

Dear all

Below you will find two documents in this one pdf file:

1. Module 1: Managing Organisations & People assignment descriptor from 2011

You will note that the case study used for the assignment is the same, but the question is different. Also, you will note that Part A of the assignment is worth 75% and Part B, a reflection, is worth 25%. As Part B is not relevant to you, it has not been included.

2. Part A of a student's assignment for Module 1 from 2011

Part B is not included, due to lack of relevancy. This is quite a good assignment and received a good grade. There are some minor issues, but overall the standard is high. This assignment has been reviewed by Dr John Lawson and I and comments have been inserted, where relevant.

Please do be aware that you should use your word count as advised.

Kind regards

Séamus

1. Assignment Descriptor

Ollscoil Na hEireann

THE NATIONAL UNIVERSITY OF IRELAND
Royal College of Surgeons in Ireland
Institute of Leadership

MSc in Healthcare Management
2011-2012
Semester I

Module: Managing People and Organisations

EXAMINER

XXXX

External Examiner

XXXX

This assignment must be entirely your own work and should not have been submitted for assessment for any other programme at this or any other University

Word Limit: Case Study 3,000 words (75%)
Word Limit: Reflection 1,000 words (25%)

Date of Submission: Dubai Tuesday 6th December 2011
Date of Submission: Bahrain Monday 15th December 2011

Learning Outcomes:

On successful completion of this module students will be able to:

1. Demonstrate the ability to apply their learning of management and organisational behaviour to their own area of practice.
2. Collaborate with inter-professional colleagues to discuss how staff can best be motivated and managed in organisational settings.
3. Critically evaluate change management theories.
4. Produce a personal development plan which can be utilised during the course of the programme and back in the workplace.
5. Demonstrate knowledge of the e portfolio process
6. Apply their learning of a case study analysis to discuss the culture of their own area of practice.

Assignment

Please complete Section A and Section B. This assignment particularly assesses Learning Outcomes 1, 2, 3, 5 and 6 listed above.

Section A: (75%)

Case Study: Leading Organisational Change: Improving Hospital Performance

- Critically discuss the sources of resistance encountered by Tracey Burns and her team? Support your discussion with evidence-based literature.
- Explore the approaches they used to manage the resistance and critically evaluate the effectiveness of those approaches, drawing on your learning from the module and key literature sources.

Section B: (25%)

2. Sample Assignment

Module Title: Managing People and Organizations

Msc Healthcare Management, Year 1, 2011-2012

Assignment:

Section A Case Study: Leading Organizational Change: Improving Hospital
Performance

[SO1]

Student ID: xxxxxxxx

Date: December 5th, 2011

Word Count: 3254 words [SO2]

Managing People and Organizations

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Introduction^[SO4]

Introducing fundamental change to organizations is no easy feat, one that is likely to ^[SO5]face resistance (Kotter and Schlesinger,1979; Bubshait et al,1998; Peccei et al,2011). Resistance to change has, in turn, been recognized as one of the major reasons behind failure to implement long lasting change (Kotter and Schlesinger,1979; Zwick,2002).^[SO6]

Bringing about such change in hospitals is doubly challenging. Hospitals are ^[SO7]infamously considered among the most difficult organizations to manage. Mainly so because they contain subcultures which lack greatly in integration and communication among them (Glouberman and Mintzberg, 2001). Introducing change to organizations with subcultures is more complex as opposed to organizations with a dominant culture (Rashid et al, 2004).^[SO8] This section of the assignment deals with a case study in which organizational change was introduced to a hospital Trust. An effort will be made to identify and critically examine the sources of resistance, the methods used to manage them, and evaluate whether they were successful or not.

The Case Study^[SO9]

In 2003, one year after merging three hospitals to form the King Edgar Hospitals NHS Trust, it was under scathing media attack. (For a complete chronological list of the case study events, see Appendix1.) The Trust was suffering from a £30 million deficit, a waiting list problem, and as a consequence, a deteriorating reputation in the community. To tackle these problems, a board meeting was held where they decided that the most urgent problem to deal with was that of inefficient patients processing. From this information, it can be surmised that the great sense of urgency needed to

drive a change process successfully (Kotter, 2006; Garvin and Roberto, 2005) was present from the outset.

The Guiding Coalition

Of utmost importance in managing change and resistance, is choosing the right people to lead and implement it. Kotter (2006), [SO10] described it as "forming a powerful guiding coalition" (p.5) of committed, experienced, networked people. Tracey Burns, current Executive Director of Nursing and former matron, was charged by Rodger Andrews, the Chief Executive, with the task of improving the admission-to-discharge chain. Burns in turn composed a team of three matrons: Sue Green, Helen Edwards, and Nikki Thorton, in addition to herself to help her implement her vision.

