Critical evaluation of change managed in practice

The Government has clearly outlined the need for nurses to develop leadership skills at all levels within the workforce in order to deliver the NHS modernisation programme (DH[1]1998; DH 1999). The leadership role expected of community practitioners is evident in ‘ Shifting the Balance of Power’ (DH 2001a) and ‘ Liberating the Talents’ (DH 2002) with the expectation that health visitors will lead teams which will deliver family-centred public health within the communities they work (DH 2001b).

The change I was to lead however was not initiated primarily to support clients, but instead to protect staff working in the community to ensure they were safe and supported in their public health work as a large proportion of the time is spent working alone. The issue of lone worker safety is particularly topical after the recent murder of a mental health support worker during a home visit (BBC News 2006).

To support this proposal, Baulcomb (2003) asserts that any change management initiative should not only yield benefits for patients but also for staff and the wider organisation.

The Health and Safety Executive (HSE 2005) reports that nurses and other health care workers are 2. 8 times more at risk of an injury[2]than clerical workers and the vulnerability of health care workers increases significantly if they are working alone[3](Chappell and Di Martino 2000). It was a particularly pertinent time to examine mechanisms for risk reduction as they had still not been reviewed despite a member of staff being off sick[4]due to an adverse incident involving lone work. As health visiting frequently

requires lone work, it was clear that lone working practices needed reviewing to reduce the likelihood of a similar or more serious incident recurring.

Further drivers for change were identified as a result of observations of workers in practice. I noted the following areas of concern: up-to-date whereabouts of staff not always provided (or out of date) and a lack of a reporting-in system which would identify whether staff had finished work safely for the day. I discussed these issues with the community nursing manager who wholly supported any attempts to introduce mechanisms that would improve lone worker safety. A further driver for change was the obligation to implement health and safety legislation. Due to limitations in report length, this information has been provided in Appendix One.

If changes are to be implemented which lead to increased worker safety, this will have a positive (although indirect) effect on clients because if staff feel safer and more supported in their roles, they will be less likely to be off sick with stress or injuries (Mahony 2006) which would impact on the team's ability to deliver the public health agenda. As workers who contribute to the implementation of health and safety measures are known to be healthier and safer than those who do not (HSE 2005), it was felt that this would be an appropriate area for the team to examine and implement change.

It was after consideration of these anteceding factors that the need for change was established and a vision created:

To improve the safety of lone workers within the health visiting team.

Implementing the change was a dynamic and multidimensional process with many facets too abundant to detail fully here, however pertinent examples will be selected and analysed. The following study will detail a reflective evaluation of my application of leadership and management theory to effect a change in practice. The successes and difficulties encountered will be given throughout with reference to the literature.

Change management requires well-developed leadership and management skills (Marquis and Huston 2000). A combination of these skills is necessary to ensure that the job is done not only efficiently, i. e. new mechanisms are put in place and embedded into the team's practice (the management dimension) (Stewart 1996) but that it is achieved in such a way that motivates and inspires staff to change their practice- the leadership dimension (Stewart 1996). To guide the changes, a change management model was selected. Deegan et al (2004) report that such models provide a theoretical sequence, which will be instrumental in helping the change manager to choose, develop, and order activities which are required during planned change episodes.

As the change was planned (as opposed to emergent), a suitable model was Lewin's three-stage model of planned change (Lewin 1951)[5]. The use of this model in the National Health Service (NHS) is widely documented and has underpinned the successful changes in many of the research papers read[6]. It is also a simple model which is not overly prescriptive and so does not restrict individual practitioner creativity (Cameron and Green 2005). The

three stages of planned change according to this model are: unfreezing the existing equilibrium (Unfreezing); moving to a new point (Movement) and refreezing the changes into practice so that they become embedded in practice (Refreezing). My change management project is currently part way through the ‘ Movement’ stage as the change has not been fully implemented or evaluated yet I continue to lead this project[7].

