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Decisional Involvement: Staff Nurse and Nurse Manager Perceptions

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Abstract

Enhancing involvement in organizational decisions is one strategy to improve the work environment of registered nurses and to increase their recruitment and retention. Little is known about the type of decision making and the level of involvement nurses desire. This was a descriptive study exploring staff nurse and nurse manager ratings of actual and preferred decisional involvement and differences between staff nurses and nurse managers. A sample of 320 RNs from a Midwestern health care network was surveyed using the Decisional Involvement Scale. Nurse managers and staff nurses had statistically significant differences in their perceptions of who was involved in actual decision making in the areas of unit governance and leadership and collaboration or liaison activities. There were statistically significant differences in preferred decisional involvement between staff nurses and nurse managers in the overall DIS scale and the subscales of unit governance and leadership and quality of support staff practice.

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There has been a documented nursing shortage since 1998 (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005). As "baby boomer" nurses begin to retire, the shortage is expected to worsen (Zangaro & Soeken, 2007). In addition to nurses retiring in greater numbers, the current shortage is fueled by an increasing aging population requiring nursing care (American Association of Colleges of Nursing [AACN], 2008; Ulrich et al., 2005) and the incapacity of nursing schools to enroll the number of students to meet the demand (AACN, 2008). The Institute of Medicine's reports on the need to improve quality, patient safety, and the work environment have added incentives to recruit and retain nurses. Enhancing decisional involvement is one strategy to improve the work environment (Havens & Vasey, 2005) and to increase recruitment and retention of nurses (Kimball & O'Neil, 2002; McClure & Hinshaw, 2002). Little is known, however, about the type of decisions and the level of involvement nurses desire or the involvement that nurse managers perceive that staff nurses should have in making these decisions. The purposes of this study were to explore staff nurse ratings of actual and preferred decisional involvement and determine differences in actual and preferred ratings between staff nurses and nurse managers overall and on the Decisional Involvement Scale (DIS) subscales. These finding will be used to suggest implications for nurse leaders.

The Magnet Recognition Program is the guiding framework for this study. The Magnet Recognition program grew out of the studies that addressed the nursing shortages in the 1970s and 1980s. Characteristics of hospitals identified as magnet (i.e., more able to recruit and retain nurses) were studied (McClure & Hinshaw, 2002). The 14 forces of magnetism are contained within the five-component Magnet model (i.e., transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; empirical quality results; American Nurses Credentialing Center [ANCC], 2008b). Research involving Magnet hospitals have shown improved job satisfaction (Aiken, Havens, & Sloane, 2000; Brady-Schwartz, 2005; Upenieks, 2002), nurse retention (Brady-Schwartz, 2005), safety environments (Armstrong & Laschinger, 2006), and patient outcomes (Aiken et al., 2000; Scott, Sochalski, & Aiken, 1999). Decisional involvement is embodied within the structural empowerment component and is an essential element of Magnet organizations.

Staff Nurse Decisional Involvement

Organizational structure is one of the forces of magnetism and describes flat, decentralized shared decision making as essential. One organizational model used to increase nurse decision making is shared governance, a formal structure that codifies nurses' right, responsibility, and power to make decisions (Kramer et al., 2008). Another force of magnetism, management style, speaks to the need for nursing leadership to create environments that support staff nurse participation in decision making (ANCC, 2008a). Havens and Vasey (2005) define decisional involvement as "the pattern of distribution of authority for decisions and activities that govern nursing practice policy and the practice environment" (p. 377).

Shared governance is a model and structure that is often implemented to increase staff nurse involvement in decision making (Hess, 1995), but a change in structure alone does not always result in a change in the distribution of authority nor guarantee nurse control over practice or shared decision making (Kramer et al., 2008). There is a need to change both nurses' attitudes and behaviors toward their role in decision making and the culture of the organization (Dunbar et al., 2007). A socialization process related to shared governance for nurse managers is essential to assist them to adopt a leadership style that embraces shared decision making with staff nurses (Baker et al., 2009).

