statistical significant difference between both groups (Mann-Whitney *U* test *p*=0.888).

Table 4.52: Recommendation for promotion of staff RNs

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1118.0	0.465				1216.0	0.888
Staff Nurse	139	1.72	1.01			138	2.42	1.07		
Manager	18	1.83	0.92			18	2.39	0.78		

4.5.4.5 Questions 56A and 56B: Determination of unit budgetary needs

Question 56A - ***Actual DI:***

One SN (bedside RN) respondent did not answer this question. As seen in table 4.53 the SNs' (bedside RNs') results (mean=1.47; SD=0.85) reveal that their actual involvement in the determination of unit budgetary needs is remarkably low with minimal or no involvement in this activity where administration/managers have most of the authority. Managers' results indicating the actual DI for this activity (mean=1.67; SD=1.03) are slightly higher than those of SNs (bedside RNs) but remain below the score of 2. This signifies that decision making occurs primarily by the administration/management with only some SNs (bedside RNs) involvement. The study hospital does not have a budget allocation at unit level except for an annual review for manpower requirements that is completed by the managers and senior managers. It is possible that some managers may review the staffing requirements with the SNs (bedside RNs).

No statistical significant difference is noted between the two groups (Mann-Whitney *U* test *p*=0.614).

Question 56B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. The results for the preferred level of involvement in the determination of budgetary needs for SNs (bedside RNs) (mean=2.09; SD=0.95) and managers (mean=2.00; SD=0.97) is higher than the actual levels but still remain low indicating that both groups have concordance and agree that the authority for this activity should primarily be with administration/management with some SN (bedside RN) involvement (table 4.53).

For this activity there is no statistical significant difference between both groups (Mann-Whitney *U* test *p*=0.721).

Table 4.53: Determination of budgetary needs

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1159.0	0.614				1177.0	0.721
Staff Nurse	139	1.47	0.85			138	2.09	0.95		
Manager	18	1.67	1.03			18	2.00	0.97		

4.5.4.6 Questions 57A and 57B: Determination of equipment/supply needs

Question 57A - ***Actual DI:***

One SN (bedside RN) respondent did not answer this question. In table 4.54 the SNs (bedside RNs) mean=2.03 (SD=1.04) identifies that they perceive that they have low DI with some actual involvement in the determination of equipment/supply needs but that the authority lies primarily with administration/managers. Managers, who have a mean of 2.44 (SD=0.98), suggest that SNs (bedside RNs) have a higher level of actual involvement in this activity but agree that the authority lies primarily with administrators/managers. At the research hospital strategic equipment is budgeted for the next financial year on an annual basis. Managers have been encouraged to include SNs (bedside RNs) in this process through discussion with the Unit Council and at the unit staff meetings. The principle of shared governance requires that the experts at the point of care must be involved in decision making processes that affect them (Swihart, 2006:3) and this is applicable in this instance

where it is the SN (bedside RN) who knows and understands what equipment and supplies are necessary for them to deliver safe, efficient and effective patient care.

The Mann-Whitney *U* test indicates that there is no statistical difference between SNs (bedside RNs) and managers (p=0.089).

Question 57B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. As indicated by table 4.54 the SNs (bedside RNs) mean of 2.62 (SD=1.01) suggests that they would prefer more involvement in determining equipment/supply needs. However, this result implies that SNs (bedside RNs) are not prepared to commit to absolute sharing of the authority with administrators/managers for this activity. Managers have a mean of 3.00 (SD=0.69) and this clearly indicates that they would prefer equal sharing of the authority for this activity between administration/management and SNs (bedside RNs). Managers recognize the value of having involvement of the experts in this activity but it is interesting that the SNs (bedside RNs) are not willing to take equal authority with the managers in an activity that will obviously benefit them in the delivery of patient care.

No statistical significant difference is noted between the two groups for this activity (Mann-Whitney *U* test p=0.076).

Table 4.54: Determination of equipment/supply needs

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				942.0	0.089				922.0	0.076
Staff Nurse	139	2.03	1.04			138	2.62	1.01		
Manager	18	2.44	0.98			18	3.00	0.69		

Review of subscale 4: Unit Governance and Leadership (tables 4.49 to 4.54)

In review of this fourth subscale of ***unit governance and leadership*** (table 4.49 to table 4.54) the SNs (bedside RNs) indicate a low level of actual SN (bedside RN) involvement in the various activities. Managers perceived that SNs (bedside RNs) have more actual involvement in the activities than SNs (bedside RNs) themselves perceive. The average preferred levels of DI for SNs (bedside RNs) is considerably higher than their perceived actual involvement, while managers are in concordance that administration/managers should

have primary authority with some SN (bedside RN) involvement. No statistical differences were identified in this subscale.

4.5.5 Subscale 5: Quality of support staff (Questions 58-60)

4.5.5.1 Questions 58A and 58B: Development of standards for RN support staff

Question 58A - ***Actual DI:***

Table 4.55 shows that the SNs' (bedside RNs') mean of 1.84 (SD=1.02) is low and suggest that they have minimal involvement in developing standards for support staff but the managers (mean=2.22; SD=0.94) indicates that they perceive that SNs (bedside RNs) have higher levels of actual DI than what they themselves rated. Support staff are considered to be licenced and unlicensed assistant nurses who are not privileged to work as a RN and are referred to as SN3s. The process in the study hospital is that standards are developed by the nursing administration, the nursing quality department and/or the nursing education department but all standards must be approved by the Nursing Practice and Quality Committee (a Central Council) where there are bedside RN representatives but who are few in number.

There is no statistical significant difference (Mann-Whitney *U* test *p*=0.109) between the two groups for the actual involvement in the development of practice standards for RN support staff.

Question 58B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. The SNs (bedside RNs) mean of 2.64 (SD=1.09) suggests that they would prefer more involvement in this activity and would like to have an almost equal authority with administration/management (table 4.55). The managers' mean of 2.89 (SD=0.76) indicates that they are in concordance with SNs (bedside RNs) that the development of practice standards for the support staff should be more equally shared between the two groups. Managers recognize that because the SN3 reports directly to the SN1 or SN2 they should be actively involved in developing standards for the SN3.

The Mann-Whitney *U* test (*p*=0.267) indicates that there is no statistical significant difference between the two groups for the levels of preferred DI for this activity.

Table 4.55: Development of standards for RN support staff

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	Mean	SD	*U*	*p*	n	Mean	SD	*U*	*p*
				967.0	0.109				1041.5	0.267
Staff Nurse	140	1.84	1.02			138	2.64	1.09		
Manager	18	2.22	0.94			18	2.89	0.76		

4.5.5.2 Questions 59A and 59B: Specification of number/type of support staff

Question 59A - ***Actual DI:***

Two SN (bedside RN) respondents did not answer this question. The SN (bedside RN) actual DI mean of 1.87 (SD=1.04) in specifying the number/type of support staff is slightly lower than a true score of 2 (table 4.56) revealing that this group has low involvement in this activity which is primarily controlled by managers. Managers' level of actual involvement (mean=1.94; SD=1.06) indicates concordance with the SN (bedside RN) group. As already discussed in **question 56** at an organizational level there is no or very limited involvement of SNs (bedside RNs) in the budgeting process where this issue would be raised and deliberated but at the unit level informal discussion may take place in a forum such as the Unit Council.

According to the Mann-Whitney *U* test *p*=0.723 there is no statistical significant difference in actual DI between SNs (bedside RNs) and managers in this particular activity.

Question 59B - ***Preferred DI:***

Two SN (bedside RN) respondents did not answer this question. According to table 4.56, the preferred level of DI of SNs (bedside RNs) (mean=2.66; SD=1.08) has increased compared to the actual level, indicating that SNs (bedside RNs) are in favour of having a more equal share of involvement in this activity. Managers' results (mean=2.56; SD=1.06) suggest they are in concordance with the SNs (bedside RNs) and would like to involve SNs (bedside RNs) in more shared decision making sharing in specifying the number/type of support staff. The increase in the SN's (bedside RN's) desire for DI in this activity suggests that they recognize the importance of deciding on the number and type of support staff to assist them in the provision of a high standard and quality of patient care.

There is no significant statistical difference (Mann-Whitney *U* test *p*=0.696) between the SNs (bedside RNs) and the managers' preferred levels of decisional involvement for this activity.

Table 4.56: Specification of number/type of support staff

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1177.5	0.723				1171.0	0.696
Staff Nurse	138	1.87	1.04			138	2.66	1.08		
Manager	18	1.94	1.06			18	2.56	1.06		

4.5.5.3 Questions 60A and 60B: Monitoring of standards for RN support staff

Question 60 A ***- Actual DI:***

One SN (bedside RN) respondent did not answer this question. The actual DI of SNs (bedside RNs) mean=2 (SD=1.01) clearly indicates that SNs (bedside RNs) have low involvement in the monitoring of standards for the RN support staff. Managers have a slightly higher result of mean=2.17 (SD=0.79) as seen in table 4.57.

There is no statistical significant variance (Mann-Whitney *U* test *p*=0.341) identified between the two groups for the actual DI for this activity.

Question 60B - ***Preferred DI:***

The preferred level of involvement in the monitoring of standards for RN staff by SNs (bedside RNs) is higher (mean=2.72; SD=0.97) than their actual level of involvement. Managers indicate (mean=2.56; SD=0.70) that they would prefer less DI for the SNs (bedside RNs) than they themselves would prefer (table 4.57).

There is no statistical difference between the preferred levels of DI in this activity between SNs (bedside RNs) and managers (Mann-Whitney *U* test *p*=0.485).

Table 4.57: Monitoring of standards for support RN staff

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1077.5	0.341				1132.0	0.485
Staff Nurse	139	2.00	1.01			140	2.72	0.97		
Manager	18	2.17	0.79			18	2.56	0.70		

Review of subscale 5: Quality of Support Staff Practice (tables 4.55 to 4.57)

The overall review of subscale 5 for ***quality of support staff practice*** (tables 4.55 – 4.57) depicts that SNs (bedside RNs) have a low level of actual decisional involvement with only some authority while administrators/managers have primarily more authority in this group of activities. Managers overall, indicate that they believe that there is more involvement by SNs (bedside RNs) but agree that the primary authority lies with administrators/managers. In all these activities there is no statistical significant difference between SNs (bedside RNs) and managers.

