The Role of Leadership in Change in Healthcare Facilities: A Qualitative Study

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Change is inevitable in all areas of business today. Studies have shown that the majority of change within organizations fails to achieve the desired results more than those changes succeed. Articles focusing on the effect leadership has on the success or failure of change efforts is lacking. The participants for this study included healthcare professionals working in leadership positions. Data was collected through the use of individual, standardized, and open-ended questions. The findings of this study reveal that leaders in healthcare have the knowledge to implement change using change management principles but still lack the ability to influence cultural change.

Keywords: change management, project management, organizational leadership, organizational change, highly reliable organizations

INTRODUCTION

Change theory and change management has been a topic of interest for researchers dating back to the 1940s. Original change ideas centered on creating models that leaders could utilize to successfully transition their organizations to meet the demands of the economy (Lewin, 1941; McKinsey, 1970; Kotter, 1995). While these models initially proved to be very successful, organizational leaders found that they simply could not keep up with the rate in which change was expected to take place (Welbourne, 2014; Worely, 2014). Even with all the theoretical perspectives and studies that have been conducted on change management, many organizations are unable to influence change and even less are able to successfully sustain change once it has been implemented (Brimstin, 2013). Most importantly an ever-evolving economy has caused the rate of change to continue to rise in order to meet the demands of the economy (Kotter, 2012).

Healthcare is a prime example of an industry with organizations that are constantly pushed to be adaptable. With an estimated 18 million reported employees in the United States and being listed as one of the Nation's top employers, healthcare administrators face challenges such as high turnover rates while being expected to perform as highly reliable organizations.

Studies surrounding health care have historically focused on the improvement and maintenance of quality patient care under high patient volumes, job satisfaction, and improving patient satisfaction (Hodgson, Matz & Nelson, 2013; Salyers, Rollins, Kelly, Lysaker, & Paul, 2013). Furthermore, the minimal

amount of literature that does exist regarding leading change in healthcare fails to address their unique leadership situation. While change management and leadership principles have been a very important topic among business professionals for quite some time, the idea of focusing on developed relationships between levels of leadership and its effect on change outcomes is a topic that does not have a significant amount of literature to back it up.

The problem addressed by this study is healthcare leadership's ineffective change management practices and how those practices prevent them functioning as highly reliable organizations (D'Alfonso, Zuniga, Weberg, & Orders., 2016; Martin & Waring, 2013; Ramthun & Matkin, 2014). A 2012 survey by McKinsey and Company of more than 2200 hospital and health system executives found that roughly 70 percent of executives said their strategic initiatives failed indicating that leaders are still unsure of how to reach their desired outcomes through change management (Fuchs & Prouska, 2014; Welbourne, 2014; Worley & Mohrman, 2014).

Historic change management models introduced by Lewin (1947), McKinsey (2008), and Kotter (1995) outlined the process in which change should take place, but they simply are not able to keep up with the rate that change occurs today (Welbourne, 2014; Worley & Mohrman, 2014). While an encompassing representation of literature on organizational change management does exist, the literature continues to lack suggestions on how healthcare leaders can maintain operations amid the obstacles they face while sustaining high performing teams.

Therefore, the purpose of this qualitative, phenomenological study is to contribute to the literature addressing leadership's role in organizational change by studying how healthcare leaders are improving their interpersonal relationships.

The fundamental questions that drove they study were:

RQ1. How do healthcare leaders implement change management in their organizations?

RQ2. How does position or status affect healthcare leader's ability to employ organizational change?

REVIEW OF THE LITERATURE

A review of current literature surrounding change management and the role of leadership shows that organizational change has been studied from multiple perspectives since Lewin's three step change model came into use in the late 1940's. The researchers reviewed literature on organizational change management, the leader's role in change management, and other factors affecting change management.

Organizational Change Management

The amount of literature encompassing the topic of change, change management and managing organizational change is innumerable (Al-Haddad & Kotnour, 2015). While researchers have come to a general consensus in defining change as "an alteration of the status quo" or "changing the old state of things to a new state of things" and organizational change as "movement from its current state to a more desirable, improved state", there is still much indecisiveness regarding how change should be carried out (Al-Haddad & Kotnour, 2015). The review conducted on the literature surrounding organizational change management proved two reoccurring themes: People are central to organizational change and organizational change is not one size fits all.

People are Central to Organizational Change

Change is a constant and at any given time, over 70 percent of organizations are experiencing it (Jansson, 2013). The concept of organizational change is to evaluate the organization's current state and to make changes based off of the needs of the organization and its employees and the market (Ahn, Adamson & Dornbusch, 2004). Regardless of the type of changes being made, the size of the organization making the change, or the predicted length of time, organizational change affects the organization as a whole (Shin, Taylor & Seo, 2012). This being said, researchers believe that sustainable change must include all levels of

the organization. Failure to include individuals at all levels of the organization results in miscommunication, organizational tension, employee resistance, prolonged change, or failed change (Jansson, 2013).