Walker (2001) states that involvement in decision making increases investment in providing quality patient care and nurse job satisfaction. There is also evidence that decisional involvement improves the nurse work environment, commitment (Kreitzer, 1990), perceived empowerment, self-growth, organizational development (Erickson, Hamilton, Jones, & Ditomassi, 2003), patient and organizational outcomes (Laschinger, Almost, & Tuer-Hodes, 2003), and employee well-being (de Jonge, Bosma, Peter, & Siegrist, 2000). In addition, Walker described development of a shared leadership model at the unit level in one specialty area. She found as staff nurses experienced success in participation in decision making, they increased their participation and accountability in decision making about other issues (e.g., physician relationships, care guidelines, patient satisfaction). Given the positive outcomes of nurse involvement in decision making, it is important to examine strategies to promote involvement.

Areas that have been described by Hess (2004) as important to target for shared decision making are hiring, promoting, and firing of staff; input into performance appraisals and disciplinary action; creation of new positions; involvement in staffing; and determining supplies and budgets. Strategies have

been identified in the literature to increase staff nurse decisional involvement. Some of these strategies include input into resource allocation, promotion of certification, development of enhanced skills in conflict resolution and negotiation, participation in self-scheduling, involvement in selection and review of leaders, and development and implementation of mechanisms for the promotion of staff RNs. These selected strategies are consistent with Havens and Vasey's (2003) Decisional Involvement Scale (DIS).

Hess (1998) argues that nurses are less concerned about control over professional practice than they are about control over resources that support practice (e.g., staffing). As early as 1993, Blegen and colleagues reported that nurses desired more decisional involvement in control of resources and in 2004 that was confirmed in a study (Mrayyan, 2004) using the same instruments as Blegen. Similarly, Rafferty, Ball, and Aiken (2001) reported that staff nurses in British hospitals associated higher levels of nurse autonomy and more involvement in decisions with greater control over resources. Fusilero and colleagues (2008) confirmed that involvement in administrative decision making increased nurse satisfaction. However, there are still limited examples in the literature of staff nurse involvement in administrative decisions (e.g., staff mix, staffing ratios) that have a great impact on clinical nursing practice. One of the most difficult areas of shared decision making for nurse managers is decisions about resources (Dunbar et al., 2007; Specht, 1996).

Certification has been found to be empowering for staff nurses. Piazza, Donahue, Dykes, Griffin, and Fitzpatrick (2006) found that empowerment structures were more readily available to nurses who were certified than those not certified and that nurses who were certified had higher perceptions of empowerment. They stated that the act of certification itself is empowering because it recognizes the nurse's expertise and knowledge in a specialty area. In a program to enhance the work environment of staff nurses, Lacey and colleagues (2008) described a plan to facilitate certification that included reimbursing for costs, providing a pay differential, and recognizing the credential on name tags. Certification contributed to the overall satisfaction of nurses in the organization and promoted their professional practice and decisional involvement.

Siu, Laschinger, and Finegan (2008) found that professional practice environments create the opportunity for nurses to engage in effective conflict management, thus increasing the nurses' ability to work effectively. The need for effective conflict management skills has been confirmed by Rowe and Sherlock (2005) and McKenna, Smith, Poole, and Coverdale (2003) in their studies of horizontal verbal abuse among nurses. Some studies have found that nurses have poor conflict management skills and often avoid confrontation

(Bartholomew, 2006; Rowe & Sherlock, 2005). Conflict resolution and negotiation skills can be developed and for successful models of professional practice, opportunities and expectations for nurses to learn and develop these skills are required. In the Readiness for Professional Governance study, Reeves (1991) identified critical staff nurse skills for successful governance and increased decision making. Conflict resolution and expert negotiation were two of the five skills described. These skills were needed to solve conflicts without interventions by managers, to negotiate requests for scheduling with peers, and to constructively manage intra- and interdepartmental conflicts.