The overall preferred level of DI in subscale 5 (tables 4.53–4.55) is higher in comparison to the actual levels for both SNs (bedside RNs) and managers. There were no statistical differences between SNs (bedside RNs) and managers in this subsection.

4.5.6 Subscale 6: Collaboration/liaison activities (Questions 61-63)

4.5.6.1 Questions 61A and 61B: Liaison with other departments re: patient care

Question 61A - ***Actual DI:***

Six SN (bedside RN) respondents did not answer this question. As depicted in table 4.58 the SNs (bedside RNs) mean of 2.47 (SD=1.12) indicates that their actual DI in liaising with other departments regarding patient care is almost midway between equally sharing the authority and having administrator/managers take primary authority with only some SN (bedside RN) involvement. The managers mean is 3.00 (SD=0.84) thus indicating that they perceive that the actual level of DI is shared equally with SNs (bedside RNs). A large number of SNs (bedside RNs) did not answer this question which is of interest because liaison with other departments especially regarding patient care is considered to be a part of the SNs' (bedside RNs') responsibility. The low result suggests that this question may have been interpreted to include liaison activities and the resolving of conflict between departments which is usually the manager's responsibility.

There is no statistical significant difference between SNs (bedside RNs) and managers in the actual involvement in this activity (Mann-Whitney *U* test p=0.054).

Question 61B - ***Preferred DI:***

As seen in table 4.58 four SN (bedside RN) respondents did not answer this question. There is concordance between the SNs (bedside RNs) (mean=2.98; SD=0.97) and the managers (mean=3.17; SD=0.79) that this activity should preferably be equally shared between both groups.

There is no statistical significant difference between SNs (bedside RNs) and managers in the preferred involvement in this activity (Mann-Whitney *U* test *p*=0.555).

Table 4.58: Liaison with other departments re: patient care

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				868.0	0.054				1118.0	0.555
Staff Nurse	134	2.47	1.12			136	2.98	0.97		
Manager	18	3.00	0.84			18	3.17	0.79		

4.5.6.2 Questions 62A and 62B: Relations with physicians re: patient care

Question 62A - ***Actual DI:***

Two SN (bedside RN) respondents did not answer this question. There is concordance between the SNs (bedside RNs) (mean=3.07; SD=1.12) and the managers (mean=3.18; SD=0.81) that the actual level of DI concerning relations with physicians regarding patient care is shared equally by both groups (table 4.59). The Unit Council is the forum in the study hospital that has the authority to address issues that impact on the work environment and physician related issues is one aspect that may be presented to the Unit Council for resolution. These findings are supported by Laschinger, Almost and Tuer-Hodes (2003:420) who suggest that greater access to workplace empowerment structures positively affects the nurse-physician relationship.

There is no statistical significant difference between SNs (bedside RNs) and managers in the actual involvement in this activity (Mann-Whitney *U* test *p*=0.846).

Question 62B - ***Preferred DI:***

One SN (bedside RN) respondent did not answer this question. As depicted in table 4.59 both SNs (bedside RNs) (mean=3.46; SD=0.83) and managers (mean=3.44; SD=0.78) indicate a higher preferred level for DI for this activity for the SNs (bedside RNs). This result is situated between a score of 3 and 4 suggesting that SNs (bedside RNs) show an interest in taking more authority for this activity than any other of the previously discussed activities. This may imply that the SNs (bedside RNs) feel comfortable enough with the current level and the type of interactions they experience with physicians and therefor are more confident to take on more authority to deal with the physicians with only minimal management input. This activity is directly linked to patient care and indicates that SNs (bedside RNs) perceive

that they have higher decisional involvement in patient care related decisions than they have over operational decisions. These findings are supported by the findings from Mrayyan's (2004:331) study of autonomy. Even though this activity scored at the level of shared decision making in the DIS, the impact of physicians was identified as a theme in **question 64** (**table 4.64**) where the respondents alluded to physicians not supporting an environment of shared decision making. This theme is continued in **question 65** (**table 4.65**) where the nurse-physician relationships are identified by the respondents as a factor that negatively impacts on the involvement of nurses in decision making. These comments may be perceived as negative but in essence they indicate that the respondents are striving to have shared decision making and in the context of decisional involvement, this is seen to be a positive step towards staff choosing to be involved in the decision making process, despite hindrances.

There is no statistical significant difference between SNs (bedside RNs) and managers in the preferred DI in this activity (Mann-Whitney *U* test *p*=0.949).

Table 4.59: Relations with physicians re: patient care

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1138.0	0.846				1239.0	0.949
Staff Nurse	138	3.07	1.12			139	3.46	0.83		
Manager	17	3.18	0.81			18	3.44	0.78		

4.5.6.3 Questions 63A AND 63B: Conflict resolution among RN staff on unit

Question 63A - ***Actual DI:***

Three SN (bedside RN) respondents did not answer this question. SNs (bedside RNs) (mean=2.65; SD=1.23) indicated in table 4.60 that they perceive that they have a higher level of actual involvement in conflict resolution among the RN staff in the unit than what managers perceive (mean=2.41; SD=1.00). The SNs' (bedside RNs') results suggest that the authority for conflict resolution is almost equally shared between themselves and the administrators/managers, while managers have a lower level which suggests that the administrators/managers have more involvement with only some involvement by SNs (bedside RNs). These results could be interpreted to mean that the SNs (bedside RNs) are involved in more conflict resolution than the manager is aware of.

There is no statistical significant difference between SNs (bedside RNs) and managers in the actual involvement in this activity (Mann-Whitney *U* test *p*=0.473).

Question 63B - ***Preferred DI:***

Four SN (bedside RN) respondents did not answer this question. Table 4.60 indicates that the SNs (bedside RNs) (mean=3.17; SD=1.02) and managers (mean=3.06; SD=0.94) have concordance that conflict resolution among the RNs should be equally shared by both groups. Having a higher preferred level of DI suggests that the SN (bedside RN) group recognizes the importance of resolving conflict amongst themselves that will improve staff relations and ultimately impact on improving patient care.

There is no statistical significant difference between SNs (bedside RNs) and managers in the preferred involvement in this activity (Mann-Whitney *U* test *p*=0.776).

Table 4.60: Conflict resolution among RN staff on unit

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				1039.5	0.473				1173.0	0.776
Staff Nurse	137	2.65	1.23			136	3.17	1.02		
Manager	17	2.41	1.00			18	3.06	0.94		

Review of subscale 6: Collaboration/Liaison Activities (tables 4.58 to 4.60)

Overall, in this subscale 6 (tables 4.58-4.60) regarding ***collaboration/liaison activities*** the SNs (bedside RNs) scores for actual DI are generally higher than in any of the other subscales. Managers are in concordance with SNs (bedside RNs) that there is more equal authority shared between both groups than there has been identified in the other subscales. The preferred levels for both groups in this subscale are also considerably higher than in any of the other subscales. There were no statistical differences identified in this subscale.

4.5.7 Overall Results Review for Decisional Involvement Scale

4.5.7.1 Statistical analysis by nursing position

A statistically significant difference was identified (table 4.61) in the overall comparison of the SNs (bedside RNs) actual and preferred levels of decisional involvement (ANOVA p=0.000). These findings clearly indicate that the SNs (bedside RNs) desire more decisional involvement than what they currently have in all the activities tested. Similarly, the managers'

overall results indicated that there was also a statistically significant difference between their actual and preferred levels of decisional involvement (ANOVA p=0.042). These findings suggest that the managers are willing to release some of their control of authority to the SNs (bedside RNs).

Table 4.61: Statistical differences in actual and preferred levels of decisional involvement by nursing position

Variable	SN (bedside RN) (p)	Manager (p)
Q.43 Scheduling	0.000	0.024
Q.44 Unit coverage	0.000	0.185
Q.45 Develop practice standards	0.000	0.019
Q.46 Definition scope of practice	0.000	0.016
Q.47 Monitoring RN standards	0.000	0.076
Q.48 Evaluation RN standards	0.000	0.005
Q.49 Recruitment of RNs	0.000	0.055
Q.50 Interview of RNs	0.000	0.028
Q.51 Selection of RNs	0.000	0.048
Q.52 Recommendation disciplinary action	0.000	0.090
Q.53 Selection unit leader	0.000	0.041
Q.54 Review unit leader performance	0.000	0.055
Q.55 Recommendation for promotion	0.000	0.008
Q.56 Budgetary needs	0.000	0.029
Q.57 Equipment/supply needs	0.000	0.014
Q.58 Standards for support staff	0.000	0.014
Q.59 Specify number of support staff	0.000	0.012
Q.60 Monitoring standards support staff	0.000	0.015
Q.61 Liaison re: patient care	0.000	0.083
Q.62 Physician relations re: patient care	0.000	0.056
Q.63 Conflict resolution among RNs	0.000	0.012
OVERALL	**0.000**	**0.042**

4.5.7.2 Actual DI

As indicated in table 4.62 the mean overall rating of the SN's (bedside RN's) actual DI is mean=1.98 (*SD*=0.64). This result, using the scale provided, indicates that the SNs (bedside RNs) perceive that they have low DI and that the authority for decision making is held primarily by administration/ management. The manager mean overall score for actual DI as illustrated in table 4.62 was 2.20 with a (*SD*=0.61). The findings signify that managers are in concordance with the SNs (bedside RNs) that they have a low DI level but their score of the SN (bedside RN) DI is slightly higher than the SNs (bedside RNs) score of themselves.

The overall result suggests that both groups are in concordance with the level of actual DI. There was no significant statistical variance between the SNs (bedside RNs) and managers' results (Mann–Whitney *U* test *p*=0.126).