Bourne (2015) conducted a phenomenological study to evaluate generation response to organizational change. Baby Boomers, Generation X and Generation Y respondents were chosen to speak on their lived experiences through organizational change. The results of the study not only exposed how different age groups respond to change but also showed the importance of employee involvement. Of the five emerging themes, employee involvement ranked second most important for Baby boomers (communication ranked first) and third most important for Generation Y (communication ranked first).

Sanoubar and Bajestani (2015) found that employee involvement significantly reduced organizational change cynicism (OCC). The findings from their study concluded that when employees feel that their opinions matter they tend to be more involved in change initiatives. Additionally, they point out that involvement as opposed to information sharing/communication involves a shift in power and shows employees that their leaders trust their opinions (Sanoubar & Bajestani, 2013). Without buy-in from the organization's employees, organizations will continue to face resistance to change.

Change is not One Size Fits All

Organizations experience many types of change: organization driven, industry-driven, small changes over long periods of time (i.e. introduction of new software, employees leaving the organization or receiving new employees into the organization) and large changes over short periods of time (i.e. reorganization, mergers, or take-overs) (Al-Haddad & Kotnour, 2015). Regardless of the type of change being made, it is important that organizations recognize that change models are not one size fit all. Dunphy (1996) reiterates this then when he states, "there is no one, all-encompassing, broadly accepted theory of organizational change and there are no agreed guidelines for action by change agents" (p. 244).

Hechanova and Cementina-Olpec (2012) examined the relationship between transformational leadership and change management because prior research studies showed mixed results in whether the relationship between the two was direct or indirect. They constructed three hypotheses in which they assumed that academic leaders showed more transformational leadership qualities than business leaders, that change management principles differed between institutional and business organizations and that transformational leadership/change management relationship's effect on a commitment to change differed among academic and business organizations.

Practical implications of Hechanova and Cementina-Olpec study suggest that business leaders and academic leaders can learn from each other in terms of implementing change and maintaining employee commitment to change. It also implies that both transformational leadership and change management be taught. The study also showed that leadership behaviors and change management practices can differ based on the organization's culture (Hechanova & Cementina-Olpec, 2012).

Leadership's Effect on Change

Bakari, Hunjra, and Niazi (2017) working with the understanding that two-thirds of change efforts fail concluded that successful implementation of planned organizational changes are dependent on positive involvement of organizational leaders. Jan and Veronika (2017) showed the failure rate of change to be between 70% and 93%. These statistics would lead one to wonder if successful change can occur and if so, what are the factors leading to success. Because change is a requirement for organizations that wish to remain relevant; many factors contribute to its success, one of which is leadership (Carter, Feild, & Mossholder, 2013); Seo, Taylor, Hill, Zhang, Tesluk, & Lorinkova, 2012; and Hechanova & Cementina-Olpec, 2012). The ability to facilitate and manage change requires leaders who can effectively communicate the need for change and encourage their employees to adopt change initiatives as their own (Carter et al., 2013). Carter et al., (2013) and Hechanova & Cementina-Olpec (2012) both conducted quantitative studies that focused on leadership during organizational change. The following are some of the factors which lead to successful organizational change.

Leaders Affect Change by Presenting a Clear Vision Through Effective Communication

Leadership's clear communication regarding the need for change has always been a priority amongst change management literature (Lundy & Morin, 2013). Another tool essential for project portfolio management is communication. One of the most important skills that a leader should have is the ability to communicate. Communication is vitally important because it allows leaders to understand and express the needs of change. The ability to understand the needs of the organization and to communicate them both internally and externally is important. Without communication and understanding of change cannot be established, therefore they must communicate even the most basic expectations to their employees to ensure success (Lundy & Morin, 2013). Burke (2011) concluded that leaders who practice clear communication are most likely to experience successful organizational change

Leaders Affect Change by Recognizing that Change Requires Learning

Knowledge is power. When individuals within the organization have an understanding of what, why and when of organizational change, they can better prepare themselves for that change. Benson (2016) puts the responsibility of employee empowerment on leaders and says that this can be accomplished through giving them new knowledge. Bass (1999) agrees with this by encouraging leaders to be aware of the developmental needs of their employees and to provide them with unique opportunities to grow.

Leaders Affect Change by Gaining not Forcing Employee Trust

Gass (2010) believes that effective leaders acknowledge that change can be frightening for many employees because most times they do not know what to expect. Scully (2008) best describes this feeling as "periods of change characterized by extraordinary levels of ambiguity and uncertainty, demanding unequivocal follower trust and faith in leadership to navigate them through the fog and ease anxieties back to a level where they are motivating, rather than paralyzing". Bass (1999) also speaks on the importance of leadership/employee trust by stating, "trust in leadership is required for willingness to identify with the organization and to internalize its values and the emergence in the workplace of transcendental organizational citizenship behavior".