Another strategy to increase nurses' control over practice and decision-making authority is the use of self-scheduling. Self-scheduling has been found to increase communication among nurses, promote development of negotiation and problem-solving skills, and increase satisfaction and retention (Hoffart & Willdermood, 1997). In a study of five medical-surgical units implementing self-scheduling, managerial support was found to be an essential component to success, and when difficulties were experienced, the nurse manager should assist with problem solving without taking control (Hoffart & Willdermood, 1997). Bailyn, Collins, and Song (2007) found that commitment from both staff and management was required for self-scheduling to be successful.

Staff involvement in selection and evaluation of nurse managers is described as an important part of shared governance (Maas & Jacox, 1977; Specht, 1996). The workbook, *Elevating Frontline Leadership: Best Practices for Improving Nurse Manager Performance* (Nursing Executive Center, 2001) includes a section on 360-degree interviewing that includes staff nurses in the interview process. Their study conducted with nurse executives via interviews and focus groups rated the evidence of involvement of staff and others in the selection process a "B," which they describe as

> recommended for most members and is a moderately effective practice for improving nurse manager performance. Further, the benefits gained from implementation of the practice outweigh the costs. The incremental cost of extending the involvement and preparing those additional persons who are involved in the process is offset by the benefits gained. The benefits gained include increased buy-in from the staff on the new leader and improved selection of a nurse manager. (p. viii)

Only one description (Maas & Jacox, 1977) of a shared governance model that included selection and evaluation of nurse managers was found in the literature.

Although there are several published tools for appraisal of the nurse manager by the staff nurses, the process of how the information gleaned from the tools is shared with the nurse manager is not explicated (Nursing Executive Center, 2001). One of the tools from a hospital in the Eastern United States is titled a Leadership Competency Feedback Scale, and it does have one item to rate on empowerment including staff authority and accountability for decisions.

Clinical ladders have been in existence for more than three decades and are one mechanism for clinical advancement for staff nurses. Clinical ladders are also an avenue for staff nurses to be involved in the promotion of fellow staff nurses through a peer review process (Drenkard & Swartwout, 2005; Kanaskie, Felmlee, & Shay, 2008). Picker-Rotem, Schneider, Wasserzug, and Zelker (2008), using a case study method, described an innovative program using a peer decision-making process to select staff nurse participants in leadership training who later became leaders in the organization. The training became a path for career advancement and contributed to trust between management and staff as well as legitimacy of the selection process.

Staff participation in interviewing and recruitment are important activities within the shared governance model. Nurses feel more empowered when they participate in interviewing and hiring nurses to work on their unit. One organization (Evans, 2006) went beyond the staff nurses just participating in the new hire interviews to creating a "staff nurse interview committee" that was educated in the interviewing process and developed position-specific questions. The formation of this committee dramatically increased their recruitment and retention numbers. Other staff recruitment strategies include proactive recruitment by engaging with area schools of nursing (Hawkins & Jekanowski, 2008) and having nurse internship programs (Austria & Childress, 2008; Beauregard, Davis, & Kutash, 2007), nurse shadowing programs (Shermont & Murphy, 2006), student clinical assistant programs (Henriksen, Williams, Page, & Worral, 2003), nurse recruiters, ambassador programs, marketing, and quality website that outlines the benefits of working at the organization (Christmas, 2007). Recruitment is everyone's responsibility, with the goal of recruiting talented nurses who share your vision, mission, and values. Staff nurses are the representatives of the organization in the community. They have a great influence on how your organization is perceived (Christmas); thus, involvement in decision making is imperative.

Nurses must feel empowered to address issues that arise from patients, families, and other departments within the organization. At Southwestern

Vermont Medical Center (Ambulatory Care Quarterly, 2007), the staff nurses have the ability to handle dissatisfied patients and families with coupons to their gift shop. If a complaint is received by the nurse manager, the complaint is discussed with the staff nurse to determine the best solution to the issue.