4.5.7.3 Preferred DI

As seen in table 4.62 the mean overall rating for SN (bedside RN) preferred DI is 2.54 (SD=0.64). A score of 3 would indicate that the authority for decision making is equally shared between SNs (bedside RNs) and managers.

As indicated in table 4.62 the mean overall rating for managers' preferred DI was 2.67 (*SD*=0.38). The managers' results suggest that they would be in favour of relinquishing some of their decision making authority to have a more equal share with the SNs (bedside RNs).

The overall result for preferred DI shows that SNs (bedside RNs) and managers desire more shared decision making authority for the SN (bedside RN) than what currently is the situation. There was no significant statistical variance between the SNs (bedside RNs) and managers' results (Mann–Whitney *U* test *p*=0.188).

Table 4.62: Overall review for Decisional Involvement Scale

	A. Actual Decisional Involvement					B. Preferred Decisional Involvement				
	n	**Mean**	**SD**	***U***	***p***	**n**	**Mean**	**SD**	***U***	***p***
				980.0	0.126				1019.0	0.188
Staff Nurse	140	1.98	0.64			140	2.54	0.64		
Manager	18	2.20	0.61			18	2.67	0.38		

The SNs (bedside RNs) and nurse managers have diverse views regarding their perceptions of actual and preferred decisional involvement of the SNs (bedside RNs) and this is supported by Hess (2011:239). On review of all the questions it is apparent that nurse managers consistently viewed SNs (bedside RNs) to have higher decisional involvement than that perceived by the SNs (bedside RNs).

4.6 SECTION D: OPEN-ENDED QUESTIONS

Question 64 comprised of two sections where the first asked respondents to select 'yes' or 'no' in answer to the question posed and the second section was an open-ended question to which participants could respond to as they felt appropriate.

4.6.1 Question 64: section 1 - Do you believe that your work environment is conducive to shared decision making? Give reasons for your answer.

One SN (bedside RN) selected both 'yes' and 'no' to this question so this respondent's answer was considered as spoiled and excluded from the final analysis. Thirteen (13) staff did not answer this question and it is of interest that all of the respondents who did not select 'yes' or 'no' to this question were SNs (bedside RNs). One possible reason for not answering the question was because the question is on the last page. On the same page is another open-ended question and reviewing the 12 respondent's questionnaires who did not answer question 64 it was identified that 10 out of the 12 respondents also did not answer the second question, question 65. One respondent's page was missing from the questionnaire and one respondent gave comments but did not select the choice of 'yes' or 'no'.

As indicated by table 4.63, the majority of respondents 76.6% (n=111) agree that their work environment is conducive to shared decision making. On secondary analysis both SNs (bedside RNs) 76.4% (n=97) and managers 77.8% (n=14) are in agreement that their work environment is conducive to shared decision making (figure 4.15). A previous question regarding shared governance as asked in **question 19 (table 4.16**) requested the respondents to choose 'yes' or 'no' if they believe that an environment that encourages decision making impacts positively on their involvement in decision making and the majority of respondents 77.1% (n=121) were in agreement that it does. Only one (1) respondent did not answer **question 19.** Shared decision making is only one element of decisional involvement but the results from this and question 19 suggest that managers are involving the SNs (bedside RNs) in decisions regarding issues that impact on them. These results also suggest that the shared governance structures that have been established for shared decision making is effective in the promotion of shared decision making between managers and SNs (bedside RNs).

Table 4.63: Shared decision making environment (n=145)

Category	Frequency (f)	Percentage (%)
No:	34	23.4
Yes:	111	76.6
TOTAL:	**n=145**	**100.0**

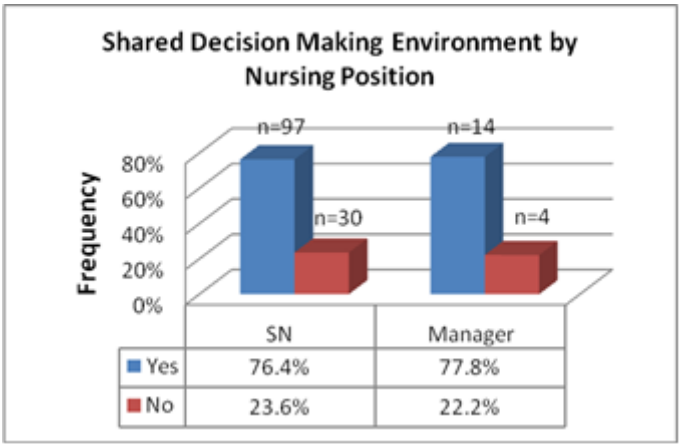

Figure 4.15: Shared decision making environment by nursing position (n=145)

4.6.2 Question 64: section 2 - Do you believe that your work environment is conducive to shared decision making? Give reasons for your answer.

Question 64: section 2 was formulated to gain information to supplement the quantitative data obtained from the questionnaire. There were 70.5% (n=110) respondents who gave their opinion, while 29.5% (n=46) respondents did not answer this question. The information specific to shared decision making was identified and grouped into core themes which are indicated in bold in the text. The frequency of the opinions given by the respondents is also noted in the text. The most appropriate quotes from the respondents have been selected to support the core themes. Some respondents gave more than one comment regarding their perception of whether they perceive their work environment as conducive to shared decision making.

Table 4.64: Factors impacting on shared decision making environment

	Yes	No
Theme	**Frequency (f)**	**Frequency (f)**
Empowerment	30	13
Unit Councils	23	3
Management	14	2
RN demographics	3	7
Physicians relationships	1	7
Staff participation	6	1
Seniority	3	2
Collaboration	3	0

The following themes emerged from the open-ended questions:

4.6.2.1 Empowerment

A large number of the respondents (n=43) identified ***empowerment*** as the reason why they perceive their work environment to be either conducive or not conducive to shared decision making. On further review 69.8% (n=30) of the respondents answered 'yes' while 30.2% (n=13) of the respondents selected 'no' in answer to section 1 of this question.

Responses from the respondents who answered 'yes' included:

- *'Nurses involved in all unit decisions'*
- *'…management have moved from being the final decision makers to being the facilitator in the unit';*
- *'…opportunity to be involved in the decision making in spite of the workload…';*
- *'…we share in making schedule of the nurses assignments and we are the one who will choose the unit council leader, resolve our problem and conflict which we face in the department'.*

Responses from the respondents who answered 'no' included:

- *'Staff are encouraged to shared decision making by lip service only, not practiced';*
- *'Put into writing but not into full practice…';*
- *'…because sometimes decisions made without consulting the concerned people OR the decision is that we need to adopt it' suggest that they are not fully empowered to share decision making yet.*

4.6.2.2 Unit Councils

Unit Councils was identified as a common theme in response to the question as evidenced by (n=26) responses of which (n=3) selected 'no' in answer to section 1 of this question. The Unit Council (UC) is considered to be a formal empowerment structure within Kanter's' Theory of Structural Empowerment and the comments given are supportive of **question 42** (**table 4.39**) regarding UC authority for decision making as illustrated by the following responses from the SNs (bedside RNs):

- *'Through Unit Council Meetings, as a SN1 I am finally sharing in decision making that affect[s] my [n]ursing practice';*
- *'… we have [a] unit council where primary nurses have their own decision making…';*
- *'… the Unit Council meeting is helpful to make new decisions and discuss the concerns of practice and work environment, I feel that it is a better place for shared decision making'.*

The managers are in agreement and responded as follows:

- *'Active UC with control over the decisions for practice' and*
- *'Staff forward suggestions to UC re: 1. practice plan for improvement 2. Education and career developments'.*

A number of the respondents agreed that the Unit Council encouraged empowerment but highlighted that the authority for decision making is not always enacted as indicated by the following responses from the SNs (bedside RNs):

- *'There is not always the authority for staff nurses to implement results or decisions taken within unit council';*
- *'Unit council is the best example for shared decision making… But final decisions of course from [m]anagement' and*
- *'We have… [a] unit council also, so we are also included in decision making, but most of the time we agree with all decisions made by only administration'; Unit Council is supporting decisions made by staff under certain limits'.*
- *One manager echoes the concerns of the SNs (bedside RNs) and states that 'UC is where the shared decision making is very apparent and working well. But as a manager I still feel that nursing management don't support the environment for shared decision making…'*

4.6.2.3 Management

The respondents (n=16) of whom (n=14) selected 'yes' in response to section 1 of the question indicated that ***management*** impacts on the environment for shared decision making as is indicated in the following responses from the SNs (bedside RNs). It is of interest that no managers identified management as a reason impacting on shared decision making.These comments are supportive of **question 25 (table 4.22)** that asks if an encouraging manager fosters involvement in decision making.

- *'Our head nurse can praise when praise is due which makes staff to be more active to decide for their practice';*
- *'When some of the staff are not willing to be part of the decision making our manager is very supportive…'*
- *'I strongly believe that managers should motivate and encourage nurses to participate in decision making'.*
- One comment by a respondent recognizes that management leadership styles impact on shared decision making by making the following comment:*'…in my opinion I can see that managers styles can limit this opportunity and it delay[s] the establishment [of] a well conductive work environment'.*

- Another respondent recognizes that there are different levels of management authority that impacts on shared decision making and states: *'My direct manager support[s] sharing [of] decision making. Sometimes high level managers decide with disregard to staff decisions or maybe without knowing the staff feedback'*.

4.6.2.4 RN Demographics

RN demographics were suggested by (n=10) of the respondents as a reason impacting on a conducive environment for shared decision making and is supportive. On further analysis (n=7) of the respondents answered 'no' in response to section 1 of this question. Responses include the following comments regarding nationality, culture and language:

- *'Somehow nationality and diverse culture will impact on involvement to share in decision making';*
- *'… as well as language and culture';*
- *'Environment is not really conducive to shared decision making due to the cultural differences'*
- *'I don't believe that my work environment is conducive to shared decision making because majority of staff from same nationality speaks their own language behind, which I couldn't understand and they argue for their decisions which I couldn't object due to insufficient support from my side'.*
- A manager identifies that different nationalities impact on a conducive environment due to a unique method of salary allocation within the different nationality groups in the study hospital and states: *'Nurses who are paid less than others are refusing to make decisions while other higher salaried staff are not willing to participate'.*

4.6.2.5 Physicians

Respondents (n=8) identified that ***physician*****s** have an influence on an environment that is conducive to shared decision making. On further analysis of this theme only (n=1) of the respondents answered 'yes' in response to section 1 of this question asking if they perceive their work environment to be conducive to shared decision making.

