Leading change with ADKAR

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How can leaders effectively manage the change they've introduced in the workplace? Our Magnet®-recognized academic medical center in New York, N.Y., was faced with transitioning over 1,000 clinicians into a new facility with a change in our care delivery model. This article describes how transformational leadership and an evidence-based change management model were used to guide our staff through the complexity of this transition.

The challenge

On June 24, 2018, our healthcare organization marked the opening of a new 830,000-square-foot, state-of-the-art facility supporting inpatient care units, operating and procedural areas, and a children's hospital. The construction of this new facility provided a pivotal opportunity to rethink our care paradigm. Our organization adopted Acuity Adaptable Care (AAC), an evidence-based model pioneered in the 1970s by Loma Linda University Medical Center in California, that

eliminates the physical transfer of patients to various levels of care, instead bringing the level of care to the patient.[1]

Our plan was to implement the AAC model on three of our adult inpatient units dedicated to the care of surgery, neurosciences, and cardiothoracic patient populations requiring the ICU or an intermediate/step-down (SD) level of care. In the AAC model, patients don't transfer from the ICU to an SD unit and then to an acute care unit before discharge. The patient's acuity may change but his or her physical location doesn't change for ICU and SD levels of care. By eliminating the traditional multitransfer system, the use of this care model can dramatically improve clinical outcomes.[2]

A systematic review found that although few hospitals have adopted the AAC model, those that have saw a reduction in the average length of stay; a rise in patient and staff satisfaction scores; and, most important, a decrease in medication errors, falls, and mortality.[2] Keeping patients with the same team of caregivers as their level of acuity changes minimizes the need for handoffs, which can open the door to potential harmful errors.

In addition to the change in patient acuity, another major impact on the nursing practice environment was the decision to create specialized patient population units, grouping patients with similar diagnoses together regardless of surgical or medical origin. In the new hospital, patients are strategically placed on units with dedicated and skilled nursing staff trained in caring for these specialized patient populations, such as cardiac, neurosciences, transplant, and general surgical services. The thought process behind this decision was that when nurses receive specialized training to care for a dedicated patient population, they have a higher level of knowledge and skills that enables them to better assess patients and identify complications earlier. Supporting this notion, one literature review concluded that clustering stroke patients on a dedicated stroke unit improved the patients' survival after a stroke and decreased the length of their inpatient rehabilitation course, allowing patients to regain their independence compared with those who weren't treated on a specialized care unit.[3]

John Kotter, a noted thought leader in change management, estimates that 70% of change projects fail.[4] However, when an organization can successfully manage change, the overall success of a project increases by six times.[5] Transitioning into a new facility with a new care delivery model was a major change that required detailed planning and the use of an evidence-based change management strategy to ensure successful implementation.