In collaborating with other disciplines, nurses and other interdisciplinary team members must have the knowledge, skills, and resources to successfully collaborate (Golanowski, Beaudry, Kurz, Laffey, & Hook, 2007). If these tools are provided, patient care issues can be resolved through better problem solving. One organization used an interdisciplinary approach that involved point-of-care staff as well as managers to solve a problem with patient flow from the emergency department (Weeks & Keen, 2009). Another organization developed an interdisciplinary shared decision-making model as one way to achieve collaboration to establish and meet patient care goals (Golanowski et al., 2007). Another model adopted by an organization was the multidisciplinary shared governance model with the goal to provide horizontal interdepartmental communication, identify problems with patient care delivery, and develop solutions to these problems (Ireson & McGillis, 1998). The success of programs such as these point to the benefit of having staff nurses involved in decision making with other disciplines for the betterment of patient care.

There are many theoretical and empirical articles surrounding the topic of staff-involved decision making. As presented in this literature review, authors and researchers have presented a variety of areas that are important for nurse leaders to consider when involving staff nurses in the decision-making process. However, no literature was found that described the differences between whom staff nurses and nurse managers perceived as actually being involved in decision making or who they thought should be involved.

This study presents a perspective from both staff nurses and nurse managers on decisional involvement that has not been previously explored and illustrates how the DIS can be used to evaluate decisional dissonance between staff nurses and nurse managers for both actual and preferred decisional involvement. The specific research questions explored in this study were as follows: (a) What was the difference in staff nurse actual and preferred decisional involvement? (b) What was the difference in nurse manager actual and preferred decisional involvement? (c) What was the difference between staff nurse and nurse manager actual decisional involvement? and (d) What was the difference between staff nurse and nurse manager preferred decisional involvement? Each of these questions was answered for the overall DIS score and for each of the subscales.

Method

This descriptive correlational study was one part of a larger primary study. The setting was a rural health care network, including a 250-bed referral center, nine rural hospitals, 33 primary care clinics, and 10 specialty clinics. Questionnaires (i.e., demographic, type of delivery system, accountability, job satisfaction, and decisional involvement) were mailed to registered nurses (RNs) and patient charts were retrospectively reviewed to gather data on patient outcomes and demographics. The study received approval from each participating organization's and Winona State University's institutional review board (IRB).

Sample

The sample for the primary study included all 857 RNs within the health care network. After two mailings, 338 RNs responded; resulting in a 39% return rate. Eighteen surveys were eliminated because the DIS was not completed and eight surveys were eliminated because they were not a staff nurse or a nurse manager. The final sample included 290 staff nurses and 22 nurse managers. The staff nurses and nurse managers were not matched by unit because unit information was unknown for the total sample.

Data Collection

Questionnaires were initially distributed to 857 RNs in November 2003, followed by a reminder postcard approximately 3 weeks after the original mailing. Two hundred seven surveys were returned, for a return rate of 24%. Because of the less than desirable return rate, the demographic question asking about what unit they worked on was eliminated in the second mailing. It was also decided to eliminate the nurses who worked in the clinic setting because their work environment was so different than nurses working in acute care hospitals or long-term-care facilities. IRB approval was obtained for these modifications. The same procedure was used for mailing the questionnaires as used in the initial mailing. Questionnaires were resent to 734 RNs in February 2004. One hundred thirty-one additional surveys were returned, resulting in a 39% return rate (338 respondents).

Instruments used for data collection were a demographic questionnaire and the DIS (Havens & Vasey, 2003). The demographic questionnaire requested information on age, gender, hours worked per pay period, hours

worked per shift, shift worked, primary work role, primary work setting (first mailing of questionnaires only), years of experience as an RN, years at the organization, years in current position, educational level, types of certifications held, and professional organization membership.