Carter et al., (2013) conducted a study in which he questioned the effect that transformational leadership, leadership/employee relationship, and change frequency have on continuous organizational change at lower hierarchical levels. With a focus on transformational leadership and relationship quality during continuous incremental change, the research study sought "to investigate how team-focused transformational leadership influences employee performance at lower organization levels where change is an integral part of ongoing operations" and "to examine whether change context affects the influences of relationship quality on change outcomes" (Carter et al., 2013, p. 943). The study proposed that transformational leadership and the relationship that leaders have with their employees is the catalyst that not only initiates but also sustains constant organizational change. Their research findings contributed to both transformational leadership and change management theories by examining the influence that transformational leadership has on change outcomes, focusing on transformational leadership and change at lower hierarchal levels, exploring the role of relationship quality in varying change frequencies and assessing change outcomes from the perspective of lower management as opposed to higher management. Specifically, Carter's study showed that the quality of the relationship between leaders and employees promoted successful change outcomes and that the frequency in which change occurred moderated the link between relationship quality and performance. Studying change from a bottom-up approach as opposed to a downward approach also made contributions. Lastly, the research study was able to gauge leadership effectiveness by using independently assessed performance criteria instead of a self-report, same-source performance assessment used in previous studies (Carter et al., 2013).

Additionally, Van der Voet (2013) analyzed the relationship between change management and transformational leadership by contributing to research on public organizations. This study was conducted to determine the effectiveness of transformational leadership in planned and emergent change. The results showed that both planned and emergent change are useful and "that a combination of both planned and emergent change may be the most effective approach to organizational change" (Van der Voert, 2013).

These studies contributed to both leadership theories and change management theories by examining the influence that leaders have on change outcomes, focusing on leadership and change at lower hierarchal levels, and assessing change outcomes from the perspective of lower management as opposed to higher management. Their findings not only prove the significance of leadership/employee relationships during a change, but also suggested that the quality of the relationship between leaders could promote successful change outcomes (Bass, 1999; Gass, 2010; Carter et al., 2012; Scully, 2008; Van der Voet, 2013).

Numerous studies have also been conducted to identify the characteristics or behaviors of leaders who initiated change. The results of these studies have identified the need for leaders who own and embrace change, have a sound understanding of the changes that are being made and showing interest in their employee's adjustment to change (Brimstin, 2013). There is also a need for leaders who put great emphasis on organizational participation, effective communication and leadership buy-in (Krause, 2012; Gordon, 2013).

Jay Brimstin (2013) conducted a qualitative case study to identify and describe the factors that are essential to successfully initiate change using a bottom-up approach. As a result of his study, he identified middle managers who owned and embrace change initiatives, had a sound understanding of the changes that were made and continuously received feedback regarding the outcomes of the changes being made as necessary leadership characteristics to maintain change that was initiated from the bottom up.

Garry Krausse (2012) looked into the experience of leaders who led organizational change. He utilized the case study method because "it allowed him to investigate the change-related experience of leaders who were on or had held membership on the municipality's leadership cabinet" (Krause 2012). He also felt that a case study would allow him to get more in-depth knowledge of the leader's experiences (Krause 2012). The results of his interviews identified five emerging themes amongst the leaders:

(1) the leaders indicated a preference for collaboration, participation, consensus building, and communication approaches; (2) the leaders preferred to use a private-sector business management approach; (3) leading organizational change contributed to long work hours, stress, frustration, exhaustion, and strained relationships for the leaders; (4) the leaders desired their own improvement through more preparation, communication, and listening; and (5) leadership turnover impacted the positional leaders. (Krause, 2012).

Lastly, Gordon (2013) recognized that many of the change management principles were geared towards traditional business and organizations and that few geared change management principles towards healthcare organizations. Gordon's approach to his qualitative study was to conduct a case study in which he would interview ten healthcare project managers within the same region. By interviewing the ten project managers he sought out the best practices for implementing change in a healthcare setting. Gordon's (2013) case study identified the following best practices to successfully implement change in healthcare organizations: Leadership buy-in, genuine stakeholder engagement and clear articulations of benefits.

Studies currently conducted by Kezar, (2012, 2013,) Goldfein and Badway, (2015), Seo, et al., (2012), and Prediscan and Bradutanu (2012) have identified that leaders are not effectively working together to promote change. Their work has found that the lack of cohesion between levels of management has caused the overall organizational change to be stifled because employees find no need to change if leadership is at odds with each other (Kezar, 2013; Goldfien & Badway, 2015). This key realization presents the need for continued research identifying how leaders can most effectively work together on change initiatives which could prevent organizations from struggling with change initiatives.

Change in the Healthcare Industry

The rate of successful change in healthcare is dismal. The industry experiences a high demand for change with the expectation of improved safety outcomes and reduced medical errors often with little time to react (Birken, Weiner, Chin & Schaefer, 2013; Formosa, 2015; French-Bravo & Crow, 2015). Many times, the rapid changes in healthcare cause implementing simple health care innovations to be challenging with a success rate of less than fifty percent (Birken, Weiner, Chin & Shaefer, 2013; Weller, Boyd & Cumin, 2014).

