Decisional Involvement Scale

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Working Conditions in Nursing – the Cycle

“Poor” Working Conditions

- Cost Concerns
  - Economic Downturn
  - Fewer Nurse Positions
  - Dissatisfaction

- Graduation of new nurses

Quality Concerns

- Shortage of nurses
- salaries, work environment
- studies. . . . Initiatives

Good Working Conditions

- Nursing School Enrollments
- Graduations from nursing schools
- Turnover

(McCloskey, J., 1995)
The PhD Thesis …
“What’s going on out there?”

1. Department of Nursing involvement in hospital governance

2. Staff nurse decisional involvement

3. Professional recognition & compensation for staff RNs
The Literature shaped the path

- Sociology of the professions
  - Managing *with* professionals versus managing professionals
- Organizational theory
- Professional nursing practice models
- Magnet hospitals
Scott – 3 models for structuring professional work

1. **Autonomous** -- control of most professional activities resides with professional staff

2. **Conjoint model** -- power is shared by administrators and professional participants

3. **Heteronomous model** -- control of most professional activities resides with administrators
Aydelotte’s Professional Nursing Governance Model 3 domains

(1) professional nurses -- patient care, improvement, certifications, and performance standards for practitioners

(2) administrators -- resource acquisition and allocation, interdepartmental and institutional relations

(3) shared -- policy development, administration of resources, scheduling, cost savings, support service, personnel policies, practice environment
Decisional Involvement

Distribution of authority among staff nurses and administrators/managers for decisions and activities that govern nursing practice and the practice environment

(Havens, 1990)
21 items re: the nursing practice environment

6 Subscales:

1. Unit Staffing & Scheduling
2. Communication/Liaison Activities With Other Providers and Departments
3. Quality of Professional Practice
4. Quality of Support Staff Practice
5. Unit Governance and Leadership
6. Recruitment
Decisional Involvement Scale (DIS)

21 items from the literature on professionals working in organizations

1. Which personnel have authority for decision-making?

2. Who should have authority for decision-making?

<table>
<thead>
<tr>
<th>Decisional Involvement Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin/Mgt</td>
<td>Admin/Mgt with staff input</td>
<td>Equally shared by RNs/Mgt</td>
<td>Staff with Admin/Mgt input</td>
<td>Staff</td>
<td></td>
</tr>
</tbody>
</table>
Psychometric Assessment of the DIS

• Content Validity – experts in field
• Construct Validity – contrasted groups
• Reliability – internal consistency – item analysis across samples
• Confirmatory factor analysis – structural modeling – 2 independent samples
• Ongoing – data base

Reliable and Valid
“Actual” & “preferred” DI (n=1,066)

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<td>Equally shared by Mgt/Staff</td>
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<tr>
<td>Staff with Admin/Mgt input</td>
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<tr>
<td>Staff</td>
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</table>
“Preferred” DI by % of agreement for each subscale (n=1,066 RNs)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Adm/Mgt Only</th>
<th>Adm/Mgt RN Input</th>
<th>Equally Shared</th>
<th>RNs - Adm/Mgt Input</th>
<th>RNs Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staffing &amp; Scheduling</td>
<td>1%</td>
<td>11%</td>
<td>39%</td>
<td>41%</td>
<td>8%</td>
</tr>
<tr>
<td>2. Collaboration/Liaison Activities</td>
<td>1%</td>
<td>12%</td>
<td>54%</td>
<td>29%</td>
<td>4%</td>
</tr>
<tr>
<td>3. Quality of Prof Practice</td>
<td>1%</td>
<td>24%</td>
<td>60%</td>
<td>14%</td>
<td>1%</td>
</tr>
<tr>
<td>4. Quality of Support Staff Practice</td>
<td>2%</td>
<td>28%</td>
<td>55%</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>5. Gov. &amp; Leadership</td>
<td>0%</td>
<td>37%</td>
<td>53%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>6. Recruitment</td>
<td>8%</td>
<td>43%</td>
<td>42%</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>
DIS – Staff and Manager Perceptions
(Scherb et al., 2010)

<table>
<thead>
<tr>
<th></th>
<th>Actual DIS Score</th>
<th>Preferred DIS Score</th>
<th>Statistical Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff RNs (n=290)</td>
<td>2.10 (SD = .58)</td>
<td>2.79 (SD = .52)</td>
<td>p&lt; .001</td>
</tr>
<tr>
<td>Managers (n=22)</td>
<td>2.22 (SD = .36)</td>
<td>2.56 (SD = .45)</td>
<td>p&lt; .001</td>
</tr>
</tbody>
</table>

No differences based on:
- Education
- Certification

Statistically Sig. differences b/w staff and managers preferred DI p<.046
- Unit governance/leadership p<.039
- Quality of support staff practice p<.014
Gap between what “is” and what “ought to be”

