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Western University

Improving Communication Among Healthcare Providers to Maximize Error Prevention Tool Use and Improve Patient Safety

An Organizational Improvement Plan

by

Heather Gordon

Submitted to the School of Graduate and Postdoctoral Studies

In Partial Fulfillment of the Requirements for the

Degree of Doctor of Education

London, Ontario, Canada

August 2019

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Abstract

In 2010, the Provincial Health Funder (PHF) mandated the reporting of unintentional adverse events that occur in the process of healthcare delivery, which result in disability, death, or prolong treatments (PHF, 2011). The results of reporting are available to the public on the Provincial Quality Advisor (PQA) website, providing transparency and accountability for Advanced Healthcare System (AHS), which has made patient safety its organizational strategic priority (AHS, 2018).

This Organizational Improvement Plan (OIP) seeks to improve communication and strengthen safety culture among healthcare providers by maximizing the use of error prevention tools to improve patient safety. The principles of distributive and transformative leadership are applied to enhance collaboration, build capacity, empower people to speak up for safety, and enhance team decision making. The organizational plan aligns with my leadership philosophy to develop others, as well as abide by the Social Work regulatory body's ethical standards, which guides my work as a change agent to support the best interest of others.

Systems theory guides the plan and Bolman and Deal's (2013) four frame conceptual framework is used to enhance the understanding of the existing state of the organization, which currently includes challenges in communication, a culture of "blame and shame", insufficient use of error prevention tools, and patient safety. The Murray and Richardson (2002) framework is utilized to guide the OIP and identify ten "winning conditions" to address the problem from a holistic standpoint, while encompassing speed and momentum.

Keywords: patient safety, error prevention tools, culture of blame and shame, capacity building, organization culture

Executive Summary

Patient safety has been identified as a top priority in Canadian Hospitals. Data indicate that patients die every 17 minutes because of adverse events or safety incidents (CPSI, 2018). Many Canadian hospitals, including Advanced Healthcare System (AHS) have made patient safety a number one priority in strategic planning. Despite the hierarchal structure at AHS, there are ongoing efforts to address systemic issues, communication challenges, and inadequate use of safety tools that contribute negatively to patient safety. AHS has maintained a steady focus to achieve High Reliability Organization (HRO) status by reducing the number of harm events while dealing with the above-mentioned issues.

This Organizational Improvement Plan (OIP) is part of an organization-wide focus on improving patient safety. The OIP focuses on improving communication among healthcare workers to maximize the use of error prevention tools, which substantiates my efforts to help AHS reduce the number of harm events that patients experience when receiving services. This OIP will start as a pilot project in one unit at AHS and will be rolled out in other departments afterwards. Considering that each department is prone to different types of errors (e.g., those occurring at the emergency room are different from those in the surgical department), the change management approach will be tailored accordingly.

Based on AHS quality indicators (AHS, 2018) the Problem of Practice (PoP) addresses: communication challenges among various healthcare providers within the organization, faults in the current safety culture, inconsistent and inadequate use of existing error prevention tools, and a reluctance to speak out regarding safety issues. As a health educator, it is my responsibility is to train employees to adopt patient safety practices, learn the use of error-prevention tools, and to optimize the organizational culture to create a positive environment of open communication.

During training staff expressed discomfort with reporting safety-related incidents due to fear of reprisal, being blamed, or lack of confidence. In a recent Employee Engagement Survey, as many as 50 percent of staff indicated discomfort with reporting safety-related incidents even when actual patient harm occurred (AHS, 2016). In addition, 60% of employees indicated discomfort with asking questions to someone in authority (AHS, 2016). To move from the current state to a future state of improved patient safety, strong leadership is paramount, authentic, transformative and situational leadership styles are employed. Furthermore, distributive and transformative leadership approaches are applied to enhance and address communication challenges to increase collaboration, build capacity and improve patient safety.

Systems Theory is utilized to outline the PoP and to frame it within the broader setting of existing employment conditions, ongoing improvement efforts, and decision-making processes. Bolman and Deal's (2013) four frame conceptual model (structural, human resource, political, and symbolic) provides further understanding of the PoP. Factors that contribute to the PoP are examined through the lens of PESTE (Political, Economic, Social, Technological and Environmental) analysis (Cawsey, Deszca & Ingols, 2016). The AHS Purpose, Values and Principles are used to frame and promote this OIP within the organization. To make the change successful and sustained, employees need to be motivated to accept the proposed change, as well as to develop and adapt new habits. Murray and Richardson's (2002) change path framework is incorporated because they identify 10 "winning conditions" that accelerate change, which are comprehensive and realistic for healthcare settings. One strategy to address the PoP is a bottom-up approach, which is more likely to be successful than attempting change from above. Formation of a Safety Committee is proposed to aid in developing processes that will increase the use of safety tools. A focus on education and team work through an iterative process allows

for continuous improvement by learning to identify and solve ongoing issues. Safety is and should be the first concern.

There will be a monitoring and evaluation process put in place to determine the effectiveness of the change, as well as a frequent process which ensures regular feedback and modifications. Finally, a communication plan will be developed to ensure that there is a clear understanding of the rationale for change, the goals to be achieved, and the expected outcomes that will benefit all parties involved.

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"Follow your passion, be prepared to work hard and sacrifice, and above all, don't let anyone limit your dreams", stated Donovan Bailey, a retired Canadian Sprinter who once held the world record for 100 meters. Baily knows the discipline involved in achieving something great, and also the requirement of significant time and commitment, which I have come to experience through this journey to obtain a Doctor of Education (Ed.D.).

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List of Acronyms

AHS:	Advanced Healthcare System
EPT:	Error Prevention Tools
HRO:	High Reliability Organization
OIP:	Organization Improvement Plan
PCSWSSW:	Provincial College of Social Workers and Social Services Workers
PESTE:	Political, economic, social, technological and environmental
PHF:	Provincial Health Funding
PoP:	Problem of Practice
PQA:	Provincial Quality Advisor
PVP:	Purpose, Value, Principles
STAR:	Strategy, structure, processes, rewards and people (Galbraith, 2014)

Chapter One – Introduction and Problem of Practice

This chapter introduces the problem of patient safety at a large urban healthcare network with regard to the ongoing goal of reducing preventable harm events to zero and strengthening a safety culture among employees. This healthcare network is continuously evaluating error prevention tools that support an improvement in the delivery of service in order to reduce the incidence of harm to patients receiving care. Poor communication between staff members has been identified as a problem leading to preventable errors that affect patient safety. This organization requires employees to report safety incidents and near-misses (those incidents that did not affect a patient) in order to increase patient safety. Yet, in spite of this requirement, staff members are not consistently reporting the errors that occur during the course of their workplace activities. As such, the number of patient injuries continues to be high. Therefore, the identified problem of practice (PoP) is ineffective communication among healthcare providers leading to patient safety issues.

This chapter elaborates the PoP and analyzes the organizational context and leadership vision for this Organization Improvement Plan (OIP). It explores frameworks to address the issue and the lines of inquiry motivated by this organizational problem. Lastly, it addresses leadership visions for change and organizational change readiness.

The Leadership Problem of Practice

The Advanced Healthcare System (AHS) has reported that every three days, a patient within their facility is harmed as a result of preventable errors, while every 33 days, preventable errors contribute to a patient's death (AHS, 2018). Error prevention tools (EPT) are a set of behaviors or processes used to prevent errors, including: inventory checklists, three-way repeat-backs, and questioning and confirming when uncertainties arise (Maxfield, Grenny, Lavandero,

& Groah, 2011). While AHS has adopted and embraced Error Prevention Tools (EPT) in an attempt to reduce preventable errors, the number of patient injuries and deaths have not been significantly reduced. Management has cited staff underutilization of EPTs as the primary reason for AHS' failure to reduce the number of harmful errors leading to patient injury or death. AHS has stated that EPT use allows the error to become a learning experience so that similar errors can be prevented in the future. Quality indicators used at AHS to measure quality performance have identified ineffective communication as the primary barrier to the optimal use of EPTs. The derived problem of practice (PoP) is ineffective communication among healthcare providers leading to patient safety issues.

Communication is defined as "a transactional process responsible for informational exchange, as well as a transformational process responsible for causing change" (Manojlovich, Squires, Davies, & Graham, 2015, p. 1). As an educator, it is my responsibility to teach safety behaviors, use of error prevention tools, and foster a culture that is conducive to open dialogue. During teaching sessions, employees have shared that many errors and safety issues go unreported. In 2015, an AHS safety culture survey confirmed that almost 50 percent of employees are not comfortable reporting unsafe practices, even if a patient might be harmed. In addition, 60% of employees indicated discomfort with asking questions to someone in authority (AHS, 2016). This "blame and shame" environment is not conducive to improving patient safety.

According to Maxfield et al. (2011), when a risk is known and not addressed, patient safety is put at risk. Maxfield, Grenny, McMillan, Patterson, and Switzler (2017) cited a report from the Canadian Institute of Medicine stating that each year, thousands of patients experience harm during their hospitalization because of actions taken or not taken by healthcare

professionals. My challenge is to aid in changing the state of the current organization to a more desired future state where communication gaps are addressed, error prevention tool use is optimized, and incidents of harm to patients are less frequent. The PoP lies in how to facilitate communication and the use of error prevention tools among healthcare providers in order to improve patient safety.

Advanced Healthcare System (AHS) (a pseudonym) has been involved in many change initiatives to improve patient safety, including cultivating a safe work culture, having safety as an area of critical focus, and mandating training for all staff (AHS, 2018). AHS's mission embodies patient-centered care and emphasizes that patients are the top priority for organizational values of safety, compassion, teamwork, integrity, and stewardship (AHS, 2018). As such, training is delivered to all staff about appropriate safety behaviors and on the utilization of error prevention tools.

Safety is a significant issue in Canadian hospitals, as someone dies from an adverse event every 17 minutes (CPSI, 2018). Communication and information exchange are critical components for the appropriate use of safety tools. Safety tools are those protocols and strategies used to prevent errors, harm events, and adverse effects (Hess, 2014). Safety tools or Error Prevention Tools (EPTs) hinge upon effective communication and ongoing training in order to minimize harm events to healthcare recipients (Hess, 2014; Joint Commission, 2017; Maxfield et al., 2011; Provincial Healthcare Funder (PHF), 2017; Ternov, 2011). AHS aspire to shift from a "blame and shame" culture that reduces the reporting of safety incidents to a culture where safety reporting is increased and provides opportunities to learn from mistakes (AHS, 2018).

The goal for this OIP is to "close the gap between the current and improved future state" (Pollock, 2013, p. 1). This can be done by leading change initiatives that result in a change in safety culture, where gaps in communication are dealt with and error prevention tool use is optimized. This closely aligns with AHS's organizational goals and an OIP to reduce harm to patients. The next section addresses AHS's organizational history, structure, and vision in the broader political, social, and cultural contexts.

Organizational Context

History of AHS. The Advanced Healthcare System (AHS) is a large healthcare institution in Canada comprising several hospitals that were amalgamated under one umbrella in the late 1990s. The purpose of this amalgamation and transformation was to amalgamate healthcare funding and simplify decision-making under one centralized system (AHS, 2018). The organization provides adult emergency, inpatient, outpatient, and rehabilitation care with the goal of delivering comprehensive and responsive healthcare services. It comprises more than 30,000 personnel: over 4,000 nurses, approximately 8,000 physicians, and over 3,000 students, with the remaining 15,000 personnel being administrators, support staff, technicians, and research associates (AHS, 2018). During 2016-2017, the AHS emergency rooms served over 120,000 patients, with approximately 1,300 bed spaces available for patients admitted for treatment. They also provide services to individuals 18 years or older who come from other provinces and countries requiring specialized care, although most patients live locally in the catchment area.

AHS is comprised of four hospital sites, with the oldest site being founded in the early 1800's and the newest in the 1950's. Over the years, AHS has undergone several change initiatives to improve services. The continued commitment to provide safer healthcare is

consistent with the current mission in identifying safety as an area of critical focus (AHS, 2018). This OIP is timely, as AHS seeks to increase the use of error prevention tools and reduce the number of preventable harms to zero.

AHS is accountable to the funding body in their province and the Provincial Quality Advisor (PQA) governing body, which helps set standards and informs the public on healthcare system quality (PQA, 2018). AHS funding from the PHF can be affected by the political climate, and there is often tension between departments around resource allocation within the funding constraints. This challenges AHS leaders to "build a power base through networking and negotiating compromises" (Sasnet & Ross, 2007, p. 1). As illustrated in Figure 1, this OIP must take into consideration several contextual factors and governing issues to address the PoP in an effort to improve patient safety. As such, there is a broader socio-political context (such as the political party in power at any given time) that determines the funding from the PHF, which in turn influences the availability and allocation of resources. There is also the factor of accountability to the monitoring body PQA, to report the number of adverse events that compromise patient safety.

The contextual environment of AHS is: a hierarchical structure, a large, complex bureaucracy with multiple layers of management, and many policies and procedures in place within an error-prone environment and hazardous conditions (inherent to healthcare organizations). On the forefront of the organization are the healthcare providers from various disciplines, which inevitably lead to communication challenges in the context of underutilization of error-prevention tools. This results in high recorded numbers of incidents of preventable harm to patients (adverse events).

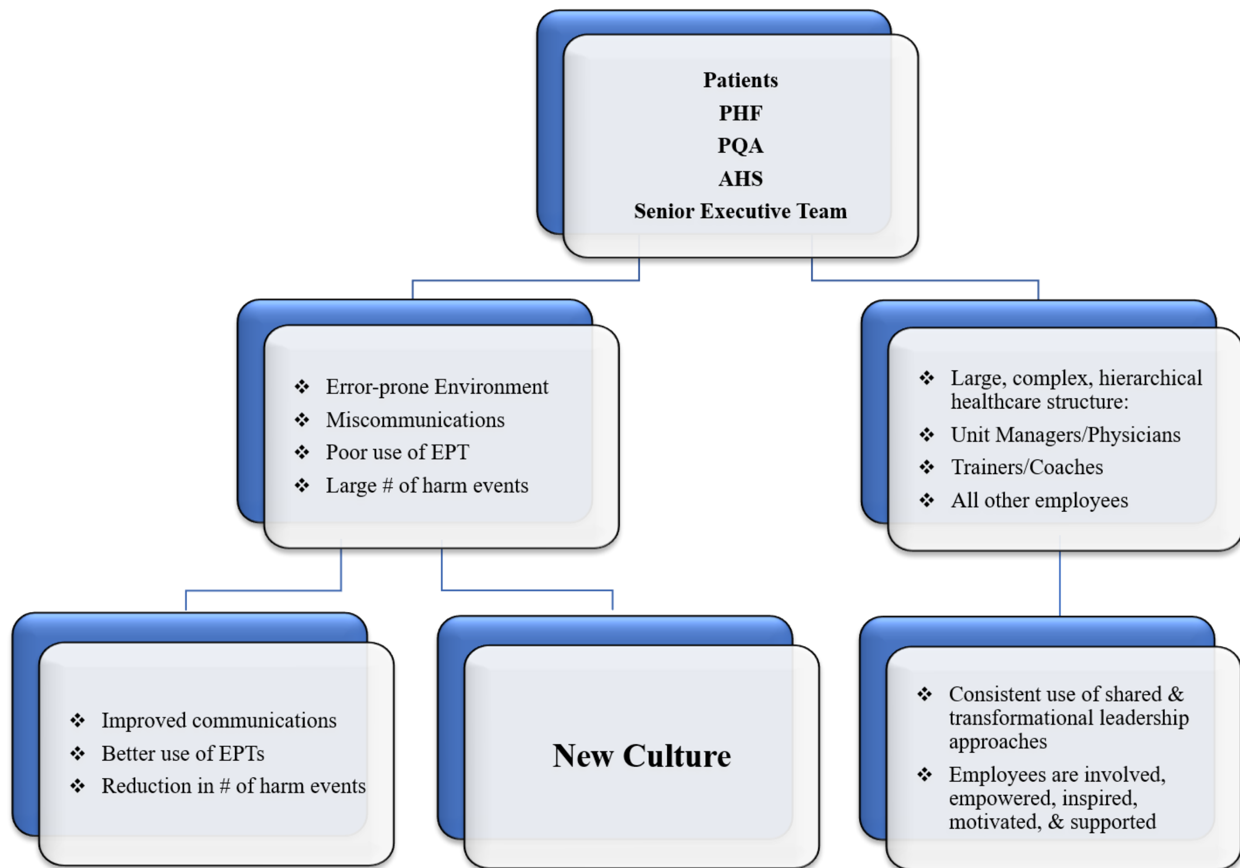

Figure 1. AHS Organizational Context

The following section examines the organizational context of AHS, including strategic goals, the purpose, values and principles (PVP), and organizational culture. It also briefly discusses the political, economic, and social factors that shape the organizational contexts and leadership, while identifying the gap between the current state and the desired future state.

Strategic goals. In 2016, AHS defined their PVP. They defined their purpose as providing excellence in patient care, research, and learning opportunities (AHS, 2018). The values were described as: safety, compassion, teamwork, integrity, and stewardship (AHS, 2018). In 2018-2019, AHS solicited feedback from employees and service users to inform the strategic vision and to help determine strategic goals for the next five years. One of the

outcomes of this initiative was the creation of the vision the organization now upholds that focus on a healthier environment.

In the spring of 2018, AHS hired a new chief executive officer (CEO) who embraced the existing PVP created under the former CEO in 2016. However, the new CEO added more dimensions to expand the care model by including work-life balance for healthcare providers, following the priority of patient-centered care. In his book, *Transforming Healthcare,* Kenney (2011) spoke to how organizational goals and visions in various sectors such as healthcare "have a long and distinguished history of being ten parts rhetoric and one-part reality" (p. 5). This is evidenced as AHS still struggles to have employees live up to the organizational PVP that has existed since 2016. For example, one of the core values of the PVP is safety, and an example of how this value is put in practice is when employees take personal responsibility for patients' and workplace safety by reporting errors. In reality and based on internally collected data and quality indicators, there are many employees who are reluctant to report instances of adverse events.