These organizational challenges include misaligned incentives, professional barriers, competing priorities, and inertia. Additionally, French-Bravo and Crow (2015) credit the lack of buy-in to failed organizational change by pointing out that leaders are often the first to identify the value and purpose for change but fail to creatively engage their employees.

Therefore, understanding the effort needed to implement change would allow managers to assess the amount of workforce buy-in needed in order to mitigate failed change (Anders & Cassidy, 2014). The next few pages discuss the most significant barriers to change in healthcare and their unique differences.

Barriers to Change

Birken et. al (2013) believe that organizations fail to meet their change initiatives due to misaligned incentives, professional barriers, competing priorities and organizational inertia. Moreover, French-Bravo and Crowe (2015), Anders and Cassidy (2014), and Formosa (2015) identify these categorical generalizations by naming misuse of power, lack of communication and lack of organizational buy-in as the main offenders.

Misaligned Incentives

The first reason for failed change initiatives refers to the unbalanced reasoning between leaders for organizational change (Birkin et al., 2013). Allan et al (2014) assert that "team effectiveness must be predicated on factors such as organizational commitment, leadership, clarity over objectives, and coordination of the different and distinctive professional contributions" (p.95). When leader incentives are not aligned, each seeks to accomplish something different causing them to put their own desired outcomes above the needs of the organization. Allen et al., (2014) refer to incentives "not just as financial motivators, but as emotional support, leadership, and relationships in teams" (pg. 95).

Narayanan and Raman (2004) stated that misaligned incentives are seen often amongst organizational leaders and blame their existence on a lack of organizational leadership cohesion, communication, and poor change initiatives. When leaders push for organizational change only to benefit their own agenda, poor change initiatives result and change is hindered. The same applies when leaders do not clearly communicate amongst themselves their reasoning and desired outcome for the change. Narayanan and Raman (2004) also reiterate how harmful misaligned incentives are to organizational change and urge leaders to deal with them sooner rather than later by offering three ways to turn misaligned incentives into cohesive ones.

First, they must accept the premise determine whether or not their incentives align with the change initiatives. Next, they suggest identifying any hidden actions, information, or poorly designed incentives. This action requires leaders to be transparent and honest to determine if valid changes are being pushed. Lastly, once organizational leaders have identified all root causes to misaligned incentives, they must come together to either align the incentives to the change at hand or both align and redesign the change initiative and the incentive.

Incentives play an important part in change initiatives. When leaders allow their personal incentives to interfere with organizational needs, they jeopardize change initiatives. A lack of cohesion between levels of management poses dangers. Foremost, overall organizational change gets stifled because leadership cannot come to a consensus. Additionally, employee resistance increases because they find no need to change if leadership is at odds with each other (Kezar, 2012). Therefore, taking the time to ensure incentives align with and benefit the needs of the organization is ideal.

Professional Barriers

Birken et al., (2013) also identify professional barriers as a hindrance to organizational change. This type of barrier is very common in hospital settings as there are many different members practicing on different levels of expertise. Additionally, Formosa (2015) blames this barrier to change on the misuse of power and a lack of communication within the organization. Furthermore, he argues for hierarchies to be removed from healthcare because they interfere with members freely voicing their opinions and concerns (Formosa, 2015). Likewise, he reveals that the holder of power is usually the government and that nurses

rank with less authority than doctors or consultants and patients rank lowest, having no power and with little or no voice in their care.

The misuse of power is commonly found in healthcare settings because the members within the organization with higher levels of expertise assume that they should make all decisions (Formosa, 2015; Weller, et al., 2014). Formosa (2015) states, "Healthcare organizations should create a culture in which all personnel, regardless of their job description can voice their opinions and concerns" (p. 424). As a result, he believes that employees are more prone to speak to each other as professional peers when they feel empowered through communication.

Weller et al., (2014) and Benson (2016) continue this thought by citing employee as a solution for quality and productivity problems. They reiterate the importance of people needing to be able to voice their suggestions and concerns without the fear of ridicule or punishment. This is not achieved by organizational leaders being overly warm or friendly, but rather by leaders creating an environment in which their employees are able to express their concerns and by modeling their own imperfections by admitting their own errors.

Professionalism is reciprocal; not one-sided (Birkin, 2014; Formosa, 2015; Weller et al., 2014). Weller et al., (2014) meta-analysis of 72 independent studies (incorporating 4795 teams) across a range of industries showed that organizations that highlighted professionalism as a priority positively predicted the performance of the team. Their implications and recommendations urge practitioners to implement three levers for change. First, they encourage practitioners to teach effective communication and to train their teams together. The findings from their study indicated that less is being done to train medical students on how to communicate with other health professionals and that teams who train together end up working better together.

