

# Decisional Involvement Differences Related to Nurse Characteristics, Role, and Shared Leadership Participation

**Shelly A. Fischer, PhD, RN, NEA-BC, FACHE;**

**Dawn Horak, MSN, RN, CPPS, CEN;**

**Lesly A. Kelly, PhD, RN**

A sample of 1933 registered nurses working in 24 hospitals with shared leadership was surveyed to examine perceptions of nurse decisional involvement. Council participation was associated with higher decisional involvement scores ( $P = .03$ ), and nurse experience was a statistically significant predictor of decisional involvement ( $P < .01$ ). Nurse manager and staff registered nurse scores were significantly different ( $P < .01$ ). Shared leadership may promote staff nurse perceptions of involvement in decision-making. **Key words:** *decision making, leadership, nurse manager, shared leadership, staff nurses*

**A**S HEALTH care organizations face the growing challenge of improving quality of care while reducing costs, hospital management teams are reevaluating nursing staff engagement and performance strategy. A common approach for improving quality and staff satisfaction is to implement a shared leadership professional practice model, as frontline engagement in decision-making has been

shown to improve organizational culture and outcomes.<sup>1</sup> Involvement in decision-making is an important aspect of shared leadership in nursing. Shared leadership has been defined as an organizational culture that empowers frontline employees to engage in decision-making with the formal leaders of the organization.<sup>2</sup>

Participative management is another term commonly associated with shared leadership, defined as a leadership environment that encourages staff at all levels of the organization to contribute to decision-making.<sup>3</sup> However, shared leadership is more than a participative management approach; it is a professional practice model based on shared accountability, authority, and decision-making.<sup>4</sup> Implementation of council structures and decision-making processes within the nursing department fosters and encourages staff nurse involvement in decision-making, thereby cultivating a culture of shared leadership among all levels of nursing employees within the organization. International appeal of shared leadership as a nursing professional practice model has grown,<sup>5-7</sup> especially in response to growing popularity of Magnet recognition in countries outside of the United States.<sup>8-10</sup>

---

**Author Affiliations:** *Fay W. Whitney School of Nursing, University of Wyoming, Laramie (Dr Fischer); Banner Health, Phoenix, Arizona (Dr Fischer and Ms Horak); and Arizona State University, Banner—University Medical Center Phoenix (Dr Kelly).*

*The authors declare no conflicts of interest.*

*Supplemental digital content is available for this article. Direct URL citation appears in the printed text and is provided in the HTML and PDF versions of this article on the journal's Web site ([www.jncqjournal.com](http://www.jncqjournal.com)).*

**Correspondence:** *Shelly A. Fischer, PhD, RN, NEA-BC, FACHE, Fay W. Whitney School of Nursing, University of Wyoming, Banner Health, 1000 E. University Ave Dept 3065, Laramie, WY 82071 (Sfische1@uwyo.edu).*

*Accepted for publication: October 27, 2017*

*Published ahead of print: December 18, 2017*

*DOI: 10.1097/NCQ.0000000000000312*

## BACKGROUND

### Shared leadership model definition and benefits

Shared leadership is characterized by “contexts in which leadership and influence are distributed across the teams.”<sup>2</sup> Work environments that reflect participative management and decentralized decision-making, 2 integral components of shared leadership, have experienced improved staff satisfaction and retention, as well as lower levels of burnout and job stress.<sup>12-14</sup> In health care settings, staff nurses must feel empowered, involved in decision-making, and given access to support in order to foster a climate of patient safety and to optimize clinical outcomes.<sup>15-18</sup> Empowerment, participatory change management, and shared leadership are key characteristics of Magnet hospitals. Research has shown that staff nurses working in Magnet hospitals perceive greater empowerment and job satisfaction than staff nurses working in non-Magnet facilities.<sup>16,19</sup> Staff nurse decisional involvement has also been associated with lower than average patient mortality<sup>20,21</sup> and with fewer patient complaints.<sup>22</sup>

