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Influence of Empowerment on Nurses' Participation in Decision Making

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Abstract:
Background: *Nursing profession is increasingly confronted with many challenges, thus nurses must be empowered to participate in all levels of decision making to enhance their commitment and improve patient care.*
Aim*: This study aimed at identifying the influence of empowerment on nurses' participation in decision making PDM.*
Method: *Descriptive-correlation design was used. The study subjects included all (645) nursing staff worked at El-Mahalla General Hospital. The data were collected using I- Conditions of work effectiveness questionnaire, encompassed structural (57 items) and psychological empowerment (9 items). II- Decisional Involvement Scale (18 items).*
Results: *(77.4%) of the study subjects had a high level of psychological empowerment. (44.4%) of them had a moderate level regarding structural empowerment, (76.9%, 72.9% and 47.3%) had moderate level of formal power, resources and information subscales respectively. Majority (93%) had low level of actual PDM and there was statistically high significant correlation between nurses' empowerment and PDM.*
Conclusion*: Regardless the considerable percent of nurses' empowerment they still need to be empowered to enhance their PDM. It is*
Recommended *to increase nurses' representation in administrative boards, and apply comprehensive strategies to improve nurses' actual PDM.*
Keyword: *Nurses, psychological empowerment, structural empowerment, actual, preferred, and participation in decision making.*

I. Introduction

Nursing staff constitute the majority of healthcare workforce. To maintain high quality and safe patient care nurses have to be involved in decision making (DM) **Shariff** (2015)[(1)]. Decisional involvement can defined as the way of sharing decision making authority as well as the activities that manage nursing practice policy and the practice environment. Nurses involvement in DM can be classified to **Liu** (2008)[(2)] actual or preferred. Actual involvement refers to the degree to which nurses have the autonomy and responsibility to make decisions. Whilst, preferred involvement refers to nurses' desire to be involved and responsible for decisions other than care activity **Poudel et al** (2014)[(3)].

Nurses' involvement in DM has positive benefits for patients, healthcare system as well as nurses **Jaafarpour and Khan** 2011[(4)] and **Havens and Vasey** 2003[(5)]. Studies revealed that nurses' participation in DM contributes to decrease the following;conflict with patient, hospital stay, patient complication, and mortality rates **Havens et al** 2003[(5)], **Di Gaudio** 1993[(6)].Thus the healthcare managers must empower nurses' participation in DM at all level. According to organizational context, the empowerment concept involves providing nursing staff with the required power, freedom and flexibility to make decisions regarding work activities **Hadi et al** (2013)[(7)], **Al-Dweik et al** (2015)[(8)] and **Basavanthappa** (2014) [(9)]. Empowerment has two main perspectives structural and psychological.

Cicolini et al (2014)[(10)] Structural empowerment; is the actual application of management and the availability of social structure that permit staff attainment of desired work outcomes. Structural empowerment can be reached through facilitate nurses' access to resources, information, support, and opportunity **Callicutt** (2015)[(11)] and **Mota**(2015)[(12)]. Support involves providing feedback and guidance from superiors, peers and subordinates. Resources refer to the materials, money and time as well as human-being needed to accomplish work goals **Liu** (2008)[(2)]. Information means availability of the knowledge required to achieve job activities. Opportunity refers to the chance to learn and grow in the work setting through expanding nurses' knowledge and skills to participate in decision making processes **Laschinger et al** (2009)[(13)].

Enabling staff access to those organizational structures can be facilitated through power. Therefore power can be defined as the nurses' ability to get things done, through mobilization of resources, and utilize whatever they require for achieving the healthcare goals. Power can stems from two different sources formal and informal. A flexible job that permits nurses' innovation and involvement in DM and maximize nurses'

perception is referred to as formal power. While informal power gained from relationships and alliance with superiors, peers, and subordinates both within and outside the organization **Cicolini et al** (2014)[10] **Martin** (2010)[14] and **Miller et al** (2000)[15].

Psychological empowerment is concerned with how those managerial applications are perceived by nurses, it comprised four dimensions: meaning, competence, self-determination, and impact. Meaning is the value of work goals as perceived by nurses' and influenced by their personal set of values, and beliefs. Competence is the nurses' ability to perform their work successfully. Self-determination is the nurses' sense of autonomy and the degree to which they feel independent and control over their work activities. Impact is the extent to which nurses feel being able to contribute to work outcome or perceive their efforts influence the workplace **Cicolini et al** (2014) [10] **Liu** (2008)[2].