Second, they encourage the creation of democratic teams. They believe structured communication strategies can help to create more democratic teams, where all members are confident of being heard and argue that such a democratic communication framework is needed in healthcare. Once again they reiterate that every member of the team needs to be empowered to contribute their information to decision making.

Last, they encourage healthcare practitioners to develop an organizational culture that specifically supports healthcare teams. Organizational culture is an important element in the prevention of error and those in leadership roles at both institutional and healthcare team levels establish this culture.

Competing Priorities

While it would be ideal for healthcare organizations to deal with change initiatives one at a time, industry demands do not allow for it (Birken, Weiner, Chin & Schaefer, 2013; Formosa, 2015; French-Bravo & Crow, 2015). Rather, these organizations, along with organizations in other industries, must be able to balance multiple types of change simultaneously in order to stay relevant and keep up with their competitors (Birkinshaw & Gupta, 2013; Brimstin, 2013; Umble & Umble, 2014; Welbourne, 2014 and Worley and Morhman; 2014).

Birkinshaw and Gupta (2013) acknowledge how difficult this can be and suggests that organizational leaders must have a level of ambidexterity in order to simultaneously manage multiple organizational activities and make clear concise decisions while doing so. They define ambidexterity as, "an organization's capacity to address two organizationally incompatible objectives equally well" (p. 291) and argue its importance by stating, "firms require managerial competence; they need managers who can make thoughtful trade-offs between competing demands, and who can find creative solutions that transcend either/or solutions" (p. 290). Furthermore, they believe that balanced decision-making is one of the most important things that happen amongst organizational leaders.

Allen et al., (2014) conducted a study on organizational change in healthcare settings that identified competing priorities as a hindrance. Their study interviewed 32 managers and 56 healthcare professionals regarding change within their organizations. Amongst challenges such as decreased organizational morale, many of the managers reported difficulties in establishing coherent teams when members of the team represented different disciplines. Furthermore, they reported that members of the team had competing

priorities and agendas, which caused them to physically separate and not be able to come to a consensus during decision making.

The ability to manage multiple change initiatives takes a large amount of skill and dedication. Four techniques (prioritization, organization, self-education, and delegation) used in managing multiple projects can be implemented here (Olsen, Gyrd-Hansen, Sorensen, Kristensen, Vedsted & Street, 2013).

Prioritization is important when managing multiple change initiatives because it allows managers to assess the top priority of each initiative and accomplish those first. Additionally, having an understanding of the organization's goals is equally important as it allows managers to focus on the organization's most important assets.

Being organized allows managers to keep each change initiative on track. An unorganized manager runs the risk of mixing up information between change initiatives and making unnecessary decisions. Communication also plays an important part in the organization as it keeps the members of the team interconnected. Even the most basic information should be communicated to ensure all members are on the same page (Olsen et al., 2013).

Self-education is another technique managers should consider. Whether its learning more about the members of the team or gaining advanced knowledge in managing change initiatives through classroom training or on the job training, both can enhance the success of a leader. Lastly, because managers cannot actively manage each change initiative, they must learn to delegate tasks. Delegation is extremely important as it allows managers to get the most rewards for their change initiatives. By choosing knowledgeable team leaders and creating effective teams, managers can successfully oversee multiple change initiatives at the same time.

Just as misaligned incentives interfere with organizational change initiatives, competing priorities also have similar negative implications. Therefore, it is important for members of change teams to not only be aware of these hindrances but also know how they can overcome them.

RESEARCH METHODOLOGY AND DESIGN

The qualitative research method was chosen over the quantitative method because the researcher's intent was to understand how successful alliances are formed between leaders when leadership turnover is high and how to navigate intergroup strife that prevents them from implementing change.

This design also aligned best with our intent because phenomenology attempts to locate the universal nature of an experience, identify shared experiences among various individuals experiencing shared phenomena, locate the essence of an experience, and portray what was experienced and how it was experienced by the individuals (Kornhaber, Wilson, Abu-Oamar, Mclean & Vandervord, 2015). Additionally, Phenomenological approach was preferred over other types of qualitative methods (case study and grounded theory) because the researcher's central goal was to understand and describe the participants lived experiences and how they perceived them (Farrelly, 2013). By focusing on the participant's mood, sensations and emotions, researchers uncover and expound the deeper human aspects of a situation (Converse, 2012; Finlay, 2009; Kornhaber et al., 2015).

While specific sample size recommendations for phenomenology studies vary across the literature, anywhere from 2 to 25 participants are most often suggested as it allows the researcher to focus on each experience and prevents them from becoming overwhelmed with large amounts of data (Alase, 2017; Creswell, 2013; Gentles, Charles, Ploeg, & McKibbon., 2015; Roberts, 2013). The requirements for the participants in this study were that they were working in healthcare and that they had experienced and/or facilitated change within their teams, departments, or organizations. Purposive sampling was then used to select a target of twenty participants.