Implementation of a shared leadership professional practice model creates an organizational culture that encourages nurses at all levels to participate in decision-making by providing structure and processes that enable empowerment at a grassroots level.<sup>23</sup> The councilor model is commonly used and is regarded by many as the most adaptable and sustainable approach to shared leadership.<sup>24</sup> The councilor model commonly employs separate councils, or groups of nurses, to address different types of decision-making. For example, unit-based councils contribute representatives to house-wide councils: perhaps, one to address nursing care quality and safety, and another council for nursing education, research, and evidence-based practice. Frequently, a coordinating council exists within the councilor model of shared leadership to coordinate the activities of the councils, in addition to providing a mechanism for horizontal and vertical bidirectional communica-

tion. A structure like the councilor model enables organizations to evaluate processes and improve performance across an entire organization rather than just at the unit level.

Once a shared leadership professional practice model is implemented, it is important to measure its effectiveness. One measure of effectiveness is the degree to which it has increased engagement of staff nurses. The degree to which a health care organization has integrated its staff nurses into decision-making processes may reflect how well that organization has implemented the professional practice model of shared leadership<sup>11</sup> and how well the model is working to engage staff nurses in decision-making about things that affect their practice. Thus, decisional involvement can be a reasonable measure of shared leadership effectiveness. Overall, understanding how to engage and involve nurses is essential to effective leadership and achievement of strategic objectives.

The empowerment of nurses through a professional practice model of shared leadership is associated with improved patient care outcomes, improved recruitment and retention of nurses, and decreased cost<sup>25</sup>; yet few research studies examine the effectiveness of the model once implemented. Given the need to evaluate the current shared leadership model, particularly its effects on staff nurse decisional involvement, this descriptive study was undertaken to examine the differences in perceptions regarding nurses' actual and preferred levels of decisional involvement at the unit level.

### Leadership influence

Nurse administrators and managers have a significant impact on the implementation, and the ultimate success, of professional practice models. Leaders who are ill-prepared for the power shift required by a shared leadership model may block the implementation of this model.<sup>11</sup> When managers can compare management's and staff's perceptions of staff nurse involvement in decision-making, they have a feedback mechanism and a means of fostering open discussion with staff. Yet,

studies evaluating perceptual differences between management and staff nurses are lacking.<sup>26</sup>

### **Nurse characteristics**

Because perceptions are largely developed through individuals' history and previous experience, in designing this study it was important to know which nurse characteristics (years of experience, certification, educational preparation, and experience with shared leadership) might be associated with perceptions of involvement in decision-making. In one previous study, education level was the only nurse characteristic associated with scores of actual decisional involvement,<sup>6</sup> while in other studies, education level was not significantly associated with actual or preferred levels of decisional involvement.<sup>5,27</sup>

### **Purpose**

The purpose of this study was to examine the influence that nurse characteristics, role, and shared leadership participation have on nurses' perceptions of involvement in decisions that affect their practice. Research questions included the following: What are the relationships among nurse characteristics (education, experience, certification), nurse role (staff or management), and participation in a shared leadership councilor model (yes or no), with nurses' perceptions of actual and preferred decisional involvement?

## **METHODS**

### **Design**

A nonexperimental descriptive survey design was used for this study. The survey was distributed to acute care nurses through e-mail using a Web-based tool to collect demographic information and measure nurses' perceptions of decision-making.

### **Setting and sample**

A convenience sample consisting of registered nurses (RNs) in staff and management roles in 1 health system across 7 states within

the US. All hospitals had implemented a councilor model of shared leadership, with maturity of the shared leadership culture varying from facility to facility. The inclusion criteria included all full- and part-time staff nurses and nurse managers employed at the participating hospitals in roles that required an RN license. Temporary personnel were excluded from the study, as they rarely if ever participate in shared leadership councils due to the transient nature of their employment with the nursing units. Before data collection, the authors gained approval of the project by institutional review board of the health care system.

