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Management of Change in an Oral Health Unit in a Primary Care Trust

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Abstract

This study has identified the importance of leadership in an area of practice undergoing change. This study will give a guide for the successful implementation of change, along with research to support the implementation of the change. The clinical unit in which the change will take place will be discussed, and the author will continue with a critical discussion and reference to literature of how the change would be implemented and a description of a change theory that could be used.

The author of this study will give consideration to how the change will take place using change methods in line with the theory. The utilisation of leadership skills will be discussed, and any matters of discord and opposition that may occur towards the change will be identified as well as proposals for how these issues would be dealt with.

Introduction

Effective teams are built upon a shared vision, team motivation, trust and mutual respect. These ingredients rarely occur by accident, but they can be fostered by proactive leadership behaviours. Organisational psychology and motivational theory explore the dynamics of effective teamwork. Much of the research into work motivation (for example Arnold 1995), however, is undertaken in predominantly male occupations and cultures. Whether these gender-biased findings are transferable to the predominantly female occupation of nursing is questionable. Individuals differ and motivational needs change as individuals and teams develop. Effective teams balance individual motivational need and personality with organizational objectives.

The area of practice chosen for this study is the development of nurses in key roles, in the planning and delivery of oral health. The project referred to in this study was aimed at assisting primary care trust (PCT) executive-level posts, in identifying some of the ways in which the public health potential of PCT board and executive nurses could be developed to support health improvement approaches within primary care, and, also to help them begin to enact these changes (Latchem, Iskander, Meyrick and Duggan, 2002).

Later in the study a number of suggestions will be made aimed at helping organisations support nurses in primary care through service reform and change in the complex adaptive nature of the NHS. The finding of the HDA project was that the increasing volume of development initiatives combined with the centrally driven performance-monitoring agenda, and limited time opportunities have negative consequences for nursing staff, including anxiety and overload (HDA, 2002). The anxiety and overload felt by the factors were seen by nurses involved in the project as mitigating against risk-taking and innovation, focusing attention on national ‘must-dos’ to the exclusion of experimental developments.

The nurses talked to as part of the project also felt that these factors obscure the larger picture across agencies, reinforcing traditional sectoral boundaries and focus, and limiting the capacity of individuals and agencies to develop truly innovative and robust approaches to whole-systems planning, which is a prerequisite for success in improving health among local communities. This project indicates the potential within nursing for transforming itself to achieve health improvement. If this potential is to be

liberated, a number of blocks and obstacles need to be removed. The evidence of this project suggests that these include:

Barriers to Change	
1.	Risk aversion
2.	The approach to health improvement within PCT's must sit equally with the drive for improvement in clinical service delivery
3.	The performance management culture of target-driven clinical service delivery gives low priority to health improvement issues and can constrain, rather than improve, performance or action
4.	Lack of dedicated resources to promote and support boundary-spanning public health networks
5.	Lack of clarity and confidence about working with, and involving, communities
6.	Board and PEC cultures that do not function effectively to perform their key functions, and lack of engagement with non-executive directors
7.	Fear of change among frontline staff.

It is the focus of this study that the quality of nurse leadership is a key dimension in addressing all these obstacles.

Leadership in Change within Health-Care

The evidence from this project reinforces the suggestion that to address health improvement, nurse leadership will require much more than traditional networking, requiring a stronger focus on achieving change through others. Leading for health improvement needs to move away from operating within institutions and defined boundaries, towards leading between services, professional groups and organisations, irrespective of the constraints of micromanagement from the centre. Future leaders need the knowledge and skills to build effective coalitions and partnerships for health, and collectively to manage actions for health improvement. Effective leaders need to manage across the boundaries, becoming skilled in managing change and in building coalitions of support for change within healthcare and other sectors. This takes courage and a clear sense of public purpose among those in leadership positions - and a commitment by the NHS, centrally and locally, to nurturing these characteristics in key staff. The overwhelming demands on PCT staff at a time of complex change militates against innovation for health improvement. A dedicated resource such as the HDA regional associate directors, with the clear brief of facilitating the emergence of innovative leadership behaviour is therefore a vital ingredient.

Change in Practice

The area of practice that the author has chosen to change concerns the assessment of oral health. Currently there is no standard assessment tool for oral health being used within the organisation where the change is to take place. The author feels that this sort of tool would be beneficial to the patients' received care and would aid the nursing staff in the planning and delivery of oral care. The nurses presently use their own assessment skills and nursing experience to decide when a patient requires assisted oral care, the choice of equipment used to provide the oral care and how often oral care is delivered. The rationale for the designing and utilisation of a standard oral health assessment tool is to provide nurses with a means of assessing patients for their oral health and as an aid that would provide a protocol for oral care planning. This would help to identify and reduce the oral complications that illness and hospitalisation can cause. (Evans, 2001) Research to support the implementation of a standard oral health assessment toot shows that some nurses lack the information and skills necessary to assess a patient's oral health. (Adams, 1996) The assessment tool would cover all areas of the oral cavity and would facilitate the observations needed as well as making suggestions for the planning of care.