There were eighteen participants that expressed interest in the study, but only fifteen followed through with the interview process. While Creswell (2013) suggests that the researcher establish rapport with the participants to help put them at ease during the interview process, it was important that the researcher made sure that the data and findings were not due to participant and/or researcher bias. To eliminate any bias, the researchers interviewed participants that they did not personally know and established rapport with the

participants without expressing and pre-conceived views of the study. Most importantly, participation was voluntary and any participants who showed interested early on but opted out of the study were not penalized in any way.

The research was conducted following the guidelines of the Institutional Review Board (IRB) of Northcentral University. Each participant received full details of the purpose and nature of the study and understood that they could opt out of the study at any time. They provided informed consent via the informed consent forms before the start of each interview and were given sufficient time to ask any questions and address any concerns on the study.

To maintain confidentiality, participants were given pseudonyms known only to the researchers. All collected data was encrypted and stored on flash drives that required a unique personal password before access. Additionally, data files were stored in a lockable container in the researcher's residence.

Data was obtained using individual, standardized, semi-structured interviews. Conducting semi-structured interviews from multiple leaders allowed for diversification and increased credibility, while the standardized, semi-structured interviews allowed the respondents to freely elaborate on the topic (Creswell, 2013; Moustakas, 1994; Parcsi & Curtin, 2013). Data analysis was processed through a coding system in which the researchers identified the reoccurring themes from the participant's responses. Participants were given a letter and number to differentiate them. For instance, interviews conducted via telephone were identified as T1 and T2 and those conducted as written interviews were identified as W1 and W2. The following steps were then used to analyze the data. The researchers first made sure that the data was transcribed into textural format. When analyzing and processing data, Abayomi (2017) and Creswell (2013) suggest reading over each participant's response a minimum of three times before formulating any themes. This is to ensure that the results of the study were truly those of the participants and not any pre-conceived results of the researchers. The data was then visually organized by identifying keywords from each interview. A table of similar responses was also built to formulate the reoccurring themes. The research objectives were then used to derive the codes during analysis and the researcher used In-Vivo coding. This In-Vivo coding system allowed the researcher to identify common themes amongst the respondent's answers (Muse & McMannus, 2016). Furthermore, the questions were open-ended and unobstructed to ensure that the responses were not influenced by the researchers (Muse & McMannus, 2016). Continual validation was also a part of this process to ensure that the researchers had chosen the correct design and method for the study.

The researchers verified that the participants had previously facilitated change as a leader and that they could relate to the questions asked. Secondly, it was assumed that the participants answered the questions honestly and in good faith. Last, assumptions were made that the research method and design that was chosen were adequate in order to answer the research questions represented in this study (Moustakas, 1994). The study was limited by the non-responses of healthcare leaders who chose not to respond even though confidentiality was assured. Those participants who intentionally or unintentionally became unavailable due to personal or work conflicts also limited the study. Additionally, the interpretation of the data could have affected the results since the study was dependent solely upon the researchers.

Findings

The first half of the interview process focused on the process that healthcare leaders use to implement change within their teams/department/organization. They were asked the following four question: How many opportunities have you had to make change in your department/organization, describe the state of your department/organization before the changes were made, describe the steps taken to employ the changes and describe the state of the department/organization after the changes were made.

When asked to describe the state of their department/organization before the changes were made, participants were able to identify the specific issues leading up to the change initiative. One recalled a time when their department's patients were experiencing long wait times due to staff members not working together as a unified team. Another followed suit by recalling a time when the organization they work in "had a high disregard for sanitary conditions and processes that promote infection control".

When asked to elaborate on the steps taken to employ the changes and the state of the department/organization after the changes had been made, participants made many references to resistance and time. Multiple mentioned that staff did not have time to be resistant to the changes being requested because they were more or less "mandated" to do so. They went on to say that the leaders decided on what course of action to take and the new change was pretty much implemented the next business day. One in particular admitted that he did not expect the change to take place over-night. He stated, "Leaders must understand the resistance to change. They must continually communicate the need for change and the benefits that come with it". Another mentioned the importance of taking small steps and making small changes over time. They established goals for the organization and conducted monthly audits to ensure that they were progressing in the right direction. He additionally stated that "this approach to implementing change provided a competitive venue for middle management to aim for higher scores. Responsibility was enforced to the staff and standards were corrected, reviewed and enforced."

The second half of the interview questions focused on the relationship between the levels of healthcare leaders when working together to implement change. Participants were asked the following questions: Describe a time when you and other healthcare leaders worked together to employ a change in your organization, describe the interaction you had with other leaders involved in the change, describe, the relationship among leaders working together to employ the change, and how did leaders handle opposition.