### **Instrument**

The instrument selected and used with permission for this study was the Decisional Involvement Scale (DIS).<sup>22</sup> Nursing decisional involvement is defined as the distribution of power for decision-making related to issues and tasks that affect nursing practice.<sup>28</sup> The DIS uses a 1 to 5 scale (1 = Decisions usually made exclusively by nursing management/administration and 5 = Decisions usually made exclusively by staff nurses) to indicate the degree to which staff nurses are involved in decision-making. The DIS has been used to measure perceived levels of decisional involvement by hospital staff nurses and members of nursing leadership. The scale also assesses and measures the gap between actual and desired levels of decisional involvement, as well as the level of agreement between staff and management perceptions.<sup>28</sup> While other instruments exist to specifically measure shared governance,<sup>11</sup> the DIS was selected to measure decisional involvement as it relates to shared leadership, as an indicator of the effectiveness of the context and content associated with a shared leadership model. The development of the DIS was guided and informed by a professional practice model of nursing that emphasizes collaborative practice and management *with* professionals in contrast to the management *of* professionals.<sup>22</sup> Previous studies find the reliability of the DIS to be reasonable for a new scale for all subscales (Cronbach  $\alpha$  =

0.68-0.85) and high for the scale as a whole (Cronbach  $\alpha = 0.91-0.95$ ).<sup>27,28</sup> Another important justification for choosing this instrument was its brevity; survey fatigue can be a significant detractor to high response rates. The DIS consists of 21 items that measure actual and desired decisional involvement, for a total of 42 scored items per survey. The time demand for completion of the DIS questionnaire is less than other instruments and was thought to be within reason for most nurses to complete while on duty. The DIS instrument is available in a previous publication.<sup>22</sup>

Six subscales of the DIS may be analyzed independently or may be added together for a total score (range of possible total 21-105). The subscales are as follows: (1) unit staffing, (2) quality of professional practice, (3) professional recruitment, (4) unit governance and leadership, (5) quality or support staff practice, and (6) collaboration/liason activities. A high total score indicates a high degree of staff nurse involvement in decision-making, and a low score suggests a low degree of staff nurse involvement.

### Data collection

The investigators e-mailed all nurses who met inclusion criteria with an invitation to participate in this study. The survey consisted of 12 demographic questions and the 21-item, 2-column DIS. Reminder e-mails were sent at 1-week intervals for 3 consecutive weeks to encourage participation. Informed consent was implied by completion and submission of the anonymous survey.

### Data analysis

Analysis was conducted using SPSS version 22 (IBM, Armonk, New York). Descriptive statistics were conducted to describe the sample characteristics. A multiple analysis of variance was conducted to test for mean differences with the actual and preferred total DIS score as the dependent variables and with shared leadership participation (yes or no) as the independent variable. To examine the relationships among nurses' individual characteristics (educational preparation, years of

experience, certification, and participation in shared leadership) and their perceptions of actual and preferred decisional involvement, correlations among the variables were conducted. Finally, to assess differences between staff nurse and nurse manager perceptions regarding actual and preferred levels of nursing staff decisional involvement, *t* tests were conducted between staff RN and nurse manager DIS scores.

## RESULTS

Overall, 1933 completed questionnaires were returned, yielding an estimated 20% response rate, approximated from an e-mail list-serv total of 9900 nurses. As a result of redundancy in demographic responses, 2 cases were deleted, resulting in a final sample of 1,931 responses. Supplemental Digital Content Table, available at: <http://links.lww.com/JNCQ/A405>, shows characteristics of the sample, including demographics and nurse characteristics.

### Influence of individual characteristics

Actual DIS scores were significantly correlated with years of experience ( $r = 0.07$ ,  $P < .01$ ) and shared leadership participation ( $r = 0.05$ ,  $P < .05$ ). Actual DIS scores were *not* significantly correlated with nursing education or certification. Preferred DIS scores *were* correlated with number of years of experience ( $r = 0.09$ ,  $P < .01$ ) but not with shared leadership participation, nursing education, or certification. The Table presents the correlations among individual RN characteristics and actual and preferred DIS scores.