Respondents who answered 'no' to section 1 of this question identified that:

- *'…physicians make their decisions about operational issues and forget to include nursing in the discussion plus decisions' and*
- *'MDs make all the decisions regarding patient care in the immediate care setting and disregard and belittle my nursing assessment or opinion'.*

4.6.2.6 Staff participation

Respondents (n=7), of which (n=6) responded 'yes' to section 1 of this question, identify that ***staff participation*** is a factor that impacts on a conducive environment for shared decision making as illustrated by the following comments:

- *'…most of the staff is willing to accept changes, and giving their opinion' and 'participation of every staff is vital in decision making'.*
- Conversely one respondent stated that the *'...majority of the staff are just so non-cooperative when it comes to unit decision making'*.

4.6.2.7 Seniority

A number of respondents (n=5), of which (n=3) selected 'no' in response to section 1 of this question, indicated that the ***seniority*** of the nurse affects the shared decision making environment as illustrated by the following comments and gives insight into the findings of **question 17** (**table 4.14**) and **question 35** (**table 4.32**):

- *'Seniority - junior staff usually go with the flow if they see that the decision is initiated by senior staff';*
- *'…if you are not senior your decision will not be count[ed] and the seniors will make you feel like you don't know what you are talking about (from the staff nurses)'*
- *'…seniority would take place but it was never a problem as to my experience and there were some juniors [to] willing to share their decisions'.*

4.6.2.8 Collaboration

Collaboration, a characteristic of decisional involvement was identified by (n=3) respondents to affect shared decision making. All of the respondents answered 'yes' in response to section 1 of this question asking if they perceive their work environment to be conducive to shared decision making.

- *'Everyone should collaborate with each other in terms of decision making in order to provide the best care to our client' and 'In my work environment shared decision making in a multi-disciplinary approach is practiced'.*

4.6.3 Question 65: Please feel free to add further comments regarding those factors, both positive and negative, that impact on your participation in decision making.

Question 65 was formulated to gain information to supplement the quantitative data obtained from the questionnaire. There were (n=56) respondents who gave comments to this question. Core themes were identified and are indicated in bold in the text. The frequency of the opinions given by the respondents is also noted in the text. The most appropriate quotes from the respondents have been selected to support the core themes. Some respondents

gave more than one comment regarding their perception of what factors impact on their participation in decision making.

Table 4.65: Factors impacting on participation in decision making

Theme	Frequency (f)
Empowerment	24
Staff participation	8
RN demographics	7
Nurse-physician relationship	5
Seniority	5
Communication	4
Time	4
Unprofessional behaviour	4
Managerial Support	4
Equality	1

4.6.3.1 Empowerment

Respondents (n=24) identified ***empowerment*** as a factor that affects their participation in decision making. Empowerment is one of the defining characteristics necessary for decisional involvement to be effectively implemented (Kowalik & Yoder, 2010:260).

Positive comments regarding this empowerment are illustrated as follows*:*

- *'As part of the decision making they are letting us to decide what are the appropriate standards of practice in relation to patient care';*
- *'We have a unit council, and a strong manager who encourages us for an active involvement - on our unit activities, as well decision making for a better patient care';*
- *'having being given an opportunity to work in partnership with the management in every unit activity [and]/or project has a positive impact on me as an autonomous nurse. This further motivates me to show up my existing talents and knowledge…because we own the process';*
- *'staff are involved [and] being consulted on issues that impact on their nursing practice'.*

Negative responses regarding empowerment as a factor affecting participation with particular reference to managers not relinquishing control of decision making are illustrated by the following comments:

- *'As most of the organizations the decisions in some of the areas are only made by administration/management, we have limitations to participate fully in decision making';*
- *'Unit council run by unit manager instead of staff at ground level';*

- *'Mostly the decision being done in unit council will just be implemented according to nurse manager decision so that in that case the nurse manager decides not the council'.*

One comment that illustrates both the positive and negative factors is illustrated as follows:

- *'SN can voice their feeling freely…unit council agendas is open for all unit staff. But final decision will be made by managers'.*

4.6.3.2 Staff participation

Staff participation was identified by (n=8) respondents as a factor that impacts on their participation in decision making. A pre-requisite for decisional involvement is for the nurse to choose to be involved in the decision making process (Kowalik & Yoder, 2010:262). The choice not to participate is illustrated by the following respondents' comments:

- *'Some colleagues are not participating, not interested [and] mostly ignoring';*
- *'I think you should feel that you are a part of any decision making, so you will be willing to participate';*
- *'group coordination [and] understanding…uncooperative [t]eam participation .. lack of interest';*
- *'when staff shows interest and the process of decision making takes too long there is a loss of interest in the participation'.*

4.6.3.3 RN Demographics

RN demographics were identified by (n=7) respondents as a factor that impacts on their participation in decision making as indicated by the following comments:

- *'employee cultures';*
- *Nationality discrimination negatively impact the participation in decision making';*
- *'Nationality!!!';*
- *'For me, nationality is one of the top most factors that influence staff in taking part in decision making';*
- *'Also I feel when new to this country/culture it is difficult to be involved in all aspects of decision making appropriately as knowledge is limited' and 'language barrier'.*

4.6.3.4 Nurse-Physician Relationship

Respondents (n=5) suggest that the ***nurse-physician relationship*** has an impact on their participation in decision making as identified in the following comments:

- *'Some of the doctor[s], they …do not trust ... the nurses... Some of them more likely to hear[d] opinion[s] or suggestions or recommendations from the western nurses';*

- *'…working with doctors who have no respect for my nursing ability, education level, or interest in patient outcome…';*
- *'I feel free to suggest and express my opinion to the health team…'.*

4.6.3.5 Seniority

A number of respondents (n=5) identified ***seniority*** as a factor that impacts on their participation in decision making as illustrated by the following:

- *'…seniorities' decision always prevail…';*
- *'Seniority issues plays a vital role...';*
- *'…junior staffs where there thoughts are not taken into consideration just because of the years of experience in the unit'.*

It is interesting to note that the potential factor of seniority impacting on decisional involvement was tested in **question 17** (**table 4.14**) and **question 35** (**table 4.32)** and found not to impact on the respondents' involvement in decision making.

4.6.3.6 Communication

Communication was identified by (n=4) respondents as a factor that impacts on their participation in decision making as illustrated by the following comments:

- Negatively perceived comments are described as *'ineffective ways of communication …';*
- *'Negative factor that usually impact[s] decision making usually [is] poor communication…'*;
- A positively perceived comment describes *'Communication or open communication…often resulted in a positive outcome…'.*

4.6.3.7 Time

Respondents (n=4) identified that ***time*** is a factor that impacts on their participation in decision making. All respondents were from the manager group and their comments are as follows:

- *'Time consuming';*
- *'Delay[ed] in address[ing] issues';*
- *'decision making often delays implementation as it takes longer to get decisions'.*

4.6.3.8 Unprofessional behaviour

A small number of SN (bedside RN) respondents (n=4) identified ***unprofessional behaviour*** as a factor that impacts on their participation in decision making as illustrated by the following comments:

- *'…problem behavio[u]rs such as workplace bullying, disruptive behaviour and disrespect can impact somebody to participate in decision making';*
- *'Victimization after voicing your concerns';*
- *'…intimidation…';*
- *'…improper behavio[u]r among RN, (bullying)…'.*

This is an unexpected finding. No supporting literature could be identified linking unprofessional behaviour to decisional involvement. **Question 20** (**table 4.17**) tests whether a positive relationship with colleagues impacts on decisional involvement and the majority of responses indicate that unprofessional behaviour is viewed as a negative factor impacting on decisional involvement.

4.6.3.9 Managerial Support

Managerial support identified as factor and tested in **question 25 (table 4.22)** is indicated by (n=4) respondents as a factor that impacts on their participation in decision making as illustrated by the following comments:

- *'Positive factors: Support from managers. Negative factors Lack of motivation from managers';*
- *'Manager and senior staff should give support and make staff feel comfortable enough to give opinion and suggestion. That will help to for the decision making process'.*

4.6.3.10 Equality

One respondent (n=1) identified ***equality*** as a factor that affects their participation in decision making as described by the following comment:

- *'…would feel good and relaxed if at all times people would be treated the same way irrespective of the gender, social status and race'.*

4.6.3.11 Other

A number of comments not relevant to the question but of relevance to the study were given by the respondents regarding the benefits and outcomes of participation in decision making as illustrated by the following remarks:

- *'Being part in decision making helps my professional growth';*
- *'I gained self-confidence and now trying to influence others…self-satisfaction';*
- *'In making schedules staff nurses should involve themselves in doing the schedule'; for equal distribution of decision making';*
- *'Staff tend to comply with the decisions they make';*
- *'It increase[s] productivity and quality of care' and*

- *'the staff feels valued and that increase[s] their job satisfaction'.*

4.7 SUMMARY OF MISSING DATA

Table 4.66 and table 4.67 are a summary of the numbers of respondents who did not respond to individual questions. Missing data is considered to be a common problem in quantitative research studies (Peugh & Enders, 2004:5252). Plichta and Garzon (2009:411) suggest that data may be missing because the participants refused to answer a question or because the question did not apply to the participants. Another possible reason in this study may be that a large number of respondents do not speak English as a first language and may have chosen not to answer because they did not understand a question.