Lewin (1951) suggests that in the change’s preliminary stage, factors which will drive or resist the change should be identified. This process is known as Force Field Analysis (FFA) and will identify the change enthusiasts, the potential objectors and the undecided (Turner, 2001) (see Appendix Three for the FFA carried out at this stage). Lewin (1951) asserted that change occurs as a result of a shift in the equilibrium between the opposing forces (those which resist change) and the driving forces and is thought to be more likely to occur successfully if restraining forces are removed rather than by simply increasing the driving forces. Hussey (1998) exercises a word of caution at this juncture warning that an increase in the driving forces may lead to an increase in the restraining forces, however if the driving forces outweigh the restraining forces, there is a positive climate for change (Cameron and Green 2005). After analysing the force field I could see that the driving forces outweighed the resisting forces and so confirmed that the change was needed and realistic.

Leaders motivate their staff by inspiring vision and encouraging followers to share in that vision (Bennis 1997, Davidhizar 1993) and like in Kassean & Jagoo’s study (2005), the unfreezing stage was initiated by facilitating people’s thoughts on the current situation (Greaves 1999)- stimulating ideas

for how to change the current situation[8]. As people can only be empowered by a vision that they understand (Sheldon and Parker 1997), it is paramount that strategies are used to foster inclusion and participation so that all team members are fully aware of the impetus for change. For change to be successful and enduring, Kouzes and Posner (1987) say that it is imperative that the leader encourages team ownership of the vision by encouraging their participation in the project. Without participation failure is likely to result due to resistance from team members. It is vital to the success of the change that it is perceived to be needed by those that will be affected by the change (Marquis and Huston 2000) and so to raise awareness of the issue and create dissatisfaction with the current state (Lewin 1951), I introduced my ideas at a team meeting. On reflection, I can identify aspects of transformational and situational leadership in how I shared my ideas and interacted with the team.

Most team members agreed that risks to lone working needed to be reduced and willingly offered their ideas (see Appendix Four). Encouraging team input and facilitating problem solving are key features of the supportive behaviours exhibited by the situational leader (Northouse 2004). Situational leadership was developed by Hersey and Blanchard (1977) and assumes the leader adapts their style according to a given situation[9]. This style has two main types of intervention: those which are supportive and those which are directive. The effective situational leader is one that adjusts the directive and supportive dimensions of their leadership according to the needs of their subordinates (Northouse 2004). As most team members were highly motivated in the project, freely offering suggestions and ideas, a directive

role was not needed. The supportive behaviours I employed encouraged a participative approach characterised by the use of finely tuned interpersonal skills such as active listening, giving feedback and praising (Marquis and Huston 2000) which can be likened to a Skinnerian approach of positive reinforcement.

In retrospect I can identify my correct use of this leadership style by looking at a later development of this model which introduced a further dimension to the leadership style: the developmental level of the participants. This is ascertained by assessing worker's competence and commitment to completing the task. The member of staff that appeared to take little interest and was not able to offer ideas displayed a lower developmental level compared to other team members and hence I directed her more using the coaching behaviours advocated by Hersey and Blanchard (1977). This coaching promoted inclusion and participation by: giving encouragement, soliciting input and questioning the participant on what they thought of the proposals and the changes they would like to see. This was done to increase levels of commitment and motivation (Northouse 2004) and thus integrate that team member into the change process. On reflection this can also be identified as an example of reducing the resisting factors to the change within the force field as by adapting to the needs of that team member, she was encouraged to take part and share ideas rather than hinder progress and potentially thwart the change.

