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Calling In a Nursing Consultant to Calm the Waves of Change

Systems theory tells us that any change in an organization's leadership sends ripples of change through the rest of that organization. Such secondary changes may be a boon for a new director of nursing who brings a fresh leadership style and new goals to a nursing department. However, since systems theory also predicts that, to restore equilibrium, an organization will resist change, a new director of nursing may find his or her ideas thwarted by a resistant staff.

A new director of nursing at a large medical center who faced just such a problem hired a nursing consultant to help change staff resistance into trust; her experiences may help others overcome similar difficulties.

The director assumed her new role at the height of the nursing shortage — a time when ensuring that nurses were satisfied in their jobs was crucial to an institution's well-being. The director believed that the way to keep staff nurses satisfied was to increase their authority and responsibility. To that end, she believed the department must be decentralized, and she subscribed to a definition of decentralized nursing as "a style of organization, communica-

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tion, and decision making that fosters autonomy, accountability, and authority at the practitioner level [1]." After assessing how capable the nursing managers and staff were to assume the new roles and responsibilities they would have in the decentralized structure, the director began to prepare the medical center for the change.

Resistance to Change

New and Coulliard have outlined the reasons staff members may resist change. They include *threatened self-interests*, *inaccurate perceptions*, *objective disagreement*, *psychological reactance*, and *low tolerance for change* [2].

Threatened self-interest means fear of changes in pay, status, job expectations, work efforts, or social relationships. At the medical center, supervisors faced losing their positions and status; head nurses and staff nurses, although facing a status boost, also faced increased responsibilities for which they did not feel adequately prepared; and all staff members faced changes in daily routines for such activities as communication, reporting, and leave approval.

Even the increased status, money,

and control the change promised head nurses and staff nurses did not counteract the threats they felt to their self-interests. This was partly due to *inaccurate perceptions*, which commonly occur during change. In this case, inaccurate perceptions about unit staffing, such as involuntary overtime or being "on call" daily, stemmed from rumors that began in the early stages of the decentralization plan.

Objective disagreement is an honest belief that a change will harm the organization. The director of nursing, aware that not all changes are positive, sought out nurses who placed the organization's interests above their own and asked them for an accurate history of what changes had and had not worked in the past. Learning their fears was a crucial step in the decentralization plan.

Some staff resistance appeared to be due to a *low tolerance for change*, particularly among nurses who had low self-confidence, were not risk-takers, or had difficulty dealing with uncertainty.

Nurses who previously had complained about staffing problems, cumbersome bureaucratic communications, and other problems inherent in a centralized department now began to cling to "the way we do things here." This was *psychological reactance*, which occurs when people feel that their freedoms are threatened and which causes them to assign more worth than before to a procedure that is changed or eliminated. For example, the director wanted

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to eliminate the standard 24-hour report, which took a great deal of time to complete and was seldom read or used. When she proposed eliminating it, the nurses began to read and to use the reports.

The Consultant

New and Coulliard have pointed out several ways to deal with resistance to change: participation, coercion, manipulation, incentives, supportive behavior, gradual introduction, and

relationships of their teams. Specifically, they said their staff members were unaccustomed to being held accountable for any particular patient because they had been practicing team nursing — charge nurses were ultimately responsible for the care of all clients on a unit for a given shift. They also pointed out that patients' records were inadequately documented for proper continuity of care; that many staff members had difficulty dealing with physicians assertively and professionally, and that too much staff time and energy were

in the workplace are more likely to look at proposed changes objectively. Therefore, a strong, confident, participating nursing staff is more of an asset to a nursing director than one that feels powerless. To build confidence and strength in her staff, a director must try to develop a spirit of mutual respect and collaboration between herself and them.

The staff members who participated in the consultant's workshop had been feeling powerless. They said inadequate salaries and benefits, too many non-nursing tasks, poor communication with and lack of support from administration, and a lack of respect within the hospital were what prevented them from practicing the way they thought they should. When the consultant asked them how they were influencing these factors, or how they thought they could, they had no responses. They blamed "nursing administration" for most of the problems, and felt alone in their attempts to change their situation. There were no mechanisms for collective collaboration among the staff nurses; very few units had team meetings more often than once a month and there were no mechanisms for cross-unit staff meetings other than periodic meetings with the director. Above all, the staff nurses did not believe that nursing administration wanted their suggestions for improvements.

The workshops addressed ways to handle these problems, including increasing individual assertiveness and creating a supportive work environment. As a start toward that environment, participants discussed the meaning of professionalism and professional behavior and how to develop a professional self-image as a tool for change. For example, less than 5 percent of the participants routinely shook hands in greeting new people. When one of the participants complained that the hospital and nursing administrators did not know who she was, another said that, because the nursing staff was large, she was responsible for introducing herself. During the weeks that followed, many participants sought out an administrator they had never met and introduced themselves with a handshake. Several did this with the director of nursing and her associates and felt more trusting of them afterward.