Purpose, values and principles. Black (2003) stated that "a culture where people share a common purpose and are willing to sacrifice to achieve that purpose is also fostered when consistent, symbolic actions are taken" (p. 2). Displaying the PVP throughout the organization, including on the badges that employees wear, is done to promote, reinforce, and sustain the safety-centered culture by the use of symbolic representation. Practicing AHS core values will allow for greater autonomous decision-making and the acceleration of cultural transformation to support staff to speak up for patient safety.

At AHS, the constant emphasis on the safety of patients being at the forefront and its relationship to the mission of the organization encourages individual and collective accountability for safety. As Galbraith (2014) posited, when policies, peoples' skill sets, and

strategies in organizations are in alignment, the result is high performance. This also helps create a high reliability organization (HRO), which strives to manage and sustain "error-free performance despite operating in hazardous conditions where the consequences of errors could be catastrophic" (Lekka, 2011, p. 1). Patient safety remains the top priority, as this best serves the organization's goal of becoming an HRO. Transforming AHS into an HRO is the overarching vision that helps prioritize and rank important decisions.

An example of an organizational initiative to address safety is the creation of a Safety Office, the allocation of resources, and the introduction of mandatory training (as previously mentioned) for all staff on appropriate safety behaviors to increase utilization of EPTs. The EPTs and safety behaviors include:

- Questioning and confirming (rather than making assumptions)
- Doing three-way repeat-backs to ensure that something is clearly understood
- Using structured communication tools when sharing much information (e.g., SBAR (Situation, Background, Assessment and Recommendation/Results)
- Using the ARCC algorithm (**A**sking questions, making **R**equests, voicing **C**oncerns, and if all else fails, using the **C**hain of command)

Training at AHS is being delivered by employees (such as myself) who are not in an assigned leadership role which makes it relatable to the participants' jobs as well as being non-threatening (AHS, 2016).

The AHS training began in 2016 and currently up to 88 percent of staff are being trained, but thus far, the decrease in harm incidents is not significant. For example, in 2017, results from an AHS quality indicator showed that every 30 days, someone is harmed from a preventable error. One year later, this rate of someone being harmed from a preventable error was reported

as occurring every 33 days (AHS, 2018). With such a small decrease in the numbers of harmful events, training effectiveness is being looked at to help improve the harm reduction goals. Potential factors contributing to ineffective training include social dynamics, as training on EPT use is mandatory and creates animosity among staff. Additionally, the training is held in a different location from the personnel's normal working environment which creates time constraints for staff. There are a few measures in place to embed EPT use at AHS through daily "safety huddles" held in each unit for 10-15 minutes, and the huddles are led by managers who are then intended to act on the information shared. In these "safety huddles", employees share their experiences of errors and harm events or "near-misses", which becomes a learning opportunity and enhances situational awareness. Critical incidents are then reported and escalated to the senior leaders' level for a root-cause-analysis for further examination and problem-solving. The organization's focus on safety aligns with this OIP; for example, improving patient safety through communication and EPTs.

AHS safety priority is further solidified by an underlying expectation placed on hospitals in the province to embark on initiatives that will reduce harm and enhance patients' experiences (PQA, 2018). The priority for patient safety closely aligns with the PHF (2017) initiative of "Patients First", where the goal is to improve patients' experiences and healthcare outcomes. The PHF called this "the new blueprint", as it explained a commitment to future health care transformation (Ministry of Health, 2016).

Leadership Structure and Approaches at AHS

The AHS (2018) annual report referenced the organization as being transformative in its approach and in utilizing principles of distributive leadership, both of which aim to engage employees and foster strong relationships and motivation in order to accomplish the goals of the

organization (Northouse, 2016). AHS is a complex bureaucracy with multiple sites, procedures, and processes, which makes it challenging to employ transformational and distributive leadership. The existing tension between the distributive approach and the hierarchal structure can deprive organizations of the ability to adapt (Kotter, 2014).

Kotter (1990) addressed the processes needed for an organization to succeed, and explained how leadership can succeed in achieving organizational change. This is done through establishing a vision for the future with strategies for actualization, and making and communicating necessary changes, while inspiring and motivating people to help develop and attain the vision (Kotter, 1990). Kotter (1990) also noted that if change is created without collaboration, it is "bureaucracy without purpose", and leads to solutions that are not practical.

AHS is a hierarchical bureaucratic organization that uses a top-down conservative approach to business, and formal authority is assigned and utilized to ensure that all hospital personnel follow policies and procedures (Ryan, 2012). According to Galbraith (2014), the function of the hierarchy becomes two-fold: addressing how decisions are made to manage the behavior of a larger group of people, and how to conduct dispute resolution. For example, I have a role in influencing change as an emergent leader (Northouse, 2016) who educates staff and can influence the vertical structure of the hierarchy (Galbraith, 2014). Individuals need to feel free to communicate with each other, as communication is a critical component in the use of EPTs. Currently, EPTs are not being utilized to their fullest potential, as communication among healthcare providers is suboptimal, which impacts patient safety. Tackling the culture of this large organization targets the root cause of the more complex issues, which Schein's Theory of Organizational Culture (2010) sheds light on.

Schein's Theory of Organizational Culture. As indicated previously, the goal for AHS is to become an HRO that promotes a culture of safe practice. Culture is defined as those beliefs, thoughts, assumptions, and perceptions we take for granted (Schein, 2010). Organizations are rich with historical culture; some are more static, and some are always in flux. The existing culture at AHS is based on how employees' function and interact with each other as well as with the patients receiving care. Culture can be created through problem-solving and seeking out new solutions. One example of a solution is the daily safety huddles that are used in the province's hospitals, including AHS. As reiterated from earlier in this paper, the purpose of safety huddles is to encourage staff to discuss any safety concerns that pose risk to patients and staff within the hospital environment. Patient safety huddles foster problem-solving, allowing others to learn from mistakes or "near misses" in order to improve their practices (PQA, 2018). When a process becomes habitual, it becomes embedded in the organizational culture (Schein, 2010); thus, speaking up for safety needs to become habitual in daily safety huddles.

The management structure of AHS strives to foster comprehensive, safe, and patient-centered care while being sensitive to current and emerging healthcare needs. The complex management structure makes it difficult to implement and realize new ideas, and there is sometimes a delay in change initiatives. Furthermore, social, political, economic, and cultural factors at AHS impact decision-making and implementation, which in turn contributes to increased harmful events. Efforts to disseminate transformational and distributive leadership approaches become challenging when trying to change the status quo due to the dominant hierarchical structure. Therefore, my goal is to contribute to the development of a new culture that will improve communication and preventable harm through an increase in the utilization of

EPTs. This will be done based on my leadership philosophy and sphere of influence, which is addressed in the leadership position statement.

Leadership Position Statement

My leadership philosophy centers on self-improvement and individual capacity-building while being consistent and honest. This has influenced my decision to focus on an OIP that aims to enhance communication among healthcare providers in order to ensure that EPTs are being utilized to their fullest potential. This section describes my leadership philosophy, perceptions of leadership, theoretical perspectives, and biases. It follows with how this influences my leadership approach and my proposed solutions to address the PoP.

Leadership Philosophy Statement

My leadership philosophy involves a commitment to my personal development and that of others. I take a strong interest in my own growth and development, and have always felt that this approach is also beneficial to those around me. The aspects of development include elements that are lacking in the realm of people's personal or professional lives; for example, social isolation or lack of community support. I am mindful of the needs of others, and it is a point of personal pride to help others address their needs and to help them connect with other individuals or resources. In addressing others' concerns, I use openness, consistency, supportiveness, and trustworthiness, which are important elements in creating relationships that are mutually beneficial (between myself and the person). Openness involves striving to hear peoples' concerns and being sensitive to their needs as well as accepting their feedback. Consistency means that my interactions and approaches to problem-solving are always stable and predictable. Supportiveness is a way to demonstrate kindness and my

compassion and empathy for others. Lastly, being trustworthy means being honest and demonstrating integrity in all of my decisions and actions.

I see myself as a guide and teacher who helps others during their journey and who helps them realize their skills and potentials, which builds relationships and trust, encourages personal development, and inspires motivation. Furthermore, I aspire to be a leader who changes lives and encourages people to tap into their intrinsic motivations, which are key tenets of authentic and transformational leadership (Northouse, 2016). I self-identify with the authentic leadership approach, and draw from the transformational and situational leadership approaches defined by Northouse (2016) discussed later in this paper. I am a social worker and one of the reasons I chose this profession is because it is guided by a set of core values that I embrace and I carry out during my professional duties which align with the ethical standards of social work practice. As a member of a regulated profession call Provincial College of Social Workers and Social Service Workers (PCSWSSW), a social worker must adhere to a code of ethics and practice standards that includes respecting the intrinsic worth of individuals, maintaining confidentiality, and looking out for the best interest of the client (PCSWSSW, 2017).

Reflections on Leadership

Leadership involves responsibility, and there is no leadership without the burden of responsibility and the ownership of the consequence(s), whether good or bad, for the decisions made. Leaders take on the responsibility of directing change by creating a vision and working towards it. For this OIP, I envision fewer harm incidents at AHS, and I have been working towards this goal. Leadership has the capacity to have influence, both as a team member and individually (Hahn, Lee, & Jo, 2012; Northouse, 2016), and to exercise leadership, one must have a key understanding of how to influence others. My leadership approach involves listening

and being consistent and authentic, and emphasizes relationship-building, creativity, and being reflective (Černe, Jaklič, & Škerlavaj, 2013). When individuals can affect others "beliefs, attitudes, and courses of action", they are said to possess influence and power (Northouse, 2016, p. 10). I consistently reflect on how my leadership can change the current state of AHS to a more desired future state where communication gaps are addressed, EPT usage is optimized, and incidents of harm to patients are less frequent. The following section addresses the theoretical perspectives that speak to biases that can seep into this OIP.

Theoretical Framework to Address Biases

We all view the world from various perspectives, and using the lens of "umwelt" suggests that the same environments are seen and understood idiosyncratically by different people (Suderman, 2012). I am aware that my perceptions of problems and solutions may differ from those of other members of my organization, and I am cognizant of biases that could surface in the organization because of my status as an "insider" who draws from social work, education, and advocacy/participatory approaches. These biases can influence my views as a leader as well as a researcher studying my organization (Wallace & Poulson, 2003). This can be detrimental when interpreting data from my organization and the literature on organizational change because the goal is to find objective solutions to the PoP. I approach this OIP as an insider caring for my organization and as someone who views employees as people who wish to improve patient safety. Therefore, my goal is to convey trust and confidence to my colleagues.

My insider status in combination with my social work background is an advantage to this OIP, as I have insight into the issues involved and I seek to address these issues as a social worker who uses a social justice lens. Additionally, I am using the advocacy/participatory approach, which addresses pertinent current social and political issues (Creswell, 2017). In this

OIP, there are a number of social and political issues that require consideration. An example of a social issue is that individuals receiving care are vulnerable, and are reliant on those within their circle of care to use appropriate tools that ensure their safety. One political issue is the oppressive nature of the organizational hierarchy, as oppression experienced by staff within the hierarchy impacts their ability to provide safe care to patients for different reasons, such as fear of speaking up or low self-esteem. The advocacy/participatory approach provides greater insight and offers an opportunity to empower employees in the process of organizational transformation. This approach aligns with my OIP and I will use my knowledge skills and influence as a social worker and address harm being done to patients based on social and political issues.

My Leadership Approaches

My dominant approach is authentic leadership. This type of leadership puts an emphasis on building relationships, fostering creativity, and earning people's trust. Authentic leadership has been found to positively influence employees' trust in their leadership and to enhance their emotions (Agote, Aramburu, & Lines, 2016). This style resonates with me because of my leadership philosophy of developing myself and others (Bass & Avolio, 1994; Ilies, Morgeson, & Nahrgang, 2005; Luthans & Avolio, 2003; Northouse, 2016). I endeavor to enhance learning and creativity and to assist AHS to build capacity among employees. I also draw from transformational leadership (which is also a dominant approach at AHS), as it prioritizes follower-leader relationships and fosters collaboration and intrinsic motivation in order to attain the strategic priorities of the organization (Ghadu & Mario, 2013; Northouse, 2016). Finally, I draw on the situational leadership approach because I believe in being flexible and adaptable, based on the needs of individuals (Northouse, 2016).

Both authentic and transformational leadership have limitations as they do not address strategies to involve disengaged individuals. Also, to date there has been limited research to prove their effectiveness (Northouse, 2016; Laschinger, Wong & Grau, 2013). Despite the gaps in the research, there are positive findings linking an authentic leadership style to employee creativity and thriving at work (Malik et al., 2016). Psychological research has demonstrated that transformational leadership is most successful during times of organizational change (Richter et al., 2016). Figure 2 is a graphical representation of my leadership philosophy to improve myself and others, which informs my dominant leadership style (authentic) and incorporates elements of transformational and situational leadership. It speaks to how my leadership approach influences my interactions with followers and represents the desired outcomes in followers to foster behavioral change. This figure illustrates transformation in the quality of relationships as it relates to the end goal of the OIP to enhance communication, build knowledge and skills, reduce preventable harm, and improve organizational culture.

I am committed to carrying out leadership through the lens of various leadership perspectives and with a strong philosophy of developing myself and others, all of which are essential to organizational development (Galbraith, 2016). This OIP enables me to participate in the development of my organization through various change initiatives that build the employees' capacity to address patient safety. According to Todnem (2012), "successful management of change is crucial to any organization in order to survive and succeed in the present highly competitive and continuously evolving business environment" (p. 369). Therefore, it will be important to examine various frameworks, models, and key organizational theories to situate the problem in the broader context.

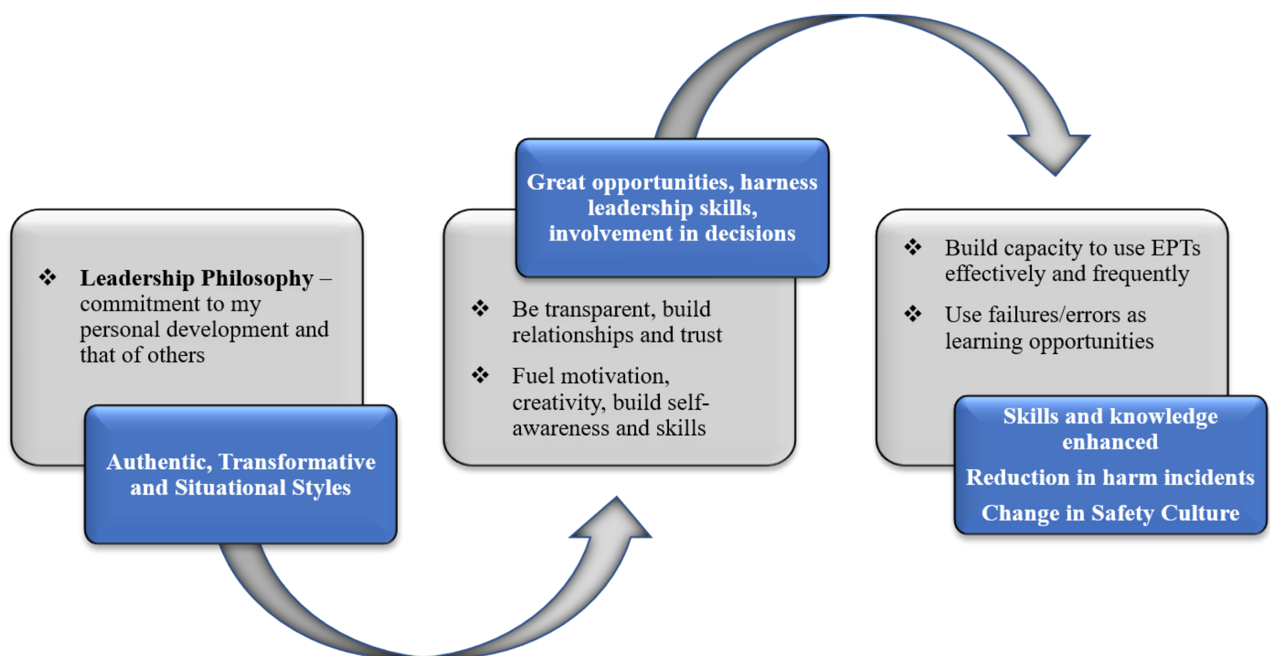

Figure 2. Leadership Model

Framing the Problem of Practice (PoP)

As a large healthcare organization within an integrated network of several healthcare institutions, AHS has undertaken several initiatives to address harmful events and become transparent by sharing information about these events as part of an organizational change. As indicated earlier, AHS is using the conceptual framework of an HRO. This centers around looking at all aspects of a problem to find the root causes, developing strategies to manage them using a bottom-up approach to empower frontline employees, and preparing for unexpected events (Christianson et al., 2011). Subsequently, AHS and other healthcare organizations have set the goal of becoming an HRO through a series of initiatives such as teaching HRO leadership methods to staff in leadership roles and providing education on safety behaviors and the use of EPTs to frontline healthcare providers. Historically, EPTs were not known to many or not used consistently in healthcare, which is why safety training at AHS has become mandatory since

2016 with the goal of enhancing communication among healthcare professionals. Despite the implementation of mandatory training, challenges in communication/information exchange remain and contribute to a significant number of serious safety events (AHS, 2018). The next section addresses organizational models and theories that support framing the PoP. It begins with the systems theory framework that guides this OIP.

Systems Theory. In the 1940s, biologist von Bertalanffy introduced the idea that parts within a system or environment function together and should thus be considered as a "whole". This idea became known as "systems theory", and it applies to individuals, organizations, and work cultures (Anderson, 2016; Mele, Pels, Polese, 2010; Stichweh, 2011; von Bertalanffy, 1969; Wilkinson, 2011). Systems theory applies to different disciplines and any system that exists in nature, including social sciences, and it became a framework to study various phenomena using holistic perspectives (Mele et al., 2010). In this work, system theory is utilized to frame the problem of practice (PoP) and set the condition that all analysis should be done with an acknowledgement that everything is related, or that everything acts on everything else. One can grasp how the system functions when it is understood how the parts work together. Systems theory can used to analyze problems across interrelated departments, situations, or functions. Looking at the whole, common problem across groups and departments can be seen.