A model which places great importance on the needs, values and morals of others is transformational leadership (Northouse 2004; RCN 2005) and elements of this could be identified in my leadership. The needs of staff

could be regarded as the need to stay safe, and values may be their desire to get home to their families at the end of the day. I was aware that on face value, looking at improving safety for lone workers would perhaps not appear to be an issue that would provoke much excitement, or according to Kotter (1999) ‘ light a fire’. However, I articulated my vision in terms of getting people to consider the impact of what the consequences could be if we were to be a victim of an adverse incident. When discussing the impact of this with staff and getting them to consider the impact of not changing practice, of how their lives and their families lives could potentially be affected, I created motivation within the team to examine working practices. This was confirmed to me as many of the staff showed their interest by their offering of ideas to meet this challenge. By tapping into the moral dimension of a proposed change i. e. promoting the need to contribute in order to protect the safety of not just themselves but also the wider team, the transformational leader further inspires staff to change by motivating followers to transcend their own self-interest for the sake of the team and organization (Bass 1985).

Once the vision had been shared and accepted by the team, several strategies were discussed that could contribute to risk reduction (Appendix Four). At this stage it was realistic to focus on a single change. A reason for this was because McIntosh (2000) highlights that many changes focus on the needs of the organisation (e. g. to provide certain services or to implement Government policy) and often overlook the needs of the employees. Applied to this case, there was an organisational need to manage risk but this had to

be balanced with not overwhelming the team with too many changes at once[10].

At the meeting it was decided by the team members present[11]that the simplest intervention to implement would be to phone into the clinic base administrators when finishing their shift to notify that they had finished work for the day and were safe[12]. Although the proposed change would not eliminate the risk of an adverse incident occurring, it would ensure that should an incident occur, it would be identified and acted upon as swiftly as possible and thus the risk would be managed more effectively.

Vroom and Yetton (1973) propose five types of considered decision-making ranging from that which may be expected of an autocratic manager i. e. a decision is made by the leader entirely alone, through to a democratic approach whereby the matter is discussed with the whole team and a consensus decision is made. When analysing my own management stance it was clear that my style had been distinctly democratic as I had sought to include everyone and promote consensus decision-making. I demonstrated sensitivity and appreciation of the pressures that others were under by ensuring that those not present at the meeting were included in the decision-making process as open consultation with key stake holders often leads to the successful introduction and adoption of change (Phair and Good 1998, cited in Deegan et al 2004). This contributed to creating a climate of a learning organisation. A learning organisation is one where all members are encouraged to increase their capacity to produce results they care about (Karesh 1994) and one which promotes the exchange of information between members in order to create a knowledgeable workforce. I was

determined that those who could not attend the meetings still be part of the decision making process. However there were difficulties with this as due to being in practice just two days a week meant that it was unrealistic to consult each absent worker individually and so I emailed out meeting minutes from the meeting and invited feedback[13]. Although the use of email to communicate ideas is one of the least popular ways to receive information, it was one of only a few methods available to me and hence justified its use. Without using this medium, communication with the team would have been compromised and could have led to some team members feeling they had been excluded from the decision-making process. Further analysis of this point reveals my own concern that all the follow up and meetings needed to be done by myself when perhaps this could have been delegated to someone else. With regard to situational leadership, if team members are motivated and committed to the change, the leader can assume a more passive role where they let team members take responsibility for doing the job and refrain from giving unnecessary support (Northouse 2004). This perhaps reveals ‘ Theory X’ management style traits (McGregor 1960) whereby the manager feels the need to keep a tight grip on staff perceiving them to need coercion to achieve tasks, deeming them to possess little capacity to explore and solve problems spontaneously without direction. This approach may convey distrust of the team (McGregor 1960) and was therefore not an ideal management style in the actual situation I was in. Rather than viewing this as a weakness however, it must be viewed as an opportunity to explore my assumptions of the team, assessing whether my assumptions had any grounding in reality or whether this style was

assumed due to my inexperience leading and hence insecurities about the role.

