LEADING AND MANAGING ORGANIZATIONAL CHANGE

QUALITY IMPROVEMENT Primer

ACS NSQIP
The ACS NSQIP Quality Improvement Primers were designed to serve as complete yet concise resources for health care providers and quality improvement professionals.

The Quality Improvement Primers contain information that has been assembled through reviews of the current literature and consultation with experts in the field.

They create a framework that can be used to prioritize and direct efforts to improve perioperative outcomes.

For more information and to learn how to access all of the Best Practices Guidelines and Quality Improvement Primers, visit www.acsnsqip.org.
ACS NSQIP QUALITY IMPROVEMENT PRIMER

ACS NSQIP Quality Improvement Primers have been developed for:

- Statistical Process Control Charts
- Leading and Managing Organizational Change
The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) surgeon champion (SC) for Hospital A notes that her hospital remains a high outlier for urinary tract infection (UTI) in the most recent semiannual report despite monthly reporting of detailed UTI data at the Morbidity and Mortality Conference. UTIs are still viewed by some providers (including nurses, residents, and staff) as trivial postoperative occurrences. Previous hospitalwide initiatives to reduce unnecessary and inappropriate use of urinary catheters and duration of catheterization met with limited, short-lived success. How can the SC change providers’ attitudes about UTIs and more effectively implement best practices to prevent catheter-related UTIs across her organization?

Change management is a structured, proactive, coordinated approach to transition individuals and organizations from a current state to a desired future state in order to achieve lasting change. As such, change is viewed not as an event, but rather as a planned process that occurs within a specified period of time. A successful change management initiative is usually guided by a strong model or framework that anticipates and mitigates resistance along the way and outlines a stepwise, gradual process of transition.

Most current models of change management represent variations of Kurt Lewin’s “unfreeze-change-refreeze” model. Lewin, one of the founders of social psychology, presented a simple model in the 1940s for changing how people think and act, which consists of three phases or stages:

1. The “unfreezing” stage, in which individuals and organizations are made ready for change and, if necessary, shocked out of the status quo.
2. The change (or transition) stage, in which the previously “unfrozen” individuals (or organizational units) are gradually led to make the changes needed to achieve the desired end state.
3. The “refreezing” stage, in which the adjustments made during the transition are embedded or hardwired into the system to ensure lasting change.

Irrespective of which change management model is used, a positive attitude toward change, effective communication, persistence, and active listening are needed to successfully lead change in any organization. This primer will help individuals understand the steps involved in the change management process and how to plan and enact lasting change within an organization.

Planning for Change

Planning for change and engaging an effective core change team are central to any change initiative and must take place before any action is taken. In fact, depending on the scope of the change being initiated, the planning stage could comprise 50 percent to 60 percent of the time allotted for the change.

STEP 1: Understand the Need for Change

All successful organizations recognize that change is unavoidable, shun complacency, and take a proactive, rather than reactive, approach to change. It is important to continually scan the external environment for signs of change and perform internal diagnostics using varied data sources and individuals to uncover “threats to the system” and identify strategic opportunities for change and innovation. When problems are identified, it is important to look for root causes hidden beneath symptoms before attempting to generate effective solutions, and that key stakeholders be involved in this process if they are to understand and agree on the need for change.

STEP 2: Build the Guiding Change Team

At the center of any change initiative is a change agent or leader. This individual must be enthusiastic, instill confidence in others, and be able to motivate the eventual target audience. Successful change leaders never act alone but, rather, are at the helm of a guiding change coalition with which they work closely to plan and execute the transformation process.

Before creating the core change team, the change leader should map potential support and resistance to the initiative, taking into account the typical distribution of champions (10 percent), helpers (10 percent), bystanders (60 percent), and resisters to change (20
percent) in most organizations. Although bystanders can often be the most difficult to identify, their inclusion on the guiding change team (along with champions and helpers) can be extremely helpful in ensuring more rapid, widespread support for the initiative.