1-The Chief Executive

The Chief Executive was a great asset to the discharge initiative. He seemed to understand the delicate balance between providing visible support (Sirkin et al, 2005), and allowing for flexibility for the team to forge bonds of commitment through their shared understanding of common goals (Katzenback and Smith, 2005).

2-Burns

In addition to combining both managerial and practical nursing skills, Burns had the added advantage of already being familiar with the shortcomings of the discharge process. Seeing an opportunity to raise the nurses' status by extending their roles beyond the traditional, she introduced the controversial concepts of discharge planning from the moment the patient is admitted and nurse-led discharge.

3-The Matrons

Green was appointed by Burns as the Steering Group Chair overseeing the discharge performance utilizing her experience with the discharge problem. Edwards was put in charge of the discharge planning initiative considering her experience with the matter at her hospital. She made the vision for change accessible and easy to understand as recommended by Kotter (2006) by producing a report stressing its importance and the steps already taken towards implementing it. Last but not least, Thorton, who was closely involved with the project and an "activist" as described by Green, took lead on the training and piloting stage of nurse-led discharge (NLD).

Sources of Resistance^[SO11]

To avoid duplication in describing the nature of resistance Kotter and Schlesinger's article entitled Choosing Strategies for Change (1979) supported by other resources will be used as follows. First to be discussed are sources of resistance that some or all of the team members had in common. Then, those faced by each individual team member. Finally, sources of resistance that the Trust faced as a whole which in turn affected the team's work. Later, the team's performance will be evaluated based on their results as mentioned in the case study and on the degree to which they adhered to Kotter's (2006) eight-stage change management model .

A-Sources of Resistance the Team Members Had in Common

The main sources of resistance that were faced by all or most of the team members were the nurses and the physicians, which was foretold by Tracey Burns at the beginning of the case study where she anticipated a "culture shock". A technical difficulty presented itself as well.

1-The Nurses

All the team members were faced by resistance from the nurses in one form or another. The first reason was that the matrons' assessment of the situation differed from that of the team, where from their viewpoint, the costs for change outweighed the need for it (Kotter and Schlesinger, 1979). [so12] That was exemplified by some of the matrons and nurses saying that discharge was boring and would only end up increasing their workload. That demonstrated how not having similar data will lead to differing analyses (Kotter and Schlesinger, 1979).

To deal with this, the team used many of the strategies described by Kotter and Schlesinger (1979). First, they attempted to educate and communicate with the matrons by providing them with the information they needed to understand the situation. Burns shared Green's findings from a bed occupancy exercise conducted earlier, showing that more than 17% of patients in hospital beds were stable and didn't need to remain in an acute bed. Edwards had a nurse who didn't understand the severity of the problem accompany her to see how bad the waiting situation was especially in the A&E department. She was able to completely alter his perspective.

Second, the team encouraged the matrons' participation and involvement. For example, Burns together with Green, organized a workshop to which she invited all the matrons. She aimed to get the discharge project off the ground and garner support for it. In addition, she encouraged input from the matrons at the workshop using their suggestions to formulate an action plan. That was important because many change plans fail due to leaders' neglect to communicate with and involve employees, not getting feedback from them, and forcing a new structure without allowing for a sense

of employee ownership of the initiative (Kotter and Schlesinger, 1979; Garvin and Roberto, 2005).

Another approach that was used to get the nursing staff on board was providing an incentive. Having obtained a promise from the Chief Executive, Burns informed the matrons that in exchange for their compliance with the new initiative, they would be relieved of their burdensome bed management duties. That was met with excitement.

The second reason the nurses resisted the change was their fear of loss of something of value (Kotter and Schlesinger, 1979), namely traditional nursing roles. To them, talking to, guiding, and working with patients and their relatives were integral parts of what made them nurses. Having nurses who'd implemented the new discharge process talk about their positive experience with it, explained that NLD allowed for better, more comprehensive relationships with their patients.

Finally, the nurses resisted the proposed discharge initiative because of their fear of not being able to develop the skills necessary to implement it (Kotter and Schlesinger, 1979), adding to that their lack of self confidence even after they received the training, both giving rise to fear of liability concerns. The team managed this form of resistance by providing continuous tangible and emotional support encouraging the matrons to do the same. Examples of each team member's effort in supporting the nurses follow.

