Objectives

- Identify the Eight Steps of Change using Kotter’s Model for change within your organization
- Discuss other change management models
- Describe DICE Tool methodology
- Describe actions required to set the stage for organizational change
- Identify ways to empower team members to change
- Discuss resistance and barriers to change
- Discuss common errors of change management
- Begin planning for the cultural change
A strategy combining a structured process with a set of tools to transform how people feel, operate and behave in an organization.

Three-step change model known as the unfreezing-change refreeze model that requires prior learning to be rejected and replaced.

Focuses on transitions and psychological changes that lie behind significant organizational change.

And many more.....
Our Iceberg is Melting (video)
Kotter’s 8 Steps of Change

Create a new culture
Don’t let up—Be relentless
Short-term wins
Empower others
Understanding & buy-in
Develop a change vision & strategy
Build the guiding team
Create sense of urgency

John Kotter
Step 1: Set the Stage and Create a Sense of Urgency

- Get people’s attention!
- Sell the need for change … sell the pain and the consequences of not changing
- Immerse people in information about the change
- Discuss ways to solve the problems people identify with the change
- Empower people to solve the “problem”

- What information do you have that may indicate a need for change in your organization?
- How is the need for change communicated in your organization? What do you think is the most appropriate way to communicate the need for change?
- What can you do to create a sense of urgency for change in your organization?
**TeamSTEPPS**

**Step 2: Pull Together the Guiding Team**

- Choose key players, especially staff-level managers
- Multidisciplinary
  - Goal is informed; intelligent decisions are being made
  - Credibility and integrity of change leaders
- Choose proven leaders who can drive the change process
  - Strong position power, broad expertise, and high credibility
- Need both management and leadership skills
  - Management skills control the process
  - Leadership skills drive the change

> **What characteristics would you look for in a team to guide change in your organization?**
> **What do you think is the most crucial thing to enable this guiding team to truly function as a team?**
Step 3: Develop the Change Vision and Strategy

Senior Leadership is responsible for:

- Establishing the definition of a “culture of safety” aligned with expectations, core values, and shared beliefs
- Informing the organization of these values and evaluating the culture
- Leading the process of:
  - Translating values into expected behaviors
  - Establishing trust and accountability
- Communicating a commitment to shaping the culture

➢ How might you best determine what your change strategy needs to be?
Step 4: Communicate for Understanding and Buy-In

- Provide supportive actions for fear, anger, and resistance
- Encourage discussion, dissent, disagreement, debate … keep people talking
- Tell people what you know—and what you don’t know
- Acknowledge people’s pain, perceived losses, and anger
- Value resisters
  - They clarify the problem and identify other problems that need to be solved first
  - Their tough questions can strengthen and improve the change
  - They may be right—it is a dumb idea!

**EXERCISE**

- How could you best ensure understanding and buy-in of needed changes in your organization?
- Identify ways to communicate and reinforce change that you believe would be most effective in your organization?

...communicate, communicate, communicate...
Step 5: Empower Others to Act

- Develop a shared sense of purpose
- Align structures with vision and goals
- Train employees so they have the desired skills and attitudes
- Align information systems and personnel with the vision and goals
- Confront high-level resisters

Where might you anticipate and eliminate barriers to change in the organization?
What do you believe might be behind people’s resistance to change?
What are the existing norms within you facility/department/unit that may interfere with change?

An organization cannot be improved from the top only
Step 6: Produce Short-Term Wins

- Provide further impetus for change
- Provide positive feedback
  - Further builds morale and motivation
- Lessons learned help in planning next goal
- Create greater difficulty for resisters to block further change
- Provide leadership with evidence of success
- Build momentum
  - Helps draw in neutral or reluctant supporters

- Identify examples of successes relative to the changes needed in your organization that you have already seen.
- What could you do to reinforce success?
Step 7: Don’t Let Up

