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**TRANSFORMATIONAL CHANGE: PERCEPTIONS OF PROCESS AND
OUTCOMES BY NURSING STAFF IN A HEALTH CARE FACILITY**

By

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Thesis submitted to the School of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Masters of Arts Education

University of Ottawa

April 2000



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Abstract

This qualitative exploratory case study focused on how nursing staff perceived a complex transformational change within a large tertiary care teaching hospital. In an effort to improve the understanding of transformational learning and change, this study examined a change that required nursing staff to critically reflect on their practice and if necessary change their values, beliefs and attitudes. The objectives of the transformational innovation were to increase professional accountability and authority by changing the decision-making of nursing staff to a more autonomous process. The structural changes introduced included implementation of unit councils and primary nursing.

Study data consisted of documentation collected over a three and a half year period during the implementation of the transformational change. During the analysis, similar phrases were coded and categorized and then re-categorized into major patterns or ideas reflecting perceptions of the innovation, transformational learning process, and outcomes of the change. Results describe the concerns, learning needs, and system considerations that influenced staff when implementing a transformational change. The results of this study will be of interest to administrators and educators as they prepare staff for future challenges.

Acknowledgments

I would like to acknowledge the individuals who have provided me with the support and encouragement throughout my graduate experience. I am indebted to my thesis advisor Dr. Anne Jefferson who never gave up on me and kept me on time. I wish to thank my committee members; Dr. Janice Ahola-Sidaway, and Dr. Ruth Taaffe who kept me focused and supported me through the process. Their different perspectives were invaluable. I extend a special thanks to Dr. Jo Logan who met me with frequently to discuss the health care perspective. Without her, all of this would not have been possible.

I would also like to express my deepest appreciation to my family, Jim, Paula and Peter for their continuous support and encouragement. I couldn't have done it without you!

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CHAPTER ONE: INTRODUCTION TO THE PROBLEM

Background

The modern organization has been challenged with a competitive environment driven by forces that include technological advance, globalization, and a need for efficiencies that have forced employers and employees to reconceptualize ways in which goals can be met. The typical organizational response is a multifaceted effort to increase productivity, to increase customer satisfaction, and to reduce costs. In order to be successful, organizations are now confronted with the necessity to encourage an environment of continuous learning in order to facilitate employee abilities to demonstrate increasingly complex skills. The health care system is challenged in similar fashion. Health care funding is decreasing at the same time that institutions are forced to manage an increase in the complexity and acuity of the health care consumer, an increase in the complexity of the care provided, and the unpredictability of client outcomes (Barker, 1992; Porter-O'Grady, 1994).

Many of the organizational changes in health care have been comprehensive and large-scale with few recognizable structures in place after a few years. The degree and rapidity of change in health care demands new ways of perceiving, thinking, and behaving by all stakeholders. This element is essential for ongoing organizational well-being. The term associated with these types of dramatic changes is known as transformational change (Barker, 1992). Transformational change in an organization involves changing the employees' values, beliefs, and attitudes with respect to the entire

Organizational process. For employers, these changes are contingent on the complex challenge of helping employees transform their values, beliefs, and attitudes to more closely align them with the structural and process changes that are necessary. For employees, this necessitates developing new ways of thinking, learning, and behaving. The process has been defined as transformational learning (Brooks, 1989).

Interest in the required changes in an individual's values, beliefs, and attitudes is one that has occupied organizational change theorists for some time; yet few investigations exist on the topic of transformational change. Experts (Bergquist, 1993; Daft, 1995) agree that employees must function quite differently if the change effort is to be successful. At the same time, there is very little discussion in the literature on how to achieve this outcome. It is only recently that organizational change theorists and educators are beginning to examine the link between organizational effectiveness and transformational learning (sometimes referred to as critical reflective learning). This line of inquiry has resulted in Brooks (1989), Porter-O'Grady (1992), Scott and Jaffe (1991), and Senge (1990) taking the stance that if transformational change is to occur, transformational learning must happen as a means of changing values, beliefs, and attitudes. The results of such inquiries are an important starting point. Unfortunately, few studies in either the organizational or educational disciplines have been undertaken. Furthermore, the research and literature that is available for insight and guidance on the connection between transformational change and critical reflective learning or transformational learning (as it will be referred to hereafter), is almost silent with respect to a complex challenging work environment. This lack of a strong foundational knowledge base to draw upon, juxtaposed with the suggestion that past practice in

addressing change is insufficient, creates interesting circumstances for those associated with organizations undergoing multiple and complex adjustments. Despite critical need and organizational survival, little is known.

Some business organizations and health care systems have responded to the rapidly changing environment by placing the problem solving and decision-making authority at the level of employees who deal directly with the client. This action is supported by the work of such authors as Hammer and Champy (1993), Porter-O'Grady and Wilson (1995) and Trofino (1995). In fact, Trofino (1995) claims that allowing people responsibility and authority for decisions that affect them will increase the speed of decision-making, and improve collaboration, creativity, and quality. To achieve this, a change in both the organizational structure and culture, and a change in the values, beliefs, and attitudes of the individual are necessary. In this study, the required transformational change of the individual was the focus of the investigation.

Purpose of the Study and Research Questions

The purpose of this study was to improve the understanding of transformational learning and change process of a professional nursing staff in a large tertiary care teaching hospital in response to a transformational change. Two objectives were identified:

Objective 1: To explore the perceptions of nursing staff with respect to the transformational change.

Objective 2: To examine the perceptions of nursing staff with respect to learning different values, beliefs, and attitudes as a result of the mandated transformational change.

In addressing each of the two objectives, the factors that affect individual and organizational transformational change were determined.

This study examined a change in a large tertiary care teaching hospital that required nursing staff to change the way they practiced. In effect, the transformational change that was expected, required nursing staff at all levels in the organizational structure to undergo a transformational learning process by examining and if necessary changing their values, beliefs, and attitudes. The initiative was driven by nursing administration to move nursing practice from a rigid hierarchical model to one that was characterized by sensitivity to limited resources, critical thinking, creativity, autonomy, and authority for decision-making at the point nearest the decision of care. Traditionally, the nurse managers, not the clinical nurses, had made decisions regarding clinical practice thereby limiting the clinicians' autonomy and accountability regarding their decision-making and practice.

A professional practice model that reflected the desired transformational change was developed. In the model, patient care decision-making authority as well as decisions related to general functioning of the nursing unit resides with the professional nurse at the bedside. The model was used to guide professional development and supporting structural change so that nurses would be able to practice in a professional, autonomous manner.

Research Questions

The research questions that guided the investigation were:

1. How does nursing staff perceive the transformational change?

2. What factors are perceived by nursing staff that facilitate or deter the learning process?
3. What factors are perceived by nursing staff that facilitate or deter their implementation of the transformational change?
4. What outcomes of the transformational change are perceived by nursing staff?
5. How have nursing staff values, beliefs, and attitudes changed throughout the transformational change?

Significance of This Study

The health care system is in a state of constant change. There is no real model remaining that can be considered adequate for the future (Porter-O'Grady, 1992). Health care workers need to be able to adapt to an ever-changing environment. In order to do this, perceptions and assumptions must be critically examined to determine if they remain valid in light of the current reality.

Research is needed on fostering a transformational change and on how such a change attempt might affect the employees in large health care organizations. To date, the body of research as it relates to transformational change in an academic health care institution is limited in both amount and scope. There have been few studies reported on the perceptions of transformational change by front line staff in a changing organization. For this reason, it is anticipated that the findings of this study will make a clear contribution to the body of knowledge available. Knowledge of staff perceptions and concerns on transformational change implementation will assist administrators and educators to understand more thoroughly the impact of such a change in an unstable environment. A better understanding will assist them to plan strategies designed to

minimize perceived threats by the staff and to facilitate learning that can lead to effective change.

Organization of the Thesis

The concept of transformational change and the argument that such change is needed to permit organizations to be successful in the contemporary environment has been presented in Chapter 1 of this thesis. The background literature and theory that led to this study, as well as the particular research questions and significance of the study that arise from the background information are also presented in Chapter 1. A structured literature review is presented in Chapter 2. This review includes a historical perspective of organizational change that sets the foundation for the current perspective of organizational transformational change. The central concept of transformational learning and its relevance in education and in the professional practice of nursing is also introduced in Chapter 2. The final element included in Chapter 2 is the conceptual framework that was developed to guide this study. Chapter 3 presents the research methodology that was used to carry out this study. A qualitative exploratory study was undertaken from a case study perspective. The study examined the documentation involving a transformational change over a three and a half year period (1994-1997). This chapter describes the case study and links the documentation data to the research questions and conceptual framework. Chapter 4 presents the results and discussion of the study. The analysis was organized according to the perceptions of the nursing staff about the transformational change innovation, implementation process, and resulting outcomes. Chapter 5 synthesizes the interpretations into a unified whole and discusses the implications for administrative practice and suggestions for possible research. Case

studies such as this provide a rich source of data on which to base further research. The study has identified apparent strengths and weaknesses as perceived by nursing staff undergoing a complex transformational change.

CHAPTER TWO: REVIEW OF THE RELATED LITERATURE AND CONCEPTUAL FRAMEWORK

Overview

In order to develop a comprehensive understanding of the impact that transformational change has on organizations and employees, it is important to review the relevant literature on transformational change and transformational learning. First the trends and developments in organizational change theory will be reviewed. This review will be used to position the current study, which deals with the implementation of a transformational change, within the overall body of thought. A review of the literature dealing with transformational learning theory and its significance to organizational change will be considered. Finally, the application of change theory and transformational learning theory will be presented in a conceptual framework that has evolved from the review. This framework was used as a guide throughout this study.

Transformational Change

Highly complex organizations, including those in the health care sector, have had to adopt new theories of management in order to be competitive in the modern economy. The theory of hierarchical management that evolved in the first part of the twentieth century is being replaced by an inverted pyramidal structure that empowers the knowledge worker to be the primary decision-maker in a rapidly changing environment. The process needed to permit the worker to accept this role results from transformational learning and change. The evolution of management structure from hierarchical to

participative with the historical perspective and the development of transformational learning as the goal of change has been a subject of much research. The following review of the literature chronicles the change in thinking that has occurred in the modern management style.

Historical Perspective of Organizational Change

According to Owens (1998) three individuals – Taylor (scientific management), Fayol (administration), and Weber (bureaucracy) were the leading organizational theorists in the 1940's. Their concepts stressed efficiency, rationality, security, impersonality, formal role relationships, and hierarchy with managers responsible for the actions of their subordinates. Policies, procedures, and protocols determined the degree of decision-making and position in the organizational structure.

The traditional hierarchical structure views power and decision-making to be concentrated at the top where all ideas are initiated and then passed down for the lower levels to be put into practice. Competing concepts have been slow to challenge these classical and bureaucratic concepts of organization and administration.

W. Edwards Deming introduced the first challenge to the traditional concept of hierarchical management in the 1950's in Japan. His contribution was the concept of total quality management (Owens, 1998). Wheatley (1992) described chaos theory and the ways by which organizations move from chaos to order when undergoing major change using examples from quantum physics and biology. Hammer and Champy (1993) used the term re-engineering to describe structural organizational change. Senge (1990), whose work is germane to the subject of the current study, described the learning organization as the central factor in the ability of an organization to respond to change. In the modern,

complex organization, elements of all these theories are needed to produce a transformation.

Current Perspectives of Organizational Change

In the organizational literature, Daft (1995), Drew and Smith (1995), and Kilmann and Covin (1988) report that there is limited research available on implementation and the outcomes of transformational change. According to Drew and Smith (1995) there are many ways to focus on the nature of change, its sources, and its complexity. Owens (1998) describes simple organizational change as one that involves adopting new technologies, adapting to new political realities, and conforming to new demands while the inner core remains relatively unchanged. In contrast, he defines transformational change as a change in culture.

Bergquist (1993) refers to first-order change and second-order change. First-order change occurs when people in an organization do more or less of something that they are already doing as a way of returning to some desired state of homeostasis. It is always reversible and resembles the dynamics of a pendulum. The change effort can always be readjusted, using feedback systems that provide information about how the organization or groups are performing relative to the goal to be achieved. Second-order change is an irreversible process that occurs when individuals decide to or are forced to do something different from what they have done before, rather than doing more or less of what they already have been doing. There is a point when the organization begins to move in a new direction and once this point arrives, there is no turning back.

Ferguson (1980) in her “Aquarian Conspiracy” suggested two decades ago that individuals and organizations approached change in four ways, namely, exception,

incremental, pendulum, and transformational. Change by exception is keeping a belief system intact, while accepting some irregularity. Incremental change is a change that is so slow that there is often unawareness of having changed. A pendulum change is one that is abandoning a certain system of beliefs in favour of another, and the fourth type of change is transformational change. Transformational change is the most multifaceted and permanent because it requires a conscious process, which results in individuals having new insights and perspectives.

Because of the complexity of a transformational change, all levels of the organization must change to be successful (Kilmann & Covin, 1988; Owens, 1998; Senge, 1990; Wheatley, 1992). A transformational change combines strategic and business aspects with human and psychological issues, and seeks to create fundamental modifications in the way all stakeholders in the organization perceive, think, and behave (Kilmann & Covin, 1988). Changing the old ways of viewing the organization, changing practices and beliefs, and formulating a new vision and new action plan, are prerequisites to any transformational effort. Transformation is based on dissatisfaction with the old and belief in the new. This belief must be widespread or the organization's employees will not change. Changing documents, such as job descriptions, policies, and procedures does not ensure a different way of functioning. Behaviour and attitude change need to occur for a true transformation to take place (Kilmann & Covin, 1988).

Transformational change usually spreads throughout the organization at different rates of adoption. The individuals in each area of the organization might require different degrees of learning. Some will transform sooner and more easily, but all will be significantly affected in some way (Kilmann & Covin, 1988; Rogers, 1995). According

to Brooks (1989), in her review of the literature, complete transformation is rare, and there is little knowledge derived from research about how to make it successful. What is known about organizational transformations is rapidly evolving. Based on current research, there does not appear to be consensus on how to approach or sustain change (Bolman & Deal, 1997). There is, however, agreement that organizations must transform into cooperative, collegial, and collaborative structures that are decentralized in the decision-making process. The decentralization of the decision-making process promotes the involvement of all the key players. Those actively involved in the decision-making process are more apt to invest in the process to ensure that the desired outcomes are achieved (Bolman & Deal, 1997).

In the nursing organizational literature, Barker (1992), Porter O'Grady (1992), and Skelton-Green (1995) describe transformational change as an innovation, a process, and an outcome primarily from the leadership role and the leadership characteristics required to change an entire organization. In the educational psychology literature (see for example Brookfield, 1987 and Mezirow, 1991), a transformational change is described as the outcome of an individual's transformational learning, whereas in the organizational literature transformational change tends to be treated both as an innovation and outcome.

Transformational Learning

Change and learning are frequently mentioned as partners in organizational change research. Drew and Smith (1995) make the distinction between learning related to simple or superficial change, in which the context remains essentially uniform, and learning related to change in which the context is transformed. Argyris and Schön (1974)

describe change and learning as single-loop and double-loop learning. Single-loop learning is described as maintaining the field of constancy by learning to design actions that satisfy existing governing variables, whereas, double-loop learning is described as changing the field of constancy itself. Learning occurs when an individual enters a process of adjusting new ideas with the presuppositions of prior learning (Cranton, 1994; Fullan & Stiegelbauer, 1991). Mezirow (1990) defines transformational learning as a social process of learning through critical self-reflection, which results in a new or revised interpretation of the meaning of an experience, allowing a more integrative understanding of the experience and acting on these insights. This theory of adult learning is of particular significance when challenging traditional values, beliefs, and attitudes in the context of organizational change.

Brookfield's conceptualization of critical thinking is similar to Mezirow's description of transformational learning. He believes that critical thinking is the recognition of the assumptions underlying beliefs and actions, and the attempt to justify the rationale for these ideas and actions (Brookfield, 1987). Cranton (1994) notes that transformational learning has taken place when, based on critical reflection, some beliefs, values, and attitudes are retained and others are revised to match the new concepts. She describes this as a conscious process based on critical reflection. According to Brooks (1989), individuals need to be able to recognize the incongruencies existing in their values, beliefs, and attitudes and to be able to determine where past habits are no longer appropriate for the present challenges. However, personal habits of the mind and of behaviour are so difficult to break that even when there is an awareness of the problem and the problem produces negative results, personal change may still not occur. As a final observation, Mezirow (1991) states

that reflective learning can be either a confirmation of one's assumptions or a transformation. It becomes transformational when assumptions are found to be distorted, inauthentic, or otherwise unjustified.