Participant responses to questions regarding the relationship between healthcare professionals led to the development of Theme 2. Few reflected primarily on the positive interaction they had with leaders during times of change. One in particular complimented the leadership above her and felt that they were engaged with the changes being presented to them. She applauded the unified front that they presented and reported no lack of buy-in from them. Of those who mentioned earlier in the interview that the specific change initiative was mandated, one spoke highly of the support the leaders provided her team and department. She attributed this to the fact that "they all had started off at the bottom and could, therefore, relate to what their jobs entailed". Of the negative responses, some reflected on the constant struggle they had with upper management when trying to get them on board with the changes the healthcare organization desperately needed. "*Lack of leadership buy-in*, *feeling like a target*, and *constantly having to prove my knowledge"* were all phrases used to describe their experiences. One expounded on this by stating:

> Leaders who are higher up seemed to be overwhelmed. They have too many higher powers dictating above them and sometimes they don't see the incentives for changes being requested at the lower level… Because they were not doing the job they could relate. I learned that change agents should be kept close to the situation. They should be the gateway between high leaders and employees.

He shared that during his experience upper management "seemed to take the side of his staff because they were not in clinical roles and couldn't relate to the patient care side of things". This caused even more resistance from his staff because they saw that their leadership was not on the same page.

Two major themes and five minor themes emerged from the two research study questions. The results of the study were derived from fifteen participants who were asked semi-structured, open-ended interview questions. The major themes presented were: 1) recognize and identify the root issues and 2) rank has a huge impact on change. Minor themes were: resistance to change is inevitable, be persistent and consistent, change takes time, bottom-up change experienced higher resistance than top-down change, and rank is not immune to resistance. The results of Theme 1 align with the literature on change management in that they show the importance of communication during change (Burke, 2011; Kotter, 1995; Lundy & Morin, 2013). Furthermore, they indicate that change whether planned or emergent follows a process in identifying the root cause of the problem (Kotter, 1995). Theme 2 also align with the literary summary presented (Carter et al., 2012; Goldfein and Badway, 2015; Hechanova & Cementina-Olpec, 2012; Hildreth and Anderson, 2016; Kezar, 2013 and Seo, et al., 2012). These studies focused on the role of change agents and how power (rank) can disrupt change initiatives. They also focused on the vital part that leadership plays in change and

how people are central to organizational change. Most importantly, the results of Theme 2 showed that rank could also have a positive impact on organizational change.

Overall, the findings of this study reveal that leaders in healthcare have the knowledge to implement change using change management principles but still, lack the ability to influence cultural change. Hence, there is a need for an environment that supports the operation of healthcare teams where professionals regardless of their rank are empowered to suggest/voice change initiatives.

Implications

Two key themes were identified through data analysis. The first, healthcare leaders implement change in their organizations by recognizing and identifying the root issue; and the second, rank/position has a huge impact on healthcare leader's ability to employ organizational change.

The results of the first research question can be used to further understanding of the process of implementing change. All participant experiences mentioned that communication was implemented as a part of their change initiatives and that time (planned or emergent) was a huge factor in the change process. These results align with the literature in change management by reiterating the importance of communication and time (Burke, 2011; Kotter, 1995; Lundy & Morin, 2013). Within the literature on leadership's effect on change management, these leadership characteristic themes seem vital to change success: Present a clear vision through effective communication, allow time for employees to embrace the change, recognize that change requires learning, gaining not forcing employee trust, and the ability to energize and motive employees (Al-Haddad & Kotnour, 2015; Carter et al., 2013; Seo, et al., 2012; and Hechanova & Cementina-Olpec, 2012). Research also places great emphasis on ongoing communication as opposed to a one-time explanation of the proposed change and suggest that it be dialogic as opposed to one-sided (Campbell et al., 2015; Simoes & Esposito, 2014). Communication is rated highly as an element to effect change, but allowing time for employees to comprehend, embrace and accept the change initiatives is also needed. Participants repeatedly made reference to the amount of time it took for the change to take place. They acknowledged that change does not happen overnight; rather it takes time, patience, and perseverance. When everyone in the organization takes time to internally understand, embrace and commit to change, then the organization is in a place to move forward (Burke, 2011). The results also indicate that change whether planned or emergent follows a process in identifying the cause of the problem (Kotter, 1995).

The intent of the second research question was to further understand how rank or position affects organizational change. Eighty percent of the participants reported the negative effects that rank has on change and twenty percent reported the positive. One participant described her experience with leadership by using phrases such as "lack of leadership buy-in", "feeling like a target" "constantly having to prove my knowledge". She reflected on the constant struggle she had with upper management when trying to get them on board with the changes the healthcare organization desperately needed. Another participant expounded by stating, "Leaders who are higher up seemed to be overwhelmed. They have too many higher powers dictating above them and sometimes they don't see the incentives for changes being requested at the lower level… because they were not doing the job they could relate". Off the positive, one complimented the leadership above her and felt that they were engaged with the changes being presented to them. She applauded the unified front that they presented and reported no lack of buy-in from them. Another spoke highly of the support the leaders provided her team and department. She attributed this to the fact that "they all had started off at the bottom and could, therefore, relate to what their jobs entailed. These results, although nearly split, correspond directly with the literature. Previous studies show that leadership characteristics along with power have a direct impact on organizational change. For instance; Kezar, (2012, 2013,) Goldfein and Badway, (2015), Seo, et al., (2012), and Prediscan and Bradutanu (2012) found that the lack of cohesion between levels of management has caused overall organizational change to be stifled because employees find no need to change if leadership is at odds with each other while other studies showed that the quality of the relationship between leaders promoted successful change outcomes and that the frequency in which change occurred moderated the link between relationship quality and performance (Carter, 2012; Gass, 2010; Van der Voet, 2013). The misuse of power is commonly found in

