I have an almost complete disregard of precedent, and a faith in the possibility of something better. It irritates me to be told how things have always been done. I defy the tyranny of precedent. I go for anything new that might improve the past. —Clara Barton

CHAPTER OBJECTIVES

Upon completion of this chapter, the reader will be able to do the following:

- Describe the nature of change and innovation in a complex environment.
- Compare and contrast principles of innovation and performance improvement.
- List techniques to assist in the development of change and innovation competence.
- Define the essential competencies and behaviors for effective change and innovation.
- Enumerate specific strategies to embrace change.
- Develop an understanding of the processes for overcoming obstacles to change and innovation.
- Identify the purpose and essential elements of a contemporary business case for advancing quality using change and innovation principles.

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Chapter

1

Change and Innovation

For this third edition of *Leadership in Nursing Practice*, the authors improved the focus on the leadership of innovation and added a discussion on the differences in leading innovation versus performance improvement in health systems. The ever-present demands and expectations for all healthcare workers to be fast, flexible, and effective now require knowledge of change and innovation as a core competency. Succeeding and making progress can occur only with an evidence-driven and passionate approach to improving the quality of the healthcare experience.

At some point in time, every nurse realizes that there are better ways to provide patient care, better policies to drive patient care, and better ways to organize and lead a patient care area. These new ideas are essential to improving quality and require changes to occur frequently—and often at warp speed. Not surprisingly, the result is sometimes chaos, including both positive and negative events. Improving the processes of patient care to improve outcomes is fundamental to quality patient care and requires skills in change management. What is also important for the clinical leader is to understand the rationale for and intended impact of change proposals and processes. Changes undertaken without a supporting rationale for improvement should be seriously questioned prior to their implementation.

This chapter focuses on the nature of change and innovation, along with strategies to embrace new ideas and overcome obstacles. The role of the clinical leader in understanding the dynamics of change and innovation, as well as developing skills to challenge assumptions of practice, use innovation techniques, and communicate recommendations for improvements are discussed.

Change and innovation are widely used concepts in all sorts of industries, and these terms are often used interchangeably. Numerous descriptions and definitions of both change and innovation exist and further confound the process of gaining clarity between the two concepts. The term *innovation*, rather than *change*, is often used to gain attention and infer that something new and special is happening. One of the reasons there are significant variations in the descriptions of change and innovation can be attributed to the various underlying assumptions about the nature of change.

Many individuals fear change and are reluctant to challenge assumptions and try something different, particularly in the work setting. A smaller number of individuals embrace change as normative and as an opportunity for new and better ways of being. What is important to remember, regardless of one's comfort with change, is that change is ever present and an inevitable attribute of being alive. There is no escaping change—except for death! Thus it makes good and prudent sense to learn as much as one can about the nature of change, including how to embrace it and how to maximize positive changes.

Most individuals and organizations see change and/or innovation as a linear process that can be managed and controlled. This perspective—that is, the view of change as a linear phenomenon—guides the processes and decisions of traditional organizations. With this perspective, it is believed that a change in one area will result in a predictable change in another specific area. It is this linear cause-and-effect assumption that most of our change processes and expectations are built upon.

Project management processes are an example of linear change that focus on predictability, equilibrium, and linear evolution while limiting flexibility, variation, and creativity so as to accomplish the goals of the change project. With this approach, deviations from the plan are viewed negatively, and the next steps focus on elimination of variances. While a linear process is helpful in providing order and structure for change processes, it also places limits on these processes. Linear change does not recognize the multiple, unanticipated human actions and

REFLECTIVE QUESTION

Change can be considered either as a predictable linear process or as a complex, highly interrelated process. Are there advantages inherent in each view? Are there times when one approach is more or less useful? Consider a recent change in which a new policy, process, or protocol was implemented. Was the process linear or complex? Describe the areas of success and the areas identified for improvement.

communications that occur and the dynamic context in which the change is occurring. As a consequence, the linear perspective often becomes rigid, control driven, frustrating, and unsuccessful. While a project may be brought to completion, new issues and challenges emerge quickly. These unanticipated events are often viewed negatively and categorized as project shortcomings when, in fact, such events are normative and are the evolving results of complex human dynamics.

Another perspective from which to view change and innovation relies on complexity science (Fonseca, 2002). Complexity science understands the world as a dynamic phenomenon in which movement is continual and unpredictable. The world is in continual motion, and movement occurs in more than linear ways. A change in one area can result in numerous, unanticipated changes in areas not considered. As one individual or a group of individuals interacts with others, numerous actions occur spontaneously as ideas are shared and information is considered. The movement does not cease with the one interaction; instead, it continues to spread from one individual to another and so on. Interactions in a complexity perspective are characterized by creativity, interdependence, unpredictability, and collective knowledge. Change in the healthcare environment is better understood from a complexity paradigm rather than a linear paradigm, because the nature of change in this setting is seldom linear and controllable and involves and affects many individuals at many times in numerous ways. See **Box 1-1** for some common myths about change.

Dynamics of Change and Innovation

The linear and complexity perspectives of change and innovation reflect two differing dynamics underlying change processes: One is linear, while the other is highly interrelated and unpredictable. Descriptions of change and innovation are presented in **Box 1-2**.

Change has been described as an alteration of the current state. Innovation is defined as a unique type of change in which there is a novel and dramatic change that fundamentally restructures the deep social and economic value of an organization (Davidson, Weberg, Porter-O'Grady, & Malloch, 2016). Change is considered normative in a complex system, whereas it is something to be managed, controlled, and minimized in a linear system.

Innovation Versus Performance Improvement

As discussed, change processes take many forms. In health care, there is a strong attraction to the use of two methodologies, innovation and performance improvement. Clinical leaders should understand the difference between the two to best use the correct tool for the correct change outcome. Innovation and performance improvement serve different purposes but are part of the same dynamic change process.

BOX 1-1 MYTHS ABOUT CHANGE

- Change can be controlled. False. Change can only be facilitated; it cannot be stopped or harnessed.
- Change is painful. False. Not everyone is reluctant or resistant to change. Some individuals readily embrace change as normative and as a way of living to the fullest.
- Change is always chaotic. False. Change can be planned or unplanned. Planned change focuses on facilitating and managing the process to achieve optional outcomes.
- Strategic planning by a leader will decrease the chaos of change. False. Strategic plans serve as general guidelines that cannot by nature include all the possible outcomes.
- The environment does not affect a well-thought-out change process. False. The environment is dynamic and continually changing. Inevitably, changes in the environment, such as the economy, the climate, and political decisions, impact strategic plans.
- Change in a digital environment increases the ability of leaders to control processes and outcomes. False. The digital environment provides capacity for increased processing complexity; it does not identify which of the multiple interrelated interactions will occur, nor does a digital resource identify what will occur in the future.

An organization needs both innovation activities and process improvement activities to survive. Innovation efforts spark new ideas, process, and practices to be introduced into the organization, thus keeping the organization relevant in a changing environment. Performance improvement efforts refine ideas, processes, and practices to optimize them for excellence, thus making the organization more efficient and effective.

If an organization does not have innovation efforts or creates a culture that does not support innovation, then the organization will fail to keep up with changing needs of patients, employees, regulation, and technology. Even if they have a highly functioning improvement department, the organization can only optimize its current work and will eventually become irrelevant without the evolution caused by innovation. Organizations that only focus on innovation will have many new processes, but without the optimization of performance improvement, the process will remain inefficient, chaotic, and suboptimal.

BOX 1-2 CHANGE VERSUS INNOVATION

Change is . . .

- Something new or different.
- To make or become different.
- To alter; to make different; to cause to pass from one state to another, as to change the position, character, or appearance of a thing;.
- To alter by substituting for something else, or by giving up for something else, as to change clothes, occupation, or one's intention.
- to give and take reciprocally with, or to exchange with, as to change places, hats, or money with another.

(*Webster's Dictionary*, 1991)

Innovation is . . .

- Anything that creates new resources, processes, or values or improves a company's existing resources, processes, or values (Christensen, Anthony, & Roth, 2004).
- The power to define the industry; the effort to create purposeful focused changed in an enterprise's economic or social potential (Drucker, 1985).
- The first practical, concrete implementation of an idea done in a way that brings broad-based extrinsic recognition to an individual or organization (Plsek, 1997).
- T slow process of accretion, building small insight upon interesting fact upon tried-and-true process (Dupree & Hessler, 2008).
- T new patterning of our experience of being together, as new meaning emerges from ordinary everyday work conversations; a challenging, exciting process of anticipating with others in the evolution of work (Fonseca, 2002).
- Toing new things that customers ultimately appreciate and value; not only developing new generations of products, service channels, and customer experiences but also conceiving new business processes and models (Cash, Earl, & Morison, 2008).

