Challenging Assumptions: a perspective on the process of generating and managing change

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Introduction

Nursing, and healthcare generally, are constantly re-building to provide better, quicker, more dependable services and care and, as a result, change is an inevitable part of our professional lives. It is also a complex process that can generate unpredictable results. Publication of the National Service Frameworks (NSF) for mental health (DOH 1999), Modernising Mental Health Services—Safe, Sound and Supportive (DOH 1998), and the Care Programme Approach (CPA) (DOH 1990) have all been intended to develop services, and CPNs have often been at the forefront of these changes. It is recognised that the management of change requires high levels of skills and knowledge in relation to the change process. Lindenfield (1992) corroborates this. He also contends that the individuals involved in the change process need to understand themselves, perhaps via their own reflection and learning from previous changes, in order to understand others while undergoing or implementing change.

The Change Agent

Rafferty (1991) and Turner-Shaw & Bosanquet (1991) identify how those in clinical leadership positions, such as sisters and charge nurses, frequently act as change agents, promoting and changing standards of care. Lancaster & Lancaster (1982) describe a change agent as someone who generates ideas, introduces innovation, attempts to develop an appropriate climate for change, and then implements and evaluates that change. They point out, however, that change will not always be successful without the full co-operation of those most affected by them.

Maulsh & Miller (1981) claim that the status of the person suggesting or promoting a particular change has a considerable influence on the manner in which new ideas are accepted, and although Ottoway (1980) claimed that all nurses could act as change agents, almost two decades later, Wright (1998) suggested that many nurses still lack the knowledge and skills to undertake this role. This may be because nurse education has only recently begun to encourage nurses to challenge events and practices. Furthermore, nurses who
were trained in a traditional and ritualistic manner may find it difficult to question practice: a position supported by Menzies (1960), who suggested that nurses often perceive change as a threatening event, and that ritualistic practices survive in order to avoid anxiety.

Ottoway (1982) describes three types of change agents: Adopters, who hear about a change, implement it, accept it and incorporate it into their practice; Generators, who recognise the need for change and provide enthusiasm for it; and Implementers, who take responsibility for bringing about change once its need has been recognised. Implementers seek to develop good working relationships and a collaborative, mutually supportive approach. Each is interdependent upon the others, and each must be involved in any successful change process. Generators, according to Ottoway (1982), although enthusiastic are not in themselves sufficient to bring about change, as their commitment is not consistent at all stages of the change process. Wright (1998) criticised this construct, particularly the idea of Adaptors, saying that they were not clinically credible because of a lack of research ability. This made them ineffective in implementing evidence-based practice and risked using unreliable and invalid findings in their attempt to improve patient care—it could, however, be argued that adopters comprise the majority of people responsible for enforcing change.

A significant aspect of the change agent’s role is to distinguish between necessary and un-necessary change (Cahill 1995). This involves assessment of the benefits of change. However, Wright (1998) argues that many nurses lack the knowledge and skills necessary to undertake this role and alleges that they are incapable of resisting negative changes when they are imposed upon them.

Preparing for Change
Prior to instituting any kind of change, it is essential to accurately assess the current situation and define the desired state (Richardson 1999). It is necessary to establish all the relevant facts in order to gain a global view of the possible effects of the planned change (Haynes 1992), and central to the implementation of change is the selection of strategies that are likely to achieve the desired outcome (Bennis et al 1976). Choosing a strategy for change helps to: clarify thoughts on the nature of the change; and, develop plans of action in a logical and orderly manner (Callaghan 1998). Haffer (1986) argues that two important issues need to be considered when selecting an appropriate strategy to facilitate change: that the strategy should focus on the appropriate change target; and, should consider the willingness and ability of the group to change.

Strategies for Change
Sugden (1984) and Keyzer (1985), amongst others, identify three change strategies each with its own advantages and disadvantages. Each strategy is based on different assumptions about what makes people change or alter their behaviour. These strategies are Power-Coercive, Rational-Empirical and Normative-Re-educative. The Power-Coercive strategy is based on the use of political and economic sanctions to achieve the desired outcome and, when necessary, the use of moral power. The assumption underpinning the Power-Coercive strategy is that persons with less power will always comply with the
plans, directives and leadership of those with greater power. Whilst being told what to do can be a comfortable way of functioning for many people, Wright (1998) maintains that the effectiveness of any particular task is increased when the individual concerned knows why it should be done in a given way. The Power-Coercive strategy is frequently viewed as a top down approach which fails to acknowledge that people require many things when going through change, including recognition, advancement, interest and overall security (Wilson & Rosenfield 1996). If change threatens any or all of these, then it can become difficult, if not impossible, to achieve with the individual or team involved. When coercion or threats are used to implement change, as in the Power-Coercive strategy, it may seem as though change has taken place initially, but this is often superficial and underlying changes in attitude or behaviour have probably not taken place at all.

The Rational-Empirical approach assumes people are going to view change in a positive manner and work constructively towards it if they are given the basic facts, and so long as there is some evidence that they will derive a degree of benefit from the change. The Normative-Re-educative approach takes this further by arguing that people need to be involved in all aspect of the change process. This approach is viewed as a ‘bottom-up’ type of strategy, and its success depends on the individual’s or group’s perceptions of the need for change and its relationship to daily practices.

**Model of Change**

Lewin’s (1951) model of organisational change provides a framework for understanding how organisations change, and is based on the idea that in any change there are two opposing forces: driving and restraining. Lewin identifies three steps in his theory of change. Stage one is identified as unfreezing which involves motivating people towards change and the unfreezing of old attitudes or ideas. Lewin suggests that force field analysis is employed in order to achieve a balance between two opposing forces. In order to progress, any restraining forces must be reduced and driving forces increased. The change agent using the Rational-Empirical and Normative-Re-educative strategies begins to unfreeze established beliefs by working from the bottom up. These strategies help the change agent to negotiate with the group in decision-making and provide supportive education programs where a theory practice gap can be identified. The change agent also employs elements of the Rational-Empirical strategy, as it is assumed nurses will adopt change if it can be rationally justified and demonstrate a positive gain. It should, however, be acknowledged that people do not always act rationally with respect to implementing research findings, and the Rational-Empirical strategy should not be used in isolation (Smyth, 1995).

Lewin identifies the second step in his theory of change as the moving stage. It is during this stage that the need for the change becomes recognised, and directions and solutions are sought. Sullivan et al (1992) describe how, during the moving stage, information about the change is collected and discussed and plans are made to implement it. Potential problems are discussed and solutions sought and the transition to a new level of working can begin. Prochaska & DiClemente (1983) term this the 'contemplation' phase: an interactive period where information is required about what the change might
mean for those involved. Wright (1998) advises that an appropriate time scale should be set in which to implement the proposed change. He maintains that this must be of sufficient length to enable everyone involved in the change process to accept it and prepare for it.

Conclusion

It is acknowledged that the implementation of change is a complex process requiring high levels of skills and knowledge and anyone entering the process of change needs to have a clear understanding of their professional boundaries and accountability. It should be accepted that not all change improves things. It should also be acknowledged that resistance to change is not always a negative process as it can challenge the proponents of change to justify and clarify the reasons for their proposals. Nurses must be able to understand the process of change in order that they are better able to determine its course and so that they can protect themselves and their patients. Knowledge is power, and knowledge of change helps to give nurses a degree of control over the change process. Thus empowered, they are not left merely to react but can become proactive in determining the course that nursing takes.

References

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