Change management strategy implementation

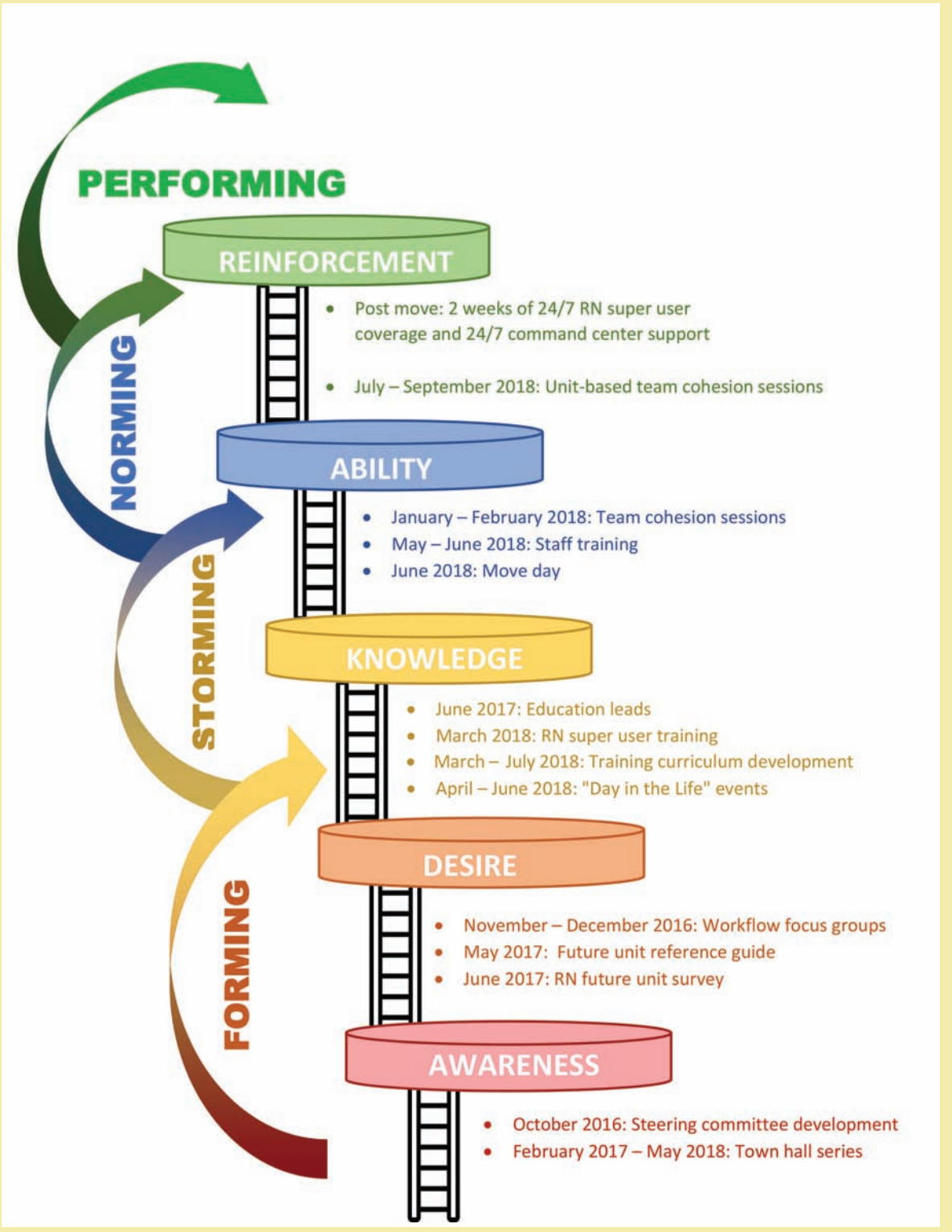
The first step in the development of organizational change capability is implementing a structured methodology for managing change. Prosci's ADKAR model was identified as best meeting our organization's unique needs, providing us with the necessary framework to facilitate such a large-scale transition. The ADKAR model outlines five milestones that an individual, unit, or group must achieve to change successfully: Awareness of the need for change, Desire to support the change, Knowledge of how to change, Ability to demonstrate new skills and behaviors needed for the change, and Reinforcement to sustain the change.[6] (See *Navigating change*.)

This evidence-based change management model has two distinct advantages. First, it creates a clear and simple language for change across all levels. Executives and frontline staff members alike can incorporate the change strategies into their everyday work life. Second, it provides the ability to scale across large and diverse organizations. By creating an understanding around the process of how people change, the approach of the organization also changes. We leveraged these two elements to create our training program, specifically tailored to meet the needs of our multifaceted change implementation.

Awareness

Recognizing the magnitude of change that this transition would have on our staff, we began our planning process 2 years in advance. We established a steering committee comprising nurse leaders and clinical nurses to assist with supporting and leading their peers through the transition. To achieve the AAC model, we needed to form new teams composed of staff members with a mix of experiences in caring for patients with varying acuity and specialized patient populations.

Navigating change



Our goal was to ensure that all our future nursing teams have the tools and competencies needed to appropriately care for patients on the newly formed AAC units. To proactively develop a strategic action plan, we wanted to be aware of the challenges that may lead to bumps in the road. The steering committee's first task was to identify areas that would potentially be the most challenging for our staff during the transition. Several areas of concerns were identified early on.

In the new facility, our nurse managers would have to manage a bigger team in a larger and unfamiliar geographic space. What tools and resources could we provide to prepare them for this? Some of our staff members would be moving to the new building as an intact team, whereas others would be splitting up and joining two or three teams on new units. How could we ease their feelings of anxiety and/or loss so they perform as a cohesive team and adjust to working with new colleagues, potentially under a new nurse manager?

We knew we had a lot to accomplish in a short time period but, before we could get to the forming of new teams or the development of competency and training curricula, we had to make sure our staff members were aware of the changes coming their way and why these changes were important and necessary.

To raise *awareness*, we conducted a series of town halls that provided staff with the latest information surrounding the transition into the new facility. A conscious effort was made to schedule multiple sessions to ensure that all staff members, regardless of shift, had the opportunity to attend. The town hall series began with a short informational presentation, followed by a leadership panel discussion. The Q&A panel allowed leadership to address questions and concerns and dispel misconceptions.