Clinical leaders should understand the different assumptions that drive innovation versus performance improvement to know what tool will work for the desired change and outcome. Innovation processes are founded on ideation, identifying the outliers, looking outside normal networks, and risk-taking. In essence,

innovation processes look for the odd, the unrefined, and the chaotic patterns and embrace trial and error. On the other side of the dynamic, performance improvement is founded on the reduction of variation, the refinement of processes, the elimination of outliers, and the optimization of known work. Therefore, performance improvement will likely not spark radical change, and innovation may not optimize existing processes. Leaders should reflect on any perceived need for change and determine which processes would be best to achieve the desired outcome.

Understanding Change

As clinical nurse leaders embrace change, it is important to establish a common understanding of what is meant by change and innovation among team members and colleagues. Additionally, leaders and team members should be clear about the intentions of the change through the use of transparent information sharing. Poorly understood and communicated change processes only serve to start the rumor mill and disenfranchise potential innovation adopters. Clinical nurse leaders should work to perfect the communication of the who, how, and why of change. As professionals, it is our obligation to adapt our practice constantly to provide the best evidenced, safest, and relevant care. Resisting rational change conflicts with nursing's professional values and ethics.

Who, Why, When, and How of Change

The dynamics of change and innovation are best understood and advanced when several things are known. These include the key stakeholders of the work to be changed (who), the rationale for the change (why), the content to be changed (what), the timing for the change (when), and the techniques to change effectively (how) (**Figure 1-1**).

Figure 1-1 Change and Changing

Who Should Change?

Most individuals work to get others to change in hopes of improving processes and outcomes; this work is often futile and frustrating. It is nearly impossible to change or motivate others. While change is best accomplished by engagement of others to support the need and rationale for changing, the process always begins with the individual. Significant effort can be expended to create reminders, guidelines, and checklists for others that do little to advance the desired outcome. Indeed, the additional work of completing checklists may become an obstacle to change and decrease the emphasis on the real outcomes desired.

Becoming competent in understanding and thriving in today's rapidly changing world requires awareness of personal change abilities first. Individuals need to understand their personal comfort and competence with change. This understanding can be gained by first undertaking an assessment of strengths specific to the person's ability to identify critical issues for change, overcome obstacles, challenge assumptions, recognize areas for growth, provide meaningful feedback, and be resilient. The goal is for all individuals to clearly understand themselves before attempting to engage with others in advancing change in the areas of knowledge of the change process, personal comfort with change and risk-taking, relationships, conflict, and negotiation skills. When the individual's personal change competence is understood, the next step is to coach others in developing understanding and competence in change and innovation. Most importantly, the change and innovation facilitator must be comfortable with his or her personal limitations and recognize the reality that a person cannot possibly know everything there is to know about any one topic. It is the combined wisdom of the team that creates effective change. Leadership behaviors that support change and innovation emerge from multiple team members working together. There rarely is a case of a lone innovator effectively influencing entire systems. Change is a team sport.

Why Change?

Often the rationale for change is not clearly identified. When there is not a common consensus and rationale for change among the key stakeholders, the work of change can be resisted through avoidance, benign tolerance, or lack of attention. In our complex healthcare world with its limited resources, the rationale for change should be clearly linked to changes that would improve patient care outcomes and the quality of the healthcare experience. Specifically, change should be considered only when patient safety is enhanced, new evidence is available, excellence is advanced, or costs are controlled (Porter-O'Grady, 2014a, 2014b).

Change for Quality Outcomes

Value in health care is measured based on the outcomes achieved, not the volume of services delivered. Process measures, while helpful tactics, do not replace

measurement of outcomes and cost. All too often, changes are made only in selected processes without logical connections to outcomes being identified. Improving processes without fully appreciating how they will change outcomes leads to misguided actions that seldom result in the desired positive change.

For example, the limited success of the national quality movement is a product of the linear process change approach. The focus on processes and completion of checklists has not impacted patient value or outcomes and continues to be problematic. In recognition of this disconnect, efforts have been made to increase the monitoring and documentation of the integration between process changes and outcomes achieved (Colevas & Rempe, 2011). Meanwhile, efforts to tightly link the desired outcomes of providing healthcare information to a patient, documentation of this process, and identifying the impact on patient health status as a result of the information are desperately needed and continue to challenge healthcare leaders. Nurses are encouraged to explore the Patient-Centered Outcomes Research Institute (PCORI) initiative to learn more about the significance of integrating patients' desired health outcomes into plans of care (Barksdale, Newhouse, & Miller, 2014). PCORI provides an evidence-driven foundation from which to determine if change is appropriate. Similarly, evidence-driven recommendations and resources are available from the federal government's Agency for Healthcare Research and Quality, including patient safety indicators appropriate for improving nursing quality (Zrelak et al., 2012). See **Box 1-3**.

As an exercise to explore these connections, consider the accompanying scenario and identify the needed linkages between processes and outcomes.

Change for Evidence

The need to implement new evidence or to meet newly identified needs of patients is driving much of current healthcare change. When there is a gap between current performance and desired performance in a facility or unit, using an evidence-based practice approach is the most logical. In an evidence-based model, patient care interventions are supported by evidence from a variety of sources and by differing strengths of research support. When there is a gap in the available evidence, patient care needs, and desired interventions, an opportunity can be identified for change and innovation to close that gap. Using the principles of evidence-based practice, linkages between clinical practice and scientific standards, the quest for consistency, minimizing idiosyncrasies, and providing a scientific basis for policy construction are the basic reasons for change in health care. Using an evidence-driven model serves to provide focus and organization of change initiatives; evidence-based practice is the platform for nurses' work. **Figure 1-2** illustrates the evidence-based practice process and the emerging gaps that provide a logical impetus for change and innovation (Porter-O'Grady & Malloch, 2010).

BOX 1-3 ONLINE RESOURCES FOR QUALITY EVALUATION

Comparative Effectiveness Research Database: https://www.nlm.nih.gov /hsrinfo/cer.html Agency for Healthcare Research and Quality: www.ahrq.gov

Patient Safety and Quality: An Evidence-Based Handbook for Nurses: www.ahrq.gov/qual/nurseshdbk

Patient-Centered Outcomes Research Institute: www.pcori.org

National Quality Forum: www.qualityforum.org

National Patient Safety Foundation: www.npsf.org

National Institutes of Health: www.nih.gov

National Patient Advocate Foundation: www.npaf.org

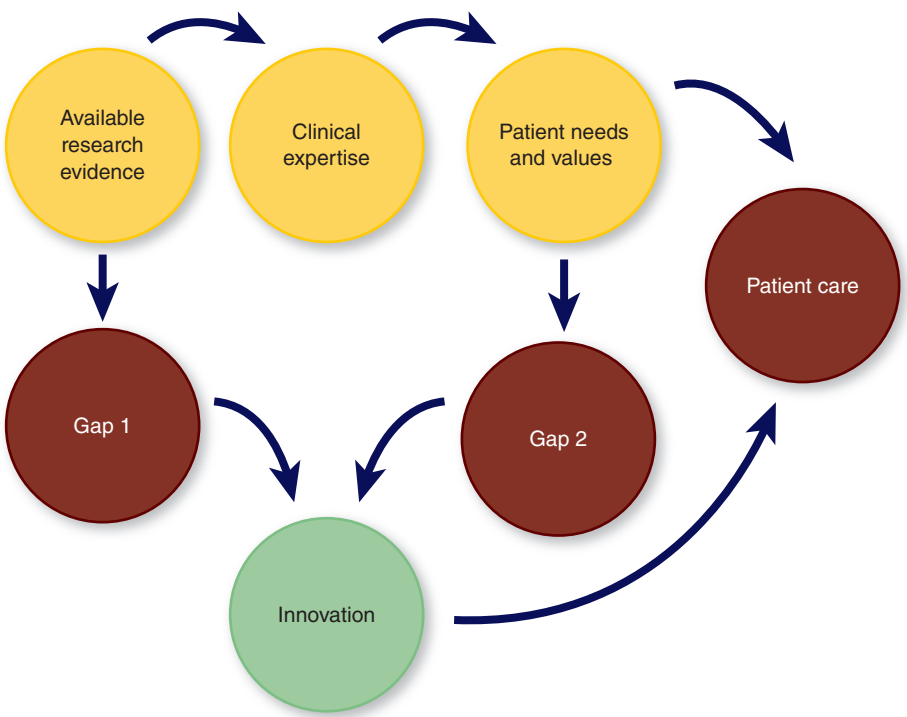

Figure 1-2 Evidence-based Processes and Gaps

SCENARIO

The following five initiatives are identified for all healthcare providers. Consider each initiative and discuss the potential patient outcomes that should occur as a result of the process changes. Discuss strategies to integrate this information into clinical processes to increase engagement of clinicians in monitoring these processes. Discuss alternative strategies to document and measure more meaningful processes to achieve improvements in patient functional health status.