Systems theory is now being applied broadly across many disciplines, including psychology, engineering, and management science. This theory has fundamental principles perceived as "largely intuitive to healthcare professionals" (Anderson, 2016, p. 1), such as working together to manage a patient's care. This approach contributes to causal analysis where the focus is not on personal failures but rather various interrelated factors that may have contributed to given incidents (Anderson, 2016); in other words, using a holistic approach in

problem-solving. To clarify, personal accountability is still a relevant component in system theory (Anderson, 2016). Applying systems theory to adverse events allows AHS to examine trends and issues as they relate to both individual and system failures (Anderson, 2016; Chuang & Inder, 2009).

Using the systems theory approach to analyze problems goes beyond single individuals to other related factors, which aids in understanding the occurrence of human errors in healthcare (Anderson 2016; Ross, 2014). Healthcare is complex and dynamic with hierarchal regulations and quality constraints around sets of behaviors (Chuang & Inder, 2009). In changing the safety culture at AHS, one must consider the existing structure that interplays with patient safety, individuals' needs, and working conditions. A potential limitation with systems theory is the need to gather accurate information for decision-making at a later time (Charlton & Peter, 2003). Figure 3 represents the interrelationships of the system in problem-solving at AHS. At the core of the figure is the patient, who may experience an adverse event by a healthcare provider who will then debrief the event with the team using a root cause analysis to find the source of the problem. This may result in a departmental change in a policy or procedure along with further analysis and documentation through the AHS safety office. Subsequently, the incident will need to be reported to PQA, which monitors and sets the standards for health quality in the province, as well as to the PHF, which is both the funder and governing body for provincial healthcare (as noted earlier).

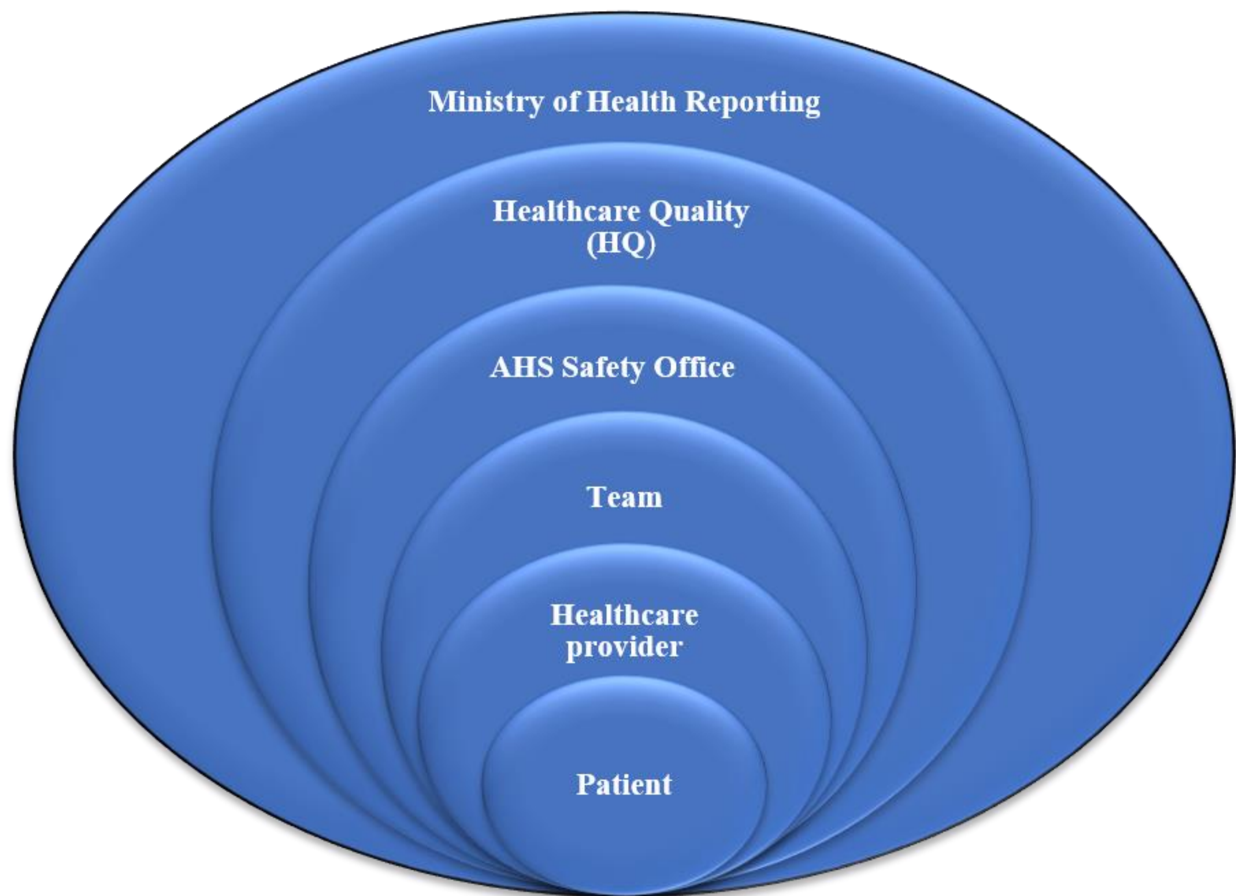

Figure 3. The Interrelatedness of Errors Using Systems Theory

Critical Components of the OIP

PESTE Analysis. A PESTE (Political, Economic, Social, Technological and Environmental) analysis examines factors impacting the PoP (Cawsey et al., 2016). An important component of this OIP is examining the PoP via a PESTE analysis and providing additional perspectives to consider when exploring how other external factors influence AHS (Cawsey et al., 2016). Table 1 provides a summary of the factors identified in the PESTE analysis, which will be further elaborated on.

Table 1

Summary of PESTE Analysis

PESTE factors	PESTE factors identified in AHS
Political	Ideologies associated with the provincial government Goals of AHS must align with priorities of the government Helps determine the agenda
Economic	Limited funding Limited resources for training and education, skill development and additional EPTs Threatens staffing ratio
Social	Communication challenges and lack of critical thinking Reluctance from employees to speak up Employees working in isolation rather than in teams
Technological	Limited procedures for error prevention use Inadequate processes for embedding EPTs
Environmental	Culture of "blame and shame" Infrastructure of AHS is not conducive to frequent performance evaluation and frequent monitoring of EPT usage

Economic factors. The economic factors are based on limits imposed to AHS hospital funding, because funding is received from an external source, PHF (AHS, 2018). Limited funding contributes to low staffing ratios and decreases in patient safety.

Political factors. Political factors influence decision making around resource navigation and attainment, as well as conflict management while negotiating for resources (Bolman & Deal,

2013). A recent change in provincial leadership (2019) saw the amalgamation of healthcare services, which includes cuts in funding and job losses (PHF, 2017). This change in provincial leadership could influence decisions around funding in healthcare, consequently impacting the resources required to embark on change initiatives. For example, more funding for employee training to build capacity around safety standards may be needed.

Social factors. The social component of this OIP addresses how people interact and relate to one another when delivering healthcare. Communication challenges is a big component of this OIP, which contributes to harm being done to patients at AHS (Maxfield et al., 2017). Hess (2014) referred to the general lack of critical thinking in society that contributes to challenges in communication, and recommended "critical thinking tools" be designed to assist in identifying "weaknesses in our mental models and to counteract our human tendencies – cognitive blindness, cognitive dissonance, cognitive biases, and our ego defenses – that make changing our mental models so hard" (p. 74). We should suspend our opinions, when we engage in dialogues to hear others point of view (Hess, 2014). According to Hess (2014), everything that we know should be considered conditional, and when we come across new evidence it should "decouple our egos from our beliefs" (p. 75). At AHS, it is necessary for healthcare providers to be aware of these innate cognitive tendencies to be able to incorporate these critical thinking tools in their social interactions as the paragraph below describes serious outcomes of poor communication.

The literature confirms that ineffective communications may result in death, medical injuries, misdiagnoses, and errors (Forondo, MacWilliams & MacArthur, 2016). The AHS Quality Indicator, used to measure incidents of harm, revealed that every three days someone is seriously harmed due to preventable errors (AHS, 2018). Maxfield et al.'s (2017) article highlighted results from focus groups with physicians and nurses, which showed that "many

healthcare workers communicate in ways that allow risks and problems to remain unaddressed – sometimes for years" (p. 2). Infante (2006) believes that it is relevant in clarifying the connection between patient safety as well as systems issues, team dynamics, organizational cultural factors, and healthcare providers, all which relates to social factors, such as interpersonal relationships among employees at AHS. Furthermore, systems theory suggests that analysis of incidents should focus on the surrounding interrelated factors, such as working conditions, resource availability, and social context, rather than just the individual, which speaks to the shift from person to systems (Anderson, 2016).

Technological factors. At AHS there are inadequate processes to embed EPT use and the use of technology to help improve this. In relation to the PESTE analysis, EPTs rely on technology for communication and help facilitate the usage to prevent errors or mistakes. Technological advancements include the use of best practices to help embed EPT use in order to prevent errors, as mistakes are a common phenomenon in healthcare that can result in serious harm or death (Mainline Health, 2019). Therefore, AHS and many healthcare organizations are adopting the use of EPTs to manage errors. Training is provided on the implementation of EPTs for all personnel who are directly or indirectly connected to the care of patients (AHS, 2018; Mainline Health, 2019). EPTs are communication strategies designed to prevent errors and technological advancement can help maximize EPT use. EPTs when used consistently will prevent skill, rule, and knowledge-based errors. AHS quality indicators point to preventable harm that occurs every three days (AHS, 2018) and frequent use of EPTs can reduce the number of harm incidents. Hobbs and Williamson (2002) shed light on how EPTs help manage human error, which may be in the form of skill, rule, or knowledge-based errors. Skill based tasks are routines such as brushing one's teeth that we do not think about, but which we may forget

occasionally Hobbs and Williamson (2002). Rule based errors are those preventions we learn through education or experience, but we may become confused, misapply, or choose not to follow the rules. A knowledge-based error is when we are in a new or unfamiliar situation with no developed knowledge, resulting in attempts to figure it out, which makes it error-prone (Hobbs & Williamson, 2002). Providing more opportunities for employees to apply information from training on how to use safety tools is one area in need of improvement.

Environmental factors. AHS is working to promote a blame-free work environment, as suboptimal use of EPTs contributes to incidents of harm and hinders the safe culture AHS is trying to foster among employees (AHS, 2018). Another environmental factor is that the structure of AHS does not allow for frequent performance evaluation or monitoring of EPTs, which will be addressed in the proposed solution of this OIP.

Bolman and Deal's (2013) Four Frames Model (human resource, structural, political, and symbolic) provides a further perspective on the PoP and on the organizational issues at AHS, which is presented below. For this OIP, these frames help us understand how AHS's governance, employees, and daily issues are facets of the change process and need to be considered in changing the status quo.

Application of Frameworks to the PoP

Human resources frame. The human resource frame aligns policies relating to employees' needs and working conditions, which together enable them to perform their work and consequently feel valued; thus, improving workplace morale (Bolman & Deal, 2013). This embodies the systems theory's holistic view on individuals' needs, their surroundings, and the various interconnected influences. Despite human resources findings that point to systemic

problems, literature reflects the prevailing view that errors and complications in healthcare are the result of individuals' failures (Stein & Heiss, 2015).

Research on human error undertaken by Reason (1994a, 1994b; 2000) defines unsafe acts committed by those who are in direct contact with persons or systems in healthcare, utilizes The Swiss Cheese Model; specifically,

> [the] failure of numerous system barriers and safeguards to block errors, each one represented by a slice of cheese. The defects in these processes are signified by holes in the cheese that allow errors to pass through and harm to reach the patient. (Infante, 2006; Ross, 2014; Stein & Heiss, 2015, p. 278)

The above example reinforces the shift in focus from individuals to systems (Reason, 2000). Infante (2006) noted the shared responsibility in addressing errors, which links to interprofessional care and patient safety. Interprofessional care fosters team dialogue and opportunities for shared decision-making that promotes safe care and reduces harm to patients. This further links to strategic goals like those of AHS in reducing harm and becoming an HRO. All of this connects to the human resource frame, which promotes linkages between employee needs, the work environment, and the organization's priorities. It does not, however, account for ambiguous situations within the context of the system. The structural frame sheds light on the systemic factors, as follows.

Structural frame. The structural frame addresses the optimization and efficiency of procedures, providing opportunities to assess whether standards are being met and whether role-change or capacity-building is required (Bolman & Deal, 2013). According to Bolman and Deal (2013), if the individual and the system do not match, there will be consequences for either or for both. A misalignment between the individual and the organization's goals could lead to poor

outcomes, specifically substandard job performance or lack of communication that may increase the number of incidents of harm to patients. AHS is mandated to detect and manage unsafe practices before they result in sentinel events or harm to patients (Banja, 2010, p. 1), but evidently there are still problems with AHS's compliance with safety standards and policies. For example, a staff member who is a second-language user and has challenges with communication could misapply or underutilize EPTs, consequently leading to unintended events of harm to patients receiving care. Based on the Swiss Cheese Model mentioned earlier, Stein and Heiss (2015) argued that several factors contribute to failures, representing the holes in the cheese, and further asserted that poor communication is "the most common cause of both active and latent adverse events" (p. 2). Therefore, performance management is a critical component in these issues, and consideration needs to be given to both individual accountability and structural factors, as they are not mutually exclusive (Anderson, 2016). Addressing the structural frame is necessary to enable capacity-building and to address all facets of learning (such as those related to systemic issues) that may arise. Healthcare providers must improve their skills (such as communications) in order to effectively use EPTs and minimize harm to patients.

Political frame. The political frame, discussed herein, plays a role in resource allocation, which in turn enables the learning resources required for skill acquisition. The political frame can be used to leverage the decision-making process, resolve conflicts, and advocate for resources (Bolman & Deal, 2013). Bolman and Deal (2013) also addressed how to use the competitive and conflicting aspects of politics as an opportunity to see varying viewpoints, build relationships, and share resources. This frame fosters engagement, allows people to strengthen relationships and have better dialogues, and build collaboration or coalitions with patients. In the context of this OIP, collective actions create opportunities for healthcare

providers and/or patients to address issues together in order to deliver safe care. At AHS, the priority goal is patient safety and there are concerted efforts to provide multiple approaches that foster safer care, both personal and systemic, however, the culture needs changing and symbols, rituals, and stories play a role.

Symbolic frame. The symbolic frame brings meaning and clarity to work changes, and uses the symbols, beliefs, and cultural capital of the organization. This is where the culture of the organization is examined in order to assess whether employees are open to its rituals, stories, and ceremonies (Bolman & Deal, 2013). When AHS's new mission and values were launched, each program was given a large poster representing the commitment of organizational members to the mission and values, which featured some of the key words. Additionally, members were given an extra badge to wear with their work ID badge that summarized the mission and values (mentioned earlier). These are examples of symbols and rituals.

Black (2003) provided a further explanation of symbolism in the workplace noting that symbolism plays a role in decisions relating to hiring, job assignments, promotions, and space allocation, as well as staff morale, and performance. At the same time, Black (2003) noted that symbolic messages have both the potential to ignite change and innovation, or in contrast, "kill a change effort" (p. 1). The poster has been an important element for the AHS change initiative, but in itself it is not sufficient to change either the culture or employees' attitudes or behaviors regarding patient safety.

As demonstrated in this section, systems theory describes the environment in which the PoP is situated. It provides a way to understand the interactions between human resource, structural, political, and symbolic frames as a complete system with interacting components. This facilitates the holistic approach to communication challenges arising from the

interactions among the four frames. Organizational change that takes into consideration these four frames has a greater chance of achieving the goal of improving communication and the use of safety tools. The next section identifies emerging questions that point to the complexity of this problem of practice.

Guiding Questions Emerging from the PoP

There are several lines of inquiry that stem from this complex organizational problem. These questions contribute to the PoP of problematic communications among healthcare providers, leading to suboptimal use of safety tools and resulting in harm incidents to patients. There are four questions as follows:

1. How do we build capacity with all healthcare workers to improve communication, engagement, confidence, and critical thinking skills?
2. How do we create a culture in which workers feel safe when speaking up for safety?
3. What are the barriers that hinder communication among healthcare providers and allow risks and problems to remain unaddressed?
4. What informal and formal communication processes (other than EPTs) between interprofessional healthcare providers can have a substantial impact on harm reduction?

Although some of these questions are beyond the scope of this project; some answers may emerge during the planning and implementation of this change initiative.

Leadership-Focused Vision for Change

There are inherent incongruences in the AHS as the objectives in fostering a safe work culture are not consistent with the reality. The 2015 safety culture survey discussed earlier

revealed that almost 50 percent of employees were not comfortable speaking up about unsafe practices, even if the practices may result in harm to patients. This signifies the need for change, as the organization's goals to provide safe care and a positive work environment are not aligned with reality (Cameron & Quinn, 2011). As mentioned earlier, AHS went through another process of "renewal" (due to a change in CEO) in 2018, with safety continuing to be the number one priority, which aligned with a new mission statement where patients' needs come foremost. To reinforce the emphasis on delivering safe care, AHS called for a significant shift in the culture from "blame and shame", which promotes non-reporting of incidents, to a "blame-free culture" where incidents are reported or resolved in a timely manner (AHS, 2016). Leadership was instrumental in fostering employee engagement to enable situational awareness for more problem-solving among staff with the goal of improving patients' safety, subsequently aligning the priorities for an improved safety culture.

AHS's strategic goals closely align with this PoP in enhancing communication among healthcare providers to enhance patient safety. It has been three years since the implementation of the "new" initiative to reduce the number of harm incidents, but the number of unsafe events remains high as evidenced by internally collected data (AHS, 2018). Szymczak's (2014) two-year ethnographic case study of a large hospital undergoing culture change revealed that too much focus on culture can "obscure uncomfortable phenomena, including history, politics and inequities in power that may contribute to unsafe care delivery" (p. 1). Talking about a need for change in culture is not sufficient in itself for this shift to occur; other conditions must also be met. Competing priorities, sometimes due to factors (as per the PESTE analysis discussed earlier) can minimize the importance of culture change for the organization. My goal as a healthcare educator at AHS is to bridge the gap from the current state to an improved future

state, but there is a need to find solutions to facilitate the shift in organizational culture which will be discussed in detail below.