Table 4.66: Numbers of missing data for Sections A and B

Variable	Number of missing data (n)
SECTION A: DEMOGRAPHIC DATA	
Q.2 Gender	3
Q.3 Nationality	0
Q.4 Language	0
Q.5 Highest Educational Level	0
Q.6 Area of work	1
Q.7 Divisional Council	2
Q.8 Nursing Position	0
Q.9A Years worked as RN	7
Q.9B Years worked as RN in hospital	3
Q.9C Years worked as RN in unit	0
Q.10 Previous Council member	3
Q.11 Current Council member	2
Q.12 Member of committee/task force	5
SECTION B: FACTORS IMPACTING ON DECISION MAKING	
Q.13 Gender	0
Q.14 Opinion	0
Q.15 Education level	0
Q.16 Personal interest	0
Q.17 Seniority	0
Q.18 Level of experience	0
Q.19 Encouraging environment	1
Q.20 Positive relationships	0
Q.21 Nationality	1
Q.22 Limited knowledge	2
Q.23 Role in organization	1
Q.24 Shared governance culture	1
Q.25 Encouraging manager	1
Q.26 Autonomous	4

Q.27 Empowered	3
Q.28 Accountable	1
Q.29 Experience gives confidence	0
Q.30 Peer pressure	0
Q.31 Culture	1
Q.32 Make a decision not agreed with	1
Q.33 Confident to voice opinion	0
Q.34 choose not to participate	0
Q.35 Intimidated	0
Q.36 Invited to decision making meetings	0
Q.37 Informed of decisions	0
Q.38 Adequate time	2
Q.39 Able to attend meetings	0
Q.40 Decisions are valued	1
Q.41 Comfortable to disagree with manager	1
Q.42 Authority	0

Table 4.67: Numbers of missing data for Section C:DIS

	SN (bedside RN)		Manager	
Variable	Actual DI (n)	Preferred DI (n)	Actual DI (n)	Preferred DI (n)
Q.43 Scheduling	0	2	0	0
Q.44 Unit coverage	2	1	0	0
Q.45 Develop practice standards	2	5	0	0
Q.46 Definition scope of practice	1	2	0	0
Q.47 Monitoring RN standards	2	1	0	0
Q.48 Evaluation RN standards	0	2	0	0
Q.49 Recruitment of RNs	0	0	0	0
Q.50 Interview of RNs	0	1	0	0
Q.51 Selection of RNs	0	1	0	0
Q.52 Recommendation disciplinary action	1	2	0	0
Q.53 Selection unit leader	1	1	0	1
Q.54 Review unit leader performance	0	1	0	0
Q.55 Recommendation for promotion	1	2	0	0
Q.56 Budgetary needs	1	2	0	0
Q.57 Equipment/supply needs	1	2	0	0
Q.58 Standards for support staff	0	2	0	0
Q.59 Specify number of support staff	2	2	0	0
Q.60 Monitoring standards support staff	2	0	0	0
Q.61 Liaison re: patient care	6	0	0	0
Q.62 Physician relations re: patient care	2	1	1	0
Q.63 Conflict resolution among RNs	3	4	1	0

4.8 SUMMARY OF SIGNIFICANT FINDINGS

Tables 4.68, 4.69 and 4.70 are a summary of the statistical significant findings identified throughout the data analysis. The findings in tables 4.68 and 4.69 indicate the significant statistical differences between the bedside RN and Manager groups. Table 4.70 shows the significant statistical differences by each nursing position.

Table 4.68: Statistical Significant Differences in Sections A and B

Variable	p
SECTION A: DEMOGRAPHIC DATA	
Q.9A Years worked as RN	0.007
SECTION B: FACTORS IMPACTING ON DECISION MAKING	
Q.24 Shared governance culture	0.003
Q.27 Empowered	0.025

Table 4.69: Statistical Significant Differences in Section C: DIS

Variable	Actual DI (p)	Preferred DI (p)
Q.49 Recruitment of RNs	0.020	**n/s***
Q.50 Interview of RNs	0.011	0.003
Q.51 Selection of RNs	0.028	0.046

***n/s – not statistically different**

Table 4.70: Statistical Significant Differences in Actual and Preferred levels of Decisional Involvement by Nursing Position

Variable	SN (bedside RN) (p)	Manager (p)
OVERALL	**0.000**	**0.042**

4.9 SUMMARY

The researcher hypothesized that the implementation of an empowering structure of shared governance should have given the bedside RNs a high level of actual decisional involvement. The findings of this study indicate that the actual decisional involvement of bedside RNs is low, regardless of an empowering structure being in place, thus refuting the hypothesis. In addition, even though the bedside RNs indicated that they perceive that there is a culture of shared decision making and that they are generally willing to participate in the

decision making process, their actual level of decisional involvement falls short of achieving full shared decision making between the bedside RN and manager. These findings suggest, and are supported by Kramer et al. (2008:540-541), that the implementation of an empowering structure alone does not contribute to a significantly higher level of decisional involvement but are contrary to the main tenet of Kanter's Theory of Structural Empowerment (1977, 1993) that the empowerment of individuals is influenced by organizational structures and not by personality differences. It is important that other independent variables, such as those identified in this study and personality differences, be examined specifically within the Middle Eastern environment and culture to assist in identifying what are those factors that impact on empowerment in decisional involvement.

However, it is one respondent's comment that summed up the positive outcome of decisional involvement stating:

'I gained self-confidence and [am] now trying to influence others…[I have]self-satisfaction'.

4.10 CONCLUSION

The results of the study were discussed in this chapter. The research question that asks "What is the decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia?'' has been successfully answered.

The following objectives have been achieved:

- The actual and preferred levels of decisional involvement of SNs bedside RNs) has been identified to be low.
- In the overall result for the DIS there was no statistical significant difference identified between SNs (bedside RNs) and nurse managers, however in the subscale of recruitment there were some statistical significant differences identified.
- The factors that impact on decisional involvement were identified and tested. The open-ended questions provided further information to supplement the data obtained in the study.

In Chapter 5 the conclusions of the study are discussed and recommendations are made.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this study was to explore decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia. The factors that impact on the decisional involvement of nurses were also explored. In chapter 5 conclusions that have been drawn from the results of this study are presented and discussed according to the set objectives for the study. Limitations of the study are identified and discussed followed by a presentation of recommendations derived from this study.

5.2 CONCLUSIONS

The aim of this study was to explore the decisional involvement of RNs in a tertiary hospital in Saudi Arabia. The discussion is presented according to the main findings of the demographic data and the objectives that were set for this study namely to

- determine SNs' (bedside RNs') actual and preferred level of decisional involvement
- compare whether there are statistical differences between staff nurses' (bedside RNs') level of decisional involvement and nurse managers' perceptions of the staff nurses' (bedside RNs') level of decisional involvement.
- identify the factors that impact on the decisional involvement of registered nurses.

5.2.1 Demographic Findings

The following are the main findings of the demographic information as gathered from the empirical findings of this study. The majority of respondents (88.6%) were SNs (bedside RNs) and 11.4% were managers. Females were identified to be the majority of respondents (91%), although it is important to note that the number of male respondents from the manager group consisted of 27.8% of the total manager respondents. The respondents were predominantly aged between 25-45 years old (73.5%). Within the nationality mix the Filipinos had the largest response rate of (50.0%). English, as a first language, was spoken by 31% of the respondents. The majority of respondents (73.4%) hold a Bachelor of Science in Nursing degree as their highest nursing qualification. The mean number of years worked as a RN at the hospital is 5.2 years. This length of tenure would have allowed most of the respondents to have been exposed to the previous hierarchical centralized decision making management model and to the recently introduced shared decision making model. Based on this it can be concluded that the majority of the respondents would have been able to make informed choices in response to the questions posed in this study.

Membership on any of the shared governance councils, which can be described as formal power structures by Kanter (1993), was asked in the questionnaire to identify what exposure the nurses have had within the recognized decision making structures within the Nursing Affairs Department. An increase in 7.3% in memberships between previous and current membership was identified. It can be concluded that almost two thirds of the respondents (65.4%) have been exposed to formal decision making through the shared governance structure and this should allow for an informed response to the questions asked in the survey.

5.2.2 Actual and preferred decisional involvement of SNs (bedside RNs)

This objective was set to explore the level of the decisional involvement of the SN (bedside RN). The main findings of the actual and preferred levels of decisional involvement of SNs (bedside RNs) as gathered from the empirical findings of this study are discussed below.

SNs (bedside RNs) perceived themselves to have low actual decisional involvement (mean=1.98 SD=0.64) and indicated that they would prefer more decisional involvement (mean=2.54; SD=0.64) but these results still remain low. The relatively low levels of decisional involvement in this study are similar to the results reported in literature of Scherb et al. (2010:10), but dissimilar to those obtained from Jaafarpour and Khani (2011:17) who reported that the preferred level of decisional involvement was much higher. A significant statistical difference (p=0.000) was identified between the actual and preferred levels of decisional involvement of the SNs (bedside RNs) indicating that the SNs (bedside RNs) are making fewer decisions than what they would prefer to make. Mangold et al. (2010:270) identified similar results in their study. These findings have important implications for managers as it is of concern that the decisional involvement of bedside RNs is low which can lead to staff dissatisfaction (Mangold et al., 2010:270) which is contradictory to attaining Magnet accreditation.

The findings in this study suggest that even though there is movement towards change with more decisional involvement being desired by the bedside RNs, they are still not aspiring to have higher authority for their involvement in decision making. This may be attributed to the predominant focus of the DIS activities being related to those activities that support the delivery of care which has traditionally been the responsibility of management. This is supported by the results obtained from a study by Mrayyan (2004:333) that suggest that autonomy related to decisions regarding patient care are higher than those related to operational decisions.

5.2.3 Statistical differences between SNs' (bedside RNs') and nurse managers' level of decisional involvement

The overall finding indicated that there was no significant statistical variance between the SN (bedside RN) and the managers in their perception of where the authority for decisional involvement lies. Both groups were in concordance that the level of decisional involvement for the bedside RN is low.