Acute Myocardial Infarction

- Patients are able to take accurate 12-lead ECGs using their smartphones.
- Hospital emergency departments can see ECGs before patients arrive and can mobilize treatment teams faster.
- Primary percutaneous coronary intervention can be received within 90 minutes of the patient's arrival at the hospital.

Heart Failure

- Equip patients with digital scales and blood pressure cuffs that upload data to case managers.
- Remotely monitor patients' weight and blood pressure each week.
- Case managers reach out when vital signs trend toward unsafe ranges and reduce unnecessary admissions and adverse patient outcomes.

Pneumonia

- Assure populations receive Pneumococcal vaccination
- Collect Blood cultures performed in the emergency department prior to initial antibiotic received in the hospital
- Review initial antibiotic selection for community-associated pneumonia in an immunocompetent patient
- Administer Influenza vaccination consistently
- Reduce Healthcare-associated infections
- Ensure Prophylactic antibiotic received within one hour prior to surgical incision

Surgeries

- Surgery teams can use CT scan images converted to 3D models to complete presurgery planning and reduce incision size.

- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The following are nurse sensitive indictors related to HCAHPS scoring of hospitals and health systems:

- Communication with nurses
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Cleanliness and quietness of hospital environment
- Discharge information
- Overall rating of hospital

Source: Data from *Federal Register 76*(9), January 13, 2011.

Additional resource: Center for Disease Control, www.cdc.gov/stltpublichealth/strategy/index.html

Although there are many reasons for change and innovation, there are also reasons *not* to change, such as a lack of compelling evidence, no specific significant risk to patients and employees, isolated issues that are closely linked with individual performance rather than system performance, and indications that an intervention or change is more likely to be a fad of the moment rather than a solution that is closely linked to a probable outcome improvement. It is important to demonstrate courage by resisting the urge to move forward when the change is not appropriate for the conditions and the time.

What to Change

After a rationale for change—such as new information, patient safety, or increasing value—has been clearly established, the what of change can be determined. The what of change begins with the identification of the specific processes and policies that need to be changed, replaced, or created. In addition to specific processes or policies, relational competencies may need to be changed to fully support the transition to new processes. Specifically, individual attitudes toward the change, behaviors to support the change, an understanding of duplicate processes

CRITICAL THOUGHT

Evidence-based practice is the integration of the best research evidence with clinical expertise and clinical values. All innovation builds upon evidence and is rarely an "Aha" moment.

- *Best research evidence* refers to clinically relevant research, often from the basic health and medical sciences, but especially from patient-centered clinical research.
- *Clinical expertise* means the ability to use clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations.
- *Patient values* refers to the unique preferences, concerns, and expectations that each patient brings to a clinical encounter and that must be integrated into clinical decisions if they are to serve the patient.

Source: American Academy of Orthopaedic Surgeons, Evidence-Based Medicine Information, www.aaos.org/Research/. © AAOS. Excerpted with permission.

CRITICAL THOUGHT

- Research is the systematic examination of an idea using rigorous principles of experimentation and measurement.
- **Research utilization** uses knowledge that is typically based on a single study.
- Evidence-based practice applies the relevant research and includes the expertise of the practitioner as well as patient preferences and values.

CRITICAL THOUGHT

Implementing the second-best idea now is a better strategy than doing the best thing a week from now. It is a bigger risk to delay making decisions than to make marginal ones.

that need to be eliminated, and the potential advancement of technology need to be identified as part of the desired change measures. To be sure, it is the changing of relational processes that is the most challenging aspect of this work.

When to Change

Several considerations arise in deciding when to change. When to change is best determined by taking into account the specific unit and system needs and resources. Although it has been said that timing is everything, sometimes the options for when to change are limited by the urgency of the situation. Some skeptics would ask if there is ever a good time to change or innovate.

In the healthcare environment, the pace and number of changes and new ideas for consideration are often overwhelming. Indeed, chaos is normative in health care. Given this fact, it is futile to continuously work to eliminate change or to wish for things to "stand still for just one minute." It is important not to try to eliminate all change and activity, because change is necessary for growth and sustainability of an organization. Most organizations are perpetually in the midst of change processes—new initiatives, new checklists, new electronic documentation systems, and so on. Learning to support staff with differing types of assignments with degrees of change activity provides a life skill useful in both work and personal settings. This change should occur when there is the greatest potential to positively impact outcomes with the desired individuals.

How to Change

Facilitating the change process involves much more than simply identifying what to do and when to do it. That is, facilitating change and innovation requires very specific competencies to fully engage others and advance the identified processes to achieve outcomes. The following competencies are essential for change effectiveness:

- Personal knowledge and accountability for one's own strengths and limitations specific to change and innovation, including technical capability and computer literacy
- Understanding the essence of change and innovation concepts as well as the tools of innovation
- The ability to collaborate and fully engage team members—that is, relational competencies
- Competence in embracing vulnerability and risk-taking

Personal Knowledge

Successful change and innovation agents develop a clear understanding of personal strengths specific to the work of facilitating change and innovation.

Previous experiences, the ability to overcome obstacles, engaging with others to elicit meaningful feedback, and courage and stamina to advance new ideas are all important to this effort. No one can be exceptionally competent in all areas of the change process; rather, the goal is to be comfortable in engaging and empowering team members to contribute their expertise. Thus the clinical leader needs to be comfortable in continuing to forge ahead and confront obstacles while recognizing that he or she cannot go it alone. The work of empowering others is a selfless process in which the work is always the focus and the individual facilitator becomes peripheral to the actual work.

Several assessment tools to identify communication, relationship, and conflict styles are quite useful in increasing personal understanding. For example, the Myers-Briggs (www.myersbriggs.org), DiSC profiles (www.thediscpersonalitytest.com), and Kilmann Conflict assessment tools (www.kilmann.com) are all assessment tools that can supplement self-understanding (Halvorson & Higgins, 2013).

Another important tool is peer-to-peer collegial assessment and coaching. Taking time with trusted colleagues to share feedback about communication, relationships, and conflict styles on a regular basis may, in fact, be more helpful than more formalized assessments.

Asking questions specific to behaviors supportive of change and innovation is vitally important. Examples of such questions include the following:

- Am I open to new ideas?
- Am I able to recognize my own personal limitations and understand that such limitations are reflections of reality and not of personal inadequacy?
- Am I able to clearly identify and share my strengths with others?
- Do I share my wisdom in a kind, caring, and nonthreatening manner?
- Do I trust that the motivations of others are basically goodwilled?

In contrast, asking colleagues questions specific to barriers that might impact one's ability to relate effectively with others can provide further insight into behaviors. Examples of such questions include the following:

- Can you tell me about times when I have displayed an attitude of aloofness or arrogance?
- Are there times when I always need to be right?
- Do I portray serious concern about losing control or that others are more competent than I am?
- Have I expressed fear that others might realize I do not know everything?
- Do my behaviors reflect a belief of personal immunity to anxiety, fatigue, and overwork?

Finally, personal knowledge is about understanding the expectations of a professional. Certain accountabilities, expectations, and contributions are important components of each professional and should continue to emerge throughout one's career. As a change and innovation agent, the professional nurse clearly understands that clinical practice autonomy does not imply independence. Rather, this concept focuses on practicing to the full extent of the nursing scope of practice and licensure in interdependent healthcare teams.

Change and Innovation Knowledge

Specific knowledge about the concepts and theories of change and innovation is an essential tool for those engaged in the change process. For the nursing leader, ensuring one's own understanding of the diversity of descriptions and definitions of change and innovation is helpful in evaluating the understanding of others. Shared understandings of what change is and is not among team members serves to increase consensus and common understanding of the work being done. Finally, an understanding of the course of events in a typical change process further assists leaders in facilitating change (**Figure 1-3**).