Priorities for Change

The first priority for change is to develop, equip, and educate employees; thus, building staff capacity to reduce harm incidents. The second priority is to foster a safe work culture by creating more opportunities for individuals to discuss safety incidents. This could be achieved if leadership (such as myself) cultivates employee engagement, thereby heightening staff situational awareness for more problem-solving and subsequent resolution to take place, thereby aligning the priorities for an improved culture. The third priority would be to adequately meet relevant stakeholders' needs. Relevant stakeholders influenced and impacted by the changes include patients and families, healthcare providers (such as nurses, physicians, educators), and support staff. Other stakeholders include external groups like Community Services, the Patient Safety Institute, and the PHF.

Elements from authentic and transformational leadership that I identify with and incorporate in my day to day work will enhance my leadership style to drive the change. These theories emphasize relationship-building, active listening, creativity, and motivation (Northouse, 2016) and will help with balancing stakeholder needs, which would then result in the enhancement of patient safety. This will be further elaborated on in Chapter Two.

Change Drivers

Change drivers are "events, activities, or behaviors" that facilitate the implementation of change, in this case persuading AHS employees that change is necessary to reduce preventable harm incidents (Whelan-Berry, Gordon & Hining, 2003, in Whelan-Berry & Somerville, 2010, p.179). Whelan-Berry and Somerville (2010) shared a literature review that summarized some

progressive steps in driving change, including: establishing a compelling vision, engaging in dialogue both at a group and individual level to help individuals adopt and sustain the change. First, AHS' vision is to become an HRO by reducing preventable harm to zero, which will be used as a change driver. Secondly, I will work with both groups and individuals around the role they can play in reducing the harm. Furthermore, I will inform employees of the compelling statistics of harm incidents and how they have a role to play in reducing the numbers. The story would be personal, if individual employees reflect upon the potential for themselves or their loved ones to have similar experiences, as recipients of healthcare with insufficient harm reduction. Thirdly, for sustainability I will remind AHS employees of PHF requirements to report adverse events on the PQA website, which could impact future funding and public confidence. Additionally, a large number of AHS employees belong to a regulatory body that governs their practice (Colleges for Nurses, Physicians, Social Workers, and so forth) and have expectations that ongoing quality improvement would include patient safety. The next section describes organizational change readiness and the recommended tools to assess competing internal and external forces that shape change.

Organizational Readiness

Creating an organization that is ready for change is an important step in preparing for transformation from its present state to an improved future state. Organizational change readiness requires setting the climate, energizing people, and creating a "buzz" or urgency that the change is necessary, as discussed in Cawsey et al. (2016) and Murray and Richardson (2002). It also requires the sharing of data to elucidate reasons why change is needed, so that everyone has the same foundational understanding (Cawsey et al., 2016). The data can expose gaps in performance between the present and the envisioned future state, help to demonstrate that

the need for change is critical, and amplify awareness throughout the organization (Cawsey et al., 2016). In pursuit of this OIP, it is important to develop a clear vision, using various communication strategies to convey the message to the members of organization (Cawsey et al., 2016; Kotter, 2014; Murray & Richardson, 2002). This section describes organizational change readiness using various tools and practices, and also addresses competing internal and external forces that shape change, identifying key change-readiness stakeholders and the roles they play. Finally, it identifies strategies to overcome resistance by any stakeholders.

Change readiness at AHS. In 2016, AHS highlighted the necessity for change by revealing the results of an organization-wide Safety Culture Survey conducted in 2015. They used several activities to engage and energize employees around the need for change. The Safety Culture Survey's findings provided baseline data for the journey towards becoming an HRO. It initiated a series of preventable harm reducers, and confirmed that safety was and is the number one priority (Chassim & Loeb, 2013). These activities included a week dedicated to safety initiatives and the launch of a campaign to encourage employees to speak up with regard to safety issues, which created the "buzz" and drew attention to the need for change. The results of the safety culture survey demonstrated that at AHS, the Patient Safety Grade was 64% compared with the United States average of 76%. The overall Perception of Patient Safety was 59% compared with the United States average of 66% (AHS, 2016). The survey was adapted from an AHRQ (Agency for Healthcare Research & Quality) survey, with five questions being adopted and which included the overall perception of workplace safety (AHS, 2016). These statistics demonstrated that AHS was not meeting the benchmarks when compared to similar healthcare systems in the United States. The data were compelling and helped energize the need for change. The leading change tools and practices are discussed in the following section.

Leading change tools and practices. According to Cawsey et al. (2016), there are multiple factors to consider when assessing organizational readiness for change, including the following eight dimensions: "trustworthy leadership, trusting followers, capable champions, involved middle management, innovative culture, accountable culture, effective communications, and systems thinking" (Cawsey et al., 2016, p. 107). Further to this, some reflective questions were presented by Cawsey et al. (2016) that stem from these dimensions, which leaders can use to assess their readiness for change. These questions relate to dimensions including: previous change experiences, executive support, credible leadership and change champions, openness to change, readiness dimensions, rewards for change, measures for change, and accountability (Cawsey et al., 2016). Upon reflection, these topics should be kept in mind in relation to developing this OIP, as it must be aligned and have a symbiotic relationship with AHS managerial structure for maximum effectiveness (Cawsey et al., 2016).

Internal and External Forces that Shape Change

There are several internal and external forces influencing change at AHS. Since 2010, provincial hospitals have been required to report patient safety indicator results, which are available on PHF website (PHF, 2011). These are available to the public in order to promote a more transparent and accountable healthcare system and to support quality improvement efforts. AHS's responsibility is to ensure that standards are met and it is accountable to both the public and the PHF. In this province, each healthcare organization competes for limited public resources, and their funding is determined by the number of patients they serve and their success in achieving the priorities of their organization (PHF, 2017). Several other external factors also shape change at AHS, and with results on patient safety indicators now available publicly, it is important for AHS to show that they are moving forward. AHS's internal and external pressures

also involve insufficient funding from their primary funder (PHF), which means that there is competition for and reliance on public donations, and therefore trust must be maintained. As stated by Cameron and Quinn (2011), "organizational success depends on the extent to which your organization's culture matches the demands of the competitive environment" (p. 71).

Key Change Readiness Stakeholders and Their Roles

Several stakeholders are involved in igniting change and providing the necessary tools to move forward (Whelan-Berry & Somerville, 2010). These stakeholders include AHS healthcare providers, patients and family members, mid-level leaders, and other educators/emerging leaders (including myself). According to Cawsey et al. (2016), these stakeholders are considered change facilitators and implementers, i.e., external and internal influencers that help to encourage and support others in the change process. Internal change influencers include the AHS board of directors, senior directors, and the CEO. External change influencers include PHF, the integrated Local Health, and Community Health Centers.

Organizational change requires a diverse network of individuals at multiple levels who can act and mobilize individuals for the change to occur. A stakeholder analysis is a relevant strategy that can be incorporated to identify all stakeholders and understand their needs, interests, and positions regarding the needed change (Cawsey et al., 2016). However, there may be impeding factors than can hinder change, including resistance from some members, which will need to be addressed (Kotter, 2014, p. 31).

A strategy for managing resistance to change is to engage all stakeholders as early in the process as possible. Cawsey et al. (2016) noted the importance of change leaders seeking out the perspectives of stakeholders, i.e., their "predisposition and reasons for supporting or resisting the change" (p. 101). Anonymous surveys are a tool that could help to engage stakeholders, as they

can seek out the stakeholders' perspectives and feedback. Also, building a shared understanding and involving interested employees can help communicate the change vision and expedite the change process (Kotter, 2014; Murray & Richardson, 2002). This helps individuals and groups who will have a voice in the change process to feel more connected as AHS prepares the environment for change.

Chapter One Conclusion

Enacting change is a long and arduous process that will bring AHS to a better and safer place than it is currently. Initiating and creating readiness for change is important to ensure that everyone understands where and why AHS will engage in change. AHS's efforts to shift from a culture of "blame and shame" to a learning and supportive culture could take a while as there is no "one size fits all" solution; there must be an iterative process of change to ensure that the strategies fit with stakeholders' needs. Systems theory, PESTE Analysis, Bowman and Deal's four frame model, and my leadership styles (authentic, leadership and situational) will address systemic issues and practices, ultimately bridging the gaps. With enhanced knowledge, safety behaviors and tools will be used repeatedly and become embedded, hence creating a new culture. The next chapter will further explore the leadership approaches, models, and styles identified in Chapter One to help determine how institutional practices at AHS can be changed to achieve the new vision, leading to an improved future state.

Chapter Two – Planning and Development

AHS has not met the goals established to reduce harm incidents but aims to be further ahead in the goal of becoming an HRO. For example, AHS's quality improvement indicators have shown a significant gap between the current state and the desired one (AHS Internal Website, 2019). This chapter addresses the adoption and use of leadership practices that will enable the implementation of strategies to increase EPT use, subsequently further reducing preventable harm to patients. Chapter Two is organized in four sections: leadership approaches to propel change, frameworks for leading the change, organizational analysis, and leadership ethics. Possible solutions to improve the state of AHS solutions are offered and the one most suitable for my OIP is identified.

Leadership Approaches to Propel Change

The role of leadership is critical when enabling change with long lasting effects, as well as for influencing and motivating followers in the change process (Northouse, 2016). Hollenbeck (2017) found that a leader's vision is diminished when they are unable to influence their subordinates, as the subordinates are required to help carry out the change. The leaders at AHS (myself included) must identify their clear expectations of how to enhance patient safety. This OIP requires participation and collaboration from teams across various levels in order to develop and sustain organizational change. Currently, AHS' leadership approaches have elements of both distributed and transformative leadership, which is why emergent leaders, such as myself, are called upon from time to time to lead changes and to remain motivated and committed to improving our organization (Northouse, 2016). Therefore, distributed and transformational leadership are utilized as a framework to develop the objectives of this OIP.

Distributed Leadership. Distributed leadership allows for members of a team to rotate their roles and positions (based on skills, knowledge, and abilities), address issues, or problem-solve (Pearce & Barkus, 2004). As previously stated, AHS' dominant hierarchical structure like most healthcare organizations, where formal processes are carried out with an emphasis on accountability and liability for healthcare delivery and the safety of people's lives. To move this OIP forward, it is beneficial to provide opportunities for employees to engage in leadership roles, in situations where they have expertise. For example, I have used my teaching expertise to facilitate learning around EPT use, which provided me with the opportunity to influence the vertical hierarchy and be a part of this change process.

Distributed leadership is an effective framework that enables leaders to foster engagement and propel changes that will maximize the use of EPTs, and thereby reduce the number of preventable harm incidents. Distributed leadership, according to Fitzsimons, James and Denyer (2011), enables leaders and followers to work together on organizational objectives which promote cohesion in order to collaborate on patient safety concerns. Bolden (2011) contended that "distributed leadership is conceived as a collective social process emerging through the interactions of multiple actors" (p.251). This type of exchange provides opportunities to address some of the human resource, structural, and systemic issues within AHS as discussed in Chapter One. Specifically, the analysis of incidents of harm would take into consideration failures in various aspects, such as: knowledge gaps, poor working conditions, misalignments between individuals and their roles, low morale, poor job performance and unmet needs, which are factors relevant to the systems theory addressed in Chapter One.

The literature indicates that the term "distributed leadership" is sometimes used interchangeably with "team" and "shared leadership" due to the strong connection between the

terms and frameworks (Fitzsimons, James & Denyer, 2011; Northouse, 2016; Pearce & Barkus, 2004). Many studies have been conducted around the benefits of team engagement and cohesiveness and how this enhances work performance (Al-Rawi, 2008; Gino, 2016; Owor, 2016; Robertson & Cooper, 2010; Stumpf, Tymon & van Dam, 2016). A literature review on distributed leadership conducted by Bennett, Wise, Woods and Harvey (2003) identified three themes. Firstly, if the framework of distributed leadership is applied, the leadership is often an "emergent property of a group or network of interacting individuals" (Bennett et al., 2003, p.7). Secondly, the boundaries of leadership tend to be flexible (Bennett et al., 2003). Thirdly, distributed leadership works to involve people with various areas of expertise to share leadership responsibilities (Bennett et al., 2003). In applying distributed, or shared and team leadership at AHS, leaders can enable collaboration on actions to reach desired outcomes to help move the organization from the current state to an improved future state (Northouse, 2016).

Transformational Leadership. Transformational leadership emphasizes follower-leader relationships and fosters collaboration and intrinsic motivation to mobilize individuals around the strategic priorities of the organization (Bass & Avolio, 1994; Stewart, 2006). This leadership theory has been a focus of research since the 1980s and has been discussed by many scholars (Chen, Chengdu, Zheng, Yang & Bai, 2016; Ghadu & Mario, 2013). It is notable that Northouse (2016) and Stewart (2006), discussed the benefits of transformational leadership as well as its shortfalls, which includes a lack of empirical evidence around outcomes. AHS is embarking on transformational changes around the culture of the organization, which involves changing behaviors, attitudes, and existing habits. According to Tucker and Russell (2004), the use of a transformational approach allows for change and movement that alters the existing infrastructure and requires the influence of leaders to gain buy-in from organizational members.

Transformational leadership enables employees to fully develop their professional potentials and achieve both their goals and that of the organization (Smith, Montagno, & Kuzmenko, 2004).

Trust in leadership is a topic common in the transformational leadership approach literature and has become a research theme that is central to organizational theory (Ferrin & Dirks, 2002). Trust is needed when engaging, motivating and inspiring followers (for example, workers) to enable successful organizational transformation, including AHS. A study by Ozaralli (2003) explored how 152 employees from various industries rated their superiors' transformational behaviors and how much the employees felt empowered. The results showed that transformational leadership contributed to the prediction of subordinates' self-reported empowerment and that the more team members experienced empowerment, the more effective the team was (Ozaralli, 2003). Transformational leadership could be an approach to empower those who are disengaged at AHS, resulting in more team effectiveness to collectively mobilize change, improve communication, and reduce the occurrence of incidents of harm. Transformational and distributive leadership are approaches that I draw on regularly as they intertwine with authentic, my dominant leadership style (notes in Chapter One). Furthermore, all three leadership styles foster awareness, motivation, relationship-building, and creativity. Leaders can inspire hope, trust, new directions, and positive behaviors in their organization through individual/institutional transformational leadership principles and change practices (Tucker & Russell, 2004).

Both transformational and distributed leadership have potential shortcomings. Tucker and Russell (2004) cautioned about the potential dangers around the strong influence of a transformational leader, and recommended that these leaders remain accountable for their actions, as well as maintain certain boundaries. Gunter, Hall, and Bragg (2013) are some of the

critics of distributed leadership who argue that there is a lack of robust data to demonstrate the evidence of effectiveness of this leadership style, which can “make exhortations to adopt distributed leadership problematic” (p. 565). Timperley (2005) argues that “distributed leadership over more people is a risky business and may result in the greater distribution of incompetence” (p.417). Despite these concerns, these leadership theories contribute to understandings of leadership, employee development and some aspects of organizational change.

Overall, strong team work is needed to propel changes at AHS, which is a key tenet of both transformational and distributed leadership. Solutions to enhance teamwork will be a key component of the OIP recommendations in Chapter Three, which addresses communication challenges that result in risk of harm to patients. When leading organizational change, both leadership styles foster collaboration in order to mobilize people to achieve strategic priorities. example, a team may collaborate on a new process that enhances communication among themselves while they deliver patient care. Creative approaches on how distributed and transformational leadership frameworks are enacted at AHS require careful consideration given the existing hierarchical structure. The next section highlights the assumptions and change theories that inform the OIP.

Framework for Leading the Change Process

This section sheds light on the assumptions of the change theories and how they will inform the OIP. The change theories include: Murray and Richardson’s (2002) winning conditions for change and Bridges and Bridges’ (2016) transitional change model. This next section elaborates on the steps that will be beneficial in creating and implementing a solid plan to reduce harm incidents at AHS.

Reactive and pro-active changes. AHS's change initiatives are both reactive and pro-active and are driven by both external and internal factors due to the nature of the services being offered. AHS's strategic goal in becoming an HRO by reducing the number of preventable harms to zero is an example of pro-active change (AHS, 2019). Reactive change is when a significant safety event occurs, particularly one resulting in serious harm, which causes organizational change to occur, sometimes at the systemic or organizational level, resulting in changes around policies or processes. As indicated in Chapter One, AHS reported findings from a safety culture survey, which demonstrated that they were not meeting their goals in achieving zero preventable harm when compared to similar healthcare systems in the United States (AHS, 2019). AHS has sought out means to address these survey results, which help shape the change readiness of the organization, as indicated in Chapter One. Furthermore, evidence for the need for change was strengthened by the importance placed on provincial hospitals to embark on initiatives to reduce harm and enhance patient experiences (PQA, 2018).

An external force that impacts AHS decisions is the fact that provincial hospitals are required to report patient safety indicator results to the public on an PQA website (PHF, 2017), which heightens accountability, transparency, and pressure to ensure that safety standards are being met for individuals receiving healthcare. These processes are a demonstration of reactive change, i.e., change forced upon AHS by governing bodies (Buller, 2015). Internal forces could significantly affect changes around patient safety at AHS, including change agents such as myself, who are embarking on this OIP. Comparatively, there are also individuals who are resistant to change, which can put a brake on change or slow it down. The models discussed below address how this OIP can help in leading change for AHS by enhancing communication among healthcare and by increasing the use of EPTs to improve patient safety.

Murray and Richardson's Model. Murray & Richardson's (2002) "winning conditions" for change model was introduced in Chapter One as being potentially effective in implementing changes at AHS and is described here in greater detail. These authors developed a 10-step process called "winning conditions" related to "deep organization change, shared understanding, speed and momentum" with the notion that organizations should be built to change rather than to last (p.25). Murray and Richardson (2002) argued that organizational change should happen quickly in order to be lasting and they highlighted factors in regular organizational changes that can impede the desired changes, including increasing customer expectations, unrelenting globalization, disruptive technologies, and problems which are difficult to predict or to plan. To counter these challenges, Murray and Richardson (2002) presented a holistic and pragmatic perspective on change, comprising of what to do and how to do it, along with ways to develop appropriate frameworks for various deep changes that are common in organizations. The authors saw change as a continuous process based on the set of "winning conditions" being established for successful changes in organizations (p.10). Kotter (2012) took a similar approach to carrying out successful organizational change, stating that change needs to be rapid with regards to speed and momentum, and that forming a coalition of people to carry out the work was a significant factor.