The environment can stimulate critical reflection, by a discussion with others, or by internal processes that can lead to self-questioning. The theorists agree on the premise that individual transformational learning is irreversible once completed, and that there is no regression after the understanding is clarified and a commitment has been made to take the action (Cranton, 1994; Mezirow, 1990).

However, the authors reporting in the educational or organizational literature who have written about transformational learning in the workplace do not appear to consider transformational learning as a process linked to transformational change (Cranton, 1994; Marsick, 1987; Mezirow, 1990; Senge, 1990). For example, in Taylor's (1997) review of Mezirow's Transformational Learning Theory, only three of the thirty-nine studies addressed transformational learning in organizations. One exception is Brooks' (1989) research, which examined critical reflective learning (transformational learning) in an organization. The purpose of her study was to examine the interaction between critically reflective learning and organizational change. The perspectives of a single small group of people and their memory of events were analyzed. She found that critical reflection by employees produced positive changes and that they strive to change the organization only when they perceive no opposition to the initiatives. Her study was a useful base for this study, but it did not address the perceptions of individuals as they implemented a transformational change.

Brookfield (1987, 1993), Cranton (1994), and Marsick (1987) have studied teaching the process of transformational learning to students, educators, and managers in educational and business organizations. Their research is based on small numbers of individuals in groups and is seen as a process that could occur on an individual basis due to a crisis or as a process that could be taught in a classroom in a controlled setting. They do not address transformational learning in organizations undergoing constant rapid change.

There is a dearth of research in health care generally and nursing in particular that identifies staff perceptions of change, especially transformational change. Lankshear (1996) studied how nursing staff changed their perceptions of their professional identity and accountability over a 14-month period of time after non-nurse managers were placed on the nursing units. The study demonstrated that the transformation of the nursing staff was still continuing. Over the 14 month period the nursing staff moved from uncertainty and feelings of vulnerability to being able to articulate their role and existing barriers to them for assuming their new role.

Ingersoll, Schultz, Hoffart, and Ryan (1996) conducted a quantitative longitudinal quasi-experimental study to measure the effects of a professional practice model on perceptions of work group relationships and perceptions of ideal versus actual nurse managers. The study focused on the manager's style of management and the movement of nursing staff towards more autonomous decision-making. The study found that the introduction of a professional practice model resulted in more favourable perceptions about the work group and a desire for a more facilitative nurse leader. The authors concluded that change in perception of work group and leader, rather than job

satisfaction, may be an early indicator of favourable outcome of change. The study did not address the important issue of staff perceptions during the change process.

McCormack (1992) used a qualitative case study methodology to identify the perceptions experienced by nursing staff that worked through a professional practice change. The model of care studied was primary nursing, and the study took place two years after the model was introduced. Eleven nurses on a 24 bed surgical nursing unit participated in the study. The data sets consisted of diaries kept by each member of the staff and a series of semi-structured interviews. This was a small-scale case study, but it did describe some issues relating to the practice of primary nursing that could be applicable to many areas of nursing. The study examined the outcome of change, but did not consider the implementation and educational aspects of the change.

In the study undertaken for this thesis, the challenge was to link individual or group transformational learning to the implementation of transformational change in a health care organization. Following Maxwell's (1996) advice that the most productive ways of constructing a conceptual framework are often those that integrate different approaches, the conceptual framework for the study was derived from a combination of the current organizational change theories and transformational learning theories.

Conceptual Framework of the Study

The conceptual framework of the present study rests on the assumption that neither current change theories nor transformational learning theories can be used alone to examine the perceptions of professional staff as they work through a transformational change. Therefore this study utilized a conceptual framework that applied the concepts of transformational learning theory to the change variables found in most change theories

such as innovation theory, system thinking theory, and organizational development theory.

The three main elements that make up the framework are: (1) transformational change as the innovation, (2) transformational change as the learning process, and (3) transformational change as the outcome (Figure 1). These three elements interact to cause change to the organizational structure as well as to individual and group values, beliefs, and attitudes.

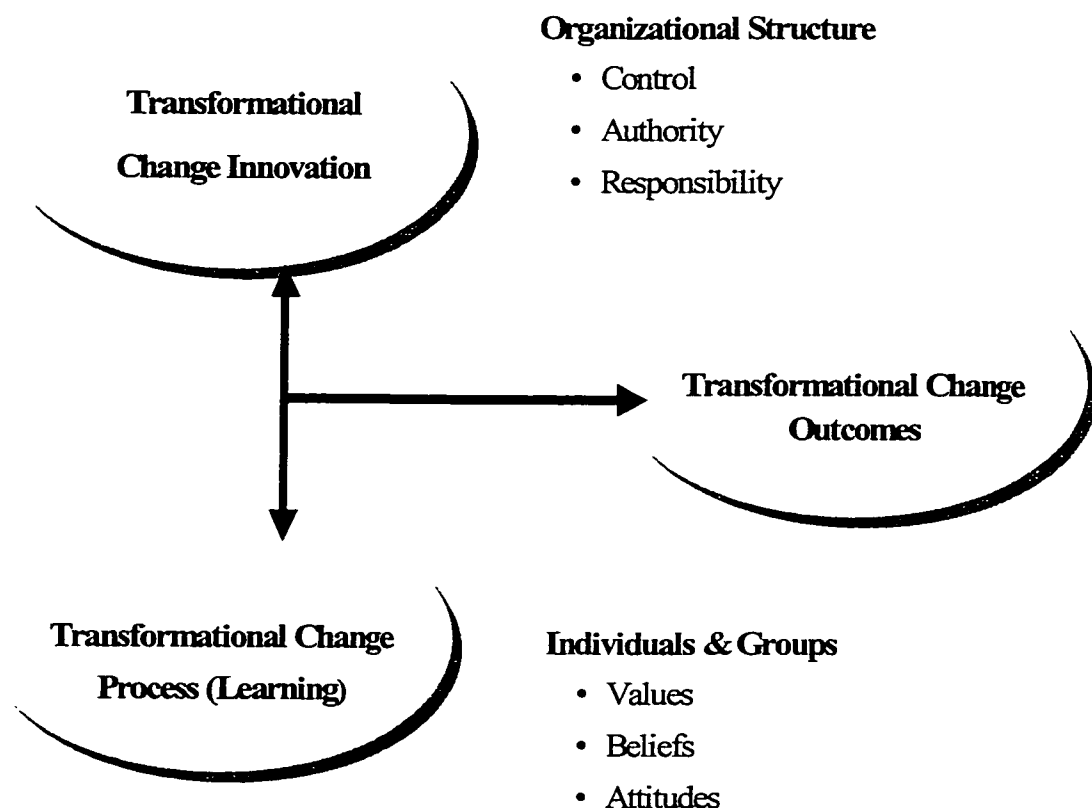


Figure 1. Study Conceptual Framework

Main Elements

Transformational Change as the Innovation

Today's unstable external environment has triggered most organizations to initiate changes that are expected to change both the employees and the culture of the organization in order to become more adaptive. Rogers (1995) describes change and innovation as being synonymous, and he defines an innovation as new if it is perceived as such by the individual. This "newness" may be knowledge, attitude, or a decision to implement something already known. Gilmartin (1998) describes innovation as a positive change through the application of specialized knowledge. Innovation is dynamic, multidimensional, and time-dependent, and is influenced by external conditions and organizational characteristics. Manion (1993) believes that innovation is closely related to empowerment and that individuals must be empowered before innovation will occur on a systematic basis.

Rogers' (1995) research on the characteristics of an innovation, as perceived by individuals, has demonstrated that a critical mass of individuals must share a vision of the importance of the innovation in order for change to occur and be disseminated throughout the organization. He identifies key factors of the innovation that shape success. First, the greater the perceived relative advantage of an innovation, the more rapid the adoption will be. Second, if the change is perceived as incompatible with the values and norms of a group, it will not be adopted as rapidly as one that is compatible with the group's values. Third, the simpler the innovation is to understand, the more rapid it will be adopted. If new skills and understanding are required, it will take longer to adopt.

Transformational Change as the Learning Process

The process of transformational learning supports the individuals and groups through the transformational change. For a learner to be truly empowered, distorted assumptions that may act as a constraint to change must be examined in light of the current reality, and revised if necessary. Mezirow (1990), Brookfield (1987), and Cranton (1994) all identify common elements in their transformational learning models. The first stage is initiated by a disorienting dilemma (Mezirow, 1990), trigger event (Brookfield, 1987), or a stimulating event or situation (Cranton, 1994) that leads to discomfort or perplexity in the learner. It can be a negative or a positive occurrence. The initial event may be stimulated by an unexpected event, such as a death, a change in work context, a sudden insight, an educator, an authoritative book, or a discussion with a friend. Events may initiate reflection by some individuals but not for others. There is no standard recipe (Cranton, 1994). The event causes an examination of personal or professional (as is the case in this study) assumptions.

The implication of challenging assumptions is that the thinking of the individual changes and that this encourages critical reflection. The purpose is to challenge something that has always been taken for granted. The change is a dynamic learning process based on the ability to recognize and question the premises on which current thinking is based. The research shows that the core of transformational learning (critical reflective learning) is the process of questioning assumptions. When a person asks whether or not his or her underlying assumptions are valid, this implies a willingness to change. Most individuals will avoid this process unless circumstances demand that they do so, because to change opinions, values, and beliefs is frightening and threatening to most

adults. Therefore the first phase is to become aware of the assumptions. The individual asks, "What is going on here?" (Brookfield, 1987). Individuals need to reflect and explore, and that process leads to a questioning of assumptions (Cranton, 1994). This exploration phase occurs when the individual tries to explain discrepancies or begins to investigate new ways of thinking or behaving. The individual is then open to new ideas and is searching for new ways of doing things. The person asks, "How do I know this? How can I validate this?" (Brookfield, 1987).

According to Cranton (1994) interaction with and support from others is probably most crucial if critical reflection is to occur and continue. In order to begin critical reflection, the individual needs to feel empowered or to be in control and have a sense of security and confidence. In the workplace setting, the employee requires the support and trust of co-workers and managers. A facilitator is also necessary to engage in this process. Cranton claims that these elements are more important in the workplace than in an educational institution because if employees feel threatened at work, they will probably not be willing to take the risks required to examine their assumptions. Once an atmosphere of trust and support has been established in the workplace setting, employees are receptive to challenges from external forces. Hearing about how others view an issue can provide a different departure point from which employees can ask questions about their own underlying assumptions. The event forces change, and this leads to critical self-reflection. Critical self-reflection may take place some time after the crisis but only when the individual feels secure and self-confident (Cranton, 1994). Once the individual feels secure, the validity of old assumptions and the new way of thinking are open for examination.

Transformational Change Outcome Element

Successful implementation of a transformational change is dependent on many factors, the most important being the acceptance of change by those whom it will affect (Campbell, 1991; Hellriegel, Slocum, & Woodman, 1995). These basic assumptions and shared meanings (values) of the members develop into an organizational culture. This integration involves the transformation of beliefs and assumptions. When the individual comes to a sense of closure, it may be visible or internal. There is a change in assumptions and perspective followed by action on the changed perspective. Integration is not easy to achieve. It is noted that the failure to transform can occur anytime, such as at the beginning, when exposure to established ideas, values, and feelings to critical analysis occur. Another point of possible failure may occur when a commitment to reflective action should follow insight but is so threatening or demanding that the individual is immobilized (Mezirow, 1991).

The outcome of an organizational transformational change is eventually a change in the culture (Coeling & Simms, 1993; Hellriegel, Slocum, & Woodman, 1995). It is because of these requirements that many transformational changes fail. These assumptions and values conflict with deeply held beliefs, limiting the members to recognizable ways of thinking and acting and not being able to change (Senge, 1990). The outcome of a transformational change requires the values, beliefs, and attitudes of the individual and work group to change along with the organizational structure or system to support the individuals and group transformation.

Interactive Result of Main Elements

The interaction of the three main elements gives rise to a series of events that lead to transformational change. Other elements essential to transformational change include changes to organizational structure and individual and group role changes.

Organizational Structure

Barker (1992) argues that commitment to a vision is not enough to ensure transformational change. A transformational change requires a change in the values, beliefs, and attitudes of individual employees, a change in organizational culture as a whole, as well as a change in organizational structure to support the desired change. In this regard, structure is the formal organizational configuration and its systems of control, authority, and responsibility (Hellriegel, Slocum, & Woodman, 1995).

A number of structural factors may hinder business organizations from undergoing a successful transformational change. Health care institutions (in particular hospitals) are particularly vulnerable. Structural factors that may hinder a health care organization from moving towards transformational change include downsizing, mergers, and cost cutting. These actions frequently result in the reduction of staff, the closure of patient care units, and the union lay-off process (Arndt & Duchemin, 1993). These factors become even more challenging when one considers the nature of service that hospitals provide. There is always a degree of uncertainty in the administration or treatment of health care. Health care professionals constantly deal with unpredictable changes in the health of their clients. Introducing any change, especially one that is transformational in nature into this environment creates further anxiety because more uncertainty is added to the professional role.

Individual/Group

Organizations are made up of people, each with his or her own personality, attitudes, perceptions, attributions, problem solving style, needs, and motives (Hellriegel, Slocum, & Woodman, 1995). Evidence indicates that even though individuals may accept the new values being introduced by the organization, their beliefs or attitudes do not change because the underlying assumptions have not changed (Brooks, 1989).

One factor hindering transformational change is the knowledge that is required by the individuals, in this time of rapid, constant change (Koerner & Bunkers, 1992). According to Porter-O'Grady (1995), previous learning and the way it was learned may be an impediment to the understanding of transformational change. Marsick (1987) contends that the learning required to create a transformational change cannot be reduced to skill training. Skill training is undertaken in organizations as short-term activities that are immediately applicable to the job (Marsick, 1987). Many innovations using training solutions fail today because the training techniques were developed under conditions very different from those prevalent in today's organizations. The how-to skills needed for autonomous decision-making, and problem solving are only a part of a complex change process that includes examination of values, beliefs, and attitudes of the individual, group, and organization. Mezirow (1991) claims that adult education, in which objectives are established, taught and measured, may be simply an enhancement of the basic belief system, and therefore do not constitute a transformation.

This was also expressed by Scott and Jaffe (1991) who claim that the reason many health care organizations have not managed to move forward after cost cutting and

downsizing is because individuals feel threatened at work, and are therefore unwilling to take the risks required to undergo a transformational learning and change. A trusting environment is essential for learning and growth. If the values and beliefs of individuals are compromised by the organizational values being created, there exists a probability that transformation may not occur, even if the structure changes (Cranton, 1994; Mezirow, 1991). These observations were reinforced by Porter-O'Grady (1992), who also found that unless employee behaviours actually change, new programs and structures have little impact on organizational effectiveness. Kerfoot (1989) extended the debate further, by showing that when both the individual and group values are in conflict with the proposed change, the culture of the organization is threatened. This leads to resistance to change.

Summary

Transformational change requires that both the organization and the employees modify the way in which the work is performed. It requires a change in values, beliefs, and attitudes as its outcome. It is irreversible once the transformation has occurred. Transformational learning may occur when the individual's values, beliefs, and attitudes are challenged. Through a critical self-reflective learning process, the individual changes or revises the values, beliefs, and attitudes.

There is limited research available relating to transformational change and learning in a complex environment. It is important to understand how transformational change and learning impact on both organizations and individuals. In particular, organizational and individual factors that affect the transformational change and learning processes need to be identified. Through such knowledge, the necessary inter-link

between transformational change and changes in the individual's values, beliefs, and attitudes will be better understood.

The conceptual framework of this study links transformational change and learning through: (1) transformational change as the innovation, (2) transformational change as the learning process, and (3) transformational change as the outcome. These three elements interact to change the organizational structure and the individual and group values, beliefs, and attitudes. The research questions as they relate to the main elements of the conceptual framework are illustrated in Table 1.

Table 1 Link between Study Conceptual Framework and Research Questions

| Conceptual Framework | Research Questions |
|--|---|
| Transformational Change Innovation | 1. How does nursing staff perceive the transformational change? |
| Transformational Change Process (Learning) | 2. What factors are perceived by nursing staff that facilitate or deter the learning process? 3. What factors are perceived by nursing staff that facilitate or deter their implementation of the transformational change? |
| Transformational Change Outcomes | 4. What outcomes of the transformational change are perceived by nursing staff? 5. How have nursing staff values, beliefs, and attitudes changed throughout the transformational change? |

These research questions served as a conceptual guide for data collection and analyses for this study.

CHAPTER THREE: DESIGN OF THE STUDY

Overview

The goal of this study was to understand more about the learning process and outcomes that are associated with the implementation of a transformational change in a large health care organization. In particular, the intent is to identify individual perceptions that affect individual and organizational transformational change. This chapter begins with an overview of the research methods utilized for this study, including the rationale for the use of the methods. This is followed by the description of the case, as well as data collection and analysis strategies.