When selecting members for the guiding change team, it is critically important to select individuals with:

- Expertise (to ensure better, more credible decisions)
- Credibility and/or a proven track record in the organization
- Leadership and management skills
- “Position power” (for example, the ability to secure resources, strategic reporting relationships, and so on)

Tools for mapping support and resistance to organizational change, such as a power and influence map (Figure 1A) and stakeholder diagnostic grid (Figure 1B), can be of significant value when selecting members for the guiding change team. Change efforts that rely on a single person (or no one) or a weak task force without the required skills or power to get the job done are doomed to fail.

**FIGURE 1A:**

<table>
<thead>
<tr>
<th>LOW</th>
<th>INFLUENCE OVER CHANGE INITIATIVE</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. Harold</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low Power in Organization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. Stone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mitta Jones</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Betty Rouse, etc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kathy Powers</td>
<td></td>
</tr>
</tbody>
</table>

The power and influence map highlights the influence levels of individuals across the organization, with a focus on selecting members for the guiding change team with the right expertise, credibility, leadership, and power to ensure successful change initiatives.
### FIGURE 1B: Stakeholder Diagnostic Grid

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role</th>
<th>Power/Influence</th>
<th>Impact of Change on Stakeholder</th>
<th>Current/Desired Support</th>
<th>Reasons for Support/Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Sue Smith</td>
<td>Head, Infection Prevention and Control</td>
<td>A High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Dr. Harold</td>
<td>Head, Acute Pain Services</td>
<td>C Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Dr. Stone</td>
<td>Urologist</td>
<td>D Medium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Betty Rouse, and so on</td>
<td>Charge Nurses, Surgery Units</td>
<td>B High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Marta Jones</td>
<td>Charge Nurse, OR</td>
<td>B High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Amanda Thomas, and so on</td>
<td>Administrative Chief Residents</td>
<td>A Medium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Kelly Richards</td>
<td>Head, Nursing Quality</td>
<td>A Medium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Kathy Powers</td>
<td>Head, Staff/Patient Education</td>
<td>B Low</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figures 1A and 1B are used to illustrate the diagnostic grid approach to stakeholder analysis. The grid helps to identify the role, power/influence, impact of change, and desired support for each stakeholder. This information is crucial for developing a successful change strategy. The grid also highlights the reasons for support or resistance, which can be critical in tailoring the change initiative to meet the needs of all stakeholders.

---

**STEP 3: Create a Vision and Strategy for Change**

Once the core change team has been enlisted, a compelling vision and sets of strategies for change must be drafted. The change vision is a description of the desired end state (in other words, to become a low outlier for UTI among participating hospitals in ACS NSQIP). The vision must be simple, tangible, and attainable. The vision must “speak” to all the members of the guiding team and should ideally be perceived as desirable by the relevant target audience (in other words, must pass the “what’s in it for me” test).

Once the vision has been created, a change strategy should be drafted to determine how it will be achieved. The strategy will help guide day-to-day operational decisions for the change initiative. Like any good strategy, it should be based on the experience and knowledge of key individuals and should be the result of an open debate of alternative options.

Before moving forward, it is imperative that the change vision and strategy are supported by as many of the relevant, key stakeholders in the organization as possible to ensure “shared ownership” of the change initiative and increase its chances of success (Figure 2).
Implementing Change

Before any actions can be taken, leaders must have a coherent, effective persuasion strategy to motivate change. Once the need for change has been communicated and accepted, the transformation is launched via sequential, purposeful adjustments to align systems, structures, and processes with the change vision and strategy.