Instrument

The DIS (Havens & Vasey, 2003) is a 21-item tool that measures actual and preferred decisional involvement of staff nurses and nurse managers. The respondents indicate on a 5-point Likert-type scale who is perceived as having primary responsibility for the decision and who is preferred to have primary responsibility (1 = *administration/ management only*, 2 = *primarily administration/management—some staff nurse input*, 3 = *equally shared by administration/management and staff nurses*, 4 = *primarily staff nurses—some administration/management*; and 5 = *staff nurse only*). By comparing the actual and preferred responses, the decisional dissonance or the gap between actual and preferred decisional involvement can be determined. High scores indicate a high level of staff involvement, low scores indicate a low level of staff involvement, and midrange scores indicate shared decision making by staff and administration (Havens & Vasey, 2003). Content validity, construct validity, and internal consistency were determined for the DIS. Content validity was established over two phases. Construct validity was determined using two independent samples (n = 849 and 650). Results indicated that nurses working in a professional practice environment had higher scores than those nurses working without a professional practice model. Reliability was assessed using Cronbach's alpha on the same two independent samples. The alpha for the overall scale was .91 to .95. The DIS also has six subscales (i.e., unit staffing, quality of professional practice, professional recruitment, unit governance and leadership, quality of support staff practice, and collaboration/liaison activities) with Cronbach's alphas ranging from .70 to .95 (Havens & Vasey, 2005). Cronbach's alphas for this study sample were similar to Havens and Vasey's findings, both for the subscales and the overall rating. The range of Cronbach's alphas on the subscales was .64 to .87. As with Havens and Vasey's findings, the reliability for the subscales of collaboration (.67) and unit staffing (.67) had the lowest Cronbach's alphas.

The purposes of this study were to explore staff nurse ratings of actual and preferred decisional involvement and determine differences in actual and preferred ratings between staff nurses and nurse managers overall and on the DIS subscales.

Table 1. Demographics

	n	%
Gender		
Female	305	97.8
Male	7	2.2
Worksite		
Urban acute care	183	58.7
Rural and nonacute care	129	41.3
Hours worked per pay period		
<64 hr	98	31.4
≥64 hr	213	68.5
Work role		
Staff nurse	290	92.9
Nurse manager	22	7.1
Educational preparation		
Associate/diploma	217	69.8
Bachelor's	92	29.6
Master's	2	0.6

Results

The convenience sample consisted of 312 RNs, with an average age of 43.32 years (*SD* = 10.57, range 20-73). Almost all were staff nurses (92.9%); 69.8% held an associate or diploma degree in nursing and averaged 1.52 (*SD* = 0.79, range 1-4) certifications. They were predominately female and averaged 17.30 years (*SD* = 10.49, range 0.5-52) of experience and 14.26 years (*SD* = 9.71, range 0.5-46) of employment by the current organization. Most of the RNs worked ≥64 hours in a pay period (68.5%) and practiced in an urban acute care setting (Table 1).

Staff Nurse Findings

The staff nurse's mean actual rating of decisional involvement was 2.10 (*SD* = 0.58), and the mean preferred rating of decisional involvement was 2.79 (*SD* = 0.52). These differences were statistically significant ($p < .001$). If decision making was to be shared equally between staff and administration, the mean score would be three. The staff nurse ratings of actual and

preferred decisional involvement were also evaluated by each of the six DIS subscales. All of the differences were statistically significant ($p < .001$).

Nurse Manager Findings

There was a statistically significant difference ($p = .001$) between the nurse managers' actual rating of decisional involvement ($M = 2.22$; $SD = 0.36$) and their preferred rating of involvement ($M = 2.56$; $SD = 0.45$). If decision making was to be shared equally between staff and administration, the mean score would be three. The nurse managers' ratings of actual and preferred decisional involvement were also evaluated by each of the six DIS subscales. There was a statistically significant difference ($p < .05$) between actual and preferred on all of the subscales except for the subscale of collaborative/liaison activities ($p = .444$).

