Managing Organizational Transitions: *The Chief Nurse Perspective*

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Organizational change and transitions are a fact of life for healthcare agencies. Hospitals find themselves responding to rapid and unprecedented changes in the paradigm of healthcare delivery. As the external environment continues its volatility, how are chief nurses (chief nurse officers and chief nurse executives [CNO/Es]) responding as they provide major leadership within their institutions? The literature postulates a number of strategies for managing successful change, including involving the multidisciplinary team in developing change[1] and a focus on transformational change to produce a fundamental change to how work was previously done.[2] Leading and managing change is one of the leader's most important roles. Shirey[3] argues that sustainable change strategies cannot be achieved unless the execution of the strategy is well understood by the leaders involved. A structured method for implementing organizational change or transition may be vital for success. Are nurse leaders using evidence-based management styles to achieve success at leading transition or change? There is a paucity of literature that describes how chief nurses (CNO/Es) lead organizational transition, as well as how effective those methods are. Using a structured interview guide based on Marks' work on facilitating adaptation to organizational transition,[4] 16 CNO/Es were surveyed to determine how they managed major change and transition within their organizations. These interviews were conducted between June and December of 2012.

BACKGROUND AND SIGNIFICANCE TO NURSING LEADERSHIP

The forces that precede and drive change in any organization are both internal and external, and can include people, culture, technology, competition, and information processing.[5] Additionally, healthcare organizations are also subject to governmental and regulatory forces that drive change.[6] Recent layoffs of nurses and nursing staff, as well as hospital closings, have demonstrated that healthcare organizations are not immune to the economic crisis that has plagued businesses worldwide.[7–9] Oftentimes there is no clear answer in how the change should be managed because there may be no single, clear solution to managing the particular force.[10]

Patient safety outcomes in hospitals are directly linked to the leadership within. A 2010 study demonstrated that leaders who

developed relationships based on fairness and empathy with their direct reports not only affected the quality of the work environment, but also contributed to patient safety—there was a documented decrease in medication errors.[11] Bohan and Lang[12] demonstrated that executive-level healthcare leaders have a direct impact on the safety of patients through policy decisions, as well as through the leaders' reactions to both internal and external forces that affect the organization. They found that leadership behavior accounted for up to a 31% improvement in performance measurements of quality and safety, and that the leadership must be carried out effectively.[12] "The most ineffective way to get individuals to change is to tell them to change in a transactional manner. The person factor is absolutely vital when we consider the practicalities of moving beyond a compliant to a proactive safety culture."[12(p187)] Successful change involves developing relationships and trust among all members of the team in order to sustain positive outcomes.[1]

Change in nursing organizations was first examined in an in-depth manner in 1983 by McClure et al.[13] in their work on the identification of factors leading to nurse retention, later known as the 14 Forces of Magnetism. Quality nursing leadership, organizational structure, and management style are the 3 forces that are tied to managing change in organizations. The concept has become further refined as organizations look internally to take steps towards achieving all 14 Forces of Magnetism. A 2011 study on the innovativeness of CNO/Es in both Magnet® and non-Magnet hospitals found that "… characteristics of the CNO/E may support organizations and health care at large to implement the evidence-based practice needed to continuously improve the quality of care delivered and patient outcomes."[14] This finding demonstrates the importance of the CNO/E's ability to support the organization's transition to a culture of quality.

In 2005, the American Organization of Nurse Executives published a collection of competencies that described skills "…common to nurses in executive practice regardless of their educational level or titles in different organizations."[15] Included in these competencies is a section on change management, with a specific reference to the use of change theory to plan for organizational change. Because there is no single educational path to becoming a nurse executive, the level of familiarity with managing change and change management theory will vary. Because of the AONE's call for consistency with the competencies, the utilization of change management theory was explored.

CHANGE THEORY USED TO GUIDE THE INTERVIEWS

Lewin theorized that every organization encounters forces for maintaining the status quo, as well as forces for promoting change.[16] Marks[4] uses these opposing features as the foundation for a framework focusing on weakening forces for the old while strengthening forces for the new at both the emotional and at the intellectual level. By organizing these tasks (strengthening the new, weakening the old) on both levels (emotional and intellectual), Marks determined 4 elements needed for successful change:

- Empathy—Weakening the old at the emotional level
- Engagement—Weakening the old at the intellectual level
- Energy—Strengthening the new at the emotional level
- Enforcement—Strengthening the new at the intellectual level

This framework "underscores the need for leaders who hope to use transition as a force for organizational renewal—or, at the very least, to minimize the unintended consequences of transition—to acknowledge the adaptation process and provide means for facilitating it."[4(p735)]

METHODOLOGY

To assess the extent to which executive-level nursing leaders use an evidence-based framework to guide organizational transition, a convenience sample of CNO/Es from across the country was solicited for a telephone interview using a structured guide to frame the discussion (*Appendix A*). The tool incorporated each of the four domains of Marks's Framework (*Table 1*). Potential participants were identified through networking and with the assistance of 2 nationally recognized nurse leaders. Twenty CNO/Es were asked to participate in the structured interview. Sixteen of the CNO/Es agreed to participate, resulting in a response rate of 80%. The participating CNO/Es represented a wide range of experience and educational backgrounds, as well as a diverse group of organizations (see *Table 2*). The number of years that each CNO/E was in his or her current position ranged from 9 months to 16 years. Eleven of the CNO/Es had completed a master of science in nursing (MSN), 4 had completed a bachelor of science in nursing (BSN), and 1 had completed a PhD in nursing (DNP). Three of the MSN-prepared CNO/Es were enrolled in DNP programs at the time of the interview, and 1 of them had completed a PhD in Health Policy. Three of the BSN-prepared CNO/Es had completed an MBA, and 1 had completed a master's degree in Health Care Administration. The CNO/E/Es represented 5 states, concentrated in the Midwest and South. Bed size ranged from 25 to 1200. Eleven of the CNO/Es reported their number of full-time equivalents (FTEs). The FTE ranged from 156 to 7200. Six reported their annual discharges, which ranged from 2100 to 43,000.

FINDINGS

Each CNO/E was asked the same set of questions, as well as given the opportunity to reflect. Each question was categorized into the appropriate domain based on Marks' framework, and the answers were analyzed for themes.

Transitions Described by the CNO/Es

The CNO/Es were asked to describe a major transition that their organization recently had undergone. The responses showed many different types of transitions from a broad spectrum of categories. Several managed transitions involving construction of new units, up to and including the construction of a brand-new facility. Workflow and role responsibility changes were also cited as transitions that were managed by some of the CNO/Es, including new staffing models, new patient flow models, new leadership structures, and electronic