Literature supported that nurses' deprived from participation in DM experience low levels of control over work activities, resist change, turn out to be inflexible. Furthermore, those nurses' level of motivation, job satisfaction, loyalty decreased. **Foot and Hook** (1999)[16], **Kramer and Schmalenberg**(2003)[17]. In spite of this, recent studies revealed that nurses' decisional involvement is still restricted to the area of the nurse practice environment besides; nurses' contribution in healthcare policy development is limited to implementation **Shariff** (2015)[1]. Also the level of nurses' desire to and the scope of their participation in decision making were not revealed yet **Liu** (2015)[18] **Warshawsky** and **Havens** (2010)[19].

Aim of the study

Identify the influence of empowerment on nurses' participation in decision making.

Research question

1- Is there a relationship between nurses' levels of empowerment and their participation in decision making?

II. Materials and method

Design: The present study followed a descriptive- correlation design.

Setting: This study was conducted at El-Mahalla General Hospital, affiliated to Egyptian Ministry of Health.

Sample: All available (645) on charge nurses were included in the present study.

Tools: Two tools were utilized for collecting data.

Tool (I) Conditions of work effectiveness questionnaire, consisted of two parts,

part 1: subjects' characteristics included age, level of education, department, position and years of experience.

Part2: Conditions of Work Effectiveness Questionnaire, developed by researchers based on Armstron (2006)[20]and Laschinger et al (2001)[21], it encompassed of six subscales of structural empowerment included opportunity (7 items), information (8 items), support (9 items), resources (7 items), formal power (9items)and informal power (17items).

Scoring System: The subject's responses were scored on three points Likert Scale ranged from 1 (did not have any) to 3 (all the time have). The questionnaire total scores were divided into three levels high ≥75%, moderate 74%-50 and, low <50%.

Part3: Modified Psychological Empowerment Instrument (PEI) by

Liu (2008) [2] based on

Spreitzer (1995) [22] included four dimensions meaning (2 items), competence (2items), self –determination (3 items), and impact (2 items).

Scoring system: The subject's responses were scored on three points Likert Scale. Ranged from disagree (1), to agree (3). The total scores of this scale divided into three levels high ≥75, moderate 74-50- % and low <50%.

Tool (II) Decisional Involvement Scale (DIS) modified by researchers based on

Liu (2008) [2] and

Havens and Vasey (2005) [23] to measure actual and preferred decisional involvement. It consisted of plan unit staff coverage (2 items) improve professional practice (4 items), recruit professional staff (3 items), unit governance activities (6 items) and unit collaboration activities (3 items).

Scoring system: subject's responses measured on five points Likert Scale ranging 1= administration only, 2= primarily administration with some staff nurse input, 3=equally shared by administration and staff nurses, 4= primarily staff nurses with some administration input, and 5=staff nurses only. The total scores divided into high ≥75, moderate 74-50% and, and low <50%. However a high score suggests a high degree of nurses' involvement, a moderate score suggests moderate degree of nurses' involvement and a low score suggests a low degree of nurses' involvement.

Method

- Researchers translated the study tools into Arabic language, then presented it to nine experts in the field of nursing administration and their comments were considered and needed correction were done. A pilot study was conducted on a 10% of the study sample 64 nurses; who were not included in present study subject; to

ensure the clarity and applicability of the tools. Cronbach's alpha for the Conditions of Work Effectiveness Questionnaire (CWEQ) was 0.92 and decisional Involvement Scale (DIS) was 0.94.

- **Ethical considerations,** Official permission was obtained from El-Mahalla General Hospital responsible authorities.The purpose of the study was explained to the nursing staff and their informed consents to participate in the study were obtained. The subjects were assured that their date will be kept confidential, and their right to withdraw was grunted.Researchers met the nursing staff individually at their workplace and distribute the study tools on nursing staff, each respondent consumed about 30 minutes to fill in study tools. Data collection phase consumed six months.

- **Statistical analysis**: The collected data was organized, tabulated, and statistically analyzed using Microsoft Excel and Statistical package for the social sciences (SPSS, version 17). For quantitative data the range, mean, and standard deviation were used. Qualitative data represented in form of number and percent. Spearman's coefficient correlation test was used to show variables correlation.