However, as supported by Hess (2011:239) the managers consistently scored the bedside RNs higher than scored by the bedside RNs themselves. Managers may have more insight into the decision making processes for each activity and thus may have scored the decisional involvement of the bedside RN accurately. Alternatively the managers may be ignorant of the true level of SNs' (bedside RNs') decisional involvement.

5.2.4 Factors impacting on decisional involvement of registered nurses

As discussed in chapter 2 there are a number of factors that impact on decisional involvement. This objective aims at identifying the main findings regarding the factors that impact on decisional involvement of RNs as gathered from the empirical findings of this study. The themes identified in the open-ended **question 65** (**table 4.65**) are similar to those factors that were identified in the literature review such as empowerment, choice to participate and management and leadership styles as possibly impacting on decisional involvement (**paragraph 2.6**) and thus give support that there are many factors that impact on decisional involvement of RNs. The main findings identified in the study are discussed as follows:

5.2.4.1 Gender and nationality

Kanter (1993) suggests that the structure of proportions impacts on the empowerment of employees. The findings indicate that gender and nationality did not impact on the decisional involvement but both of these variables had disproportionate numbers favouring a specific group, i.e. females and Filipinos. This could suggest that the findings were as a result of the dominance in numbers of these two variables and not be a true reflection of the decisional involvement of the minority groups. This is supported by Liu (2008:293) who cites Denton and Zetinoglo (1993) suggesting that gender and minorities are influencing factors. As already discussed in chapter 2 the Asian nurses that consist of the Filipino, Indian and Malaysian nationalities within this study, were identified to take a more passive role in nursing (Xu, 2006:420). Thus, the low levels of decisional involvement could possibly be attributed to their lack of desire to become involved. These two variables may possibly be factors that do impact on decisional involvement. However, it was not in the scope of this

study to examine if there were any relationship and no other studies were found that explore this relationship.

5.2.4.2 Management and leadership styles

It is the shared governance structure that provides the formal forum where the RN is empowered (Anderson, 2011:197) and this is supported by the findings of this study that indicated there is a culture of shared decision making within the Nursing Affairs Department and that the Unit Councils have the authority for decision making, thus suggesting that the decisional involvement should be higher for the bedside RN than the findings propose. Of concern was the fairly large percentage of bedside RNs who disagreed that there is a shared decision making culture in their unit and this may be attributed to individual leadership styles in specific units (Laschinger, 2008:323; Mrayyan, 2004:327; Sullivan & Decker, 2005:111). However, this study did not allow for relationships between individual unit's perceptions of a culture of shared decision making and the leadership style to be empirically tested.

5.2.4.3 Choice to participate in decisional involvement

Decisional involvement is highly dependent on the choice of the individual to participate (Kowalik & Yoder 2010:262). The findings of this study suggest that the RNs essentially do choose to be involved in the decision making process but are selective in their choice due to a number of varied reasons as supported by the factors tested in this study and by the literature (Kramer et al., 2008:541; Kowalik & Yoder, 2010:262; Mangold et al., 2006:271 and Scherb et al., 2010:13). It is important that the reasons why the RNs are selective are further researched so that these barriers can be addressed.

5.2.4.4 Autonomy, empowerment and accountability

The findings indicate that the RNs are in agreement that they have autonomy in decision making, are empowered in decision making and are held accountable for decisions taken which are all defining characteristics for decisional involvement as discussed in **paragraph 2.4**. The positive results for these three defining characteristics are indicative that the essential elements for decisional involvement are present within the study hospital. Even though the findings of the actual levels of decisional involvement are low for the SNs (bedside RNs), the positive results for these three characteristics are significant in that they indicate that the foundation for decisional involvement is present and can be built upon.

5.2.4.5 Unprofessional behaviour

One unexpected finding identified in the open-ended **4.6.3 question 65** was that unprofessional behaviour impacts the decisional involvement of nurses. No supporting literature could be found that links unprofessional behaviour to decisional involvement.

5.3 RECOMMENDATIONS

Based on the empirical findings and literature review the following recommendations are suggested. Further research should be conducted and this is discussed in further detail in **paragraph 5.5.**

Nurse executive management should use the results of this study as a baseline and encourage dialogue between the bedside RNs and nurse managers to discuss the differences in perceptions in the levels of decisional involvement. The factors that impact on decisional involvement should be examined by nurse executive management and strategies should be identified to address or enhance these factors. The DIS results should be used by the nurse managers to guide the development of specific plans for advancing the decisional involvement of the bedside RN at the unit level. Efforts should be focused on areas that bedside RNs have high preferred level of decisional involvement.

Executive management needs to explore whether there are specific processes or structural limitations that exclude the RNs from participating in decision making. Strategies to assist bedside RNs in having enough time to attend decision making meetings and educational activities that support growth in decisional involvement and the skills necessary to effectively use the authority given to the bedside RN, should be explored by the nurse managers.

A review of educational opportunities should be conducted to identify whether there is adequate emphasis on staff empowerment in decisional involvement. Strategies to increase the level of decisional involvement of the bedside RN should be considered by the nurse executive management through the provision of professional development in activities that were previously not within the scope of the bedside RNs, such as recruitment, staff selection and scheduling. Educational activities such as assertiveness training and conflict management skills should also be considered. Formal education for the nurse managers should be considered in leadership management courses with the focus on staff empowerment and staff motivation to support the successful implementation of environments where bedside RNs are given full authority for decisional involvement.

5.4 LIMITATIONS OF THE STUDY

The limitations of a study are described by Burns and Grove (2007:37) as those “restrictions in a study that may decrease the credibility and generalizability of the findings”. The limitations for this study are discussed below.

The DIS tool was developed and validated for use in a Western environment and the use of this tool in a multicultural environment where the majority of nurses are not Western could be

considered as a limitation to this study. However, the concepts underlying the statements of the tool are based on literature and are similar to those within the study hospital that operates within an American system, therefore those concepts that are crucial to the tool could be measured.

A limitation to this study is that only one hospital has been used to gather data and this may affect the generalizability of the findings. However, it must be noted that there was a high response rate of 83.3% (n=140) from SNs (bedside RNs) and 85.7% (n=18) from nurse managers to the survey, contrary to many survey response rates that are generally low. The high response rate in this study can possibly be attributed to the researcher who has worked in the hospital in a management position for many years, and is well-known to the staff as the person instrumental for implementing the shared governance model at the unit level.

Another possible limitation to this study is that English is the not the first language of the majority of the respondents. The interpretation of the questionnaire may have been affected and this is distinctly noticeable in the open-ended questions where the researcher suspects that the questions were misunderstood resulting in responses not having applicability and therefore could not be used. The chosen methodology is quantitative in nature, consequently the researcher cannot follow up and assess the understanding of the respondents.

The use of focus group interviews as the chosen methodology may have been more valuable to gain richer information regarding the factors that impact on decisional involvement and to eliminate the potential for misunderstanding due to the language issue as discussed previously. However, because the researcher is in a management position in the study hospital this may have led to bias of the information obtained due to staff not having anonymity in voicing their perceptions regarding their decisional involvement.

The limited published literature regarding decisional involvement in similar settings may be considered to be a limitation to this study as only one study from the Middle East has been published.

A further limitation to this study is the high level of missing data. Missing data is considered to be a common problem in quantitative research studies (Peugh & Enders, 2004:5252). The terminology used in the questionnaire is commonly used in the study hospital but because English is not the first language of the majority of the respondents this may have resulted in the choice not to answer the questions.

5.5 FURTHER RESEARCH

Overall, the findings of this study in a tertiary hospital in Saudi Arabia lack generalizability to other health care facilities. The study does, however, indicate the usefulness in comparing the perceptions of bedside RNs to nurse managers in the levels of decisional involvement, thus providing insight into the success of the implementation of a shared governance structure. This study can however be used as a baseline for further studies. As the study hospital progresses in its development of shared governance it is recommended that a repeat study regarding the decisional involvement of RNs be completed for comparison.

Even though this study did not identify nationality and gender as factors that impact on decisional involvement, further research using nationality and gender as a variable should be considered in this multi-nationality environment. The impact of leadership styles on the empowerment of subordinates in decisional involvement would provide insight into the nurse managers' role in the successful implementation of structures to support decisional involvement. Further studies seem warranted to explore the relationships of variables, such as the willingness to be involved in the decision making process and the levels of empowerment, autonomy and accountability within decisional involvement.

5.6 SUMMARY

The guiding framework for this study was Kanter's Theory of Structural Empowerment (1977, 1993) that proposes organizational structures influence the empowerment of individuals more than personality traits and socialization experiences. Thus it can be surmised that the implementation of a shared governance structure in the study hospital should support the empowerment of the bedside RN and thus increase their level of their decisional involvement.

Kanter suggests that employee empowerment is derived from formal and informal power systems within the organization. Shared governance in principle affords formal power to the bedside RN. However, the level of bedside RN engagement and acceptance of this formal power is dependent on the individual themselves as identified in the prerequisites for decisional involvement. The findings of this study indicate that there is a culture of shared governance (**questions 19 and 64**) thus giving credence that the staff perceive that they have formal power. Informal power evolves from relationships and alliances with people inside and outside the organization. This concept was not tested in the study but collaboration did emerge as a theme in the open ended question (**question 64**). Collaboration is also a key characteristic essential for decisional empowerment to be effective.

The systemic power factors influence the employees' access to three job related empowerment structures namely opportunity, power and proportions. These empowerment structures impact the success and performance of the employee. The structures of opportunity and power were not tested in this study. The structure of proportions refers to the social composition of the employees within the organization and the impact of this on decisional involvement was tested through questions asked regarding gender (**question 13**), nationality (**question 21**) and culture (**question 31**). The social composition in this study is diverse but the respondents identified that these group dynamics did not impact on their involvement in decision making.