Research Method

A qualitative exploratory study was undertaken from a case study perspective. Case studies may be quantitative and/or qualitative. Strauss and Corbin (1990) argue that qualitative research is of value where little is known about the area of study because the research can reveal processes that go beyond surface appearances. Understanding the meanings that respondents attach to events and circumstances is central to qualitative research (Brooks, 1989).

Case study is appropriate for this research because it allows an intensive description and analysis of groups within their work environment. Merriam (1988) states that a case study examines a specific occurrence such as a program, an event, a person, a process, an institution, or a social group. A case study strategy is recommended when “how” or “why” questions are being posed; the investigator has little control over events,

the focus is on a contemporary phenomenon within a real-life context, especially when the boundaries between phenomenon and context are not clearly evident, and behaviour cannot be manipulated (Yin, 1994). Lincoln and Guba (1985) support this strategy of reporting as appropriate to describe the multiple realities that may be encountered, to account for the biases that may result from the researcher's interaction with the participants, and to describe the variety of mutually shaping influence. They suggest that the case study be used when rich, full understanding is required. The principles guiding case study strategies have emerged from a variety of qualitative traditions and as a result are very similar to those guiding many types of qualitative analysis (Eisenhardt, 1989; Lincoln & Guba, 1985; Stake, 1994; Yin, 1994).

The concern of qualitative research is to understand both the subjective perspective and the behaviour of the person who experiences the phenomena of interest. Its purpose is to raise the readers' level of understanding. A major strength of case study data collection is the ability to use multiple sources of evidence. This allows the researcher to address a broader range of historical, attitudinal, and behavioural issues (Merriam, 1988; Yin, 1994). In the present study, the case study approach has the potential to show how and why individual transformation of values, beliefs, and attitudes can shape the success or failure of implementation of a transformational change in an organization.

Overview of the Case

This case studied the documentation involving a transformational change over a three and a half year period (1994-1997) in a large health care organization.

Setting

The setting for this study was a large tertiary care teaching hospital that had over several years downsized from 604 to 524 beds, and from 40 to 30 nursing wards or units. The number of registered nurses (1500) had remained constant but the ratio of full time to part time employees has changed from approximately 60:40 to 40:60, suggesting a decrease in the continuity of the caregiver at the bedside. The organizational structure of the hospital in 1990 was a traditional departmental, centralized, hierarchical model. The nursing organizational chart consisted of a vice president of nursing, directors of nursing services, supervisors responsible for patient care units over the 24 hours, nurse managers assigned to each unit, and registered nurses caring for the patients. Nursing education and nursing research departments were well established and recognized as valuable within the institution. The nursing division consisted of centralized management decision-making, a “total patient care” delivery system, and registered nursing staff who had traditionally permitted the decisions regarding clinical practice to be made by those above them in the hierarchy.

Total patient care is the delivery of care by one nurse to a group of patients for an 8-12 hour shift. The nurse is responsible and accountable for all aspects of the care during the shift. It is also the responsibility of the nurse to communicate any change in the condition of a patient to a team leader or charge nurse to follow up on any issues with the health care team. Each nurse arranges the patient plan of care daily. Continuity of the patient care exists only if the nurse is assigned to the patient for more than one shift.

Elements of Organizational Change within the Setting

Continuity in patient care and lack of autonomous nursing decision-making has long been a concern of nursing administration and nursing staff. However, it was only in 1990 the nursing administration decided to address the situation. A professional practice model was developed, which was to serve as the foundation and direction of nursing practice, quality, research, and education. The implementation of the model consisted of phasing in decentralization, namely the introduction of autonomous decision-making at all levels, particularly at the professional nursing staff unit level. Roles were changed for the administrative and clinical practice levels. The main elements of the innovation consisted of a participative decision-making model at the unit level and a primary nursing patient care delivery model.

Professional practice models consist of control over practice and accountability for client outcomes (Ingersoll, Schultz, Hoffart, & Ryan, 1996; McDaniel & Wolf, 1992; Wolf, Boland, & Aukerman, 1994, Part 1 and 2). The nurse/patient relationship is the central element of professional practice models and implies that nursing excellence, through knowledge, research, empowerment, and accountability, will result in positive patient care outcomes. The model is also believed to create a culture of independent, caring professional nurses (Trofino, 1996). In the present study, the participative decision-making model, referred to as a unit council, was designed to facilitate participation of staff in decision-making involving the unit business, professional practice, and patient care. The purpose of the unit council was to create a vehicle for group collaboration and group consensus decision-making within the context of individual accountability to patients, peers, and the organization. Changing the decision-

making from authoritative to participative is a major transformational change for all individuals on the units.

The second element in the professional practice model was a primary nursing patient care delivery model. Primary nursing is a philosophical cornerstone of nursing. It is a patient care delivery system in which a nurse is accountable for planning the care and management of a group of patients from admission to discharge. The nurse provides direct care during the assigned shifts and is expected to act independently in planning and evaluating nursing care, and to communicate directly with all health care members (Manthey, 1980; Zander, 1985).

Changing the structure from total patient care to primary nursing is a major transformational change even though the individual patient care aspects are similar in approach. In both structures one nurse provides care to a group of patients. The difference is the complete authority, responsibility, and accountability for patient care in the primary nursing care model. The intended outcomes of primary nursing are: (a) autonomy to make clinical decisions, (b) accountability and responsibility for the process and outcome of care, (c) continuity of care for both the patient and the caregiver, and (d) effective use of resources (Hastings, O'Keefe, & Buckley, 1992; Manthey, 1980). Autonomy, accountability, responsibility, and coordination are all elements of a professional practice model.

The Implementation

The first three years (1990-1993) of this change consisted of changing the structural reporting system to improve autonomous decision-making at the nursing director and nurse manager level. Nurse managers were given control over hiring and

their budgets. In 1994 unit councils and primary nursing were introduced to the clinical nurses. One-day workshops were offered by one facilitator to all the nursing staff to discuss the changes. Concepts about unit councils and primary nursing were taught and implemented together because they both required re-examination of professional practice values. The nurse managers and educators were given a separate workshop. Nursing administration encouraged maximum participation by paying the nurses to attend. Fifty-six workshops were presented to 1294 nurses over a two-year period (1994-1996). Sixty-four percent (n=36) of the workshops were completed and seventy-three percent (n=939) of the staff attended during the first year (1994) of the project.

The objective of the workshop was to introduce the transformational change innovation. Concepts of professional empowerment, participative decision-making, guidelines for a unit council, and discussion of skills required such as chairing a meeting, minute taking and problem solving techniques were discussed in the morning. The concepts of primary nursing were introduced in the afternoon. The method of instruction was balanced with theory and open discussion. This method encouraged the nurses to participate and reflect on their current practice.

The nurses and nurse manager on each nursing unit determined the timing of implementation according to unit priorities. The nurses who attended the workshops were expected to implement the transformational change innovation on their units after ninety percent of the nurses on the unit were taught. They were given control over how the innovation was to be implemented. Upon completion of the workshop, most units implemented unit councils before primary nursing. All units (n=34) had unit councils by the spring of 1996. To establish a unit council, the staff selected a unit council core group

and then met with the facilitator to review the principles. The facilitator then acted as a resource person by attending unit council meetings when invited.

Following the implementation of unit councils, the staff on the unit had a planning day to implement primary nursing. The same person who facilitated the introduction of unit councils supported the primary nursing planning day. A unit primary nursing committee was selected to examine the principles that had been introduced and to design unit guidelines. This process occurred over several meetings with the facilitator in attendance. The facilitator continued to function as a resource during the implementation. Three units had implemented primary nursing prior to 1994. Therefore of the units participating (n=31), ninety-seven percent (n=30) of the units implemented primary nursing model by fall 1996.

Evaluation of the Implementation

The Corporate Primary Nursing Evaluation Committee was constituted to oversee the change process. This committee was broadly based under the chairmanship of the Director of Nursing Research and included the Director of Surgical Nursing, clinical educators, and myself serving as the change facilitator. The committee recommended that four evaluative techniques be used.

1. Pre-implementation quantitative surveys (1994) and 18 months post implementation surveys (1996) were completed by the clinical staff.
2. Focus groups with the clinical staff, patients, and other health specialists were undertaken to examine primary nursing in the six months to one-year period post-implementation (1995-1996).

3. Focus groups with nurse managers were conducted in 1996 to examine the impact of unit councils.
4. Qualitative primary nursing and unit council surveys were completed three and a half years after the introduction of the transformational innovation (Summer 1997).

The qualitative project data collected by the focus groups and 1997 Survey plus the workshop evaluations and notes from open forums and minutes later served as the documentation base for the present study. The quantitative surveys were not part of this study.

Emergent Changes during Implementation

A number of unanticipated changes occurred during the period in which the transformational change occurred. Although the organization began to slowly downsize in 1990, the most widespread changes occurred from 1995 to 1998. Insecurity was introduced into the system in 1995 when the District Health Council was ordered by the province to recommend changes to the delivery of health care in the region. In 1996-1997, the budget of the hospital was reduced seven per cent per annum. This resulted in rapid downsizing of the institution. At the level of the nursing units, six units were closed and six nurse managers were dismissed. In 1998, a new level of insecurity was introduced when the Health Services Restructuring Committee of the province ordered that two regional hospitals be closed and the two teaching hospitals and a community hospital undergo a merger.

Role of the Researcher

Prior to and throughout the duration of the study, I was employed at the subject tertiary care teaching hospital in the position of Coordinator of Nursing Education

Programs as a member of the Department of Nursing Professional Practice. It was part of my professional role within the organization to facilitate the education, implementation, and evaluation of the professional practice change. In my role as facilitator, I worked very closely with all the nursing staff to assist them with this transformational change. I believe that a relationship of trust and mutual respect existed between myself and many of the nursing staff because of participation by clinical nurses in educational programs or prior teaching assignments that I had developed over the years. The comments written on the workshop evaluations supported my belief. As the facilitator, I was also involved in the focus groups for the clinical staff and nurse managers.

Data Collection

Case study data may come from six sources: documents, archival records, interviews, direct observation, participant observation, and physical artifacts (Yin, 1994). Data for this study were collected from all the hospital units over a three and a half year period. The selection of more than one unit increased the range and scope of data available.

The primary source for this study was the documentary data collected during the implementation of the transformational change in order to learn the perceptions of the nursing staff of the change process and the outcomes. The data were derived from multiple sources. Table 2 summarizes the documentation data analyzed.

Table 2 Documentation data

| Documents | Dates | Number of units involved | Number of units participating | Number of focus groups | Number of respondents |
|--|----------------------------|--------------------------|-------------------------------|------------------------|-----------------------|
| Workshop evaluations | January 1994 to April 1996 | 34 | 34 | | 1170- 90% (n=1294) |
| Primary nursing focus groups | March 1995 to June 1996 | 31 | 17 | 39 | 212 |
| Unit council focus group with nurse managers | November 1996 | 30 | 24 | 4 | 24 |
| Unit council & primary nursing unit survey | July 1997 | 28 | 26 | | 72 surveys (n=500) |
| Notes and minutes from open forums | 1994-1997 | | | | |

Table 2 illustrates the timeline of the data, and the number of units involved with each documentation group and the number of participants involved.

The workshop evaluations and surveys were completed anonymously.

Participants completed an evaluation upon completion of the workshop (Appendix A).

These evaluations (n=1170) provided the researcher with an assessment of the effectiveness of the program with regards to the content, process, and the nurses' reaction to the transformational change on a continuous basis. Out of the total number of nurses taught, ninety percent (n=1170) completed the evaluations, and from those received, 832 had written comments.

Focus groups to evaluate primary nursing were used as another method of evaluation to determine the perceptions of the nursing staff to the changes. They were conducted from 6 months to 1 year after the unit implemented primary nursing. Two

focus groups were conducted on each unit. Focus groups produce qualitative data that provide insights into the attitudes, perceptions, and opinions of participants (Krueger, 1994; Love, 1991). To ensure that the focus groups were successful as a data collection tool, a semi-structured interview format was used. The Primary Nursing Evaluation Committee designed the focus group questions (Appendix B). The questions were arranged in a natural logical order allowing the group to work through the aspects of the change. Seventeen units (n=31) participated. Thirty-nine focus groups were conducted with the nursing staff (n= 212). All the nursing staff focus groups were conducted from March 1995 to June 1996. To evaluate unit councils, four focus groups were conducted with the nurse managers in November 1996 (Appendix C). Twenty-four managers (n=30) participated, twenty-one attended the interviews and three replied in writing. As moderator of the focus groups I was able to observe the participants as they interacted with each other and me. A second observer noted the responses then had the notes typed and confirmed their accuracy.

The last documentation analyzed were the unit council/primary nursing unit surveys that were distributed to twenty-eight units two to three years after the units implemented the change in July 1997 (Appendix D). Seventy-two surveys were returned.

The link between the main elements of the conceptual framework, the research questions, and the source of qualitative data used in the study is shown in Table 3. The main data sources used were workshop evaluations, the focus groups (primary nursing and unit councils) six months to 1-year post implementation, and the follow-up surveys two to three years post implementation depending on the unit. The workshop evaluations provided the data for the transformational change innovation and the transformational

change process. The focus groups and surveys provided data for both the transformational change process and the transformational change outcomes.

Table 3 Link between Conceptual Framework, Research Questions, and Data

| Conceptual Framework Main Elements | Research Questions | Documentary Data |
|--|--|--|
| Transformational Change Innovation | 1. How does nursing staff perceive the transformational change? | Workshop evaluations |
| Transformational Change Process (Learning) | 2. What factors are perceived by nursing staff that facilitate or deter the learning process? | Workshop evaluations Notes from unit meetings and open forums Focus group interviews: |
| | 3. What factors are perceived by nursing staff that facilitate or deter their implementation of the transformational change? | <ul style="list-style-type: none"> ◆ Staff relating to primary nursing ◆ Managers relating to unit council Surveys <ul style="list-style-type: none"> ◆ Unit follow-up survey |
| Transformational Change Outcomes | 4. What outcomes of the transformational change are perceived by nursing staff? | Notes from unit meetings and open forums Focus group interviews: |
| | 5. How have nursing staff values, beliefs, and attitudes changed throughout the transformational change? | <ul style="list-style-type: none"> ◆ Staff relating to primary nursing ◆ Managers relating to unit council Surveys <ul style="list-style-type: none"> ◆ Unit follow-up survey |

Data Analysis

Data analysis for this study was consistent with methods described by Miles and Huberman (1994). Data were divided into units of meaning. The unit of analysis was any statement about feelings, thoughts, or actions relating to the innovation, implementation, and outcomes of transformational change. Analysis was achieved through a process of coding and categorizing, and then examining the meaning and context. The data were first separated into chronological order. All documents were read to get a sense of the whole. The individual documents were then coded.

Coding

Each datum incident provided by the participants was coded as it reflected the study purpose and related to study questions. A code was a word used as an index marker to aid in reducing the transcripts to their essential meanings. The code word reflects the essence of the data that leads to ease of recognition as the number of code words increases. Code definitions were developed from the analysis of the data. For example after reading through all the workshop evaluations, the data were initially coded as workshop logistics, comments about the change, knowledge, trusting environment, sharing, resistance, and open thinking.

As the data were coded, categories were derived from collections of all the material that were similarly coded. The categories were then related to the study questions. The coding was developed inductively during the examination of the data to guard against biases and assumptions that can develop during the research process (Strauss & Corbin, 1990).

Categorizing

Regularities and patterns were sought to develop tentative ideas about categories and relationships. These were then categorized into broad groupings related to the study questions. Categories formed the major unit of analysis. The categories that evolved by this method were linked together as relationships emerged and the theoretical properties and their interrelationships were defined. For example, “gauging workability” evolved as a category in the workshop data, and “increased knowing” was a category in the primary nursing focus group data.

Distinct and/or unique categories emerged since transformational change on a professional nursing unit is different from transformational change in business applications where the phenomenon has been studied more frequently. For example, increased consistency in care and increased professional control emerged as broad categories.

Reflective notes, memos and mapping were also employed throughout the phases of the analytical process. Memos were used to record and collate the results of the analysis into recognizable clusters. Maps provided visual representations of the analytical themes and their interconnections and relationships.

Procedures to ensure Study Rigor

The goal of qualitative research is to present an accurate picture of reality as it is experienced by the participants. Trustworthiness is used as an equivalent to validity and reliability in qualitative research (Lincoln & Guba, 1985). The following techniques were employed to maintain a high degree of rigor during the proceedings, to ensure an audit trail, and to monitor any possible bias on the part of the researcher. The unit focus group

data were labelled according to patient care units. This identification was removed and in order to further minimize the probability of bias, the data were analyzed as a whole in the main groupings of data, for example, the primary nursing focus groups were all merged into one file.