### Influence of role

Managers had a higher overall actual decisional involvement score ( $M = 46.33$ ,  $SD = 14.82$ ) than did staff nurses ( $M = 41.95$ ,  $SD = 15.88$ ),  $t_{1,931} = 5.36$ ;  $P < .01$ . Staff nurses had slightly higher preferred scores ( $M = 58.48$ ,  $SD = 12.16$ ) than did managers ( $M = 57.27$ ,  $SD = 11.45$ ), although this difference was only marginally statistically significant,  $t_{1,931} = 1.89$ ;  $P = .06$ . The comparison that is likely

**Table.** Correlations Among Nurse Characteristics and Total Scores

	1	2	3	4	5	6	7
1. Nursing education	...						
2. Years of experience	0.110 <sup>a</sup>	...					
3. Shared leadership	0.150 <sup>a</sup>	0.100 <sup>a</sup>	...				
4. Management role	0.270 <sup>a</sup>	0.220 <sup>a</sup>	0.270 <sup>a</sup>	...			
5. Current certification	-0.009	-0.002	0.010	0.067 <sup>a</sup>	...		
6. Actual DIS total score	0.010	0.070 <sup>a</sup>	0.050 <sup>b</sup>	0.120 <sup>a</sup>	0.032	...	
7. Preferred DIS total score	0.040	0.090 <sup>a</sup>	0.010	-0.04	0.010	0.420 <sup>a</sup>	...

Abbreviation: DIS, Decisional Involvement Scale.

<sup>a</sup> $P < .01$ .

<sup>b</sup> $P < .05$ .

most important in the analysis of staff RN versus management perceptions is the dissonance between actual and preferred scores for each group: the mean difference in actual and preferred scores between the groups was  $-0.267$  (95% confidence interval:  $-0.332$  to  $0.201$ ), which is a significant difference ( $P < .001$ ). This result indicates incongruence in views, suggesting that there is a potential for dissatisfaction among staff RNs that is not understood by nurse managers, largely due to differences in perception of the gap between what is actual and what is preferable.

### Influence of shared leadership participation

The specific aims of the study included describing the effect of shared leadership council participation on actual and preferred levels of staff RN decisional involvement. The actual and preferred total DIS scores were dependent variables, and shared leadership participation (yes or no) was the independent variable. While the multivariate model was only marginally significant ( $P = .07$ ), actual total DIS scores were higher for those with shared leadership participation ( $M = 43.61$ ,  $SE = 0.45$ ) than those without shared leadership participation ( $M = 41.99$ ,  $SE = 0.58$ ),  $F_{1,1931} = 4.86$ ;  $P = .03$ . Preferred total DIS scores did not differ between those with shared leadership participation ( $M = 58.29$ ,  $SE = 0.35$ ) and those without shared leadership participation ( $M = 58.05$ ,  $SE = 0.44$ ),  $F_{1,1931} =$

$0.18$ ;  $P = .67$ . Shared leadership participation was associated with a perception of greater involvement in decision-making and yet was not associated with greater preference for involvement.

### DISCUSSION

The purpose of this study was to assess the influence that nurse characteristics, role, and shared leadership participation have on perceptions of decisional involvement. Analysis of actual and preferred decision-making demonstrated that, in general, nurses desired greater involvement in decisions affecting their practice than they had. Analysis of nurse characteristics indicated that nurses with more experience and involvement in shared leadership models felt more involved in decision-making than did less experienced nurses and those who had not participated in councils. Nurse managers believed that staff RNs had greater involvement than the staff RNs themselves felt they had, and the gap between actual and preferred involvement was greater for nurses than was perceived by nurse managers.

