# Selecting the best theory to implement planned change

Improving the workplace requires staff to be involved and innovations to be maintained. Gary Mitchell discusses the theories that can help achieve this

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## Abstract

Planned change in nursing practice is necessary for a wide range of reasons, but it can be challenging to implement. Understanding and using a change theory framework can help managers or other change agents to increase the likelihood of success. This article considers three change theories and discusses how one in particular can be used in practice.

**Keywords**
Theory of change, implementing change, organisational change

THERE ARE many ways of implementing change. However, planned change, which is a purposeful, calculated and collaborative effort to bring about improvements with the assistance of a change agent (Roussel 2006), is the most commonly adopted (Bennett 2003, Jooste 2004, Murphy 2006, Schifalacqua *et al* 2009a).

The Nursing and Midwifery Council (NMC) (2008) says nurses 'must deliver care based on the best available evidence or best practice', which suggests there is a continual need to update, or make changes to, practice. However, implementing change is more challenging than it is sometimes perceived. Szabla (2007), for example, estimates that two thirds of organisational change projects fail, while Burnes (2004a) suggests that the figure is even higher.

Various forces drive change in health care (Burritt 2005), including rising costs of treatments, workforce shortages, professional obligations, such as clinical governance and codes of conduct, advances in science, an ageing population, the potential to increase patient satisfaction, and promotion of patient and staff safety. These are invariably coupled with restraining forces, such as poorly developed action plans, under-motivated staff, ineffective communication and inappropriate leadership (Arkowitz 2002, O'Neal and Manley 2007). Price (2008) adds that nurses now feel 'bound by corporate policies' and that health care currently changes through 'revolution rather than evolution'.

Change is vital to progress, yet the nursing literature identifies numerous complexities associated with transforming plans into action, and attempts at change often fail because change agents take an unstructured approach to implementation (Wright 1998).

It is important, therefore, that managers, or change agents, identify an appropriate change theory or model to provide a framework for implementing, managing and evaluating change (Pearson *et al* 2005).

Equally important are the attributes of change agents who are, according to Marquis and Huston (2008), skilled in the theory and implementation of planned change and who are often nurse managers. This is discussed in more detail later in the article.

## Change theories

Many authors have attempted to address how and why changes occur, but the pioneer is, perhaps, Kurt Lewin. Lewin (1951) identified three stages through which change agents must proceed before change becomes part of a system (Figure 1):

- Unfreezing (when change is needed).
- Moving (when change is initiated).
- Refreezing (when equilibrium is established).

He also discussed how certain forces can affect change, which he called force-field analysis.

Lewin's work was expanded and modified by Rogers (2003), who described five phases of planned change: awareness, interest, evaluation, trial and

adoption. Another change theorist, Ronald Lippitt (Lippitt *et al* (1958), identified seven phases.

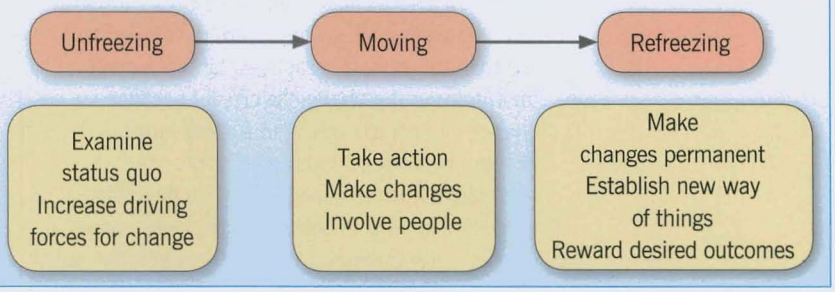
Tomey (2009) suggests that Lippitt's seven phases and Rogers' five can be clustered within Lewin's three (Box 1). Box 1 also shows how change agents are motivated to change and affected members of staff are made aware of the need for change during Lewin's unfreezing stage. The problem is identified and, through collaboration, the best solution is selected.

Roussel (2006) suggests that unfreezing occurs when disequilibrium is introduced into the system, creating a need for change. This corresponds directly to phase 1 of Rogers' theory: awareness.