On review the findings of the study indicate that there is a culture of shared decision making in the study hospital thus endorsing the existence of an empowering structure. However the findings indicate that the actual level of decisional involvement of the bedside RN in this study is low, thus not supporting Kanter's conjecture that an empowering organizational structure positively influences the empowerment of the staff. Nevertheless caution must be taken when challenging Kanter's theory based on the results of this study because not all the elements within the theory were tested. In addition no pre-test was done in the study hospital before the implementation of the shared governance structure and thus a comparison of the levels of decisional involvement cannot be completed to identify if there has been a positive move towards empowerment of the staff in a work environment that is still in the process of change.

5.7 CONCLUSION

Decisional involvement has been proven to be an empowering tool in the literature. Thus, the purpose of this study was to explore the decisional involvement of RNs and factors that impact on decisional involvement in a tertiary hospital in Saudi Arabia. The first two objectives explored the decisional involvement of the bedside RN and the third objective identified those factors that impact on decisional involvement.

The overall conclusions that can be drawn from this study of RNs' decisional involvement in a tertiary hospital in Saudi Arabia is that bedside RNs have a low level of actual decisional involvement which implicitly implies that the authority for decisional involvement lies predominantly with the nurse managers. The bedside RNs indicate a desire to have more decisional involvement but are not willing or are not yet ready to fully accept the responsibility and/or accountability to have comprehensive decisional involvement control. Overall there is no statistical difference in the perception of decisional involvement between bedside RNs and nurse managers but there are significant differences identified in the subscale of

recruitment in the DIS. Factors impacting decisional involvement that were identified in the literature were tested and those identified to impact positively include educational level, experience, leadership styles, the work environment and a culture of shared decision making. Recommendations include for nursing executive management to use the results as a baseline and encourage discussion regarding the results by the bedside RNs and nurse managers and for nurse managers to focus on developing strategies to address those identified areas of preferred decisional involvement.

The research question and hypothesis, goal and objectives that guided this study have been answered. Recommendations based on the outcomes of the study, the limitations of the study and suggestions for further research have been explored.

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ADDENDA

Addendum A: Final HREC approval of research study

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17 June 2011 **MAILED**

Ms T Schoombie
Department of Nursing
2nd Floor
Teaching Block

Dear Ms Schoombie

Decisional Involvement of Registered Nurses in a Tertiary Hospital in Saudi Arabia.

ETHICS REFERENCE NO: N11/05/150

RE : APPROVAL

A panel of the Health Research Ethics Committee reviewed this project on 20 May 2011; the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 17 June 2011 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 17 June 2011 Expiry Date: 17 June 2012

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support
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Addendum B: Extension from HREC to continue study

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23 August 2012 **MAILED**

Ms T Schoombie
Department of Nursing
2nd Floor
Teaching Block

Dear Ms Schoombie

Decisional Involvement of Registered Nurses in a Tertiary Hospital in Saudi Arabia.

ETHICS REFERENCE NO: N11/05/150

RE : PROGRESS REPORT

At a review panel meeting of the Health Research Ethics Committee that was held on 22 August 2012, the progress report for the abovementioned project has been approved and the study has been granted an extension for a period of one year from this date.

Please remember to submit progress reports in good time for annual renewal in the standard HREC format.

Approval Date:22 August 2012 Expiry Date: 22 August 2013

Yours faithfully

MRS MERTRUDE DAVIDS
RESEARCH DEVELOPMENT AND SUPPORT
Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za
Fax: 021 931 3352

23 August 2012 14:29 Page 1 of 1

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Addendum C: Approval from Chief of Nursing Affairs – KFSHRC (J)

مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة
Jeddah Branch - فرع جدة

NURSING AFFAIRS
MBC J-73 Phone 65839 Fax 63442

Internal Memorandum

TO:	**TRACY SCHOOMBIE** Head Nurse, Neuroscience Nursing Affairs	**DATE:**	06 Rajab 1432 (08 June 2011)
FROM:	**SANDY LOVERING, RN, DHSc** Chief Nursing Affairs	**REF#:**	NA-J 854-32

SUBJECT: **NURSING AFFAIRS' PERMISSION TO CONDUCT RESEARCH STUDY**

Thank you for submitting your proposal to Nursing Affairs for a study entitled: *Decisional Involvement of Registered Nurses in a Tertiary Hospital in Saudi Arabia.*

Your proposal has been reviewed and it is my pleasure to grant approval for the study from a Nursing Affairs' perspective. Nurses will need to complete the questionnaire and scale in their own time, as participation is also voluntarily.

You thus can now proceed with submitting your proposal to IRB. You may only conduct the research if IRB grants approval.

The topic of Decisional Involvement and Shared Governance is of great importance to us in Nursing Affairs as part of our Magnet Journey. All our best wishes for your study and we will appreciate it if you will share with us a copy of the thesis once it is completed.

cc. Christina Copplestone, Assistant Chief, Nursing Affairs
Pauline Lagmay, Program Director, Specialty Services, Nursing Affairs
Estelle Bester RN, DCur, Program Director, Nursing Practice, Quality & Research, Nursing Affairs

SL/hu

Form 11100-14 (09-29) I.C. 82125001061 Printed by Reprographics KFSH&RC

Addendum D: Research approval from IRB Chairman- KFSHRC (J)

088

مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة
Jeddah Branch - فرع جدة
MBC-J04 | Fax # 62983 | Tel # 62984/62982

INTERNAL MEMORANDUM

TO : **Tracy Schoombie**
Principal Investigator, IRB 2011-25
Head Nurse, Neuroscience Unit
Nursing Affairs

DATE: 18 Rajab 1432
20 June 2011

REF.: RC-J 174-32

FROM : **Osman Hamour, MD**
Chairman, Institutional Review Board (IRB)
Research Centre

SUBJECT : RESEARCH PROTOCOL APPROVAL
Retrospective Chart Review
IRB 2011-25: *Decisional involvement of registered nurses in a tertiary hospital in Saudi Arabia*

Thank you for submitting to us the above-mentioned research protocol. It was reviewed at the Board meeting yesterday and I am happy to let you know that the Board is satisfied with the protocol as presented. However, a suggestion was brought up regarding the title of the protocol. The Board felt that it would be more clear if the title reflects the type of decision making that the nurses are involved in, *i.e.*, Decisional involvement on clinical practice. Also, kindly indicate on the Cover Page the duration of the study, *i.e.,* start and end dates.

Scientific and ethical approval has been granted and you may start with the research project.
Please submit to us the first Biannual Progress Report on or before **19 December 2011**.

CC: Sandra Lovering, RN, DHSc, Chief, Nursing Affairs

Addendum E: Participant information cover letter and research questionnaire

TITLE OF RESEARCH PROJECT

Decisional Involvement of Registered Nurses in a Tertiary Hospital in Saudi Arabia

When staff are involved in decision making regarding their work environment, their working conditions and their practice they are said to have decisional involvement. The aim of this study is to explore registered nurses' actual and preferred level of decisional involvement and the factors that impact on their decisional involvement.

I am inviting you to participate in this research project regarding decisional involvement of registered nurses. This research is being conducted to fulfill the requirements for my Master's Degree in Nursing at the Stellenbosch University, South Africa.

You have been chosen to participate by random selection. Participation in the study and the completion of the questionnaire is entirely voluntary. You retain the right to decline participation at any time. If you say no, this will not affect you negatively in any way whatsoever. If you agree to participate in this study, the completion and return of the questionnaire will be interpreted as your informed consent to participate in the study.

To ensure total anonymity the completed questionnaire does not require any identifying information. All information received will be kept confidential. Only the researcher, the research supervisor and the statistician will have access to the collected data. All collected information will be stored in a locked cupboard in a room with controlled access of other persons.

There are no financial benefits for you in this study. However, the benefit of the study to nursing practice will be to gain insight into the actual and preferred levels of decisional involvement of registered nurses and the factors that impact on the involvement in the decision making process.

Raw data obtained from the demographic section and the Decisional Involvement Scale (DIS) will be entered into a data base at the University of North Carolina where it will be used as part of an ongoing evaluation of the DIS tool. All data supplied to the University of North Carolina will contain no identifying information and will be entered anonymously into the database.

The questionnaire will take approximately 25 minutes to complete. On completion, please place the questionnaire in the addressed envelope that is provided, seal the envelope and return to me through the hospital's internal mail. It will be appreciated if you can return the completed questionnaire before/on 17 September 2011. If you have any questions, require any clarifications or do not understand anything, please do not hesitate to contact me at the information provided below:

Tracy Schoombie, Head Nurse, 1 South - Neurosciences

Telephone Ext: 667 7777 Ext: 61824 or Pager: 13010

E-mail: tschoombie@kfshrc.edu.sa

Mobile: 0509636127

Thank you for taking the time to complete this survey

Addendum F: Research questionnaire

SECTION A DEMOGRAPHIC DATA

Instructions:
Please provide your answer with a cross (X) in the appropriate box.

1. Age

☐	< 25 years	☐	25 – 35 years	☐	36- 45 years
☐	46-55 years	☐	55-65 years	☐	> 65 years

2. Gender

☐	Female	☐	Male

3. Nationality

☐	Filipino	☐	Indian	☐	Malaysian
☐	Middle Eastern (Lebanon, Jordan, Egypt)	☐	Saudi	☐	Singaporean
☐	South African	☐	Western (Australia, Canada, Europe, New Zealand, USA)	☐	Other (Please indicate) _____

4. Please indicate which is your first language:

☐	Arabic	☐	English	☐	Other (Please indicate) _____

5. Highest educational level: (Fill in one)

☐	Associate Degree	☐	Bachelors Degree in Nursing	☐	Bachelors Degree in another Field
☐	Diploma	☐	Doctorate	☐	Masters Degree in Nursing
☐	Masters in another field				

6. Please select the work unit to which you are primarily assigned to work on a permanent basis: (Fill in only one)

☐	Ambulatory Care	☐	Medical	☐	Pediatrics
☐	Emergency Dept.	☐	Med/Surg	☐	Intensive Care
☐	Obstetrics	☐	Surgical	☐	OR/Recovery Room
☐	Special Procedures/Cath Lab	☐	Other (please name)_____		

7. Please indicate your primary work area according to Divisional Council Structure (Fill in only one)

☐	Adult Division (Adult CVT, Adult Oncology, Medical, Neuroscience, Surgery	☐	Ambulatory Care Division (Family Med&VIP Clinic, HHC, OPD)	☐	Critical Care Division (CSICU, EMS, MSICU, NICU, PICU, SICU)
☐	Mat/Child Division (ART, L&D, NICU, OBGYN/NNN)	☐	Pediatric Division (Peds, PedsCVT, Peds Oncology)	☐	Procedure Areas Division (DPU, Endoscopy , OR, RR, RDU)
☐	I do not know				

8. What nursing position do you currently hold:

☐	SN 1	☐	SN 2
☐	Head Nurse /Assistant Head Nurse		

9. How many years have you worked: (<u>including</u> those years in the roles of CNC/HN/AHN, if applicable)

a. As an RN?