Researcher

My role as an employee responsible for the implementation of the transformational change and my position as investigator of this current study have been noted previously. Because of my position within the organization, I was also the facilitator who taught, implemented, and evaluated the transformational change. That role with the organization enhanced by the researcher role has helped me gain an appreciation of the realities and actions of the participants. The dual role does not limit the value of the study. Maxwell (1996) states that the goal in a qualitative study is not to eliminate the researcher's influence but to understand it and use it productively.

Triangulation

Data collected from multiple sources produce "richer data", and provide for triangulation and validation. Triangulation of data provides the researcher with a more holistic view of the event, helps reduce bias, and promotes validity (Miles & Huberman, 1994). In the current study, data from three separate major sources were analyzed to examine the transformational change. Collating the data derived from workshop evaluations, focus groups, and surveys provided a double check on the common conclusions and assisted in the development of new categories.

Audit Trail

A system of internal controls was established to preserve the data for analysis and audit. The internal controls consisted of maintaining all notes and records in chronological order within the data sub-sets. Comments derived from workshop evaluations, focus groups, and surveys were logged in computerized files in chronological order. Analysis of the logged comments and subsequent categorizations were maintained in separate computerized files.

Periodic Debriefing Methods

The thesis committee consisted of a member from the Faculty of Health Sciences and three members from the Faculty of Education. The broad experience and differing expertise assisted the researcher in exposing tacit knowledge. Regular meetings were held with the thesis advisor to discuss process, timelines, and progress. The substance of the study, clarifications, and the analysis were discussed frequently with another faculty advisor. All members of the committee contributed to the organization of the thesis and to the style and substance of the dissertation.

Ethical Considerations

The study was approved by the Graduate Studies Ethics Committee of the University and by the Research and Ethics Committee of the Hospital. Hospital administrative approval to access and analyze the documentary data was obtained with normal protection of identity of nursing units. There were no known risks or direct benefits to the participants. Anonymity of the patient care units and all individuals was preserved. All documents are confidential and only reviewed by the researcher and the professors involved with the researcher.

Study Limitations

There were two major limitations to the study. The data were limited to groups of nurses captured at different time periods and did not rely on day-to-day experiences of individual nurses. The unstable health care environment, both internally and externally, was also a major limitation. Staff movements within the organization as well as time itself made it impossible to confidently extrapolate study findings to the current circumstances and perceptions of individuals and work groups.

CHAPTER FOUR: RESULTS AND INTERPRETATION

Introduction

This chapter presents the findings and a discussion of the study based on an analysis of documents created over a three and a half-year period during the implementation of a transformational change. Congruent with the study's conceptual framework, the analysis of the perceptions of nursing staff is reported in three sections: (1) the transformational change innovation, (2) the transformational change process, and (3) the transformational change outcomes. A process of coding and categorizing was used to examine independently and chronologically the major sources of data on the transformational change.

The purpose of this study was to understand the learning and change process of a professional nursing staff in a large tertiary care teaching hospital in response to a transformational change. The analysis describes the perceptions of the nursing staff from the introduction of a transformational change through the implementation of the change and resulting outcomes of the transformational change. The objective of the innovation was to increase professional accountability and authority by changing the decision-making of nursing staff to a more autonomous process. The structural or system changes were unit councils and primary nursing, which were introduced to assist the nurses to gain control over nursing decisions relating to unit business and direct patient care. Table 4 shows the data categories linked with the research questions and conceptual framework elements. Research findings will be presented in terms of this framework.

Table 4 Link between Conceptual Framework, Research Questions, & Data Categories

| Elements | Questions | Categories |
|------------------------------------|---|---|
| Transformational Change Innovation | 1. How does nursing staff perceive the transformational change? | 1. Gaining Professional Control 2. Gauging Workability |
| Transformational Change Process | 2. What factors are perceived by nursing staff that facilitate or deter the learning process? 3. What factors are perceived by nursing staff that facilitate or deter their implementation of the transformational change? | 1. Sharing with Others 2. Valuing Time 3. Working the Rules |
| Transformational Change Outcome | 4. What outcomes of the transformational change are perceived by nursing staff? 5. How have nursing staff values, beliefs, and attitudes changed in regard to practice throughout the transformational change? | 1. Increased Consistency in Care 2. Increased "Knowing" 3. Changed Relationships 4. Increased Professional Control 1. More Accountable 2. More Committed |

The Transformational Change Innovation

The decision to introduce a transformational change innovation into the practice of nursing was made by the Executive of the Division of Nursing. The transformational innovation consisted of the introduction of change associated with the increase of nursing autonomy, accountability, and professionalism by means of unit councils and primary nursing.

Research Findings

The following question guided this aspect of the analysis:

How does nursing staff perceive the transformational change?

The data presented are reflective of nursing staff perceptions of the introduction of the transformational innovation. The innovation was introduced to nursing staff in 1994 through workshops that were presented to all nursing employees. At the time of the workshop, the internal and external environments were beginning to show some instability. Externally, the local District Health Council was considering closure of hospitals and the Provincial Government was continuing to reduce the health care budget. Internally, over the three previous years (1990-1993), five nursing care units had closed. At staff open forums, the nurses frequently expressed to the Vice President of Nursing their anxieties about rumours of more units closing or staff layoffs.

Study findings of the perceptions of the nurses to the innovation came primarily from workshop evaluation data and nursing staff open forums. Fifty-six workshops were conducted between 1994-1996 with 1294 nurses in attendance. Two-thirds of the workshops were conducted within the first year (1994). Over time, the written evaluation comments decreased. In the first third of the workshops most of the evaluations included comments regarding the innovation. The comments from the second third of the workshop evaluations expressed the value of dispelling rumours. The last third of the workshop evaluations had very few written comments. The derived analysis categories were based on the information given by the nursing staff.

The innovation as conceptualized required a change in the organizational structure on the units. For this structural change to be successful, it was necessary to change the

behaviour of the staff. The workshops were designed as the vehicle to introduce the change to the staff. Sixty-five percent (n=764) of the written comments reflected support for the change and 1.4% (n=16) were not in favour of the change. Eighty-three percent (n=973) graded the content of the workshop as very good to excellent. Some nurses perceived the introduction of such concepts as autonomy, responsibility, authority, control over clinical decisions, and participation in unit decisions as a positive innovation and these nurses were ready to embrace the change with genuine excitement. The innovation was recognized as something very different from the current practice. It was perceived as a “new concept,” a “new experience to venture into,” a “good idea” that was “long over due.” The innovation was perceived by the nursing staff as “so pertinent,” and needed “for a change, nursing needs this.”

Two categories arose from the data reflecting the nurses’ perceptions about the innovation. They were: (a) gaining professional control and (b) gauging workability.

Gaining Professional Control

Gaining professional control emerged as a category when the study participants described their perceptions of the transformational innovation. Cook and Buck (1999) referred to control as the ability to determine what one does or what others do. One nurse recognized the innovation as giving them control over their practice: “there is so much that could be done, we have high potential energy; empowerment would facilitate change!” Another nurse reflected, “it is too bad it has taken so long to implement these changes. The feeling of powerlessness took over many years ago, but this sort of change of direction just may help us find it again.” Over 80% of the nurses perceived the unit council information as valuable. Unit council was seen as a way to make decisions and to

solve work-related problems through participative decision-making. The only issues over which the unit council could not make decisions were budgets and the hiring or terminating of staff. The innovation was viewed as a change that would “increase autonomy due to increased control over the environment” and as “a starting point to get involved in participating in decision-making within the unit.” One nurse felt that “with more understanding I now feel the units will benefit from them [the changes], and I am now more prepared to take a more active role.”

However, during the workshop many of the nurses indicated to the presenter that they did not believe the authority to make decisions would be allowed to occur on their own units. This concern was also reflected in the minutes from a staff open forum on April 27th, 1994:

Some of the nursing staff stated that they were never involved in planning for change and their ideas were not listened to nor solicited; however, several other nurses at the same discussion stated they had a lot of input and they were surprised this was not happening on the other units.

Some nurses perceived unit council as “really important to the unit” because of the problem solving capabilities and possible creation of “a more secure and stronger staff morale and, in particular, [it will] iron out long existing personal clashes....” The staff open forum minutes of May 26th, 1994 also reflected this point:

They stated that they see unit councils as making them more autonomous and that their minutes would be formalized and if particular things were not happening there would be a mechanism

for having the issues raised. Also, unit council is a means to facilitate the unit work and allow openness towards innovation.

Gauging Workability

The workability of the innovation was the second category reflecting the nurses' perceptions of the innovation. Workability means practical, sensible, useful, and effective and can be adapted or designed for use because it pertains to ordinary activities. The nurses needed to know that it was practical. One nurse stated that she/he "really enjoyed the practicality of it – can see how they both will work and make sense." One reason the innovation was regarded as workable was because of its adaptability to the individual units: "I'm anxious to see initiating both programs with adaptations to our particular unit," because it "dealt with real nursing issues" and was "directly applicable to the work place."

Conversely, a few nurses viewed unit councils as impractical for their practice and more than a few nurses felt that primary nursing fit into that category. The concepts and content were not felt to be "practical to nursing," and some nurses felt that the workload would be increased: "I feel we'll have an excess of paperwork, why change something that is working well." The emotions expressed about primary nursing were anger, scepticism, rejection, and some were insulted that the administration did not think that they were giving good care.

Primary nursing was perceived by two nurses as "only enhance the reason we are here - patient care" and "I understand the concepts of primary nursing better now and hope to use it in my practice." There was a sense expressed that primary nursing was important to the improvement of the practice of nursing. One nurse wrote that primary

nursing would “definitely give a positive approach to my profession” and “-it will work – [we should] not get hung up on the nit-picky issues.”

There was difficulty visualizing how primary nursing could be practically applied to their own units: “a great concept and wonderful in theory, but it is very difficult to visualize this happening.” One nurse felt that it was “difficult to discuss primary nursing since there is so little experience [available in the hospital].” Another nurse regarded primary nursing as frightening: “the subject matter is a little frightening to already stressed-out nurses, but [it] was presented in a manner that was positive but realistic, therefore [we] feel less threatened.”

However, some nurses saw the benefits of primary nursing but were more sceptical: “well I’ll keep an open mind and try to make it work. I foresee a lot of hard work; let’s hope in the end the patient benefits,” “still don’t feel it will work! Will try,” and one nurse challenged the facilitator to show “how it will work on my unit.” Though very few completely rejected the concepts: “I don’t feel primary nursing is a good thing,” and “I do not agree with primary nursing. I feel it will not work well on our unit.”

In summary, the transformational change innovation (unit councils and primary nursing) was greeted with a mixed reaction. The reactions of the nurses were diverse, ranging from enthusiasm to rejection. Two key categories, gaining professional control and gauging workability evolved from the analysis relating to the nurses perceptions of the transformational change innovation. Although unsure of the outcome, 90% (n=1056) of the nurses by the end of the workshop found that the information was professionally and personally very valuable. Ten percent of the participants believed that the innovation

was not realistic, would not be feasible on their units, or had no opinion at the time of the workshop evaluation.

Interpretation

Transformational change is likely to involve challenging or overturning clearly held beliefs and attitudes, and this is a potentially painful process (Shein, 1999; Sheehan, 1990). Introducing an innovation that required all nurses to examine and be accountable for their care, practice, and behaviour was very “threatening”. This involves having to unlearn beliefs, attitudes, values, and assumptions as well as learning new ones. This is congruent with transformational learning literature. A disorienting dilemma or trigger event that causes an examination of assumptions is the first phase of transformational learning (Cranton, 1994; Mezirow, 1990). Most individuals will avoid this process unless circumstances demand that they do so, because to change opinions, values, and beliefs is frightening and discomfoting to most adults. The characteristics of the change in this study challenged the nurses’ values, beliefs, and attitudes. There is evidence of a reflective process occurring as staff commented on how the change had triggered thinking. This is also reflected in the literature linking change and the grieving process as a major factor to explain employees’ reactions to innovation (Schoolfield & Orduna, 1994). Change involves loss of the old established ways and requires a grieving process before accepting the new way. Employees may feel threatened, ambivalent, disoriented, or angry (Davidhizar & Bowen, 1990; Perlman & Takacs, 1990). The introduction of the innovation initiated the grieving process. In my role as researcher, the first time I read over the workshop evaluations as a whole, I was astonished that more negativity and concerns were not expressed. I vividly remember the nurses’ expressions of anxiety and

at times anger over the content that was presented. Because I felt that the nurses were expressing their fears, I did not take the staff comments personally. This belief was confirmed a number of times when staff members would come up to me after the workshop or even days later and apologize for their behaviour. They reassured me that their anger was not directed at me personally, but was directed at the changes I was introducing. It is possible that the number of negative comments was low because by the end of the workshop, the discussions had allayed concerns. It is also possible that staff felt that there was no need to write down what had been said during the workshop.

The nurses' perceptions of the innovation were very similar to Rogers' (1995) research, which found that if an innovation has a relative advantage to the individual, is compatible with the group's values, and is simple to understand, it will be adopted more rapidly. However if new skills and understanding are required, the innovation will take longer to be adopted. A number of nurses perceived both aspects of the innovation (unit council and primary nursing) as practical and advantageous because they thought that it would work and would give them more control over their practice. They perceived the problem solving exercise presented at the workshops as a new skill but easy to use.

Ninety-nine percent (n=1154) of the nurses' workshop evaluations were in favour of unit council, rating the information (content) as good to excellent and 88% (n=1024) rated primary nursing content as good to excellent. All units (n=34) implemented their unit councils prior to the introduction of primary nursing. In my opinion, the nurses believed that unit councils would provide them with some control over their environment without requiring much change in behaviour.

Workshop participants regarded primary nursing as an innovation that would change practice to a significant degree. A recurring sentiment was that the current practice was satisfactory. There was a strong feeling among many of the nurses that primary nursing conferred no relative advantage to the nurse but could possibly be of value to the patient. This is why most of them verbally agreed to implement the change. The primary nursing innovation created a more negative response than did the unit council innovation because the staff were changing from a nurse-driven care delivery system to a patient-driven care delivery system. The innovation challenged the historical ways of structuring nursing care and practice within the institution.

Much of the content in the workshop focused on empowerment or taking control over the decisions involving the nurses' professional practice. Empowerment is the recognition of the power already present in a role and allowing it to be expressed plus it involves transfer of power from one individual or group to another (Porter-O'Grady, 1996; Rodwell, 1996). The reaction by the nurses with regard to the term empowerment made me stop using the term during the workshops. Many comments from workshop participants referred to empowerment as an empty term and a means of assigning more work, reflecting a distrust of management and the organization. Explaining the concepts of autonomous decision-making using the terms control of practice and environment created fewer comments of mistrust. This finding is in accordance with the work done by Beer, Eisenstat, and Spector (1990) who believe that empowerment is a meaningless term unless explained in concrete terms.

Workability of the innovation was very important to the nursing staff. Due to the nature of the nurses' work, the change had to be practical, safe for the patient, and require

no additional time. Implementing a change with outcomes that could even remotely result in harm to patients competes with their values as professional nurses. In this research, it was important to understand how the nurses perceived the innovation. Some nurses were anticipating the change, others were unsure, and some were unimpressed.

In summary, the Executive of the Division of Nursing mandated the transformational change to unit councils and primary nursing. The purpose of the unit council was to give nurses control over their work environment. The nursing staff readily accepted unit councils. Acceptance was reflected in the evaluations and comments taken from the workshops. The second part of the transformational change innovation was primary nursing. The change was designed to increase autonomous decision making on the part of nurses directly responsible for patient care. The results of the research showed that primary nursing was more difficult to comprehend, and produced greater anxiety than did unit council. The transformation innovation was widely accepted by the staff, although with reservations.

The Transformational Change Process

The units began the process of implementing unit councils once ninety per cent of the staff from the unit had been introduced to the concept through the workshops. Most units introduced primary nursing after unit councils were in place. The implementation of the transformational change occurred over 2 years (1994-1996), depending on the units and their readiness to change. This was a very complex transformational change that required changing the structure of patient care, the hierarchy of decision-making, roles, and behaviour, and for many nurses changing their values, beliefs, and attitudes. The findings presented here describe the nurses' perceptions of what facilitated or deterred

their transformational learning and the implementation process of the change. Data consisted of workshop evaluations, notes from focus groups on primary nursing and unit councils conducted six months to 1 year after implementation, and unit surveys completed 3 years post introduction.

Research Findings

The following research questions guided this aspect of the analysis.

What factors are perceived by nursing staff that facilitate or deter the learning process?

What factors are perceived by nursing staff that facilitate or deter their implementation of the transformational change?