Lippitt's theory, meanwhile, uses similar language to the nursing process (Tomey 2009) (Box 2), a model of nursing that has been used by nurses in the UK for a number of years. It is comprised of four elements (Pearson *et al* 2005) that are intrinsically linked:

- **Assessment** The nurse makes a detailed assessment of the patient that includes biographical details, relevant clinical history, social details and medical observations. This phase is normally considered to be the initial part of the nursing process, even though activities continue throughout a patient's period of care.
- **Planning** Following assessment, the nurse collaborates with the patient, relatives and multidisciplinary team wherever possible to determine how to address the needs of the patient.
- **Implementation** This phase relates to the nurse carrying out and documenting the care previously agreed at the planning stage.
- **Evaluation** This occurs often points during the period of care. Evaluation is ongoing and links back to the assessment phase of the nursing process. This provides opportunity for regular assessment of patient needs, which can become more or less important during the care period.

**Figure 1** Lewin's (1951) change model




Lippitt's assessment stage, or phase 1, incorporates Lewin's unfreezing stage and Rogers' awareness phase, but it also offers much more of a framework for change agents and includes assessment of motivation.

During Lewin's movement stage and Rogers' interest, evaluation and trial phases, change agents gather all available information and solve any problems, develop a detailed plan of change and test the innovation (Marquis and Huston 2008).

This corresponds with Lippitt's phase 2 (Box 2), which includes, for example, selection of 'progressive change objectives', and is the stage at which deadlines and responsibilities are assigned to team members.

Lewin's refreezing stage corresponds with Rogers' adoption stage and Lippitt's implementation and

**Box 1** Comparison of change theories

| Lewin | Rogers | Lippitt |
|---|---|---|
| Unfreezing | Awareness | *Phase 1.* Diagnose the problem |
| | | *Phase 2.* Assess motivation and capacity for change |
| | | *Phase 3.* Assess change agent's motivation and resources |
| Moving | Interest<br>Evaluation<br>Trial | *Phase 4.* Select progressive change objective |
| | | *Phase 5.* Choose appropriate role of the change agent |
| | | *Phase 6.* Maintain change |
| Refreezing | Adoption | *Phase 7.* Terminate the helping relationship |

(Adapted from Roussel 2006)

**Box 2** Lippitt's theory compared with the nursing process

| Nursing process elements | Lippitt's theory |
|---|---|
| Assessment* | *Phase 1.* Diagnose the problem |
| | *Phase 2.* Assess motivation/capacity for change |
| | *Phase 3.* Assess change agent's motivation and resources |
| Planning† | *Phase 4.* Select progressive change objective |
| | *Phase 5.* Choose appropriate role of the change agent |
| Implementation‡ | *Phase 6.* Maintain change |
| Evaluation‡ | *Phase 7.* Terminate the helping relationship |

**Key:** * Assessment = Lewin's unfreezing stage
† Planning/implementation = Lewin's moving stage
‡ Implementation/evaluation = Lewin's refreezing stage

(Lewin 1951, Lippitt *et al* 1958, Pearson *et al* 2005)

evaluation stages (Box 2, phases 6 and 7). At this point, the change has been successfully integrated in the system and strategies are developed to prevent a return to previous practices. Lippitt's stage of 'maintaining the change' is crucial because successful change can often regress to former, outdated practices (Carney 2000, Cork 2005).

While the three change theories described above are similar problem-solving approaches to implementing planned change, they are also subtly different. It is up to nurse managers to select the most appropriate model based on the specific circumstances of their work environment. It is also worth noting that, although these three theories are the most widely used, there are many others, including Reddin (1989), Havelock (1995) and Leavitt (Leavitt and Bahrami 1988).

Burnes (2004b) acknowledges the relevance of Lewin's work half a century on, but highlights that his three-tiered approach attracts major criticisms. It is argued, for example, that it is only suitable for small change projects, that it ignores organisational powers and politics, that it is top down and management driven, and that it assumes that organisations operate in stable states.

Lippitt's work is more detailed. While it requires a greater level of understanding of change theory, it is likely to be more useful to nurse managers because it incorporates a more detailed plan of how to generate change and it is underpinned by the four elements of the nursing process: assessment, planning, implementation and evaluation (Pearson *et al* 2005). Throughout the remainder of the paper, Lippitt's theory is therefore used to demonstrate how managers can implement planned change.