STEP 4: Create a Sense of Urgency

In any organization, the status quo often breeds a false sense of security. As such, a focused persuasion campaign is frequently necessary to overcome “business as usual” and, in some instances, shock the system out of complacency. Change leaders must identify and discuss external threats to the system and explain the organizational and personal consequences of clinging to status quo. Rather than creating a dry business case, it is better to use dramatic evidence from within and outside the organization to create a “burning platform”
for change. For example, sharing financial data or other metrics that show the current state is not sustainable can be a powerful tool for helping people understand the need for change. Ideally, at least 75 percent of the relevant people must be persuaded that the status quo is no longer acceptable, or else complacency, fear, and anger will eventually undermine and sink the change initiative.

STEP 5: Communicate the Vision and Strategy for Change

An effective persuasion campaign must increase urgency by tempering external threats with viable solutions; otherwise, it may result in widespread anxiety and uncertainty. It is important to make the change vision simple and compelling. Repetition using symbols and slogans across multiple channels (for example, buttons, posters, flyers) and forums (for example, the Morbidity and Mortality Conference, staff meetings, town hall meetings, and so on) is needed to avoid undercommunicating the change vision and strategy. The change leader and other member of the guiding team must also visibly “walk the talk”; otherwise, the change initiative may soon lose credibility and momentum.

It is not uncommon for major change to breed uncertainty and resistance. Time and support are needed to help affected individuals understand, process, and accept the need for change. As such, it is imperative that change leaders continually present the right message, in the right format, at the right time to remind people where they are heading (and why).

STEP 6: Empower Broad-Based Action

If the change initiative is to take hold, obstacles preventing individuals from acting on the vision must be identified and removed (so they won’t grow discouraged), and creativity in carrying out the vision and strategy should be solicited, encouraged, and rewarded. Resistant supervisors, systems, and/or structures that undermine the change should be aligned with the change vision by updating training programs, realigning reward and incentive systems, reassigning of roles or tasks, and creating cross-working teams across “functional silos.” If the obstacle is an individual who is actively resisting and even damaging progress, transfer or termination of that employee may need to be explored.
STEP 7: Generate Short-Term Wins

Careful selection of small, manageable projects that are more likely to result in highly visible, quick wins is imperative to ensure early success of the change and to encourage growing acceptance across the organization. These quick wins provide ready credibility for the change and facilitate recruitment of additional manpower and resources. In contrast, slower, less visible wins are less compelling to bystanders and may not be perceived as clearly related to the change, sapping its momentum.

STEP 8: Exploit Gains to Produce More Change

Although it is important to stop and celebrate the attainment of short-term objectives, it is imperative not to claim absolute victories. Rather, these opportunities should be used to set tougher goals and further change systems, structures, and processes not congruent with the change strategy. Successful change leaders ensure momentum by strategically choosing what project to tackle next and promoting and developing people who implement the change vision. In addition, they avoid “burnout” and continually reinvigorate the process by bringing on new people and projects that will perpetuate the change vision and strategy.

STEP 9: Hardwire Change

Despite successful implementation of the “unfreezing” and “change” phases cited previously, major change is often short-lived and individuals and organizations soon revert back to the previous state. As such, it is imperative that explicit steps are taken to “refreeze” new beliefs and behaviors, encourage acceptance and stability, and ensure lasting change. It is important to continually highlight connections between new beliefs and actions and organizational success to help “root” change within the organizational culture (in other words, explain to providers how recent hospitalwide, surgical site infection prevention protocols reduced wound infections rates, improved the hospital’s reputation within the community, and reduced costs). Means to ensure leadership development and succession congruent with the new transformation (for example, revamped reward and promotion criteria) should be also developed.
An Example of Leading and Managing Organizational Change

The ACS NSQIP SC for Hospital A notes that her hospital remains a high outlier for urinary tract infection (UTI) in the most recent semiannual report despite monthly reporting of detailed UTI data at the Morbidity and Mortality Conference. UTIs are still viewed by some providers (including nurses, residents, and staff) as trivial postoperative occurrences. Previous hospitalwide initiatives to reduce unnecessary and inappropriate use of urinary catheters and duration of catheterization met with limited, short-lived success. How can the SC change providers’ attitudes about UTIs and more effectively implement best practices to prevent catheter-related UTIs across her organization?