Differences in Staff Nurse and Nurse Manager Findings

Graphing of individual responses was done, which revealed that the item frequencies do not show distributions at the ends of the scale, with managers responding at one end and staff nurses at the other. Although the distributions differ between staff nurses and managers, they do tend toward the middle, thus providing our rationale for treating the scale as a continuous linear variable.

An independent sample *t* test was used to analyze the differences between staff nurses and nurse managers on their actual and preferred ratings of decisional involvement (Table 2). There was no statistically significant difference between the staff nurses' and nurse managers' ratings of actual decisional involvement for the overall DIS ($p = .164$), but there were statistically significant differences in the subscales of unit governance and leadership ($p = .011$) and collaboration/liaison activities ($p = .021$). The staff nurses reported less decisional involvement in both of these subscales than the nurse managers.

In studying the total scores for preferred ratings of decisional involvement, there was a statistically significant difference ($p = .046$) between the staff nurses and nurse managers. On examination of the subscales, unit governance and leadership ($p = .039$) and quality of support staff practice ($p = .014$) were significantly different.

Discussion

Although there were statistically significant differences between actual and preferred decision making for the staff nurses, the results indicate that the

Table 2. Independent Sample *t*-Test Between Staff Nurses and Nurse Managers for DIS Actual and Preferred Involvement

		Actual Involvement				Preferred Involvement			
	n	*M*	*SD*	*t*	*p*	*M*	*SD*	*t*	*p*
Overall scale				−1.426	.164			2.001	.046*
Staff nurse	290	2.10	0.58			2.79	0.52		
Nurse manager	22	2.22	0.36			2.56	0.45		
Subscales									
Unit staffing				1.542	.135			1.682	.106
Staff nurse	290	2.91	1.03			3.40	0.71		
Nurse manager	22	2.64	0.79			3.07	0.92		
Quality of professional practice				−1.067	.296			0.718	.480
Staff nurse	290	2.34	0.81			2.90	0.67		
Nurse manager	22	2.51	0.70			2.80	0.67		
Professional recruitment				−0.489	.628			1.446	.161
Staff nurse	290	1.76	0.74			2.57	0.73		
Nurse manager	22	1.82	0.52			2.35	0.69		
Unit governance and leadership				−1.706	.089			2.074	.039*
Staff nurse	290	1.68	0.60			2.52	0.61		
Nurse manager	22	1.91	0.35			2.24	0.47		
Quality of support staff practice				−0.433	.669			2.475	.014*
Staff nurse	290	1.95	0.78			2.75	0.68		
Nurse manager	22	2.00	0.49			2.38	0.58		
Collaboration/liaison activities				−2.442	.021*			0.751	.460
Staff nurse	290	2.57	0.78			3.04	0.57		
Nurse manager	22	2.85	0.49			2.94	0.59		

*$p < .05$.

staff nurses' levels of actual involvement and their preferred involvement overall did not reach an equally shared decision-making level. For shared governance to be effective, nurses have to be willing to participate; they must be willing to be involved at some level in decision making for the nursing unit and the care provided. Some nurses enjoy the process, whereas others may fear it or their family obligations may limit their participation (Kramer et al., 2008).

As Walker (2001) questioned, would nurses' desire for decision making increase in other areas, if they had more involvement in the areas examined. Real opportunities to influence and have involvement in decisions that make a difference to practice may yield a higher desire for more decisional authority. It is unknown why the staff nurses did not desire more involvement, but it may be due to involvement being ignored by the decision makers or that the permitted decisions were of little consequence. Also, nurses who desired more decision-making authority than available may have left the organization or the profession, leaving more nurses who did not want decisional involvement.

The total survey scores indicated that nurse managers rated actual and preferred involvement at a level that does not reach equally shared decision making. Also, the nurse manager's preferred rating of decisional involvement is less than what is desired by the staff nurses. These findings give the nurse managers an opportunity to evaluate why staff nurses are not more involved in decision making when they, the nurse managers, believe the staff nurses should have more involvement. It may be necessary to raise the questions about whether there is something structurally or a process that prohibits staff nurse involvement. It may also be a matter of the nurse managers' knowing how to let go of decision-making power or develop staff nurse's abilities for increased decisional involvement.