III. Results

Table (1): The study subject's characteristic data. (N=645)

Items	No.	%	Items	No.	%
Age			**Experience(years)**		
<30	271	42.0	**<10**	293	45.4
30 – 40	227	35.2	**10 - 20**	213	33.0
40	147	22.8	**20**	139	21.6
Range	20-56		**Range**	38-1	
Mean ± SD	32.64±8.10		**Mean ± SD**	12.42±8.8	
Position			**Department**		
Head nurses	74	11.5	**ER**	154	23.9
Nurse	571	88.5	**ICU**	156	24.2
Qualifications			**Surgery**	112	17.4
Post graduate studies	17	2.6	**OR**	93	14.4
Bachelor of Ng.	254	39.4	**Medical**	56	8.7
Deplume	346	53.6	**Outpatient**	29	4.5
Associate	28	4.3	**Obstetric**	25	3.9
			Pediatric	20	3.1

Table (1) shows the study subject's characteristic data. The highest percent (42.0%) of the study subject age were <30, the subjects' age ranged between 20 upto56 years. Majority (88.5%) of the study subjects was nurses and only (11.5%) were head nurses. Above half (53.6%) of the sample had a Deplume degree and minority (2.6%) had post graduate nursing studies. The highest percent (45.4%) of the sample had <10 years of experience. Around quarter (24.2% and 23.9%) of the sample worked in intensive care units (ICU) and emergency room (ER) respectively.

Table (2): Distribution of nurse according to their level of empowerment

Nurses' empowerment items	Nurses' levels (N=645)		
	High	Moderate	Low
	No. (%)	No. (%)	No. (%)
Structural empowerment	**333 (51.6)**	**287 (44.5)**	**25 (3.9)**
Opportunities	**538 (83.4)**	**82 (12.7)**	**25 (3.9)**
Information	**183 (28.4)**	**305 (47.3)**	**157 (24.3)**
Support	**562 (87.1)**	**47 (7.3)**	**36 (5.6)**
Resources	**139 (21.6)**	**470 (72.9)**	**36 (5.6)**
Formal power	**62 (9.6)**	**496 (76.9)**	**87 (13.5)**
Informal power	**318 (49.3)**	**282 (43.7)**	**45 (7.0)**
psychological empowerment	**499 (77.4)**	**143 (22.2)**	**3 (0.5)**
Meaning	**614 (95.2)**	**30 (4.7)**	**1 (0.2)**
Competence	**573 (88.8)**	**70 (10.9)**	**2 (0.3)**
Self –determination	**278 (43.1)**	**263 (40.8)**	**104 (16.1)**
Impact	**154 (23.9)**	**357 (55.3)**	**134 (20.8)**

Table (2) illustrates distribution of nurse according to their level of empowerment. High percent (77.4%) of the study subjects had a high level regarding psychological empowerment and around half (48.4%) had moderate and low level regarding structural empowerment. Concerning structural empowerment majority of the study subjects had a high level of empowerment (87.1% and 83.4%) regarding support and opportunity subscales respectively, while high percent (76.9% and 72.9%) had moderate level of empowerment regarding formal power and resources subscale. Concerning psychological empowerment majority (95.2% and 88.8%) of

the subjects had high level of empowerment regarding meaning and competence subscales respectively, while considerable percent (55.3% and40.8%) had moderate level of empowerment regarding impact and self-determination subscale respectively.

Fig. (1) Study subjects' actual and preferred participation in DM (N=645)