**Box 3 Characteristics of three leadership styles**

| Autocratic | Democratic | Laissez-faire |
|---|---|---|
| Strong control maintained over group. | Less control maintained. | Little or no control. |
| Others motivated by coercion. | Economic and ego awards are used to motivate. | Motivated by support when requested. |
| Others are directed by commands. | Others are directed through guidance and suggestions. | Provides little or no direction. |
| Communication flows downward. | Communication flows up and down. | Uses upward-downward communication. |
| Decision making does not involve others. | Decision making involves others. | Disperses decision making throughout the group. |
| Emphasis on different status ('you' and 'I'). | Emphasis is on 'we' rather than 'you' and 'I'. | Places emphasis on group. |
| Criticism is punitive. | Criticism is constructive. | Does not criticise. |

(Adapted from Marquis and Huston 2008)

## Leadership styles

Before embarking on change, managers may first consider their strengths and weaknesses in terms of their leadership skills, because these can greatly affect the outcome of a change project (Cutcliffe and Bassett 1997). As various authors point out, good leadership is not a prerequisite of management (Gerrish 2003, Outhwaite 2003, Salter *et al* 2009).

The literature suggests that leadership, effective communication and teamworking are among the most important elements for planned change (Hewison and Stanton 2003, Jooste 2004, Schifalacqua *et al* 2009a).

The role of leaders is multifaceted. Schifalacqua *et al* (2009a) state that an 'impassioned champion' is essential in all change models, because they provide inspiration, vision and support to everyone involved. Murphy (2006), meanwhile, suggests that leaders should be seen as team players with the same goals as the rest of their team, rather than as stereotypical organisational leaders.

Jooste (2004) sets out attributes of effective leadership:

- Influence: leaders have an enormous role to play in influencing followers in the right direction, and shortcomings in leaders' characteristics can lead to problems among followers.
- Clarity: are workers clear about their tasks?
- Commitment: what do workers need from their leaders?
- Self-image: do followers know their own abilities, what they can and cannot accomplish?
- Price: what is the price followers pay or the rewards they receive for working well.
- Behaviour: does the leadership style promote positive and effective behaviours among followers?

There are various leadership styles, including autocratic, democratic and laissez-faire (Marquis and Huston (2008) (Box 3), and whichever one is adopted will affect the change in question.

**Autocracy** Autocratic leadership is regarded as predictable, with a high level of productivity, but often with low motivation, creativity and morale (Marquis and Huston 2008). However, it can be useful in crisis situations and is frequently seen in large bureaucracies. Autocracy is applicable when change is demanded, for example through the use of a top-down approach, while democratic leadership is more appropriate for groups working together and where autonomy is promoted (Rycroft-Malone *et al* 2002).

**Democracy** Democratic leadership is useful when co-operation and co-ordination between groups are necessary, so it is therefore a more appropriate style for implementing change (Tomey 2009). However, Marquis and Huston (2008) warn that it is often less efficient than authoritative leadership.

**Laissez-faire** Meanwhile, a laissez-faire leadership style can be non-directional and frustrating, and managers who adopt it tend to allow their subordinates to take control (Roussel 2006). It is not generally a useful style for planned changes, but it can work when team members are highly motivated and self-directed, and can lead to greater creativity, motivation and autonomy than autocratic or democratic leaderships (Benton 1999).

This style does, however, require multiple change agents and often there is much resistance from group members (Delmas and Toffel 2008), where democracy tends to lead to better results in planned change (Richens 2004).

Having considered which change theory to adopt and what style of leadership best suits the project, managers or change agents can begin to work towards achieving change.