Murray and Richardson's (2002) framework will guide changes around motivation, creativity, individualism, and innovation at AHS, which in turn can build momentum and, fuel empowerment and commitment. This will result in solutions for improving communication to maximize the use of EPTs and improve patient safety. At AHS, the need to involve patients and caregivers in decisions regarding change is critical, as this can improve innovation and fuel pro-active change (PHF, 2017). The "winning conditions" mentioned are parameters for successful

changes that should be established within the first 100 days of a change plan, which can help accelerate change activities at AHS. These winning conditions are as follows:

1. Correct diagnosis of the nature of the change challenge
2. Early development of shared understanding
3. Enrichment of shared understanding
4. Establishment of a sense of urgency
5. Creation of a limited and focused agenda
6. Rapid, strategic decision making and deployment
7. Human flywheel of commitment
8. Identification and management of sources of resistance
9. Follow-through on changing organization enablers, and
10. Demonstrated leadership commitment (Murray & Richardson, 2002, p. 25-30).

The first three conditions are intended to provide initial and continuous shared understanding; the second three generate speed; and the final four are about engaging "the critical mass" (Murray & Richardson, 2002, p. 11). In the context of AHS, a clear communication plan will be pertinent to this OIP in developing shared understanding that builds momentum. It would be beneficial to share internal data at AHS on the number of patients who experienced preventable harm to bring attention to the seriousness and frequency of safety concerns. In building a critical mass, the existing safety coaches at AHS can play a vital role in championing the change. These "winning conditions" intertwine with distributed and transformational leadership approaches, as they promote creativity and collaboration and motivate people to share in the vision of getting the work done. Bridges and Bridges' (2016) transition model is complimentary to Murray and Richardson's (2002) 10-step change approach,

as transition is inherent to the change process. Bridges and Bridges' (2016) model is described below.

Bridges and Bridges' Transition Model. Bridges and Bridges (2016) discussed three stages (beginning, middle, and end) of change transition. These three stages are critical to managing the change process, as there is a lack of recognition of transition changes in change and transition, which is not given enough priority. However, it is noteworthy that describing the transition process as involving a beginning, middle, and end is not practical in terms of implementation, since "transition begins with an ending and finishes with a beginning" (Bridges & Bridges, 2016, p. 5). The transition phase is cyclical and not linear and the beginning is the end of one phase and a transition to a new phase. The first step in Bridges and Bridges' (2016) model is the Ending stage, which is the end of one way of doing things and the start of a transition period leading to the beginning of a new way of doing things. Thus, the Ending phase is the ending of a way of how things are done, which involves "letting go" of how things are in the present.

Bridges and Bridges' (2016) second stage is the Neutral Zone, which is the in-between stage when the old way is gone but the new way has not set-in. Bridges and Bridges (2016) described this stage as the time when "critical psychological realignments and re-patterning take place", as the old and new realities are still present, and individuals may experience resentments, openness to learning, options and self-doubts (p. 5). In the Neutral Zone stage, it will be important for me as a change leader to use my authentic leadership style to pay special attention to individuals who may have doubts or resentments and instead build awareness and trust and offer support.

The third stage, called the New Beginning, involves leaving the transition stage and starting the new beginning to establish a new phase or energy, while gaining a sense of purpose and sharing as “the change begins to work” (Bridges & Bridges, 2016, p. 5). In Bridges and Bridges’ (2016) model, the New Beginning is a guide to support the employees at AHS in their transition into using EPTs more consistently and frequently, so that this becomes the new habit and ultimately reduces errors and harm incidents. It is important to note that in large organizations like AHS, different departments and individuals will be adapting to changes differently, and thus, will be at different stages simultaneously. Hence, it is imperative to diligently manage the transition using Bridges and Bridges’ (2016) transition management guide to help individuals through the transition stages, particularly when the OIP is implemented.

Bridges and Bridges (2016) noted that leaders often start with the Ending stage of the transition, which involves having employees do things the new way, without taking them through the Neutral Zone and the New Beginning, thus resulting in failure. Bridges and Bridges (2016) further asserted that the differences between change and transition are often overlooked as people use the terms interchangeably, whether the change is perceived as progressive or unfinished change. A take-away lesson for leaders from the model is to understand that “situational change hinges on the new thing, but psychological transition depends on letting go of the old reality and the old identity you have had before the change took place” (p.7). Bridges and Bridges’ (2016) model is complimentary to Murray and Richardson’s (2002) model, as transition is inherent to the change process. A description of their integration is provided in the following section.

Integration of Bridges and Bridges' Model with Murray and Richardson's Model

For this OIP, I integrated Bridges and Bridges' model (2016) with Murray and Richardson's (2002) model so that both the psychological and operational aspects of organizational change are addressed. To further clarify, Murray and Richardson's (2002) model focuses on how to act on needed change to improve patient safety while Bridges and Bridges' (2016) model helps people emotionally through the change. At AHS, the mandatory requirement of using a more structured approach in the form of EPTs in the prevention of patient harm is critical. Change requires individuals to change their behavior, which can evoke various emotions. For example, in the Neutral Zone, the ending (of the transition) involves emotions, so individuals may self-identify as having enthusiasm for, impatience with, or hope for the changes. Furthermore, the staff could self-identify as ambivalent, skeptical, or accepting. The third zone, the New Beginning, involves shock, denial, anger, and frustration/stress (Bridges & Bridges, 2016). The strategies provided by Bridges and Bridges (2016) will help manage the various emotions from each stage, which includes having one-on-one meetings, providing active listening, and coaching to individuals.

As a leader, it is important to be cognizant of individuals who need my support in ending old habits, which may involve providing guidance to employees so they can adopt the new habits. For example, changes related to programs and activities, like installing new software or incentivizing a new program are much easier to accept than psychological changes (Mackinnon, 2007). Acknowledging the ending and the associated losses with support from leaders helps employees have an easier transition, as "failure to identify and get ready for endings and losses is the largest difficulty for people in transition" (Bridges & Bridges, 2016, p. 7). Thus, support for

staff during change transitions will alleviate some of the negative symptoms associated with loss much faster, which enables them to embrace the new changes.

In summary, Murray and Richardson's (2002) winning conditions for change, as well as Bridges and Bridges' (2016) transition model are used to propel change at the organizational and individual levels. Specifically, for this OIP there are many opportunities to engage individuals in the change process in order to improve communication among healthcare providers at AHS using small changes that are tangible and lasting. The next section identifies the gaps and examines the current state of AHS to determine the best approach to bring the organization to an improved future state.

Critical Organization Analysis

Critical organizational analysis involves uncovering what to change at AHS. Gap analysis looks at the current and the future state to determine what processes to change (Cawsey et al., 2016). This process is a proactive approach to identify and seek out where the gaps are so that leaders can take measures to improve communication and EPTs at AHS (Cawsey et al., 2016). As a change leader, I am actively assisting AHS achieve its goals by assessing their current needs around communication challenges, patient safety, and the use of EPTs. Subsequently, this proactive approach could aid AHS in moving closer to its goal of being an HRO by increasing communication and maximizing EPT use, thereby improving patient safety. As discussed in Chapter One, HROs focus on patient safety by studying problems, examining root causes, and using collaborative approaches to identify and implement solutions (Christianson et al., 2011). This section addresses areas that need improvements by beginning with an examination of the current state of AHS in order to determine the most effective change strategies.

Current state. Patient safety is a critical issue for all Canadian hospitals and is a key component of this OIP. The impact of injury and preventable harm is significant as it touches all aspects of patients' lives and the lives of their care providers (AHS, 2017). It also affects the overall work environment, with respect to staff morale, sense of safety and security, and other aspects of work (CPSI, 2017). Having the knowledge that in 2017, "every 17 minutes someone dies (in Canadian hospitals) from an adverse event, which is equivalent to 31,000 people a year" is an important issue to address (CPS1, 2017, p.1). Adverse events can include medication errors causing adverse drug reactions, documentation errors, and injuries (CPSI, 2017). As noted in the 2015 AHS employee engagement survey results, almost 50 percent of AHS employees revealed reluctance to speak up for safety. The fear of speaking up for safety creates an environment that undermines the use of the very tools that are in place to enhance safety (Maxfield et al., 2011). This fuels my passion for being involved and focuses my efforts on improving communication among healthcare providers by teaching them to use EPTs. I became involved in an AHS training initiative to bridge knowledge gaps and to reinforce the mission and goals of creating a safer work culture. While teaching EPTs, I learned firsthand about the reasons for the insufficient use of EPTs and the challenges around speaking up about safety issues. By instilling confidence in employees and providing opportunities in a safe work environment for individuals to discuss safety, I can help foster a safer work culture. At the same time, it is important to recognize that the "prevailing culture of blaming" in healthcare contributes to medical errors and to gain commitment to improve rather than letting the blaming culture prevail. The existing communication challenges at AHS are clear and have been identified as an unsafe current state with communication gaps to address.

The communication gap. Communication challenges create a gap to be addressed because communication challenges contribute to the inadequate use of EPTs. Due to AHS' complex bureaucracy with multiple hospital sites, various procedures and processes to follow, the challenge is to design new, effective, and appropriate communication processes that improve the use of EPTs by employees who may have learning needs, lack of critical thinking skills, or are resistant to change (Hess, 2014). Some employees are ill-equipped to address patient safety practices and require behavioral changes or higher levels of critical thinking skills to engage in discretionary decision-making (Devers, Pham, & Liu 2004). Overall, the healthcare system, including AHS, has been attempting to improve quality and safety for many years, and has made some gains however, the challenges that remain are significant. For example, in 1847, Semmelweis discovered that lives could be saved through handwashing (WHO, 2009) yet we continue to work on hand-hygiene in the 21st century to ensure that preventable harm, in the form of skin-to-skin bacteria, does not impact upon patients. As in hand-washing, where the challenges are significant, so too are the communication challenges that hinders the optimization of EPTs. Therefore, communication gaps need to be closed to create an improved future state where EPTs are being optimally utilized by healthcare providers.

Analysis of Changes Needed

To close the gap in communication challenges, AHS needs an organizational framework to gain insight into the "complexity and interrelatedness of organizational components" (Cawsey et al., 2016, p.265). The Murray and Richardson (2002) framework is used to analyze the needed changes at AHS. This framework is also used as a guide to examine the structures the organization needs to simplify communication and develop strategies for change. Murray and Richardson's (2002) 10-steps are briefly discussed here as they relate to this OIP.

Step 1*: *Diagnosing the nature of change. This step helps identify the scope, details and likelihood of acceptance of the changes. In this case, the need for employees to feel safe when communicating about safety incidents will help AHS achieve their goal of reducing harm incidents (Murray & Richardson, 2002).

Step 2: Development of shared understanding early in the process. This requires the key stakeholders and champions of the change to be "on the same page", which Murray and Richardson (2002) saw as a multifaceted enabler for change in obtaining greater buy-in and successful outcomes. During the recent strategic development at AHS, leaders, employees and patients were engaged in the process to determine strategic goals to reduce incidents of harm. One hundred and fifty individuals were formed into working groups to address the safety concerns, develop training on EPT use, and establish benchmarks for progress. As AHS moves forward in this process, the goal is to foster wider understanding of this initiative and to involve more individuals.

Step 3: Shared learning to deepen shared understanding. Strategic change throughout the agency necessitates much learning and understanding, and requires key stakeholders, sponsors, and champions to be committed to the change. The mechanism for change is to use various communication channels to solicit input and share the goals and objectives. For this OIP, focus groups, emails, displays and posters, intranet and annual reports, and anonymous portals to solicit feedback from employees regarding the change will be used. Bi-monthly meetings will also be held by change champions (also called Safety Coaches) in order to deepen shared learning and understanding (Murray & Richardson, 2002).

***Step 4: Building momentum through speed and quick decision making*.** Murray and Richardson (2002) advocate for making decisions quickly when attempting change. This may be

difficult in a bureaucratic and hierarchical structure like AHS, where decision making and changes do not always happen quickly despite the urgency placed on improved safety measures for hospitals across the province. As mentioned earlier, the AHS funder, PHF, mandated the "Patient First" initiative, requesting that all healthcare services prioritize the need of patients, including their safety. Thus, systemic pressure will need to be used to communicate the urgency in quicker decision-making when it comes to this change.

Step 5: Creating a limited and focused agenda. This OIP focuses on patient safety as it relates to communication challenges and the under-utilization of EPTs among healthcare providers. The goal is to stay focused on these priorities with the overarching goal of improving patient safety. As previously discussed, safety is a top priority at AHS and a part of the focused change agenda.

Step 6. Using a parallel deployment methodology. This step will be used to speed up the implementation process. For example, instead of waiting for every staff member to receive mandated EPT training, the Patton Evaluative Thinking Framework (to be discussed in Chapter Three) would be used as a basis to guide a safety committee to look at some of the gaps that need to be addressed to improve communication.

Step 7: Create a human flywheel of positive changes. This metaphor refers to having people that are continuously driving change. AHS has engaged and rapidly mobilized employees, such as myself, who are committed to safety changes. These individuals are championing safety and engaging other individuals in the change process by sharing their knowledge with new employees. There will be opportunities to allow members who are motivated, skilled, and emotionally invested to become change agents (Kotter, 2014).

Step 8: Managing resistance and resources. Time will be spent building awareness and providing a variety of training and learning opportunities for the change initiatives. This includes monthly updates to all personnel on safety activities and how AHS is meeting its safety benchmarks. Resistance is evident through the lack of engagement by some employees, but understanding the reasons behind resistance and change, lack of engagement, and buy-in is helpful in guiding strategies to work with these individuals in bringing them on board.

Step 9: Effective follow-through on changing organizational enablers. One key organizational enabler for change is performance evaluation and employee development. Alignment is key to change performance measures to correspond with recognition and reward systems as per Murray and Richardson (2002). In 2018, AHS changed the performance measurement system with the key strategies embedded in the organizational core values of safety, compassion, teamwork, integrity and stewardship. Currently, an employee's performance is measured through these core values. It has been communicated that safety is the priority value and it should permeate the remaining four values. This means that efforts around compassion, safety, teamwork, integrity and stewardship should lead to safer patient care and a safer work environment. Employees who demonstrate these values (as evidenced through their work) receive financial rewards in the form of salary increases or recognition/awards and those who underperform should receive coaching and support. However, the performance management plan may not address the gap existing for all employees who are under-performing, particularly those with unique challenges that impede their ability to communicate effectively and maximize the use of EPTs.

Step 10: Demonstrate leadership commitment. For AHS to experience successful change, leadership by example is required at all levels. Utilizing authentic, distributive and

transformative leadership styles allows members to lead initiatives, celebrate small wins, and further the discourse around organization culture. AHS' diverse engagement strategy is in place for change and leadership commitment, but the inherent bureaucracy and hierarchy that exist in healthcare (identified in this chapter and Chapter One) could impact the speed of change and de-motivate individuals interested in change leadership (Kotter, 2012). There are challenges within the AHS hierarchy given that almost 60% of employees indicated difficulty making inquiries to individuals with more authority. The complex processes and procedures associated with a multi-hospital configuration, such as AHS, presents obstacles to designing new, effective, and appropriate communication processes that facilitate the use of EPTs by employees who may have learning needs, a lack of critical thinking skills, or are resistant to change. AHS's leaders must be knowledgeable about historical incidents, government policies, and best practices, which will enable them to analyze the work environment to produce the desired resources (Cawsey, et al., 2016; Murray & Richardson, 2002). Additionally, having continuous feedback from employees allows leaders to be aware of their blind spots, which aids in continuous improvement and internal alignments (Cawsey et al., 2016).

The 10-steps of the winning conditions (Murray and Richardson, 2002) demonstrate the analysis processes enacted through this OIP for AHS. Furthermore, this framework is used as a guide to examine structures the organization requires in order to simplify communication and develop strategies for change. It is important that AHS's organizational components work both individually, and also function as a system to move forward to achieve our goals. Consideration must be given to the challenges and barriers to improving patient safety that are systemic in nature, given that they include attitudes, beliefs, and cultures. These factors are critical and I propose solutions in the next section of this OIP.

Possible Solutions to Address the PoP

This section proposes solutions to improve communication, optimize EPT use and improve patient safety of the individuals receiving health care at AHS. The three proposed solutions are: rounding for outcomes approach, continuing with the status quo, and communication through evaluative thinking. A discussion and comparison of the resources needed for the three solutions is presented below. The preferred solution incorporates Patton's Evaluative Thinking Framework, which has been identified as effective through research and best practices (Buckley, Archibald, Hargraves & Trochim, 2015; Patton, 2015).

Solution One: Rounding for outcomes. The first solution uses a Rounding for Outcomes approach (StuderGroup, 2019) to address the inadequate communication with respect to the utilization of EPTs at AHS. The Rounding for Outcomes (StuderGroup, 2019) approach is based on best practices to engage employees, leaders, patients, and physicians by asking specific questions and obtaining information that can be used to provide quality care (StuderGroup, 2019). The method was developed by the StuderGroup (2019) as an evidence-based leadership model to maximize engagement with all employees. Managers can exercise Rounding for Outcomes in one-to-one meetings with each employee every one to two months to discuss what is working well, what needs improvement, the tools and equipment required to do the job, set clear expectations, and provide rewards and recognition (StuderGroup, 2019). During the one-to-one meetings between employees and managers, the Rounding for outcomes approach provides opportunities to focus on and address employee-specific issues and concerns including: training, support needed, work challenges, as well as provide positive reinforcements, recognition and rewards (StuderGroup, 2019). One-to-one meetings provide an opportunity for managers to assess employee communication abilities and to find out the extent in which

employees are utilizing EPTs to enhance patient safety. Strategies that need to be utilized to facilitate the use of Rounding for Outcomes are discussed further in this paper. Reich (2017) described the rounding program as an effective approach for leaders to support employees by hearing concerns, building relationships, and standardizing behavior. Rounding for outcomes using MyRounding software (Cliniko) to aid in the documentation of any action barriers, the identification of best practices, and track progress—all of which are beneficial to continuous improvement (StuderGroup, 2019). This will be piloted in one area first, followed by a safety campaign to promote EPT use and inform employees of “Rounding”. Three months will be allocated for change readiness using this new method. While undergoing the change, there will be heightened engagement to ensure that the information reaches everyone using technology (e.g., twitter, internal email, internet, video descriptions). Each department will host a staff meeting dedicated to sharing information around this new strategy, along with three Town Hall meetings where employees and senior leaders can exchange ideas.