Nurses that have a positive sense of their power and ability to influence events in the workplace are more likely to look at proposed changes objectively. Therefore, a strong, participating nursing staff is more of an asset to a nursing director than one that feels powerless. To build staff confidence, a director must try to develop a spirit of mutual respect and collaboration between herself and her staff.

external agents [3]. Although she was employing several of these techniques herself, the director of nursing decided that using an external agent would help overcome the resistance. She believed the situation was too emotionally charged and stressful for someone inside the hospital to change staff attitudes. She also thought the staff would be more likely to trust an objective outsider not influenced by the institution's politics and with no vested interest in the hospital. She also recognized that no one in the hospital had the expertise or the time to develop the program she wanted.

The director selected an appropriate consultant and met with her to discuss her goals for the department, her philosophy, and the problems the department was having. They decided that staff accountability for practice was the most serious problem they would have to overcome.

The consultant met with the supervisors and head nurses to find out how they saw the problem and how they thought she could help. The managers also believed staff accountability was the major problem, and they were able to discuss it in detail and to site examples of problems in the working re-

being spent on complaining rather than on problem-solving.

The consultant designed a four-day program on accountability that a staff nurse from each unit was to attend. Although the last half of the program focused on using the nursing process to foster accountability, the first two workshops examined attitudes and behaviors relating to professionalism, team play, and accountability in general.

Powerlessness vs. Professionalism

Dorothy Brooten and her colleagues have said that nurses often try to undermine or to exert rigid controls on each other in order to feel powerful and in control on the job [4]. The consultant believed that much of nurses' resistance to change comes from their sense of powerlessness, and that resisting change is a way to exert at least some control over one's practice. Psychological reactance, inaccurate perceptions, threatened self-interests, and low tolerance for change may result from such feelings of powerlessness.

On the other hand, a nursing staff that has a healthy, positive sense of its power and ability to influence events

Participants also examined their relationships with one another and with their colleagues. They talked about professional collaboration as an alternative to collaborative complaining and heard examples of how supportive relationships were prerequisite to problem-solving, to an enhanced professional self-concept, and to increased power for the entire service.

These explorations of professional identity and behavior set the stage for discussing how to use the nursing process to develop more effective decision making about patient care. The consultant showed the participants how the nursing process could help them stand behind their decisions and their rights and responsibilities to provide those aspects of client care that are uniquely in nursing's domain. She also gave them examples of how sound decision making enables nurses to collaborate with other health team members as equals.

Outcomes

Participants' evaluations revealed that the program improved their images of themselves, their colleagues, and their practice. Both the director of nursing and the nursing consultant recognized sustained behavioral changes and improved attitudes among the participants. Throughout the program and afterward, the director noticed staff nurses introducing themselves with a handshake to new nurses and physicians, the hospital director, the director of nursing education, herself, and patients. Staff nurses began to help one another handle problems rather than bringing them to the head nurse. They developed a consultation list of staff nurses with special areas of expertise, started a reference library of cassette tapes on nursing and health care topics that they presented at unit inservice sessions, and worked at channeling each other's energies away from chronic complaining and into constructive problem-solving. They improved their documentation, developed a pre-operative teaching checklist, and began using a nursing diagnosis-based assessment form.

The staff nurses themselves noticed that using the nursing process assertively improved the way they dealt with problem patients. For example, one ICU nurse discussed her "problem" patient

— a middle-aged man who had become dependent on a respirator — and asked her fellow participants to help develop a care plan. Initially, the nurses thought respirator insufficiency was the primary nursing problem. After a more thorough assessment of the data, they redefined his primary problem as anxiety and fear caused by previous episodes of acute anoxia when left off the respirator unattended. They set short-term behavioral objectives that called for him to be left off the respirator for five minutes at first, then building gradually to complete independence, gaining his trust and confidence by teaching him relaxation and breathing techniques and offering emotional support along the way. His physicians initially opposed the plan, until the nurse who had participated in the workshop asserted her right and responsibility for such decision making and agreed to be held accountable for the results of the plan. The patient was successfully weaned off the respirator. The nurse saw the results of the assertive use of the nursing process and became more confident in handling an accountable role.

One of the most important results of the workshop was the formation of a Staff Nurse Forum to pinpoint areas of concern and to develop strategies for

articles in the nursing department's newsletter for the benefit of nurses who were too busy to attend a particular inservice program. Recognizing the importance of staff nurses in resolving departmental problems, the Nursing Executive Board, which was the decision and policy-making body of the service, invited a forum representative to sit on the board. The forum also formed a committee to work with the nursing coordinator for recruitment and retention to attract and keep good staff nurses. The Staff Nurse Forum was a major force toward professional collaboration and constructive change for the nurses at the medical center.