Three categories emerged from the data that reflected the perceptions of nursing staff to factors that facilitated or deterred the transformational change implementation process and/or transformational learning. These categories were sharing with others, valuing time, and working the rules. Some of the perceived factors like barriers or catalysts to learning and change began with the workshop and others developed during the implementation of the innovation.

Sharing with Others

Sharing with others was the first category reflecting the innovation implementation. The nurses perceived sharing with others as facilitating the change process. This category contained two sub-categories: reducing concerns and learning the facts. The workshop evaluations provided the data for the analysis. Table 5 reflects examples of excerpts from the participants.

Table 5 Excerpts Reflecting the Category “Sharing With Others”

| Sub-category | Excerpts |
|--------------------|---|
| Reducing concerns | <ul style="list-style-type: none"> • “took away some of the anxiety of the unknown” • “cleared all misconceptions and fears” • “safe to express concerns” • “freedom to voice opinion” • “good atmosphere for discussion to honestly express concerns and fears without feeling threatened.” • “able to ask questions openly and clarify...” • “able to give input and get feedback.” |
| Learning the facts | <ul style="list-style-type: none"> • “exchange of ideas about nursing care and problems of each unit was excellent.” • “learned a lot –opened up other opinions [re practice and the change].” • “my views on unit councils were quite negative before the workshop.....” • “it is difficult to take everything in and remain positive about it but I’m trying and it’s worth a try.b” • “great learning experience and a springboard’ to more work and direction.” • “learned a lot because everybody contributed to a good discussion.” • “it helped to be educated more on the benefits of the unit council and primary nursing. It cleared up a lot of questions I had about primary nursing.” |

Reducing concerns.

The nurses perceived that sharing their concerns and ideas during the workshop with the peers and facilitator as a beneficial factor of the change process. The workshop provided the nurses with the opportunity to share, learn, and reflect. As a result the atmosphere of the workshop was perceived as “relaxed,” “friendly,” and one that was “open to discussion”. A number of excerpts were taken from the workshop evaluation comments that reflected the category sharing and the sub-category reducing concerns.

(Table 5)

Many commented how the facilitator contributed by helping “people work through questions and difficulties,” by being “a good caring listener.” However, not all the nurses found the vetting of fears and concerns helpful. One nurse “...found this [the discussions in the workshop] a very tense and uncomfortable time,” while another nurse felt that “conversations /questions were ‘petty’ sometimes.”

Discussions relating to what they valued in nursing and patient care helped some of the nurses reflect on their own practices and attitudes and allowed “personal attitudes to speak out.” Hearing how other nurses were feeling or what they thought made them more aware of their own feelings. Comments such as: “stimulated thinking towards nursing practice” and “got us thinking about our profession and changes,” were written on the workshop evaluations. A few felt that it “promoted a sense of professionalism that tends to get forgotten,” “re-establishes that nursing is important and is finally being recognized as a group to be dealt with,” “made me think re: the future,” and “as a new grad it helped ‘put things together’ to help me realize that this is a dynamic profession as I had hoped but hardly expected.”

Nurses frequently commented that it was reassuring to meet staff from other areas and discuss problems and to hear others’ “point of view”. The realization that they were not alone helped them to be more open. Two comments illustrate this point: “this is off topic, but I realized other units have similar problems to our unit, and this is reassuring,” and “knowing that in all areas of nursing all the same problems exist and which makes these problems universal and easier to solve.”

Learning the facts.

The second sub-category that emerged from sharing with others reflecting the transformational change was learning the facts. Learning new information and exchanging ideas with their peers supported the change process and began the process of reflection. Examples of excerpts reflecting the sub-category learning the facts are illustrated in Table 5.

Learning the facts was also demonstrated by the response of workshop attendees to nurses with experience as primary nurses who were asked to speak as workshop guests. These excerpts illustrate this point: “hearing nurses speak regarding their own PN [primary nursing] experience provided some practical information of concepts,” and “hearing from units already practicing PN was very helpful- it sheds a more positive light on the topic.” In fact, it was perceived as a weakness of the workshop and learning when primary nurses were unable to attend the workshop to discuss their roles and give practical examples. This peer expertise was seen as a major supportive factor to learning and change.

A few nurses in the workshop expressed a need for more information despite the sharing of concerns and information, and listening to nurses who were practicing primary nursing. For example, one nurse wrote: “give information out prior to workshop to prepare people better and as a result decrease uncomfortable feelings such as those expressed by the group about primary nursing.”

Valuing Time

The second category reflecting the nursing staff perception of the transformational change process was valuing time. Most of the working time for nurses is spent

performing direct patient care. Participating at meetings and non-clinical decisions was perceived as a challenge. Two sub-categories relating to time evolved from this portion of the analysis. The sub-categories are: (a) problematic participating and (b) making decisions. Table 6 illustrates examples of excerpts from the nurses that were reflective of the problems encountered with participation and decision-making during the implementation of the innovation.

Table 6 Excerpts Reflecting the Category “Valuing Time”

| Sub-category | Excerpts |
|---------------------------|--|
| Problematic participating | <ul style="list-style-type: none"> • “very difficult getting to meetings on work time and staff are <u>too</u> busy in daily lives to make time outside work” • “finding a good time that we can get more than five people together at once sometimes is a problem.” • “unit council is very difficult to have. Most people don’t want to deal with hospital issues when they aren’t scheduled to work. Plus, our floor is too busy to have a meeting during the day.” |
| Making decisions | <ul style="list-style-type: none"> • “many people have lost interest because decisions take too long to make” • “too slow a process therefore people have been turned off.....stuff not resolved in timely manner. Issues drag on forever.” • “changes take too long to be implemented.” • “lack of support for decisions” • “unless there is a patient issue staff seem to have forgotten all about it” • “main problem is the communication and follow-through of decisions made.” |

Problematic participating.

The nursing staff identified the fact that there were many different aspects of participation in the transformational change process. During the workshops, the nursing

staff discussed the circumstances under which participation might facilitate or deter the transformational change. The workshop was identified as being a positive factor. The nursing staff felt valued by management because they were paid for the day and the workshop was conducted off the unit. Two comments from workshop participants illustrate the point: “the fact that we had one day of learning new concepts without the distractions we have when we try to do it while working” and “I wish there were more days like this for understanding new ideas and dispelling all the rumours. Would make us more enthusiastic.” During the implementation phase, the administration continued to support the change process by providing planning days off the unit to plan for the primary nursing part of the innovation. The primary nursing planning days allowed the nurses to take control over the application of the changes to their individual units. The value of participating in these days was reflected in notes from the planning day facilitator on November 14, 1994 indicating that these days seemed to help the nurses put their workshop knowledge into practice and develop ownership to make primary nursing work.

Although unit councils were set up first, lack of staff participation at the unit councils became a major frustration for those nurses committed to making it work. The units attempted to hold their unit council meetings at a time when the maximum number of staff would be available to participate. Participation at these meetings was voluntary and no dedicated paid time could be offered, leaving nurses to attend when at work or come in on their own time.

Participation in unit councils and primary nursing was influenced in 1996 by the unstable political environment surrounding health care and the hospital. The nurses

perceived the instability as being a significant barrier to successful change. The hospital responded to the political environment by closing units. The downsizing was necessitated because of a withdrawal of operating funds from the system. Management positions were eliminated and a seniority-based bumping process was implemented which displaced many nurses from their units. On some units over half of the nursing staff was displaced. These reactions caused anger and frustration among the staff. The managers and staff found themselves without a unit culture. Examples of excerpts from the 1997 Survey reflected these sentiments: “fear and general uncertainty of the internal and external environment,” and a “general feeling of apathy [among] the staff at the moment,” because of the “uncertainty re: keeping our jobs.” One nurse wrote “I hope once the bumping ends, staff will feel less threatened.” A loss of professional identity was perceived by some of the nurses: “nursing feels lost,” and “many groups feel they are losing their identity.” The innovation required participation. The nurses perceived their lack of time to participate as a major barrier to the implementation of the transformational innovation.

Making decisions.

The second sub-category of valuing time was making decisions. Participative decision-making meant that all the staff had the right to participate and express their opinions. Decisions were not to be made by voting but by negotiation and discussion. The difficulty was the large number of nurses on the units, the different schedules, shift work, and the perceived unwillingness of some staff to participate. To ensure that all members were informed, the units agreed to have issues discussed for three months and then a decision would be made. The 1997 Survey and unit council meeting notes indicated that a

number of nurses observed that this was not an easy process. The nurses who participated in the survey recommended that additional education on problem solving and decision-making was needed.

Traditionally nurses have not been taught to make participative group decisions or to engage in problem solving. The problem solving exercise during the workshop showed that the basic skills needed to group problem solve with consensus were lacking. The nurses approached the exercise by “solving” the problem before analyzing the problem and before developing a range of solutions. Group participative problem solving and decision-making was different than the patient care decision-making expected of them. The practical approach and practice sessions were perceived by many of the nurses as being supportive as was shown by two workshop comments: “generally I don't like group work –however the group problem solving exercise was very beneficial” and “I found the unit council part of workshop quite informative and the actual problem solving session positive as it allowed us to use problem solving techniques to resolve a specific problem.”

However, as the implementation of unit councils progressed, the nursing staff on many of the units perceived the decision-making process as a detriment to gaining professional control and making decisions. This was considered to be a barrier because the decision-making process was protracted. Some comments taken from 1997 Survey are shown in Table 6. These illustrate the barriers to transformation that were caused by problem solving and participative decision-making.

Working the “Rules”

The third category that emerged from the analysis on the implementation process was working the “rules”. The nurses felt that they needed rules or guidelines to assist them with the implementation of the innovation. Working the “rules” became an issue for many nurses on the units. The nursing staff designed guidelines for both unit councils and primary nursing to suit their individual unit needs. These guidelines were intended to support the nursing staff and managers with the changes in their roles and the structure of the transformational change. The guidelines were specifically created for primary nursing to accommodate the changes in patient assignment that were made necessary by the innovation. Two sub-categories arose from this category: (a) changing roles and (b) assigning the care. The unit council issues preoccupied the changing roles sub-category and primary nursing was the major concern in the assigning the care sub-category. Table 7 offers examples of excerpts reflecting this category and sub-categorie

Table 7 Excerpts Reflecting the Category “Working The Rules”

| Sub-category | Excerpts |
|--------------------|---|
| Changing roles | <ul style="list-style-type: none"> • “success depends on the strength and skill of core [group]” • “spell out role of nurse manager for staff and managers,” • “issues are vetoed by the nurse manager before we can get started” • “unit council is still being management run. A lot of staff do not verbalize concerns, questions etc. due to management’s presence – so some things that should be said are not” • “I feel that people do not bring many issues to light that could be discussed either for fear of backlash, or feeling that nothing can/will be done about it.” |
| Assigning the care | <ul style="list-style-type: none"> • “sometimes we get frustrated when we are harassed about taking more primaries when others have no primaries” • “patients aren’t always being picked up - sometimes they sit for days.” • “problems that arise are due to skill level. You sometimes can’t get your primary patient back due to being in charge [of the unit], or taking a ventilator [caring for a patient on a mechanical ventilator]” • “staffing is difficult to keep the primary nurse and patient together as patient needs change on a hour to hour basis and many nursing staff changes requires that primary nurse may have to take on a new admission,” • “acuity of patients has increased therefore it is becoming harder and harder to make up a nurse/patient assignment, including giving the primary patients to their primary nurse.” |

Changing roles.

During the workshops, the nurses’ perceptions of individual unit cultures were discussed to assess readiness for change. Specifically, staff examined whether or not their unit had an environment that was trusting, open, allowed freedom of opinion, allowed mistakes, and was a unit of decision-making. Each workshop was arranged so that nurses

from several units participated. Throughout the 56 workshops there was consistency in the perceptions that the nurses had of their own nursing unit culture. Some nurses perceived their unit as practicing all of the characteristics of a unit prepared for change while other nurses felt their unit met none of the characteristics. The discussion allowed the nurses to openly reflect with their peers in a safe environment. The discussion challenged what some nurses perceived as the norm for all the units. Some staff believed that the nurse manager established the culture and some believed that it could not be changed. The difficulty for learning new role functions constituted a barrier to change.

In order to successfully implement the change, it was necessary for the managers and nursing staff to modify or change their roles and behaviours. All the managers (n=24/30) who participated in the unit council focus group perceived that the unit councils were worthwhile: “very necessary but needs more support [by the manager].” Most of them agreed a “strong assertive core was needed.” The managers stated that they attended the meetings on their off duty time because they believed that it was “important to show staff that unit council is supported.” Some of the managers were attempting to change the practices they used to support the staff. One manager reflected on some of the mistakes she made: “in the beginning [I] solved problems for the group but now [I] assist the group to problem solve.” Three managers stated that they were still solving some problems that should be rectified by the unit council. Other managers expressed their frustration because they perceived that unit councils encroached on their role as nurse manager and that clarification of their position was needed.

Five hundred surveys were distributed in 1997 to the remaining 28 units who participated in the transformational change. Seventy-two (36%) staff responded from

twenty-six (93%) units. Eight staff (11% of respondents) from four units responded that the manager's role had not changed as illustrated by the examples in Table 7.

Some managers and nursing staff had mixed perceptions about the unit council meetings and the expectations of their roles and questioned whether or not unit councils were all that different from the former staff meetings. One manager thought, "some staff were still holding out waiting for 'staff meetings' even though it has been explained time and again that unit council replaces this." Staff meetings are chaired by the manager and used in a variety of ways; the most common being a vehicle for communication. Unit councils are chaired by a member of the staff and are intended to be used to problem solve clinical and unit concerns. The manager focus group indicated eleven (n=24) managers discontinued staff meetings when unit councils started and seven managers stated they had continued with their staff meetings.

The 1997 Survey showed that some staff nurses had perceptions similar to the managers. One nurse preferred staff meetings: "we have always done well when we had consistent staff meetings where we sat and vented. When these meetings stopped, we ran into problems, however these problems are not solved by unit council but by being allowed to express our opinions finally and getting feedback." Another nurse found the unit council "similar to old staff meetings but it is our agenda not the nurse manager's, except fewer people coming." A third nurse expressed a preference for managerial control: "why should we have unit council meetings when all the issues get discussed and solved by the manager at the weekly staff meetings?" The role change required by unit council was generally supported, but the excerpts illustrate the variation in opinion and the fact that some nurses viewed the unit council innovation as a problem.

The guidelines were developed to facilitate the change process by defining the roles of the manager and nursing staff in the new paradigm. On some units the guidelines became a barrier to the change process because the individuals would not or could not change their behaviour.

Assigning the care.

The second sub-category of working the “rules” is assigning the care. The primary nursing part of the innovation required the units to examine the decisions that lead to patient assignments. The nurses shared in the development of the guidelines that were necessary to accommodate primary nursing assignments. The rules associated with primary nursing consisted of the expectations of the nurses, provision of assignment continuity, and communication of flow supports. These guidelines were perceived as facilitating or deterring the change process. Prior to the innovation, patient assignment on the units was usually by blocks of patient rooms, for example, nurse A will be assigned room 5-bed 3 and 4, room 6-bed 1 and 2, and room 7. The guidelines facilitated the implementation process of primary nursing by applying structure. At the six-month evaluation, there were a few common issues that were a concern on the units (n=31) practicing primary nursing, namely geographical layout of the unit and selection of the patient.

During the primary nursing planning days, the nurses anticipated several problems such as the geographical layout of the unit, the movement of the patients within the unit, the skill level and experience of the nurses, and the selection of the primary patients. Initially the nurses tried to merge the current practice of assigning patients with the concepts of primary nursing. Many units established geographical boundaries to

protect the nurses from the need to care for patients who were widely located throughout the unit. The boundary was an issue because of the increased workload associated with geographically disparate patient assignments that resulted from patient movement. Patients were frequently moved about the unit during the hospitalization for many reasons. The guidelines gave the primary nurse the option of relinquishing the care of their primary patients if they were moved outside the boundary. Summary notes from the resource nurse indicated that nurses often waived this rule in order to care for their primary patients. As units gained experience with primary nursing, the boundary issue disappeared. Upon implementation of the primary nursing innovation, the nurses on one unit were adamant about adhering to the geographical boundaries. Two years after implementation, the guidelines were revised without geographical boundaries.

The assignment selection of the primary patient to the primary nurse was perceived as a problem and a major frustration. On some units the primary nurse was assigned to a primary patient by the manager or charge nurse, while on other units the nurses selected their primary patients. One group of nurses felt that there should be no choice in the assignment process. However, one nurse preferred not to assign patients to their peers because they were “made to feel uncomfortable if you assign a primary.” On some units, only a small group of nurses were selecting primary patients. When the nurses did select a primary patient, they were frustrated when subsequent assignments excluded their existing primary patients. This frustration is illustrated by a comment from one nurse: “difficult to stay connected (emotionally) with family and patient when not assigned to that patient for extended periods.”

