Culture Change Is Not Easy… But It Can Be Done

Changing an embedded culture is a monumental task for any management team. For those of us in psychiatric-mental health (PMH) nursing, we are accustomed to facilitating change in those we serve and have a bag of strategies to use when we face resistance and try to promote growth. For those of us who go on to become nurse executives, we find that some of those strategies transition well, while others, such as trusting staff maturity level or thinking our communication has been accepted, seem to fall flat. Changing the culture of a large institution during times of rapid change and fiscal downsizing seems to challenge even the best psychiatric leaders. Yet, PMH nurse leaders can effectively work toward culture and practice changes by drawing on skills we have used with individuals, families, and smaller groups.

PMH nurse executives can draw from their clinical skill sets; tactics such as a sound understanding of how individuals and systems operate can serve us well. We can use our talents in assessment and intervention to employ methods such as reframing (Townsend, 2008); we can shift our view and that of our staff from emphasizing what is being done “wrong” to how can we improve. Our skills working with individual change, with such strategies as “catching them doing good,” instead of always pointing out omissions, errors, and inadequacies, can be translated to groups or unit/divisional staff. And our abilities to build trust and listen (Marshall, 2011; Townsend, 2008) for signs of struggle can be brought to our meetings and interactions with the divisional workforce.

Two years ago when I arrived in my position as an associate vice president, I was met with a file box and multiple binders containing plans of correction to meet deficiencies cited by several accrediting bodies for our 300+ bed behavioral health division. Morale was low, productivity was minimal, and patient care was safe—but not driven by current standards—nor was it evidence based.

This was what our new management team faced on arrival to the facility: seven labor unions, staff suspicion of management, ineffective communication, and high management turnover. These elements required the new leadership of the behavioral health division to strategize and plan to build trust, decrease suspicion, enhance communication, and move the care of our patients from a model of low provider-patient interaction to that of an interactive program of services.

Nursing, business, and sociological theories have been developed on working with change in large systems; somehow, most seem to miss an element or two. I have found that an eclectic combination of several seems to be the most effective approach. Culture reflects who we are as human beings, and institutional culture reflects who we are as health care professionals. Low morale, suspicion, resistance to change, and stale practice are symptoms of an unhealthy environment. Most RNs would not run to join such a team. Additionally, many stay only because they
fear that leaving would place them in another environment even worse! It’s the old axiom that it is better to deal with the devil you have than risk finding one you don’t know.

Lewin’s (1936) Model of Change, Prochaska and DiClemente’s (1986) Stage of Change Model, and Rogers’ (2003) Diffusion of Innovations theory, along with Watson’s (2008) Caring Science Theory lend elements that can be effective in large organizational change. By using systems theory and an understanding of the homeostatic process, a macro-level view can be ascertained within the larger organization. This view can assist in guiding the PMH executive to note areas for improvement and strategize for implementing changes.

Familiarity enhances trust and helps develop working relationships. Just as a therapist and client must develop a working relationship, so must the PMH nurse executive be present, visible, and involved with organizational staff. Change cannot occur if unilaterally dictated from “above.” The astute PMH nurse executive who has had clinical experience knows that change only occurs when the “client” is at a stage of readiness and actively seeking change. As stated by the surveyors in their exit interview, the organization “has made significant strides in improving the quality of care.” The atmosphere here is charged with jubilation, relief, and a sense of pride. It has been a challenging road, and while some would scoff that this is a Joint Commission survey not a Magnet designation, it is significant for our organization. Changing practice patterns and organizational culture are significant challenges for PMH executives. To achieve an accreditation without major POC is a testimony to administration, nurse managers, and staff that their efforts have proven successful.

This is not the end of the story. As every PMH nurse knows, change must be anchored and sustained. This can be done through ongoing reinforcement of the change that has occurred and through the quantification of change as noted in organizational performance improvement projects. When an individual makes a positive change, his or her life is better. When a health care organization makes significant changes, many lives benefit. According to Marshall (2011), “Transformational leaders must believe in their abilities to accomplish their dreams and enhance that belief in others. They also must provide ongoing support and encouragement to others through the journey” (p. ix). Let’s use our PMH skills to grow our services and our staff.

REFERENCES

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