Resources. The resources needed for this solution include $60,000 to hire approximately six casual nurses and two administrators to provide extra patient care and coverage during the transition period in the pilot area. Dispersing information in multiple ways will require stationary supplies for posters and flyers to be used in the campaign. Some of the change champions could be delegated to manage the social media, video creations and emails in collaboration with the existing AHS Communication Department. Lastly, hospital volunteers need to be recruited to help with flyer distribution and to champion this change by spreading the word and discussing strategies to gain commitment. New technology hardware/software/training for training managers on how to utilize the “Rounding” approach is required. As the Rounding for Outcomes approach is too costly and requires too much one-to-one time between

management and employees. Hence, the Rounding Approach was not chosen to address the PoP identified in this OIP.

Solution Two: Continue with the Status Quo. Continuing with the status quo could be one solution to reduce the number of harm events as AHS. It has been acknowledged by the Institute of Medicine (1999) that errors are expected to happen and have used the phrase "To Err is Human" to help increase reporting of medical errors. AHS has been striving to reinforce the use of EPTs among employees by incorporating safety into the organizational strategic mission and values statements, and providing training on the use of tools to all employees (AHS, 2018). Based on several sources (e.g., safety assessment, diagnostic and culture surveys, "Root Cause Analysis Files", and commonalities between events), the most common cause of incidents are as follows: the lack of critical thinking/questioning attitude, normalized deviance (where employees develop workarounds of care process, which are difficult to follow or do not work properly), and ineffective communication (AHS, 2018).

Daily safety huddles are being utilized to help with the implementation of the change initiative, however, there are power differentials between staff and leaders that prevent staff members from speaking up about safety incidents. The huddles are facilitated by leaders, which further reinforces the inherent hierarchy in healthcare, as well as the lack of critical thinking and questioning attitudes (Black, 2013; Hess, 2014; Maxfield, et al., 2017). The benefit of the huddle is that employees get to practice the use of EPTs and share how they have applied EPT to help prevent harm events. Huddles also provide an opportunity to address issues that arise, by looking at the root causes of harm incidents and problem solving together as a team. The safety huddles reinforce the HRO framework to engage employees at every level in resolving issues and improving quality (Chassim & Loeb, 2011).

Resources. Continuing the status quo in AHS quo requires $40,000 to bring in additional staff to improve the ratio of staff to patients, which could improve patient care. There may need to be some purchase of whiteboard stationary supplies, such as a whiteboard to display the framework being used, results from tracking the number of errors, and the goals to be accomplished. A dedicated time of 5-10 minutes at the start of each day will provide adequate time to huddle and raise concerns, as well as to learn from incidents or near misses. The next section is a third solution that will address communication challenges more effectively to maximize the use of EPT and to improve patient safety.

Solution Three: Communication through Evaluative Thinking. As indicated in Chapter One, the Canadian Medical Protective Association (2011) case files shed light on communication challenges, barriers, and the lack of knowledge that contribute to errors during patient care. As a leader, I am committed to finding solutions that address knowledge enhancement, addressing the gaps in the uptake of EPT, and develop processes and strategies that improve communication and maximize EPT usage. Effective communication strategies prevent errors from reaching patients, such as team-based work that utilizes the Evaluative Thinking Framework (Patton, 2015) to improve the sub-optimal use of safety tools. This solution requires strategies such as forming team-based safety committees, having change agents attend training on Patton's Evaluative Thinking Framework, and developing communication processes and algorithms that identify steps or processes to take in order to prevent incidents of harm. In addition, the use of tools that help in daily interactions between organizational members can enhance communication about the full utilization of safety tools. When implemented correctly, these communication methods prevent harm to patients.

According to Patton (2015), evaluative thinking is a systematic process oriented to achieving all results that answer the following questions: 1) What are the results expected? 2) How can these results be achieved? 3) What information is needed to inform future decisions and actions? and 4) How can we improve future results? The byproduct of using Evaluative Thinking Framework is the building of consensus around what reality looks like and determining the best way to navigate through it. Evaluative thinking is the main characteristic of learning organizations (Patton, 2015) because useful evaluation supports action. Patton's (2015) Evaluative Thinking model enables people to share what is on their minds which has the potential to foster cohesion among inter-disciplinary team members, enhance communication, and reduce harm events. Patton (2015) argues that "evaluative thinking becomes most meaningful when it is embedded into an organization culture" (p.1).

The Evaluative Thinking Framework (Patton, 2015) is based on work in fields of education, cognitive science, and critical thinking and Patton's own experience as an evaluation capacity builder (Buckley, Archibald, Hargraves & Trochim, 2015), but further research is still being conducted on Patton's Evaluative Thinking Framework (2015). According to Buckley et al. (2015), "evaluative thinking is essentially critical thinking applied to contexts of evaluation" (p.375). Therefore, embedding evaluative capacity building at AHS will be the lubricant that smooths out the decision process and minimize inconsistent communication between team members. The evaluative thinking process can be embedded into the existing daily Safety Huddle discussed earlier. The guideline for promoting evaluative thinking involves defining how staff and decision makers practice evaluative inquiry. Evaluative thinking helps the change process move along when people engage with each other in the process of evaluative inquiry (Patton, 2015). Hence, Evaluative thinking could be implemented as a process to support

actionable decisions by the Safety Committee at AHS (proposed in Chapter Three) as they come together to share understanding of the changes to be implemented. Buckley et al. (2015) outlined strategies to promote evaluative thinking which include: engaging team members, starting with small bite size chunks; giving each member opportunities to practice, while catering to the learning needs of participants (both in formal and informal settings); helping individuals ask questions and apply evaluative thinking in multiple environments.

***Resources*.** The resources needed for this solution include a budget of approximately $50,000. The cost of travel and lodging expenses could amount to $30,000 for Patton to provide a week-long training session at AHS with respect to the Evaluative Thinking Framework and its process. The remaining $20,000 is to be used for training development, materials, and refreshments for leaders (a train-the-trainer strategy is proposed) and compensate relief staff for those attending training. Once we have a group of staff who are trained in the Evaluative Thinking model and process, they would provide mentorship to employees in various units with respect to using this framework. Other resources associated with this approach include training room space, refreshments, printing, and materials.

Comparison of all three solutions. Table 2 below demonstrates how all three solutions lead to only one possible answer. The table highlights the differences between the three solutions. If the status quo is maintained, it does not allow for adequate time for problem solving. The daily Safety Huddles are being facilitated by leaders (reinforcing hierarchy) yet communication challenges remain an issue, as evidenced by the high number of harm incidents discussed earlier. Safety Huddles are also situational and do not allocate enough time for substantial discussion and team decision-making. The Rounding for Outcomes approach has the potential to break down hierarchy barriers at AHS, as well as provide opportunities to give

everyone a voice during the one-to-one meetings, which would further enhance communication among healthcare providers of various disciplines/departments. Although the Rounding for Outcomes solution provides for one to receive individualized training to bridge gaps in communication, the advantage afforded by group interaction is missing, which is needed at AHS to utilize team-based structures and to break down hierarchies.

Table 2

Possible Solutions to the Problem of Practice

Comparison of solutions	Rounding for Outcomes	Maintaining Status Quo	Evaluative Thinking Framework
Purpose	Meetings between leaders and employees to raise concerns. Focus on key questions Improve satisfaction and quality of service	Safety huddles lead by leaders Employees to raise concerns to improve quality, prevent errors and reinforce EPT.	Pro-active approach to problem solving, Team based problem solving Reflect and evaluate situations and share work to be done
Resources	Allocate time to meet, purchase of software MyRounding to guide process. $60,000	Allocate for all employees to meet, use of root cause analysis framework. $40,000	Use of Patton’s Evaluative Thinking Framework. Key leader receives training, then mentor others to learn this approach. $50,000
Timeliness	Allocate time to meet each staff member every 1-2 months. 6 months Campaign for Change readiness.	Daily meetings, issues are resolved, based on situations that happened in the past or have potential to happen	Bi-weekly safety committee, Training time, cost for travel and stationery to develop processes and tools
Pros & cons	Inexpensive Time consuming Frequent support	Hierarchical, costly Opportunity to speak-up Limited time	Build cohesion, break down hierarchy, principles are easy to learn, costly, limited meeting, easy to measure success

Based on the analysis shown in Table 2 above, the best solution for this OIP is Solution Three*:* Forming a team-based Safety Committee using the Evaluative Thinking Framework to help with effective communication and decision making. The Evaluative Thinking Framework is a pro-active approach with the potential to change how people think, rather than situational based, as seen in the Safety Huddles of Solution Two. Furthermore, the Evaluative Thinking Framework promotes the principles of distributed and transformational leadership because it involves collective action as the team solves problems. The next section addresses ethical responsibilities of different players at AHS during the change process using this solution.

Leadership Ethics and Organizational Change Issues

This section addresses leadership ethics and organizational change issues. It sheds light on the transformational and authentic leadership approaches that I identify with. Ethical considerations and challenges relating to the change process at AHS are discussed in relation to improving communication to increase EPT use.

Ethics and My Leadership Approaches

Ethics are centered upon trust, honesty, morality, respect, relationships, and support for others (Liu, 2017). Ethics are the code of values and moral principles that help shape moral requirements and behaviors and that can dictate the ways of society (Kapur, 2018; Liu 2017; Northouse, 2016). Kapur (2018) suggests that ethics address the intentions of individuals and their virtuousness. Ethical theory gives us a framework that includes principles or rules that assist us with decision making (Kapur, 2018). A plethora of literature speaks to the ethical behavior of leaders, the impact of ethics on their decision-making, and how ethics drive their response to circumstances around them both implicitly and explicitly (Kapur, 2018; Liu, 2017;

Mihelic, Lipicnic & Tekavcic, 2010; Northouse, 2016). Therefore, it is important to engage in ethical practices to build trust, motivate others, and drive change.

My authentic, transformational and situational leadership style enables an ethical approach in leading changes at AHS. Authentic leadership emphasizes relationship building, self-awareness, trust and reflection, which are needed to harness a strong and supportive work environment (Černe, Jaklič & Škerlavaj, 2013; Northouse, 2016). In using an authentic approach, my aim is to model ethical practices through trust, honesty, and respect during my interactions with employees at AHS. Using an authentic style allows me to foster strong relationships with individuals and support them in the modification of their behavior for improved communication and patient safety. I will carry out ethical practices based on my authentic leadership style, which can be accomplished through my role as an educator, to teach, build awareness, inspire, and role-model—to foster ethical behaviors and help shape moral requirements around safe practices.

Transformational leadership overlaps with my authentic leadership—authentic leadership comes natural to me and I draw on transformational leadership, as discussed in Chapter One. An authentic and transformational leadership approach will enable me to continue carrying out my ethical responsibility to support others, build relationships, and to be honest and trusting (Ferrin & Dirks, 2002; Ghadu & Mario, 2013; Northouse, 2016). In using a transformational approach, I expect to influence individuals by my intentions and virtuousness (Kapur, 2018). The leadership approach facilitates viable solutions that address the time needed for employees at AHS to adequately learn and practice the use of EPTs and have a safe work environment to address safety concerns.

I am committed to ethical practices, which includes abiding by the Code of Ethics and Practice Standards of the Provincial College of Social Workers and Social Service Workers (PCSWSSW, 2015). Furthermore, the Practice Standards, which inform my values and belief systems, guide my practice in addressing safety issues related to patients receiving healthcare. Todnem By, Burnes and Oswick, (2012) noted that "leadership and change are underpinned by a clear and transparent system of ethics and accountability" (p.3). As I pursue the solution described in the previous section, I am aware that I am responsible for my actions and decision making for which others can hold me accountable. Additionally, a tool called IDEA (Identifying the facts, Determining the relevant ethical principles, Exploring the Options, and Acting) is used by AHS, which is an ethical decision-making framework (Regional Ethics Program, 2013). It is my responsibility to ensure I adhere to these Ethical frameworks and guide others to have similar awareness of the three frameworks, which can aide them in carrying out ethical practices that ensure patient safety (AHS, 2018).

Ethical Considerations and Challenges at AHS

Ethical dilemmas are a hallmark of leadership because the accountability process starts and ends with the leader (Kapur, 2018). Ethical dilemmas impact daily life of patients and result in significant harm or death at AHS. Ethical responsibility and accountability lie with AHS and their employees to work through ethical dilemmas and ad hoc situations. Organizational ethics refer to the values, culture, trust and norms of the workplace and its employees and addresses rules, policies, procedures, and outcomes (Kupar, 2018). Organizational ethics address relevant components of the core values while embarking on organizational change; in this case the change centers around AHS' responsibility to ensure that patients receive safe healthcare and that employees are equipped to carry it out. The employee engagement survey conducted by AHS in

2015, which showed employees' reluctance to address safety even if a patient faces harm, speaks to power imbalances and fear of reprisals, which underscores the ethical dilemma at AHS. Ethically and legally, employees are obligated to speak-up when there is potential that someone could be harmed. More resources and support that empower employees to speak up for safety are needed. The employees at AHS are likely making a risk-reward judgement and perhaps concluding that there is a greater risk to speaking up versus not speaking up. The AHS environment needs to change so that the benefits of speaking up prevail, which is why this OIP is needed.

Chapter Two Conclusion

This OIP presents a significant change for all employees at AHS. Leadership and change processes are the foundation for propelling the change. The organization has made some progress in their existing vision and strategies to reduce the number of harmful events based on a reactive and pro-active approach, but due to the ongoing occurrence of preventable harm, it requires appropriate solution. Patton's Evaluative Thinking Framework involves team decision making with a supportive structure that could aid AHS to abide by organizational ethics as they strive to improve services to patients receiving care. Leading with an authentic, situational, and transformational leadership approach allows me to be transparent, supportive, build self-awareness, and inspire ethical behavior and collaborative practice. Additionally, using Murray and Richardson's (2002) 10 winning conditions to propel the change, as well as Bridge's (2016) Change Transition model, will enable this OIP to move forward. The next chapter addresses the change implementation plan, which includes the communication process, resources needed, potential challenges, monitoring, and evaluation of the change.

Chapter Three: Implementation, Evaluation and Communication

The purpose of this chapter is to outline the change implementation plan for the PoP: Ineffective communication among healthcare providers leading to patient safety issues. Chapter Three outlines the change implementation plan, a process that will enable the increased use of EPTs, which is a critical component of this OIP. It operationalizes this OIP with a multi-pronged approach that seeks to address communication as it relates to the use of EPTs. This chapter also develops a plan for implementing, monitoring, and communicating the changes that address the problem of practice. This first section identifies the goals and priorities for change, then describes a plan for managing the transition, and ends with the acknowledgement of limitations, challenges, and next steps for future consideration.

Change and Implementation Plan

Goals and priorities for change. In working to improve safety for patients receiving healthcare at AHS, the goal of this OIP is to incorporate Patton's Evaluative Thinking Framework, identified in Chapter Two, to aid in the reduction of preventable harm, with the primary focus being on communication challenges and barriers that prevent optimal use of EPTs. The initiatives involve: 1) providing education that increases healthcare providers' knowledge in order to bridge gaps in the uptake of EPTs; 2) facilitating group work with healthcare providers in order to develop processes and skills to help find a consistent way of communicating among themselves; and 3) creating tools to ensure that EPTs are being embedded into practice.

As illustrated in Figure 4, there are three timeframes for implementation. The first (January – March) addresses the initial planning stage. The second (March – September) focuses on the implementation of the plan. The final phase (September – Ongoing) of this OIP speaks to the ongoing process of change and the iterative planning that is essential to ongoing

organizational improvement. The steps to accomplish the three initiatives are outlined in Figure 4.

Figure 4. Implementation Plan for the Reduction of Preventable Harm

Knowledge gaps. The first initiative is filling the knowledge gap to increase EPT usage is essential in reducing preventative harm events at AHS and it is within my sphere of influence as a safety instructor to address the suboptimal use of EPTs. The underutilization of EPTs is known to lead to significant safety incidents that could have otherwise been prevented. This change plan outline strategies to address the healthcare knowledge gaps mentioned under goals and priorities for change.

1. Standardize yearly performance appraisals to include questions on EPT use by the Human Resource (HR) department
2. Mandate managers to assist employees with individual goal-setting around safety tool acquisition and utilization

3. Develop a 20-minute e-learning module on EPTs and ways to communicate safety incidents for the Safety Education program
4. Have the e-learning module adapted as part of a mandatory, yearly e-learning course and "Refresher Training"
5. Monitor e-learning through quarterly check-ins between employees and managers and introduce a greater than 80-percent passing grade as a requirement
6. Monitor compliance through a built-in tracking system by IT department
7. Conduct outcome-based evaluations for all employees on the new performance appraisal system by using anonymous surveys
8. Use pre- and post-training surveys to determine the uptake of EPTs

Develop processes and skills. The next initiative focuses on the steps and ways to develop processes to facilitate a consistent way of communicating among healthcare providers by using Patton's (2015) Evaluative Thinking Framework. The outcome of Patton's framework use is predetermined as it uses a robust process for team involvement. As described in Chapter Two, Patton's framework has guidelines for effective decision-making, which makes it effective for team-based committee meetings. It also fosters cohesion among interprofessional team members, thereby enhancing communication, which in turn reduces harm events. Furthermore, evaluative thinking allows for team-based reflection, encourages critical thinking, and enhances decision-making (Buckley et al., 2015). Stimulating discussion on EPTs, and more specifically, reviewing what went wrong, the lessons learned from it, and identifying which safety tools could have prevented that safety incident from occurring, will augment situational reporting and help prevent future safety incidents. Guidelines for promoting evaluative thinking are shown in Figure 5.