STEP 1: Understanding the Need for Change

Further investigation into the semiannual report revealed that Hospital A’s UTI rate is unacceptably high (almost 10 percent) among gastrointestinal (GI) surgery patients. Among patients who underwent upper GI surgery with placement of an epidural, more than 80 percent of patients had indwelling catheters for longer than two days postoperatively. An informal survey of surgical residents and staff uncovered poor understanding of the indications for urinary catheter insertion (and for continued catheterization, particularly among patients with epidurals). This information is shared with the chairs of surgery and anesthesia, as well as with the director of nursing and the hospital’s quality czar. Shortly thereafter, a hospitalwide quality improvement initiative to avoid and/or reduce urinary catheterization in surgical patients and to reduce catheter-related UTIs (CAUTIs) in surgical patients is approved and launched.

STEP 2: Building the Guiding Change Team

With the SC at the helm, a core change team is enlisted. The team consists of members from infection prevention and control (including the head, who reports directly to the quality czar), the head of the acute pain service, an urologist, and charge nurses from the operating room and the various surgical units. Potential support and resistance to the initiative is mapped, and as a result of this step, administrative chief residents from various surgical services and the heads of nursing quality and staff/patient education are added to the team.
STEP 3: Creating a Vision and Strategy for Change

The core change team sets “low outlier status for UTI on the ACS NSQIP semiannual report within 12 months” as a goal. Plans are put into place to achieve this goal by (a) educating patients and staff about the association between prolonged catheterization (greater than 48 hours) and CAUTIs and (b) reducing the number of surgery patients who are catheterized for longer than two days postoperatively (unless medically indicated) to less than five percent. Potential ways to reduce prolonged catheterization are discussed, including physician reminders (that can be placed in the chart), as well as nurse-initiated and/or automated “stop orders.”

STEP 4: Creating a Sense of Urgency

The change team prepares a PowerPoint presentation outlining the clinical and economic impact of CAUTIs, risk factors for CAUTIs (in particular, prolonged catheterization), the hospital’s high outlier status for UTI, rates of prolonged urinary catheterization across surgical services, the Centers for Medicare and Medicaid Service’s nonpayment policy for CAUTIs (and its potential impact on the hospital’s “bottom line”), and growing interest (public reporting) of hospital process and outcomes data. Members of the guiding team are assigned to give the presentation across multiple forums (for example, Morbidity and Mortality Conferences, resident teaching conferences, nursing staff meetings) to create a “burning platform” for the change.

STEP 5: Communicating the Vision and Strategy for Change

Ways to reduce the risk of postoperative CAUTIs (in other words, minimizing the use of indwelling urinary catheters and reducing prolonged catheterization) are discussed at the end of these presentations and at each of these forums. Key slides from the PowerPoint presentation are posted at strategic sites (for example, the operating room lounge, resident work rooms, nursing staff break rooms, and so on), screen savers with the message “Does your patient really need that Foley? Let’s get it out!” are rolled out across the hospital, and buttons with the slogan “Stomp Out UTIs” are distributed to surgical staff, residents, and nurses.
STEP 6: Empowering Broad-Based Action

Urinary catheter physician reminders and removal order forms are placed on the Intranet and made available to nursing staff to print and place in patient charts. Staff and nurses from the various surgical services are empowered and encouraged to identify specific surgical patients (in other words, patients undergoing laparoscopic cholecystectomy) who may not require urinary catheterization at the time of the operation and/or whose catheters could be removed immediately thereafter. Patients and their families are also provided with educational materials outlining ways to prevent CAUTIs (to help reinforce appropriate provider adherence and encourage self-protective behaviors).