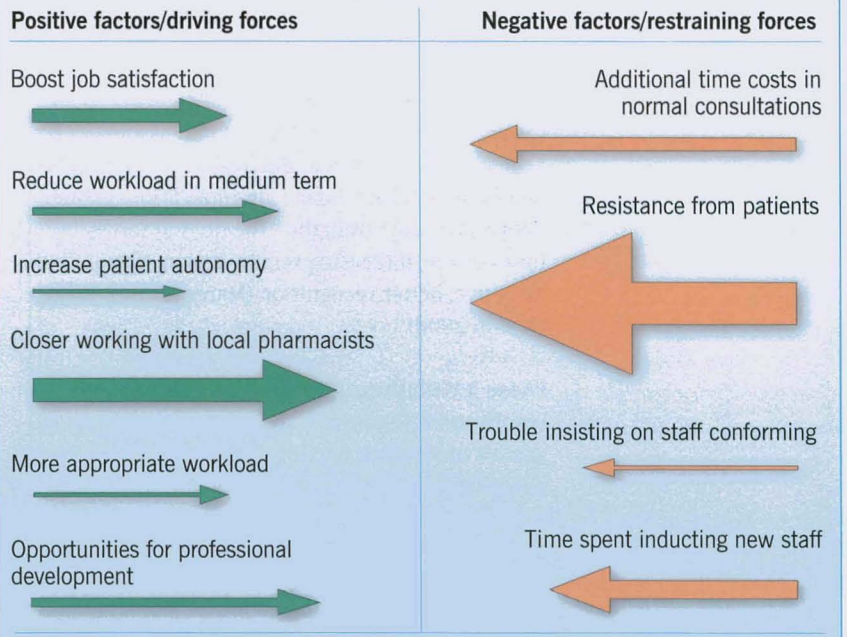
## Using Lippitt's change theory

Lippitt's theory, alongside a democratic style of leadership, is a popular and effective combination. Phase 1 (Boxes 2 and 3) is concerned with diagnosing the problem and is when a need for change has been noticed. Bennett (2003) recommends undertaking a comprehensive literature review at this point, or delegating this task to someone with good critical appraisal skills, to assess all available data and to use the findings to bolster the change agent's position.

**Phase 1** Project management begins at this stage because this provides the framework for implementing change (Schifalacqua *et al* 2009a). It involves developing a detailed plan or draft guideline of the proposed change, which should be given to everyone likely to be affected (Bennett 2003, Guy and Gibbons 2003). However, Roussel (2006) warns nurse managers not to overplan and to leave some room for people to exercise their initiative.

It is also important to have an agreed and appropriate timescale, which can prevent alienation and increase the likelihood of success (Carney 2000). Schifalacqua *et al* (2009a) warn not to underestimate the 'power of the grapevine', so effective communication should begin at phase 1 (Snow 2001) and is, in fact, integral to the entire change process (Tomey 2009).

**Figure 2** Example of a force-field analysis




Once driving and restraining forces have been identified, change agents can determine their relative strengths and rank these by numbers or, as illustrated, by the thickness of arrows.

(Chambers *et al* 2006)

**Phase 2** At this stage, motivation and capacity for change are assessed. It involves communicating with those who might be affected, responding to concerns and, if required, justifying the change. Focus group interviews are one way to achieve this (Carney 2000).

This phase should also address resistance or, as Lewin (1951) puts it, the 'driving and restraining forces'. He suggests that both driving forces (facilitators) and restraining forces (barriers) operate during change, with driving forces advancing a system towards change, while restraining forces impede it (Marquis and Huston 2008).

Resistance to change is inevitable, and managers would be naive to think otherwise (Baulcomb 2003, Cork 2005, Price 2008). Meanwhile, Roussel (2006) suggests that change induces stress that in turn leads to resistance. However, using force-field analysis can counter this resistance.

*Force-field analysis* This is a framework for problem solving and planned change, developed by Lewin (1951). It illustrates that restraining forces cannot be removed and they can be countered only by increasing driving forces. One simple example can be used to illustrate this. A staff nurse does not believe that a new infusion pump is better than a previous model. The change agent cannot remove this restraining force but can bolster the driving

force by explaining why the new pump is more effective and by organising training in how to use it. Figure 2 provides an example of a force-field analysis.

When the force-field analysis is completed, change agents must develop strategies to reduce the restraining forces, which include issues such as fear of losing job satisfaction, or fatalism based on previous failed change attempts (Tomey 2009). They must also strengthen the driving forces by, for example, increasing remuneration, promotional incentive, better recognition (Marquis and Huston 2008).

**Phase 3** With the capacity for change addressed, Lippitt turns to phase 3: assessment of the change agent's motivation (Box 2). Change agents are not always managers (Murphy 2006), nor do they have to be part of the organisation where change is being introduced. External change agents can be more objective than internal ones, but can be costly, take more time to assimilate duties and be seen as a threat by other team members (Roussel 2006, Marquis and Huston 2008, Tomey 2009).

**Phase 4** This phase, the planning stage, is the point at which the change process is defined and a final draft of the plan is developed, taking into account the force-field analysis, change agents' status, staff attributes and cost. A timetable is drawn up to ensure cost-effective implementation of the change (Benton 1999) and each team member is assigned a responsibility. At this stage, change agents might consider some broad change strategies.

*Change strategies* Bennis *et al* (1985) describe three groups of change strategies that are appropriate for nurses wishing to implement change:

- Empirical-rational.
- Power-coercive.
- Normative re-educative.

One of these can be selected at phase 5 to help guide change (McPhail 1997).