There were many opinions on the flexibility of assignments. The nurses working on specialty units like the intensive care units had difficulty maintaining continuity when there was a difference in skill level or clinical expertise of the nurses. On one unit, the degree of flexibility of the primary nursing guidelines was perceived as a detriment and equated the guidelines with possible unfair work distribution. This attitude is reflected by the comment from a focus group participant who stated that: there “needs to be a reason for making changes to the guidelines, we need to distribute the work fairly.” Another group of nurses at a focus group believed that the guidelines needed to be flexible and adjustable: “we need to verify that flexibility can be there even though it is primary nursing” because some nurses were too inflexible and considered the guidelines “etched in stone.”

In summary the findings regarding the transformational change process focused on three categories: sharing with others, valuing time, and working the “rules”. As the nursing staff implemented the transformational change, they perceived factors that both facilitated and deterred the progress toward complete implementation. These factors included sharing with peers to reduce concerns, a trusting environment, and obtaining the education off the unit while being remunerated for the time spent were perceived as facilitating the implementation and learning process. The unit councils and primary nursing guidelines that were designed by the nurses for their units to facilitate the implementation process created frustrations on some units.

Interpretation

The analysis suggests that some factors may have simultaneously facilitated and deterred the learning and change process. The trusting environment created by the workshop supported the nurses to share their concerns and learn from their peers and the

facilitator. This helped reduce their fears and anxiety, and in turn developed openness to the change. By being able to express their emotions, some of the nurses were reflecting a willingness to try the change. Others, in the workshop, declared resistance. The reaction to the transformational innovation during the workshops and the comments on the evaluations offer adequate references to suggest that transformational learning was starting to occur during this period. The research on transformation learning process (Brookfield, 1987; Cranton, 1994; Mezirow, 1990), the grieving-change process (Perlman & Takacs, 1990; Schoolfield & Orduna, 1994; Wells, Barnard, Mason, Adrienne, & Minnen, 1998) and the learning process described by Buckler (1996) support the findings in this study. Sofarelli and Brown's (1998) study claimed that trust is essential in the transformational change process and Cranton's research supported the fact that the interaction with others and the support from their peers and manager is crucial if critical reflection is to begin and continue.

Lack of participation once unit implementation of the change commenced was perceived as a major detriment. The nurses who were ready to change expressed frustration with their peers who were not ready to change. This is congruent with the research by Kilmann and Covin (1988) and Rogers (1995), which shows that change usually spreads throughout the organization at different rates of adoption and that individuals require different degrees of learning. Some early adopters commit to change sooner and more easily based on their own reasons or motivations. Bolman and Deal (1997) indicated that when staff was involved in the decision-making process they are more willing to invest in the process to ensure that the desired outcomes are achieved. However, according to Manion (1993) not all individuals who are empowered will accept

responsibility for innovation. This may be due to the specific skills needed, or to the many barriers present in traditional bureaucracies. In my role as facilitator, I was consulted several times by the nurses on the units to attend their unit councils for the first year of implementation. The nurses' comments on participation and decision-making at unit councils indicate that the process was still in its beginning stage. Many of the staff were inexperienced with the conduct of meetings and the non-clinical decision-making process. For this reason, many staff nurses requested support. This may be one of the reasons for lack of involvement.

The analysis also indicated that another major deterrent to participation was the lack of time the nurses had to participate in unit council activities. It is difficult for staff to find time outside of patient care to participate in-group activities. Additional barriers to participation were an increase in patient acuity that reduced the time for non-clinical activities and the chaos of restructuring that led to a decrease of nursing personnel on the units. These results are similar to those of Anthony (1999) and Hastings and Waltz (1995) on decision-making behaviour, who concluded that the lack of participation may be due to the fact that most work related decisions required longer participation than care giving decisions. They further concluded that nurses did not want to or could not expend the time required to participate in unit related decisions. They also concluded that the process was burdensome and anxiety provoking (Anthony, 1999; Hastings & Waltz, 1995). In the present study the downsizing of the organization intensified the anxiety experienced by nurses.

Findings pertaining to the perception of the role change and degree of involvement in decision-making of both the nursing staff and managers varied according

to the unit staff and manager. Even though all the managers were given the same information as the nursing staff, mixed opinions about types of decisions that could be made by the unit council created conflict between the manager and nursing staff on some units. This study showed that the behaviour of the manager and the staff facilitated or deterred the autonomy of the staff. This is congruent with other research. Argyris (1998) found that employees are often ambivalent towards empowerment and think that it is great as long they are not held personally accountable. He discovered that managers support empowerment in theory, but know and prefer the command-control model. Ingersoll, Schultz, Hoffart, and Ryan (1996) found in their study that as the nurses became independent in decision-making and self-governing, they were more satisfied when the leader's style was facilitative and consistent with their expectations. If the leader's style remained directive, or structured, as the staff moved to a more independent decision-making approach, conflict and dissatisfaction resulted. The process of participation in decision-making for care giving and work conditions required that the nurse managers and nursing staff change their behaviour. The failure to change behaviour by one or the other party was perceived as a detriment to the success of implementation of the innovation by the unit.

Until the fall of 1996 the transformational change was progressing well. Unit council and primary nursing structures were in place and the nursing staff were continuing to work through the problems. The local environment was a major influence on the change process. The workshop environment was a positive factor in initiating the change process. The response on the individual units varied. Some units were supportive of the change while others were detrimental to the change process. By the fall of 1996,

the external organizational environment became the overarching factor in the ability of the units to sustain the change. After several units were closed and staff changes occurred, the innovation started to unravel. The staff could not maintain their momentum when many of the nurses who believed in the change were transferred to other units in the union bumping process. Other research concurs with these findings. Davidhizar and Bowen (1990) found that the attitude of employees and their feelings of value to the organization are often critical in implementing and maintaining a desired change. The nursing staff felt they were valued in 1994 with the paid support to learn and implement this transformational change, but by the fall of 1996 they were demoralized with the unit closures and the lay-off of their peers and were unable to maintain the change process.

In summary, the transformational change process is a complex series of elements that lead to a new way of conducting a practice or a business. The goal of the transformation in this case was to implement the innovation to a professional nursing staff that would increase autonomy and decision-making relating to work environment and patient care. The innovation was the establishment of unit councils and the practice of primary nursing. In analyzing the implementation of this transformational change, the categories that emerged were (a) sharing with others, (b) valuing time and (c) working the "rules". The change was introduced at a time of minimum instability in the hospital. The response of the nursing staff was generally positive, although some resistance to change was identified. Ultimately, organizational restructuring derailed the change process.

The Transformational Change Outcomes

The evaluation of the outcomes of the transformational change began with the six-month focus groups and was completed with the 1997 Survey. Since implementation occurred unevenly across the units, the data presented here are the outcomes of the transformational change as perceived by the nurses 6 months to 3 years after the innovation was implemented. A transformational change requires visible results, but to be successful, individuals need to integrate their beliefs and assumptions with the transformational change.

Research Findings

The following question guided this portion of the study analysis.

What outcomes of the transformational change are perceived by nursing staff?

The outcomes are examined qualitatively by the relationship between the nurses' perception of the effects of their changes to care giving, unit decisions, and to themselves professionally. The four categories derived from analyses that reflected the system outcomes are: (a) increased consistency in care, (b) increased knowing, (c) changed relationships, and (d) increased professional control.

Increased Consistency in Care

Increased consistency in care was the first category reflecting an outcome of the transformational change. Analysis of the 6-month focus groups showed that most nurses perceived that a change had occurred following the introduction of primary nursing. This is illustrated in Table 8 with examples of the participants' excerpts reflecting comments about consistency of care.

The excerpts are representative of the views of over half the nurses (n=212) who attended the 6-month primary nursing unit focus groups. They stated that there was a “difference in the quality of care, it is better for the patient” as a result of consistency of the caregiver and care. The increased consistency in care improved on most units because the primary nurse cared for the patient whenever on duty. This provided those who practiced primary nursing positive feedback from the patients and family members and personal satisfaction for the care they delivered.

Table 8 Excerpts Reflecting the Category “Increased Consistency In Care”

-
- “there is more emphasis and focus on patient care with primary nursing”
 - “continuity of care has improved i.e. things are done consistently”
 - “it provides continuity for nursing on the unit - over time it will be okay.”
 - “families have reported the benefits of having consistency [of the caregiver].”
 - “if I was on the other end of the stick, it would be nice to have the same nurse”
 - “patients appreciate being seen and cared for by a familiar person on the day of surgery, this has been expressed numerous times.”
 - “...now you can see patient going from point A to B,”
 - “if the patient stays longer, we sometimes see a difference.”
 - “some patients don’t stay long enough to have a primary,”
 - “short stay-if a primary nurse isn’t identified early on, it seems pointless to identify when only 12-24 hours of stay remain,”
 - “we have such a fast turnover it just doesn’t work.”
-

The nurses on the medical units believed that it was easier to provide continuity of care to longer-stay patients than to shorter-stay patients. Many nurses perceived that “the longer stay patients tend to have a primary nurse more frequently than the short stay patients.” The surgical nurses also mentioned this frequently where the patient stays were usually short. They believed that continuity of the caregiver could not be provided

because the patients did not stay long enough in the hospital. However, the difficulties expressed about the primary nursing system were that providing consistency of care to the same patient for a long time “can be very draining and frustrating with unstable long-term patients” or “when there is a difficult patient with a difficult family, nobody wants to pick him up (i.e. cultural, language differences).”

There were a few nurses who believed that the consistency of care had not changed as a result of the introduction of primary nursing but many of the nurses at 6 months perceived that there was an increase in consistency of care and knowing more about the patient supported this.

Increased “Knowing”

The second category derived from the analysis was increased “knowing” about the patient. This emerged from the primary nursing unit focus groups. The participants in this study, perceived an increase in knowledge about the patient because they spent more time caring for specific patients. They also believed that increased time with specific patients translated into improved care. The information gleaned from the patient was shared with all team members via a care plan. On a few units, the nurses perceived a difference in the patient’s hospital length of stay because of the follow-up and communication. Table 9 illustrates examples of the nurses’ comments.

Most nurses believed that increased “knowing” was advantageous, but some nurses found that caring for the same patient all the time stressful: “the relationship with my primaries is good, but it is stressful trying to know what else is going on [on the unit]” and “sometimes the difficult families feel you may not know the patient because you may not be the primary nurse.”

Table 9 Excerpts Reflecting the Category “Increased Knowing”

-
- “our knowledge about our own patients has changed”
 - “[we] know patient’s history better as well as what has happened overall to patient-what has worked in past and what has not”
 - “nurses know their patients very well and in more depth and at a deeper level”
 - “repeat patients who we know well, generally do not stay as long because we don’t have to start at square one [getting to know them]”
 - “the better we know the patient, the more we get involved”
 - “majority of nurses like the feeling of really knowing the patient (and family) well and can see the progression of care and feel that their involvement does make an impact”
 - “I feel I am more aware of what my patient wants”
-

At the 6-month focus group, there was still resistance to the change but only 20 nurses (n=212) preferred the previous nursing care delivery system. Several excerpts taken from the focus group demonstrate the resistance and show the range of reasons for the resistance: “I like total patient care because primary nursing doesn’t allow the changing around of patients,” “you get to know the ward better with total patient care,” and “before you always knew what to expect with all the patients, but now you only know or are in tune with your own patients.”

An outcome of the transformational change perceived by the nurses was an increased knowledge level about their patients. A nurse gained this knowledge by providing care to the same patient whenever possible. The knowledge was gained because the nurse accepted the responsibility to work with the patient, to provide a plan of care, and to communicate this plan to the team members. As a result the relationship with the patient, family, and health care team changed.

Changed Relationships

The third category that reflected a transformational change outcome was labelled changed relationships. The nurses identified, particularly on the medical and surgical units, that the relationships between the nurses and patients/family members and between the nurses and health care team had changed since primary nursing was introduced on their units. Two sub-categories relating to changed relationships arose from the analysis: (a) increased patient trust and (b) improved communication. Examples of the participants' comments are reflected in Table 10.

Table 10 Excerpts Reflecting the Category "Changed Relationships"

| Sub-category | Excerpts |
|-------------------------|--|
| Increased patient trust | <ul style="list-style-type: none"> • "I've been the primary [nurse] with a patient who is blind and had a stroke... It is better for her to have the same nurse; she has developed trust," • "[the] patient said at least you'll be here. He felt more comfortable." • "the patients identify one individual that they can relate to and I feel that they are more likely to call with questions. They are less apprehensive knowing that someone is available to them on this level." • "Primary nursing makes family feel safer when they see the same face." • "[primary nursing] creates increased involvement and a better relationship with patients" |
| Improved communication | <ul style="list-style-type: none"> • "primary nursing facilitates communication - there is no go between and less information gets misconstrued," • "they [the team] know who to go to and [speak to] the primary nurse who knows the whole picture." • "primary nursing has promoted more discussions with allied health, residents, etc," • "[we are] working with everyone (i.e. Social Worker) more closely." • "the [nursing] team now feels recognized, different than before – they now know our names, i.e., the doctors." |

Increased patient trust.

Increased patient trust was perceived as being a positive outcome of primary nursing. The patient/family and nurse developed this relationship because the patient received care from the same nurse on a more consistent basis. Some of the nurses stated that both the patients and families were more comfortable with one person being responsible for their care plan and therefore would seek them out whenever the nurse was on duty. A concern articulated by some of the nurses was an increased dependency by some patients: “patient and family become too dependent on one nurse.”

Improved communication.

The six-month focus group and the 1997 Survey showed that primary nursing improved communication between health care team members and the nurses. The perception of improved communication is shown by quotes taken from the data (Table 10). Before primary nursing was implemented, most of the team members communicated with the nurse manager or the nurse in charge. After the implementation, the teams were asked to discuss the patient care issues with the primary nurse or his/her substitute. The nurses on the majority of the units saw a difference in the relationship between themselves and the other team members. However, a few physicians expressed concerns that the manager or charge nurse was no longer available and that they didn't “like it because there is not someone who is central or central core, they may need to talk to three different people.” One nurse reported that: “doctors have said to me - primary nursing is wonderful, but it is nice to have someone who knows what is going on [on the whole unit].” A positive outcome that the nurses reported was the recognition of their names by the team members. This is a change from the lack of recognition by the physicians and

other team members, which was a common comment by the nurses during the workshop and primary nursing planning days.

There were few comments from the nurses identifying unit councils as a means of improved communication. Unit councils were perceived by some of the nurses as a valuable way of providing a forum for open communication: “very good forum for passing information,” and “people feel they have a platform to get concerns addressed.” The comments from the manager focus group data one year after most units had implemented a unit council reflected some positive results: “worthwhile; very necessary but needs more support,” and “people are starting to place their issues on agenda (not just managerial).” One manager, found that an outcome of unit council implementation was an increased use of coaching skills: “it takes up more time of the manager because now she must coach staff through decisions- not just do it.”

Increased Professional Control

The fourth category reflecting system outcomes that emerged from the analysis was the perceived increased professional control by the nurses as a result of the transformational change. The change was designed to give the clinical nurses authority to make decisions related to direct patient care and to conditions of work on the unit. There were very few comments from the nurses about patient care decision-making because few nurses perceived that they had problems making patient care decisions prior to the change. This was expressed by most of the nurses during the workshops and was repeated in the focus groups and the 1997 Survey. Once the innovation was implemented, there was a belief by many nurses that they were in greater control of patient care as illustrated by three comments: “yes, maybe I feel I have more control - not control over the patient,

but the care,” “I feel like I have control so I like it,” and “I really like the continuity and control.” Perceived positive outcomes relating to increased professional control over work related conditions at the unit councils were dependent on the involvement of the nursing staff and the nurse manager. The comments in Table 11 are taken from the July 1997 Survey indicating that some unit councils survived organizational downsizing and the ensuing chaos that began in 1996 with the closure of six units. The nurses and managers on the units with surviving unit councils valued the professional control and the inclusiveness of the decision-making that this format provided. The respondents also viewed unit councils as being a non-threatening agent of change.