Reaching a consensus on the change to implement was an example of how in situational leadership, decision-making can be shared between the leader and motivated followers (Hersey and Blanchard 1977). From a management point of view, this participative approach facilitates the process of completing the task but it is also an example of how leaders empower their teams by transferring some of their power to the follower to enable them to be active participants in the decision-making process. After confirming the change intervention, the safety plan was devised (see Appendix Six). This was a contingency plan detailing the steps to take should a team member fail to report in. The team agreed that I should draw this up due to my previous experience of using one. As the manager is responsible for ensuring a task is completed on time and is done efficiently (Stewart 1996) there was no reason for this task to be delegated elsewhere as this would have taken up time and hence been an inappropriate use of resources.

During the movement stage, I positively reinforced the importance of the change by acting as a role model. Role modelling is a key feature of transformational leadership whereby the leader demonstrates specific types of behaviours that they want their followers to adopt (Northouse 2004). Stewart (1996) also reports that the ‘ greatest power as a leader is the example that you set’ (p. 25) and so I did this by ensuring that I implemented the proposed changes i. e. I always reported into base on finishing work even before the agreed implementation date. The change is currently in the latter stages of the ‘ Movement’ phase with implementation

and evaluation still required to complete the phase[14]. Refreezing is the final stage of Lewin’s model and involves the change agent (myself) supporting staff to integrate the change into practice so that it becomes part of the ‘ status quo’ (Marquis and Huston 2000) ensuring that over a period of time everyone’s practice changes and there is no chance of reversion to former ways.

A strategy for the future development of the change and to conclude the refreezing stage would be to carry out an evaluation to determine the change’s effectiveness. A summative (or outcome evaluation) could be conducted to investigate: whether the intervention is effective in reaching planned goals; what happens to the participants as a result of the change and whether it is worth continuing with the change intervention (Robson 2003).

The first question could be assessed by carrying out a risk assessment of the hazards faced by lone workers including strategies in place to reduce risk. The HSE (2005) detail a five-step risk assessment guide that can be carried out to assess the extent of risk post-intervention. Ideally a risk assessment should have been carried out in the unfreezing stage and thus provide a baseline to compare against.

Another strategy to obtain objective data would be to keep a copy of all reporting-in records which should identify those failing to report in[15]. Although this appears to be a policing measure which may imply distrust for staff (typical of a ‘ Theory X’ manager, McGregor 1960), it may be the only way of conclusively being able to tell if people are actually putting the new

change into practice. If an audit of these records revealed certain team members were not engaging in the process and were having to be chased by administrators to ascertain whether they had finished work safely, I would use responsive leadership skills incorporating effective interpersonal communication to work with these staff members to identify what the problems and issues were. It is vital that this is done as if ignored these resisting factors could impede the change and failure could result (Hussey 1998). A key goal of refreezing is supporting those involved so that the change remains in place (Marquis and Huston 2000) and so this audit may reveal those who need further support[16].

The change detailed in this case study has first and foremost considered the needs of the employees (i. e. to be safe in their lone work) yet has many benefits for the wider organisation and staff: potentially decreased litigation due to decreased adverse incidences affecting staff, increased recruitment and retention due to the organisation’s increasing attractiveness as a supportive employer and many more. This highlights effective use of a combination of leadership skills to inspire and motivate staff coupled with the ability to function in a management capacity by directing changes necessary in order to meet the organisation’s requirements (Marquis and Huston 2000).

Change management requires well-developed leadership and managerial skills (Marquis and Huston 2000). However as a student health visitor many of these skills were far from being well developed and rather than use and manipulate models as I went along, elements of models such as transformational and situational were recognised retrospectively. However in

doing so my knowledge of the theoretical underpinning has been developed and consolidated arming me with a plethora of skills to draw on in future.

Northouse (2004) states that leadership style refers to the behaviours shown by an individual who attempts to influence others. I felt this was a daunting task as in my student role I felt very much the subordinate as opposed to the leader. However, Government papers such as ‘ Making a Difference’ (DH 1999) stress for the need to develop leadership at all levels meaning it is not an activity reserved for the upper echelons of an organisation (Garvin 1996).