BOX 1-4 REFLECTIONS ON PROFESSIONAL NURSING AUTONOMY

- Autonomous practice is a highly evolved clinical attribute.
- Leaders are visible, accessible, and able to communicate effectively with the staff to support decision-making processes.
- Staff leadership is about developing skills of coaching, risk-taking, and challenging the status quo.
- Leaders supporting autonomous practice are knowledgeable, strong, visionary risk takers. Their philosophy is clear and well articulated, and it guides day-to-day activities.
- A participative management style is pervasive, and staff feedback is not just welcomed but expected by leaders in making decisions about the work of patient care.
- Shared governance is a structure and process that embodies the principles of equity, partnership, accountability, and ownership, which are necessary for autonomy to flourish.
- Competent clinicians, with expertise as autonomous professionals, function most effectively in the context of a team of similarly competent professionals.

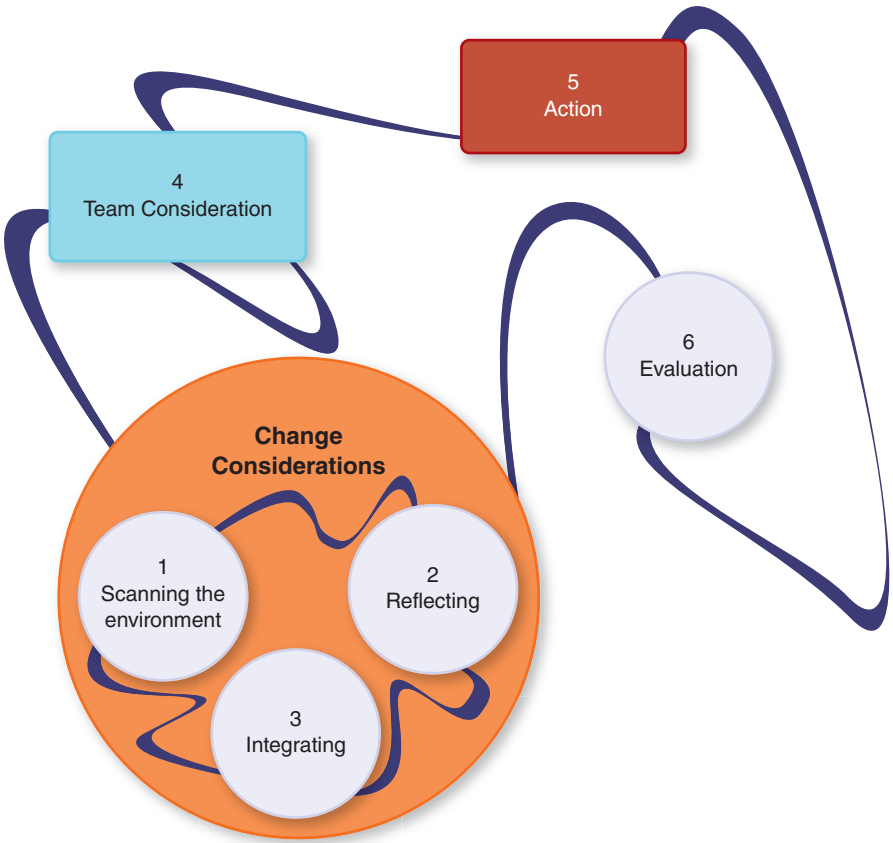

Figure 1-3 The Change Process: Essential Considerations for Effective Change and Innovation

In addition to understanding the concepts of change and innovation, basic knowledge of the tools and techniques that support change and innovation advancement is important. Tools such as **mind mapping**, brainstorming, **directed creativity**, construction of prototypes in innovation spaces, scenario planning, and **deep dive** experiences are helpful in engaging others and increasing the diversity and creativity of dialogue and change effectiveness (Endsley, 2010). See **Box 1-5**.

Collaboration

Working together effectively with wide ranges of diverse individuals is another important competency; it is necessary not only with the initiation and implementation of change but also for sustaining new processes and correcting the organization's course when appropriate. In health care, little change can be successful

BOX 1-5 SELECTED TOOLS TO ADVANCE CHANGE AND INNOVATION

Deep dive: A particular area is selected for observation in multiple ways. Workflows, photos, interviews, and observations are gathered by a team to analyze current processes and brainstorm new ways of doing the current work processes (Kelly, 2005).

Directed creativity: A situation is proposed to encourage and advance new ideas. For example, individuals are presented with the following scenario and are directed to respond: "A new unit is being designed for medical-surgical patients. If there were no limits on space, technology, resources, staff, or financial resources, how would you design the unit for the future in a way to dramatically improve the cost and quality of the healthcare experience?" (Plsek, 1997).

Mind mapping: A software tool for collecting, organizing, and synthesizing large amounts of data in layers with complex relationships. A very useful tool for documenting connectivity, interdependencies, and emerging phenomena in health care.

without the engagement of the interprofessional team. Too often, the upfront work of planning, designing, and implementing occurs with minimal challenges, and the efforts at fully integrating the new processes into the culture and operations become blurred, minimized, or marginalized. In the end, the intended change does not fully occur as planned, nor are the desired outcomes realized. Clinical nurse leaders should build change advisory teams that represent the end user of the change and that can support and challenge one another in the process. A team of blind supporters leads to failed innovation.

With the availability of digital communication, networks of communication have become critical for success (Battilana & Casciaro, 2013). Forming personal networks among colleagues—regardless of those individuals' power or position—reaching out to disconnected groups or individuals, and being close to those who are not fully committed are strategies that, when reinforced using social media, enhance the potential for success in implementing new ideas. It is the process of reaching out to multiple constituencies that increases involvement and enhances the potential for high levels of success and sustainability.

Collaboration among all team members or within a network provides the vehicle to improve numerous processes. The team becomes able to identify processes to be changed, the linkages between new processes and other organizational

processes, the research evidence to support the change, technology to support the change process, anticipated policy changes needed, clear specification of the evaluation criteria, frequency of evaluation, and processes for course correction.

Embracing Vulnerability and Managing Risk

Often, change and innovation processes require individuals to take risks and to challenge long-standing status quo work processes and patterns within a strong culture. Risk-taking has not always been perceived as a positive leadership behavior, nor has it traditionally been welcomed and encouraged. Instead, risk-taking is often viewed negatively and as something that increases the organization's exposure to unforeseen hazards and to loss of net income and reputation. By comparison, playing it safe and being a hard-working employee is the more preferred behavior. The reality is that playing it safe will lead the organization nowhere; it encourages the organization and its employees to live in the past and to continue the practices that have been deemed to work yesterday, while ignoring what will work best in the future.

Taking risks in which the outcome is uncertain requires individuals to be comfortable with the reality that each person is indeed vulnerable; no one can be certain of the outcome when challenging the status quo. Despite the uncertainty and challenges encountered in day-to-day work when one takes risks, vulnerability can be a positive clinical characteristic that is vital for success. Further, the patient safety movement has created a paradoxical situation in health care: Standardization has been identified as a characteristic of high-reliability processes (Weick & Sutcliffe, 2001), yet the need to challenge long-standing processes that may not be as safe as previously believed is also a mandate.

Taking risks is inherent in healthcare work and requires skills to accept one's lack of total knowledge and develop rational risk-taking skills. Just as one uncertain situation is embraced and managed, another one is likely to appear. The feelings of vulnerability that accompany each risk-taking experience need to be recognized and

CALLOUT

Outside of health care, companies like Pixar Animations Studios, Google, and Zappos thrive on continually challenging their processes. In team meetings, individuals are incentivized to challenge assumptions and break apart processes to achieve excellence. Meeting leaders support and facilitate the process by focusing the discussion on the outcome of the change rather than on any one individual's idea. This facilitation helps remove the stigma that criticism is a personal attack and shifts the focus on achieving excellence together.

embraced willingly rather than avoided. Intentionally creating stressors in areas of vulnerability, either personal or organizational, helps build capacity and resilience for healthier functioning. (See Scenario box below.) Taking risks and acknowledging one's vulnerability is not about being irresponsible or incompetent, but rather about recognizing the reality of the ever-evolving and advancing world we live in.

Interestingly, there is no better person than the point-of-care clinical leader to identify opportunities for new ways of providing optimal patient care. The clinical leader understands the patient care need, the context in which the care is being provided, and the situations in which practices work well and do not work well. Thus the clinical leader needs to become an expert at identifying opportunities and engaging in rational risk-taking as a means to advance knowledge in the system.