Staff nurses reported desiring more decisional involvement, but nurse managers' ratings indicate they do not believe staff nurses need as much decisional involvement as the staff nurses desire. The DIS provides a tool to critically assess dissonance that may exist between the perception of actual decision making and desired decision making. Furthermore, because there were differences in this study between staff nurses and nurse managers for the actual and preferred ratings of decision making, the tool provides a mechanism for staff nurses and nurse managers to discover the areas of difference and begin to discuss how these differences could be eliminated or overcome. In addition, results of the tool could help to identify priority areas for efforts to increase decisional involvement of staff nurses. Areas indicated from this study are decisions about unit governance and leadership (e.g., selection of unit leader,

review of unit leader's performance, recommendation for promotion of staff RNs, determination of unit budgetary and equipment or supply needs), quality of support staff practice (e.g., specification of number or type of support staff, monitoring of standards for RN support staff), and collaboration or liaison activities (e.g., liaison with other departments re: patient care, conflict resolution among RN staff on unit).

The areas of dissonance between the staff nurses and nurse managers are consistent with what Hess (2004), Mrayyan, (2004), and Fusilero and colleagues (2008) found. Staff nurses want more decisional authority over resources than they have traditionally been given. It is obvious that resources (e.g., staff, equipment, and knowledge) greatly influence the care provided, and nurses have consistently wanted to be able to be involved in decisions that have an impact on care. However, consistent with other studies, these are also the areas hardest for nurse managers to share (Dunbar et al., 2007). There are few tested models in the literature to guide this change in decisional involvement for staff nurses. It is an area ripe for innovation and pilot projects that could be developed jointly between staff nurses and nurse managers and could yield positive results for the organization and the people it serves.

Decisional involvement has been identified as a positive factor in nurse job satisfaction and retention and has many other positive outcomes for organizations, nurses, and the patients they serve. It needs to be carefully assessed and strategies implemented to increase decision making of staff RNs through developmental opportunities like conflict management and negotiation, through specific programs that promote decisional involvement like peer review and self-scheduling, and through growth opportunities like certification.

Overall, the specific findings of this study lack generalizability to other health care organizations, but they do show the value in using the DIS to measure decisional dissonance within an organization. Whether an organization has a shared governance model or not, decisional dissonance may still be present. Using the DIS to evaluate who is actually making key decisions and who is preferred to be making these decisions offers the organization a chance for staff nurses and nurse managers to dialogue about the issue. If staff nurses desire more involvement in some decisions than they currently have, the issue can be discussed and resolved between staff and management. If management wants staff nurses to be more involved in certain decisions, this would be an opportunity to teach the staff about those decision processes and elicit their involvement. Such dialogues will strengthen the work environment.

This study has some limitations that include convenience sampling, surveying of only one health care network, inability to match nurses to their

work units or staff nurses to their nurse manager, and lack of ethnic diversity. Self-selection bias may be an issue in that nurses who feel a responsibility to participate in surveys or those that having strong opinions about the subject matter are more likely to respond. Although these limitations may limit the generalizability of the findings, they do not negate the value of understanding the perspective of these nurses and the gaps between the staff nurse and nurse manger perceptions about decisional involvement. Nor does it diminish the potential of the DIS as a mechanism to evaluate an organization's perceived decision-making structure and ability to guide discussions for action and change.

Greater staff nurse decisional involvement calls for changing the traditional staff nurse and nurse manager's decision-making role and expectations. Organizations will need to assist and support nurse managers to develop the style, comfort, and skills that enable shared decision making with staff nurses. Staff nurses also need to be supported in their growth as they are expected to be more involved in decision making. These actions will increase nurse recruitment and retention and enhance their contributions to the patient care mission of the organization.

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