I found it hard at times to reconcile the requirement to develop leadership skills with the need to embrace evidence-based practice as the two often clashed due to the fact that there is little empirical evidence of the effectiveness of many leadership models (Northouse 2004) including those I used. To further illustrate this point Wright and Doyle (2005) conclude ‘ it is impossible to say how effective transformational leadership is with any degree of certainty and it is not possible to say here that another approach would have been more effective without trying it’. Northouse (2004) also criticises other models of leadership including situational leadership, and questions their validity commenting that they are under-researched and with few published research findings.

I had not viewed myself as a ‘ born leader’ and coupled with my student status, I felt nervous embracing a leadership role. Marriner-Tomey (1996) however asserts that leadership skills can be developed over time, indicating that skills can indeed be learnt, dispelling the myth that leaders are born not made. This provides me with reassurance that with further experience of leading in practice, along with a deeper knowledge of leadership theory, I may become a more effective and inspiring leader.

References

Bass, B. M. (1985) Leadership and Performance Beyond Expectation. New York, Free Press.

Baulcomb, J. (2003) Management of change through force field analysis. Journal of Nursing Management. 11. pp. 275-80.

BBC News (2006) Man held as charity worker killed. News item [Internet], BBC. Available from: [Accessed 20th May 2006].

Bennis, W. (1994) On becoming a leader. NY, Perseus Press.

Burns, J. M. (1978) Leadership. New York, Harper Row.

Cameron, E. and Green, M. (2005) Making sense of change management: a complete guide to the models, tools and techniques or organisational change. London, Kogan Page.

Chappell, D. and Di Martino, V. (2000) Violence at work. 2nd ed. Geneva, ILO.

Davidhizar, R. (1993) Leading with charisma. Journal of Advanced Nursing. 18. pp. 675-9.

Deegan, C., Watson, A., Nestor, G., Conlon, C. and Connaughton, F. (2004) Managing change initiatives in clinical areas. Nursing Management. 12 (4), pp. 24-29.

Department of Health (1999) Making a Difference: strengthening the contribution of nursing, midwifery and health visiting. London, HMSO.

Department of Health (2001a) Shifting the balance of power: securing delivery. London, HMSO.

Department of Health (2001b) Health visitor practice development resource pack. London, DH.

Department of Health (2002) Liberating the talents: helping PCTs and nurses deliver the NHS Plan. London, HMSO.

Elkan, R., Kendrick, D., Hewitt, M., Robinson, JJA., Tolley, K. and Blair, M. (2000) The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. Health Technology Assessment. 4(13).

Garvin, J. (1996) Leadership and nursing: traditional attitudes and socialisation. Nursing Management. 3 (3). pp. 20-22.

Greaves, C. (1999) Patient’s perceptions of bedside handover. Nursing Standard. 14 (12). pp. 32-5.

Health and Safety Executive (1974) The Health and Safety at Work Act. London, HMSO.

Health and Safety Executive (2005) Work related violence: lone workers. [Internet], HSE. Available from: [Accessed 26th April 2006].

Hersey, P. and Blanchard, K. H. (1977) The Management of Organizational Behaviour. 3rd ed. New Jersey, Prentice Hall.

Hussey, D. (1998) How to be better at managing change. London, Kogan Page.

Karash, R. (1994) Learning-Org Dialog on Learning Organizations. [Internet]. Available from [Accessed 22nd May 2006]

Kassean, H. and Jagoo, Z. (2005) Managing change in the nursing handover from traditional to bedside handover- a case study from Mauritius. [Internet], BMC Nursing. Available from: [Accessed on 2nd April 2006].

Kotter, J. (1999) John P. Kotter on what leaders really do. Boston, Harvard Business School.

Lewin, K. (1951) Field Theory in Social Science. New York, Harper Row.

Mahony, C. (2006) Risk reduction. [Internet], Nursing Times. Available from: [Accessed 14th May 2006].