Rational risk-taking is about taking risks for the right reason. Rational risk-taking is more than thrill seeking and experience enhancing; it is focused on and consistent with the organization's goals, values, and resources as well as consideration of others involved. This kind of risk-taking can be organized into four categories: advancing the organization, developing skills, mandatory reporting, and whistle-blowing.

Advancing the organization, the first category of rational risk-taking, is about learning to thrive and survive in the organization. Challenges in providing

SCENARIO

Trust infers that one individual is vulnerable to the actions of another. The greater the trust, the stronger the expectations are that individuals will consider others' intentions and actions based on established roles, relationships, experiences, and interdependencies.

Trust is one individual's willingness to be vulnerable to another based on the belief that the other person is competent, open, concerned, and reliable, thus rendering risk-taking more rational and realistic.

Discussion Questions

1. In a small group, discuss the level of trust among your work colleagues. Consider these topics: belief in others' promises, trust in the knowledge and data shared, and how you know when trust is lost.
2. Is there a relationship in which you can identify the behaviors that support trust and those that decrease trust levels?
3. How can you apply this information to your work team?

patient care, as well as the external introduction of new ideas, need to be considered carefully and regularly. New clinical interventions, new programs, expansion of existing services, selection of equipment, and prioritization (what comes first) are common challenges. Choices that are rational and minimize risk are those that are made on the basis of the organization's core values, respect for others, the safety of individuals, strategic goals, and available resources. The risk in proposing new ideas and challenges is that the new ideas might be rejected or dismissed. Learning to thoughtfully propose new ideas with a well-developed rationale at the right time is a basic requirement for all nurses.

Developing skills is the second rational risk-taking category. Regardless of their current competence levels, all individuals need to learn new skills to continue to be effective in the ever-changing healthcare environment. Acquiring new knowledge and skills that are rational includes learning skills specific to the job role and developing personal preferences to support the role in the most robust way. Considerations should be given to enhancing physical capability, computer skills, public speaking expertise, athletics, art, and personal protection skills. Each of these areas extends the competence and value of the individual caregiver and leader. The risk in developing new skills is that one might not be successful on the first attempt. Persistence, however, is the lifeblood of progress.

Developing teamwork expertise is vital in times of high risk and uncertainty. The greater the teamwork and support for creativity, the more new ideas that will emerge—and such ideas are ultimately the only way to accomplish this challenging and uncertain work. In addition, teamwork competence can be developed by reaching out beyond one's normal network of colleagues to others with related skills. Developing relationships beyond traditional healthcare disciplines can provide new insights and greater depth of understanding. High-functioning team collaboration also includes well-developed professional autonomy and interdependence to maximize each discipline's contribution to patient care.

The third category of rational risk-taking is mandatory reporting. Many state licensing agencies require licensees to report the unprofessional conduct of other licensees to the licensing board. The goal is to protect the public from licensees who commit repeated errors, who abuse alcohol or drug substances, or who are incompetent to do the entrusted work. Proponents of mandatory reporting believe other similarly licensed professionals are best able to identify such issues and, therefore, must speak up to protect the patient and the profession. According to most state statutes, it is not an option whether to speak up; in fact, failing to report known behaviors is itself considered an act of unprofessional conduct. Other examples of unprofessional conduct include repeated medication errors, boundary violations with patients, and theft from patients.

CRITICAL THOUGHT

Job security is truly a myth. No job is ever guaranteed forever—or even for the next month! Jobs are eliminated because of downsizing, the need for new skills, new locations, and different delivery model structures.

The workplace environment changes frequently, owing to new leaders, new colleagues, new work, and other developments. The goal for every individual is to always be employable—to always have the skills that are needed in the current and future environment.

Being employed is shortsighted; being employable is futuristic!

The fourth category of rational risk-taking is whistle-blowing. Whistle-blowing is about righting a wrong—a wrong that is believed to be dishonest and that has resulted in the mistreatment of others. The need for whistle-blower protection arises when the culture of the organization does not support open communication, honesty, differing opinions, and fairness. When individuals believe that they have not been heard on an issue and that the public interest is compromised, the federal False Claims Act provides a mechanism to report fraud and corruption while protecting those who expose information from wrongful dismissal and loss of security and benefits. Seeking the protection of this whistle-blower legislation is considered a rational and necessary risk and involves personal and professional risk, regardless of the outcome.

Embracing rational risks requires knowledge, skill, and engagement with the team to best support new ideas and changes. In contrast, avoiding irrational risks—also a learned skill—requires an understanding of the nature of irrational risks. Four categories of irrational risk are discussed in the next section: a history of failure and oppression, poor judgment, unrealistic expectations, and lack of potential benefit for the action.

When there is a history of failed efforts, it is not prudent to attempt the same change unless new energy, new approaches, or new technology is available that would increase the potential for improvement and success. Often, education programs are provided to increase knowledge or compliance with desired practices, yet little improvement occurs. Continuing the same actions is futile without further examination of the situation and consideration of other options. Repeated notices, alerts, and education sessions to complete checklists, for example, are all poor uses of time and energy. Instead, the organization would be better served by exploring the reasons underlying the low compliance rates.

Poor judgment seems to be an obvious, irrational risk; however, it needs to be explicitly recognized. Consider the example of walking out into traffic. The risk of

injury to both the pedestrian and those driving is present and probable. This type of irrational risk is similar to the leader who hires individuals without adequate depth and competence for hard-to-fill positions. It is only a matter of time until the inadequate job performance negatively impacts quality and productivity. As a result, the organization incurs additional cost and risk. When facing the challenge of a hard-to-fill position, the clinical leader must instead challenge the assumptions of that position and brainstorm other ways to consider the rational risk approach; he or she must assume some level of risk to advance the organization by creating a new role or developing another person's skills to meet the hard-to-fill position. This irrational approach further complicates a situation that is already overly complex and high risk.

Another irrational risk occurs when unrealistic expectations are embraced as the way to do business. Often, there is little potential for success when an organization attempts to implement "just one more" program or initiative in an environment in which staff are already overwhelmed. It is irrational to believe that such endeavors will be successful, even marginally.

When there is no known benefit from an action, the work can be considered an irrational risk of resources. Examples include planning education programs for which there is no audience, establishing committees for individual attendance when the work can be done electronically, and disciplining employees for outcomes over which they have no control.

In addition to rational and irrational risks, individuals often insert irrational negative fantasies into the discussion and decision-making processes for change and innovation. These negative fantasies can paralyze or hamper individuals from taking action. The irrational fears seem very real to some individuals, however, so they need to be challenged. Consider these comments and fill in the blanks:

- My dad will kill me if . . .
- I'll get fired if I say something . . .
- No one will like me if . . .
- The nurses will quit if . . .

Perhaps the most common negative fantasy in health care is the perception that one will be fired for taking risks and speaking up. Individuals worry that speaking up will have a negative impact on their reputation, their ability to communicate openly and honestly with others, and, ultimately, the security of their position. The reality is that individuals are seldom involuntarily removed from their jobs for speaking up and taking risks (see **Box 1-6**). Involuntary termination is more about incompetence, substance abuse, poor attendance, dishonesty—and *not* speaking up! Identifying and confronting negative fantasies can decrease barriers and resistance to change and innovation. See **Box 1-7**.

BOX 1-6 TAKING RISKS: TRUE AN FALSE

The more risks you take, the more secure your job is.

- This is true if with every risk, you are growing professionally and learning information that is helpful to both yourself and the organization.
- In an organization supportive of creativity and growth, this is certainly true. In a risk-averse organization, this is probably false.

The more risks you take, the greater the probability of being fired.

- This is true if taking risks compromises the organization's financial status and reputation when new approaches do not work.
- This is true in risk-averse organizations and false when rational risks are taken and the organization is supportive.

The more risks you take, the better the organization will be.

- This is true when each new attempt supports a culture dedicated to finding new and better ways to accomplish the work and more efficient ways of doing business that will increase the profitability and sustainability of the organization.
- This is false when risk-taking overshadows the ability of the organization to accomplish the work at hand. There is a need for balance between operations and stretching the limits of current processes.

BOX 1-7 CHECKLIST: DECREASING FEAR, INCREASING TRUST, AND UPWARD COMMUNICATION

- Have the right people been involved in making decisions? If not, identify who should be involved and why. Avoid the temptation to complain and mumble, "If they only had asked me."
- Are the goals and values of the organization being respected? If a decision does not seem consistent with the goals and values, take two actions. First, identify what specifically is not consistent with which value. Second, identify what you would like to see done to improve congruence with values.