Table 11 Excerpts Reflecting the Category “Increased Professional Control”

-
- “things don't get missed when we use primary nursing”
 - “families feel more comfortable and patient problems (i.e. weaning, nutrition etc.) get tracked and followed up better,”
 - “by giving a specific RN contact person for the patient to call if there are questions or concerns before the surgery, we have greatly increased the number of return phone calls that occur. This is excellent for the patients/families.....”
 - “if you have anyone that's involved and needs planning you come in and know everything,”
 - “satisfaction with a sense of follow-up – we didn't always have the chance to follow-up patients,”
-
- “[unit council] does excellent work, makes decisions and gets things done,”
 - “all issues are allowed to be discussed.... therefore a more efficient unit implementation of changes.”
 - “able to voice concerns. Generally agree on problems and feel that things are changing.”
 - “after two years, we still are not tackling bigger issues,”
 - “we can only make decisions about very minor things – management still “dictates” the big issues,”
 - “a lot of concerns deal with budget and staffing. Frustration results because these are issues that unit council has little control over.”
-

The categories that described the transformational change outcomes reflecting the system are (a) increased consistency in patient care, (b) increased “knowing” more about the patient, (c) changed relationships by increased trust with the patient/family and improved communication with the health care team, and (d) increased professional control over direct patient care decisions and work related issues on the unit. It was apparent that by the time of the 6-month primary nursing focus groups and the 1 year unit council manager focus groups were undertaken that many nurses and units had system-related positive outcomes as a result of the transformational change. This trend was weakened by the time of the 1997 Survey due to the disruptive external environment although as illustrated in Table 11 some unit councils managed to survive the chaos.

However, as has been stated in a review of the literature, a transformational change is not complete unless there are personal or professional changes to the individual’s behaviour, values, beliefs, and attitudes.

The following question guided this portion of the study analysis.

How have nursing staff values, beliefs, and attitudes changed in regard to practice throughout the transformational change?

Two categories emerged reflecting a change in attitudes and behaviour: (a) more accountable and (b) more committed.

More Accountable

This more accountable category reflects the analysis from the primary nursing focus groups and the 1997 Survey. Accountability can be defined as a structural outcome, meaning that it is a formal obligation expected by the employer of everyone participating in the organization (Nadler, 1988). It is not found in what one has or is; it is found in

what one does with it. It is the formal obligation to be answerable for what one has done (Porter-O'Grady & Wilson, 1995; Wolf, Boland, & Aukerman, 1994). There is also a perceptual predisposition toward feeling accountable. This perceptual state may be independent of the actual organizational realities (Nadler, 1988). It is this perceptual statement that is reflected as a personal or professional outcome.

When asked if they perceived a change in their personal or professional behaviour, increased accountability was identified by a small number of the nurses. During the workshop a critical discussion was on accountability. Clearly, many nurses at that time were concerned about assuming more accountability. The implementation of primary nursing required a transformation in beliefs and practices for a number of nurses. The excerpts in Table 12 demonstrate that the critical reflective process was beginning.

Table 12 Excerpts Reflecting the Category "More Accountable"

-
- "I may feel more accountable,"
 - "for me it is accountability."
 - "no [would not go back to total patient care] more accountability with primary nursing."
 - " wouldn't go back, however, it is a change when you have been doing something one way for a long time - like total patient care."
 - "they don't feel they are different because they always have been a pt advocate."
 - "I am now more concerned about my own patients,"
 - "I think you look at your patient as your own - you look after them."
 - "more knowledgeable and more concerned about my patients."
 - "we are more of a patient advocate,"
 - "yes, it is working we are more diligent, we listen more,"
 - "RNs are thinking about their patient's discharge day ahead of time and planning homecare needs,"
 - "you are thinking a bit more about the patient"
 - "I try to think ahead a little more."
 - "more nurses now take more initiatives in providing complete care for their patients."
-

More Committed

The second category reflecting changes in personal or professional behaviour, values, beliefs, or attitudes was the perception of being more committed. Argyris (1998) describes commitment as being internal or external. Individuals define internal commitment and their behaviour or change in behaviour as being based on their own reasons and motivations. It is participatory and reinforces empowerment. External commitment is contractual compliance. Management defines the roles and tasks resulting in the employees not feeling responsible or accountable for their actions.

Table 13 reflects the examples of excerpts of the participants during the 6-month primary nursing focus groups and 1997 Survey. Some nurse managers and nursing staff were committed to the transformational change and commented that they perceived a change in themselves. A few nurses felt more satisfied: “you can see them [patients] progress and they [patients] feel more secure,” and “we feel good that we have managed a difficult problem- it is satisfying.” One nurse commented, “it is good for us as well.” However, there were still nurses who were resisting or refusing to change and saw no change in their practice. The July 1997 Survey revealed fewer positive comments about primary nursing and more representing a frustration or anger: “leave us alone and call what we are doing primary nursing,” and “we do not practice primary nursing; however, nursing care is given in a very efficient manner, using a minimal number of staff for (coffee breaks, lunches etc.). Primary nursing would not be as efficient or as cost effective.”

Table 13 Excerpts Reflecting the Category “More Committed”

-
- “primary nursing did bring an awareness,”
 - “I think I care more,”
 - “I don't want to give up primary nursing, ...I can see the progress [of the patient].”
 - “it [primary nursing] is a positive part of the job- it keeps you going,”
 - “primary nursing helps me tie my professionalism into practice”
 - “primary nursing gives us more focus/balance.”
 - “energy and interest is there to make it work well and the system is positively viewed by patients/families.”
 - “we feel more involved.... ”
 - “because nurses have become more involved, I have noticed that people say that we have a kind and caring staff – we are more sensitive to the patient's psychosocial needs”
 - “you receive a more global picture of what is going on, we attribute this to primary nursing.”
 - “I feel primary nurses do a more thorough job, more on the ball, they know the patients.”
 - “there are individuals who have fully adopted and integrated primary nursing into their practice and others who are functioning at a name only level,”
 - “we have come a long way. Still have some people who are not keen on primary nursing and require some coaxing or encouragement to take responsibility.”
 - “staff were not committed to the change. They constantly need to be convinced that it is better,”
 - “staff have not bought in; practice hasn't changed.”
 - “I don't notice any difference,”
 - “I give the same care as I always did,”
 - “total patient care is much easier; many of the nurses want to change back to total patient care.”
-

Transformational change outcomes were reflected in this study as system or structural outcomes and professional or personal outcomes. The structural outcomes that arose from the analysis were: (a) increased consistency in care, (b) increased knowing, (c) changed relationships, and (d) increased professional control. The professional or personal outcomes that reflected the nurses perceptions were: (a) more accountable and (b) more committed.

Interpretation

A central element of professional practice models is nursing excellence, through knowledge, research, empowerment, and accountability. This will result in positive patient care outcomes and create a culture of independent, caring professional nurses (Hoffart & Woods, 1996; Trofino, 1997). This is accomplished by encouraging professional autonomy over practice, nursing control over the practice environment, and effective communication between nurses, physicians, and administrators (Havens & Aiken, 1999). At the time of the introduction of the innovation, most of the nurses were willing to consider the change for their units. On implementation, the reality of the workplace and the complexity of the transformational change were immensely frustrating to those nurses who were attempting the change. Despite the multiple structural frustrations, the nurses expressed positive outcomes and some admitted that they would not give up primary nursing or unit councils. Many of the concerns during the workshop were about primary nursing and the majority of the problems during the implementation were related to primary nursing, but when the nurses discussed their perceptions of what had changed the positive outcomes were related to primary nursing. One explanation for this inconsistency may rest with the valuing time issue. Unit councils require a time commitment away from the patient by the nurses, but primary nursing substitutes one delivery of care structure for another, therefore is not perceived as requiring extra time.

The positive outcomes of primary nursing presented in this study were: (a) increased consistency in patient care, (b) knowing and understanding the patient and family better, (c) a more trusting relationship with the patient and family, and a more respected relationship with the health care team, hence (d) an increased control over

professional decisions. The nurses' perceptions about primary nursing presented in this study are supported in the literature. Several authors have found that the outcomes of primary nursing are autonomy to make clinical decisions, continuity of care for the patient and the caregiver, effective communication and collaboration among health care providers, and accountability for the patient plan of care (Hastings, O'Keefe, & Buckley, 1992; MacLeod & Sella, 1992; Manley, Hamill, & Hanlon, 1997). The nurses in this study found that when they provided continuity of care to the patient, they knew more about the patient. This study's findings are congruent with Radwin (1996) who stated that the overall concept of knowing the patient is important to practice and may be relevant to changes in practice conditions. It may also be a factor in positive patient outcomes.

Another major outcome was the changed relationships that occurred between the patient, the family and the health care team. Greater in-depth knowledge by the primary nurse resulted in improved patient and family relationships. This change in relationship was apparent to other members of the team, which in turn caused a change in the team relationships. Improved communication between the members of the health care team evolved from the changed team relationships. Nurses were more satisfied with their work because they knew the patient better, the medical staff and health care team recognized their knowledge of the patient, and the positive patient outcomes were noticed.

Some of the nurses realized that they were more accountable, with an increased awareness and advocacy. These changes are reflective of professional values changing and demonstrate that critical reflective thinking may have occurred with some nurses. Some stated that they would not return to the "old" system. The findings of this study

confirm the research on primary nursing (Manley, Hamill, & Hanlon, 1997) and transformational learning (Brookfield, 1992; Cranton, 1994).

Positive outcomes from the implementation of unit councils were less apparent than those that arose from primary nursing. The nursing staff brought forward several reasons to account for this observation. Unit councils require participative decision-making on conditions of work. The nurses believed that more skills were needed to problem solve and conduct meetings. Practicing these skills took time and nurses valued their time. In some cases, the outcome was not effective because of management control issues. This is congruent with Anthony's (1999) research, which showed that increasing the nurses' control over their practice is pointless if they do not exercise their authority to make decisions. Finally, the implementation of the innovation occurred at the beginning of environmental turbulence in the organization. This eventually resulted in a lack of interest by some staff because of staff upheaval.

The transformational learning stages move from a triggering event to exploration of assumptions through critical reflective thinking to integration or internalization of the change. Integration is a change in assumptions and viewpoint followed by action on the changed perspective. A conscious recognition of the difference between one's old viewpoint and the new one occurs and a decision is made to acquire the newer perspective as being of more value. There were nurses who believed that they were more committed and more accountable in their practice. Mezirow (1978) states that as the individual moves to a new perspective, he or she is dependent upon association with others who share the new perspective. This may explain why some nurses accepted and sustained the transformational innovation despite the organizational chaos.

In summary, innovation to be successful required a transformation of the attitudes, values, and beliefs of the nursing staff. The early evaluation results taken from the focus groups (1995-1996) demonstrate that the transformation begins with structural or system changes and is followed by behavioural changes. The categories that arose were: (a) increased consistency in care, (b) increased knowing, (c) changed relationships, and (d) increased professional control. The categories that reflected the beginning of behavioural changes were: (a) more accountable and (b) more committed.

Transformation in the organization is a unit-based event that is dependent on management and staff skills, role changes, and support structure changes. The early results indicate that some of the nursing staff have revised their assumptions with respect to their accountability and professional practice. I believe that those nurses and managers who have transformed their beliefs are continually re-evaluating their perspectives and moving forward.

CHAPTER FIVE: SYNTHESIS AND IMPLICATIONS

Introduction

To order to enhance the understanding and increase integration of the study findings, the interpretation of study findings was incorporated within the analysis in Chapter 4. Chapter 5 is limited to a synthesis of the interpretations into a cohesive whole and this is followed by a discussion of the implications for administrative practice and suggestions for possible avenues of research.

This case study set out to understand the links between a transformational change and required transformational learning of professional nursing staff in a large tertiary care teaching hospital. Exploring the perceptions of nursing staff with respect to the transformational change and changes in their values, beliefs, and attitudes as a result of the transformational change did this. The five research questions were:

1. How does nursing staff perceive the transformational change?
2. What factors are perceived by nursing staff that facilitate or deter the learning process?
3. What factors are perceived by nursing staff that facilitate or deter their implementation of the transformational change?
4. What outcomes of the transformational change are perceived by nursing staff?
5. How have nursing staff values, beliefs, and attitudes changed throughout the transformational change?

The elements of the conceptual framework that guided this study are: (1) transformational change as the innovation, (2) transformational change as the learning process, and (3)

transformational change as the outcome. These three elements interact to cause change to the organizational structure as well as to individual and group values, beliefs, and attitudes. The data were analyzed according to these elements and Figure 2 summarizes the categories that resulted as they relate to the conceptual framework.

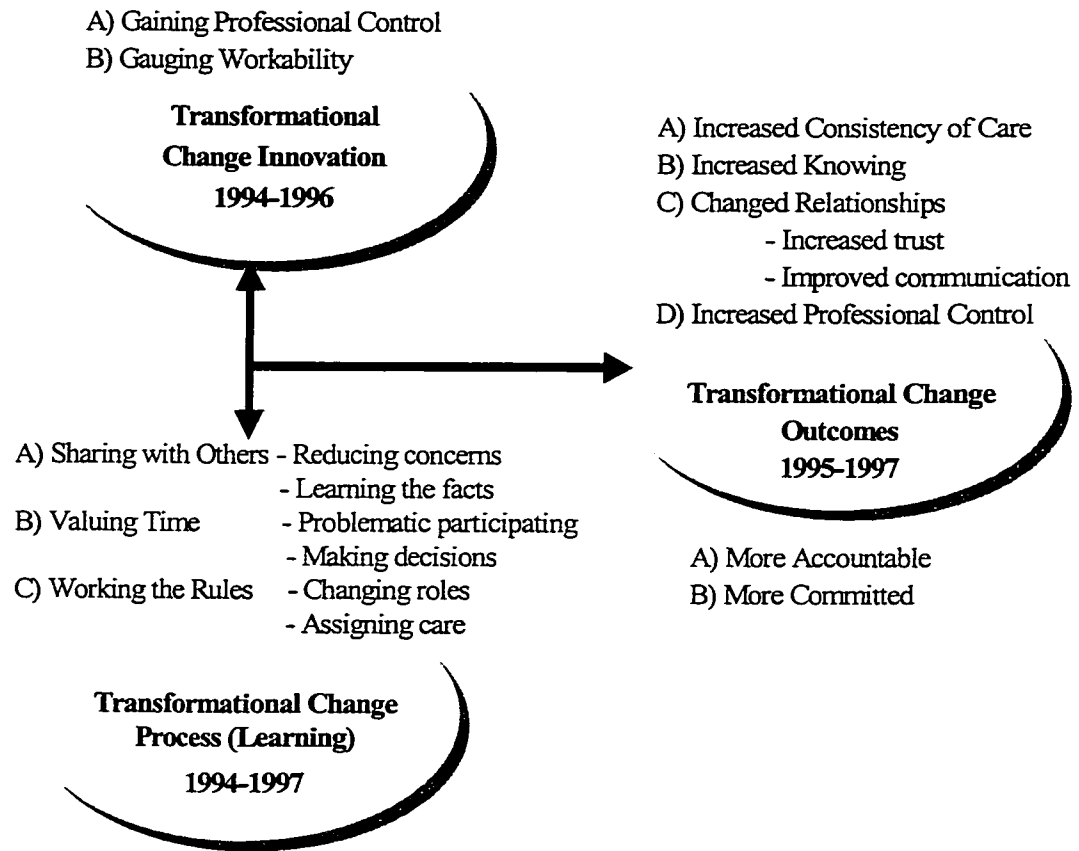


Figure 2. Conceptual Flow of Major Categories

Interpretative Synthesis

Transformational Change Innovation

Over the time period of the study (1994-1997) the dynamics of change were witnessed at three levels: the individual, the unit, and the organization. The executive of the Division of Nursing mandated the transformational change innovation. The innovation as presented to nursing staff in a workshop consisted of two important aspects, unit councils and primary nursing. The present study argues that the workshop participants formed an understanding about the innovation relating to an increase in professional control and the workability of the proposed change. The innovation was perceived as potentially providing staff with additional control over professional decision-making and was sufficiently flexible that individual units could adapt both aspects to be workable. The participants came to realize that although the decision to proceed with the innovation was top-down, details of the implementation process would occur only with the agreement and support of the staff.

For many, the introduction of the innovation concepts was the triggering event that began the reflective transformational learning process. The workshop was the event that initiated awareness of old patterns of behaviour and started the creation of an opening for new understanding and behaviour. The shortcomings of current practice were openly discussed in the workshops. This caused a belief in many participants that a better way of practice was possible and needed. As Schein (1999) showed in his work, it is essential to articulate a positive vision so that employees believe that both they and the organization will be better off once the innovation is implemented. From the outset, it was understood that the workshop format had potential limitations. It was possible that

the vision presented was overstated and could result in disappointment that would act as a barrier to the transformation later in the implementation process.

The nurses resisted the change during the workshop by expressing their thoughts and feelings. The degree of anxiety and anger towards the change was probably understated in the evaluations because many nurses did not commit their sentiments to paper. It is also possible that the relationship with the presenter was responsible for the understatement. This may be a possible limitation that could arise from depending only on written documents but since I was the researcher and the change agent, I was aware that positive evaluations of the workshop were not completely reflective of the nurses' anxiety during the workshops. Someone reading and analyzing the workshop evaluations alone might have missed this very important aspect of the perceptions toward change.