Burns reminded the nurses that more often than not, it's the nurse who notices that a patient is ready for discharge and informs the physician. Edwards and the Discharge

Manager organized full-day monthly workshops, during which sisters were constantly reminded of their critical role in the initiative. They were also encouraged to attend rounds and challenge the current discharge practices, for employees should be encouraged to get involved in the change process and try new methods (Kotter, 2006). Green supported the frontline nurses by continuous monitoring through her physical presence, presentations, and by training them to perform "mini" point prevalence assessments. Thorton developed a comprehensive NLD training program with input from nurses from each specialty. When she found out that some nurses who'd undergone NLD were afraid of liability in cases of readmission, she assured them the Trust had their backs as long as they can justify their decision to discharge. Thorton also asked the matrons to support and encourage the nurses who'd undergone NLD training. Moreover, she set up a clinical incidence reporting system to determine whether any of the readmissions were related to the patient's previous problems. None were reported.

2-The Physicians

Physicians, by virtue of their training, are autonomous and specialized tending to take decisions independently and decisively. (Glouberman and Mintzberg, 2001). This autonomy in turn allows for a great deal of justification of their actions acceptable in their world (the culture of hospitals), making it difficult for them to accept change (Weick and Sutcliffe, 2003).

A grave mistake made by the team during the initial phase of introducing the new discharge initiative was not making more of an effort to involve the physicians. Undercommunication of a vision to key stakeholders will increase the chances for

resistance to occur (Kotter, 2006). For a complete stakeholder analysis, see Appendix2.

They could have avoided that mistake subsequently reducing the degree of resistance they faced later on by doing two things. First, they should have contacted the senior physicians directly rather than through a third party (the hospital general managers), an attribute Garvin and Roberto (2005) noted to be helpful in having better success at persuading people of a participatory management style. Second, when it turned out that many of the senior physicians had not received the invitation, they should have postponed rather than cancelled the meeting. This would have shown that Burns and her team were serious about tackling the "specialized (cure) curtain" barrier between nurses and physicians hindering coordination between them (Glouberman and Mintzberg, 2001).^[SO13]

Physicians at the Trust exhibited varying degrees of resistance ranging from ignoring the letters Thorton sent them regarding discharge criteria as per their specialty, to passive compliance without much conviction, to outright refusal to go along with the new guidelines. One might argue that ^[SO14]they feared loss of power (Kotter and Schlesinger, 1979), should they relinquish the role of patient discharge to the nurses. In response, Thorton formed her own guiding coalition rallying specialist physicians for support asking them to write about the advantages of NLD. She also approached two others she thought of as "strong enough to deal with their colleagues" to speak about NLD at their fortnightly medical group meetings and to emphasize the fact that NLD is a done deal. This seemed to do the trick with more and more physicians participating in the initiative.

Some physicians were not convinced the nurses possessed the necessary skills to carry out discharge. In other words, there was a lack of trust (Kotter and Schlesinger, 1979) in the nurses' abilities. In response, Thorton had an intensive training program regarding discharge criteria. She used the expertise of nurses from different specialties to formulate the criteria in order to have something concrete that would gain the physicians' approval.

Other physicians failed to see the benefits the new discharge initiative could bring them, some even described it as "a waste of time". Edwards utilized the method of involving a resistor, a senior physician, in implementation of an aspect of the change (Kotter and Schlesinger, 1979). In the process, he became a supporter of discharge planning and agreed to speak on its behalf to his two junior colleagues, showing that involving employees can turn them into champions of new initiatives (Sirkin et al, 2005). The first physician complied passively, while the second absolutely refused to participate saying he wouldn't randomly choose a discharge date for a patient whose condition might worsen. Using Kotter and Schlesinger's (1979) combined strategies of communication, involvement and co-optation, Edwards explained the purpose of daily patient assessments, had the nurses set dates for themselves, and tried to wear him down with constant reminders of how his colleagues were complying. He further resisted writing the Chief Executive saying it was a useless initiative. Leaving no choice but coercion (Kotter and Schlesinger, 1979), the Chief Executive strictly replied that "resistance was futile" voicing full support for the nurses' efforts. This physician eventually complied, albeit grudgingly, demonstrating the effectiveness of the (C1) group or powerful executives' visible commitment to a change initiative (Sirkin et al, 2005). Complete compliance by the junior physician might have been

perceived as an admission of his being wrong previously, which he might have equated with losing face (Kotter and Schlesinger, 1997).

3-Lack of Adequate NLD Precedents

A technical source of resistance arose when no adequate precedents of nurse-led discharge could be found. Guidelines clarifying what was required from nurses to be deemed qualified to perform NLD were needed. Edwards decided not to waste any more time on searching for preset guidelines and to write their own based on what they thought was right. So, they prepared a short set of guidelines which was signed by the Executive Director Group.