- Acknowledge hard work
- Celebrate successes and accomplishments
- Reaffirm the vision
- Bring people together toward the vision
- Acknowledge what people have left behind
- Develop long-term goals and plans
- Provide tools and training to reinforce new behaviors
- Reinforce and reward the new behaviors
- Create systems and structures that reinforce new behaviors
- Prepare people for the next change

Describe what you think it will take to really keep change going in your organization.
What resources and/or support will people need to implement the needed change?
Step 8: Create a New Culture

- Develop action steps for stabilizing, reinforcing, and sustaining the change:
  - Give people time to mourn their actual losses
  - Provide skill and knowledge training
  - Revise job descriptions
  - Develop new reward systems
  - Strengthen social connections and relationships
  - Recognize and celebrate accomplishments

- Develop performance measures to continually monitor the results from the change and to identify opportunities for further improvements

- Make adjustments to the change vision and strategy to reflect new learning and insights

- Challenge people to be open to new challenges, forces, and pressures for the next change

> Describe the new culture that you see for your organization. What will the benefits of such a culture be?
DICE Tool (handout)

Methodology for scoring and statistically analyzing dynamics of DICE allowing for an objective assessment of the likely outcome for transformation.

- **D** = Duration of the project
- **I** = Integrity of the team
- **C** = Commitment to change
- **E** = Effort required of staff
## Resistance to Change

<table>
<thead>
<tr>
<th>Resistant Behaviors</th>
<th>Why?</th>
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<tbody>
<tr>
<td>Parochial self interest</td>
<td>Individuals are concerned with the implications for themselves; their view is often biased by their perception of a particular situation.</td>
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<tr>
<td>Misunderstanding</td>
<td>Communication problems, inadequate information</td>
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<tr>
<td>Habit</td>
<td>Habit provides both comfort and security.</td>
</tr>
<tr>
<td>Low tolerance to change</td>
<td>Insecurity</td>
</tr>
<tr>
<td>Different assessment of the situation</td>
<td>Disagreement over the need for change, disagreement over the advantages and disadvantages</td>
</tr>
<tr>
<td>Economic implications</td>
<td>Employees are likely to resist change which is perceived as affecting their pay/other rewards.</td>
</tr>
<tr>
<td>Fear of unknown</td>
<td>Proposed changes which confront people tend to generate fear and anxiety.</td>
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</tbody>
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### Solutions:

Explain the need for change, provide information, consult, negotiate and offer support and training, involve people in the process, build trust and sense of security, build employee relations. Embed Team STEPPS into your everyday practices. Ie: Team Debrief Form; Root Cause Analysis Process, Forms, Policies etc.
Errors Common to Organizational Change

- Allowance for complacency
- Failure to create a sufficiently powerful Guiding Coalition and Change Team
- Not truly integrating the vision
- Allowance for obstacles
- Not celebrating “short-term wins”
- Declaring victory too soon
- Neglecting to anchor changes firmly in the culture
Culture Change Comes Last, Not First!

- Most alterations in norms and shared values come at the end of the transformation process.
- New approaches sink in after success has been proven.
- Feedback and reinforcement are crucial to buy-in.
- Sometimes the only way to change culture is to change key people.
- Individuals in leadership positions need to be on board.
  - Otherwise, the old culture will reassert itself.

...Reculturing takes time and it really never ends.
SPCH - Team STEPPS Journey

So far...
<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>Spring 2009</td>
<td>Concept of Team STEPPS was first introduced to SPCH; however we did not have resources to pursue.</td>
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<tr>
<td>Spring 2010</td>
<td>4 instructors selected to complete Team STEPPS Master Training</td>
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<tr>
<td>Summer 2010</td>
<td>Planning and implementation planning takes place with Executive Team</td>
</tr>
<tr>
<td>Fall 2010</td>
<td>5 more instructors are trained and a physician lead gets involved</td>
</tr>
<tr>
<td>Fall 2010</td>
<td>All hospital and clinic employees receive training including physicians</td>
</tr>
<tr>
<td>2011</td>
<td>Instructors spend time walking the talk on unit rounds, team debriefs, case reviews and root cause analysis sessions</td>
</tr>
<tr>
<td>2012</td>
<td>New monthly employee training begins</td>
</tr>
<tr>
<td>2013</td>
<td>Instructors meet regarding sustaining strategies including annual competency</td>
</tr>
</tbody>
</table>
Course