Collaboration

Such constructive changes did not result from the workshop alone, but from effective collaboration among the nursing consultant, the director of nursing, and the nursing staff. Pate has identified five functions of the nursing consultant: analyst, facilitator, problem solver, resource, and educator [5]. Although Pate defines these as distinct categories that can be fulfilled singly or in combination, the director and the consultant thought the facilitator function was linked to each other function. Pate explains that this function "pro-

A consultant's ability to help lower staff resistance to change is directly related to whether the staff considers her trustworthy and objective. To gain the staff's trust, the consultant assured them that she would keep specific concerns that arose in the workshops in confidence.

solving problems. Two of the workshop participants started the forum after a discussion of collective problem-solving strategies; now each nursing unit elects a forum representative. Minutes of the meetings are recorded and reviewed with the director of nursing within a week. During the first year, the forum sponsored several social events to bring staff nurses together, worked with the director to eliminate the inappropriate use of nurses' time for moving furniture, and recorded educational cassettes and wrote clinical

motes processes and interaction, both group and individual, that enhance understanding and acceptance of changes and growth within an organization [6]."

A nursing consultant's ability to help lower staff resistance to change is directly related to whether the staff considers her trustworthy and objective. To gain the staff's trust, the consultant explained that, although she might let the director know the general concerns that arose in the workshop, she would keep specific concerns in confidence and leave it to the participants to take

them through the proper channels. When the staff saw the consultant as objective, they were able to openly explore their stereotypes of the "nurse administrator." Since they clung to their views of the old nursing department and administration, the consultant encouraged them to test those perceptions. They felt that legitimizing the Staff Nurse Forum was important, so they asked the director for permission to hold forum meetings during work hours. The director agreed and offered compensatory time to those nurses who attended on their days off. Later she responded to the minutes of the forum meetings, either by asking for more information, offering suggestions, or following through on specific items. These actions showed the staff that the director valued their problem-solving efforts.

The director of nursing and the consultant must also trust one another. At no time was this more important than during the development of the Staff Nurse Forum. The nurses in the medical center were not unionized; in the same situation, many nursing directors would fear that such a forum would be a precursor to a collective bargaining unit.

The consultant knew that the new director valued staff input. She also knew that, for the forum to succeed, nursing administration would have to lend support during its start up. She recommended that the staff nurses include the nursing coordinator of recruitment and retention in their meetings to help administration accept the forum and to help move problems and solutions through the bureaucracy. Although the director had appointed the coordinator as staff liaison and advocate, the staff nurses suspected her allegiances and feared that her presence would impede the group's process. However, in the new spirit of collaboration, they suggested that the coordinator attend every other meeting. At one meeting, the staff would discuss their problems and consider solutions; at the next meeting, they would further refine the process with the coordinator. Later the staff nurses decided that they preferred to have the coordinator available for consultation during every meeting rather than actually present at every other one.

As trust began to develop between the director of nursing and her staff,

staff resistance to change brought about by threatened self-interests, psychological reactance, and inaccurate perceptions diminished.

How far did the director get with her plans for decentralization? The organization hierarchy of the medical center nursing service was "flattened." Staff nurses worked with their head nurses and supervisors to decentralize the staffing of their units in order to eliminate the pulling of staff from one unit to another. The decentralized plan required continual refining, but the changes that were made increased staff morale, decreased turnover, and increased staff nurse participation in the

The nursing director and the nursing consultant did achieve their mutual goal. A sense of community permeated the entire nursing service; it included the LPNs and nursing assistants as well as the RNs.

functions of the entire hospital.

Interestingly, as the staff nurses' resistance to decentralization decreased, the resistance of the head nurses and supervisors grew. Although the same consultant did a one-day workshop on team-building and primary nursing with these managers, it did not reduce their resistance, primarily because they saw the consultant as a staff nurse advocate and questioned her objectivity. Therefore, the director and the consultant called in another consultant to work with the supervisors and head nurses. This consultant used many of the strategies the first consultant used, as well as teaching management concepts. The head nurses said that, at first, they feared the staff nurse workshops would be divisive, but that they subsequently received more support from the staff nurses in finding and solving problems. The two consultants working collaboratively helped both groups to work collaboratively as well.

Perhaps the most rewarding outcome of this collaborative effort was

the change in staff members' attitudes. The hospital was part of a national study on recruiting and retaining nurses. The project director and an outside consultant made two site visits, one year apart, which gave the director and the consultants a unique opportunity to have a third party evaluate their efforts. The project director and the project consultant interviewed staff members at all levels on both visits and were struck by the changes that had been made. During their first visit, which they made shortly after the first staff nurse workshop, they had a sense that the nurses felt like underdogs with no control over their practice and no solution to their problems. On the second visit, after three series of the workshops had been completed and the Staff Nurse Forum was a year old, they noticed that the staff had developed a sense of pride and strength. The staff were willing to use their own resources and to solve their own problems; they had discovered their power.

The interviewers also noted that the staff had a sense of community. This attitude is remarkable because of the geographic spread of nurses throughout the hospital and because of the feelings of powerlessness and intra-group conflicts that nursing has experienced as a predominantly women's profession. This sense of community permeated the entire service, including the licensed practical nurses and nursing assistants.

When collaborating as change agents, directors of nursing and nursing consultants must pinpoint both the reasons for resistance to change and how to deal with them. In the case of a new director, this included developing a trusting, collaborative relationship with her staff. A nursing consultant helped make that job easier.

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