A point of merit for the team that should be mentioned is that they took a preemptive measure against potential future resistance. They realized the importance of obtaining guidelines and baseline data against which they could measure future results. The importance of planning for measurable, small wins lies in the credibility they lend the change process, as well as in the resulting confidence boost experienced by those supporting the change (Self and Schraeder, 2009; Kotter, 2006). For more details see Appendix3, specifically the row "plan for and create short term wins".[SO15]

B-Sources of Resistance Faced by Individual Team Members

Green faced resistance from the line managers supervising the seven matrons driving the discharge improvement projects. They were not happy because the matrons were spending 30% of their time on the initiative. They probably didn't agree that the discharge initiative was a top priority, therefore, their resistance could be attributed to differences in assessment of the situation (Kotter and Schlesinger, 1979). Green had anticipated that by building good relationships with the general managers. She later set up weekly timetables for the matrons assigning three sessions per week

specifically dedicated to discharge activities, an important step according to Sirkin et al (2005) who recommend setting time aside especially for the new project. Also, there was a ward sister who was resistant to the idea of discharge coordinators preferring to have an extra nurse instead. She came to appreciate them with time.

Encouraged by the nurses' response to the workshops, Edwards decided to organize one for medics, therapists, and social workers in order to get them on board with the multidisciplinary discharge initiative. However, only one therapist attended. There was nothing done at this point to fix that.

Thorton faced lack of secretarial support due to the reorganization of matrons' responsibilities. She confessed it was hard, because she had to do the secretarial work on top of her responsibilities as a matron. Sirkin et al (2005) recommend no more than 10% increase in workload during a change initiative or it will likely face trouble. But because she possessed the admirable quality of "commitment to excellent performance through renewal" (Kotter, 2006 p. 5), she performed the clerical tasks required herself in order to make sure that each physician received a letter explaining the NLD policy with the relevant discharge criteria.

C-Sources of Resistance Faced by the Trust Affecting the Team

Some sources of resistance faced by the Trust hindered the team's ability to implement the change. First was the dire financial situation the Trust was in. While a bad financial situation could have the benefit of creating a sense of urgency, it has the disadvantage of limiting resources (Kotter, 2006). The Trust could neither hire new

staff members neither send nurses for training in prescription writing, a course that would've been most beneficial in aiding NLD.

In addition, the relationship with Social Services was poor. On one hand Social Services did seem to lag and not respond to invitations to discuss the discharge problem. On the other, there was a lack of adequate alternatives to the hospital in the community. The fact was that a "blame culture" permeated the hospital staff who held Social Services responsible for not providing prompt solutions for stable patients. This source of resistance was managed by creating three new positions dedicated to liaising with outside agencies including Social Services, therefore providing direct and indirect support to the discharge process. These positions were Discharge Manager, Discharge coordinator, and Site Managers, and they proved to be of great value.

Burns showed true problem solving skills, an attribute of a good team leader according to Sirkin et al (2005) by killing two birds with one stone: providing finances to support her team who lacked an official budget, and initiating rapport with Social Services. She did so by securing £300,000 from Social Services' annual reimbursement funding by leading almost two months' discussions with the Social Services and local politicians coming up with this as an alternative to sanctioning delays by Social Services. The money was to go towards bettering the discharge systems, earlier notification of Social Services about patients going to need their help upon discharge, and financial support for the discharge coordinators.

Finally, making things more complicated for the team was that there were many change initiatives running simultaneously. This tends to overstretch expertise and

resources (Sirkin et al, 2005). This difficulty was partially resolved when some of the initiatives were put on hold while others were cancelled.

Evaluation

As mentioned, Kotter's (2006) eight stage model for change management aiming at decreasing resistance, will be used to evaluate the team's performance. It was found that the team averaged a score of 7/8 indicating a high level of success in adhering to the model. For more details, see Appendix3. This is supported by the results Burns and her team obtained at the end of the case study. They were successful at achieving most of what they'd set out to do. There were significant improvements in uptake of NLD, a more proactive and energized discharge planning, drop in percentage of stable patients in acute beds, more efficient use of the discharge lounges, and improved relations with external agencies. Not to mention that the nurses of The King Edgar Trust were now considered successful pioneers of NLD, prompting other Trusts to contact them requesting advice, assistance, and training.

Even though they made some mistakes such as not increasing the sense of urgency at the Bronte site, as well as not including the physicians in the early stages of discharge plan development, and the inadequate support systems in some wards, they recognized these mistakes intending to learn from them.

Conclusion^[S016]

As proven by the case study and following review of the literature, organizational change and resistance management are very difficult. Yet, despite the many obstacles and sources of resistance they faced, Burns's team succeeded on many fronts as mentioned previously. It can be inferred that a combination of many factors led to the aforementioned success of the newly implemented discharge process. Among these

factors are the unique attributes and expertise the guiding coalition brought to the table, as well as their high degree of solidarity and commitment to reach their shared goals, and desired results. They were indeed what Kotter (2006) would call change champions.

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