healthcare settings because the members within the organization with higher levels of expertise assume that they should make all decisions (Formosa, 2015; Weller et al., 2014).

From the perspective of the healthcare leaders interviewed, organizational change methods along with leadership's role and importance are well understood, but there remains a large amount of work to be done in order for healthcare organizations to perform at highly reliable levels. This is significant because leaders have the knowledge to perform organizational change but lack the ability to influence cultural change.

Recommendations for Practice

The following recommendations are presented from the findings of this study. First, practitioners are encouraged to perceive resistance as a positive. Multiple occurrences of resistance are mentioned, which align with change management methodologies and earlier change management literature. This is insightful because it notifies practitioners that resistance is inevitable and will more than likely be apart of all change initiatives. Because of this, it is recommended that healthcare professionals become more aware of resistance and seek to understand the underlying causes of it instead of fighting it. Studies have mentioned that when leaders build quality relationships with their employees and allow them to voice their concerns that they are more open to change (Bass, 1999; Carter et al., 2013; Gass, 2010; Scully, 2008; Van der Voet, 2013).

Second, it is recommended that healthcare professionals become more open to accepting change from all levels of leadership and place organizational culture at the top of their priorities. The data from this study reported that organizational change coming from lower and middle management experienced more resistance than change initiatives coming from upper management. This finding aligns with many studies conducted on the change in healthcare facilities (Anders and Cassidy, 2014; Erlingsdottir, Borell, Rydenfaelt, and Ersson, 2018; Werberg, 2012). The rank structure in healthcare (doctor, nurse, nurse assistant, etc.) is a contributing hindrance as it gives the perception that those in higher positions have a bigger voice than those lower in rank (Anders and Cassidy, 2014; Erlingsdottir et al.,2018). While the healthcare rank structure helps to organize individual tasks and responsibilities, this study recommends that all levels of leadership be empowered to suggest/voice change initiatives. Furthermore, previous studies report that change agents (those closer to where the change takes place) can have a positive effect on the success of organizational change (Birken et al., 2013; Kezar, 2012). Creating an environment where healthcare leaders (regardless of rank) are empowered to influence change requires a shift in organizational culture. If the culture of the organization continues to diminish change initiatives coming from lower or middle managers, the organization will repeatedly fail to successfully implement change (Benson, 2016; Formosa, 2015; Stephenson, 2016; Tarriff, 2014). Therefore, this study recommends and suggests that healthcare leaders create a culture for their organizations that support healthcare teams (Birkin, 2014; Formosa, 2015; et al., 2014). This type of support would include an environment where team members are given opportunities to be innovative and to partake in departmental and organizational problem-solving.

Future Research

Opportunities for future research are recommended based on the findings and implications of this study. The initial intent of this study was to focus on change in military healthcare facilities, but when seeking the final steps for site approval the military facility selected declined participation in the study. Therefore, the researchers changed the focus of the study from a change in military healthcare facilities to a change in healthcare facilities due to time limitations. One common factor, outside of the requirements for the study, was that the majority of the participants worked in government healthcare. The findings of this study and historical data reveal that change in healthcare settings is challenging. It is recommended that future researcher conduct site-specific studies within government healthcare facilities to identify the barrier to organizational change. Additionally, it is recommended that future studies incorporate how military rank structure further affects the change process and begin to identify best practices on how to create a culture of change that is conducive to healthcare settings.

CONCLUSIONS

This study addressed healthcare leader's ineffective change management practices and how it prevents them from operating as highly reliable organizations. While numerous amounts of studies exist surrounding leadership's role during the change, few focus on the relationship between levels of leadership during times of change. Healthcare leaders are expected to create and maintain highly reliable organizations while experiencing frequent turnover. Therefore, a study conducted on the lived experiences of healthcare professionals during times of change provided insight on how these organizations are able to maintain operations amid the obstacles they face.

While healthcare leaders have an understanding of change management principles, the findings of this study showed that they lack the ability to influence cultural change. Furthermore, the rank system in healthcare was identified as a barrier because it prevented levels of leadership to effectively work through change initiatives. Therefore, healthcare leaders are encouraged to create a culture for their organizations that support healthcare teams.

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