The study's most predictable result was that nursing experience and participation in shared leadership councils were associated with greater perceptions of actual levels of involvement in decision-making. This might be explained by the tendency for the expert bedside nurse to be, overall, more confident and

vocal with ideas and opinions as compared with new or novice nurses. Other findings from the study were less expected. One result that could raise concern is the difference in perceptions between managers and staff, especially in terms of actual involvement scores. This indicated a gap in the views of reality between the 2 groups; the gap may be explained by a mere lack of communication, but perhaps a deeper disconnect is indicated. Regardless, further attention to this finding is warranted. An important finding of the study is related to the value of shared leadership as a strategy for engagement and improving nurses' perception of involvement in decision-making. Because the shared leadership model is intended to engage frontline staff in decision-making, it is valuable to know that there is a relationship between a perception of greater decisional involvement and participation in councils. This finding also supports the use of the DIS as a measure for the effectiveness of shared leadership as a decisional engagement strategy. While these findings may be unique to inpatient settings, they are not limited to nursing in the United States. Desire for decisional involvement reaches well beyond geographic, ethnic, and cultural boundaries.<sup>6</sup>

### Limitations

Efforts were made to limit social desirability bias by reassuring participants that findings would be reported to administration in aggregate only; still, the potential remained that nursing staff would respond in ways that they believed their supervisors would prefer. Another limitation of the findings is that the perceived levels of decisional involvement are mistaken as being *equal* to the actual levels of decisional involvement or to the actual levels of shared leadership. This measure, perceived level of decisional involvement, should constitute just 1 among several types of infor-

mation that inform nursing and guide professional practice improvement efforts. The measure should not be construed as an absolute measure of effectiveness, other than in evaluations of strategic efforts aimed at increasing decisional involvement.

### CONCLUSION

This study highlights areas for additional attention from nursing leadership. First, a check-in between staff and leadership is essential to validate differences and similarities in perception of the culture. Awareness of how staff perceives the work culture is an important first step in identifying strategic opportunities for organizational and leadership development. Finally, identifying specific areas for focus and improvement in shared leadership culture offers the greatest return on investment of time and energy. Each nursing unit should be assessed to identify areas of greatest decisional involvement dissonance, which can be targeted for improvement efforts; in addition, areas of least dissonance can be identified for purposes of celebration and sharing of best practices.

As more health care organizations focus on delivering high-quality care and ensuring patient safety with limited resources, shared leadership can support achievement of organizational goals. The employment of a shared leadership model that works in real time can be beneficial not only for helping the organization to meet performance targets but also for promoting staff satisfaction and retention. Measuring actual and perceived levels of decisional involvement can provide a starting point to better understand the nursing work environment. The DIS may be used as a diagnostic or evaluative measure within these settings, as well as in settings where the implementation of a shared decision-making model is anticipated.

### REFERENCES

1. Laschinger HK, Finegan J, Wilk P. Context matters: the impact of unit leadership and empowerment

on nurses' organizational commitment. *J Nurs Adm.* 2009;39(5):228-235.