(continues)

(continued)

- Do not get lost in the process. If something is not working, then give it up—even if it means retreating and regrouping. Identify the fact that the work has drifted off course and a course correction is needed. It is too easy to lose sight of the original goal.
- Identify when work-arounds are created that avoid the real issue. New policies that add to all employees' workloads are often developed in response to isolated, aberrant behaviors. Challenge leaders to address the issue rather than creating another policy.
- When decisions are made on biased or impartial information, offer the additional information. Offer the information not to one-up another person, but for the purpose of achieving the best decision with all of the information.

Strategies to Minimize Risk in Change and Innovation Scenarios

Speak Up

The first strategy to minimize risk is to speak up with evidence or a rationale for action. The best safeguard to avoiding poor outcomes is using data, evidence, and a rationale. When there are significant variations in practice patterns, multiple opinions about the best solution, and little use of technology to validate the assumptions, focused communication is needed to determine the supporting evidence based on standards, experience, and values. To be sure, it is these conditions of uncertainty that precipitate evidence-based practice initiatives, thereby reducing the risks involved in attempting new strategies.

Timing and Tinkering

The second strategy is timing. As previously noted in the section on when to change or innovate, timing is always an important consideration. Not every risk needs to be or must be addressed immediately; sometimes waiting is the prudent approach. Levels of workload, the availability of key participants, and the overall climate of the organization need to be considered prior to taking risks. Classical leadership behavior encompasses strategic planning and the purposeful review of ideas. With the recent advances in information technology, however, these processes are becoming increasingly ineffective and outdated. The emphasis now

includes short-term, incremental strategies that are similar to the concept of tinkering, introduced by Abramson (2000).

When this approach is embraced, tinkering becomes the expectation, the status quo—team members seriously challenge assumptions and ask questions, not out of idle curiosity but rather by looking carefully at current dogma and raising issues that open the door to substantial improvements. The values of tinkering include the following:

- It provides an opportunity to learn how to take risks.
- A little tinkering and a lot of team member experience allow a small group to make changes with big goals in mind and to evaluate the change efficiently.
- Team members' skills are stretched with little risk to the organization; support for constant tinkering minimizes the chance that the organization will drift into inertia. Rational risk becomes the norm, change is internalized as essential for survival, and employees benefit from new experiences and develop new skills.

Encourage Upward Communication

The third strategy to minimize the risk of change and innovation is about focused communication—that is, communication that gains the attention and support of decision makers. Top-down communication remains the most common type of communication in organizations today. By comparison, cultures with shared leadership structures reinforce and support vertical, horizontal, and multidirectional communication more effectively than traditional organizations; however, the need for upward communication remains a great need in organizations. Greater emphasis is needed to assure upward communication so leaders know what is going on in the organization and are able to support the best decisions.

The first step is to realize that leaders cannot and do not know everything; the second step is to learn to share the appropriate information—information that impacts the operations and reputation of the organization. Knowing which information to share and when to share it is a skill that evolves with experience and commitment to core values. Teams function based on the information they have available. The strongest tool a clinical nurse leader has is the way they gather, interpret, and craft the message related to information. This information flow can influence in powerful ways and begin to shift organizational culture.

Accelerate Personal Competence

The fourth strategy is to increase one's competence quickly as new equipment, technology, and processes become available. The more an individual can learn

CRITICAL THOUGHT

- Recognize that mistakes happen!
- Right the wrong as quickly as possible.
- Be sincere and apologize when appropriate.
- Use humor only when appropriate.
- Admit you were wrong—avoid the silent treatment.
- Do not try to rationalize and blame it on someone else.
- Say you are sorry when you are.
- Shake hands and make up!

about new approaches, the more competent that person is not only to evaluate the innovations, but also to determine if the new approach is right for the organization. Further, this approach reinforces evidence-based principles as the supportive rationale for change. Assuming a posture of risk avoidance and waiting for others to test and critique new approaches decreases the individual's ability to support an organization that stays on the cutting edge and is able to integrate processes and equipment into the work of patient care.

Further, competence can be developed by reaching out beyond the normal network of colleagues (boundary spanning) to others with related skills. Developing relationships beyond traditional healthcare disciplines can provide new insights and greater depth of understanding. Embracing environmental psychologists and human factors experts to assist in team collaboration and communication, for example, can greatly enrich work processes. Florists, musicians, and potters also give new meaning and understanding to the work of healing—and they serve to sustain the focus on healing and avoid the tendency to focus only on technology or publications.

Apologize with a Flair

The fifth strategy to minimize risk is to apologize quickly and appropriately when an error or misstep is recognized. Resiliency is the key. No patient ever expects to be harmed while under the care of a healer; further, no healer ever expects to harm a patient. Yet, unexpected events and deviations encountered in the provision of care do occur and injuries result. All healers will make mistakes, no matter how competent they are. The responsibility accepted by healers is indeed awesome, because patients entrust their care to them and give these caregivers enormous power and authority. It takes considerable spiritual and emotional

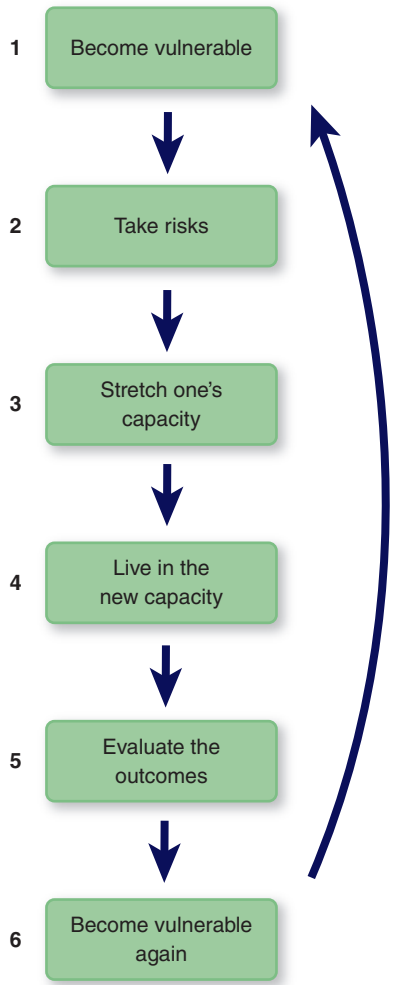

Figure 1-4 The Risk-taking Cycle

maturity to accept patient trust, understand that mistakes happen, and modify conditions when needed.

When a misstep occurs, leaders must be resilient and able to regroup and move on. Recognizing negative situations and acknowledging them with others can be therapeutic. Discussions of unsuccessful events provide an open forum in which to consider strategies to avoid similar situations in the future. It is far better to acknowledge the misstep than to ruminate endlessly. This approach avoids leaving others to wonder about the healthcare provider's competence and assists in putting everyone back on the right path (**Figure 1-4**).

Making Change and Innovation Happen

With a solid foundation in the dynamics of change and innovation, risks, and risk minimization strategies, the clinical leader is well positioned to move forward. Risk-disposed leaders develop a very high level of self-discipline that allows the processes of change and innovation to evolve. A strong sense of commitment can be more valuable than intelligence, education, luck, or talent. Clinical leaders who are adept at taking risks neither surrender nor overreact to crises or marginally successful efforts; instead, they regroup and return. They take stock of the situation, often pulling back temporarily (but not too long) while they plan their next steps. They realize that sometimes it is best to put aside personal feelings and let bygones be bygones. Finally, they focus on the present and the future, both of which offer perils and possibilities, rather than on the past, about which nothing can be done.

In the complex healthcare world, it is impossible to escape the reality of risk and the associated feelings of vulnerability. The goal for all clinicians is to examine each situation and embrace those risks that are rational and avoid or at least minimize risks that are believed to be irrational. This course of events usually begins with recognizing that one is vulnerable and then recognizes rational risks as a means to stretch one's capacity and ultimately move the work of the organization to greater quality and excellence.

Clinical leaders need to focus across the longer continuum of the change process using reflection, accountability measures, and persistence to ensure full engagement of the change. The "Change Considerations: Scanning, Reflecting, and Integrating" appendix provides specific interventions for the assessment, reflection, and integration phases of the change process. Each phase is discussed in the next section. The change process includes three major phases: assessment of the conditions, reflection with the team specific to the needed work to occur, and integration of information into a plan.