☐	Less than 1 yr	☐	More than 1 year (report number of years) _____

b. As an RN at this hospital?

☐	0-3 months	☐	4-11 months
☐	If 1 year or more, report number of years _____		

c. As an RN on your current unit?

☐	0-3 months	☐	4-11 months
☐	If 1 year or more, report number of years _____		

10. Please indicate if you were <u>previously</u> a member of any of the following Shared Governance Councils (Fill in <u>all</u> your relevant membership(s))

☐	Unit Council	☐	Divisional Council	☐	Magnet Council
☐	Nurse Recognition Council	☐	Nursing Informatics Council	☐	Research Council
☐	Practice and Quality Committee	☐	Ethics and Cultural Advisory Council	☐	Professional Development Council
☐	Management Council	☐	Nurse Executive Council	☐	Shared Governance Coordinating Council
☐	None				

11. Please indicate if you are <u>currently</u> a member of any of the following Shared Governance Councils
(Fill in <u>all</u> your relevant membership(s))

☐	Unit Council	☐	Divisional Council	☐	Magnet Council
☐	Nurse Recognition Council	☐	Nursing Informatics Council	☐	Research Council
☐	Practice and Quality Committee	☐	Ethics and Cultural Advisory Council	☐	Professional Development Council
☐	Management Council	☐	Nurse Executive Council	☐	Shared Governance Coordinating Council
☐	None				

12. Please indicate if you are currently and/or were previously a member of any other committee(s) and/or tasks force(s) within this organization

☐	Yes	☐	No
☐	**If yes**, please indicate the committee(s) and/or task force(s) _____ _____		

SECTION B FACTORS IMPACTING INVOLVEMENT IN DECISION MAKING

Instructions:

- Please answer every question as honestly as possible.
- Read each question carefully and choose **one** of the possibilities next to the question as your answer.
- Indicate your answer by placing a **cross (x)** in the applicable box next to the question.

Do you believe that the following impacts positively on your involvement in decision making?

		No	Yes
13	Your gender	☐	☐
14	Your opinion regarding the decision being made	☐	☐
15	Your educational level	☐	☐
16	Having a personal interest in the decision being made	☐	☐
17	Your seniority in your area of work	☐	☐
18	Your level of experience in nursing	☐	☐
19	An environment that encourages decision making	☐	☐
20	A positive relationship with your colleagues	☐	☐
21	Your nationality	☐	☐
22	Having limited knowledge regarding the decision that is to be made	☐	☐
23	Your role in the organization	☐	☐

Please indicate whether you agree or disagree with the following statements:

		Strongly Disagree	Disagree	Agree	Strongly Agree
24	There is a culture of shared decision making in my unit	☐	☐	☐	☐
25	I have a manager that encourages my involvement in decision making	☐	☐	☐	☐
26	I am autonomous in decision making regarding my practice	☐	☐	☐	☐
27	I am empowered to make decisions	☐	☐	☐	☐
28	I am held accountable for decisions that I make	☐	☐	☐	☐
29	My experience gives me confidence to participate in decision making	☐	☐	☐	☐
30	Peer pressure prevents me from making a decision that I believe is the correct decision	☐	☐	☐	☐
31	I feel that I am reluctant to participate in decision making because of my culture	☐	☐	☐	☐

Please indicate your agreement or disagreement with the following statements:

		Never	Sometimes	Always
32	You feel that you must make a decision that you do **not** agree with	☐	☐	☐
33	You feel confident enough to voice your opinion	☐	☐	☐
34	You choose **not** to participate in the decision making process	☐	☐	☐
35	You feel intimidated by more senior members of staff	☐	☐	☐
36	You are invited to decision making meetings	☐	☐	☐
37	You are informed when a decision, that will impact you, is being made	☐	☐	☐
38	There is adequate time to attend decision making meetings	☐	☐	☐
39	You are able to attend a meeting where a decision is being made	☐	☐	☐
40	You feel that decisions made by you, or that you participate in, will be valued	☐	☐	☐
41	You feel comfortable disagreeing with your manager about a practice decision	☐	☐	☐
42	Your Unit Council has the authority to make decisions	☐	☐	☐

SECTION C **DECISIONAL INVOLVEMENT**

For each of the following questions please **circle one** number in **Section A** and **one** number in **Section B.**

In **Section A, circle** the number that **best reflects** the group that you perceive ***usually has the authority*** to make the decisions or carry out the activity described.

In **Section B, circle** the number that **best reflects** the group that you believe ***should have the authority*** to make decisions or carry out the activity described.

Use the following scale to respond to questions:

5 = Staff nurses only

4 = Primarily staff nurses – some administration/management

3 = Equally shared by administration/management and staff nurses

2 = Primarily administration/management – some staff nurses

1= Administration/management only

		A Group that makes the decisions						**B Group that you believe should make decisions**				
43	Scheduling	1	2	3	4	5		1	2	3	4	5
44	Unit coverage	1	2	3	4	5		1	2	3	4	5
45	Development of practice standards	1	2	3	4	5		1	2	3	4	5
46	Definition of scope of practice	1	2	3	4	5		1	2	3	4	5
47	Monitoring of RN practice standards	1	2	3	4	5		1	2	3	4	5
48	Evaluation of RN practice	1	2	3	4	5		1	2	3	4	5
49	Recruitment of RNs to practice on the unit	1	2	3	4	5		1	2	3	4	5
50	Interview of RNs for hire on the unit	1	2	3	4	5		1	2	3	4	5
51	Selection of RNs for hire on the unit	1	2	3	4	5		1	2	3	4	5
52	Recommendation of disciplinary action for RN's	1	2	3	4	5		1	2	3	4	5
53	Selection of unit leader (e.g. head nurse)	1	2	3	4	5		1	2	3	4	5
54	Review of unit leader's performance	1	2	3	4	5		1	2	3	4	5
55	Recommendation for promotion of staff RN's	1	2	3	4	5		1	2	3	4	5
56	Determination of unit budgetary needs	1	2	3	4	5		1	2	3	4	5
57	Determination of equipment/supply needs	1	2	3	4	5		1	2	3	4	5
58	Development of standards for RN support staff e.g. SN 3	1	2	3	4	5		1	2	3	4	5
59	Specification of number/type of support staff e.g. SN 3	1	2	3	4	5		1	2	3	4	5
60	Monitoring of standards for RN support staff e.g. SN 3	1	2	3	4	5		1	2	3	4	5
61	Liaison with other departments re: patient care	1	2	3	4	5		1	2	3	4	5
62	Relations with physicians re: patient care	1	2	3	4	5		1	2	3	4	5
63	Conflict resolution among RN staff on unit	1	**2**	3	4	5		1	2	3	4	5

Adapted from the Decisional Involvement Scale (Havens & Vasey, 2003)

SECTION D OPEN ENDED QUESTIONS

64. Do you believe that your work environment is conducive to shared decision making?

☐	Yes	☐	No
Give reasons for your answer:			

65. Please feel free to add further comments regarding those factors, both positive or negative, that impact on your participation in decision making:

Thank you for taking the time to complete this survey

Addendum G: Permission to use DIS from Dr Donna Havens

Re: Permission to use DIS

From: **Donna Havens** (dhavens@email.unc.edu)
Sent: 09 September 2010 09:05:30 PM
To: Tracy Schoombie (tracyschoombie@hotmail.com)

Dear Tracy -- I am delighted to have you use the DIS. Please use the demographic items and send the raw data to me electronically so that it can be entered into our data base anonymously to continue to evaluate DIS performance.

Please feel free to contact me if you have any questions.
Donna Havens, PhD, RN, FAAN

On 9/9/2010 5:55 AM, Tracy Schoombie wrote:
> From: Tracy Schoombie<tracyschoombie@hotmail.com>
> Subject: Permission to use DIS
>
> Message Body:
> Dear Dr. Havens.
> I am a Masters student studying at the University of Stellenbosch, South Africa. I currently work in a tertiary hospital in Jeddah, Saudi Arabia where I will be conducting my research.
> I hereby apply for permission to use the DIS and to obtain a pdf copy of the survey form. I undertake to provide any information that you require.
> Regards.
> Tracy Schoombie
>
>
> --
> This mail is sent via contact form on Decisional Involvement Scale http://decisionalinvolvementscale.web.unc.edu
>
>

--
Donna Sullivan Havens, PhD, RN, FAAN
Professor, Healthcare Systems and Outcomes
The School of Nursing
The University of North Carolina at Chapel Hill
Carrington Hall, CB#7460
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Addendum H: Language editor's declaration

LONA'S LANGUAGE SERVICES

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TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proof-read and edited the document contained herein for language correctness.

(Ms IA Meyer)

Email: illona@toptutoring.co.za Tel: 27 21 9514257 Cell: 27 78 264 8484 Fax: 0865148540
3 Beroma Crescent Beroma Bellville 7530

Addendum I: Declaration of technical formatter

Lize Vorster Communication

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, have performed the technical formatting of Tracy Bashamakh's thesis which entails ensuring its compliance with the Stellenbosch University's technical requirements.

Yours sincerely

Lize Vorster

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221