The nurses left the workshop with perceptions of the innovation. Learning the facts led to increased concerns regarding wanting more professional control and a workable innovation. They thought that the innovation would work, but worried about how easy it would be to implement because they had no time to modify it. Throughout this process the facts triggered a reflective thinking process that their current practice was not optimal. This reflection resulted in concerns. The workshop began the implementation process and provided an opportunity for concerns to be raised and discussed, which was helpful and enhanced critical reflection. The opportunity for sharing with others provided the confidence to pursue the innovation. Sharing with their peers and the facilitator reduced the anxiety about the innovation and supported creative problem solving during the workshops.

Transformational Change Process

While the workshops were well received, the unit implementation experience was difficult. When the nurses returned to their units, they faced a new set of concerns regarding limited time to design the new practice structure and gain necessary skills. During this period there was little time for reflection to support the transformation of values, beliefs, and attitudes. During the transformational change implementation some issues decreased the process of critical reflection.

The first issue was associated with time constraints. During the workshop the nurses frequently stated that they had limited time to care for their patients. They attributed this difficulty to staff shortage, lack of funding, and patient acuity. The workshop introduction of the innovation provided time for discussion and problem solving. However, the unit implementation process did not provide for any additional time to participate. This resulted in frustration because there was insufficient time to participate and not enough time to learn the new roles due to increased instability in the system.

The nurses partly gauged the degree to which the innovation would work by the extent to which they would be able to adapt it on their units. The notion that they had professional control to develop and change the rules was valued. However, frustration with the transformational change developed when the ability to change rules was not allowed or when individuals on the unit did not follow the new rules. A specific example leading to frustration is illustrated by concerns about the new way of assigning patients to nurses. This change in assignment practice was frustrating for many nurses because this required a change in their behaviour and attitude towards patient care.

Transformational Change Outcomes

Although the introduction of the innovation could be described as successful, many problems occurred during the implementation process that impacted on the final outcome of the transformational change. Despite the frustrations and chaotic environment, the nurses did perceive positive outcomes resulting from the transformational change. The nurses indicated that primary nursing improved the consistency of care to the patients. The assignment of one nurse to a patient throughout the hospital stay resulted in the nurse knowing more about the patient. This led to a positive change in the relationship between the nurse and the patient and between the nurse and the health care team. Knowledge about the patient provided the nurse with the confidence to take risks and to communicate with the health care team with authority. This increased control over patient care led the health care team to state that patient care had improved. This enhanced the identity of the nurses and added to their professional control. The change in perceptions about nurses by other stakeholders may have supported those nurses interested to critically reflect on their own practice and move towards a new perspective. As a result, some nurses perceived that they had changed by becoming more accountable and more committed professionally.

There were factors that affected the degree to which the transformational change was successful. There are several possible explanations for the problems encountered on the units. First, neither the nursing staff nor the nurse managers were experienced at change management, and this probably impaired their ability to implement such a complex change. Even though the workshop provided the information and implementation resources were available, the lack of skills for participative decision-

making and problem solving was apparent on some units. Transformative learning occurs through experimenting with new ways, and developing solutions unique to the individual workplace. Although staff perceived that they had increased professional control to set the rules for the change, frustrations were apparent when their peers did not support the solutions that were developed by staff. Implementation problems also occurred because the analytical skills needed to develop and revise rules were lacking. The evolution of rules throughout the process is critical to the success of the trial and error technique of transformation. The trial and error process is a much slower implementation method, but when it is successful, the learning has more of a chance of being internalized because it supports staff ownership (Brookfield, 1987; Pascale, Milleman, & Gioja, 1997; Schein, 1999). Trial and error had been selected for the organization despite the pitfalls because the goal was to create a permanent change in the way nursing practice was conducted throughout the organization. One unit demonstrated the trial and error method by attempting to implement primary nursing three times using different approaches before being successful. Success was achieved on the unit when there was a critical mass of nurses in support of the change.

A second factor that affected implementation was the difference in the size, function, and experience of the various units. For example, surgical units found it more difficult to implement primary nursing than medical units due to the shorter length of patient stay. Unit councils were more supported in areas where there were a greater number of experienced nurses, such as in critical care or specialty units. The experienced nurses were better able to apply their clinical decision-making and problem solving skills to the unit council participative decision-making process than were the less experienced

nurses. This was supported by Anthony (1999) who found that the greater the expertise of the nurses, the more participation occurred.

To further complicate matters, on some units, the individual values, beliefs, and attitudes created a unit culture that was antagonistic to change. To overcome this type of resistance, it is necessary to create a supportive environment. Creating a supportive environment for risk taking, autonomy, and empowerment is the most difficult of changes (Fullam, Lando, Johansen, Reyes, & Szaloczy, 1998; Pascale, Milleman, & Gioja, 1997; Schein, 1999). Although the executive of the Division of Nursing supported the change, the resources that were made available during the implementation process were insufficient to create or sustain the supportive environment needed on the front line.

Lastly, the chaotic environment that existed in the organization throughout the change process may have been the most powerful barrier to transformational change. In any change process, learning new skills is an important element in completing the transformative learning process because the learner's anxiety is high. It is important in a change process to reduce the learning anxiety curve over time (Schein, 1999). In this case, as the environment became more chaotic, the beliefs of those who were positive or neutral about the innovation were being eroded and the beliefs of those who were negative were being reinforced.

Cranton (1994) describes transformation in terms of reintegration and reorientation. Mezirow (1991) refers to this stage as integration and Schein (1999) refers to it as refreezing. Irrespective of the terminology employed, this is the point in time when the concepts leading to new behaviour are internalized. If the behaviour is congruent with the expectations of the group and work environment, then the behaviour

becomes part of the person forever. If the new behaviour does not fit with the group or work environment then the individual will revert back to past practice. In some cases where the new concepts are highly valued by the group and the individual fails to transform, he or she may choose to leave the group. Conversely, if the group refuses to change but the individual transforms, he or she may choose to leave the group (Mezirow, 1991; Schein, 1999). The present study illustrated this phenomenon. Many nurses who were ready to transform their attitudes and beliefs about their practice were frustrated in their efforts by peers and managers in the group. I witnessed this phenomenon on many occasions and on a number of different units. Fullam, Lando, Johansen, Reyes, and Szaloczy (1998) noted that success or failure of a transformational change is dependent on a symbiotic relationship between the nurse, the environment and leadership styles. By the end of the study period, there was very little evidence that transformation of values, beliefs, and attitudes had been completed for the majority. The units did not have sufficient time to complete the process before the environment shifted. Time was needed to care for the patients, to learn new concepts, roles, and skills, and to participate. Lack of time led to frustration, which decreased the transformational change progress.

According to some writers, managing complex transformational change requires vision, skills, incentives, resources, a plan, and internalization (Beer, Eisenstat, & Spector, 1990; Hellriegel, Slocum, & Woodman, 1995; Nadler, 1988). The organization provided most of these elements, but circumstances relating to chaos in the health care sector impeded implementation. The responses of the individuals, the units, and the organization to the innovation demonstrate the positive or negative influences each of the elements played on the transformational change.

All change requires a vision. A lack of vision leads to confusion. This change had a strongly communicated vision articulated through the workshops that provided education to the greatest possible numbers of staff nurses. Open forums were offered monthly and special education sessions were provided to clarify the vision for the innovation and to prevent confusion.

The second element required is skills. Inadequate or absent skill sets needed to understand the change lead to anxiety. The study participants reflected anxiety as expectations of the new skills for role changes and decision-making progressed. Some managers and nursing staff expressed a need for more skills with conflict resolution, problem solving, and coaching, believing that these skills were missing. This limitation resulted in gradual change or no change on some units. However, providing skill training alone, does not lead to transformational learning and change (Marsick, 1987).

Most change theorists state that incentives are necessary to produce transformational change. The inability of the organization to offer incentives may lead to a prolonged change process or act as a barrier to change. The incentive for this change was internally driven by the individual (control over their practice) and not externally controlled. Initially, the organization provided incentive by remunerating the nurses who attended the workshop. Individuals and units lost their will to support the change as the barriers mounted and the unstable environment increased.

The fourth element leading to transformation is resources. Lack of resources may result in frustration. This change provided limited resources for such a profound transformation. The resources provided were front-end loaded during the introduction phase and early implementation, but were less available during the later implementation

phase. Because the resources were limited, some individuals and units were left to flounder for long periods without support.

The fifth element required for transformation to be successful is the availability of a plan. False starts in the transformation process result from lack of a cohesive plan. In this transformation, the plan was clearly articulated. The confounding variable was the unexpected change in the environment. The administrative and educational plans were thoughtfully conceived and congruent with transformational change principles but the chaotic environment and timelines thwarted the results.

The last element is internalization or integration. Transformational change does not occur unless the individuals internalize or integrate the change. The changed behaviour starts to become a way of life. Values, beliefs, and attitudes are changed once internalization occurs. Given the relative complexity of a transformational change like the one examined in this research, the process to internalize takes much longer than the three and a half years studied. The research was conducted on change data from 1994-1997. Subsequent to 1997, I witnessed through my organizational role, indications that transformational learning and change had occurred in some of the original participants in the program. The nurses, on some units, initiated consultation with me to help them re-examine unit councils or primary nursing or both on their units. This suggested to me that some nurses reached a higher level in their transformational learning and thinking than did other nurses. It is conceivable that these nurses may have reached the final stage of transformational learning and internalized the change. There are three implications from this observation. Firstly, this confirms the understanding that transformational change is irreversible. There were nurses who may have transformed during the implementation

process and retained the new beliefs, attitudes, and practice despite organizational disruption. Secondly, the individuals who transformed, if supported and encouraged, may form a core of people who will catalyze the change process. Thirdly, the institution has an opportunity through the support and evaluation of transformational change to achieve the original intended goal. Transformational change is an ongoing process of learning and quality improvement.

Implications for Administrative Practice

The results of this study have implications for many areas of administrative practice in education and health care. The knowledge generated from this study can be used when considering similar changes.

The study may be of particular importance to health care organizations that are planning to change nursing practice. The strength of this study lies in the positive responses of the nurses to the implementation format used to introduce the transformational change. The results of the study clearly indicated that a useful method to present a transformational innovation is to frame the innovation as workable and to grant the staff the power to make it applicable to their work setting. The establishment of a trusting educational environment, with resources to remunerate the staff while attending the workshop is important. It is also important that the facilitator be credible. The data from the study described the concerns, learning needs and system considerations that are required to support staff when preparing for the implementation of a professional practice model. There is also a need to address the negativity due to the changing circumstances in the external environment and to address the impact of those who are reluctant to change.

The findings of the present study suggest that the nursing staff generally perceived the transformational change innovation as positive, yet there were many gaps that need to be addressed. The nurses in the present study were inexperienced in conflict resolution techniques and in non-clinical problem solving. These deficiencies should be dealt with by organizations planning similar changes. It would also be of value to provide managers with coaching and negotiating skills as the process unfolds. Such a change goes beyond education and implementation. Given that participative decision-making is one of the most important elements to ensure empowerment, administrators need to find ways to support staff to participate without losing time away from the patient. One example suggested by nurses was to have computer access for all staff to share information, opinions, and reach a consensus on decisions might support this process.

Administrators who are anticipating implementing a transformational change should be aware that the follow-up support is essential to the staff making the change and funding should be adjusted to provide for this support. Administrators should also be aware that transformational change is not an instantaneous process and may proceed at different paces on different units. Evaluation of a transformational change process needs to be at multiple points and at multiple locations over a long period of time.

Implications for Research

This study opens a number of avenues of investigation that can be pursued in future studies. When considering the findings relating to the nursing staff perceptions of the implementation of a transformational change, areas for further consideration are a more extensive examination of the transformation of the nursing staff over a longer period of time. The determination of the number of nurses who transformed their

behaviour was not within the mandate of this study. The study data and my recent experience suggest that there were nurses who made the transformation to a more professional practice, but their numbers were not identified. A follow-up study to confirm that observation would be of value. That information once obtained could be used to determine whether a critical number of nurses who have transformed may facilitate the transformation process on a unit.

There is a need to develop instruments and algorithms to illustrate profiles of groups where transformational learning and change occurred so that administrators can more accurately judge the time and techniques that facilitate favourable outcomes. Methods to support critical reflective thinking in a multicultural fast paced environment are another need that should be addressed. A final need is to find better ways to involve more members on the unit in the decision-making process, given there is no time available for lengthy meetings.

Conclusion

This study addresses the importance of the perceptions of the nursing staff through the implementation of a transformational change in a large tertiary care teaching hospital. The mandate of the transformational change innovation was to increase professional accountability and authority by changing the decision-making of nursing staff to a more autonomous process. Unit councils and primary nursing were implemented to support the nurses' control over decisions about nursing unit related business and direct patient care. This change required nurses to transform their behaviour, values, beliefs, and attitudes. Transformational learning is a voluntary, individual process of critical reflection. The study found that certain factors supported this process and other

factors frustrated the transformational change. Although the nursing staff perceived the innovation to be positive, the implementation illustrated that there were many gaps that need to be addressed.

There are three main conclusions to be drawn from the findings of the study. It is essential that the organization provide educational support for nursing staff and management if a transformational change is to be successful. A second finding from the study shows that resource support is essential for a long period of time, particularly through the implementation phase of the change process. The third finding may be unique to this study because of the timing of the change. The change was initiated during a time of relative stability in the organization, but implementation was completed during a period of environmental chaos caused by hospital downsizing. The study showed that this disruptive environment only delayed or slowed the advancement of individuals who had transformed values, beliefs, and attitudes. Recent support requests to restart the innovation on some units suggest that transformation is enduring. Further research is needed to study the effects of a chaotic environment on transformational change and to study the role of individuals who have transformed.

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Appendices

Appendix A: Unit Council/Primary Nursing Workshop Evaluation

0 - N/A 1 - Poor 2 - Fair 3 - Good 4 Very Good 5 - Excellent

| SESSION | CONTENT | 0 | 1 | 2 | 3 | 4 | 5 |
|--|--------------|---|---|---|---|---|---|
| Professional Practice: Responsibility, Authority, Accountability | Organization | | | | | | |
| | Content | | | | | | |
| Unit Councils | Organization | | | | | | |
| | Content | | | | | | |
| Group Process: Responsibilities | Organization | | | | | | |
| | Content | | | | | | |
| Problem Solving Method | Organization | | | | | | |
| | Content | | | | | | |
| Principles of Primary Nursing | Organization | | | | | | |
| | Content | | | | | | |
| How would you evaluate the overall program? | Organization | | | | | | |
| | Delivery | | | | | | |
| | Content | | | | | | |
| | Handout | | | | | | |
| | AV | | | | | | |
| How valuable was the day for your job | | | | | | | |
| Did the day meet your personal objectives? | | | | | | | |
| What did you like about this workshop | | | | | | | |
| Suggestions for improving this workshop | | | | | | | |
| Suggestions for future workshops | | | | | | | |

Appendix B: Nursing Unit Focus Group for Primary Nursing Evaluation

Nursing Unit: Date:

Attendance:

1. What, if anything, is different on your unit now compared to before Primary Nursing was started? In what way, if any, is nursing different than before?
2. Describe any changes to the care of your patients that you have noted since primary nursing was implemented. Are you getting any feedback from patients?
3. Describe a situation where you think Primary Nursing improved continuity of care (or prevented a gap in continuity)
4. Give an example of the changes, if any, in your communication with each other since primary nursing started.
5. How do you think primary nursing is working?

 What, if anything, is working well? What, if anything, is not working well?

 What are the problem spots as you see them?

 If I told you that you could go back to total patient care, would you?

 Have you had any feedback from other members of the team?
6. In your opinion, do you feel that most of the nurse on your unit: understand primary nursing; support primary nursing.
7. Let's talk about the planning and implementation process on your unit. How well did it work?

 Did you feel involved in the process? Did you receive enough information?

 If given the opportunity to do it over again, what would you do differently?

Appendix C: Clinical Services Managers Focus Group for Unit Council Evaluation

What is working well?

What problems have been encountered?

Frustrations as Nurse Manager

Barriers to success

Mistakes made

Suggestions and Recommendations

Appendix D: Primary Nursing And Unit Council Evaluation Survey 1997

Unit:

Number Of Staff Involved In This Evaluation Feedback

Primary Nursing

How many staff do you think are trying to practice primary nursing?

What are some of the reasons that some of your patients do not have a Primary Nurse?

How well do you feel it is working on your unit?

What exactly is working well?

What is not working well?

What concerns do you still have?

What suggestions do you have to make it work better on your unit?

Unit Council

How many staff do you think are participating in unit council?

How well do you feel it is working on your unit?

What exactly is working well?

What is not working well?

What concerns do you still have?

What suggestions do you have to make it work better on your unit.

Any suggestions that you have to improve future implementation of changes will be appreciated,
plus what support or resources you feel would be helpful.