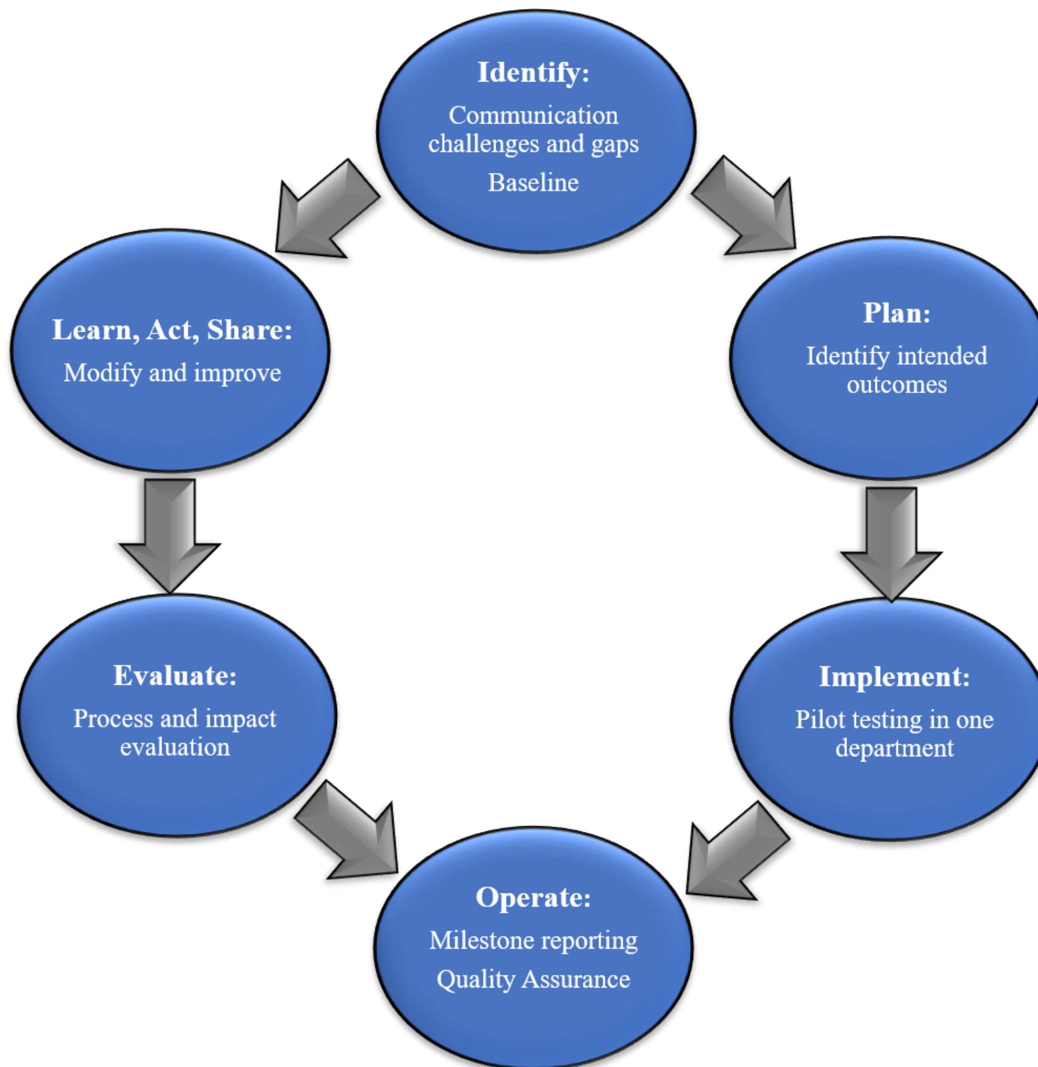

Figure 5. Guidelines for Embedding the Evaluative Thinking Framework. Adapted from Patton (1990), in Community tool box. (2018). Retrieved from: https://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/framework-for-evaluation/main

As demonstrated in Figure 5, the six boxes outline the steps in team decision making based on Patton's (2015) decision-making framework, which includes Identifying, Planning, Implementing, Operating, Evaluating, Sharing and Learning. All of these steps in the group work process will enable a new culture of safety, improve EPT use, and reinforce a positive culture. The act of doing things over a time becomes the norm and part of the culture at AHS.

Distributed leadership will be managed and orchestrated in fostering shared vision and collective problem solving (Gunter & Bragg, 2013). The steps for fostering consistent team communication include:

1. Forming team-based Safety Committee to develop strategies to embed EPT use
2. Developing processes to address consistent communication among committee members
3. Forming a committee representative of members from various professional groups and have change champions present at the meetings
4. Inviting patients and/or caregivers to participate on the committee
5. Encouraging active participation from all community members, i.e., chairing and minute-taking
6. Having the committee report on their progress at each team meeting
7. Making use of Patton's Evaluative Thinking Framework (2015) mandatory, which includes identifying the issues, planning, implementing, evaluating, learning, acting, and sharing of takeaways
8. Including monitoring activities such as bi-monthly milestone reporting and celebrations of small wins

Embed safety tools. The next step in implementing a change to improve patient safety is to create strategies to ensure that EPTs are being embedded. Sustaining change is very important in transforming the culture of AHS. As a safety instructor and a change agent at AHS, it is within my sphere of influence to ensure follow-through on this change plan, and therefore, I will engage the various departments to allocate adequate resources and help champion the changes

through coaching, mentoring, and support. The following strategies will be used to embed EPT use:

1. Creating a 45-minute webinar with interactive tools, question and answer document, case scenarios, and reflection that will address the communication challenges impacting EPT use
2. Posting safety-themed boards in central areas of AHS to display the EPTs
3. Putting up charts indicating the relevance of EPT use as per regulatory College requirements
4. Creating opportunities for participation in Canadian Patient Safety Week
5. Handing out materials that contain visual cues on EPT use
6. Incorporating storytelling on EPT misuse in team meeting agendas
7. Scheduling regular leaders' walk-arounds to monitor progress
8. Appointing a designated team-based safety coach on every unit who will provide peer support and encouragement, give feedback, organize team-based activities, and reinforce the use of EPTs
9. Monitoring the effectiveness of Webinars based on attendance and feedback, and modifying as necessary
10. Conducting content- and outcome-based evaluations to determine the effectiveness of the strategies

The above-mentioned steps fit within the context of the overall organizational goals and are intended to assist AHS in its vision to become an HRO. This vision establishes the framework for decision-making and places safety as the top priority at AHS. My goal is to reduce knowledge gaps, develop processes for consistent communication between healthcare providers,

and implement strategies to entrench EPT usage. These are all in alignment with AHS's vision to reduce the number of harm incidents. Change readiness is an ongoing process at AHS, as indicated in Chapter One, which will be beneficial as this OIP implements changes to augment AHS's existing strategies.

Improvement for social organization actors. This plan will lead to an improved situation for other social and organization actors. I will do this by: 1) helping create situational awareness by bringing attention to safety events and using my sphere of influence as a Safety Instructor to build capacity; 2) engaging patients and employees by giving them a voice; and 3) creating opportunities for patients and employees to become part of the decision-making and modification processes to best meet their needs.

This OIP is an added value for AHS's senior leaders, including the Vice-Presidents of Safety Education, Education, Human Resources, and Interprofessional Practice, as it fits within their portfolios and AHS's organizational vision. The OIP increases engagement and brings more resources and meaning to AHS's safety vision, which also helps AHS in its effort to meet its funder's (PHF) mandate to reduce harm events, as indicated in Chapter One. The above-mentioned strategies will begin on my unit, where a framework for change will be developed to disseminate throughout AHS. At this present time, this plan will not require a new organizational chart.

Stakeholder Reactions

It is important to factor in stakeholder reactions to the change and that a plan to manage the adjustment process must be put in place. Change agents such as myself must seek to understand the various reactions to help in making decisions as the communication plan is developed. The reactions will not always be negative, and the positive reactions should be

harnessed (Cawsey et al., 2016). Change recipients will cope differently, and some may need additional time to transition through the change. Bridges and Bridges' (2016) model (described in Chapter Two) will inform how I, as a change agent, will help the recipients cope throughout the transitions of the stages of change. Table 3 outlines the process of mitigation in managing the reactions and adjustments to the changes.

Table 3

Stakeholder Reaction and Adjustment to the changes

Stakeholder reactions	Ways to manage reactions to changes
2017 CHS created change readiness This OIP will be additional changes	Communicating that the OIP seeks to augment existing changes Being strategic around the approaches to introduce it Guide individuals to discover, accept and embrace changes using a three-step process (ending, losing and letting go) (Bridges and Bridges, 2016)
Allow time for individuals to adjust to change in status quo Requires time for adjustment as behavioral or procedural changes are required	Negotiate acceptance of the process Use influencing skills to be a conduit for concerns about Safety issues Build relationships and involve employees in process Engaging stakeholders (including change champions) to assist with the adjustment process
Help individuals develop understanding of change process due to barriers such as negative perceptions or resistance to change	Engage in 1 to 1 dialogue to find mutual grounds Support individuals' transition into the change
Plan for both positive and negative reactions to the change	Engage these stakeholders as leverage to negotiate and help allocate adequate resources

Overall, the table describes foreseeable issues that may arise during the implementation of the change process and a number of strategies are outlined to mitigate or resolve challenges or obstacles that arise.

Personnel to engage and empower. Murray and Richardson's (2002) framework is an essential tool to establish some positive conditions around getting buy-in in order to achieve the early development of shared understanding, enrichment of shared understanding, and establishment of a sense of urgency, as these are key tenets in moving forward with changes. Engaging and empowering AHS's employees will improve the efficacy of the EPTs. This requires employees to share the vision that error prevention can have improved efficiency. I will outline details of the plan and use communication methods to share information with all relevant stakeholders. I will use strategies, such as sharing results of the gap analysis in the outline in order to educate individuals about safety concerns. Furthermore, I will provide opportunities for employees to share their understandings of the process, as this is a key enabler for change and transition.

Support and resources required. Incorporating Murray and Richardson's (2002) steps, which involve creating a limited focused agenda and a human flywheel of positive change, will involve prioritization of the three key initiatives (stated above), which are: create situational awareness, engage patients and staff, and involve them in decision making. I will engage patients as stakeholders in the safety committee in order to gain their support for the change process. After obtaining supervisory approval, I will reach out to leaders in various departments at AHS to assist with resource procurement; for example, HR for personnel, and Information Technology (IT) for technology resources, such as extra laptops for incident reporting and data management. Additionally, I will include the finance department to obtain required goods and

services, including funding for Patton to attend AHS to deliver training, as well as salary to pay employees that provide coverage while staff are being trained.

Potential implementation issues. Murray and Richardson's (2002) steps for Managing Resistance and Resources highlight the importance of working closely with individuals who lack understanding of change. Resource constraints are a potential challenge in the change process which can be addressed by reaching out to the key stakeholders in the safety office to allocate the existing resources, since we share the goal of patient safety. Resistance is inevitable in organizational change, and one role of the change agent is to fill individuals' knowledge gaps and to put processes and supports in place to help them through the transition.

The momentum-building process employs Murray and Richardson's framework steps for creating a parallel deployment method. This is where planning and implementation can happen simultaneously and help build momentum over the course of the change, whether it be short-, medium-, or long-term.

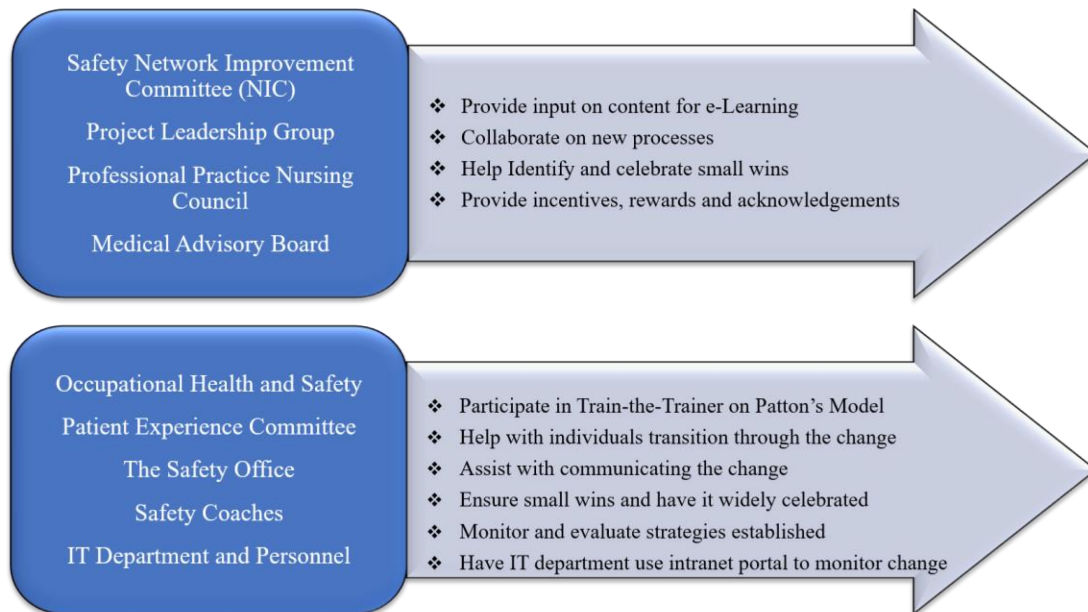

Figure 6. Personnel Groupings for Building Momentum

Table 4

Summary of timeframes to build momentum

Time frames to build momentum		
Short-term	Medium-term	Long-term
Strategies to be implemented to generate team involvement	Stakeholders' transition through the change	Consistent use of feedback loops
Training on Patton's Framework		Incorporate new changes
Heighten stakeholder engagement	Celebrate small wins	Provide incentives, e.g., rewards and acknowledgements
Develop key performance indicators	Milestone reporting	
Monitoring the strategies established	New processes implemented and utilized	Yearly refresher course developed and disseminated
Deploy education project team	Train-the-trainer on Patton's framework	Yearly performance evaluation
Integrate Murray and Richardson (2002) steps for effective follow-through	Feedback loop established	Summative evaluation looking at impacts and outcomes
Celebrate small wins	Safety coaches assigned to each unit	Benchmark against organization-wide reporting of harm incidents
Establish change champions	Formative evaluations	

Acknowledgements and limitations. It is important that the collaborative efforts, performance management plan, and new processes being implemented address the gap existing for all employees (particularly those with unique challenges that impede their ability to communicate effectively) and to maximize EPT use. The OIP will implement diverse engagement initiatives and provide strategies to mitigate the deeply entrenched bureaucracy and hierarchy that exists in healthcare (identified in this chapter and Chapter One) that could impact the speed of change and demotivate individuals interested in change leadership. This implementation plan also includes strategies that address barriers to participation whilst being cognizant that AHS is providing a very complex service that is labor-intensive and demands a lot of time and energy.

Conclusively, some elements of the proposed solution are being incorporated into existing priorities at AHS, such as the "daily safety huddles" that everyone is expected to attend. The OIP endeavors to change these meeting forums to ensure that AHS's safety priority is further advanced. The safety committee would be a new endeavor and it will be important to get staff skilled in the use of Patton's framework to enable this change. Patton's (2015) Evaluative Thinking Framework serves as a guiding principle to evaluate the process and maximize team effectiveness, and will be an added value once it is adequately utilized. Drawing on the principles of authentic, transformational and distributive leadership, Murray and Richardson's (2002) winning conditions will addresses inconsistent communications among healthcare providers, leading to the maximization of EPT use and a new culture at AHS. The next section outlines the monitoring and evaluation process, which is critical to performance improvement and achieving results.

Monitoring and Evaluation

This section proposes tools and measures that track changes, gauge progress, and assess outcomes in order to refine the change implementation plan. Change is never easy in a complex healthcare system, and AHS has several recent change initiatives that compete for attention. Therefore, these proposed OIP changes will build on existing infrastructure. The monitoring and evaluation of the change centers around the activities in the change process. Bennett's (1975) seven categories of criteria for evaluation will be utilized to evaluate the change.

Bennett's Evaluation Model. Bennett's (1975) Hierarchy of Evidence model is a seven-step process (depicted in Table 5) to identify approaches to resolving the PoP and addresses how to enhance communication among healthcare providers to maximize EPT use and improve patient safety. This model helps guide decision-making about program priorities, modifications, and continuation. It is used for analysis and structured hierarchically with hard evidence (i.e. quantifiable and more objective) at the top and soft evidence (i.e. observation, more subjective) as you go lower down on the hierarchy (Bennett, 1975).

Bennett's Hierarchy of Evidence model (1975) informs what processes require monitoring and evaluation and the steps taken to show the effectiveness of the change plan. It is necessary for the leaders and safety coaches to identify the most meaningful activities for this safety initiative and to create a plan for data collection and analysis. The parameters adapted from Bennett's model should be used throughout the implementation of the safety initiative, while adapting the high-reliability framework to ensure the success of the change initiatives. Table 5 following illustrates the plan to evaluate the recommended solution of the PoP.