STEP 7: Generating Short-Term Wins

Protocols outlining which patients do not require catheterization at the time of the operation (and/or whose catheters can be removed immediately thereafter) are agreed upon and put into place. “Wins” resulting from these protocols (for example, number of potential CAUTIs avoided, low rates of urinary retention and subsequent catheterization, and so on) and the names of their respective physician and nurse champions are posted in the operating room lounge each month. Declining rates of prolonged catheterization on each surgical unit are also tracked and posted each month.

STEP 8: Exploiting Gains to Produce More Change

As the initiative gains momentum, additional staff and nurses from other surgical services are encouraged to identify other patient populations that may not require perioperative catheterization and develop similar protocols. A “CAUTI Prevention Module” is created and incorporated into the orientation program for all new nursing staff. Nurse-initiated urinary catheter removal orders (for physician cosignature) are created and incorporated into the hospital’s computerized physician order entry system.
STEP 9: Hardwiring Change

Connections between the change initiative, reduced rates of urinary catheter insertion and prolonged catheterization, and reduced rates of CAUTIs (and potential morbidity, mortality, costs avoided) are highlighted and disseminated periodically across various private and public forums. Physician and nurse champions of the change initiative are openly recognized and rewarded. Soon, the new standard-of-care becomes “just the way we do things around here.” It becomes rooted within the hospital’s culture of quality and safety.

Bibliography


Helpful Websites for More Information

ExperiencePoint

http://www.experiencepoint.com/
APPENDIX

Steps Involved in Leading and Managing Organizational Change

<table>
<thead>
<tr>
<th>PLANNING FOR CHANGE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1: Understand the Need for Change</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DO:</strong> Continually scan the external environment and perform internal diagnostics</td>
<td></td>
</tr>
<tr>
<td><strong>DON’T:</strong> Become complacent</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 2: Build the Guiding Change Team</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DO:</strong> Enlist other individuals with expertise, credibility, leadership and management skills, and “position power”</td>
<td></td>
</tr>
<tr>
<td><strong>DON’T:</strong> Act alone</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 3: Create a Vision and Strategy for Change</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DO:</strong> Make it simple, tangible and attainable; engage key stakeholders (ensure “shared ownership”)</td>
<td></td>
</tr>
<tr>
<td><strong>DON’T:</strong> Ignore silos and power centers that pose potential barriers to change</td>
<td></td>
</tr>
</tbody>
</table>
## Implementing Change

**STEP 4: Create a Sense of Urgency**

**DO:** Use tangible and dramatic evidence from both within and outside the organization to make a case for change

**DON’T:** Rely on a dry business case (rather, create a “burning platform”); create a sense of urgency without proposing solutions (which breeds anxiety and uncertainty)

**STEP 5: Communicate the Vision and Strategy for Change**

**DO:** Make the change vision simple and compelling; present the right message, in the right format(s), at the right time

**DON’T:** Undercommunicate; fail to “walk the talk”

**STEP 6: Empower Broad-Based Action**

**DO:** Recognize and reward individuals who have “bought into” and promote the change vision and strategy

**DON’T:** Try to remove all barriers at once; ignore intractable resisters

**STEP 7: Generate Short-Term Wins**

**DO:** Ensure and celebrate quick, visible, and meaningful wins early on

**DON’T:** Launch too many projects at once (which leads to burnout); declare absolute victories

**STEP 8: Exploit Gains to Produce More Change**

**DO:** Promote “change champions”; continually reinvigorate the change process with new people and projects

**DON’T:** Let up; tie yourself to a rigid plan (rather, allow for flexibility and take advantage of unforeseen opportunities)

**STEP 9: Hardwire Change**

**DO:** Ensure the change “roots” itself into the organizational culture; use the orientation and promotion process to create new advocates

**DON’T:** Rely on individuals, structures, and processes alone to hold major changes in place
For more information and to learn how to access all of the Best Practices Guidelines and Quality Improvement Primers, visit www.acsnsqip.org.