- Moving target
- Instructor meetings
- Post course debriefs
- Varying teaching styles
- Non patient-care staff
- Continuous reworking of material
<table>
<thead>
<tr>
<th>Obstacles</th>
<th>Solutions</th>
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</thead>
<tbody>
<tr>
<td>Physician buy-in</td>
<td>Champion and $$$</td>
</tr>
<tr>
<td>Manager buy-in</td>
<td>CEO and Executive Team assistance</td>
</tr>
<tr>
<td>Employee buy-in</td>
<td>Peer Pressure</td>
</tr>
<tr>
<td>Instructor burn-out</td>
<td>Support instructors</td>
</tr>
<tr>
<td>Instructor drop-out</td>
<td>Train more</td>
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The Wave Effect

• A few brave souls ventured out and tried the Team STEPPS techniques.

• Instructors made themselves available to assist with conflict and other team issues.

• Instructors attended codes, traumas, RRT. Modeled Team STEPPS debrief and identified excellent team behaviors.

• Huddles started happening spontaneously.
We started to “get” it.

- Team events and evaluations
- Team STEPPS terminology used in policies, procedures
- Forms
- Based our RCA model on Team STEPPS
- MMI Meetings – based on Team STEPPS
- Disruptive Behavior Task Force – May 2011
- Disruptive Behavior Employee Survey – Sept. 2011
- Disruptive Behavior Formal Education – October 2012
- Launch of reporting system – November 2012
Staff started to “get” it.

- Rumors of huddles hospital wide
- Improving attention to debriefs of high risk events
- Better attendance and participation in RCA meetings
- MMI Meetings – Packed House!
- Increased awareness of communication-related issues
- Dealing with and/or reporting of disruptive behavior
“They” started to “get” it.

• Invited to Oregon Coast Community College to present Team STEPPS to 1\textsuperscript{st} and 2\textsuperscript{nd} year nursing students

• Disruptive Behavior presentation given to OCCC nursing students

• Invited back again to teach this year’s first year nursing students this coming October
Measure Outcomes

- Culture of Safety Survey (CSS) conducted in early 2010 and again in late 2012 after training all departments.
- Separated audiences this time so 2010 sample all employees vs. 2012 sampled just hospital employees.
<table>
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<tr>
<th>2012 Culture of Safety Strengths</th>
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<tbody>
<tr>
<td>When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?</td>
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<tr>
<td>My supervisor/manager say a good work when he/she sees a job done according to established patient safety procedures.</td>
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<tr>
<td>My supervisor/manager seriously considers staff suggestions for improving patient safety.</td>
</tr>
<tr>
<td>Whenever pressure build up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.</td>
</tr>
<tr>
<td>We are actively doing things to improve patient safety.</td>
</tr>
<tr>
<td>2012 Culture of Safety Improvement Needs</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Staff worry that mistakes they make are kept in their personnel file.</td>
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<tr>
<td>Hospital units do not coordinate well with each other.</td>
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<tr>
<td>Things “fall between the cracks” when transferring patients from one unit to another.</td>
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<tr>
<td>Important patient care information is often lost during shift changes.</td>
</tr>
<tr>
<td>Problems often occur in the exchange of information across hospital units.</td>
</tr>
<tr>
<td>Shift changes are problematic for patients in this hospital.</td>
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</tbody>
</table>
Sustaining and Thriving

• Instructors considering Refresher Course
• Recruit trainers
• New employee training
• Annual competency
• Culture of Safety Survey- Inpatient and Clinics
• Considering changing the model for hand-off
  – Hand-off Table Top training planned
• Engaging the Nursing Practice Committee in culture of safety improvement initiatives