The first town hall was held a year and a half before the move date, with a focus on the space and design of the new building. The second town hall was held 3 months later, focusing on the new staffing framework and the AAC model. The third town hall was held 6 months later and addressed training, competency, and the team cohesion activities we had planned for our staff in the remaining months leading up to the move. The fourth and final town hall was held 1 month before the move date, focusing on the final preparations and logistics that we needed to accomplish to safely transfer close to 200 patients into the new facility. Each town hall had approximately 200 to 300 attendees from multiple patient care services.

Desire

Once we laid the foundation by raising awareness of the need and necessity for change, we began to build the *desire* to change. To achieve this, we provided our nursing staff members with a level of control over their prospective work environment. We held focus groups with clinical nurses to obtain feedback and input as we developed new workflows to accommodate the new care delivery model.

The steering committee also wanted staff members to have the opportunity to take an active role in staffing solutions rather than assigning them to new work areas without their input. Nurse managers were provided with their new unit assignments: either moving as an intact team, staying on their current unit as an intact team, or splitting their staff into two to three teams and moving to a new unit. In areas where new teams needed to be formed to accommodate the AAC model and patient population changes, nursing staff members were presented with the opportunity to provide their future unit preference.

A year before the move, nurses were able to submit their future unit input in order of preference

Navigating large-scale change is a complex process involving multiple stakeholders and detailed planning.

via an electronic survey. Along with the survey, we provided a reference guide that summarized the type of acuity and patient population of each unit, along with a personalized note from the nurse manager of each unit highlighting his or her experience and leadership style. Nurses were then assigned to their future units based on preference, seniority, and staffing needs required to adequately care for our patients.

The survey was sent to close to 400 nurses who were affected by this staffing change. We had an 80% participation rate; of those who participated, 89% received their first choice, 8% received their second choice, and 3% received their third choice. Nurses who may not have received their first choice were then flagged and reconsidered when a vacancy became available on their preferred unit. By move day, almost all nurses who took the survey were placed into the unit of their choice. The feedback received after this unit placement process indicated that nurses felt empowered and appreciated the opportunity to voice their unit preference. Having staff closely involved in planning and decision-making created a desire to participate and support the change.

Knowledge

The next strategy employed in the change management journey was ensuring we provided our staff with the *knowledge* on how to change. Five nurses were selected by their nurse managers 1 year before the move to lead the development of training and competency curricula. These education leads dedicated most of their time to creating lesson plans and developing new workflows and scenarios that would be played out at our "Day in the Life" (DitL) events.

Staff from different service lines and departments came together during three DitL events to role-play and work through mock patient care and workflow scenarios in the new building. During these sessions, staff were given the opportunity to identify any potential workflow issues. A total of 2,634 issues were identified during the three DitL events, and these issues were addressed and resolved in smaller multidisciplinary subcommittees before the opening of the new building. The mock scenarios also offered staff members the ability to work together with their new teams and familiarize themselves with the new environment.

As we worked through the DitL scenarios, the education leads used the lessons learned to create comprehensive training curricula for the "just-in-time" training that all staff would have to complete before move day. This training was tailored to each individual's role and assigned work location. To train approximately 3,000 nursing staff members in a short time period, the nursing department selected a total of 63 RN super users from all the units moving to the new facility to receive additional training 4 months before the move. These RN super users and education leads became the dedicated clinical experts who facilitated the training of all nursing staff members to provide them with the knowledge needed to implement the change.

In preparation for the transition to the AAC model, we collaborated with the nursing education department to refine our critical care curriculum and developed a 6-week classroom and preceptorship-led training program for our clinical nurses. Due to time and resource constraints, only one of our AAC units was able to achieve the AAC model competency training before opening day. The training for the other two units was deferred until after opening day.

Ability

In collaboration with the nurse managers, RN super users, and educational leads, we provided training for our staff using a combination of electronic and hands-on sessions to maximize resource efficiency while ensuring the safety of staff and future patients. For this transition to be successful, it was vital that our staff had the essential resources, competencies, and *ability* to implement the change. We also recognized that beyond technical and competency training, we needed to provide our staff members with another set of tools to enable them to perform as a cohesive team.

We collaborated with our organizational development and learning (ODL) colleagues to design a 90-minute facilitator-led team cohesion program centered around Tuckman's Team Development Model. Thirty-five sessions were held over a 2-month period with 487 participants from multiple departments and

disciplines. Tuckman's model was selected to facilitate the forming of new teams and the development of their identities.

The goals of these sessions were to provide staff members with the ability to adapt to their new environment, tackle upcoming challenges, find solutions, and deliver improved results. According to Tuckman, group formation typically follows four stages of development: forming, storming, norming, and performing.[7] In our team cohesion sessions, staff members worked through the phases of Tuckman's model with members of their newly formed teams.