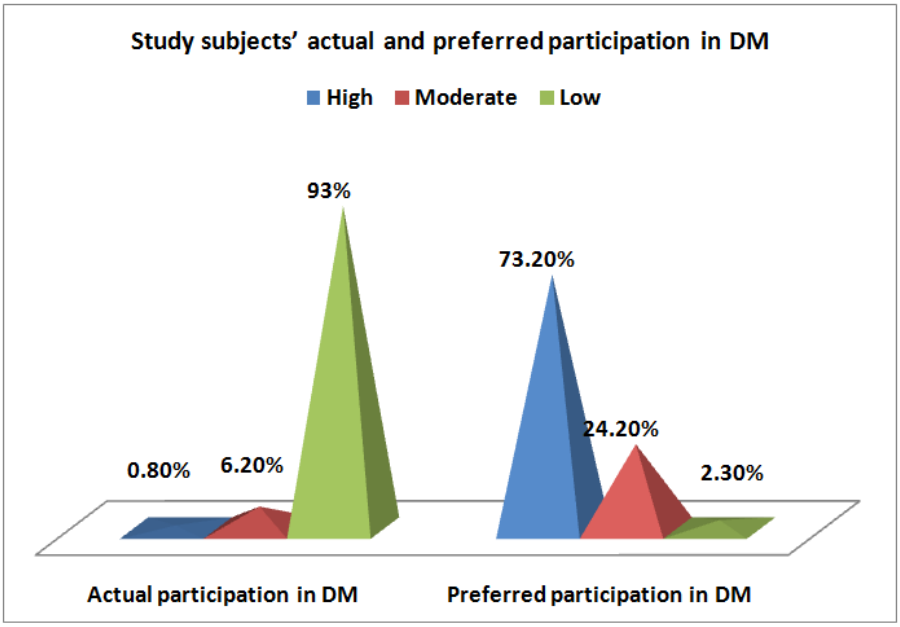

Figure (1) illustrates study subjects' actual and preferred participation in decision making. The vast majority (93%) of the study subjects had low level in actual participation in decision making, while high percent (73.2%) had high level of preferred participation in DM.

Table (3): Differences between study subjects' actual and preferred participation in decision making

Participation in decision making (PDM)	Current PDM			Preferred PDM			One way Anova
	Mean	±	SD	Mean	±	SD	
Plan unit staff coverage	**1.72**	±	**1.67**	**4.08**	±	**2.52**	**3.868 (0.000*)**
Improve professional practice	**1.60**	±	**3.41**	**3.95**	±	**5.01**	**7.606 (0.000*)**
Recruit professional staff	**0.39**	±	**1.54**	**2.99**	±	**2.55**	**9.407 (0.000*)**
Unit governance activities	**1.20**	±	**3.26**	**3.02**	±	**4.80**	**1.614 (0.058*)**
Unit collaboration activities	**1.21**	±	**1.99**	**3.06**	±	**2.41**	**1.592 (0.097*)**
Total	**1.32**	±	**9.78**	**3.27**	±	**16.97**	**2.361 (0.000*)**

*** □ 0.05**

Table (3) represents differences between study subjects' actual and preferred participation in decision making. The study subjects' expected level of PDM (3.27 ±16.97) was higher than their current level of PDM (1.32 ±9.78). The expected level of participation in all decision making subscales were significantly higher than the current level of PDM.

Table (4): Correlation between nurses' empowerment and participation in DM.

Variables	structural empowerment	psychological empowerment	current PDM	expected PDM
structural empowerment	1.000			
	.			
psychological empowerment	.419**	1.000		
	.000	.		
current PDM	.187**	.245**	1.000	
	.000	.000	.	
expected PDM	.298**	.201**	.180**	1.000
	.000	.000	.000	.

*** □ 0.01**

Table (4) shows correlation between nurses' empowerment and participation in decision making. The table revealed that there was statistically high significant correlation between nurses' empowerment and their participation in decision making.

IV. Discussion

The healthcare environment is becoming more complex and sophisticated; as a result nursing profession face great challenges and need to respond more rapidly for the changing technology. Thus, nurses require to think critically and to be able to make suitable prompt decisions. Consequently healthcare organizations have to empower their nursing staff and permit their participation in decision-making which in turn lead to improve nurses' satisfaction, commitment, retention, and over all patient care.

Our study results showed that around half of the study subject had a moderate and low level of structural empowerment. Majority of the study subject had a high level of empowerment regarding support and opportunity subscales. On the other hand high percent had moderate level of empowerment regarding formal power, resources and information subscales.These findings may be due to the highest percent of the study subject were adult nurses (less than 40 years), so they accept the work challenges, need to refine their knowledge and skills, and searching for opportunities to improve their position in the hospital. But they face obstacles such as limited resources, limited representation of nurses in administrative boards and lacking information about organizational policies. **Kanter** (1993)[24] in her studies concluded that providing staff with formal power that permit their flexible, visible and central work will lead to achieve organizational goals. In addition, if leaders did not have the required formal power, they turn out to be dominant, and become less flexible with subordinates.