The empirical-rational strategy assumes that people are rational and will adopt change if it can be justified and is in their self-interest. Meanwhile, power-coercive strategy is top down and assumes that people obey instructions from higher authorities, although Cutcliffe and Bassett (1997) note that these instructions are usually accompanied by some sense of threat, such as job loss. Finally, the normative re-educative strategy assumes that providing information and education will change people's usual behaviour patterns and help them develop new ones (Tomey 2009). Most successful change projects require a combination of these strategies (Strunk 1995).

**Phase 5** This phase focuses on choosing an appropriate role for the change agent. Cooke (1997, 1998) says that change agents are an active part of the change process, particularly in terms of managing staff and supporting change, and will aim to transform intentions into actual change efforts at this stage. It might be useful to undertake another force-field analysis now, as resistance can intensify at this point (McPhail 1997, Benton 1999, Roussel 2006, Tomey 2009).

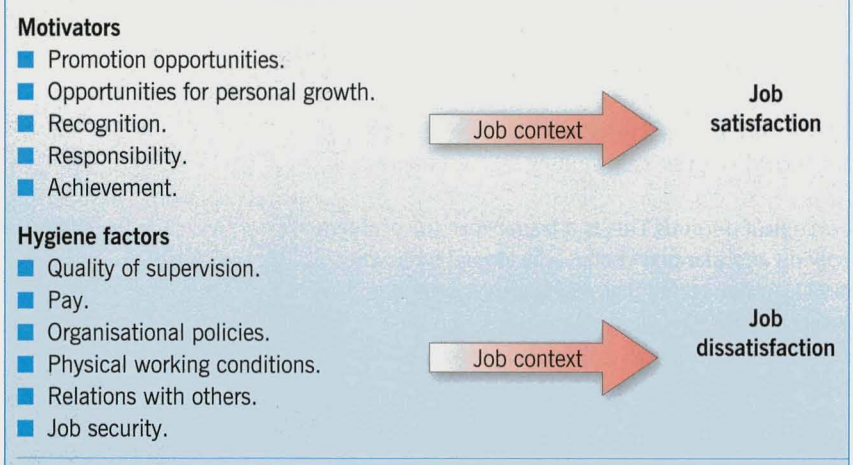
**Phase six** This phase corresponds to the implementation stage of the nursing process (Box 2) (Pearson *et al* 2005) and is concerned with maintaining the change so that it becomes a stable part of the system (Cooke 1998). During this phase the emphasis is on communication, feedback on progress, teamwork and motivation.

Change agents need to use their interpersonal skills to inspire change, and having an understanding of motivation theory can support this. For example, the Herzberg (1959) two-factor motivation theory (Figure 3) proposes that individuals have intrinsic and extrinsic needs, described as satisfiers (motivators) or dissatisfiers (hygiene factors), which need to be fulfilled (Bennett 2003).

If change agents strive to meet staff's intrinsic motivational needs, this is likely to increase job satisfaction and improve co-operation and performance, and could be achieved through praise, continual feedback and effective communication (Cubbon 2000).

Ongoing training is important in this phase. Martin (2006) recommends training to support

**Figure 3 The Herzberg two-factor motivation theory**




(Adapted from Cubbon 2000, Cork 2005)

change because it allows the change to be embraced more effectively. Conversely, Cork (2005) suggests that training shows only how to behave in a certain system and not how to change it. However, Schifalacqua *et al* (2009b) found that staff education and training was a pivotal part of the change process. They claim that the relationship between training and stabilising change is not accidental.

Good communication is a prominent feature of every phase of the change process and almost all researchers cite it as fundamental to effective implementation (Robb 2004). Strong, open communication across teams strengthens the chance of firmly embedding change by supporting the development of therapeutic relationships and removing barriers (Murphy 2006).

**Phase 7** The final phase, 'terminating the helping process', is evaluation and withdrawal of the change agent on an agreed date, although Roussel (2006) recommends that change agents remain available for advice and reinforcement, since past behaviours can re-emerge and render even successful change useless.

Finally, any change must be evaluated to determine whether standards have improved. This can be done through clinical audit or patient satisfaction surveys.

## Conclusion

Attempts to implement planned change face numerous barriers, but using a framework, such as Lippitt's, proactively rather than retrospectively can help eliminate some of the potential problems, and address and act on others.

However, while this will not guarantee success, since planned changes are vulnerable to failure at every stage in all change theories, careful consideration of change theory can simplify the process for change agents and help those affected by change to be more receptive to it.




**Conflict of interest**
None declared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