In the forming stage, team members come together and struggle with uncertainties about their new team's focus, structure, processes, and leadership. To accelerate forming, ODL facilitators provided participants with an 11"x17" predrawn coat of arms. This icebreaker activity encouraged team members to draw and share aspects of their professional and personal lives with everyone in the room.

During the storming stage, team members no longer want to conform, preferring to stand out as unique individuals and challenging one another for recognition. To provide participants with a tool for coping better with *storming*, ODL facilitators presented elements of *Crucial Conversations*, a program aimed at challenging assumptions that can potentially contribute to conflict.[8] The techniques learned during the team cohesion sessions gave staff members a framework for how to use nonthreatening language when raising concerns to others during times of conflict.

When in the norming stage, team formation matures to a point where members become more comfortable with their place in the group. Team members gain a greater understanding of how to function as a unified team, resolving differences when conflicts arise. To best engage participants in this stage, ODL facilitators led norming discussions, guiding the newly created teams through the process of identifying acceptable team behaviors and norms.

In the final stage of performing, the group has a well-developed identity, a strong sense of purpose, defined unit processes, and a solid understanding of member roles and responsibilities. As team members transition into the performing phase, they're able to productively function as a highly efficient team and resolve newly identified issues. We've observed the utilization of the tools learned during the team cohesion sessions in staff members' daily routines, especially during safety huddles.

Recognizing that the completion of team development wouldn't occur until after the move into the new building, our ODL colleagues continued to support the staff before, during, and after the move. After months of planning and preparations, through "just-in-time" training and team cohesion sessions, our staff had the foundation to transition into the new facility. Over 400 staff members and student volunteers assembled to safely transfer 176 patients in under 5 hours into the new building.

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Reinforcement

Once we settled into the new facility, our next focus was to ensure that the changes we implemented were sustainable. Change often fails because resources and support are quickly reallocated to the next project soon after implementation. Keeping this in mind, we continued to provide staff with *reinforcement* of the change through technical, clinical, and team development support. For several weeks after the move, 24/7 RN super user support and a command center were available to troubleshoot issues related to workflows, technology, and facilities.

In the weeks after the transition, we observed that our

staff members were still having some difficulties adjusting to the changes associated with the new building and care delivery model, causing them to waver between the stages of storming and norming. We scheduled weekly meetings with the nurse managers to give them an opportunity to talk through the struggles of their units, share lessons learned, and develop action plans to strengthen their team. A recurring theme found on units with newly formed teams was the lack of team cohesiveness. In response to this, nurse mangers held regular unit-based team cohesion sessions with their staff, utilizing the tools learned to facilitate team development.

Embracing change, driving innovation

Navigating large-scale change is a complex process involving multiple stakeholders and detailed planning. Our change efforts began 2 years before the transition into a new building with a new care delivery model. Including frontline staff in the decision-making process garnered increased engagement, buy-in, and ownership of the change process. Frontline staff members provided feedback that there was a high level of support from nurse leaders, who were visibly working alongside them during this transition. Nurse leaders continue to incorporate the change management principles into their daily routines to ensure the sustainability of the implemented changes.

We've already seen positive outcomes since our move into the new building. Having all single patient rooms and a decrease in the need to transfer patients between the three acuity levels has led to an increase in our patient satisfaction scores. Preliminary Hospital Consumer Assessment of Healthcare Providers and Systems survey scores for our new facility as a whole showed an overall rating increase of 26.8% in the initial month after the move when compared with our old facility. There was also a 23.3% increase in willingness to recommend, an 11.7% increase in communication with physician, and a 29% increase in the hospital environment categories compared with our old facility.

As previously mentioned, competing priorities and resource constraints delayed full implementation of the AAC model on two of our adult ICU/SD units. Six months after the transition into the new facility, our medical center decided to eliminate SD and move toward a two-level care model of acute and ICU. We continue to adopt the AAC model on our neurosciences unit, caring for both acute and ICU patients. We plan to continue monitoring clinical outcomes and staff satisfaction data on this unit to determine if implementation of the AAC model will show similarly positive results as other hospitals that have adopted it.

Through this process, we've learned that change is an ongoing process and can't be achieved overnight. We recognize that the sustainability of change requires continuous reinforcement over time. The ADKAR change management model was a useful tool that guided us through the complexities of a large-scale organizational change. We'll continue to use this framework in our daily operations as we adapt to the rapidly changing healthcare environment, creating a culture that embraces change and drives innovation. NM

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