ICU MANAGEMENT & PRACTICE

ICU Volume 7 - Issue 2 - Summer 2007 - Management

Change Management: Part 1 – Sources of and Barriers to Change

Author

Ronald Pauldine, *MD*

Assistant Professor,

Department of Anesthesiology and Critical Care Medicine,

Johns Hopkins Bayview Medical Center,

Baltimore, USA

Todd Dorman, *MD, FCCM*

Associate Professor,

Department of Anesthesiology and Critical Care Medicine,

Johns Hopkins University School of Medicine,

Baltimore, USA

Introduction

This is the first of three articles in a series devoted to change management in the Intensive Care Unit (ICU). In this article, we will review a number of areas in ICU management and practice where adaptation and initiating change are likely to have high relevance and importance. We will also examine some of the barriers to successfully implementing change. In the second installment, we will look at the subject of leadership, focusing on the importance of leadership in initiating and maintaining change at all levels of the organization, and provide an overview of leadership theory. That discussion will also cover leadership characteristics mostly associated with success in creating and maintaining change. Leadership factors associated with organizational culture will be explored, as well. In the final installment, we will offer approaches to consider when undertaking the introduction of change in the ICU and provide some practical examples of change management.

Sources of Change in the ICU

The rate of change within healthcare is increasing as the conflicting pressures of consumers, producers and educational interests collide in an arena of limited resources (Bigelow and Arndt, 2000). Change may be viewed by some as an exciting opportunity to advance creative solutions, while others may view change as a negative force with loss of familiar surroundings and procedures, fear of the future and extreme frustration (Wagstaff, 2006). There are many factors that may act as driving forces in necessitating or promoting change globally within the scope of the entire healthcare system and within the specific domain of the intensive care unit. Some of these factors will be internal to the ICU staff, such as solving an identified process problem within the ICU. Some of the factors will be external to the ICU and may come from a variety of sources, including the hospital administration, governmental bodies, payors or regulatory agencies. Change is usually undertaken with a specific, targeted result in mind. These goals vary widely. Examples of strategic goals in the ICU include: improving quality of care, enhancing patient safety, containing costs, promoting patient satisfaction, improving efficiency of care, conforming to governmental requirements and meeting payor requirements for reimbursement.

Change can be classified according to the organizational level where the change initiative is occurring, the type of change being pursued or by the mode of change (Bigelow and Arndt, 2005). The type of change occurs across a continuum ranging from continuous change patterned on those procedures and processes that are already in place to radical and discontinuous change conceptualized by re-engineering. Mode of change refers to mechanisms ranging from determinism based on coercive pressure and imitative patterns to voluntarism driven by the vision and charismatic direction of transformational leadership. Examples of specific kinds of initiatives frequently associated with change in ICU operations include: alterations in the organizational structure of a department, division or entire institution; implementation of practice guidelines; promulgation of evidence-based therapies; and introduction of new technologies, such as information systems (e.g. computerized physician order entry or telemedicine). Additional initiatives may address new requirements for compliance in documentation required by payors including pay-for-performance initiatives, documentation of performance improvement and alterations in staffing patterns imposed by work hour restrictions for trainees. As can be seen from the above list, there is no shortage of factors that may force initiatives directed at changing the status quo in a particular ICU. The difficulty lies in the successful implementation of new ways of conducting business and in sustaining those strategies and processes that are effective after the initial introduction. This difficulty is best underscored by the high failure rate in business,

where success is achieved in as little as 50% of all transformational attempts (Strebel 1996).

Barriers to Change

Barriers to change may result from systems issues within the institution, environmental factors or resistance from individuals at all levels of the organization, including senior leadership, management and staff. Leadership has been identified as a central element in successful change management and will be examined in detail in the next article in this series. Lack of effective leadership, including the ability of leadership to provide a clear vision of what change will accomplish and the effective communication of that vision throughout all layers of the organization, will create a significant barrier to change (Kotter, 1995). Leadership also has the responsibility to provide continued support, in order to maintain the change effort. Roadblocks to change can be an unwelcome result when there is insufficient feedback provided to staff. Feedback should reflect a sense of real progress and success with regard to a specific initiative. This factor is more likely to become important with long-term projects and in situations where performance improvement data are not supplied to staff. Without feedback and encouragement, staff may believe their efforts are not having the desired effects, and they may, therefore, lose motivation. Leadership must also help build a strong consensus of key individuals within the organization to support the change effort.

Failure to identify obstacles, whether they are systems issues or relate to specific personnel, can rapidly undermine initiatives. In these cases, strategies to overcome and eliminate obstacles may be as important as the overall scheme for change. Other traps can be created when there is a failure to appreciate the time required to engage in tasks related to the change initiative and change implementation competes with the ability of staff to perform their required duties. In this instance, the new process is seen by the staff as disruptive and intrusive and is, therefore, unlikely to be followed. Such considerations are often important in implementing new technology, as the learning curve for staff can be steep. For example, ICU staff, finding that tasks take longer initially with a new information system, will naturally wonder why they should change from comfortable systems that seemed to work well in the past. An effective manager will anticipate this attitude and communicate to the staff the necessity and utility of the new process.

Closely linked to leadership is the notion of organizational culture. Organizational culture can be defined as patterned ways of thinking that are characteristic of an organization. This culture is comprised of values, beliefs, assumptions and biases. Within the context of the whole organization, many subcultures may exist (Wilkes et al. 2005). In implementing new processes, culture change is often required to prevent regression to the status quo. Failure to embrace new cultural norms can be an insidious barrier to successful change management; early phases of an initiative may appear to be on track, but as the process matures, momentum may be lost and old culture returns, thereby derailing the new process.

Perhaps the most studied change initiatives in medicine involve the implementation of practice guidelines. Barriers described in implementing guidelines include knowledge deficits, such as lack of awareness that a particular guideline exists, genuine lack of agreement with regard to the evidence, lack of motivation, low expectations that the interventions will translate to a favourable outcome, a tendency of change efforts to focus on the behavior of a single class of providers (i.e. physicians) rather than the entire ICU team and the tendency to direct efforts at people as opposed to the system (Cabana et al. 1999). Failure to consider the specific elements of a new system may result in a system that is unnecessarily complex. Complexity creates barriers by decreasing the likelihood of compliance and increasing the risk of error (Berenholtz and Pronovost, 2003).

In addition to those factors outlined above, other structural, personal and environmental barriers to change have been identified (Bosse et al. 2006). Structural barriers include: failure to provide adequate resources, including facilities, financial support, personnel and time. Personal barriers are related to the issues of knowledge, perception, attitude and motivation previously mentioned. Environmental barriers may result from a resistant culture fueled by political, economical and social factors opposing change. Barriers can be created at the start of a change initiative by failure to prepare the staff for the road ahead. Groundwork needs to be laid that encourages the staff to listen to messages they may not want to hear, question the standard operating procedure, and explore new ways of working (Garvin and Roberto 2005).

We have reviewed a number of factors present in the operations of intensive care units that may result in the introduction of change at various levels of the organization. Barriers to implementing initiatives leading to change in organizations have also been discussed. In the next installment, we will examine the role of leadership in change management and organizational culture.

Published on : Thu, 15 Aug 2013