Marquis, B. and Huston, C. (2000) Leadership roles and management functions in nursing: theory and application. 3rd ed. Philadelphia, Lippincott.

McGregor, D. (1960) The human side of enterprise. New York, McGraw-Hill.

McIntosh, N. D. (2000) Implementing clinical education for phlebotomists. Nursing Standard. 15 (1). pp. 43-6

National Audit Office (2003) A safer place to work: Improving the management of health and safety risks to staff in NHS Trusts. [Internet], NAO. Available from: < http://www. nao. org. uk/publications/nao_reports/02-03/0203623. pdf> [Accessed 26th April 2006.]

NHS Institute for Innovation and Improvement (2005) Working with groups: improvement leaders' guide. Coventry, NHS.

Northouse, P. G. (2004) Leadership theory and practice. 3rd ed. London, Sage.

Peters, T and Waterman, R. (1998) Re: planned change. [Internet], Shropshire and Staffordshire Workforce Development Confederation. Available from: [Accessed 15th April 2006.]

RCN (2005) Transformational leadership processes. [Internet], RCN Practice Development Institute. Available from: [Accessed 1st May 2006].

Robson, C. (2003) Real world research. 2nd ed. Oxford, Blackwell.

Selby & York Primary Care Trust. (2004) Lone worker policy. York, SYPCT.

Sheldon, L and Parker, P. (1997) Leadership and team building. Nursing Management. 4 (2). pp. 24-5

Stewart, R. (1996) Leading in the NHS: a practical guide. 2nd ed. Wiltshire, Macmillan Business.

The Suzy Lamplugh Trust. (2005) Personal safety at work: guidance for all employees in the workplace, working off-site and travelling for work. UK, SLT.

Turner, L. (2001) Introducing a medical emergency team. [Internet], Nursing Times 97 (40). Available from: [Accessed 14th May 2006.]

Vroom, V. and Yetton, P. (1973) Leadership and decision-making. Pittsburgh, Pittsburgh Press.

Wright, M and Doyle, M (2005) Classical leadership. [Internet]. Available from: < http://www. infed. org/leadership/traditional_leadership. htm> [Accessed 26th April 2006].

Bibliography:

Alexis, O. (2005) Managing change: cultural diversity in the NHS workforce. Nursing Management. 11 (10), pp. 28-30.

Handy, C. (1999) Understanding organizations. 4th ed. London, Penguin.

Home Office. (2005) Research development statistics: violence at work. [Internet], Home Office. Available from: [Accessed 26th April 2006].

Maslow, A. H. (1954) Motivation and personality. New York, Harper Row.

Mayhew, C. (2003) Occupational violence: a neglected occupational safety and health issue? Policy and Practice in Health and Safety. 1 (1) pp. 31-58.

NMC (2004) Standards of Proficiency for Specialist Community Public Health Nurses. London, NMC.

Percival, J. (2005) Inspire the team. Nursing Standard. 19 (34), p. 71.

Reporting of Injuries, Diseases and Dangerous Occurences Regulation (RIDDOR) website. [Internet]. Available from:

Appendices

APPENDIX ONE Health and Safety Legislation in Practice.

The Lone Worker Policy (SYPCT 2006) in my practice area is heavily influenced by the Health and Safety at Work Act (HSE 1974) and the Health and Safety at Work Regulations Act (HSE 1999 cited in SYPCT 2006) which stipulate the duties of the employer[17]and the employee[18]. The more recent legislation requires employers to assess the nature and scale of any workplace risks to health and ensure there are proper control measures to reduce or eliminate risk. Although the policy encompasses the relevant legislation and raises awareness, its aims are particularly broad and apart from indicating particular training, there are few suggestions of good practice to help staff understand exactly how they can take ‘ reasonable care’. It was also evident that although Lone Worker safety training was mandatory, fewer than half of the members of the team had accessed this within the l