The hospital this unit is based in has a hierarchical communication network, this means that communications that affect the whole hospital staff are formal and follow standard procedures and protocol (O'Connor, 1995). However, in the practice setting within a specific ward changes can occur providing they conform to overall hospital policies. The elderly care ward in which the author works comprises of a ward manager, various grades of nursing staff, health care assistants, and has input from many other professionals. The proposed change would affect the registered nursing staff who have the required training to access patients, plan care, deliver care, and evaluate care.

The author decided to use Lewin's (1958) change theory, this theory is straightforward and functional (Nicholson, 1998). The first step in Lewin's theory is the unfreezing stage, this involves unfreezing the pattern of behaviour that was currently used. The author would unfreeze the pattern of behaviour and attempt to allay resistance to the change by providing the staff with research articles and information pertaining to the delivery of evidence based oral care. The author would also provide examples of standard oral health assessment tools and invited the staff to an informal meeting to discuss their thoughts concerning the change, and to gauge the preliminary reaction amongst the staff. Prior to the informal staff meeting the author would discuss the change implementation with the ward manager and gain support regarding the benefits of the proposed change. This management collaboration is seen by the author as extremely necessary because it is said that change can only really happen when it has managerial support and a management decision to help implement it (Johnson and Redmond, 1998). The second stage of Lewin's theory involves the actual implementation of the change. The author proposes the use of team building strategies to implement the change, and the utilisation of a suggestion scheme as described by Marchington (1993) to facilitate staff involvement in the designing and choice of the particular oral health assessment tool they would use. One criticism of using this particular method is that not all the suggestions would prove feasible, and therefore there is the possibility of creating disappointment and conflict amongst the staff members whose suggestions would not be used. In line with the second stage of Lewin's theory it would also be necessary to ensure that all the staff were fully conversant with the new method of

oral health assessment, and this would involve staff training sessions. The staff would then be empowered with the skill to use the new assessment tool, however there may be resistance towards holding formal training sessions because of time limitations on a busy, often short staffed ward. In this case the training would then have to be accomplished impromptu, whenever time was available. The third stage of Lewin's (1958) theory would be engaged with the refreezing of the change. An audit of the use of the oral health assessment tools could be done, however, this would probably prove time consuming and expensive. To reinforce the change the staff could be invited to give feedback on how valuable and effective they found the assessment tool and, from the information gathered, the tool could then be modified to better meet their needs, as well as the needs of the patients in their care.

Leadership Skills

To effectively manage change the utilisation of leadership skills is obligatory. There are many skills pertaining to leadership; the aptitude to interact with other people, the capability to recognise other people's needs, the ability to think clearly, the ability to be proactive, and the maturity to handle stressful situations and to seek help when it becomes necessary are just a few (Leigh and Waiters, 1998). The skill of effective listening is also important for leadership, (Rees, 1991) and whilst implementing change it is particularly vital to listen carefully and effectively to the feedback that the staff give, this could be verbal feedback or non verbal feedback such as facial expression and body language. Listening carefully gives a manager or leader an insight and understanding of how the staff may be feeling toward the change implementation. Stressful situations may occur during any of Lewin's (1958) stages of change theory. The ability to handle stress utilising a variety of leadership skills is imperative. An example of the skills that could be utilised at each stage is the ability to recognise the needs and opinions of others and the capacity to think clearly when dealing with problems such as resistance to the change.

In order to achieve the implementation of the assessment tool for oral health, the staff would have to make an effort to endeavour to bring about the change, and this would require motivation. There are four main types of motivation theory that have been developed; these are needs theory, equity theory, reinforcement theory and expectancy theory (Thornely and Lees, 1993). The needs theory works along the principle that people make an effort to achieve goals in order to meet their own personal needs. In the implementation of the proposed change the leader could maximise the idea that nurses need to be delivering good quality evidence-based care in order to fulfil the expectations of the code of professional conduct (Nursing and Midwifery Council, 2002) to which they are obliged to adhere.

The equity theory assumes that people compare their results from their perceived efforts to the results and perceived efforts of others. Staff on the ward may be more motivated towards using the oral health assessment tool if they could see other staff utilising the tool efficiently and if the ensuing patient care was considerably improved. In this situation the manager could take the lead by showing staff the benefits of using the tool in practice, and by praising the staff who do use the tool. The reinforcement theory is based on the assumption that past behaviour and it's subsequent rewards determines the future motivation of a person. This motivation theory would be difficult to use unless a similar change in the past has resulted in a desired recompense. However, the staff members who comply with the proposed change could be rewarded in order to facilitate future use of this theory. The reward would not have to be financial or of any monetary value, it could be in the form of

praise and acknowledgement of good practice. The expectancy theory depicts motivation as the consequence of a person's goals and the expectations of achieving them. This theory is quite complex in comparison to the others and many factors are incorporated, including the relationship between productivity and reward.

