Practice Evaluation

The success of the International Classification of Functioning, Disability and Health (ICF) depends on its implementation in practice. This article describes an evaluation of the introduction of the ICF framework into an occupational therapy service. Reflections from the working party responsible for its introduction were related to change management theory. The experiences throughout the implementation project could be mapped to an eight-stage process of creating major change (Kotter 1996). The working party concluded that the explicit use of and closer adherence to change management theory could enhance the uptake of the ICF in clinical practice. Further exploratory research is required to support these reflections.

Using Change Management Theory to Implement the International Classification of Functioning, Disability and Health (ICF) in Clinical Practice

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Introduction

The International Classification of Functioning, Disability and Health (ICF)

The ICF is a framework and classification endorsed by the World Health Organisation and aims to provide a common language for use within the multidisciplinary team (WHO 2001). The common language can also help to describe the clinical reasoning behind an intervention (Tempest and McIntyre 2006).

This article does not seek to describe the ICF because previous articles have explained the framework and classification (Steiner et al 2002, Rentsch et al 2003). The College of Occupational Therapists (COT 2004) and the World Health Organisation both offer guidelines (http://www3.who.int/icf/icftemplate.cfm).

Research has evaluated the use of the ICF within rehabilitation and concludes that it improves the quality of intervention and the multidisciplinary team process by providing a systematic basis for team communication (Stucki et al 2002). The literature does not describe the implementation process, yet the success of the ICF depends on the uptake within clinical practice (Geyh 2004).

It is also recognised that introducing a new framework into a service involves significant change and that strategies should be employed to improve the change process (Kotter 1996).

Change management

Change can be described as the process of moving from one system to another (Parsley and Corrigan 1994) and can be complex, especially where attitudinal and behavioural changes are required (Goodwyn 1996). People differ in their response to change and resistance can be attributed to four common factors: parochial self-interest (seeking to protect the status quo), misunderstanding and lack of trust, contradictory assessments and low tolerance for change (Bedeian 2004).

There is criticism of the amount of change within the health system and some believe that change has become the only constant (Managan 1996). Some commentators consider that change is part of a chain of events and can only be implemented during a period of stability (Goodwyn 1996, Managan 1996). However, this view has been challenged because periods of stability rarely occur. Instead, it has been suggested that embracing change as a continuous process will have a positive effect on implementing change, rather than waiting for a period of stability (Sauser and Sauser 2002).

There are conflicting views on who can implement change within a service. Some believe that change has become a central management issue, and that an effective change agent is someone with a broad and well-developed range of qualities and skills, in an influential position (Buchanan and Huczynski 2004). However, irrespective

of their position within the team, individuals assume different roles during the change process, including catalyst, process helper, solution giver and resource linker. These individuals aid the process by enhancing ownership of change, forging honest relationships and setting goals and action plans (Goodwyn 1996).

For change to be successful, there must be a change in the organisational culture and there are three factors that must be addressed: the evidence for change, the context in which change is being introduced and how the change will be facilitated (Rycroft-Malone et al 2002).

Introducing the ICF framework into an occupational therapy service

Until 2002, the occupational therapy department in a teaching hospital in London was using the International Classification of Impairments, Disabilities and Handicaps (ICIDH; WHO 1980) as the framework for service delivery. This had been adopted to facilitate multidisciplinary team working and to communicate the clinical reasoning for occupational therapy intervention.

Difficulties were encountered using the ICIDH, however, because it did not describe the contextual factors affecting an individual's functional performance. The framework felt incongruent with the holistic perspective of health and, therefore, it did not allow therapists to demonstrate their clinical reasoning. At that time, the WHO revised the ICIDH and endorsed the International Classification of Functioning, Disability and Health (ICF) as its replacement. There was emerging evidence for the use of the ICF in clinical practice (Stucki et al 2002, COT 2004) and this was chosen as the new framework for service delivery.

A working party of senior occupational therapists was formed in May 2002 including both authors. The aim of the working party was to introduce the ICF as the framework for service delivery and this was achieved by December 2003. A variety of methods was adopted to aid implementation, including teaching sessions, the development of resources on the ICF and altering documentation to use the new terminology. The process of implementation was not without challenges and the working party reflected on the experience in order to share the journey and to learn for future service changes.

Near the end of the project, the first author completed a Diploma in Management and explored change management theory within the course. Therefore, some of the theory was used to guide the reflections from the working party.

Process of reflection

The reflections were gathered from the working party and mapped onto the concepts within the change management theory by the authors. Opinion was gathered as part of practice evaluation and service development, therefore formal ethical approval was not required at the time of collecting data. However, as a result of the intention to publish, permission was subsequently sought from and granted by the occupational therapy service to share the experiences.

The experiences throughout the implementation project could be mapped to an eight-stage process of creating major change (Kotter 1996). The working party concluded that explicit use of and closer adherence to change management theory could enhance the uptake of the ICF in clinical practice.

Discussion

An eight-stage process has been identified to create major change (Table 1). If successful change is to take place, it is vital that barriers are addressed proactively. It is recommended that the process is implemented in sequence for change to be managed successfully (Kotter 1996).

The discussion has been structured using these headings to share the experiences during the implementation process at individual stages.

Evidence and establishing a sense of urgency

The initial driver for change was a general sense of frustration within the occupational therapy team at the challenges in communicating their role within the multidisciplinary team. The working party was able to draw upon this to support the need for change.

In addition, there were difficulties in using the ICIDH, largely due to the negative terminology and the lack of contextual factors. The emerging evidence using the ICF supported the need for change and information was sought from the WHO (2001) and COT (2004).