Our study findings are in congruence with **Bish et al** (2014)[25], **Ning et al** (2009)[26], **Laschinger et al** (2009)[27] and **Nedd** (2006)[28] they found that nursing staff had moderate level of structural empowerment. Also, **Liu** (2008)[2] and **Cho et al** (2006)[29] found that nurses had moderate level of structural empowerment , they had the most access to opportunity and the least access to information and formal power. There were contradiction between the present study results and **Cawley** (2012)[30] and **Parker et al** (2010)[31] found that nursing staff did not perceive that they were empowered as they did not have open access to power structures, work opportunities, or even support.

High percent of our study subjects had a high level of psychological empowerment. Majority of the subjects had high level of empowerment regarding meaning and competence subscales, while more than half of them had moderate and low level of empowerment regarding impact and self-determination subscale. This may be attributed to more than half of the study subject had more than 10 years of experience, so they had self confidence in their level of competency and they care for their work that provide them with sense of personal identity and integrity that energize them to do their best. On the other hand, they did not had control over their work, they lack autonomy to make independent care decisions as the physicians have the upper hand and dominate the patient care decisions. Adding to that lake of recognition of nurses' role in patient care by administration as well as community they view physician as the main contributor to patient recovery.

These findings go in the same line with **Liu** (2008)[2] and **Faulkner & Laschinger** (2008)[32] who revealed that nursing staff had high-moderate level of psychological empowerment, their highest mean score regarding meaning subscale and the lowest subscale was the influence. Whilst, their nursing subjects reported a sense of meaning in their work, they believe being unable to make a significant impact in the organization.

Barden et al (2011)[33], **Lewin and Urmston** (2000)[34] and **Laschinger and Wong** (1999)[35] viewed that to improve nurses' practical autonomy healthcare organizations must develop shared governance without management interference, that in turn improve their self-efficacy. Therefore, it is crucial for healthcare organizations to address the need for leadership skills and shared governance, and reflects on management practice and critique itself on an ongoing basis to ensure it meets the growth and development needs of nurses as well as patients.

The vast majority of the present study subject had low level in actual participation in decision making, while high percent had high level regarding preferred participation in DM. Also the expected level of participation in all decision making subscales were significantly higher than the current level of PDM. Regarding the actual participation, these results can be viewed logic as the majority of the subject were staff nurses and have no contribution in organizational decision making. While the high level of their preferred participation in DM perhaps this may be due to majority of those nurses were adults and ready to accept new challenges and responsibilities brought to their role as a result of changes in technology. Furthermore those nurses during their undergraduate education were equipped with different skills such as critical thinking, problem solving and decision making, thus they are more apt to participate in decision making process.

These results were congruent with **Nooritajer and Mahfozpour** (2008)[36] and **Harmon et al** (2000)[37] found that highest proportion of their study sample had a moderate level of participation in decision making. Also these results were confirmed by **Ahmed and Safadi** (2013)[38] concluded that there was significant difference between actual and preferred participation in decision making among all categories of nursing personnel. Additionally, **Jaafarpour and Khan** (2011)[4], **Scherb et al** (2011)[39] and **Mangold et el** (2006)[40] found that nurses' preferred level of PDM is higher than their actual level of PDM and that the most preferred forms of PDM were unit governance, leadership and quality of support staff practice and the least preferred

PDM was professional recruitment. Also **Eid et al** (2009)[41] found that nurses' PDM was limited including patient care as well as administrative dimensions.The present study results revealed that there was statistically high significant correlation between level of empowerment and level of participation in DM. These results go in the same line with **Emamgholizadeh et al** (2011)[42] and **Liu** (2008)[2] as they found a significant positive correlation between nurses PDM and total dimension of empowerment.

V. Conclusion

Around half of the study subject had a moderate and low level of structural empowerment. High percent of them had moderate level of empowerment regarding formal power, resources and information subscales. The vast majority of the present study subject had low level in actual participation in decision making, while high percent had high level regarding preferred PDM. Also the expected level of participation in all decision making subscales were significantly higher than the current level of PDM. The present study results revealed that there was statistically high significant correlation between nurses' level of empowerment and their level of PDM.

Based on the findings of this study, we recommend that:

1- Hospital administration have to:

- Increase nurses' representation in administrative boards, and
- Foster work environment that enhance nurse-physician collaboration.
- Guarantee resources availability.
- Ensure open communication networks.

2- Nurse Managers have to:

- Ensure nurses' participation in decision making,
- Delegate more power for nursing staff.

3- Nurse educators have to:

- Integrate critical thinking and decision making process in undergraduate nursing education courses.

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