- “actual” - “desired” = dissonance score
- “take steps” to close the gap.
- units with no gap or a small gap = opportunities for learning
## DIS “actual” & “desired” performance (n=1,315 clinical nurses)

<table>
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<tr>
<th>Decisional Involvement Scale</th>
<th>Actual Mean</th>
<th>Desired Mean</th>
<th>Actual &amp; Desired Difference (t and sig.2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staffing/Scheduling</td>
<td>2.63</td>
<td>3.23</td>
<td>$t = -22.375, p = .000$</td>
</tr>
<tr>
<td>2. Collaboration/Liaison Activities</td>
<td>2.36</td>
<td>2.97</td>
<td>$t = -25.811, p = .000$</td>
</tr>
<tr>
<td>3. Quality of Professional Practice</td>
<td>1.92</td>
<td>2.62</td>
<td>$t = -33.340, p = .000$</td>
</tr>
<tr>
<td>4. Quality of Support Staff Practice</td>
<td>1.60</td>
<td>2.64</td>
<td>$t = -43.838, p = .000$</td>
</tr>
<tr>
<td>5. Unit recruitment</td>
<td>1.40</td>
<td>2.36</td>
<td>$t = -39.959, p = .000$</td>
</tr>
<tr>
<td>6. Unit Governance &amp; Leadership</td>
<td>1.41</td>
<td>2.26</td>
<td>$t = -49.062, p = .000$</td>
</tr>
<tr>
<td>Composite DIS Score</td>
<td>1.90</td>
<td>2.68</td>
<td>$t = -48.595, p = .000$</td>
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**Admin/Mgt**

1. Admin/Mgt
2. Admin/Mgt with staff input
3. Equally shared by Mgt/staff
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5. Staff
Decisional Dissonance
(Alutto and Belasco 1972)

- Discrepancy between actual & preferred = the participation continuum
- Decision equilibrium - actual = preferred
- Dissonance conditions:
  - (1) deprivation – actual = less than preferred
  - (2) saturation – actual = exceeds preferred

- Education, manufacturing and health care
Decisional dissonance – the literature

• **Cognitive Dissonance Theory** (Festinger, 1957)
  - Psychological “discomfort” & tension
  - Job related tension
  - Negative association - job involvement
  - Negative association - job satisfaction

• **Discrepancy Framework** (Alutto & Belasco, 1972; Alutto & Arito, 1974)
  - Discrepancy b/w actual & preferred - greater job-related tension
  - Greater discrepancy = greater negative associations:
    - job commitment
    - job satisfaction
  - *** Over and under participation associated with dissatisfaction
Decisions About Unit Staffing & Scheduling

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The chart shows the actual and desired scales over time, with peaks and troughs indicating areas for improvement or alignment.
Experienced dissonance by unit type
Significant Associations

- Higher perceived “actual” - more satisfied
- Higher “preferred” - less satisfied - ? Dissonance
- Greater “actual” -- lower EE
- Greater “preferred” – higher EE
Significant Findings in the Literature re: DI

• Staff RN DI generally lower than desired
• Staff dissonance – stat. sig.
• Staff/Mgr concordance – stat. sig. difference
• More DI in magnet hospitals – stat. sig.
• Education/certification – mixed findings
• Academic health center RNs desired more DI – stat sig.
• Nurses in Turkey, Taiwan & South Korea – lower actual and preferred DI
DIS Uses ...
Who would have guessed?

- actual levels of DI
- desired levels of DI
- decisional dissonance
- staff & manager concordance
- areas for change
- evaluate initiatives to enhance DI
- program of benchmarking, feedback, & dialogue – strategy for implementation of professional practice
  - “Important conversations”
  - Positive Deviance
DIS use today

• A measure to gage decisional involvement
  • actual vs. desired
  • evaluate progress
  • identify gaps

• Nurse Advisory Board “White Paper” -- implementing Shared Governance

• Transforming Care at the Bedside (AONE)

• Used in more than 18 countries

• Translated for use in more than 10 countries
  • The K-DIS

• Adapted for ambulatory care (Theiss, 2014)
Motivation to enhance decisional involvement

• Key -- professionals working in organizations
• Related to patient, nurse & organizational outcomes
• Recruitment and retention
• IOM report (2004)
  • *Keeping Patients Safe: Transforming the Work Environment of Nurses*
• ANCC Magnet Recognition Program™
• ANCC Pathway to Excellence Program™
• Quality initiatives
  • Engage frontline workers to enhance quality & safety
Application for managers and leaders

• Decisional Involvement may not be a “one size fits all”
• Control may not be equally meaningful to all nurses
• Simply increasing decision latitude may not be the solution
• Consider dissonance
• Differences by education ?
• Differences by generational cohort ?
• Differences by unit type (? “Positive Deviants”?)
Questions??