Assessment

Assessment and scanning the environment to determine current practice requires a level of consciousness that allows the leader to take in as much about the environment as possible. Data from multiple sources are involved in the activities of assessment. First and foremost, the leader must become skilled in sensing the environment, listening, and learning from the current activity. *Stilling one's mind* to be open to what is going on in the environment is essential in this process and requires discipline, practice, and commitment. To be sure, there is no template or format in which environmental scanning should occur. Each situation requires

different considerations identified by the individual who best knows the organization and situation. The individual scans and assesses the environment based on previous experiences, knowledge of the current environment, and desired outcomes.

Team Reflection

The second phase is discussion with the key stakeholders about the change and innovation work. To begin the discussions, it is important to have the right individuals in the group. Team members should carefully reflect to be sure the needed stakeholders are present so the work can progress. It is equally important to exclude participants who do not add value to the processes of change and innovation.

After the environment is assessed, team members further consider past experiences, the potential impact on current events, and work to avoid negative experiences. Consideration is given to how individuals will react in new circumstances—positively or negatively. This understanding serves as critical background information in moving forward.

Integration of Ideas into a Plan

The third phase is to integrate the critical information learned in the assessment and reflection processes. The process of integration entails the assimilation of the data collected during the assessment and reflection phases—that is, all of the relevant research, values, perceptions, experiences, intuition, and the political, technological, economic, and social data. The ever-present challenge of this phase is developing skill in selecting which data to include and which data to exclude to affect the best decision. Out of necessity, effective integration is not an activity carried out by a single person; rather, full integration of work and efforts of all members of the group is required. To be sure, the preparation for change and innovation is as important as the actual work.

Integrating the data into a business plan template also provides guidance in building and documenting the rationale, plan, and expected outcomes for a change and innovation project.

REFLECTIVE QUESTION

Dare to move to a virtual world. How does one enmesh oneself in the world of technology and still retain the human touch? Moving aggressively to greater levels of technology is about advancing into uncharted territory.

Caveat: Technology, Change, and the Human Element

Much of the change in health care today involves the addition of new devices, software applications, and communication enhancements to advance the patient care experience. Clinical leaders should regularly ask what value these new technologies provide in improving patient care outcomes; in other words, they should recognize that the technology does not drive the work but rather supports the human work. Bell (2010) reminds us that when everything is digitized and connected, there can be neither stability nor genuine innovation. In particular, decisions still need to be made by humans rather than completely relegated to computer applications. The computer generates the data, and the clinical leader interprets the data within the specific patient care context.

Caveat: Measuring the Impact of Change and Innovation (What Problem Are You Fixing?)

In a world of scarce resources, the goal is to utilize resources appropriately with the expectation of success of the desired plan. In spite of the best projections and anticipated risks and benefits, precise and accurate projections of the costs of change and innovation projects are usually estimations —albeit estimates that must be constructed as carefully as possible. Creating a business case for innovation can be most helpful in identifying the many variables involved and many of the associated costs. A business case for change and innovation should become a standard practice when resources, efforts, and expertise will be expended (see **Box 1-8**). Clear and accurate business cases also provide essential information in prioritizing processes for change.

Another consideration is the challenge of benchmarking innovation work (see **Box 1-9**). Phillips (2011) identified the practice from the late 1980s through the 1990s of benchmarking against industry standards as an indication of performance compared to other companies. Interestingly, the relevance, value, and benefit of benchmarking were not determined. Benchmarking of innovation methods and processes across the industry may provide insights into practices, as well as differences in practices, which are equally important. Benchmarking of specific metrics does not provide similar value and direction.

Benchmarking innovations with other organizations is difficult for several reasons. The first reason is that innovation is closely tied to strategy and vision, which vary widely across organizations and make them difficult to compare. A second reason is that the time period over which the innovations were

BOX 1-8 BUSINESS CASE FOR INNOVATION: ESSENTIAL CONSIDERATIONS

1. Clear description of the product or service—work to be done
2. Purpose of the product or service—the goal to be accomplished
3. Projection of costs to begin and manage the project, including staff, equipment, and supplies
4. A list of costs not included and rationale for not including them
5. Estimation of benefits and evidence for the anticipated benefits
6. Timeline for development and launching of the project
7. Anticipated profit or loss for the first two years
8. Other qualitative benefits anticipated, such as community benefit, reputation, and satisfaction of staff and patients
9. Anticipated risks involved and plans to mediate the risks
10. Summary statement of short-term and long-term value to all stakeholders

Source: Adapted from Malloch (2010).

BOX 1-9 GUIDELINES FOR SELECTION OF INNOVATION METRICS

- Select metrics to assess innovation progress and costs in advance. Incremental benchmarks are especially important to track and trend progress. Different sets of funding, testing, and performance criteria for incremental, experimental, and potentially disruptive innovations are needed.
- Aim to identify early successes. Major initiatives often require significant time to realize the full benefits. Interim achievements are necessary to demonstrate progress and the likelihood of achieving the full potential of the innovation.
- Get data to back up your gut. Successful innovators begin with the gut feeling but then move quickly to develop the quantifiable, supporting data.

implemented can vary widely, from 90 days to several years. The third reason is specific to the assumptions about the customer or patient. The varying approaches to the driving force behind the innovation—namely, the company, the customer, or

SCENARIO

Often individuals state they are supportive and want to participate in change or changing; in the end, however, the change does not happen. Consider the following underlying assumptions documented by Kegan and Lahey (2001):

- Stated commitment: I want to be a team player.
- I am struggling with making this happen because I don't collaborate enough. I make unilateral decisions too often, and I really don't take people's ideas and input into account.
- Competing commitment: I am committed to being the one who gets the credit and to avoiding the frustration or conflict that comes with collaboration.
- Big underlying assumption: I assume that no one will appreciate me if I am not seen as the source of success; I assume nothing good will come of my being frustrated or in conflict.

Discussion Questions

1. Using your understanding of change and innovation, the process and dynamics, the strategies to manage resistance, and the tools of innovation, how could you and your team address this type of resistance?

2. More importantly, how could the team be proactive in minimizing the chance for this resistance in the planning phase?

the patient—provide different perspectives on consumer research and how it is integrated into the innovation work. Some believe that current customers or patients are not able to envision a radically new and better future; thus the practice of asking them to participate in the innovation process varies from organization to organization.

Managing Resistance to Change

In spite of the best preparation and planning, resistance to change and innovation occurs. In addition, the results of the anticipated change may not be optimal.

Resistance to change occurs in many formats, ranging from outspoken, verbal reactions to subtle, nonverbal, indirect avoidance of the issue. In general, individuals resist change when they perceive a threat to their safety and security or

LEADER TIP

Bringing resistors into the change process will help you understand differing viewpoints and may lead to further innovation. Leaders should know that bringing the resistant voice into the process can also derail the project if left unchecked, and leaders should plan to highly facilitate the meeting.

position. The culture of an organization or the leadership style can also impede change and innovation (Schein, 2004). Likewise, competing commitments have been identified as a source of resistance. Individuals may want to change, but other deep-seated factors may become barriers to change.

Understanding change theory can help leaders use the resistance to change as a support tool rather than a barrier. The diffusion of innovation model has been used thousands of times to study how change occurs in groups (Rogers, 2003). In any population there will be roughly 18% of people that will resist change while 82% of the population will adopt the change. Novice change leaders spend the majority of their energy and time trying to engage the 18% instead of creating a critical mass within the 82% that will eventually adopt the change. Resistance is also a point of information for the clinical leader. Resistance signals that there is disruption to the normal operating patterns of the team or organization. Not all resistance is negative. Clinical leaders should embrace the resistance, explore it, confront it, and engage it to learn how to improve the idea or process.

Course Correction

It is traditional to assign the label "failure" to those change and innovation projects that did not result in favorable outcomes. A new perspective that recognizes and values the information gained from such less-than-successful attempts is needed in health care. Embracing these situations as courageous acts that provide new insight and opportunities for further dialogue is congruent with cultures of excellence. When the less-than-optimal results are identified, the next step focuses on course correction and new attempts. The new knowledge gained from the unsuccessful effort is critical to continuing success; this information serves to inform others of a course of action that should not be repeated.

Documenting this information is essential in advancing change. Further, it is important to avoid individual employee sanctions when the outcomes involve the team and the supporting system. Punishing individuals for outcomes that involved many factors and many individuals is futile and demoralizing. Such

punishment also discourages individuals from future risk-taking that could be of great benefit to the organization.