Implementation of the change to a standard oral health assessment tool could be met with resistance, and this resistance could be overcome by considering the reasons and actual cause of the refusal to go along with the change. It may be that staff are concerned about the extra time that would be spent using the assessment tool, or the staff may complain about additional paperwork. This sort of resistance could be overcome by even further explanation of the rationale and the research related to oral health, which would reinforce the benefits of making the change. The staff could be gently reminded that oral health assessment and the planned care has to be documented regardless of how the assessment is carried out, and that a tool for such an assessment may even prove to be beneficial towards reducing the paperwork involved. Some of the resistance towards the implementation of the change could be due to lack of understanding concerning the completion of the assessment tool, and in this case further teaching would help to alleviate the objection to it's use. Good communication skills and an attitude that takes into account the needs of others are also important to alleviate discord. (McCalman and Paton, 1992)

Taking the Nursing Staff Through Change

The transformational leadership style is described by Markham (1998) as collaborative, consultative and consensus seeking, and as ascribing power to interpersonal skills and personal contact. Transactional leadership, on the other hand, relies on the power of organisational position and formal authority to reward and punish performance. Research by Rosner (1990) suggests there are gender differences in leadership styles, with women preferring transformational styles of leadership. For the purpose of this article, transformational leadership theory will be used to demonstrate the impact of active leadership on the quality of patient care in a community trust. Kouzes and Posner (1997) identify the key practices in transformational leadership in relation to the role of the follower as enabling others to act.

Enabling others to act required a change in local culture and a change in management style in the Oral Care unit. It took nearly a year to establish effective clinical leadership. New staff were recruited from a variety of backgrounds, based on their integrity and commitment to high-quality individualized patient care. Cultural change was achieved by an open, participative leadership style. Staff were supported and encouraged to challenge practice, and good clinical practice was recognised, rewarded and shared across the unit. The noticeable improvement in staff morale had an immediate impact upon the quality of care. Poor practice was identified and stopped. Unit routine was redesigned with a patient focus. Patients' choice became the norm; negotiated care decisions with patients and relatives became standard practice.
Leaders had to be credible and demonstrate the ability to deliver effective change. This was achieved by working in the unit, directly supporting the senior ward staff and guiding their leadership styles. All staff and leaders shared their insight into their strengths and generously accepted and compensated for each others' weaknesses. Staff were shown a commitment in practical ways:

- Staff on temporary contracts were given permanent contracts.
- A programme of refurbishment and investment in their work environment began.
- Obsolete equipment was replaced.
- Staff training and personal development became a high priority.

Some of the leadership behaviour employed, such as the management of poor performance and sickness, is characteristic of a transactional management style. Performance management meant actively tackling poor performance. Most staff perceived this direct and challenging management style in a positive way. The positive response to performance management was rooted in work motivation and based in justice theories (Arnold *et al* 1995). Justice theory suggests that the greater inequity an individual feels, the greater their dissatisfaction. There was a perception among the staff that some of the decisions were tough, but they were fair. Effective members of the teams were clearly tired of carrying colleagues with a history of poor performance and unmanaged sickness. Expectations of staff, discussed conceptually in a visioning process, were clearly explained in new job descriptions and personal objectives. At that time, the trust's personal development planning process focused on individual personal development. This emphasis was changed to personal development within the context of service development.

Conclusion

To conclude the author has identified the assessment of oral health as the area to be changed and proposes to instigate a standard oral health assessment tool. Rationale for the implementation of the change has been given, along with relevant evidence to support this. The author discussed how the implementation of change could take place using Lewin's (1958) theory, and attention was given to the principles of unfreezing, implementation and refreezing. The theory was related to the chosen change. It has been shown that leadership skills are of great importance in the successful implementation of change and that motivation theories could be utilised to increase the amount of effort from the staff, which in turn makes the change possible. It has been accepted that there may be resistance to change, but suggestions have been made to help alleviate the resistance and promote acceptance and co-operation. Overall the author has deduced that change is always possible but knowledge of change theories and the use of transformational leadership skills would assist with making the change process easier and more efficient. The benefits of using the Transformational leadership approach is the ability to motivate others to pursue high standards and long-term goals. This humanistic approach is defined by an open, empowering culture where communication, strong values and mutual respect are paramount. Transformational leaders concentrate on '...articulating a vision and mission, and creating and maintaining a positive image in the minds of the followers and superiors' (Kouzes and Posner 1987). Transformational leadership is clearly a pivotal factor in optimising team performance in the delivery of care. The leader keeps hope and determination alive by sharing and investing in the team vision. The leader provides purpose and direction for the team while enabling others to act. By developing an intimate knowledge of the team, the leader is able to manage the relationship between motivation and work performance, thus optimising the capacity of the team to deliver high-quality patient care. Leadership requires the unravelling of bureaucracy in the creation of opportunities and achievement of objectives. Finally, effective leadership ensures the team is fit for, and delivers its objectives – in this case, clinically effective, high-quality patient care.

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