2. Pearce CL, Manz CC. The new silver bullets of leadership: the importance of self- and shared leadership in knowledge work. *Organ Dyn*. 2005;34(2):130-140.
3. Sashkin M. Participative management is an ethical imperative. *Organ Dyn*. 1984;12(4):4-22.
4. Anderson EF. A case for measuring governance. *Nurs Adm Q*. 2011;35(3):197-203.
5. Ahmed MZ, Safadi EG. Decisional involvement among nurses: governmental versus private hospitals. *Health Sci J*. 2013;7(1):18-27.
6. Liu Y, Hsu H, Chen HC. Staff nurse decisional involvement: an Internet mixed-method study in Taiwan. *J Nurs Manag*. 2015;23:468-478.
7. Wong CA, Laschinger H, Cummings GG, Vincent L, O'Connor P. Decisional involvement of senior nurse leaders in Canadian acute care hospitals. *J Nurs Manag*. 2010;18(2):122-133.
8. Kvist T, Mäntynen R, Turunen H, et al. How magnetic are Finnish hospitals measured by transformational leadership and empirical quality outcomes? *J Nurs Manag*. 2013;21(1):152-164.
9. Ridley J, Wilson B, Harwood L, Laschinger HK. Work environment, health outcomes and magnet hospital traits in the Canadian nephrology nursing scene. *CANNT J*. 2009;19(1):28-35.
10. Walker K. The international Magnet® journey. *Nurs Manag*. 2013;44(10):50.
11. Overcash J, Petty LJ, Brown S. Perceptions of shared governance among nurses at a midwestern hospital. *Nurs Adm Q*. 2012;36(4):E1-E11.
12. Aiken LH, Havens DS, Sloane DM. The Magnet® nursing services recognition program: a comparison of two groups of Magnet hospitals. *J Nurs Adm*. 2009;39(7-8 suppl):S5-S14.
13. Kluska KM, Laschinger HK, Kerr MS. Staff nurse empowerment and effort-reward imbalance. *Nurs Leadersb (Tor Ont)*. 2004;17(1):112-128.
14. Laschinger HK, Almost J, Tuer-Hodes D. Workplace empowerment and magnet hospital characteristics: making the link. *J Nurs Adm*. 2003;33(7-8):410-422.
15. Armellino D, Quinn Griffin M, Fitzpatrick J. Structural empowerment and patient safety culture among registered nurses working in adult critical care units. *J Nurs Manag*. 2010;18:796-803.
16. Armstrong K, Laschinger H, Wong C. Workplace empowerment and Magnet® hospital characteristics as predictors of patient safety climate. *J Nurs Adm*. 2009;39(7-8 suppl):S17-S24.
17. Armstrong KJ, Laschinger H. Structural empowerment, Magnet® hospital characteristics, and patient safety culture: making the link. *J Nurs Care Qual*. 2006;21(2):124-132, quiz 133-124.
18. Manojlovich M, DeCicco B. Healthy work environments, nurse-physician communication, and patients' outcomes. *Am J Crit Care*. 2007;16(9):536-543.
19. Lacey SR, Cox KS, Lorfing KC, Teasley SL, Carroll CA, Sexton K. Nursing support, workload, and intent to stay in Magnet®, Magnet-aspiring, and non-Magnet hospitals. *J Nurs Adm*. 2007;37(4):199-205.
20. Ausserhofer D, Schubert M, Desmedt M, Blegen MA, De Geest S, Schwendimann R. The association of patient safety climate and nurse-related organizational factors with selected patient outcomes: a cross-sectional survey. *Int J Nurs Stud*. 2013;50(2):240-252.
21. Cummings GG, Midodzi WK, Wong CA, Estabrooks CA. The contribution of hospital nursing leadership styles to 30-day patient mortality. *Nurs Res*. 2010;59(5):331-339.
22. Havens DS. Measuring staff nursing decisional involvement: the Decisional Involvement Scale. *J Nurs Adm*. 2003;33(6):331-336.
23. Johnson K, Johnson C, Nicholson D, Potts CS, Raiford H, Shelton A. Make an impact with transformational leadership and shared governance. *Nurs Manag*. 2012;43(10):12-14, 17.
24. Scott L, Caress A. Shared governance and shared leadership: meeting the challenges of implementation. *J Nurs Manag*. 2005;13:4-12.
25. Barden AM, Griffin MT, Donahue M, Fitzpatrick JJ. Shared governance and empowerment in registered nurses working in a hospital setting. *Nurs Adm Q*. 2011;35(3):212-218.
26. Yurek LA, Havens DS, Hays S, Hughes LC. Factorial validity of the Decisional Involvement Scale as a measure of content and context of nursing practice. *Res Nurs Health*. 2015;38(5):403-416.
27. Mangold KL, Pearson KK, Schmitz JR, Scherb CA, Specht JP, Loes JL. Perceptions and characteristics of registered nurses' involvement in decision making. *Nurs Adm Q*. 2006;30(3):266-272.
28. Havens DS, Vasey J. The staff nurse decisional involvement scale: report of psychometric assessments. *Nurs Res*. 2005;54(6):376-383.