When there is an individual action of concern, remediation is the preferred option. Specifically, remediation is preferred when the potential risk of physical, emotional, or financial harm caused by the incident is low; the event is a singular event with no prior pattern of poor practice; and the individual exhibits a conscientious approach to, and accountability for, his or her practice and now appears to have the knowledge and skill to practice safely. Punitive actions are reserved for matters of last resort. These actions should be considered only when an individual has repeatedly disregarded advice and directions to modify actions, previous remediation attempts have failed, and there is evidence of incompetence that cannot be rectified.

SCENARIO

When the result is less than optimal, consider the following steps:

- Acknowledge the outcome.
- Correct negative outcomes quickly; ensure personal safety.
- Apologize to those affected by the outcome.
- Review the goal and the selected processes, and identify areas of vulnerability.
- Be sure the goals and work are still the right thing to do.
- Modify the processes to avoid further negative outcomes.
- Never be reluctant to abandon the goal if safe and effective processes cannot be determined.

Consider the scenario in which the goal is for all departments in an organization to use the SBAR (situation, background, action, recommendation) handoff method for lunch relief and shift change. Several departments, housekeeping, pharmacy, and behavioral health units are now refusing to use the SBAR process because they believe it is cumbersome and not helpful; omissions are still occurring and staff are dissatisfied.

Discussion Question

1. Which additional information do you need to determine if the SBAR should be continued or discontinued in these areas?

Leading and Managing

Clinical leaders need to be able to discern innovations that add value to the work and innovations that serve as obstacles to the work. Creating more work to streamline processes that ultimately decrease productivity and the timely achievement of quality outcomes is not a rational approach.

In times of high risk and uncertainty, the goal is to focus on effective communication through highly skilled teamwork. The greater the teamwork and the support for creativity, the more likely that new ideas will emerge as the only way to accomplish this challenging and uncertain work. Encouraging all members of the organization to share and develop their leadership skills requires passion and engagement in the richness of the collective decision-making process.

Looking to the future to support change and innovation requires a clinical leader mind-set that includes a strong personal awareness of one's strengths and vulnerability, openness to other ideas, courage to challenge the status quo, and a highly developed comfort with rational risk-taking. Innovation leadership is associated with the following characteristics:

- Self-aware
- Courageous, hopeful

CRITICAL THOUGHT

Innovation leadership is not about being an inventor; it is not about a specific leadership role. Instead, it is about envisioning a better future using the following behaviors:

- Looking outside one's immediate network (boundary spanning)
- Having the courage to challenge the status quo (risk-taking)
- Looking for resources in different places (leveraging opportunity)
- Facilitating and empowering others to be as creative as they can be (facilitation)
- Thoughtfully communicating information (coordinating information flow)
- Adapting one's work and behaviors to meet emerging needs (adaptation)
- Seeing a better future (visioning)

Source: Adapted from Weberg (2016)

SCENARIO

A whistle-blower reported a nurse colleague for unethical practices. Another whistle-blower—a physician in the Veterans Administration system—reported administrators for unsafe patient care practices.

Discussion Questions

1. How do these actions qualify as rational risk?
2. Which information should be gleaned from these cases for other nurses?

- Proactive, future oriented
- Inquisitive
- Optimistic
- Able to experiment, course correct, remediate

In contrast, management characteristics include the following:

- Focused on sustaining and strengthening the present
- Reactive
- Proof driven
- Discipline/root cause focused; blame placing

Innovation leadership behaviors at the point of service are more important now than ever before as new ideas are introduced frequently and the demands for higher quality are emphasized. Shifting from a universal focus on sustaining current practices and being proof driven before attempting new processes that support change and innovation will necessarily require time, persistence, and a different way of thinking.

The clinical leader at the point of care must necessarily continue to look for new role opportunities, improvements in decision-making structures, management of the physical space for patient care, potential partnerships, and equipment and technology needs to support the continual advancement of patient care excellence—and, of course, enjoy this very special journey of advancing healthcare excellence.

CHAPTER TEST QUESTIONS

Licensure exam categories: management of care: performance improvement, quality improvement, concepts of management

Nurse leader exam categories: leadership: systems thinking, change management; patient safety: performance improvement/metrics

1. Change
   - **a.** is always associated with chaos.
   - **b.** can be controlled using project management software.
   - **c.** is an inevitable life process.
   - **d.** is best managed by an individual with expertise in change theory.
2. Innovation and change
   - **a.** are similar but distinct concepts.
   - **b.** are the same concepts.
   - **c.** are based on the same assumptions.
   - **d.** are avoided by healthcare workers.
3. Innovation and performance improvement
   - **a.** are two different change methodologies.
   - **b.** exist as a continuum, each informing the other.
   - **c.** are in direct opposition to one another.
   - **d.** are both required in high performing organizations.

4. Resistance to change and innovation

- **a.** increases the chances for creativity.
- **b.** is not uncommon and needs to be mediated.
- **c.** provides a stopgap measure that halts inappropriate changes.
- **d.** is limited to individuals with excessive workload requirements.

5. There are certain times when change is not appropriate and should not occur. Change should be avoided when

- **a.** the funding to support the change is not available.
- **b.** the anticipated value is positive.
- **c.** selected team members are resistant.
- **d.** there is no clear rationale or improvement anticipated.

6. Project management templates and processes

- **a.** are ideally suited for complex change and innovation.
- **b.** can remove obstacles to creativity.
- **c.** consider deviations from the plan to be negative.
- **d.** accelerate the orderly work of change.

7. Change competencies include

- **a.** common understanding of definitions and descriptions of change.
- **b.** expertise in completing checklists.
- **c.** knowledge of team members' ability to create a business case.
- **d.** emphasizing the limitations of other team members' competencies.

8. Which innovation leadership behaviors support building networks of people?

- **a.** boundary spanning
- **b.** leveraging opportunity
- **c.** risk-taking
- **d.** visioning

9. Measurement of change

- **a.** is best done with financial metrics.
- **b.** is best done with a single quantitative or qualitative metric.
- **c.** should be distinct from measurement of innovation.
- **d.** requires consideration of the goals and variables involved in the change.

10. Negative fantasies about change

- **a.** are important considerations in reality checking.
- **b.** encourage creativity and innovation.
- **c.** can be serious obstacles to embracing change and innovation.
- **d.** are more prevalent in newer employees.

11. An innovation process should start by

- **a.** brainstorming solutions.
- **b.** implementing ideas.
- **c.** asking colleagues about possible solutions.
- **d.** understanding the evidence and literature of the problem.

12. A leader's role in change and innovation is to

- **a.** take credit for others ideas.
- **b.** facilitate the conditions for change and innovation to occur.
- **c.** provide permission to staff to solve problems.
- **d.** take suggestions but make the ultimate decision unilaterally.

13. Taking risks to advance change and innovation

- **a.** catalyzes change efforts.
- **b.** disrupts change efforts.
- **c.** is not recommended for nurses.
- **d.** helps maintain the status quo.

14. Performance improvement and innovation cannot occur in the same organization.

True

False

15. Innovation differs from performance improvement because innovation

- **a.** uses a process to achieve an outcome.
- **b.** is founded on evidence.
- **c.** creates something new to the population experiencing it.
- **d.** improves existing solutions.

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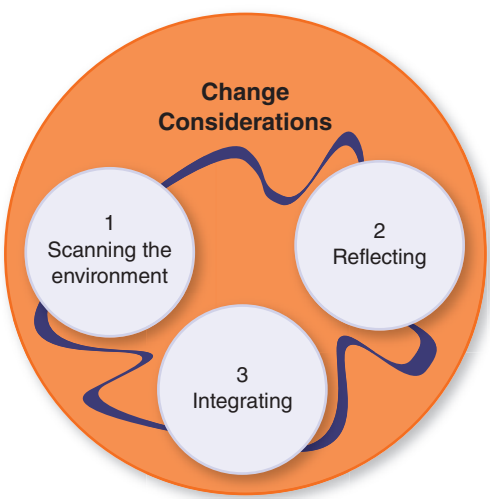
APPENDIX A

Change Considerations: Scanning, Reflecting, and Integrating

Planning for Change

After an issue is identified, careful analysis is needed to ensure the issue is legitimate and deserving of attention. The depth and range of considerations for a change process are assessed by scanning the environment, reflecting on the current and desired state, and integrating critical information into a plan for action.



Note that these steps are deliberately detailed for illustration purposes. When an individual is familiar with these steps, they tend to occur quite quickly and more automatically. However, missing one of the steps can be problematic. A quick move to action without a comprehensive assessment of the situation and reflection with the team can lead to incomplete solutions that will ultimately need to be redone and incur unnecessary costs.