Table 5

Bennett's Model for Evaluation and Monitoring

Steps	Activities	Evidence
End results	Improved patient safety	Reduction in the number or reported harm events, and positive change in safety statistics Healthier communities, effective communcation, less expenditure for healthcare at AHS
Practice change	Improved communication, increase in use of EPTs and rates of compliance with mandatory e-module on safety, speaking up for safety, improved incident reporting	Self-reporting of improvements in communication among team members, reaching the target of 100 percent; completion of training modules; self-reporting through employee engagement surveys; audits on quality of incident reporting
KASA Change (knowledge, attitude, skills, aspirations)	Increased knowledge of and attitudes towards patient safety, and acquisition and application of EPTs, creating a culture of safety and continuous improvement	Post-training surveys; results of e-module completion; observations; staff engagement surveys; and staff self-reporting
Reactions	Attitudes towards solution change such as acceptance, resistance, ambivalence	Pre- and post-training survey results, staff engagement surveys, observations, informal conversations, feedback from change agents
People involvement	Change agents, committee members, various levels of management, staff, patients involved with change plans	Recorded attendance in improvement and registration lists
Activities	Meetings, consultations, coaching sessions, communications, reporting	Evidence in meeting minutes, written reports, presentation materials
Inputs	Piloted department to formulate a safety committee; material resources required to accomplish the tasks (display boards, charts, and stationery); IT department time to create e-module	Staff time as reflected in their self-reported statistics Monetary spending on material resources (expenditure reporting)

Monitoring and Evaluation Plan

As the change agent, I will be responsible for monitoring and evaluation of the change process. According to Markiewicz and Patrick (2016) monitoring is defined as tracking what has been done and how it is being achieved by using predetermined performance indicators to examine the process, output, and immediate outcomes. It is a process that is iterative as corrective actions can be taken that facilitate program accountability and implementation (UNDP, 2009). Monitoring and evaluation are interdependent as they rely on common methods, tools, and analytical skills. These methods allow for regular feedback on whether the goals and objectives of the OIP are being achieved (Markiewicz & Patrick, 2016; Royse, Thyer & Padgett, 2013). Evaluation goes beyond tracking, as its predominant orientation is on "forming judgements about program performance, generally undertaken periodically and sometimes more episodically" (Markiewicz and Patrick, 2016, p. 12). Evaluation aims at providing a more meaningful understanding of the change, resulting in learning and reflection that can inform policy-making and program development. Evaluation allows one to form judgements about a program, articulate conclusions, and make recommendations. The following section focuses on four parameters utilized for the monitoring and evaluation of the proposed changes.

Evaluative Thinking Framework. The first measurement category of Bennett's (1975) model is Patton's Evaluative Thinking framework, which will be utilized by the safety committee as it develops strategies to aid with consistent communication. The desired outcome from the safety committee's work is improved communication in order to increase EPT use. Ongoing monitoring of the new strategies developed as part of the communication change implementation is critical for the successful outcome of the OIP (Markiewicz & Patrick, 2016).

These monitoring strategies include metrics such as surveys, self-reporting, and progress reports related to employees' performance in their use of the tools and processes developed.

Effective communication. Communication challenges is the second parameter to monitor and evaluate (identified in Chapter Two), and involves the use of an existing standardized tool called SBAR (Situation, Background, Assessment, and Recommendation) in verbal and written communication. SBAR is a mechanism that healthcare workers use with patients. For example, when meeting with a patient, a nurse will document on the patient's chart or clipboard the current situation, background data, the nurse's assessment, and any recommendations. Mandatory and consistent use of SBAR in communication exchanges can be monitored by measuring the data reporting on patients' charts, emails sent and received, self-reporting, and observations. Complementary to SBAR is hands-off communication, which involves the passing of patient information or care responsibility from one caregiver to another. If information about a patient's care is unclear, inaccurate, incomplete, or not timely, it could result in minor to severe harm (The Joint Commission, 2017). Therefore, the safety committee will develop an algorithm to standardize the hands-off process between healthcare providers and monitor the progress.

Maximize use of Error Prevention Tools. Despite the existing mandatory EPT course taken by the majority of staff at AHS (indicated in Chapter One), harm events remain high, and therefore there is a need for refresher e-learning courses and continuous education about EPTs, with the portal being monitored for participation and completion in order to ensure that employees pass with a score greater than 80 percent. This third metric for monitoring and evaluation involves the increased use of other communication tools such "three-way repeat-backs", where one party sends a communication, the receiver confirms receipt of the message

and repeats it back, and the sending party confirms its accuracy. "Clarifying questions" are when the receiver of information asks one or two clarifying questions in any high-risk communication situation and the initiator responds with clarification. The use of these two latter tools can be measured by observations, self-reporting, and anecdotal evidence, which points to "soft evidence" that is easier to measure, but sometimes perceived as subjective and not as credible (Benefit, 1975, pg.2).

Improved patient safety. The final parameter for monitoring and evaluating patient safety involves using AHS's existing monitoring and reporting tool called the "balance score card" (used to track execution of activities) and organization-wide monthly reports on patient safety. At AHS, the "balance score card" tracks incident-reporting for quality improvement, risk management, and patient safety. The balance score card is an internal document intended for internal use only (AHS, 2018). At AHS, all incidents are tracked through an incident reporting portal, and employees are expected to report all incidents and occurrences so that they can be documented, addressed, and used as lessons learned. Tracking of the number of harmful incidents is pivotal since the evidence is used to determine where AHS is with respect to achieving their goals of high reliability. It is also hard evidence, which is higher on the hierarchy of Bennett's model indicated above (Bennett, 1975).

Summary. This section has laid the groundwork for monitoring and evaluation of the change process to determine the progress and effectiveness of the implementation plan. The next step will consider that a project of this size requires a robust process of monitoring and an evaluation mechanism to continue to track and assess, and if required, take the necessary steps to modify the change process. The next section addresses ways to build awareness of the need for

change and recommends strategies to communicate clearly and persuasively to relevant audiences.

Communication Plan

There is an enormous amount of change currently being communicated and implemented within AHS. This has been precipitated by the existing culture of continuous improvement and renewed commitment to safety as a priority through the strategic goals of the organization. My PoP is closely aligned with AHS's organizational priorities and strategic direction, and addresses communication improvements among healthcare providers in order to maximize the use of EPTs and improve patient safety. This section of the chapter describes how I will communicate the change plan to recipients by using the communication strategies described by the Implementation Management Associates (IMA) (2018) and Kotter (2012).

Kreps (1990) described organizational communication as the process by which members learn relevant information about the organization and the changes happening within it. Organizational communication can be formal, such as a presentation, or informal, such as a discussion in the lunchroom. Cawsey et al.'s (2016) addresses mobilizing change as well as the need to communicate the changes, while managing recipients and stakeholders "as they react to and move the change forward" (p. 218). When embarking on change, effective communication is pivotal in encouraging collaboration to move things along and gain commitment. As Kotter (2012) stated, "communicate, communicate—capture the hearts and minds of employees by communicating through multiple channels and multiple times the vision for change" (p. 59). Communicating about the change process will be critical to keep employees interested in the proposed change, and thus, decisions should not be made without employee involvement. Success of the change initiative largely depends on the perceptions and attitudes of the

employees, and therefore, one can never overestimate the importance of a robust communication plan for the change process (Cawsey et al., 2016).

A plethora of research addresses the importance of having well thought-out communication and information strategies during the planned change process in order to avoid pitfalls and obstacles (Cawsey et al., 2016; Christensen, 2014; Husain, 2013; Kotter, 2012). When people have a shared understanding of a goal or vision, change is likely to succeed (Kotter (2012). Kotter (2012) presented seven key elements (simple, paint a picture, multiple forums, repetition, leadership by example, and two-way communication) to effectively communicate a vision. These elements are complementary to IMA's (2018) seven best practices to communicate change, which include: regular and frequent communication, no over-reliance on email, use a variety of communication means, an approach that is not a "top-down-one size fit all" process, targeting specific communication, use of feedback loops, and monitoring and evaluation of effectiveness. Together, Kotter's (2012) and IMA's (2018) studies solidify this OIP. A more detailed description of Kotter (2012) and IMA (2018) strategies and how they complement each other are given in the following sections.

Regular, frequent, and simple. This represents best practices that reinforce the importance of having regular and frequent communication. This communication approach involves setting expectations that communications will be consistent, credible, and concise in order to reach a wide audience and reinforce the message. If leaders plan to have regular and frequent communications with their employees, it is best that they be simple; for example, Kotter (2012) described simple communication as being free of jargon and buzzwords, not being overly technical, and understandable by the group for which it is intended. In the context of AHS, this

communication strategy could warrant stakeholder consultation with leaders in the Education department around plain language as well as stakeholder feedback.

No over-reliance on emails and use of multiple forums to communicate. To communicate the change effectively, using a variety of settings and tools will be important. IMA (2018) pointed out the abundance of emails people receive daily, which makes email an unreliable and ineffective method for communicating change information. Kotter's (2012) suggestion of using multiple forums supports IMA's advice, as this strategy provides more opportunity to communicate the message frequently and gain more interest in the change process.

Examples of different forums to communicate change include: conducting meetings of various sizes, using memos and newsletters, and interacting in both formal and informal ways. This communication plan is an opportunity to engage many stakeholders in this communication process, and they could assist with different tasks such as storytelling regarding EPTs. Team meetings or informal interactions provide addition methods to engage with individuals and gather testimonials to communicate in team newsletters. In addition, the use of regular communication channels includes bi-weekly memos with tips for EPTs, and employee testimonials on their successful use or a missed opportunity thereof.

Paint a picture and incorporating a variety of communication techniques. In communicating change, I want to have a relatable story that incorporates metaphors and analogies, with the goal being to gain interest and commitment (Kotter, 2012). A compelling story will convey information that is relatable, and allow people to see themselves in the story and in the change process. Complementary to this is IMA's best practice of using a variety of communication means, with face-to-face communication being considered the most powerful

(IMA, 2012). As the change agent, I will create a compelling story to help ignite the change, then arrange for various types of meetings, including video conferences, individual and group meetings, team meetings, and small group discussions to share the story and foster meaningful discussions and queries.

Collective decision-making. IMA (2018) discussed how communication is often "top down" and written from senior leaders' perspectives rather than those of the recipients. Crafting communications that are sensitive to the audience they are intended for would be a superior approach. Thus, refraining from using a "one-size fit all" approach when communicating information (IMA (2018). The dominant stakeholders in this process are the recipients of the change, such as the patients. Kotter (2014) further addressed the influence of leadership and suggests that leaders lead by example, and that a leader's personal behavior cannot be in contradiction to the message or goals they are asking others to pursue. To ensure that they receive accurate information, individuals must learn about upcoming changes from their leaders, and no other sources, such as news channels or rumors (Cawsey et al., 2016). As the change agent, I am bound by the change I am promoting; I am not outside of this process.

Use "target specific" communication and give and take. These communication strategies involve customizing the message for each group, as per IMA (2018), and involve adapting the message to the group-specific context. Messages that are customized, however, may have more relevance for one group than another, and I plan to establish a dialogue among the various stakeholders and myself in order to help me understand how each message can be best communicated. I will use particular language or points of reference for the various health professionals, in order to ensure that each group understands the changes that could affect them

the most (IMA, 2018). This communication strategy involves setting up a process for ongoing communication between the group and myself, the change agent.

IMA's (2018) strategy for "target specific" communication complements the "give-and-take" strategy Kotter (2012) discussed, where two-way communication between senior leaders and change recipients results in a consensus on the strategy to be used. For example, as the leader of this change process, I plan to use multiple means of communication (groups, meetings, bulletin boards, newsletters, intranet, and email) for the relevant audiences. I will also be open to acquiring information through informal exchanges with these audiences. Such exchanges aid in maintaining understandings of the organization's perceptions and attitudes towards change, as per Cawsey et al. (2016). Obtaining regular feedback that can be used for iterative planning to promote the culture of continuous improvement involves the use of a cycle of feedback (loop) and repetition of the changes being made in the organization.

Feedback loops and repetition. These are communication strategies that are closely aligned and which address the cyclical nature of the decision-making process. These strategies involve evaluating the outcome of a decision-making process and using that information as input for a new decision-making process. IMA (2018) indicated that this process allows targeted stakeholders to express opinion and thoughts. This feedback loop strategy can be utilized as a "continuous improver" Cawsey et al. (2016). This communication strategy serves as a means of analyzing the change process and ensuring that a thoughtful, logical, and systematic approach is used in changing the organization in a positive way. Complementary to feedback groups, repetition, as suggested by Kotter (2012), is an important approach to institutionalize a process, where after repeated use, the process becomes part of the culture.

Table 6

Summary of Strategy, Stakeholder involvement and Timelines

Timelines	Strategies	Communication Plan	Stakeholders
Ongoing	1) Regular, frequent, and clear communication	Send out weekly updates that will include progress reports, success stories, and plans;	Change champions; Senior leaders in Education Dept
	2) Use multiple means of communication	Use clear, "plain" language	Existing safety coaches; team members; Executive leads; Project Leads
	3) Use feedback loops and repetition	Use a variety of techniques and settings to reach out to individuals (emails, personal communications, displays and boards, etc.); Create suggestion box	Change recipients; Senior leaders; Safety coaches
January to March	1) Use the "Paint a Picture" strategy	Create an engaging story about the change	Change leaders
	2) Use a bottom-up and audience-specific approach	Invite team members to take leadership in the safety committee	Change leaders; Senior leaders
	3) Use various modalities and customize message	Ask to speak at team meetings; Meet with various stakeholders to gain input	My direct report; Director & VP of Safety; Team Members
April to September	1) Use "Give and Take"; Target specific communication	Schedule timeframes to communicate	Senior leaders; Change recipients; Patients

In addition, Kotter (2012) stated that repetition ensures that information is absorbed and understood over time. This will involve engaging senior leaders, change agents and champions, and hospital representatives who can further reinforce the change plan and incorporate it in their activities (e.g., the CEO highlighting this initiative in their weekly communication, or the editor of a clinic newsletter publishing the same message), thereby making it frequent and repetitive. Table 6 presents the strategies, communications, and stakeholders involved as discussed to this point.

Anticipate questions and responses. This involves thinking about relevant questions regarding the development of communication strategies. It is anticipated that questions will be common among employees as they seek to gain understanding of the OIP and how it could impact them or the way they perform their daily tasks. I will anticipate relevant questions and incorporate them into my communication messages, as follows:

1. What exactly is the change?
2. How will it affect my workload?
3. Why change?
4. Why not maintain status quo, given that new changes were recently proposed in the organizational renewal plan?
5. When will this change occur?
6. How long will it take to transition to the new process?

Cawsey et al. (2016) noted the importance of timelines as an important aspect of minimizing the negative effects of change. In the communication strategies being used for this OIP, I will equip myself to respond to the above questions and make necessary modifications to the change implementation. The recipients will be given time and channels to respond to and

communicate their questions or understandings of the process and how the changes are affecting them, both individually and collectively.

Summary of the Communication Plan. In the process of monitoring and evaluation, I will ensure that the messages being communicated meet effectiveness criteria (IMA, 2018). Kotter (2012) identified the need to address any seeming inconsistency in order to ensure that messages are understood and being conveyed as intended. The combination of the feedback loop and the methods established with the "Target Specific" (in this case employees at AHS) approach will be part of the monitoring and evaluation process. It is through this process that I will determine any remedial measures necessary to ensure effective and consistent communication. Using the strategies suggested by IMA (2018) and Kotter (2012) will enable a robust communication process that is regular, frequent, and simple. These strategies are the guiding principles to communicate the change in order to create readiness and enable participation in and understanding of the vision. I will ensure that OIP is adaptable to each group, and I will emphasize the message and process I am enacting so that there will not be any inconsistencies between my actions and what I am endeavoring to implement. This is easily done if there is always an open line of communication between leaders and change agents and the various groups affected by the change.

OIP Conclusion

My PoP is situated in a large urban healthcare network and focuses on patient safety issues and the ongoing goal of reducing preventable errors. Specifically, this OIP seeks to improve communication among healthcare providers, so that they can maximize the use of EPTs to address the concerns noted throughout this paper. The importance of this OIP has been elevated because of AHS's organizational vision of being an HRO, has ensured that all issues

concerning patient safety and error prevention will be at the forefront of the organizational concerns.

In most healthcare facilities, safety and error prevention are of great importance, but the solutions to these issues are not often considered in a holistic manner. This OIP addresses communication at a systems level, adapting as needed to each context as it relates to EPT use. It is important to have a standard set of processes to identify the issues, irrespective of which department the OIP is being implemented in. Systems theory (discussed in Chapter One) encompasses a large set of tools which are chosen contingent on the information gathered during an evaluative inquiry (Social Worker Helper, 2017). Learning how to use a systems approach and the skills to analyze things from a system level is important in order to help change the culture at AHS.

This OIP outlines a set of problems that need to be addressed, including communication challenges, and what is being proposed is intended to help AHS gain a culture of safety through the appropriate understanding and use of the tools necessary to solve the ongoing safety issues. An important tool to mobilize this improvement plan will be Murray and Richardson's (2002) organizational change framework, as it will facilitate the acceptance of the proposed change and improve communication. The emphasis on distributive leadership in Chapter Two speaks to how leadership can be involved in educating followers to solve problems while educating themselves about the concerns and challenges the followers face. A good relationship between the two groups is important in implementing solutions to reduce preventable errors. This is the bottom-up approach, where solutions are more likely to be implemented and supported by followers than when someone or something pushes down from the top. Therefore, a proposed solution of a Safety Committee being formed helps develop processes to increase safety tool use. The

committee will utilize an Evaluative Thinking Framework (Patton, 2015) to help with decision-making. The inclusion of more people in the decision-making process also brings the necessity of teaching them how to use this analytical tool to optimize/upgrade their decision-making processes. The implementation plan includes an educational focus at every encounter; as well, groups will be learning from each other and setting educational learning targets in order to improve how to identify and solve problems related to error prevention use.

The communication plan is designed to inform AHS about the goals and priorities for change, the details of the plan, possible challenges, and future considerations. The strategy for selling the change would be the use of storytelling to persuade members of the organization that this OIP is a concrete actualization of AHS's purpose, values, and principles.

Next Steps

The next steps would involve consideration of the fact that a project of this size requires a robust process of monitoring and evaluation mechanisms. An iterative process is needed by AHS to manage some of the interrelated and/or unintended results of actions taken. In the future, AHS would have attained HRO standing, thus there will be a higher level of predictability between actions and outcomes, which will result in higher level of patient satisfaction and public confidence. This is especially important considering the costs of healthcare, both for patients as well as providers, but these costs are easier to justify when the organization is considered to have high reliability. Another important next step would be to address the guiding questions below that stemmed from the OIP lines of inquiry and fall outside the scope of this OIP. These questions deserve a project of their own:

- What are the barriers that hinder communication among healthcare providers and allow risks and problems to remain unaddressed?

- Is there a relationship between performance appraisal practices and the reduction of harm events?
- What informal and formal communication processes (other than EPTs) between interprofessional healthcare providers can have a substantial impact on harm reduction?

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