Creating the guiding coalition

Discussions initially occurred informally, until the decision was taken to form a working party. The guiding coalition (the working party) had a shared concern regarding the lack of clinical reasoning demonstrated in the current documentation. As senior members of the occupational therapy team, the working party had authority within the service, a prerequisite to implementing change successfully (Kotter 1996). However, the team later reflected that a mix of staff would have been beneficial to enable the working party to appear less hierarchical.

Context and Developing a vision and strategy

The working party devised a strategy to implement the ICF by altering the documentation to include the ICF terminology. In order to do this, the occupational therapy team needed information and education on the ICF framework and its use in clinical practice.

The occupational therapy team works within a context where change is normal, therefore the working party anticipated that changes would be accepted. However, at this stage the working party deviated from the eight-stage process for creating major change, resulting in conflict.

Table 1. The Eight-Stage Process of Creating Major Change (Kotter 1996)*

1. *Establishing a sense of urgency*
   - Examining the market and competitive realities
   - Identifying and discussing the crises, potential crises, or major opportunities
2. *Creating the guiding coalition*
   - Putting together a group with enough power to lead change
   - Getting the group to work together like a team
3. *Developing a vision and strategy*
   - Creating a vision to help direct the change effort
   - Developing strategies for achieving that vision
4. *Communicating the change vision*
   - Using every vehicle possible to constantly communicate the new vision and strategies
   - Having the guiding coalition role model the behaviour expected of employees
5. *Empowering broad-based action*
   - Getting rid of obstacles
   - Changing systems or structures that undermine the change vision
   - Encouraging risk taking and non-traditional ideas, activities and actions
6. *Generating short-term wins*
   - Planning for visible improvements in performance, or 'wins'
   - Creating those wins
   - Visibly recognising and rewarding people who made the wins possible
7. *Consolidating gains and producing more change*
   - Using increased credibility to change all systems, structures and policies that don't fit together and don't fit the transformation vision
   - Hiring, promoting and developing people who can implement the change vision
   - Reinvigorating the process with new projects, themes and change agents
8. *Anchoring new approaches in the culture*
   - Creating better performance through customer and productivity orientated behaviour, more and better leadership, and more effective management
   - Articulating the connections between new behaviours and organisational success
   - Developing means to ensure leadership development and succession

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The vision was to improve the clinical reasoning within the documentation using the ICF. However, the concept was not fully embraced or understood by the wider team in the early stages. On reflection, the working party should have made a distinction between wanting to improve the standard of documentation within the team and adopting a new framework. The ICF should have been introduced as the framework for service delivery, with the benefits of aiding clinical reasoning. Any necessary changes to the documentation to demonstrate the enhanced clinical reasoning would have followed. The working party therefore reflected that the initial vision required further development and had been communicated too early.

Leadership and communicating the vision and strategy

The consequence of a lack of clarity for the vision meant difficulties in communicating the vision. However, the working party was prepared to admit that it was learning itself and this aided the development of a discussion culture to resolve conflict. The working party clarified the new vision, that is, to implement the ICF as the framework for service delivery, thus overcoming the resistance felt by some staff. Team members who demonstrated support for the changes, for example, the process helpers and solution givers, were encouraged to participate in leading the developments, thus promoting change at the grass-roots level.

On reflection, the working party felt that the use of the eight-stage change management process would have been beneficial. By using the staged approach, it would have been evident that stages three and four were not followed sequentially, resulting in confusion and conflict.

Facilitation and empowering broad-based action

An interactive facilitation style was adopted, including small-group activities, reflection during supervision and informal discussions. Case studies were used to map information to relevant headings within the ICF and discussions were facilitated to identify how this aided clinical reasoning. This enabled the occupational therapists to analyse, reflect and change their attitudes and practice. The small teams were encouraged to share challenges and successes, using the framework to promote further learning and development.

Generating short-term wins

Short-term objectives were established for implementation and the ICF terminology was introduced into the initial part of the documentation. Staff were encouraged to reflect on their progress in small teams for a period of 4 months. Feedback during this period demonstrated a heightened appreciation of the limitations of the previous documentation and the advantages of using the ICF to structure the new documentation and communicate clinical reasoning.

Staff also used the framework to aid the development of clinical reasoning with new staff and students. Students on fieldwork placement were learning the ICF within their degree course and this helped to maintain motivation for the therapists in practice because they realised the currency of the changes.

Evaluation, consolidating gains and producing more change

Change was introduced gradually over 2 years and all documentation now incorporates the ICF terminology. The ICF is the framework for service delivery and has aided clinical reasoning, although continuing training is required to cement the changes. The documentation is reviewed regularly as part of ongoing service development.

The process has been invigorated by renewed smaller projects. The team contributed to the COT guidelines on the use of the ICF in clinical practice and was publicly acknowledged for its work (COT 2004). This proved a significant motivating factor for all staff, who have taken pride in the achievements of the service.

Anchoring new approaches in the culture

No discipline works in isolation. As the occupational therapists began to use the ICF framework, interest spread through the multidisciplinary team. Presentations have been given to physiotherapy colleagues and the stroke multidisciplinary team. Learning about the ICF is now part of the induction process and was identified within the service marketing strategy for recruitment.

The future

The occupational therapy service focused on the ICF framework and further developments in the use of the classification system are being considered. The team also awaits the findings of the field-testing for the ICF core sets for the acute hospital and early post-acute rehabilitation facilities (Grill et al 2005).

Conclusion

The International Classification of Functioning, Disability and Health framework was implemented successfully into clinical practice, but not without challenges during the process. Explicit use of change management theory, such as the eight-stage process for implementing major change, could enable a smoother journey and enhance the uptake of the ICF in clinical practice. Further exploratory research is required to support these reflections.

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